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

Invitational Exploratory Roundtable Psychiatric Patient Waits in Emergency Departments

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Proceedings Report

Host

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Health Canada
Mental Health Commission of Canada
Canadian Institute for Health Information

Background

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. More important, the care of psychiatric patients is impacted greatly by overcrowding.

In its position statement on overcrowding,[1] 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.[2]

The Mood Disorders Society of Canada was asked to convene a group of respected experts in the provision of emergency services – and interested others - to participate in an **Exploratory Roundtable on Psychiatric Patient Waits in Emergency Departments**. (See Appendix 1 for a list of delegates and Appendix 2 for summaries of comments from the featured speakers who introduced the day)

Overview of Roundtable Discussion

On January 17 2008, 22 experts from across the country participated in the inaugural Exploratory Roundtable, representing key national organizations and the critical experiences needed to discuss possible approaches to resolving the challenges currently facing the system and its patients.

The full-day discussion was positive and constructive, with delegates sharing their perspectives and experiences in an effort to help increase the level of awareness and understanding among the assembled group, and ultimately drive to consensus on a series of priority recommendations for areas of improvement. According to delegates,

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

[2] 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

the Roundtable constituted ***the first time*** a national panel of experts had gathered together to address this important issue.

While there were many different views on the nature and specifics of the challenges facing psychiatric patients in emergency departments across Canada, by the end of the session it was clear that there was a strong degree of consensus on many of the core issues.

Overall, delegates agreed on the fundamental principles of the discussion, including:

- There are significant challenges for patients in emergency departments who present with a psychiatric emergency and something needs to be done to improve programmatic care and patient experiences;

- These challenges are – for the most part – systemic in nature and not isolated to emergency departments. In fact, there are issues:
    - before the patient arrives, involving police and paramedics, regional coordination and training;
    - in the hospital, involving how they are triaged and assessed, access to beds, effective bed management and the standards used to evaluate and treat; and
    - after they leave, involving the availability of supportive housing, community programs and crisis services.

- Many of the concerns expressed by patients about their experiences involve he issue perceived as stigma associated with mental illness and the way it may impact training, evaluation, treatment and support contributes to many of the concerns expressed by patients about their experiences.

- Despite these challenges, there was complete consensus that professionals across the system are doing the best they can, often without the tools, training or support necessary to significantly improve the emergency assessment of psychiatric patients on a sustained basis.

- Moreover, delegates at the Roundtable agreed that it is critical to work together, to drive inter-disciplinary and organizational collaboration in order to address these issues and identify workable solutions.

The agenda for the Roundtable focused on the following two areas of inquiry:

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?

Most of the discussion centred on the areas for recommendation, with delegates agreeing to a number of core areas to be improved. There was not a lot of discussion about linkages. Some suggestions are embedded in the recommendations themselves.

Areas for Recommendation

Delegates raised numerous issues and possible solutions throughout the day, however, by the conclusion of the Roundtable it was apparent that most of the ideas and suggestions could be grouped into five thematic areas for recommendation.

1. Standards for assessment
2. Data collection
3. Addressing perceived stigma
4. Clearinghouse for information
5. System coordination

Since it was not within the scope of a one-day roundtable discussion to develop detailed recommendations and implementation plans, delegates agreed to address each recommendation by considering the following questions:

- What is the problem that we are trying to solve with the recommendation?
- How do we describe the recommendation itself?
- What are the key characteristics of the recommended solution?
- What are the main barriers to implementing it?
- What are the linkages and processes that can help it become a reality?

This framework helped the Roundtable describe their recommendations in a manner that was comprehensive and could lead

to action. What follows is a description of each recommendation and the key consensus points on the above questions.

Recommendation #1: Standards for Assessment

The Problem:

There was a strong consensus that one of the central challenges involves inconsistent approaches to the assessment of psychiatric patients, post ED triage, and the ability to direct them to the appropriate resources in a timely manner.

