Crisis Response Service Standards

for Mental Health Services and Supports

May, 2005

Ontario

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Introduction

Crisis Response Services

Crisis response services are a key part of the continuum of mental health services and supports for people with serious mental illness. Crisis response services offer treatment and support to individuals experiencing a crisis. They provide immediate relief from symptoms, prevent the condition from worsening and resolve the crisis as soon as possible. Because mental health crises differ in their origins and symptoms, crisis response services must be able to respond to individual need by providing a range of appropriate services in a variety of settings. Services must be integrated and coordinated within the broader mental health system to meet differing needs, including those of individuals currently accessing other mental health services as well as those accessing the mental health system for the first time through crisis response services.

Crisis response services provide individuals with timely access to a variety of crisis service options such as telephone crisis response, walk-in services, mobile crisis outreach, crisis residential services, and psychiatric emergency/medical crisis services. These services reduce unnecessary hospitalization and improve quality of life for individuals experiencing a mental health crisis through symptom relief and access to on-going support to prevent future crises.

Need for Crisis Response Service Standards

The Ontario health system is dedicated to achieving a consumer-oriented system that provides access to effective, quality health services through accountability and performance management. As well, the Ministry of Health and Long-Term Care is committed to providing a reformed mental health system that is focused on the delivery of comprehensive, coordinated and results-driven mental health services. The ministry documents *Making It Happen: Implementation Plan for Mental Health Reform*, *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* and the *Mental Health Accountability Framework* guide the mental health reform process and direct the development of an accountable mental health system.

To date, crisis response services have been provided in communities across Ontario. Because programs are often developed in response to local needs, service components are not consistent across the province. As part of the commitment to achieve mental health service system responsibility and accountability, standards have been developed to ensure that crisis response services reflect the goals and principles of province-wide mental health reform. Standards set expectations for crisis response services so services across the province are consistent and incorporate evidence-based best practices. Service provision in accordance with standards will permit development of performance measures and data collection requirements for monitoring the delivery of crisis response services.

This document sets out the ministry standards for crisis response services. It also describes the process for developing and validating the standards and the next steps in developing mechanisms to monitor services to ensure they are being provided appropriately and effectively.

Broad Policy Context

The development of crisis response service standards is occurring within a context of broader healthcare reform which is dedicated to achieving a healthcare system that is consumer oriented and community-based and focuses on improved access to quality, accountable and evidence-based services. The provision of accountable, evidence-based, accessible crisis response services is consistent with broad national and provincial government directions and policies for healthcare reform and provides opportunities for the integration of mental health services and supports with some of these broader healthcare initiatives.

Current healthcare initiatives in Ontario such as Local Health Integration Networks, Primary Care Reform and Family Health Teams focus on creating an integrated healthcare system that provides access to consumer-centred, comprehensive and appropriate healthcare (*Ontario Ministry of Health and Long-Term Care, 2004*). The goals of mental health reform, including crisis response services, reflect similar objectives. Current initiatives present an opportunity to expand health system capacity through the development of linkages between broader healthcare reform and mental health services.

National healthcare initiatives in recent years have specifically committed to the provision of improved community-based mental health services, including crisis response services. The Commission on the Future of Health Care in Canada's (2002) *Final Report: Building on Values: The Future of Health Care in Canada* made a number of recommendations intended to ensure the long-term sustainability of Canada's healthcare system. It recommended investing in home care services, including acute mental health services, as a priority. Services to support individuals at home when they are experiencing a crisis were identified as a key component of acute mental health services.

The First Ministers' Health Accord on Health Care Renewal (*Health Canada, 2003*) is the Federal, Provincial and Territorial governments' commitment to improve the quality, access and sustainability of health services. Three priority areas were identified to meet these goals. One of the priorities was home care, and, as part of this, a commitment was made to invest in the provision of acute community mental health services, including crisis response.

The Ontario Government has also identified its commitment to addressing community mental health services. The 2004 Ontario Budget committed to expanding community mental health services to serve an additional 78,600 clients annually by 2007-08 through access to crisis response, case management, assertive community treatment and early intervention in psychosis services (*Ontario Government, 2004*).

