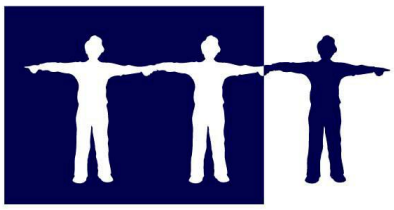

Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Invitational Exploratory Roundtable
Patient waits in Emergency Departments: Mental health

Background Paper

October 19th 2007

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Executive Summary

Overcrowding in Canadian Emergency Departments (EDs) is of general and widespread concern. Psychiatric emergencies are a contributing factor. It has been established that EDs are experiencing more and more complex psychiatric emergencies. This form of emergency arises out of a complex set of circumstances that begin and end far from the ED door. This paper provides a discussion of wait times for psychiatric clients in EDs within the context of the whole public health care system. It also provides a compendium of promising ideas (with only some meeting the bar of "best practice") aimed at addressing psychiatric emergencies more effectively. And it concludes with proposed discussion points as a foundation for deliberations at the Exploratory Roundtable.

Community mental health supports and services:

Psychiatric inpatient beds have closed rapidly while investment in community mental health supports has been slow to materialize. Of the many possible community services, supportive housing and Assertive Community Treatment (ACT) teams have evaluative research attached to them that show effectiveness. These findings do not negate the need for a full array of community services. Additional advances are recovery and relapse prevention models, early intervention in psychosis programs and diversionary community-based crisis services.

Psychiatric emergencies:

While a functioning community mental health system goes a long way in averting psychiatric emergencies, EDs will likely always serve people with mental health crises. Examples of positive initiatives are the Canadian Triage and Acuity Scale (CTAS), Psychiatric Emergency Plans (an initiative out of Scotland that requires plans for each of its health authorities), and Psychiatric Emergency Care Centres (originally an Australian program that has been replicated in many Canadian hospitals). In addition, British Columbia has made provision for Observation Units for its rural and remote hospitals which do not have psychiatric inpatient wards and Leamington, Ontario has developed a Virtual Psychiatric Emergency Room which has been awarded a 2007 Ontario Hospital Association silver medal for innovation. Also discussed is the protocol of mandatory medical clearance before psychiatric assessment in EDs, its utility and its effect on wait times.

Inpatient efficiencies:

Effective inpatient care and solid discharge plans that re-connect patients with their communities help prevent post-hospitalization psychiatric emergencies. Inpatient bed management and the utilization of objective symptom monitoring scales have shown their usefulness. Quality discharge planning is valued by all, but at time of writing, it appears to be a neglected area of practice.

The paper poses two questions for discussion at the Exploratory Roundtable:

1. If a set of recommended solutions for easing wait times in EDs for people with psychiatric emergencies were to be included in a National Mental Health Strategy, what would this group advise they should be?
2. What are the recommended linkages and partnerships that could move these solutions forward?

Preliminary remarks

Wait times for psychiatric clients in Emergency Departments (EDs) cannot be viewed in isolation of wider social influences, health system failures and the complex nature of psychiatric disorders.

1. People with psychiatric emergencies do not "just appear" on the doorsteps of EDs. Among other complex factors, these emergencies are a result of fewer inpatient psychiatric beds, slow investment in a community mental heath system, and missed therapeutic opportunities when clinicians use outmoded practice approaches – for example, the slow adoption of recovery principles, early intervention in psychosis, crisis planning, and relapse prevention.
2. Wait times can be attributed to processes in EDs themselves such as general understaffing, lack of specialized mental health staff and ED staff who feel unskilled dealing with psychiatric emergencies. While ED staff are working flat out to meet patient demands, testimony before the Kirby Committee by consumers and families interpreted the long wait times, rightly or wrongly, as further evidence of the stigma they encounter regularly in daily life.
3. Wait times in EDs also relate to sheer overload on all fronts; overcrowding, violence, the pressure of repeat users, lack of inpatient beds and the use of the ED as a default care provider. Strategies that address overcrowding appear to have limited impact according to Canadian Agency for Drugs and Technologies in Health research - findings published in 2006.[1]
4. Finally, hospitals struggle with implementing effective inpatient bed management strategies and there is a limited emphasis on quality discharge planning for many types of patients, but particularly for psychiatric clients. Poor discharge plans lead directly back to ED pressures when psychiatric clients return to hospital in crisis.

A caveat

There appears to be little evaluation research and a general lack of literature in this subject area. As a result, there are few practices that meet the bar for "best." However, there are many promising ideas and innovations that may evolve, overtime, to best practices.

[1] See: http://www.cadth.ca/index.php/en/hta/reports-publications/search/publication/621

Introduction

In April, 2007, the Mood Disorders Society of Canada submitted a report to Health Canada on Patient Wait Time Guarantees for Mental Health.[2] The report was based on key informant interviews from three sources of expertise: direct service providers, researchers, and consumers and families who have "been there." Among the findings was one of excessively long wait times in Emergency Departments (EDs) experienced by consumers and families. Additional respondents, who were health providers, tended to agree with consumers' reports and are struggling with ways to serve people with mental health problems more effectively in Emergency Departments.

Overcrowding in Emergency Departments (EDs) is an area of general concern across the country and has been particularly resistant to solution.[3] In its position statement on overcrowding,[4] the Canadian Association of Emergency Physicians argues that the causes are multiple: a shortage of inpatient beds, staffing shortages, lack of investment in community support services and poor integration between community services and hospitals. The result is use of the ED as a general health service provider and a defacto inpatient ward, resulting in poor patient care and unsafe conditions for all.[5]

More and more complex psychiatric emergencies

People with mental health emergencies are a significant factor in pressures on EDs. In its position paper, the Canadian Psychiatric Association (CPA) attributes a rise in psychiatric patients presenting in EDs to an clearer link between medical disease and alterations in mental status, a rise in alcohol and drug abuse and an increased reliance by those with serious mental illness on EDs for their primary

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[2] Everett, B. (2007). Patient wait time guarantees: Mental health. Mood Disorders Society of Canada. Available upon request.

[3] Emergency department overcrowding in Canada: What are the issues and what can be done? (May 2006). Canadian Agency for Drugs and Technology in Health (CADTH). Available at: http://www.cadth.ca/index.php/en/hta/reports-publications/search/publication/621

[4] Position statement on emergency department overcrowding (Feb 2007). Canadian Association of Emergency Physicians (CAEP). See: http://www.caep.ca/stopthewait/

[5] In recognition of Emergency Department waits, Ontario recently announced a wait times strategy (News release, October 12, 2007), as well as publishing an earlier ED staffing reference guide. See: http://www.healthforceontario.ca/upload/en/whatishfo/ed%20staffing%20reference%20guide.pdf

treatment needs (both physical and mental).[6] The CPA also found that, along with increased volumes, have come increased complexity.

This complexity relates to:

- The multiple psychosocial factors that can be a reality of life for people with mental illness, for example, homelessness, poverty, unemployment, community and domestic violence, and substance abuse.
- New immigrants and refugees, particularly in urban areas, who may bring with them the residual mental effects of trauma or experiences of severe psychological strain related to an inability to find work or adjust to their new country.
- The addition of the pathological gambler as a relatively new category of person with mental health problems visiting EDs.[7]
- The involvement of police who arrive with psychiatric patients in EDs leading to two levels of complexity: possible charges that must be dealt with upon return to the community and the need to ensure that police are not waiting for excessively long periods escorting patients who require assessment.
- Patients presenting who are high or intoxicated, managing their behaviours, and determining the substance taken and the detox interval required.
- Managing clients who are violent (psychotic and/or intoxicated), while keeping staff and other patients safe.

Research has shown that it is difficult to develop a consistent profile of "typical" presentation in EDs for psychiatric clients[8] due to the many complicating factors that they bring with them. However, studies have shown that there are two identifiable sub-populations that put a strain on ED resources: repeat users and those presenting with a primary problem of substance abuse.[9]

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[6] Dawe, I. (2003). Emerging trends and training issues in the psychiatric emergency room. Canadian Psychiatric Association position paper. See: http://ww1.cpa-apc.org:8080/Publications/Position_Papers/2004-44-en.pdf

[7] Chaput, Y. et al (2007). Pathological gambling and the psychiatric emergency service. Canadian Journal of Psychiatry, vol 52(8), p. 535 – 538. See: http://publications.cpa-apc.org/media.php?mid=492

[8] Chaput, Y & Lebel, M-J. (2005). The psychiatric emergency service patient. Letter to the Editor. Canadian Journal of Psychiatry See: http://ww1.cpa-apc.org:8080/Publications/Archives/CJP/2005/april/letterChaput.asp

[9] ibid

What comes before a psychiatric emergency

Psychiatric emergencies are defined as "an acute clinical situation in which there is imminent risk of serious harm or death to self or others unless there is some immediate intervention."[10]

A crisis, on the other hand, is "a serious disruption in the individual's baseline functioning, such that coping strategies are inadequate to restore equilibrium." [11] A crisis is conceptualized as a turning point that can lead to better functioning and increased self-understanding or it can descend into an emergency. Crises most often become emergencies when they are accompanied by a number of failures in the broader health and social systems.

Psychiatric emergencies appear to arise suddenly but this is rarely the case. Their origins lie far from ED doors. The Emergency Department is the portal to the last resort in psychiatric treatment – hospitalization - and, as such, becomes a crucible fed by inadequate community supports and a series of missed therapeutic opportunities.

A complete community mental health system

Wait times for psychiatric emergencies in EDs is a symptom of a larger failure. The etiology of an emergency most often begins with inadequate mental health supports in the community.

After two years of investigation, the Standing Senate Committee on Social Affairs, Science and Technology published its final report, *Out of the Shadows at Last,* on the Canadian mental health system in May 2006.[12] Among other findings, the report argues that the mental health system is not a system at all. One important reason for this failing is that, everywhere, mental health services are in transition – moving from institutionalization to community-based. Across Canada, the closure of psychiatric inpatients beds has been relatively swift, while investment in community mental health has been slow to

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[10] Keespies (1998) as quoted in Emergency mental health: Educational manual. (2000). (pg. 14) Available at: http://www.mheccu.ubc.ca/documents/publications/emh-manual.pdf

[11] Emergency mental health: Educational manual. (2000). (pg. 14) Available at: http://www.mheccu.ubc.ca/documents/publications/emh-manual.pdf

[12] Out of the Shadows at Last (2006). Report by the Standing Senate Committee of Social Affairs, Science and Technology (pg. 14). Available at: http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-/rep02may06-e.htm

materialize. However, there has been extensive advice on what *ought* to be in place,[13] along with pockets of investment and some evaluative research looking at what does and does not work for people.[14] The following are the necessary components of a community-based system which, if it were in place, would reduce pressures on Emergency Departments.

1. Adequate community services and supports

Community mental health services range from housing, case management, vocational initiatives, peer support, drop ins, Assertive Community Treatment (ACT) teams, safe beds and mobile crisis teams. Some provinces have also enacted Community Treatment Orders (CTOs) which serve a narrow, but thought to be important group of people when it comes to heavy use of EDs. However, a recent review of CTOs in Ontario found only weak anecdotal evidence that CTOs kept people out of EDs and hospitals.[15]

While consumers, families and providers advocate for funding for all these supports, evaluation studies endorse two approaches as being particularly effective in averting psychiatric emergencies and subsequent hospitalization:

1. Housing remains first among equals in supporting people with mental illness in the community. Safe, affordable housing is in scarce supply ranging from non-existent in many rural and remote communities, to long waiting lists in urban areas. Programs focused on housing the homeless mentally have shown themselves to be successful, as have programs that put housing first, meaning that people do not have to stop drinking or using in order to be housed.[16]

2. ACT teams provide 24/7 services to people with severe mental illness, meeting with people where they live and helping them

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[13] Review of best practices in mental health reform (2003). The Public Health Agency of Canada. See: http://www.phac-aspc.gc.ca/mh-sm/pubs/bp_review/index.html

[14] Making a Difference: Ontario's community mental health evaluation initiative (2004). See: http://www.ontario.cmha.ca/cmhei/making_a_difference.asp

[15] Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the *Mental Health Act* (December 2005). See: http://www.ppao.gov.on.ca/pdfs/cto-review.pdf

[16] Mental health and homelessness: Canadian population health initiative (2007). Available from the Canadian Institute for Health Information (CIHI) at: http://secure.cihi.ca/cihiweb/products/mental_health_report_aug22_2007_e.pdf

with medication compliance and the activities of daily living. Evaluations show that ACT teams are able to retain clients in their program effectively. In doing so, they reduced hospitalization rates, visits to Emergency Departments, and helped people get and maintain stable housing.[17]

An additional dynamic which arises in urban environments particularly is an all-or-nothing phenomenon. People with severe and persistent mental illness are often well served by community mental health supports and, in some cases, over-served - while those who have not yet made their way into the system have nothing.[18]

2. Recovery and relapse prevention

The last two decades have seen the emergence of the "recovery movement" in the mental health field. The fact that people can and do recover from mental illness is, perhaps, not surprising. However, in a system whose history is that of long term institutionalization, optimism has traditionally been in short supply. Recovery is a whole body of thought and relates closely to how recovery is defined in the addictions field – and its principles are defended most vigorously by consumers and families – although there is considerable uptake of recovery language among professionals. Recovery is not a cure – it is defined as living well despite significant challenges related to your illness – some would say disability. Recovery approaches combine hope, self-mastery, education, self-advocacy and support – along with treatment.[19] For the medical community, it is best understood through a chronic disease management lens – medicine and pharmaceuticals can only do so much, the rest is up to thoughtful, informed and individual self-management. As hopeful as the recovery movement is for relapse prevention and reducing ED visits and hospitalizations, the current reality is that it not well integrated into formal mental health treatment.[20] It is left, more or less, up to individual practitioners and programs as to whether or not they adopt recovery principles.

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[17] Making a Difference: Ontario's community mental health evaluation initiative (2004). See: http://www.ontario.cmha.ca/cmhei/making_a_difference.asp
[18] John Trainor as quoted in Everett, B. (2007). Patient wait time guarantees: Mental health. Mood Disorders Society of Canada. Available upon request.
[19] The Wellness Recovery Action Plan. See: http://www.mentalhealthrecovery.com/aboutus.php
[20] Everett, B. et all (2003). Recovery rediscovered: Implications for mental health policy in Canada. See: http://www.ontario.cmha.ca/admin_ver2/maps/recovery_rediscovered.pdf

3. Early intervention in psychosis programs

These programs are also a hopeful development for the mental health system – and for young people and their families. Early intervention programs are multi-faceted. Activities include educating teachers and other professionals who are in regular contact with youth so that they can identify the symptoms of psychosis (most typically related to schizophrenia, although not always). Families are intimately involved in these education sessions and in the treatment of their family member. The central goal is to treat the youth as soon as possible, in the community and on limited doses of neuroleptics. Hospitalization is a last resort. Post-stabilization, the emphasis is on a return to school – and a return to growing up and living life.[21] Early intervention programs go a long way towards preventing chronicity – traditionally understood as the inevitable result of a diagnosis of schizophrenia. Early intervention programs have been funded in a number of provinces but are not, as yet, commonly available.

4. Crisis planning

There are two sites of intervention for crises: individual plans and a system response.

a) Individual plans

As with a recovery orientation, whether or not clinicians or programs take the time to develop individual crisis plans with clients is a hit and miss affair. There is, however, an example of practice where individualized crisis plans are systematically used. In 1989, the Maudsley Hospital in South London (UK) responded to an idea developed by two consumer groups originally seen as an advocacy tool. Wishing to maintain as much control as possible in their lives, consumers filled out their own cards stating how they wished to be treated in the event of a crisis – a kind of informal advanced directive. The cards were as detailed as the individual wanted them to be, from preferred place and modality of treatment to who was to take care of their pets. The crisis cards proved hugely popular and, while decidedly a low-tech intervention, proved highly effective. An evaluation study found that, for those carrying the cards, admissions to hospital fell by

[21] Youth and mental illness: Early intervention. Canadian Mental Health Association. See: http://www.cmha.ca/english/intrvent/

one-third in one year.[22] Presently, the cards have evolved into Joint Crisis Plans – plans mutually developed and agreed to by both consumers and their clinical team. A four-year randomized control trial began in 2007 to test whether or not the joint plans facilitate the early detection of relapse and, thus, affect the incidence levels of ED visits and compulsory treatment.[23]

b) Diversion crisis intervention programs

In order to relieve pressure on EDs and scarce inpatient psychiatric beds, crisis responses systems (CRS) have been developed in Canada and elsewhere where a range of services focus specifically on resolving crises by utilizing the least intrusive methods. These services are not only welcomed by consumers and families, but they are also important to maintaining housing as in-home crisis visits and short-term alternative crisis housing avert evictions. [24]

In a review of best practices in mental health, commissioned by the Public Health Agency of Canada, the key elements of a diversion crisis system were identified as telephone crisis lines, mobile crisis units, walk-in crisis programs and safe beds – temporary housing where people in crisis can stay for several days.[25] As a best practice measure in establishing these types of services, Ontario developed a set of standards for its crisis response services to ensure accountability.[26] In research into these types of services, findings showed that crisis housing is a viable alternative to ED visits and hospitalization and that crisis programs were particularly effective in helping people resolve the psychosocial pressures that are prominent factors in psychiatric crises.[27]

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[22] Thornicroft, G. & Reynolds, A. (2001). Crisis prevention on the cards. Available at: http://society.guardian.co.uk/mentalhealth/story/0,,536837,00.html

[23] A randomised controlled trial of Joint Crisis Plans to reduce compulsory treatment of people with psychosis. See: http://www.iop.kcl.ac.uk/departments/?locator=355&project=10204

[24] A report on mental illnesses in Canada (2002). The Public Health Agency of Canada. See: http://www.phac-aspc.gc.ca/publicat/miic-mmac/index.html

[25] Review of best practices in mental health reform (2003). The Public Health Agency of Canada. See: http://www.phac-aspc.gc.ca/mh-sm/pubs/bp_review/index.html

[26] Crisis response service standards for mental health services and supports (May 2005). Ontario Ministry of Health and Long Term Care. See: http://www.health.gov.on.ca/english//public/pub/ministry_reports/mentalhealth/cris_resp.pdf

[27] Review of best practices in mental health reform (2003). The Public Health Agency of Canada. See: http://www.phac-aspc.gc.ca/mh-sm/pubs/bp_review/index.html

Psychiatric emergencies

In many parts of Canada, significant attention is being paid to ways to avert psychiatric emergencies – both for the sake of reducing pressure on EDs and inpatients resources - and for consumers and families who see ED visits and hospitalization as an undesirable and absolutely last resort. However, the reality is that investment is spotty and even under the best of situations, there will always be some level of psychiatric emergency traffic in EDs.

There have been a number of approaches to dealing with psychiatric emergencies so that they can be addressed swiftly, effectively and safely.

In the Canadian context, a principle advance was the introduction of a five-level acuity scale to assist ED staff in setting priorities for the assessment and treatment of patients – essentially a tool to decide who must be seen first. The ***Canadian Triage and Acuity Scale*** (CTAS) was adopted as a national standard in 1998 and was endorsed by the Canadian Association of Emergency Physicians, the National Emergency Nurses Affiliation, L'association des medecins d'urgence du Quebec, the Canadian Paediatric Society and the Society of Rural Physicians of Canada. The five levels are: 1. resuscitation (time to physician immediate), 2. emergent (time to physician approximately 15 minutes), 3. urgent (time to physician approximately 30 minutes), 4. semi-urgent (time to physician approximately 1 hour) and 5. non-urgent (time to physician 2 hours or more).[28] Practically speaking, for psychiatric emergencies, people who present in the ED with clear statements of the intent to kill themselves along with a specific plan are categorized as Level 2. Anecdotal reports indicate that adopting CTAS standards has been helpful for ED staff as they have taken the "guess work" out of responding to people who are suicidal.[29] Other psychiatric problems are covered under CTAS Levels 3 – 5. It is acknowledged, however, that dealing with psychiatric emergencies in EDs has been, and remains, a "huge problem" and "we just sort of ping pong them around."[30]

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[28] For the complete CTAS guidelines, see: http://caep.ca/template.asp?id=B795164082374289BBD9C1C2BF4B8D32

[29] Conversation with Janis Spivey, Past President, National Emergency Nurses Affiliation, Sept. 25th 2007.

[30] ibid

Scotland has developed ***Psychiatric Emergency Plans*** for each of its health authorities.[31] These are multi-agency plans, including hospitals, community groups, consumer organizations, ambulance services and police, for the safe and appropriate transport of people requiring emergency detention in hospital. PEPs, as they are called, are mandated under the Mental Health Care and Treatment Act (Scotland) 2003. By 2005, all health authorities had a PEP in place. The plans, while individual to each authority, cover such matters as escorts, detention in "places of safety" – not jail cells - and are accompanied by a declaration of rights and safeguards that set out principles such as respect for diversity, respect for caregivers and their role, and involvement of consumers in the process – insofar as it is possible. There has been data collection on authority compliance with implementing the plans and some on usership; however, there appears to have been no research as yet on how well the plans are working.[32]

Psychiatric Emergency Care Centres (PECCs) are based on a model of emergency care developed originally in Australia. PECCs are co-located with EDs and are intended to provide rapid access to specialized mental health care. Patients presenting with psychiatric emergencies must first be medically assessed in the ED before proceeding to the PECC. The model provides for two approaches to care: 1) assessment and discharge planning for those not requiring admission and 2) observation and short-term stays on the PECC unit. There are some preliminary indications the PECCs have reduced overcrowding in Australian EDs (although this is anecdotal and tentative). In addition there has been a noted improvement in dealing with patients presenting with drug-induced psychosis by diverting them from inpatient admission. Evidence also points to the benefits of discharge planning (from PECCs) which puts people in touch with community mental health services not previously accessed. Criticisms relate to yet another siloing of mental health patients and services.[33]

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[31] Psychiatric Emergency Plans (Scotland). See: http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/Surveys/PEPs#a1

[32] ibid

[33] View from the peak (newsletter) (Winter 2006). The lowdown on PECCs. P. 8 – 9. Published by the Mental Health Commission of Australia. See: http://www.mhcc.org.au/Current_Issues/2006/Winter%20VFP/The%20lowdown%20on%20PECCs.html

In addition, without a high quality relationship between ED and PECC staff, friction can arise over perceived workload differences.[34]

In Canada, Psychiatric Emergency Centres have been developed in numerous hospitals.[35] As one example only, St. Michael's Hospital in downtown Toronto has a range of psychiatric emergency services including a 24/7 emergency crisis unit offering medical and psychiatric assessments and referrals to either inpatient care or community services, a short stay crisis stabilization unit (3 beds, 72 hours), a mobile crisis intervention team, and a community mental health liaison team to provide short term case management to clients who present in the emergency crisis service.[36]

There appears to be little formal research on the effectiveness of specialized Psychiatric Emergency Centres. However, as one informal data point only, one of the more well-known, the Archie Courtnall Centre[37] in the Royal Jubilee Hospital in Victoria, experienced a public crisis when its director resigned in 2006 due to "long standing frustrations" related to an overwhelm of clients with uncontrolled addictions presenting at the Centre.[38] The Victoria Island Health Authority did not respond to a call for additional funding and instead, maintained its focus on community solutions for this client group.

In response to psychiatric emergencies in rural and remote locations, British Columbia has developed programs that established ***observation units*** in hospitals that do not have psychiatric inpatient units. The standards, developed by the BC Ministry of Health, describe the physical requirements of the units as well as prescriptions for assessment, restraint and behavioural management.[39] In a 21st

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[34] Personal communication, former vice president, suburban Toronto hospital, Sept 26, 2007.

[35] Note that, at time of writing, there is no centralized source of data that lists the Canadian hospitals that have PECs so precisely how many there are is unknown.

[36] St. Michael's Hospital, programs and services: Psychiatric emergency services. See: http://www.stmichaelshospital.com/programs/mentalhealth/emergency.php

[37] The Archie Courtnall Centre was established subsequent to fundraising efforts by the Courtnall family whose two sons are well-known hockey players. It was named in honour of their father who died from suicide due to depression.

[38] Harnett, C. August 23rd, 2006. Patients overwhelm psychiatric facility (Archie Courtnall Centre). Times Colonist. See: http://www.canada.com/victoriatimescolonist/news/story.html?id=af561476-dee2-4321-a771-6fde7c6aa4e3

[39] Standards. Hospital-based psychiatric emergency services: Observation units. Ministry of Health and Ministry Responsible for Seniors. (March 2000). Physical plans

century strategy for a rural hospital also without an inpatient psychiatric unit, the Leamington District Memorial Hospital instituted a ***virtual psychiatric emergency room***. Through a partnership with the Chatham-Kent Health Alliance (a schedule 1 facility), a person experiencing a psychiatric emergency in the ED at LDMH has access to the on-duty mental healthy crisis nurse at Chatham-Kent who then provides an assessment via video-conferencing technology. In the first six months of operation, 13 assessments were conducted with only one admission. The remaining 12 patients were successfully referred to community mental health services and discharged from the ED.[40]

An additional and welcomed service in EDs who do not have specialized psychiatric emergency services, is the presence of ***social workers*** to assist with the complex psychosocial factors that often accompany patients experiencing mental health crises. In research regarding frequent visitors to a downtown ED in Vancouver, it was determined that psychosocial factors were particularly complex for this group. Characteristics were homelessness, addictions, HIV, and a variety of long standing medical and psychiatric problems. A focused social work/case management program was shown to dramatically reduce ED visits among this group.[41]

A noted project to address long waits for people with psychiatric emergencies is the ***Mental Health and Addictions Emergency Alliance*** Initiative, supported by seven Toronto hospitals and aimed at delivering integrated comprehensive and best practice care.[42] The project is in its formative stages.

A further issue for people with psychiatric emergencies and their families, which has no known solution at time of writing, is ***mandatory medical clearance*** in EDs. Medical clearance means that

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and standards for rural and remote hospitals in BC that lack psychiatric units. See: http://www.healthservices.gov.bc.ca/mhd/pdf/standards.pdf

[40] Research on this project has not yet been published. The program will be awarded a silver medal for excellence at the Ontario Hospital Association's HealthAchieve convention in November 2007. For further information, contact Lena West, Patient Representative and Administrative Assistant at LDMH, 1 519 326 2373 x4118.

[41] Pope, D. Fernandes, C. Bouthillette, F. & Etherington, J. (2000). Frequent users of the emergency department: A program to improve care and reduce visits. Canadian Medical Association Journal, vol 162(7). See: http://www.cmaj.ca/cgi/content/full/162/7/1017

[42] For further information on the project, contact Dr. Don Wasylenki, Chair of the Department of Psychiatry at the University of Toronto.

anyone presenting in EDs must first be assessed by the duty physician to ascertain what their medical condition is.[43]

In the United States, medical clearance is legislated under the Emergency Medical Treatment and Active Labour Act (1986) (EMTALA).[44] Canada has no comparable legislation but, in practice, medical clearance is mandatory. There is no doubt that medical clearance in EDs lengthens wait times for psychiatric clients because, for them, there is a two-part assessment process – first for medical problems and second for their psychiatric complaints.

The practice of medical clearance can be appreciated by inpatient psychiatric staff who don't have the equipment or expertise to investigate medical complaints. In addition, medical clearance can involve toxicology tests that measure substances in urine and blood, ensuring that people who are drunk or high are identified by means other than observation. The downside, aside from extending wait times, is that many psychiatric clients have no medical condition that requires intervention and scarce resources are wasted. In addition, psychiatric clients can be more than surprised to present with a psychiatric emergency and end up in a gown being investigated for medical problems. Further, people who are agitated due to their psychiatric disorder can resist medical testing, leading to unsafe conditions for everyone.

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[43] The Canadian Council on Health Services Accreditation (CCHSA) is currently piloting (in 17 hospitals) new standards for ED's that include a *draft* standard for medical assessment post triage. It is as follows: 8.1 Following triage, the team comprehensively assesses each client. **Guidelines:** Building on information collected from the triage process, new information collected from the assessment should include medical history, allergies, current medication profile, details of present health status, and nutritional status and special dietary needs. The team should also take into consideration psychosocial elements such as functional and emotional status, including clients' ability to communicate and care for themselves; **mental health** status, including personality and behavioural characteristics; socioeconomic situation; spiritual orientation; and cultural beliefs. The team should also assess individual and practical considerations including clients' perceptions of their needs, desired outcomes, and expectations of services; community and family supports available after service is finished or discontinued; and the client's knowledge of how to prevent health problems. A comprehensive assessment includes coordinating among service providers and other organizations to prevent duplication, and is shared with clients, families, and other providers in a timely, accurate, and easy-to-understand way.

[44] A discussion of EMTALA is available at the American Academy of Emergency Medicine website. See: http://www.aaem.org/aboutaaem.php

Recent US work reviewed policies on psychiatric patients in EDs and argued that medical clearance for all was inappropriate and that new standards should be developed.[45]

Inpatient efficiencies

Bed utilization and management

The closure of inpatient psychiatric beds has placed additional pressures on EDs and has challenged hospital staff to utilize this scarce resource in the most effective and efficient manner. In addition, a recent report from the Canadian Institute of Health Information [46] showed that people with mental illness represented high usage of hospital resources. For example, patients with psychiatric disorders accounted for six percent of all general hospital discharges but utilized 13% of all inpatient days due to longer stays (17 days as opposed to 7 days for other illnesses). Average stays in psychiatric hospitals were even longer at 109 days.

The presence of a bed manager (an assigned staff member whose job is to ensure that inpatient beds are well utilized) depends on the policies of individual hospitals. It is a difficult job and when vacancies occur, it is hard to recruit a replacement. In addition, it is often the case that a hospital will have only one bed manager, regardless of size, leaving over-night and weekend management to nurse supervisors.[47]

Aligned with the goal of efficient bed management, research has shown that the use of objective monitoring tools has been helpful in assisting psychiatric inpatient staff move people effectively through their inpatient stay to discharge. For example, an ongoing monitoring project out of the South London and Maudsley NHS Trust (affectionately known as SLAM), found that utilizing the Health of the Nation Outcome Scale (HoNOS) – a scale developed by the Royal

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[45] Stefan, S. (2006). Emergency department treatment of the psychiatric patient: Policy issues and legal requirements. Oxford University Press (US). Excerpts available through a google search.

[46] Hospital mental health services in Canada 2004 – 2005 (2006). Canadian Institute of Health Information. See: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_810_E&cw_topic=810&cw_rel=AR_364_E

[47] Personal communication, October 2nd, Jane Paterson, Deputy Chief of Professional Services, Center for Addiction and Mental Health.

College of Psychiatrists' Research unit in 1993 which offers 12 items measuring behaviour, impairment, symptoms, and social functioning[48] - in combination with weekly inpatient/community staff meetings resulted in dropping blocked beds from 36% to 9%.[49] A similar study in Peterborough, Ontario utilized the InterQual ISD-AC coding tool (a trade-marked measure of acuity) to assist inpatient decision-making. Results showed an increased in separations and a reduced average length of stay.[50]

Discharge planning

Discharge planning is an important component of efficient bed management. It is also critically important to patients and their families. Consumers have anecdotally complained that they are discharged from hospital unprepared and without follow-up plans. Families, also anecdotally, report that they are not involved in discharge plans and can be totally surprised when a loved one turns up on their doorstep post hospitalization.[51]

Discharge planning is regularly referred to as a service of the inpatient psychiatric unit however, there is limited attention paid to this activity in the literature. One of the reasons can be that it is often framed in research as how inpatient staff determine when discharge is appropriate.[52] Granted, this is an activity related to discharge but what is commonly understood as "discharge planning" is how people are reconnected to services in their community, post-discharge.

Professionals, also, regard discharge planning as a neglected practice area. It is a labour intensive activity that relies on active outreach to community resources and an orientation towards relationship building.

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[48] What is HoNOS. The Royal College of Psychiatrists. See: http://www.rcpsych.ac.uk/crtu/healthofthenation/whatishonos.aspx

[49] Smith, K. (July, 2007). Bed management and health outcomes measurement. NHS Institute for Innovation and Improvement. See: http://www.institute.nhs.uk/index.php?option=com_mtree&task=viewlink&link_id=2944&Itemid=301

[50] VanderBroek, M. McNestry, F. G. & Dobby, A. (2001). Utilization management in inpatient psychiatry. Hospital Quarterly, Fall, p. 60 – 64. See: http://www.longwoods.com/product.php?productid=16695&page=3

[51] Everett, B. (2007). Patient wait time guarantees: Mental health. Mood Disorders Society of Canada. Available upon request.

[52] Flynn, G. Smith, T. Herdes, J. & McDonald, P. (2003). Predicting expected time to discharge among inpatients diagnosed with schizophrenia based on the RAI-MH. A JPPC Symposium at the University of Waterloo. See: http://www.jppc.org/raimh/symp_slides/day2_1145am.pdf

It is viewed as an important, but poorly deployed service – across the whole of the mental health system.[53]

One area of discharge planning where there has been some best practice work is in the area of new mothers hospitalized for post-partum depression.[54] A second source of best practice ideas (untested) are those developed by families. Frustrated with a lack of professional attention to this area, families have taken matters into their own hands and developed discharge planning checklists that can be used in their interactions with inpatient staff. Perhaps as a measure of their level of concern regarding this area of care, families' checklists are nothing if not thorough.

The result of poor discharge planning is that patients may have limited tenure in the community and suffer repeated crises – which brings them back to Emergency Departments.

Closing remarks

The problem of wait times for people presenting with psychiatric emergencies in EDs is not easily addressed. There can be no doubt that ED staff are doing their best for everyone as they work under pressure and at top speed. They are all too well aware that there are unsolved problems related to clients with mental health needs – as are consumers and families. However, there is little literature in this subject area and even fewer evaluation studies. The Exploratory Roundtable's role is to inaugurate a national discussion intended to more precisely define the origin of the problems, and suggest possible solutions.

Proposed question to ground deliberations:

3. If a set of recommended solutions for easing wait times in EDs for people with psychiatric emergencies were to be included in a National Mental Health Strategy, what would this group advise they should be?

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[53] Personal communication, October 2nd, Jane Paterson, Deputy Chief of Professional Services, Center for Addiction and Mental Health.

[54] Mental illness during the perinatal period: Discharge planning and community follow-up. Reproductive mental health guideline 2 (2003). BC Women's Hospital Health Centre. See: http://www.bcwomens.ca/Services/HealthServices/ReproductiveMentalHealth/BestPractices.htm

4. What are the recommended linkages and partnerships that could move these solutions forward?

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