Lack of agreement and lack of standardized definitions for presenting problems, acuity, assessment tools and diagnosis were identified as issues. Questions included, "What is the seriousness of the illness or acuity? What is need for admission? Is this a social crisis or is this the symptom of a specific diagnosis? Is medical clearance *always* necessary prior to/concurrent with a psychiatric assessment?"

The Recommendation:

There was general agreement that the Canadian Triage and Acuity Scale (CTAS) [3] is an important tool for the initial triage of these patients. It will be important to collaborate and provide ongoing feedback regarding CTAS modifications in order to maximize the utility, acceptability and national implementation among all care providers.

Furthermore, delegates agreed that more work is needed in the development of a National Standard for Psychiatric Assessment focusing on the specific needs for emergency-based assessments, either by ED staff or by psychiatric services.

Similarly, there should be activity to create and implement psychiatric emergency assessment standards to assist the process of transferring care of a patient from the emergency department to specialized psychiatric services or between psychiatric services at different sites. It was thought that, adjunctive to medical diagnosis, a functional/behavioural scale that would describe the severity of symptoms and the impact on a patient's life would be helpful so everyone is 'speaking the same language.'

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

Characteristics:

There was broad consensus that the national standards for assessment should incorporate some key characteristics in order to be successful.

- First, delegates stressed that standards and assessment systems need to be sufficiently flexible to consider the needs of the patient in the context of his or her presenting problem.

- There was strong agreement that any new standards should not replace the work that has already been done (e.g., triage standards such as CTAS); current systems should be informed as much as possible by existing psychiatric experience and expertise. Future CTAS modifications should continue to follow the current model to ensure consistency when applied to psychiatric or non-psychiatric ED presentations. This may involve the use of additional modifiers for type and severity of psychiatric symptoms which could be objectively applied in a manner that complements existing measures. Delegates noted that psychiatric symptomology can be complex, and therefore requires clinical judgment and expertise that does not easily reduce to a checklist.

- Of note was the challenge associated with patients triaged to CTAS Level III, many of whom may experience waits longer than are recommended in the current system.

- There was also consensus that any standards and assessment tools that are developed should incorporate specific teaching materials that are aligned across systems and jurisdictions in order to facilitate widespread adoption.

- Finally, some felt that implementation of the standards and assessment tools could be improved if mental health professionals are involved more closely into the process.

Barriers:

While there was strong support for the recommendation, delegates identified a number of barriers that will need to be overcome as the recommendation moves forward.

- One of the main challenges associated with standard psychiatric assessment is the lack of consensus on diagnosis and/or severity. Delegates highlighted that given the difficulty in diagnosing psychiatric patients with certainty, many in the profession do not have the same level of confidence (or "trust") in diagnoses by their colleagues perhaps in contradistinction to medical and surgical conditions.

- Challenges are associated with the different needs of the psychiatric patient when compared to other medical and surgical patients who present to the ED. Despite perceived cultural differences between emergency medical workers and psychiatric medical workers, delegates stressed that there is an ongoing support for collaboration based on goodwill, strong communication, and a fundamental desire to improve the care of this unique population.

- It is important that new standards and tools do not solely add new steps but lead to substantive improvements in the ability to triage and assess psychiatric patients.

- There was some concern that it may be difficult to overlay standard diagnostic and type/severity scales for symptoms of mental illness (given its complexity), and that efforts to do so could face some skepticism that may make adoption of new standards a challenge.

Process & Linkages:

Clearly an immediate and critical linkage in advancing this recommendation involves working closely and collaboratively with emergency-based partners, involved in all stages of care (including community, out of hospital, ED and in hospital). Additionally, many agreed that closer linkages are needed with those involved at pre-emergency stages, particularly police and paramedics.

Finally, further research and data are necessary for the development, validation and ongoing improvement of standards and assessment tools.

Recommendation # 2: Data

The Problem:

Currently, there are many points of data collection for general wait times, as well as for psychiatric emergencies. However, these data pockets are isolated and uncoordinated. There is presently no central body responsible for the identification, collection and standardization of data which makes comparisons among organizations and jurisdictions challenging.

In order to support the development of the standards described in the first recommendation, it is important to have current, reliable data. Moreover, as a finite amount of health care money is allocated to competing priorities, solid data that highlights the salience of mental illness can help drive further funding.

The Recommendation:

There was general agreement on the need for better data to describe the current experience of psychiatric patients who present to emergency departments (i.e., who goes where, and what happens to them?). Data need to be current, complete and readily available.

Characteristics:

- Delegates agreed that one of the characteristics associated with this recommendation is that the data capture process be robust and useful, but stressed that it must not add additional work burden in the process. This was a fundamental issue for all delegates. While there is strong support for more robust data, there is no appetite for the development of data standards that add layers of effort on an already over-burdened system.

- Another key characteristic of this recommendation is the need to agree upon the common data elements and definitions to be collected which will describe the experience of psychiatric patients.

- Delegates stressed that it is important to build on existing systems, such as CTAS, the Canadian Emergency Department

Information System (CEDIS) and others.[4] There was a sense that these systems would benefit from closer coordination so that any additional data-gathering functions would complement these systems, rather than replace or duplicate them.

Finally delegates emphasized the need to ensure that whatever is done to improve data collection, efforts need to focus equally on data dissemination, so that all components of the system are able to access and benefit from the information that is collected and the insights that are provided.

Barriers:

Delegates identified a number of barriers that will need to be overcome for this recommendation to be successful.

- As indicated above, the primary issue is ensuring that the process for collecting the data does not add a additional effort for health professionals in their day-to-day lives. Not only was it felt that this would make adoption difficult, but many felt that it could compromise the quality of the data, as over-burdened staff may choose not to take the time to fill in the information.

- The lack of common approaches to data collection and definition specific to psychiatric patients, and the limited degree of collaboration and coordination was also identified as a barrier. Examples were provided from across the country that elaborated on this point and highlighted the significance of the challenge.

- In addition, the mental health system has historically suffered from a lack of resources with most available funding dedicated to services. In such an atmosphere of scarcity, data collection has had limited to no attention. Despite pockets of investment, this situation continues to this day. In this vein, delegates noted that any effort to improve and expand data collection and dissemination would inevitably have resource implications, which could be a barrier to implementation.

[4] CEDIS was initiated by the Canadian Association of Emergency Physicians in collaboration with the National Emergency Nurses Affiliation (NENA) and the Association des médecins d'urgence du Québec (AMUQ). For a full explanation of CEDIS, see http://www.caep.ca/template.asp?id=4DCA2D0014A4408FACB06DC5CC0E81D3#work

Process & Linkages:

Delegates agreed that there are some clear initial process steps that need to be followed in order to move forward, including:

- Defining who will lead the effort and with whom it will be coordinated;
- Fostering an awareness of the need for data among health professionals and others;
- Setting priorities about what to focus on first, including articulating what the data will be used for and why.

Supporting these process steps, delegates noted that there were also some clear linkages that should be made, including with regional health authorities, provincial governments and existing data collection systems. This was seen as an important step in ensuring that collaboration takes place and duplication of effort is avoided. Finally, delegates felt there would be value in linking these efforts with those of the Canadian Institute for Health Information and Canada Health Infoway, which may have resources and insights to share that could be valuable.

Recommendation # 3: Dealing with Stigma

The Problem:

Throughout the day there was a robust discussion of the issue of perceived stigma and the potential impact it has on patient waits in particular, and the overall patient experience in general. As one delegate noted, the challenges with respect to wait times - from a patient perspective - is often interpreted as being evidence of discrimination caused by stigma (i.e., many psychiatric patients feel that patients with other medical conditions wouldn't have to wait as long and wouldn't be treated the same way). However, there is little or no research to bring this issue to the fore.

There was a strong consensus that the perception of stigma remains a significant problem across the whole system and may include not only hospital-based, but also community services.

Delegates acknowledged that *all* health professionals, including mental health professionals, can hold potentially stigmatizing attitudes towards psychiatric clients.

It is critical to note that delegates were not suggesting that the medical profession is deliberately discourteous or rude to psychiatric patients. In fact, there was broad agreement that everyone involved is doing the best they can with limited resources and often insufficient tools to support more efficient interactions. In fact, this is precisely why delegates felt that more needs to be done to provide professionals with information and tools to better manage crisis situations when these arise. Some tools could be as simple as a clear understanding of what questions to ask when responding to a psychiatric emergency. This was one area where delegates agreed that many health professionals are uncomfortable to engage.

It may be most helpful to recognize that the issue of stigma must be framed within the current realities of the overcrowded ED. *There are long wait times for everyone.* Staff are frustrated. The working environment is often noisy and chaotic. This can be distressing for staff as well as patients.

The Recommendation:

Delegates did not have a set solution to the issue of perceived stigma; it is too large an issue to review comprehensively in a single day's discussion. That said, delegates agreed that an area for recommendation is the development of approaches for dealing with the potential for stigma in institutions and professions related to health care provision.

Characteristics:

While there were no set solutions, delegates did identify a number of characteristics that could form part of the recommended approaches for dealing with this issue.

- In the first instance, many delegates felt that there needs to be some set standards for identifying and responding to stigma, which could be promulgated through professional training programs and re-enforce positive interactions throughout the whole system.

- Some delegates indicated that one contributor to stigma is the design of most hospitals, which don't provide adequate, safe, and comfortable space for mental health patients. For example, special Crisis Stabilization Units could be dedicated to short stay psychiatric emergencies, or there could be different access

points for psychiatric patients to engage with medical services (Psychiatric Emergency Care Centres). On the other hand, some felt that segregating mental health patients could contribute to stigma. Despite these differences of opinion, it was clear that these issues merit further examination.

- There was strong consensus that issues related to perceived stigma need to be more closely integrated into training at all levels for those professions who work with psychiatric patients. There was general agreement that there is a need for a greater orientation toward customer service, which emphasizes kindness and understanding, respect and courtesy when dealing with all patients.

- Expanded training which provides professionals with information and tools to better manage crisis situations when these arise is required. Some tools could be as simple as a clear understanding of what questions to ask when responding to a psychiatric emergency. This was one area where delegates agreed that many health professionals are uncomfortable to engage.

- Finally, there was some discussion about technical solutions that could help address the issue of perceived stigma. Some delegates talked about concepts such as medical passports, portable electronic health records, and Medic-Alert bracelets for mental health patients. These ideas were not discussed in great detail, but there was general agreement that they warranted further exploration.

Barriers:

Delegates identified a number of the barriers that will need to be overcome in order to address the issue of stigma.

- There was agreement that one of the challenges is the allocation of resources to the mental health system. In many emergency departments, there are fewer medical professionals with specific training and/or interest in mental health when compared to other conditions. Furthermore, with resources in EDs already limited, several delegates noted that it is difficult to allocate some of those scarce resources (personnel, space, and mental health training and skills development programs) exclusively to psychiatric emergencies.

- Arrival with the police may also increase the potential for stigma for psychiatric patients. While there have been some very positive examples of collaboration with local police forces (some of which were discussed during the Roundtable), the very fact of a patient having been brought into the hospital by police may exacerbate stigma. It was also noted that patients brought to the emergency department by police incur a "record" in electronic form showing that they have had an interaction with police and the reason for this interaction. In some instances, this record has followed people with devastating consequences such as not passing police checks for certain types of jobs or not being able to cross the border.

- Finally, some delegates noted that for psychiatric patients who suffer from a concurrent substance abuse disorder and/or addiction, there may be a greater potential for stigma.

Process & Linkages:

There were a number of general comments made about process and linkages, but the one that seemed to interest and engage most delegates involved establishing a link between efforts to mitigate stigma with hospital accreditation. There was a sense that linking these recommendations to hospital and program accreditations could be one method to focus the attention of hospital administrators and executives who allocate the resources. Similarly, this could provide a more direct link into pre- and post-licensure programs within the professions. There was agreement to explore this issue further with the Canadian Council on Health Services Accreditation.

Recommendation #4: Clearinghouse for Information

The Problem:

Throughout the Roundtable discussion it became apparent that there were a number of leading practices and positive experiences from across the country that most delegates were not aware of. This highlighted the need to share best/better practices and clinical models more effectively so that more people could benefit from positive developments.

The Recommendation:

There was general agreement that it would be worth exploring the value of a “clearinghouse” to share best practices and clinical models.

Characteristics:

Delegates agreed that for such a system to be useful it must be easy to provide input into and access data from. Similarly, the content would need to be reliable and consistently uniform, which could present a problem since there was a sense that common information of this nature may not be currently available.

Some delegates suggested that even sharing anecdotal experiences, which outline the clinical models and the successes that have been achieved, would be a helpful step toward improving understanding and the availability of information.

Barriers:

Delegates raised concerns about possible privacy issues as data points are shared. There was a sense that this issue could be overcome by secure technology and the use of aggregate data, but it was an important barrier to raise so that it can be managed.

The lack of consistent terminology/definitions, few – if any - “best” practices, and incomplete information, particularly in respect of longitudinal data and/or a unique patient identifier, were also raised as barriers that could make it difficult to compare and validate experiences across setting/jurisdictions.

Process & Linkages:

Delegates identified a number of groups who would have to be engaged in the further development of this recommendation, including the Canadian Institutes of Health Research, the Canadian Institute for Health Information, Canada Health Infoway, the Mental Health Commission of Canada and others.

Recommendation # 5: System Coordination

The Problem:

There were a number of generalized "systems" problems that were identified throughout the Roundtable discussion, which delegates agreed could all be grouped together under the heading of System Coordination. This includes issues such as:

- *Interaction between the police and emergency departments:* While there have been some individual successes (e.g., in Toronto and Vancouver), there is still a lot of work to be done in terms of how both organizations are trained, how they understand each others' needs, and how they interact on a day-to-day basis;

- *Access to beds:* There was a strong view that the lack of information about where beds are, which are available and how they are being utilized – as well as disagreement about the definition of an "occupied" bed – creates significant challenges for making any real progress on patient wait times;

- *Allocation of scarce resources and limited coordination of those that do exist:* In the end, delegates agreed that many of the outstanding issues came down to a question of the allocation of scare resources, which is complicated by the fact that different parts of the system do not work well together and no one appears to have "perfect knowledge" about what is going on across the mental health system.

- *Dealing effectively with aggression:* While it is not often talked about openly, some psychiatric clients have the potential for violent behavior. The police assume that the EDs and the mental health system can and should deal with them but some parts of the health system are not equipped for such clients.

Within the context of system coordination, these were felt to be main problems that need to be addressed.

The Recommendation:

While there was a great deal of discussion about the need for greater system coordination, there were no comprehensive solutions or recommendations offered by delegates. Some pointed to the

experience of the Canadian Stroke Network, which achieved a high degree of system coordination as a possible model, but others noted that there are substantive differences between the two situations.

As some delegates noted, they have spent the better part of several decades dealing with these same issues and there are no easy fixes. That said, there was general agreement to look at different approaches to system coordination and to try to move in the direction of greater collaboration and integration over time.

Delegates noted that, even in the absence of widespread system coordination, there is consensus on the key elements of a diversion crisis system which include telephone crisis lines, mobile crisis units, walk-in crisis programs and safe beds – working in coordination with EDs and emergency response personnel.[5] However, most jurisdictions have not implemented the full spectrum.

Characteristics:

Delegates identified a number of characteristics that should be considered in the context of a broader effort at system coordination.

- As a starting point, delegates agreed that any such effort must address the need for better collaboration among first responders (e.g., police and paramedics) and hospital staff in emergency departments. There were a number of models discussed during the Roundtable that may be able to be applied elsewhere. The general sentiment was that this will be driven by a concerted local effort to work more closely together and to consider the needs of all of the respective parties in these interactions. Similarly, issues related to definition and identification of occupied beds need to be addressed.

- Several delegates highlighted the need to work toward greater system coordination within the mental health profession and the various services associated with it. There was general agreement that greater intra-organizational cooperation and coordination is just as important as collaboration with other parts of the system.

- During the Roundtable, several delegates identified the need to work toward broader systems issues that could include initiatives

[5] 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

such as a single funding envelope to address better coordination, identification of a leader (or as one delegate put it – a czar) who would be responsible for having access to all available information and would be empowered to make decisions that impact the system as a whole, with appropriate levels of accountability built in. There was a general understanding that these types of initiatives are well beyond the scope of the Roundtable itself and would extend beyond the issues of psychiatric patient waits at Emergency departments, however there was a feeling that moving in this direction would be beneficial over time.

Barriers:

When looking at the issue of broad system coordination, several barriers were identified that make it difficult to attempt to take on the whole issue all at once. Delegates noted the systemic barriers within the health profession and cultural differences between the various players (e.g., police and medical profession), as well as the need for almost universal buy-in from the various constituency groups, many of which have resisted such moves in the past. Several other barriers were identified, ranging from the sheer volume of resources and effort that would need to be expended on such an initiative to the lack of trust and understanding that exists between the various levels and components of the system.

Process & Linkages:

In the end, delegates agreed that the barriers to wholesale change are too significant to attempt to move forward with a top-down only effort at driving system coordination. Building on the experiences of many of the delegates who have been through such exercises in the past, delegates agreed that this is one area where incremental, bottom-up initiatives are a necessary part of the way forward.

Next steps

Arising from the discussion were some pointers that suggested next steps.

1. Delegates offered themselves for collaboration on the ongoing development of CTAS modifiers for mental health – as led by the Canadian Association of Emergency Physicians, Association des

médecins d'urgence du Québec, National Emergency Nurses Affiliation, Canadian Paediatric Society, and the Society of Rural Physicians of Canada.

2. The Mental Health Commission of Canada is developing a National Mental Health Strategy. One component for the Strategy should be recommendations on resolving problems related to psychiatric emergencies in Canada's Emergency departments. The Roundtable's deliberations point to a foundation for these recommendations.

3. The Canadian Council on Health Services Accreditation can have an active role in moving this issue forward. In the near future, the Mood Disorders Society of Canada will meet with representatives from the CCHSA to obtain commitments on its role in assisting in reform.

4. The recommendations, as encapsulated in this report, provide Health Canada, the Canadian Institute of Health Information and the Canadian Institutes for Health Research with valuable insights on how they can contribute to the collection of basic data and the development and sharing of best practice and evaluation research. The Public Health Agency of Canada – with its role of surveillance – will also find the recommendations of interest, as will the provincial and territorial governments.

5. The Mood Disorders Society of Canada (and other consumer and family organizations) now have guidance on potential next steps towards improved consumer and family engagement in developing solutions to the problem of psychiatric emergencies in Canada's emergency departments.

6. The Wait Times Alliance conference, The Taming of the Queue, scheduled for the spring, will have a portion of its program devoted to wait times in emergency departments. [6]

7. Delegates, themselves, are now supplied with the names and coordinates of colleagues with whom they share a common interest. Informal networking can continue long after the conclusion of the Roundtable.

[6] http://www.cma.ca/index.cfm/ci_id/45087/la_id/1.htm

8. There will be wide dissemination of these recommendations. The Mood Disorders Society of Canada, as host for the Roundtable, will post the report on its website and forward it via email to its many contacts throughout the country, including senior provincial and territorial officials, national agencies and professional associations. It will also be made available at the Taming of the Queue conference. All delegates will be encouraged to disseminate the report among their local contacts.

Conclusion

At the end of the Roundtable discussion, there was broad consensus that the session had been worthwhile, that delegates had learned from each other, and that there were a number of areas of agreement that will help advance the issue of psychiatric patient waits in Canada's Emergency departments.

Delegates have had a chance to review this report. As such, this represents a consensus view from the Roundtable discussion and provides the Mental Health Commission of Canada with recommendations and suggested approaches for moving forward.

Appendix 1: Delegates

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Appendix 2

Featured Speakers Summary of comments

***Dr. Barbara Everett**:* In preparation of the Background Paper for this historical day, all sources stated that psychiatric emergencies in Canada's Emergency departments are an unaddressed problem. However, there is a notable absence of research and evaluation data, and no best practices to offer solutions, although there are some "promising" practices. What goes on before and after the Emergency Department seems at least, if not more, important than ED processes themselves. As with many health care issues, solutions appear to be systemic – although, as we all know, systemic coordination/integration is much easier said than done.

***Justice Edward Ormston**:* Police are calling themselves "psychiatrists in blue." They can wait an average of 8 – 10 hours with patients before an assessment. Unfortunately, if people are turned away at the ED, they end up in jail. Some solutions that police have seen work:

- Mobile crisis teams made up of police and mental health workers who can do crisis de-escalation and/or pre-screening,
- Social workers located near the hospital who can address social crises and, with psychiatric back-up, can place a patient on a Form, thus avoiding long waits in the ED,
- Psychiatrists on call for telephone advice so an intervention can begin before an ED visit is required,
- Police want to be trained in how the Canadian Triage and Acuity Scale (CTAS) is used – and conversely, police want mental health professionals trained in how to deal effectively with police.

There is a moral responsibility not to criminalize the mentally ill. Police are anxious and willing to be involved.

***Dr. Manon Charbonneau**:* I want to refer the group to the Canadian Psychiatric Association's position paper on wait times.[7] I come from a rural community. When something is not working, we know it immediately. In order to improve, we need to address issues such as communication and coordination – and share expertise among professionals. I think a triage check list is very important to see that the right person gets to the right treatment – at the right time. The

[7] 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

Quebec Plan d'action en sante mentale 2005 – 2010: La force des liens[8] created 95 areas in Quebec. All providers are linked together. Centres de Sante et de Service Sociaux (CSSSs) are responsible for these areas so they (and we) can see exactly what is not working. When a person presents at an Emergency Department, we ask, "What went wrong?" We see an ED visit as a systems problem. So we have good clinical coordination – we take calls from everywhere and we have a system of triage. We ask, "Is this a social crisis?" If so, there are a lot of things that can be done before to prevent a visit to Emerg. Then there is the output side. We have another person working on the post-emerg situation which is also managed by triage. Psychiatrists *must* reserve open appointments in their schedules to see people pre- and post-emerg. This ensures that people who are in the ED are supposed to be in the ED.

Dr. Julie Spence*:* The Canadian Triage and Acuity Scale (CTAS) was implemented in 1998. Prior to this time there was not a standardized triage tool for Canadian emergency departments. The CTAS National Working Group is a collaborative partnership of 5 organizations, including the Canadian Association of Emergency Physicians, Association des médecins d'urgence du Québec, National Emergency Nurses Affiliation, Canadian Paediatric Society, and the Society of Rural Physicians of Canada. This volunteer committee is responsible for ongoing revisions of the triage tool, definitions, and associated teaching materials. Further information may be found at http://www.caep.ca/template.asp?id=B795164082374289BBD9C1C2BF4B8D32.

A subcommittee of the CTAS-NWG has recently revised the mental health modifiers for CTAS. However, we need a mechanism to develop the interest and education for emergency based healthcare workers. With mental health patients, there are repeated admissions and discharges so we ask ourselves, "What can we really do to be effective?" In a similar manner that expertise was developed in trauma, cardiac and stroke care, we need to develop expertise in mental health care. In mental health, we're not sure what we're doing that really helps. I believe we need to look much more closely at recovery and relapse models, education, and an integrated system of care.

[8] The plan created Centres de Sante et de Service Sociaux (CSSS) which, among other health services, have the responsibility for first-line (primary care) and second-line psychiatric services for children and adults. It also involved the transfer of resources (budgetary and staff) from psychiatric institutions and general hospitals with psychiatric units to CSSSs to ensure capacity. The plan is not available in English.