Provincial Policy Context

Various Ministry of Health and Long-Term Care documents have emphasized the need for mental health service accountability. Accountability ensures the continuous setting of standards, monitoring of performance and reporting on outcomes, to permit evaluation and improvement of the efficiency and effectiveness of programs and services and to meet system-wide goals. The development of system-wide program and service standards is a key part of this accountability.

Making It Happen

In 1999, the Ministry of Health and Long-Term Care released its implementation plan and operational framework for mental health reform. The implementation plan, *Making It Happen: Implementation Plan for Mental Health Reform*, provides the overall context for the reformed mental health system and sets out the principles and goals for mental health reform.

One of the stated principles is that mental health services will be provided in accordance with evidence-based best practices.

Among the goals for mental health reform presented in *Making It Happen: Implementation Plan for Mental Health Reform* are ensuring that mental health services and supports:

- Are provided within a comprehensive service continuum developed to meet consumer needs and based on best practices;
- Are appropriately linked to other services and supports within geographic areas;
- Achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and
- Are simplified and readily accessible, according to the consumer's needs.

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports defines the comprehensive continuum of supports and services available in the reformed mental health system, and guides how the services should be organized and delivered. Crisis response services are considered to be part of the comprehensive continuum of supports and services. The *Operational Framework* also lays out the overall features and functions of crisis response services and provides a framework for the development of the crisis response service standards. (See Appendix D for Functions of Crisis Response Services.)

Mental Health Accountability Framework

The *Making It Happen* documents identify accountability as key to mental health system reform. In April 2003, the Ministry of Health and Long-Term Care released the *Mental Health Accountability Framework* that provides guidelines for monitoring the accountability, efficiency and effectiveness of mental health services and supports. Accountability mechanisms strive to continually evaluate and improve the mental health system through setting performance standards and measuring outcomes. The *Mental Health Accountability Framework* defines the performance domains and their accompanying indicators that inform the development of service standards and related outcome-based performance measures and data collection tools. (See Appendix A for definitions of the domains.) Multiple indicators have been developed for each performance domain, although not all indicators will be relevant to every crisis response service. (See Appendix B for a table presenting the domains and indicators.)

Process for Developing Standards

Interjurisdictional Review

An interjurisdictional review of the status of standards development for crisis response services in Ontario, the rest of Canada and key international jurisdictions was conducted. Within Canada, most provinces are at some stage of describing programs and services and developing standards, including British Columbia and Nova Scotia, which have fully articulated program standards for crisis response services (*British Columbia Ministry of Health, 2003; Nova Scotia Department of Health, 2003*). British Columbia defined standards for five key crisis services: crisis lines, mobile crisis outreach services, walk-in crisis stabilization services, community crisis stabilization services, and hospital-based services (*British Columbia Ministry of Health, 2003*). Nova Scotia has developed crisis response standards to address accessibility, appropriateness, competence, safety, acceptability and continuity and used a typology of evidence to evaluate the standards based on available evidence supporting best practices (*Nova Scotia Department of Health, 2003*).

Work at the national level and in several states in the United States was reviewed. California, Ohio and Vermont have well-defined services which were often standards-focused and described specific expectations (i.e., access) (*California Mental Health Planning Council, 2003; Ohio Department of Mental Health, 1999; State of Vermont Department of Developmental and Mental Health Services, 2002*). In Oklahoma, specific crisis response standards for community-based crisis organizations address requirements for service provision, crisis stabilization, triage, consumer rights, etc. (*Oklahoma Department of Mental Health and Substance Abuse Services, 2003*).

In the United Kingdom and Australia, there is no specific information on direct statements of crisis response service standards. However, both countries have developed national service standards for all mental health services (*Commonwealth of Australia, 1996; National Health Service, 1999*). In Australia, the standards related to crisis response services include the provision of a system to prioritize referrals, the availability of services 24 hours a day/seven days a week, and the provision of an integrated mental health system that includes crisis response services (*Commonwealth of Australia, 1996*). In the United Kingdom, the standards focus on the provision of effective services for people with serious mental illness, families/key supports and for service providers (*National Health Service, 1999*). In both countries, the standards were based on the best evidence available and are intended to be used to monitor, evaluate and improve mental health services.

Stakeholder Working Group

In June 2003, the ministry consulted with a stakeholder working group of front-line providers, including consumer organizations, regarding the content for crisis response service standards. (See Appendix C for a list of participants.) Using the functions for Crisis Response Services set out in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* and the Nova Scotia standards (*Nova Scotia Department of Health, 2003*) as a guide, the group developed draft standards. Each standard was linked to a performance domain and associated indicators in the *Mental Health Accountability Framework*. A sub-group of the original working group met again in November 2003 to review and refine the draft standards.

Validation of Standards

The set of standards drafted by the stakeholder working group was validated through a review of academic literature and a scan of crisis response service standards in provinces across Canada. A "levels of evidence" typology was based on a typology developed by the Nova Scotia Department of Health (*Nova Scotia Department of Health, 2003*) (See Appendix F for a description of the levels of evidence typology) to compare the proposed standards with available evidence. Relevant literature was reviewed against the standards. Each standard was rated based on the levels of evidence typology and evidence supporting the standard was identified.

Crisis Response Service Standards

Features of Crisis Response Services – A Vital Component of the Service Continuum

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports describes the features of comprehensive crisis response services.

A crisis is defined as the onset of an emotional disturbance or situation distress (which may be cumulative) involving a sudden breakdown of an individual's ability to cope.

Crisis response services are part of an integrated system of mental health services and should provide timely access to a wide range of crisis options on a 24 hour basis. Active treatment and support is offered in a variety of environments as soon as possible after an individual is identified as in acute distress. Services should provide immediate relief of symptoms and rapid stabilization so the condition does not worsen. Crisis response services also offer the opportunity to develop longer-term treatment and rehabilitation plans and have the potential to mobilize community resources and avert the need for short and/or long-term hospitalization.

Examples of crisis response services include telephone crisis response, walk-in services, mobile crisis outreach, crisis residential services and psychiatric emergency/medical crisis services.

Crisis response services are available to all people with symptoms of mental illness and take into account the age, gender, race, language, etc., of the person. Priority is given to individuals with serious mental illness and those who may be at risk of causing harm to themselves or others.

Crisis Response Service Functions

A range of services and supports are required by consumers and their families to assist in crisis prevention and on-going support. *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* sets out the following specific functions of a crisis service. (See Appendix D for a definition of the functions.)

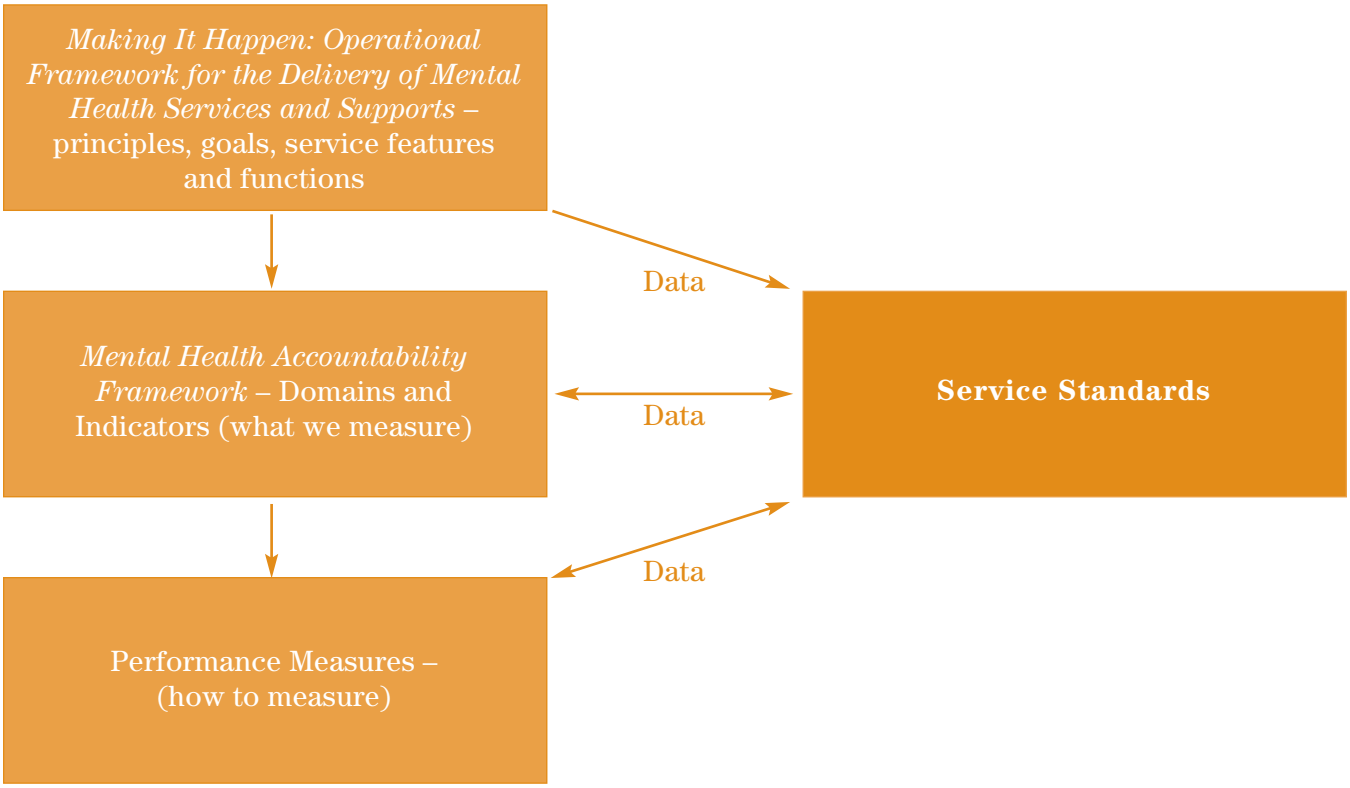
- Assessment and Planning
- Crisis Support/Counseling
- Medical Intervention
- Environmental Interventions and Crisis Stabilization
- Review/Follow-up/Referral
- Monitoring and Evaluation
- Information, Liaison, Advocacy and Consultation/Collaboration

Standards were developed for each of the crisis response service functions and reflect the general features of crisis response services.

Relationship Between Service Standards, Functions, Domains, Indicators and Performance Measures

Compliance with standards will ensure services are comprehensive, coordinated and based on consumer need and best practices. The crisis response service standards reflect the key features and functions of crisis response services laid out in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, and the performance domains and indicators identified in the *Mental Health Accountability Framework*.

Figure 1: Relationship Between Service Standards, Functions, Domains, Indicators and Performance Measures



Each crisis response service standard relates to one or more of the domains and indicators.

The next step will be the development of performance measures based on the applicable domains and indicators. For this reason, every standard is associated with domain(s) and indicators and has been worded so it can be translated into measurable statements. (Refer to Appendix E for a table presenting the standards and the related domains and indicators.) Each indicator may encompass a number of measurements relevant to the service provided. For example:

- **Indicator**: Accessibility – Wait times for needed services.

  Standard: Upon identification of a crisis, the first contact with the consumer by the crisis response service must be established within 90 minutes.

Measure:
Number of consumers where first contact was established in:
Under 15 minutes
Between 16 and 30 minutes
Between 31 and 45 minutes
Between 46 and 60 minutes
Between 61 and 75 minutes
Between 76 and 90 minutes
Over 90 minutes

- **Indicator**: Acceptability – Consumer/family satisfaction with service provided.

  Standard: A consumer satisfaction survey should be developed and implemented on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS.

  Measure:
  Percentage of consumers who reported in the consumer satisfaction survey that they were satisfied with the service received.
  Less than 50%
  51-60%
  61-70%
  71-80%
  81-90%
  91-100%

Once performance measures are developed for each indicator related to a crisis response standard, data will be collected and used to evaluate services and further refine the standards as required. Standards and services will continually be re-evaluated based on the measures and collected data to ensure the standards reflect best practices.

Crisis Response Service Standards

The standards presented in this document have been developed based on the service functions in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, and the domains and indicators defined in the *Mental Health Accountability Framework*. They also reflect consultation with the stakeholder working group, developments in other jurisdictions and research evidence.

The following chart presents each standard, its related service function and domain(s) and identifies the level of evidence (i.e., research evidence, expert opinion) supporting the standard. (See Appendix F for a description of the levels of evidence typology.)

Table 1: Crisis Response Service Standards

Function	Standard	Domain	Levels of Evidence[1]			
			1	2	3	4
Assessment and Planning	• Upon identification of a crisis, the first contact with the consumer by the crisis response service (CRS) must be established within 90 minutes.	Accessibility				✓
	• A crisis requiring in-person contact will be responded to as soon as possible. Response time should be within 24 hours, with consideration for travel time, weather, etc.	Accessibility				✓
	• Crisis support telephone lines must be configured to include a queuing system that lasts no longer than 15 minutes. During the wait time, voice instructions for alternative crisis management options must be provided (e.g., 911, local emergency number, another crisis line).	Accessibility				✓
	• Protocols must be in place with related service providers (e.g., case management services, psychiatrists, hospitals, primary care teams, etc.) in order to ensure access to necessary medical, psychiatric and psychological/social assessments and existing crisis management protocols. If access to other health records will assist in planning with the consumer, documented consent is required.	Accessibility		✓		✓
	• Services must be provided in the consumer's place of choice wherever possible.	Accessibility				✓

[1] Levels of Evidence
- Level 1 involved direct evidence of effectiveness (i.e., specific standard evaluated as independent variable in a study and shown to produce positive outcomes).
- Level 2 considered indirect evidence of effectiveness (i.e., specific standard is one of the characteristics or ingredients of a program which has been shown to be effective).
- Level 3 involved studies based on expert opinion/consensus of effectiveness or correlational evidence of standards being associated with positive consumer outcomes.
- Level 4 involved expert opinion (i.e., defined by the working group or other Canadian jurisdictions in absence of empirical support in research literature).

Table 1: *continued*

Assessment and Planning (continued)	• The CRS will ensure that staff have training and core competencies in a variety of areas, to the best extent possible, (e.g., risk assessment; suicide assessment; crisis intervention; safety standards; conflict resolution; anti-racism training; psychiatric symptomatology and psychiatric medications).	Competence				✓
	• The CRS must ensure that workers are provided with information regarding relevant legislative reporting requirements.	Competence				✓
Crisis Support/ Counseling	• Services are consumer directed and will be provided in the least intrusive manner possible.	Accessibility, Acceptability and Appropriateness				✓
	• Written protocols for consumer and service provider safety must be established.	Safety				✓
	• Written protocols must be developed to ensure that timely consultation is available with various service providers (e.g., physicians, guidance counselors, CAS workers) to assist in identifying and intervening in actual emergencies; documented consent is required.	Accessibility				✓
	• Short-term crisis support/counseling will be available to provide risk assessment, de-escalation and safety planning, to the best extent possible, given the mandate of the CRS.	Accessibility				✓
Medical Intervention	• The CRS must have written protocols for initiating and accessing medical interventions in a timely manner.	Accessibility				✓
	• The CRS will have procedures/ guidelines for responding to emergency and non-emergency medical situations.	Appropriateness				✓
Environmental Interventions and Crisis Stabilization	• All CRS will have access to other services 24 hours a day, seven days a week.	Accessibility				✓
	• All CRS will have access to current community contact information.	Competence				✓

Table 1: *continued*

Environmental Interventions and Crisis Stabilization (continued)	• Protocols are in place for providing referral and support (i.e., income support, dealing with employers, access to long/short-term housing, addressing family issues) based on consumer-articulated needs.	Appropriateness and Accessibility				✓
Review/ Follow-up/ Referral	• The consumer must have the opportunity to review, discuss and comment on the service and its appropriateness.	Appropriateness and Acceptability				✓
	• A review process must be established that includes an assessment of consumer outcomes including status and stability (e.g., Did the consumer perceive return of control? Was the crisis stabilized?)	Effectiveness				✓
	• Written protocols must be established for providing referral and transition to post-crisis services. Referrals to post-crisis services must be based on consumer-articulated needs.	Appropriateness				✓
	• CRS must ensure that staff are provided with information about other relevant community resources.	Competence				✓
	• A written follow-up plan must be developed upon completion of service, which will include criteria for follow-up, re-entry and linkage with other services.	Effectiveness and Acceptability				✓
Monitoring and Evaluation	• Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements.	Acceptability				✓
	• A consumer satisfaction survey will be developed and implemented on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS.	Acceptability				✓
	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.	Effectiveness and Appropriateness				✓

Table 1: *continued*

Information, Liaison, Advocacy, and Consultation/ Collaboration	• Service providers must identify gaps in service and develop means for collaborating with other relevant community resources in order to meet unmet needs.	Efficiency and Continuity				✓
	• A plan must be developed and published that identifies community linkages.	Effectiveness				✓
	• The crisis worker must be knowledgeable about services that are accessible and relevant to consumers' interests in order to provide up-to-date information.	Competence and Appropriateness				✓
	• CRS must ensure that staff is provided with information about other relevant community resources.	Effectiveness				✓

Next Steps

This document describes crisis response service standards and represents the next step in the development of accountable crisis response services in Ontario. The ministry will be further developing the components of the *Mental Health Accountability Framework* in order to define and implement an accountability relationship and process with the mental health system.

The principles, goals and essential components of a reformed mental health system have been defined. Performance domains, indicators and standards have been developed, based on system principles and goals and program components. This represents one step in the provision of clear program direction for crisis response services to the field. While all service providers may not be able to meet all standards immediately, significant funding is being invested in the enhancement of crisis response services to ensure that services will be able to meet standards.

The ministry will also develop data collection requirements and outcome-based performance measures to monitor and report on the provision of crisis response services. As these performance measures and data collection requirements are implemented, the available data will be used to measure crisis response services and supports against the identified standards.

With these components in place, the ministry will be able to implement an accountability process to monitor how crisis response services are being provided and answer important questions.

Are services being delivered across the province in a manner that is consistent with ministry policy and with evidence-based best practices?

Most importantly, are consumers satisfied with the service they are receiving and is the service helping them to achieve their personal goals?

This will inform the continual improvement and evaluation of the system of crisis response services within Ontario's mental health system.

Appendix A: Performance Domains[2]

Domain	Definition
Acceptability	Services provided meet expectations of service users, community, providers and government.
Accessibility	Ability of people to obtain services at the right place and right time based on needs.
Appropriateness	Services provided are relevant to service user needs and based on established standards.
Competence	Knowledge, skills and actions of individuals providing services are appropriate to service provided.
Continuity	The system is sustainable, comprehensive, and has the capacity to provide seamless and coordinated services across programs, practitioners, organizations and levels of service in accordance with individual need.
Effectiveness	Services, intervention or actions achieve desired results.
Efficiency	Organizations/programs achieve desired results with the most cost-effective use of resources.
Safety	Organizations/programs avoid or minimize potential risks or harms to consumers, families, mental health staff and the community associated with the intervention/lack of intervention or the environment.

[2] Ontario Ministry of Health and Long-Term Care (2003). *Mental Health Accountability Framework.* p. 18

Appendix B: *Mental Health Accountability Framework* – Performance Domains and Indicators[3]

DOMAIN				
INDICATORS	**Acceptability**	**Accessibility**	**Appropriateness**	**Competence**
	Consumer/family satisfaction with service received	Service reach to persons with serious mental illness (SMI)	Existence of best practice core programs	Resources available to train staff to meet required competencies for role
	Consumer/family involvement in treatment decisions	Service reach to the homeless	Fidelity: adherence to best practices	Resources available for on-the-job development and continuous learning
	Formal complaints mechanisms in place	Access to psychiatrists and other mental health professionals	Best practices services/ supports provided to persons with SMI	Meets provincial certification/ professional standards (where applicable)
	Patient bill of rights	Identify human resource gaps	Treatment protocols for co-morbidity	
	Consumer/family involvement in service delivery and planning	Access to primary care	Hospital readmission rate*	
	Cultural sensitivity	Wait times for needed services	Involuntary committal rate*	
	Consumer/family choice of services	Availability of after hours care	Length of stay in acute care*	
		Availability of transportation	Time in community programs	
		Denial of service	Use of seclusion/ restraints	
		Early intervention	Level of service and setting appropriate to needs of individual	
		Consumer/family perception of accessibility	Needs-based funding and spending	
		Access to continuum of mental health service	Consumer/family perception of appropriateness	
		Criminal justice system involvement	Availability of community services	
			Criminal justice system involvement	
			Community/institutional balance	

[3] Ontario Ministry of Health and Long-Term Care (2003). *Mental Health Accountability Framework.* pp. 20-21

DOMAIN			
Continuity	**Effectiveness**	**Efficiency**	**Safety**
Continuity mechanisms	Community tenure	Mental health spending per capita	Complications associated with electro-convulsive therapy (ECT)
Emergency room visits*	Mortality	Proportion of staff funding spent on administration and support	Medication errors
Community follow-up after hospitalization	Criminal justice system involvement	Needs-based allocation strategy	Medication side effects
Documented discharge plans	Clinical status	Community/institutional balance	Critical incidents
Cases lost to follow-up	Functional status	Resource intensity planning tool	Suicides
Clear, visible and available points of accountability	Involvement in meaningful daytime activity	Unit costs and cost per consumer	Homicides
	Housing status	Budget and tools for evaluation and performance monitoring	Involuntary committal rate
	Quality of life		Risk management practised
	Physical health status		Identify research/ practices to reduce adverse events and errors

INDICATORS

NOTE: Indicators marked with an asterisk are often used as measures. They are included here as indicators to reflect that they may signal system function or problems.

Appendix C: List of Stakeholder Working Group Participants

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Nancy Douglas/Aimee Watson,
Mental Health and
Rehabilitation Policy Unit,
MOHLTC

Appendix D: Functions of Crisis Response Services

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports (1999) defined the functions of a crisis response service.

- **Assessment and Planning** – includes gathering pertinent information from the consumer and other key supports to develop an understanding of recent events, and psychosocial and biological factors related to the presenting crisis. This function also includes the development of an intervention plan which takes into account the consumer's immediate needs, strengths, weaknesses and social support system.
- **Crisis Support/Counseling** – provides the individual and family with emotional support, practical assistance and access to a range of appropriate resources available to resolve the immediate crisis.
- **Medical Intervention** – is an integral part of the crisis response system. It is important to develop links between medical and non-medical service providers to ensure access to resources to resolve the crisis. Medical interventions may be provided by nurses, physicians and pharmacists.
- **Environmental Interventions and Crisis Stabilization** – involves access to required services to stabilize the crisis and includes direct action within the individual's community to provide supports such as arranging for money/income support, dealing with employers, planning for long/short-term housing/accommodation issues and addressing family issues.
- **Review/Follow-up/Referral** – provides appropriate referral to ongoing services and supports that have been mutually defined by the consumer and service provider once the crisis has dissipated.
- **Monitoring and Evaluation** – evaluates the achievement of goals (from the perspective of both the consumer and service provider) and consumer satisfaction.
- **Information, Liaison, Advocacy and Consultation/Collaboration** – provides information to the consumer, family/key supports and service providers regarding types of services and supports available. Works to establish partnerships among service providers to create an integrated service network, and advocates and consults on behalf of consumers and families/key supports within the service network.

Appendix E: Crisis Response Service Standards, Domains and Indicators[4]

Function	Standard
Assessment and Planning	• Upon identification of a crisis, the first contact with the consumer by the crisis response service (CRS) must be established within 90 minutes.
	• A crisis requiring in-person contact will be responded to as soon as possible. Response time should be within 24 hours, with consideration for travel time, weather, etc.
	• Crisis support telephone lines must be configured to include a queuing system that lasts no longer than 15 minutes. During the wait time, voice instructions for alternative crisis management options must be provided (e.g., 911, local emergency number, another crisis line).
	• Protocols must be in place with related service providers (e.g., case management services, psychiatrists, hospitals, primary care teams, etc.) in order to ensure access to necessary medical, psychiatric and psychological/social assessments and existing crisis management protocols. If access to other health records will assist in planning with the consumer, documented consent is required.
	• Services must be provided in the consumer's place of choice wherever possible.
	• The CRS will ensure that staff have training and core competencies in a variety of areas, to the best extent possible, (e.g., risk assessment; suicide assessment; crisis intervention; safety standards; conflict resolution; anti-racism training; psychiatric symptomatology and psychiatric medications).
	• The CRS must ensure that workers are provided with information regarding relevant legislative reporting requirements.

[4] Based on the domains and indicators defined in *Mental Health Accountability Framework* (Ontario Ministry of Health and Long-Term Care, 2003).

	Domain	Indicators
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Wait times for needed services • Availability of after hours care • Availability of transportation • Denial of service
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Wait times for needed services • Availability of after hours care • Availability of transportation • Denial of service
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Wait times for needed services • Availability of after hours care • Denial of service
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Access to psychiatrists and other mental health professionals • Wait times for needed services • Access to primary care • Availability of after hours care • Access to continuum of mental health service • Criminal justice system involvement • Denial of service
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Access to psychiatrists and other mental health professionals • Availability of transportation • Consumer/family perception of accessibility • Access to continuum of mental health service • Criminal justice system involvement
	Competence	• Resources available to train staff to meet required competencies for role • Resources available for on-the-job development and continuous learning • Meets provincial certification/professional standards (where applicable)
	Competence	• Resources available to train staff to meet required competencies for role • Resources available for on-the-job development and continuous learning

Appendix E: *continued*

Function	Standard
Crisis Support/ Counseling	• Services are consumer-directed and will be provided in the least intrusive manner possible.
	• Written protocols for consumer and service provider safety must be established.
	• Written protocols must be developed to ensure that timely consultation is available with various service providers (e.g., physicians, guidance counselors, CAS workers) to assist in identifying and intervening in actual emergencies; documented consent is required.
	• Short-term crisis support/counseling will be available to provide risk assessment, de-escalation and safety planning, to the best extent possible, given the mandate of the CRS.

Domain	Indicators
Accessibility	• Consumer/family perception of accessibility • Access to continuum of mental health service
Acceptability	• Consumer/family involvement in treatment decisions • Consumer family involvement in service delivery and planning • Consumer/family choice of services • Cultural sensitivity
Appropriateness	• Best practices services/supports provided to persons with SMI • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Availability of community services • Community/institutional balance
Safety	• Critical incidents • Suicides • Homicides • Involuntary committal rate • Risk management practised • Identify research/practices to reduce adverse events and errors • Medication side effects
Accessibility	• Access to psychiatrists and other mental health professionals • Access to primary care • Wait times for needed services • Availability of after hours care • Availability of transportation • Access to continuum of mental health service • Criminal justice system involvement • Denial of service
Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to homeless • Access to psychiatrists and other mental health professionals • Access to primary care • Wait times for needed services • Availability of after hours care • Availability of transportation • Consumer/family perception of accessibility • Access to continuum of mental health service • Criminal justice system involvement • Denial of service

Appendix E: *continued*

Function	Standard
Medical Intervention	• The CRS must have written protocols for initiating and accessing medical interventions in a timely manner.
	• The CRS will have procedures/guidelines for responding to emergency and non-emergency medical situations.
Environmental Interventions and Crisis Stabilization	• All CRS will have access to other services 24 hours a day, seven days a week.
	• All CRS will have access to current community contact information.
	• Protocols are in place for providing referral and support (i.e., income support, dealing with employers, access to long/short-term housing, addressing family issues) based on consumer-articulated needs.

Domain	Indicators
Accessibility	• