B.C.'s Mental Health Reform

INPATIENT / OUTPATIENT SERVICES

BEST PRACTICES

Ministry of Health and Ministry Responsible for Seniors
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
B.C.'s MENTAL HEALTH REFORM
BEST PRACTICES FOR
INPATIENT/OUTPATIENT SERVICES

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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

The report of the Inpatient/Outpatient Services Best Practices Working Group includes six sections, which cover a large range of inpatient and outpatient services. These sections underscore both what is good about what we already have in British Columbia and what we most clearly need to improve.

Integration

Mental health services are best delivered in an integrated system. Hospital and community services should be unified into a single system within a local mental health area. A number of regions in British Columbia are integrating their mental health services. The models that have been developed include both common elements and variations.

Variety in the spectrum of services is often a better goal for new funding than is enhancement of existing services in a discontinuous system. Following the principle of least-restrictive treatments, the current system needs attention to certain under-supported forms of service, such as partial hospitalization, acute home treatment, assertive community treatment and outpatient electroconvulsive therapy (ECT) for geriatric patients. Far from being a threat to general inpatient beds, continuity in the spectrum of service delivery is necessary to protect these beds for their most appropriate purposes.

In addition, mental health systems work better in a particular geographical area when a centralized intake function is in place, with appropriate administrative and high-level clinical support.

Inpatient services

General inpatient program

The general inpatient program applies to all patients requiring psychiatric care who do not meet admission criteria for other specialized units (e.g., Psychiatric Intensive Care, adolescent, geriatric). All inpatient programs should be designated to admit involuntary patients under the Mental Health Act.

The general inpatient program provides concurrent, multidisciplinary assessment and treatment for people with psychiatric disorders as one component of a continuum of care. Characteristics of the inpatient program for a specific community will be heavily dependent on the other services and programs available in the community.
Other patient populations that present special challenges in a general unit include those with eating disorders, head injuries and mental handicaps, as well as forensic patients.

Once patients can be managed in a less restrictive environment, they are discharged, unless it can be demonstrated that remaining in hospital leads to a better clinical outcome.

**Psychiatric Intensive Care**

The Psychiatric Intensive Care Unit (PICU) is a secure (locked) unit for patients requiring the highest level of observation and containment. Ideally, there should be at least one PICU for each region and protocols for admitting patients from other hospitals.

The PICU is intended to provide optimal clinical assessment and treatment of the most severely ill and aggressive patients, while preventing harm to themselves and others in a secure environment, until sufficient improvement has occurred to allow transfer to the general inpatient unit. The PICU generally includes the option of locked room within a locked unit and allows for greater mobility and socialization of confined patients than seclusion rooms.

Each region should have a Psychiatric Intensive Care Unit. Specialized units are required for adolescents and for geriatrics in acute care. Comprehensive treatment programs, including access to dedicated beds, are required for eating disorders and for mentally handicapped psychiatric patients.

**Adolescent inpatient unit**

Adult psychiatric inpatient units are not ideal for children and adolescents. Each health region therefore needs a residential assessment and treatment unit exclusively for adolescents and with programming specifically tailored to their developmental needs.

**Adolescent residential treatment**

Because there are very few segregated inpatient services for children or adolescents in British Columbia, particularly outside the Lower Mainland and Victoria, the working group believes it would be premature to describe a detailed best practices model for adolescent residential treatment.

**Geriatrics**

It is desirable to have a specialized unit, designed and staffed for the geriatric patient population, rather than mixing it with others. However, if there is a need to mix inpatient beds with another program in order to have a viable unit, geriatric medicine is preferable to most adult psychiatry because of the frail nature of this population.
Outpatient services

There is no single detailed description of best practices for psychiatric outpatients. However, some principles can be identified:

- A system is needed for prioritizing referrals.
- Urgent referrals should be seen within 72 hours, others within 10 days.
- Where possible, group therapy should be emphasized. (There is evidence that the outcome from group therapy for the majority of clients is as good as from individual treatment.)
- Best practice outpatient treatment may include short-term active case management and/or short-term psychotherapy, for cases that are serious but not persistent.
- Providing marital and family counselling may serve a preventive purpose and reduce the need for further service.
- More awareness of the importance of vigilance for possible first-break symptoms is needed.

Any treatment program should be describable and defensible in terms of its evidence base. In addition, every part of the mental health service should have a quality assurance program.

Other services in the continuum of care

Partial hospitalization
Partial hospitalization includes day hospitals, day treatment, and day care. Partial hospitalization should not be compared with day hospitalization, but with intensive outpatient interventions.

Potential advantages of this approach include:
- potential to be consistent with best practices, in that they offer less restrictive environments than do inpatient programs
- better maintenance of autonomy and links with community
- reduced risk of institutionalization
- possibly lower overall treatment costs.

Acute home treatment
Acute home treatment is an effective alternative to hospitalization for acute psychiatric illness and can reduce LOS for necessary admissions. Acute care is provided in the home for a limited period to treat acute psychiatric symptoms that would otherwise require inpatient treatment.
An estimated 40 to 60 per cent of consumers currently admitted to acute psychiatric beds could be treated at home by trained, experienced nurses and other mental health clinicians. Acute home treatment provides a less restrictive, more cost-effective treatment setting than an inpatient psychiatry unit. Good clinical outcomes have been demonstrated with schizophrenia, major affective disorders, other acute psychoses and personality disorders. Families report decreased care burdens. Both clients and families report satisfaction with, and preference for, home treatment.

Tertiary services
In this context, “tertiary” means specialized and long-term services. The goal of mental health tertiary services is to support the primary and secondary mental health system by providing:
- consultation
- education
- outreach services to secondary units
- acceptance of challenging patients from secondary units
- assistance in follow-up of discharged tertiary patients to secondary units
- research and dissemination of results to secondary units
- teaching of undergraduate and graduate students.

To date, tertiary services have developed unsystematically, with different terms of reference, funding bases, organizational affiliations, emphasis on service or research, etc. A systematic examination of the role, function and governance of these services is needed, with a view to providing some standardization and coordination. Recommended areas for provincial tertiary services include:
- eating disorders
- mood disorders
- refractory psychosis
- anxiety disorders
- early psychosis
- personality disorders
- mental handicap and psychiatric disorders
- neuropsychiatry
- substance abuse and psychiatric disorders
- disorders of the elderly
- child/youth disorders.
Shared care

Family physicians see a great many people with mental health problems, including high-acuity problems. The family physician plays a critical role in the early recognition, treatment and/or referral and follow-up management of clients with mental disorders. Fifty per cent of people with mental disorders requiring mental health care receive that care primarily from their family physician.

Shared-care models allow for improvements in the expert support available to family physicians. “Shared care” refers to collaborative activities between family physicians and psychiatric services designed to improve mental health care for consumers by:

- improving communication and working relationships between psychiatrists/services and local family physicians
- establishing liaison relationships between psychiatrists/services and local family physicians
- integrating psychiatrists or other mental health clinicians into primary care offices.
1. INTRODUCTION

Within the general array of programs and organizations that deliver inpatient and outpatient care, practice undoubtedly varies, and there is much to learn from improvements and effective innovations. The material presented by this working group is organized into six sections:

- Integration
- Inpatient best practices (including general inpatient program, Psychiatric Intensive Care Unit [PICU], geriatric, adolescents)
- General outpatient best practices
- Other services in the continuum of care (partial hospitalization and acute home treatment)
- Tertiary programs
- Shared care (linking family physicians with mental health specialists).

These six sections, which cover a large range of treatments, were identified as suitable to underscore both what is good about what we already have in British Columbia and what we most clearly need to improve.

1.1 Key principles

When reading the six sections that follow, it may be helpful to consider the following eight key principles:

Integration
Mental health services are best delivered in an integrated system. Hospital and community services should be unified into a single system within a local mental health area. Child and adolescent mental health services should belong in the Ministry of Health and health authorities. Dually diagnosed patients, with both alcohol/drug and mental health problems, should be treated within the Ministry of Health mental health system.

Centralized intake
Mental health systems work better in a particular geographical area when a centralized intake function is in place, with appropriate administrative and high-level clinical support. Accessibility is improved. Wait lists and exclusion criteria face the challenge of regular external scrutiny.
Shared care with family physicians

Family physicians see a great many people with mental health problems, including high-acuity problems. Shared-care models allow for improvements in the expert support available to family physicians. For patients who do receive treatment from mental health services, mental health services must improve their communications to family physicians.

Early intervention

Delays in treatment have negative consequences. “Early intervention” can be construed in three useful ways: public education about mental health problems; early treatment of potentially chronic patients; and the promotion of accessibility as a key value underlying mental health services. Urgent short-term follow-up services, for the most acute and complex cases that can be treated on an outpatient basis, should be regarded as a core service in each region.

Continuum of care

Variety in the spectrum of services is often a better goal for new funding than is enhancement of existing services in a discontinuous system. Following the principle of least-restrictive treatments, the current system needs attention to certain under-supported forms of service, such as partial hospitalization, acute home treatment, assertive community treatment and outpatient electroconvulsive therapy (ECT) for geriatric patients. The literature includes clear implications for program planning in such forms of service. Far from being a threat to general inpatient beds, continuity in the spectrum of service delivery is necessary to protect these beds for their most appropriate purposes.

Specialized units

Each region should have a Psychiatric Intensive Care Unit. Specialized units are required for adolescents and for geriatrics in acute care. Comprehensive treatment programs, including access to dedicated beds, are required for eating disorders and for mentally handicapped psychiatric patients.

Utilization management

Active utilization management processes should be designed into mental health systems, including outpatient services.

Quality assurance

Every integrated mental health system should have a quality assurance program.
1.2 Key concepts

Best practice means that mental health programs and initiatives for care are based on evidence that they will achieve the outcomes government, clinicians and consumers want, specifically:

- reduction of symptoms
- decreased use of more intrusive and/or more costly services
- improved functioning in various areas of clients’ lives
- enhanced quality of clients’ and their families’ lives, and
- consumer and provider satisfaction with mental health services.

Evidence on which to base program design and clinical care is available from different sources and in different forms. Common sources include clinical trials, consumer reference groups, outcomes research and evaluation, expert consensus and, finally, clinical practice guidelines (CPGs). The purpose of CPGs is to bridge the gap between producers of health care research and the providers who wish to use that research in their clinical decision making and care. Effective guidelines promote informed decision making by providers and clients and are flexible enough to allow both groups some choices in individualizing care. They reduce the variance between practice known to be effective according to the best evidence available and the actual practice taking place. This can promote:

- better outcomes for clients
- decreased utilization of health care services, and
- decreased health care costs.

Common barriers to implementing best practice guidelines may include the association of guidelines with cost cutting or rationing of services or with attempts to control clinicians’ practice. Clinicians and consumers may not realize that the usual care and programs being provided are in fact sub-optimal and so may not spontaneously see the need for CPGs.

Implementing best practices in the form of CPGs or other guidelines will involve planning by a multidisciplinary team, because the best practice for most clinical conditions depends on coordinated care from a variety of disciplines. Implementing best practices requires adapting guidelines and tailoring strategies to the local setting and to factors such as client populations and resources.

CPGs are only one option for improving the quality of care. They are useful where clinicians are unsure about the best practice, when scientific evidence can provide the answer, and when resources to carry out the CPG recommendations are available. Implementing best practices in mental health services in British Columbia involves more than specifying what best practice is. Where clinicians already know what best practice is, the system will need to focus its attention on identifying the specific barriers beyond knowledge that are preventing clinicians from providing that best practice.
Finally, implementation of best practice guidelines cannot be optimally effective in providing better mental health services for British Columbians unless those guidelines are broken down into understandable, measurable criteria and targets for quality improvement.

1.3 Key terms

Clinical trials: Research studies that compare clients receiving one treatment with another “identical” diagnostic group receiving a different treatment (e.g., drug therapies).

Consumer feedback/evaluations: Clients’ and families’ perceptions of what works.

Outcomes research: Tracking and measuring the relationships among program; treatment interventions and client outcomes; and health care costs.

Expert consensus: Acknowledged experts engage in a structured process including consideration of the sources cited above and reach consensus recommendations.

Clinical practice guidelines (CPGs): Summaries of evidence about best practice developed through a systematic analysis of the best scientific evidence available and agreed-on recommendations. Practice guidelines are quality improvement tools that can serve both to support decisions about practice and as benchmarks for measuring practice. When followed, CPGs are very effective in reducing the variance between practice known to be effective according to the best evidence available and the actual practice taking place in a mental health service system.
2. INTEGRATION

*Best Practices in Mental Health Reform* promotes the integration of mental health services across the hospital and community, from both administrative and clinical perspectives. It emphasizes breaking down silos in the funding and management of mental health care, allowing for a broader review of systems issues and consumer needs.

A number of areas in the province are at various stages in the process of integrating mental health services. These include Kelowna, Surrey, the Northern Interior, Central Vancouver Island and the Capital Health Region.

2.1 Goals of integration

The goals of integration from each of the above-noted perspectives are:

**Administrative**
- a single body or authority over the spectrum of mental health services across the hospital and community for a defined area
- a single funding envelope for mental health services within a defined area (i.e., inpatient psychiatric services, psychiatric day and outpatient services, psychiatric facilities and community mental health programs)
- the redistribution of resources to where they are most needed
- information systems for planning service and monitoring performance
- a central point of entry for referral/intake into the mental health system
- housing and bed registries to monitor availability
- collaboration with other ministries/services serving mental health clients (e.g., the Ministry for Children and Families, the Ministry of Social Development and Economic Security, Continuing Care Division of the Ministry of Health).

**Clinical**
- easier access to the mental health system for clients, families and referring agencies
- the implementation and coordination of crisis response systems
- the provision of outreach services and other case finding methods
- case management across the spectrum of mental health services
- improved continuity of care within a seamless continuum of mental health services
- a decrease in both duplication and fragmentation of service
- the electronic transfer of clinical data
- improved communication among the various components of the mental health system
- shorter periods of hospitalization
- collaboration with primary care physicians
- increased engagement of the target population
- better communication with consumers and family members.

### 2.2 Access criteria

Integration emphasizes simplifying and expediting access to the various components of the mental health system. Each component of the system should have clear admission and discharge/transfer criteria that are explicit and known to the other components of the system, as well as the various referral sources. It is strongly recommended that entry into the system be through some form of central intake. Examples of central intake exist in the areas noted above.

The following table outlines the main functions and standards of an integrated mental health service delivery system:

<table>
<thead>
<tr>
<th>Functions</th>
<th>Standards</th>
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<tbody>
<tr>
<td>Easier access into the mental health system</td>
<td>• A central intake system will be developed for each defined mental health service area.</td>
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<tr>
<td></td>
<td>• Screening by structured telephone conversation or face-to-face interview will occur within 24 hours of referral.</td>
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<td></td>
<td>• Every effort will be made to provide for early intervention.</td>
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<tr>
<td>Implementation and coordination of a crisis response system</td>
<td>• Mental health services in each defined area will have a range of crisis response services based primarily within the community.</td>
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<td>• Urgent cases will be seen within 72 hours from the time of referral.</td>
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<td>• Hospital emergency staff will be trained in the provision of mental health care.</td>
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<tr>
<td>Provision of outreach services and other case finding methods</td>
<td>• Where possible, and when it clinically makes sense, service will be delivered where the client is situated.</td>
</tr>
<tr>
<td>Case management across the spectrum of mental health services</td>
<td>• Each client will have a case manager assigned in a timely fashion, who will follow them no matter where they are receiving service within the system.</td>
</tr>
</tbody>
</table>

Inpatient/Outpatient Services
<table>
<thead>
<tr>
<th>Functions</th>
<th>Standards</th>
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</table>
| Improved continuity of care within a seamless continuum of mental health services | • Clients will be registered with a central registry for the mental health service, so their whereabouts within the system will be easy to determine.  
• Clinical data will follow clients wherever they receive services within the mental health system (ideally, electronically).  
• Each component of the mental health system will have clear admission and transfer criteria that are known to the other components of the system and referral sources.  
• Follow-up will be provided to ensure that clients’ transfer between services has occurred. |
| A decrease in both duplication and fragmentation of service               | • Communication will occur among the various components of the mental health system to ensure that duplication between services provided is minimal, gaps in service are addressed, and continuity is provided between service components. |
| Collaboration with primary care physicians                               | • Primary care physicians will be recognized as having a pivotal role in the mental health care delivery team.  
• Clinical data will be shared with clients’ primary care physicians. |
| Increased engagement of the target population                            | • Clients will be involved in planning for their care across the mental health system.  
• Consumers and family members will be involved in planning, evaluating and, where appropriate, providing mental health services. |
| Better communication with consumers and family members                  | • Timely communication will occur with clients and their family members about planning care.  
• Education will be provided to consumers and family members on mental health promotion/prevention, early intervention, diagnosis and treatment.  
• Consumers and family members will be kept informed of changes to the care delivery system. |

### 2.3 Implementation

As noted above, a number of areas within this province are integrating their mental health services. The models that have been developed include both common elements and variations. The health authorities are encouraged to contact these areas directly for examples of their respective integration models.

Some of the barriers to implementing an integrated model of service delivery are:
• collective agreement issues
• lack of trust between hospital and community sectors
• differing “cultures” within hospital and community
Some of the barriers to implementing an integrated model of service delivery are:

- collective agreement issues
- lack of trust between hospital and community sectors
- differing "cultures" within hospital and community
- anxiety on the part of various stakeholders whether integration will in fact improve service delivery.

In addressing these barriers, it is important for management and union representatives to enter into discussions early in the process of moving toward an integrated model, in an attempt to work through contract issues. As more systems are integrating, collective agreement language will likely follow to ease this process. During the integration planning process, it is critical to bring together staff across the hospital and community mental health services, to talk about philosophies of practice, current service provision and changes necessary to move toward a more integrated model. The various stakeholders (i.e., consumers, family members, physicians, staff and other service providers) all need to have input throughout the planning, implementation and evaluation process. They also need to be supported during the implementation phase of integration.

Once the existing systems have been fully implemented and have had the opportunity to evaluate their service, more will be learned about implementing integrated mental health service delivery models.
3. INPATIENT BEST PRACTICES

Psychiatric inpatient programs in general hospitals have a broad mandate. They must provide appropriate, multidisciplinary, biopsychosocial care for all age groups, in a manner consistent with the philosophy of "least restrictive environment," while meeting the specific requirements of the Mental Health Act as designated facilities. The best practices described in this document are only feasible where the inpatient program is one component of a continuum of care.

3.1 General inpatient program

Program description

The general inpatient program encompasses all patients requiring psychiatric care who do not meet admission criteria for other specialized units such as Psychiatric Intensive Care (PICU), adolescent and geriatric. In most community hospitals, this will be the only inpatient unit. Other patient populations who present special challenges to management on a general unit include those with eating disorders, head injuries, forensic issues and the mentally handicapped. Apart from crisis intervention, stabilization and initiation of treatment, patients with eating disorders are best dealt with in a specialized program. A general psychiatric unit without a dedicated treatment team for eating disorders is not the place for more extensive intervention. Likewise, patients with head injuries can be assessed and treatment initiated to assist with behavioral control either on the general unit or in the PICU; but these units are not well designed for more extended treatment of these patients. Forensic patients are appropriate as long as the security required is compatible with normal unit policies and the patients have psychiatric conditions consistent with the admitting criteria for the unit. An admission to a general inpatient psychiatric unit is not appropriate for a court ordered forensic assessment. This should be done at a specialized forensic centre. Patients with mental handicaps can be dealt with on a general unit, providing there are appropriately trained and interested staff (including psychiatrists) and, preferably, a specialized outpatient team as well.

In general, the more severe the patient’s mental handicap, the greater the difficulty meeting their needs on a general unit. At present, there are insufficient inpatient programs for these patient groups in British Columbia and they tend to be concentrated in the Lower Mainland rather than geographically distributed.

The general inpatient unit provides concurrent, multidisciplinary assessment and treatment to people with psychiatric disorders as one component of a continuum of care. The characteristics of the inpatient program for a specific community will be heavily dependent on the other services and programs available in that community.
When a full continuum of care and all the other best practices outlined here are present, it is likely that fewer beds per 100,000 population, shorter average length of stay (ALOS) and lower bed utilization rates will be necessary, other variables being equal.

Historical systemic barriers to achieving these targets include:

- admitting and treating privileges for psychiatric beds not limited to psychiatrists
- no active bed utilization management process
- insufficient number of group homes, extended care beds, crisis beds, supportive recovery homes, personal care homes and other residential alternatives to hospitals
- difficulty accessing psychiatric consultation and outpatient treatment of all types, including assertive case management
- lack of administrative integration between various components of the system (i.e., hospitals, mental health centres, alcohol and drug services, child and adolescent services, continuing care, private psychiatry and various community counselling services).

**Goals and objectives**

The general psychiatric inpatient unit is intended to provide optimal biopsychosocial clinical assessment and treatment and to meet the requirements of the *Mental Health Act* while providing services in the least restrictive environment necessary. The goal is to make “sick” people less “sick,” not necessarily “well.” Once they can be managed in a less restrictive environment, they are discharged unless it can be demonstrated that remaining in hospital leads to a better clinical outcome.

Best practices in this area will contribute to reducing hospital ALOS and hospital bed utilization rates. This is to be achieved by utilizing more active management of available resources and creating a broader array of assessment, treatment and residential options within an integrated mental health system.

**Access criteria**

Inpatient programs should have admission and discharge criteria that reflect the overall goals of the integrated mental health system and differentiate them from other elements of the continuum. Active management of the program requires a process for regular review of admissions, inpatient goals and discharge planning. Weekly multidisciplinary team conferences allow all members of the treatment team to review their goals with each patient, to plan discharge, to coordinate follow-up and to ensure appropriate communication of plans to the patient and family. An admission and discharge checklist has been found by some to aid the consistent completion of all necessary tasks.

A bed utilization committee is recommended to ensure that admissions are appropriate, that discharge plans are in place and that there are no systemic obstacles to the achievement of these plans. Composition might include representatives of several
disciplines, some of whom have administrative authority for the unit and who collectively have some knowledge of the treatment and discharge plans for most patients in the unit. Their deliberations will be guided by knowledge of the “serious and persistent” guidelines of the British Columbia mental health plan and by various available practice guidelines.

**Standards**

The following are suggested best practice standards. This list is intended to highlight certain areas that may be controversial or not yet widely in practice, rather than provide a complete list of all relevant standards involved in hospital care. There is/are:

1. A medical director who is a psychiatrist.
2. A psychiatrist on call at all times.
3. A patient care coordinator/manager.
4. A multidisciplinary team with representatives from psychiatry, nursing, family practice, social work, occupational therapy and psychology.
5. Availability of a full range of psychiatric treatment, including ECT and those pharmaceutical agents approved by the local Department of Psychiatry and Medical Advisory Committee.
6. A multidisciplinary clinical services committee to review and develop clinical protocols, policies and practices.
7. A core inpatient treatment program that includes educating patients about their psychiatric diagnosis and treatment, an activity program, community meeting and other group programs recommended by the multidisciplinary clinical services committee.
8. A non-smoking environment with nicotine replacement available to patients who are unable to leave hospital to smoke.
9. A majority (90 per cent) of single occupancy rooms, the remainder double occupancy.
10. Policies on levels of observation, suicide prevention, use of restraint.
11. A quality improvement program.
12. A multidisciplinary bed utilization management committee.
13. No waiting period for admission.
14. A pre-discharge meeting between the patient and outpatient case manager/counsellor, when requested by the attending psychiatrist.
15. An outpatient follow-up appointment scheduled at the time of discharge.
16. An outpatient follow-up available within one week.
17. Continuing care provided by the patient’s family physician during admission in collaboration with the psychiatric attending physician.
18. Encouragement of family physicians to participate in multidisciplinary clinical rounds including their patients.

19. Electronic records accessible by care team in and out of hospital.

20. Resources necessary to support the inpatient goals and objectives:
   - partial hospitalization
   - psychiatric follow-up
   - psychiatric consultation-liaison service to medical and surgical inpatient units
   - family physicians who have additional psychiatric training, where psychiatric manpower is insufficient
   - crisis response system
   - assertive case management
   - mental health group homes (licensed or unlicensed)
   - supportive recovery homes
   - home care
   - family physician
   - support groups
   - counselling services, group and individual
   - extended/long-term care facilities
   - crisis housing
   - advocacy services
   - educational and vocational rehabilitation services
   - central intake for outpatient referrals.

Standards governing the physical design characteristics of inpatient units are largely beyond the scope of this paper. There is a consensus, however, that inpatient units need to be purpose built with patient safety in mind. Ground floor location with outdoor access is preferred and suicide prevention design considerations (to reduce the possibility of death or injury by hanging, jumping, stabbing, cutting and asphyxiation) are extremely important. General units should be unlocked and have at least one seclusion room that can be locked. Single seclusion rooms should not be included in the bed census, so they can be used for the very short term without the possibility of having to prolong a patient’s confinement, just because there is no alternate bed available. As the number of beds increases, so will the need for additional seclusion rooms. Where possible, seclusion rooms should be replaced by a PICU which includes a locked common area as well as lockable rooms.
3.2 Psychiatric intensive care

Program description
The Psychiatric Intensive Care Unit (PICU) is a secure (locked) unit for patients requiring the highest level of observation and containment. All patients in this unit will be certified under the Mental Health Act, but not all certified patients require intensive care. These may be patients at high risk for harming themselves, harming others or elopement, or patients who would be disruptive on the general inpatient ward. Any involuntary patient requiring constant observation would be appropriate for this unit.

The PICU is to be distinguished from a simple seclusion room or rooms. The PICU generally includes the option of locked rooms within a locked unit and allows for greater mobility and socialization of confined patients than seclusion rooms.

Examples of non-tertiary PICUs in British Columbia are Victoria, Surrey, Prince George, Kelowna and Vancouver General Hospital.

Historical systemic barriers to achieving these targets include:
- lack of physical facilities
- lack of funding
- lack of awareness of the need.

Goals and objectives
The PICU is intended to provide optimal clinical assessment and treatment of the most severely ill and aggressive patients, while preventing harm to themselves and others in a secure environment until sufficient improvement has occurred to allow transfer to the General Inpatient Unit.

Best practices in this area will contribute to reducing hospital suicides, elopements, abuse of staff and patients, injuries to staff and patients, hospital ALOS and hospital bed utilization rates.

Access criteria
Inpatient programs should have admission and discharge criteria that reflect the overall goals of the integrated mental health system. Active management of the program requires a process for regular review of admissions, achievement of inpatient goals and discharge planning. Weekly multidisciplinary team conferences allow all members of the treatment team to review their goals with each patient, to plan discharge, to coordinate follow-up and to ensure appropriate communication of plans to the patient and family. An admission and discharge checklist has been found by some to aid the consistent completion of all necessary tasks.
We recommend a bed utilization committee to ensure that admissions are appropriate, that discharge plans are in place and that there are no systemic obstacles to the achievement of these plans. Composition might include representatives of several disciplines, some of whom have administrative authority for the unit, and who collectively have some knowledge of the treatment and discharge plans for most patients in the unit. Their deliberations will be guided by knowledge of the “serious and persistent” guidelines of the British Columbia mental health plan and by various available practice guidelines.

In addition to the access criteria for the general inpatient unit (italicized above), the PICU requires certification under the Mental Health Act and daily review of treatment plans by the psychiatrist and treatment team.

Ideally, there should be at least one PICU for each region and protocols for admitting patients from other hospitals. Patients transferred from other hospitals should be transferred back to the hospital of origin as soon as PICU is no longer necessary, in order to preserve continuity of care and to optimize discharge planning in their community of origin.

Standards

The following are selected best practice standards. There is/are:

1. A medical director who is a psychiatrist.
2. A psychiatrist on call at all times.
3. A patient care coordinator/manager.
4. A multidisciplinary team with representatives from psychiatry, nursing, family practice, social work, occupational therapy and psychology.
5. Availability of a full range of psychiatric treatment, including ECT and those pharmaceutical agents approved by the local Department of Psychiatry and Medical Advisory Committee.
6. A multidisciplinary clinical services committee to review and develop clinical protocols, policies and practices.
7. Education of patients about their psychiatric diagnosis and treatment.
8. A non-smoking environment, with nicotine replacement available to patients who are unable to leave hospital to smoke.
10. Policies on levels of observation, suicide prevention, use of restraint.
11. A quality improvement program.
12. A multidisciplinary bed utilization management committee.
14. No waiting period for admission.
15. Protocols for admission from other hospitals.
16. Protocols for transfer to other hospitals.
17. Continuing care by the patient’s family physician during admission, in collaboration with the psychiatric attending physician.
18. Electronic records accessible by the care team in and out of hospital.
19. Appropriate physical design characteristics—Although all psychiatric units have special physical design requirements, these are especially important in the PICU. It is a locked unit and each room is lockable. All rooms are single and provide for unobstructed video observation of the occupant from the nursing station. Windows, walls, doors and everything in the room are unbreakable and cannot be dismantled. There are no protuberances from which patients could hang themselves and no sharp edges on which patients could harm themselves. At least some of the rooms include toilet facilities within the room. These require shut-off valves that can be accessed from outside the locked room and are designed to reduce risk—i.e., not enough water in the toilet bowl to drown.
20. Experienced trained staff: Staff in this unit are among the most experienced psychiatric staff and have special training in dealing with aggressive patients, in physical restraint techniques and in avoiding conflict and confrontation with psychotic patients. There are protocols for dealing with assaultive behavior, physical restraint and suicide prevention.
21. Very short ALOS—In keeping with the least restrictive environment philosophy, the ALOS for this unit is very short. Patients are reintegrated on the general unit as soon as their behavior permits. Patients requiring long periods of confinement should be considered for transfer to a tertiary facility because, in most cases, these units are more spacious and in that sense less restrictive.

3.3 Adolescent inpatient unit

Program description
Adult psychiatric inpatient units are not ideal for children and adolescents. Each health region needs a residential assessment and treatment unit exclusive to adolescents and with programming specifically tailored to their developmental needs.

3.4 Adolescent residential treatment

The inpatient treatment of children and adolescents is the mandate of the Ministry of Health, even through the outpatient services for the same population are the mandate of
the Ministry for Children and Families. It would be preferable to have the full range of health services for the entire age spectrum under the Ministry of Health. There are very few segregated inpatient services for children or adolescents in British Columbia, particularly outside the Lower Mainland and Victoria. For this reason, we think it is premature to describe a detailed best-practices model for adolescent residential treatment. We are prepared to make the following few recommendations:

- Adolescent inpatients are best treated in a setting separate from the adult inpatient units.
- Adolescent units should be distributed throughout the province, where population permits.
- These units do not have to be in an acute-care hospital and preferably would have a more residential atmosphere than a traditional acute-care hospital.
- The admission criteria should be consistent with the priorities of the British Columbia mental health plan.
- Services should be coordinated with those of the Ministry for Children and Families.
- Inpatient or residential adolescent units should be part of a spectrum of care to be used in a “least restrictive” manner.

3.5 Geriatrics

It is desirable to have a specialized unit, designed and staffed for this patient population, rather than mixing this patient population with others. If there is a need to mix inpatient beds with another program in order to have a viable unit, geriatric medicine is preferable to most adult psychiatry because of the frail nature of this population.

Program description

Patient population

- complex, co-morbid—combining two or more conditions: psychiatric (dementia and depression) or medical/psychiatric (Parkinson’s/delirium)—often have complicating chronic medical conditions that need ongoing medical care
- frailty
- generally over 65 years of age with a psychiatric disorder that meets the criteria specified in DSM IV. The disorder is:
  - a psychiatric illness arising in later life
  - a psychiatric illness first arising in the adult years, but continuing into later life
  - results from neuro-degenerative disease arising in the pre-senile or geriatric age range, for example:
    - depression
- a psychiatric illness arising in later life
- a psychiatric illness first arising in the adult years, but continuing into later life
- results from neuro-degenerative disease arising in the pre-senile or geriatric age range, for example:
  - depression
  - dementia with psych overlay—agitation, aggression
  - delirium
  - movement disorders—Parkinson’s
  - behavioral disorder—importuning, sexual inappropriateness, aggression, agitation
  - psychosis
  - substance abuse

**Principles**

- multidisciplinary team requiring specialist training—geriatric psychiatrist, nursing, neuropsychiatry
- biopsychosocial environmental model
- case management (GP, LTC, MH) to follow the patient through the system
- critical mass of patients/beds, to ensure critical mass of specialized staff and expertise
- seamless system from community to hospital
- integrated hospital and community
- integrated with geriatric medicine in acute care
- program located in an acute hospital setting, with anesthesia and access to a variety of subspecialties
- ability to certify
- inpatient unit is one component of a comprehensive and coordinated program, rather than a stand-alone unit

**Hospital components**

- inpatient
- outpatient clinic—geri-psychiatrist (assessment and follow-up)
- ECT—inpatient and outpatient
- consultation and liaison to other acute units
- teaching of medical, nursing and other students
- education and consultation to nurses in long-term care facilities and other hospital units
• mental health teams
• GPs
• psychiatrists in private practice
• LTC/ECU beds
• home-based treatment (outreach)
• day programs
• alternative housing, residential and support

**Integrated components**

• follow-up care—GP, psychiatrist or mental health team
• joint educational rounds
• joint care rounds
• integrated with LTC/ECU
• centralized intake (need for differentiation of various components, so when and where to refer is clear)
• outreach—community, home and LTC facilities
• joint utilization rounds (Kelowna)

**Examples of best practices**

• Geriatric Psychiatric Outreach Team—Vancouver General Hospital
• Capital Region—Eric Martin Pavilion
• St. Vincent’s Hospital

**Historical systemic barriers to best-practice models**

• different staffing models, community and hospital—generic vs. discipline-specific
• transfer of information, confidentiality issues, complete and accurate information
• follow-up care recommendations often not adhered to
• not enough education of multidisciplinary team (e.g., GPs, nursing in other acute inpatient units and LTC facilities) to know when to refer; depressed residents in LTC often not identified, only aggressive residents
• lack of emergency services specifically for the elderly
• lack of acceptance/availability of ECT
• ageism—reluctance to treat the elderly
• lack of LTC/ECU beds in the community
• community facilities close the door when a patient is transferred to an acute-care bed

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Community components

- mental health teams
- GPs
- psychiatrists in private practice
- LTC/ECU beds
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• lack of LTC/ECU beds in the community
• community facilities close the door when a patient is transferred to an acute-care bed
• barriers to discharge—care plan not transportable, staffing levels and policies (e.g., no restraint) of LTC facilities
• lack of/minimal access to diagnostic testing on an outpatient basis (e.g., CT scan, MRI)
• collective agreements impede integration

Goals and objectives
• assessment, diagnosis and treatment; development of a practical/workable treatment plan
• discharge to place of residence—home, LTC
• evaluation of outcomes
• education of providers and families

Access criteria
There is a need to differentiate between secondary and tertiary geriatric psychiatry units. Both have specialized multidisciplinary assessment (e.g., nursing, psychiatry, neuropsychology, specialized medicine, rehabilitation therapy, radiology, laboratory).

Secondary geriatric psychiatry—Regional resource
• transfers from other hospitals in the region
• admissions from LTC/ECU facilities in the region, after community resources have failed
• those who cannot be successfully treated in a secondary inpatient unit may be referred to tertiary inpatient
• admission through an emergency department, referred by a GP and screened by a psychiatrist

Tertiary geriatric psychiatry—Provincial resource
• high degree of complexity and co-morbidity
• academic (research)

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• support to secondary geriatric services mental health team and acute psychiatric units
• waitlisted (not admitted through emergency)
• transferred from other acute psychiatric units

a) **Eligibility criteria for client placement in inpatient unit**

• patient requires specialized diagnosis and treatment in an inpatient setting
• residential facilities unable to cope despite adequate community support
• agreement to return patient to their place of residence after inpatient treatment—acute care, LTC, ECU or home

• **Excludes:**
  • those suitable for treatment in a general psychiatric unit
  • healthy schizophrenics over 65
  • elderly depressed patients not complex/co-morbid, not requiring specialized treatment
  • patients who are acutely medically or surgically ill, who would normally be admitted through emergency into an ICU, acute medical or surgical bed (e.g., exhibiting delirium)

b) **Screening and assessment tools available to assist client placement**

• nursing assessment tools: Geri-Snap—SABRE, sleep chart, movement chart
• physician assessment (e.g., MMSE/3MS, HAM – D/HAM–G, ADAS–COG AIMS, CGI [under review])
• ADL/IADL—Barthol

**Discharge criteria**

• improvement in assessment tools (e.g., Geri-Snap)
• workable treatment plan
• treatable component treated/treatment plan successful and can be continued on an outpatient basis, discharge planning complete—community resources set up

**Procedures to ensure continuity of care when clients are discharged from service**

• transferral of information to referral sources—discharge checklists (Kelowna/ St. Vincent’s)
• consults, lab, nursing-care plan, discharge summary, etc.
Standards

Staffing standards: Inpatient—closed unit

- sufficient beds to ensure critical mass of staff and expertise
- geriatric psychiatrist—average of one session per bed per week, 24-hour on-call coverage by a psychiatrist
- intake nurse
- nurse clinician for education and consultation, CNS shared community/hospital/LTC
- nurses with specialized training in geriatric psychiatry
- safe environment—century tub, dining room, lounge, ability to secure the unit for wandering patients
- OT, ADL, safety assessments and home visits
- PT—chest physio, falls protocol
- SW—discharge planning, link with referring facilities
- pharmacy, pastoral care and clinical nutrition staff
- GP to follow up with medical care
- access to consults—anesthesia, cardiology, neuropsychology, neurology, surgery, geriatrician, etc.
- basic laboratory and radiology
- access to specialized testing—EEG, CT scan, MRI
- access to speech/audiology, ENT, dental, ophthalmology

Utilization standards

Inpatient unit admission and discharge criteria:

- admission—previous attempts to resolve on an outpatient basis have not been successful
- discharge—treatable component treated/treatment plan successful and can be continued on an outpatient basis; discharge planning complete; community resources set up
- ALOS, CHI by CMG, depend upon case mix (e.g., depression with course of ECT—28 days)
- psychiatry utilization tools—Interqual
- RIW—3.0-4.0: (tertiary) based on direct admission to service, not transfer from another service after primary problem resolved
- indicators—case mix, actual to expected length of stay, RIW

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Standards for service linkages: referral, exchange of information, transfer of responsibility for care

Practice is to send all relevant information to and from:

- sending agency—GP/MHT/psychiatrist: reason for/expectations of inpatient admission, copies of admission or discharge summaries, as well as reports of relevant investigations
- Geriatric Inpatient Unit to send discharge summary, relevant lab and radiology reports, all assessment, treatment and discharge plans from OT, PT and dietitian, as well as nursing care plan, assessment tools and nursing transfer summary

Client follow-up

- follow-up by GP for medical issues—by psychiatrist, GP or mental health team for psychiatric issues
- invite community team to care rounds, participation in ward rounds (assessment, diagnosis and treatment plan) and discharge planning
- invite attending GP to participate in discharge planning
- inpatient geriatric psychiatrists often work part-time on the community mental health team

Epidemiology figures:
- prevalence of dementia
- prevalence of psychosis
- prevalence of depression

References

- APA Clinical Practice guidelines, dementia, depression
- CCHSA standards for mental health
- performance indicators for mental health
- CSR—Canadian Consortium of Centres for Clinical Cognitive Research
- Canadian Academy of Geriatric Psychiatry

Staffing standards

Inpatient unit

- sufficient beds to ensure critical mass of expertise
- geriatric psychiatrist—one session per bed per week, 24-hour on-call
- nursing
- nurse clinician for education, consultation, CNS (shared with community) for research
- RN/RPN mix, plus care aide for activities of daily living
- 5.0 nursing care hours (NCHS)
- budget for 1:1 care (aide) suicidal, aggression
- escort to outside tests if the patient’s family cannot take them or if patient’s condition requires it
- safe and secure environment (e.g., ability to secure the unit for wandering patients, restraint, filming of windows)

**Staffing for a 20-bed unit**

- clinician
- days—one RN to four patients, plus one care aide, seven days a week
- unit clerk, Mondays to Fridays
- afternoons—one RN to five patients, plus one care aide (12:00 pm to 8:00 pm), seven days a week
- nights—one RN to 10 patients
- OT, ADL, safety assessments and home visits—1.0 FTEs per 20 beds
- PT—chest physio, falls protocol—one FTE per 20 beds
- pharmacy and clinical nutrition staff
- GP to follow up with medical care—internal (five sessions per 20 beds) for tertiary, or family physician (for secondary) if prepared to follow the patient and work into the schedule (e.g., diagnostic rounds)
- access to specialists for consults—anesthesia, cardiology, neuropsychology, neurology, surgery, geriatrics, etc.
- basic laboratory and radiology
- access to specialized testing—EEG, CT scan, MRI
- intake RN (0.5 for 20 beds)
- outpatient ECT—0.5 RN/RPN for pre- and post-ECT care, for 15 patients per week including home visits
- outreach/home assessment—psychiatrist, RN/RPN with SW/OT/neuropsych back-up
- outpatient—geriropsychiatrist with access to SW, neuropsychiatry as required

Inpatient/Outpatient Services
4. GENERAL OUTPATIENT TREATMENT

4.1 Preamble

People who are referred or who refer themselves for mental health services may require any one of the range of services—crisis intervention, assertive case management, specialized housing, hospitalization, day program, rehabilitation program or outpatient treatment. The importance cannot be overestimated of an effective central intake process to ensure that the client gets prompt service from the appropriate part of the system.

The revised “Adults with Serious Mental Illness—Draft Screening Criteria for Identifying Persons with Highest Priority for Service” defines these diagnostic categories for high priority:

- all schizophrenia and related disorders
- all bipolar disorders
- 20 per cent of major depressive disorders
- 20 per cent of panic and obsessive-compulsive disorders
- 10 per cent of social phobia (co-morbid with avoidant personality disorder)
- 10 per cent of substance-abuse disorders (principally drug dependence).

Although omitted from the above list, people with personality disorders—particularly those in crisis—receive and very much need clinical services. Suitable services for such people would include attention to suicide risk (often in the form of appropriate brief individual therapy) and treatment of chronic difficulties in affect regulation and interpersonal functioning (often in the form of longer-term group therapy).

Dual-diagnosis patients who have co-morbid psychiatric disorders and substance abuse are a particularly underserved group. There is strong evidence, for example, that co-morbid psychiatric/alcohol disorders are stronger predictors of service utilization than a pure alcohol or psychiatric disorder (Wu et al., 1999).

Many cases are serious by their acuity, but not necessarily persistent. Suicidal and/or homicidal ideation, as well as severe situational reactions, can usually be better assessed and treated on an outpatient basis, via central intake screening, diversion and urgent short-term follow-up, than through emergency room and inpatient units. Clinical outcomes are usually better (i.e., less trauma/stigma is added to presenting problems); the risk of institutionalization is reduced; and there is less frustration and cost for both the client and the health-care system.
4.2 Program description

There is no single detailed description of best practice for psychiatric outpatients. The CPA and APA have produced practice guidelines for some conditions (schizophrenia, bipolar illness, OCD, eating disorders) which make reference to outpatient care in the spectrum of care for these conditions.

All the essential components are not identified. This area of practice is the one about which there is likely to be the most controversy over what is and is not best practice and who the target populations should be. There is an inevitable tendency to “upwards drift” (i.e., seeing clients who are compliant and rewarding to work with, but who may not be most in need of service according to the draft criteria).

Essential terms are either vaguely defined or not defined at all, permitting a wide variation in practice. The definitions are clearer for the more severe illnesses and become vaguer for people with depressive disorders, anxiety disorders and situational problems. It is not well defined which people in the diagnostic groups that include clients with “severe and persisting illness” are the ones needing service; and this loophole allows for inclusion of more “rewarding” clients, possibly at the expense of the more impaired. The risk of resources being lost to less urgent cases can be reduced by regular reviews of case loads for cases at or beyond a short-term limit (e.g., 12 sessions); and policy requirements for urgent short-term psychotherapy outpatient services to triage and prioritize according to acuity, risk and viability for short-term treatment. The “front door” of the mental health system (e.g., central intake, emergency rooms and mobile emergency outreach teams) can best be kept open if there are prioritized accountabilities for the transfer of urgent cases. This kind of emphasis in the planning of programs may also be described as an emphasis on the directness of the links between outpatient services and crisis/emergency services.

While there is no specific description of best practice for outpatient treatment, some principles can be identified:

- A system is needed for prioritizing referrals.
- Urgent referrals should be seen within 72 hours, others within 10 days.
- Where possible, group therapy should be emphasized. While clients may prefer individual therapy, there is evidence that -- after appropriate pre-group orientation -- the outcome from group therapy for the majority of clients is as good as from individual treatment. While it is important that clients have choices, group therapy needs to be “sold” as effective and a fair way to make use of scarce resources.
- Such groups include:
  - diagnosis-specific groups
  - medication clinics
  - psycho-educational groups
  - life-skills groups
- crisis intervention groups
- walk-in groups for clients with personality disorders
- dual-diagnosis groups
- consumer groups
- family groups
- support groups

- Best practice outpatient treatment may include short-term active case management (up to 90 days) and/or short-term psychotherapy of one to twelve sessions over several months, for cases that are serious (high acuity or risk) but not persistent.

- While marital and family counselling are not within the mandate of mental health services, providing those services (possibly by contracted agencies) may serve a preventive purpose and reduce need for further (particularly crisis response) service.

- More awareness is needed of the importance of vigilance for possible first-break symptoms.

- Models that may merit further examination for best practice include:
  - the Changeways program
  - the Shared Care concept
  - the literature on brief psychotherapies
  - the CPA position paper on psychotherapies.

- Some of the historic systemic barriers are mentioned above—poor definitions, preference for "rewarding" clients, lack of diagnostic rigor. Others include geographic variations in availability of trained staff, numbers of staff to meet the volume of need, poorly defined intake processes and poor integration of services.

4.3 Goals

- a range of programs in the continuum of care
- new service-delivery models linking family physicians with mental health specialists
- integration between hospital and community treatments

4.4 Access criteria

- As mentioned in the preamble, these are clearer for the more severely ill.
- Screening and assessment tools are available (BPRS, Hamilton Rating Scale, etc.).
• Exit criteria need to be developed, possibly by means of rating scales based on symptoms at entry. Development of exit criteria is an essential element for maintaining accountability.
• Procedures for continuity of care are extremely variable locally.

4.5 Standards
• Any treatment program should be describable and defensible in terms of its evidence base.
• One benchmark for service planning would be demographic (i.e., given a population, how many people would require service?).
• Other available standards are those of the professional bodies of service providers working in mental health.

4.6 Utilization management
• Effective and efficient utilization/distribution of resources needs to be demonstrated.
• Continua of service exist in patchy and locally-variable ways. Linkages of service providers vary.
• Variable mechanisms to determine an appropriate match between intervention and client.
• We do not know whether interventions are directed at the correct target groups (at least for the less ill clients, they probably are not).
• Responsiveness and accessibility of service to the target population are geographically variable.
• Outpatient treatment by itself will not result in case finding.
• Need to develop utilization management protocols for outpatient treatment in the same way they have been for inpatient treatment.

4.7 Quality assurance
• Every part of the mental health service should have a quality assurance (QA) program.
• Certification and accreditation of outpatient programs could be linked to QA initiatives.
• Need to develop ways to determine if system enhancements have closed the gap between knowledge of best practices and actual practice.

• No consensus on a suitable evaluation process for outpatient care in the province.

Adequate QA will cost time and money. Infrastructure and expertise needed to select appropriate measures and analysis of data.
5. NEITHER A BED NOR A WEEKLY OUTPATIENT VISIT: OTHER SERVICES IN THE CONTINUUM OF CARE

5.1 Partial hospitalization

Program description

"Partial hospitalization is an attempt to combine the advantages of intensive treatment with the advantages of keeping individuals in their home environment" (Review of Best Practices in Mental Health Reform, 1997). The term has been used to cover day hospitals, as well as evening, night and weekend programs.

The literature distinguishes between day hospital (for acutely ill patients who would otherwise be inpatients); day treatment (for diverse functions, including specific target groups such as adolescents or substance abusers, or patients in remission from acute illness or in transition from inpatient stays to outpatient treatment); and day care (for chronically disabled patients in longer-term maintenance or rehabilitation). British Columbia examples of each type are:

- Day hospital—McNair Ambulatory Care Program at Kelowna General Hospital
- Day treatment—Adult Day Program I at Burnaby Psychiatric Services; Day Treatment Program at Lions Gate Hospital
- Day care—Adult Day Program II at Burnaby Psychiatric Services; Schizophrenia Rehabilitation Day Program at UBC; Supportive Treatment Program at Lions Gate Hospital; Living and Learning, Skills Training, and Employment Programs at Arbutus Vocational Society

Partial hospitalization programs have the potential to be consistent with best practices, in that they offer less restrictive environments than do inpatient programs. Other potential advantages are better maintenance of autonomy and links with community; reduced risk of institutionalization; and (possibly) lower overall treatment costs (Davidson et al, 1996; Andrews et al, 1999). "For those who can be safely treated in either an inpatient or partial hospital setting, the latter option produces equivalent outcomes in terms of symptom improvement, relapse reduction, and family adjustment" (Hoge et al, 1992, in Andrews et al, 1999).

Some caveats must be stated, to guard against partial hospitalization programs being inaccurately seen as a cheaper way to provide the functions currently performed by general inpatient programs. First, especially when a wide range of psychiatric disorders is receiving services, programs that provide alternatives to inpatient hospitalization should have residential boarding and intensive care services available. Second, the literature that compares partial hospitalization with other forms of service delivery is not fully developed. The combination of mixed diagnostic profiles in single studies is just one of

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the methodological problems that reduces certainty about the value of such programs, which cover a wide range (Piper et al, 1996). Nevertheless, some general conclusions about research findings are possible.

In the Review of Best Practices in Mental Health Reform (1997), the reviewers urge that inpatient care should not be compared with day hospitalization. Rather, day hospital programs should be compared with intensive outpatient interventions. This advice implies that partial hospitalization is most usefully evaluated alongside services that are closest to it in a continuum of care.

Goals and objectives
All three of these program types are designed for people whose needs are greater than can be well met in an outpatient treatment model allowing one visit per week. The general goal of having an array of treatment alternatives to inpatient hospitalization requires that a service delivery system foster the careful development of all three types.

Day hospitals
Such programs can effectively address psychiatric needs while avoiding inpatient care (Breakey, 1996). Overall, the research evidence shows that day hospital programs have direct impacts on social and work-role functioning (Piper et al, 1996). The treatment environment is likely to be less restrictive. Hospital ALOS and bed utilization rates might be reduced, although there are warnings in the literature that LOS may increase over what would have occurred in a standard inpatient unit (Review of Best Practices in Mental Health Reform, 1997). It is recommended that, if day hospital programs are used, their actual effect on ALOS and bed utilization be monitored.

In the literature, the day hospital approach has been commonly described for acutely ill schizophrenic patients or acute decompensations among inpatients with severe personality disorder; there is evidence that mixing psychotic with nonpsychotic patients in the same program has serious adverse effects on treatment outcome (Piper et al, 1996).

Day treatment
In an integrated mental health system including a continuum of care, day treatment should have a place. It is recommended that it be used for carefully chosen groups, such as the tertiary program for severe personality disorders at Vancouver General Hospital (Integrative Personality Program). The literature provides evidence that day treatment appears to be particularly effective “for patients with more severe neurotic disorders or personality disorders of some duration. The patients commonly have a previous history of unsuccessful outpatient treatment” (Piper et al, 1996). For schizophrenics, day treatment can reinforce the continuity of psychiatric care, while also reducing the costly and often inappropriate use of medical services as a form of aftercare (Piper et al, 1996).
Day care
In the Best Practices Review, the carefully-planned transfer of long-stay patients from provincial psychiatric hospitals into alternative care models is described as a key element of best practice. Mental health services research has increased awareness of the critical importance of continuous care rather than episode-based treatment (Offson and Goldman, 1996). In comprehensive trials, a day care approach has been effective “in reducing readmissions and length of rehospitalizations, promoting symptom change, and improving social functioning” (Piper et al., 1996). Many day care patients are older schizophrenics with medical problems. Some day care programs have been criticized for not teaching independent living skills, and not giving support to burdened caregivers; such deficiencies may foster “implacable dependency” (Piper et al., 1996).

Access criteria
Partial hospitalization programs should have admission criteria that reflect the specific goals of the program being considered for the patient. Patients must have appropriate ways of travelling to and from the program. The risks of self-injury or harm to others must not be out of proportion to the scope of treatment resources available. Where supervision and support of patients are required at night, these must be at appropriate levels (Breakey, 1996). Steadily lengthening wait-lists should be regarded as system failures, requiring intervention and renewed attention to the design of the overall system.

Standards
- Programs should be designed to minimize wait-lists. Unless strong clinical rationales are provided, regular intakes into ongoing treatments are preferable to delays allowing sufficient cohorts of suitable patients to accumulate.
- Treatment staff should have the ability to transfer patients to both more and less intensive types of care. Programs should be nested within integrated mental health systems to facilitate service linkages and continuity of care.
- Family physicians should be informed and consulted about intakes, goals and discharges/terminations from treatment.
- Multidisciplinary treatment teams are required, including representatives from psychiatry. Prior training and experience should equip treatment professionals with the conceptual background to undertake intensive work. More intensive programs often require particular attention to team development and continuing education.

Inpatient/Outpatient Services
5.2 Acute home treatment

Program description

Acute home treatment is an effective alternative to acute hospitalization for acute psychiatric illness, and can reduce LOS for necessary admissions. Improvements in psychotropic medications have contributed to clinicians’ growing confidence in acute home treatment. An estimated 40 to 60 per cent of clients currently admitted to acute psychiatric beds could be treated at home by trained, experienced nurses and other mental health clinicians. Acute home treatment provides a less restrictive, more cost-effective treatment setting than an inpatient psychiatry unit; these are key features for a mental health system with the current policy shifts to community treatment, consumer/family satisfaction and fiscal accountability. Good clinical outcomes have been demonstrated with schizophrenia, major affective disorders, other acute psychoses and personality disorders. Families report decreased care burdens. Both clients and families report satisfaction with, and preference for, home treatment. Acute home treatment may be most effective as part of a treatment continuum that includes assertive community treatment, clinical case management, day hospital programming and access to emergency mental health service and crisis/short-stay beds.

The approach must be considered experimental in British Columbia, but worthy of serious consideration. It is discussed in the Review of Best Practices in Mental Health Reform (1997). Acute home treatment is different from a related approach, Assertive Community Treatment; the latter typically involves longer-term care and falls more readily into the scope of another best practices working group. The two approaches do share, however, an emphasis on less restrictive forms of treatment that aim to help the client outside the context of the inpatient ward.

Acute home treatment programs are defined as acute care provided in the home for a limited period to treat acute psychiatric symptoms that would otherwise require inpatient admission. “Home” may also refer to a SIL unit in the community or a residential facility. A multidisciplinary team provides care, working from a partnership model with client and family caregivers. Treatment needs may include crisis response and management of acute symptoms, establishing a medication regime requiring close monitoring and/or education in managing acute illness and medications. Average length of treatment is frequently three to six weeks, with two to three hours of service per day.

Descriptive studies dating back to the 1960s document successful home treatment of a wide range of psychiatric disorders. Knapp et al. (1999) recently described the Daily Living Program operating out of the Maudsley Hospital in London, England. This program offered “intensive home-based care with problem-centered case management for seriously mentally ill people facing crisis admission to the Maudsley Hospital” (page 506). Cost-effectiveness, examined over a four-year period, was reported as modest and declining by the end of the project; but client and family satisfaction and preference for home treatment remained high throughout the four years. The program was based on
assertive community treatment care services developed in the Madison Model (Stein and Test, 1980) and the Sydney Model (Hout et al., 1983).

An early Canadian experience was a British Columbia project, the Vancouver Home Treatment Service Study (Goodacre and Shieldrop, 1972; Goodacre et al., 1975), which compared active home treatment with mental hospital care in Riverview Hospital. Fenton, Tessier and Struening documented their work in Montreal in 1979.

Wasylenski et al. (1997) reported on a successful acute home treatment program for acute psychosis from the Clarke Institute of Psychiatry in Toronto. This program continues to operate and several programs operating out of psychiatric hospitals in Ontario were apparently modelled on the project. The original Clarke project was a joint undertaking by Clarke Psychiatric Services, a community home care nursing service and a community homemaker service. Homecare RNs and community homemakers received training in caring for psychiatric patients.

The home treatment program described as “acute” has been operating out of the University of Alberta and Royal Alexandria Hospital in Edmonton since 1995. Established to prevent nursing staff layoffs when an inpatient psychiatry unit closed, the program employs psychiatric RNs and RPNs to provide cost-effective care for a diversity of mental health clients in crisis. The program borrows from the Sydney Model (Hout et al., 1983). Hibbard and Bahry reported on the program at the Canadian Psychiatric Association Meetings in 1998, but results have not yet appeared in the mental health literature. Hibbard and Bahry reported that over 50 per cent of the clients in the programs have primary Axis II personality disorders. Depression is also highly represented. The program cares for few acutely psychotic clients.

In British Columbia, Capital Health Region Mental Health Services in Victoria recently received a Federal Health Transition Fund Grant for a 12-month acute home treatment pilot program for acute psychosis, modelled on the Clarke Project. The program began taking referrals on June 28, 1999. Good outcomes have been achieved to date with several early discharge clients and with initiation of Clozapine treatment for two community clients who would otherwise have been admitted. Treated clients have had a variety of diagnoses including schizophrenia, acute delusional disorder, major depression and bipolar disorder. Primary differences from the original Clarke study are that inpatient RNs and RPNs were trained for acute treatment in the home and homemaking services were not included as treatment providers. Home support referrals have not been required to date, nor have social work referrals been required. The project has been extensively evaluated. A primary contextual difference in the Victoria Project is that virtually all previous programs reported have operated from academic centres. In such centres, psychiatric residents and medical students can be key team members available for home visits and team meetings. Research infrastructure and expertise is also readily available.

Very little is reported on acute home treatment programs in rural communities.

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Goals and objectives

Clients meeting the criteria for acute home treatment:

- experience acute exacerbation/symptoms of mental illness requiring acute psychiatric care in hospital, if acute home care is not available
- require a limited period of continued acute treatment in the home, following an abbreviated admission to the more secure environment of the hospital
- need close assessment and monitoring
- do not represent an imminent risk to themselves or others
- do not suffer from a primary substance addiction disorder.

The objectives of acute home treatment are to:

- provide brief care in their home to selected clients needing treatment of acute psychiatric illness/symptoms who would otherwise require admission or a continued admission
- increase access to inpatient psychiatric beds for clients who cannot be treated in the community
- educate clients, families and support networks about management of acute episodes of illness
- increase positive attitudes toward acute home care among health care providers, family members and clients.

Access criteria

By definition, an acute program is useful when access is rapid. Previously admitted patients with known patterns of decompensation can sometimes be most readily served in an acute home treatment program. When the staff of such a program is functioning within an integrated mental health system, free of barriers to the exchange of relevant information with inpatient staff, patients are likely to have improved access. Explicit restrictions to the length of acute home treatment per episode will serve to maintain access by protecting program resources. Access to such programs is sustained by availability of psychiatric consultations in home or office; the security of recourse to short-stay/crisis-stabilization beds; appropriate language interpreters; and sensitivity to cultural variables.

Standards

- rapid access
- clarity of primary care physicians’ role with regard to ordering physical health care

Best Practices for B.C.’s Mental Health Reform
• availability of psychiatry role
• programs to be nested within integrated mental health systems to facilitate service linkages and continuity of care
• client/family agreement to home treatment
• clear criteria for acute home treatment
• clients and family/caregiver involved in identification of target symptoms and behaviors
• contract for acute home treatment specifying client/family responsibilities
• cultural variables respected in planning and providing care
• language interpreters available
• psychiatrist involved in assessment, completes referral form
• in rural setting, primary care physician or other mental health professional performs assessment and referral
• team of psychiatric RNs/RPNs trained for home care
• in rural areas, home care nurses with special preparation in managing acute psychiatric illness
• regular psychiatric consultation available in home or office
• evaluation data incorporated in improving service delivery
• specific criteria for identification and management of suicidality or homicidal ideation
• prompt access to crisis/short-stay beds
• treatment protocols
• explicit discharge criteria
• scheduled treatment team conferences
• regular education and supervision for home treatment nurses
• standard form to notify, update primary care physician of client’s admission to acute home treatment and progress/discharge
• documentation standards and policies
• case managers and community supports kept current with treatment outcomes
• standardized instruments to assess client symptoms and clinical status, caregiver burden and client and family satisfaction

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6. TERTIARY SERVICES

6.1 Program description

Definition
While it is generally agreed that tertiary means third in number or degree, in psychiatry there is not a clear demarcation between secondary (generally taken to mean inpatient services of a psychiatric unit in a local general hospital) and tertiary services. Two meanings appear in practice: specialized services and long term services. For example, Riverview Hospital is generally regarded as a tertiary facility; however, people go there not just because they have specialized needs that cannot be met in a secondary unit, but because the illness is taking a great deal of time to stabilize. (This issue needs to be addressed further.)

Tertiary program areas
A number of specialty (or “tertiary”) services have been developed including eating disorders, mood disorders, neuropsychiatry children’s disorders, dual diagnosis, etc. One could probably justify a provincial specialty program for most of the DSM IV disorders. (It might be useful for our committee to develop such a prioritized list.)

Recommended provincial tertiary (regions could establish similar services) include:

- eating disorders
- mood disorders
- refractory psychosis including aggression
- anxiety disorders including obsessive compulsive disorders
- early psychosis
- personality disorders.
- mental handicap and psychiatric disorders
- neuropsychiatry
- substance abuse and psychiatric disorders
- disorders of the elderly
- child/youth disorders.
Organization and governance of tertiary services

Since the primary purpose of the tertiary system is to serve the needs of the secondary system, it is important that the regions be involved in governance or at least have very close input into the operation and development of the tertiary services. In addition, tertiary services need to be in contact with the many people in the regions who have similar interests. Both these concerns can be addressed in a governance/advisory structure for each provincial specialty service as follows:

- Establish an advisory board with representation from the regions, the university and the ministry for each specialty service.
- Establish a group of interested people from the regions as a large electronic focus group or support group for each specialty service, for the purpose of receiving advice for the service and fostering interest in the specialty area throughout the province.

Development of tertiary services

To date, specialty services have developed unsystematically with different terms of reference, funding bases, organizational affiliations, emphasis on service or research, etc. Given regionalization and the maturing of many of these services, it is now timely to examine systematically their role, function and governance with a view to providing some standardization. In addition, coordination between the specialty centres and the health authorities will be necessary, since centres have similar mandates and sometimes similar patients, educational and other strategies.

It is recommended that a Task Force on Provincial Specialized Psychiatry Services be struck. Within a regionalized system where the health authorities have the responsibility for providing services, the mandate would be to recommend on the need for, function, governance and development of provincial specialized psychiatry services. The services would be aimed at assisting the health authorities through by providing education, consultation and services.

Membership on the task force would include representation from the health authorities, existing specialty services, the ministry, the university and family and consumer groups.

6.2 Goals

To support the primary and secondary mental health system by providing:

- consultation (e.g., on diagnostic, treatment, management issues)
- education (e.g., on diagnostic, treatment, quality assurance best practice clinical guidelines etc.)
- outreach services to secondary units (e.g., telepsychiatry)

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• acceptance of challenging patients from secondary units
• assistance in follow-up of discharged tertiary patients to secondary units
• research and dissemination of results to secondary units
• teaching of undergraduate and graduate students.

6.3 Access

Access criteria need to be developed for all tertiary services, including regional and provincial services. For provincial services, health authorities need to know the capacity available for their region, prioritization criteria and discharge/follow-up protocols.

6.4 Standards

Each tertiary service needs to provide standards around access (including wait times, information requirements, etc.), admission criteria and process, treatment services, discharge and follow-up. These should be communicated to referring agencies.
7. SHARED CARE: LINKING FAMILY PHYSICIANS WITH MENTAL HEALTH SPECIALISTS

7.1 Preamble

The family physician plays a critical role in the early recognition, treatment and/or referral and follow-up management of clients with mental disorders. Fifty per cent of persons with mental disorders requiring mental health care receive that care primarily from their family physician. There is some evidence that only 10 per cent of psychiatric clients formally access mental health services in any year. Family practice statistics suggest that 83 per cent of the population see their family physician for a medical visit during the year. Twenty-five per cent of all clients visiting family physicians have a diagnosable mental disorder. The position paper Shared Mental Health Care in Canada (Canadian Psychiatric Association and The College of Family Physicians of Canada, 1998) specified collaborative care between family physicians and psychiatrists as a critical step toward improving mental health care for Canadians. The literature suggests that sharing care with primary care physicians expands access to mental health services for large populations.

Evidence of the need for better linkages with family physicians in the treatment of mental illness includes:

- Early identification and prompt, adequate treatment results in better lifetime outcomes for major mental illness.
- Costs to consumers, families and society of undetected and/or inadequately treated mental illness include:
  - decreased ability to fulfill family and societal roles
  - decreased quality of life for clients and family members
  - employment days lost
  - increased severity and refractoriness of the mental illness
  - increased utilization of health care services
  - increased utilization of other social support services.
- Untreated major depression is a predictor for death from acute myocardial infarction.
- Refractory depression is implicated as a risk factor for coronary artery disease.
- Depressed mood is an independent risk factor for all-cause mortality for medical inpatients.
- Mood and substance disorders are highly co-morbid in primary care practices.
• Delirium affects 40-50 per cent of elderly persons during an acute hospitalization; 50 per cent are not diagnosed, lengthening morbidity and LOS, increasing mortality and contributing to long term care placement.
• Depression a more significant factor for decreased mobility in the elderly than age.
• Benzodiazepines and tricyclic antidepressants are significant causes of falls/fractured hips in the elderly.
• Somatization affects 25 to 65 per cent of all primary care clients presenting for treatment of physical symptoms.
• Standardized group behavioral medicine interventions led by mental health providers significantly reduce both visits to physicians' offices and discomfort from physical symptoms for both somatization disorders and chronic mental illnesses.

7.2 Definitions

“Shared care” refers to collaborative activities between family physicians and psychiatric services designed to improve mental health care for clients by:
• improving communication and working relationships between psychiatrists/psychiatric services and local family physicians
• establishing liaison relationships between psychiatrists/psychiatric services and local family physicians
• integrating psychiatrists or other mental health clinicians into primary care offices.
Use of specific strategies depends on local needs and on the clinical and organizational resources available.

Shared care emphasizes enhancing family physicians’ skills in the detection and management of mental illness. Linking family physicians with mental health specialists includes links in both clinical practice and training. Both links are emphasized in a consultation-liaison model, where ongoing management is provided by the family physician, with additional advice or support from a psychiatrist or other mental health care provider. Such an approach is essential to addressing a chronic and potentially life-long mental illness such as depression. The family physician/client relationship is strengthened, respected and supported. Referrals of milder disorders are reduced and referrals of serious mental illness are selectively increased.

7.3 Goals and objectives

• increased skills of family physicians in detecting, diagnosing and treating mental health disorders
- improved communication between family physicians and mental health clinicians caring for the same client
- increased access by family physicians to mental health consultation, referral and education
- increased opportunities for personal contact between family physicians and mental health clinicians
- increased awareness by family physicians of anxiety and somatization disorders and their impact on utilization of services and on course of chronic mental illnesses
- promotion of CPGs for treatment of mental disorders
- promotion of family physicians’ comfort in treating mental disorders and discrimination for consultation, referral
- support for family physicians in educating clients about mental health and mental illness.

7.4 Access criteria
- Clients with both substance abuse disorders and other mental health problems should not be denied access to the mental health system.
- Central intake process for referrals, to reduce the confusing patterns in many areas where there are multiple entry paths to mental health services, with varying referral criteria and intake policies.
- Availability of manuals for community mental health resources (e.g., resources for substance abuse in British Columbia). These should be supplied to family physicians.
- Availability of behavioral medicine treatment groups.
- Promotion of generic referral forms, agreed-on by respective providers within integrated mental health systems.
- Priority call-back available for clients transferred back to family physician’s care.
- Family physicians’ access to psychiatrists/mental health clinicians by telephone.

7.5 Standards
- Clients of mental health services have an identified primary care provider.
- Family providers receive timely copies of consultations for clients referred and notifications of changes in mental health status, medications, or treatment plans. Family physicians are routinely notified of patient’s discharge from mental health services.
- Screening instruments are promoted to clients and family physicians.
• Specific screening for clients presenting frequently with physical symptoms, but no underlying medical disorder.
• Condensed documentation forms that incorporate CPG algorithms; abbreviated CPGs published in local medial publications and/or Web sites.
• Explicit guidelines and criteria for consultation and referral of serious and/or refractory mental disorders.
• Explicit guidelines for management and referral of suicidality.
• Mental health service provider available to family practice by face-to-face consultation or telephone.
• Clear guidelines on respective roles of service providers who are co-managing clients.
• Clients informed of and consulted on respective roles and who to contact for which problems.
• Local family physicians are members of outpatient and inpatient mental health services planning committees.
• Videos, pamphlets on mental health and mental illness available in family physicians' waiting rooms, for borrowing by clients.
• Opportunity for joint educational sessions/rounds at times convenient for family practitioners (e.g., early morning, lunchtime).

7.6 Best practice examples

Several programs in Canada and the U.S. have implemented aspects of a shared care model:
• A continuing project in Hamilton, Ontario brings psychiatrists and counsellors into 36 offices used by 88 family practice physicians. Psychiatric and counsellor care are more accessible. New approaches have been developed for continuing education. Continuity of care has been enhanced. Family physicians report improved support and improved communication. Clients and family physicians have been satisfied with the process.
• Also in Hamilton, a psychiatrist visited 18 family physicians on a regular basis to provide clinical consultation as part of the previously described program, and provided telephone back-up to those physicians. Over a 12-month period, 128 calls averaged eight minutes in length; the psychiatrist spent an average of 20 minutes a week on the phone. Fifty calls were urgent, 78 calls concerned routine management or medication issues. The service was effective in reducing utilization of other mental health services.
• In Seattle, several programs have experimented with bringing psychiatrists and psychologists on a regular basis into large health management practices, with an emphasis on assisting primary care practitioners in implementing clinical practice guidelines. Results were similar to the Hamilton projects. When the programs were discontinued, compliance with CPGs fell back toward pre-program levels.

• An integrated care program in Colorado, designed by a group of mental health and medical providers with research assistants, places mental health clinicians in family practice and internal medicine departments. Clinicians meet on a weekly basis about collaboration, management of difficult clinical situations and medication management issues. A computerized instrument, the Quick Diagnostic Panel, is used to screen for mental disorders; identified patients are given a shared decision-making form that describes available treatment options, based on evidence in the literature. Willing clients agree to take part in behavioral medicine treatment groups. Preliminary results have been positive in terms of patient satisfaction, reduction of symptoms and utilization of health services.

• In Georgia, a 1998 pilot study integrated Behavioural Health Services into Primary Care Services, including a chemical dependency clinician and use of mental health screening tools. Again, preliminary results indicate satisfaction for client and provider and decreased utilization.

• The Mindfulness-Based Stress Reduction Clinic in Mind-Body Medicine operates out of University of Massachusetts Memorial Health Care. Well-evaluated studies have proved the eight-week group treatment program effective in producing long-lasting physical and psychological symptom reduction and decreased utilization of health care services, with a variety of somatization disorders, chronic illness and chronic pain.

• The Personal Health Improvement Program has been offered at Harvard Pilgrim Health Care in Boston for 13 years, with results similar to the program above in many clinical trials. Both programs offer training sessions for mental health clinicians and have been instituted in many HMOs throughout the US.

• Capital Health Region Mental Health Services in Victoria recently sent clinicians for training at the Mindfulness-Based Stress Reduction Clinic and is planning to start trials with these behavioral medicine group treatments for clients of CHR Medical Programs.
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 percent 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, skilled staff and the Canadian Mental Health Association National Framework for Support.

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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 (CPG). 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 psychosocial 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 behaviors 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. Electroconvulsive therapy.

**emergency accommodation.** Facilities that offer short-term emergency accommodation in a supportive environment for people with marked behavioral 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.

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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.

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, behavior 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 behavioral 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 misuse 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 behaviors.

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 behavior 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 misuse 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.
REFERENCES


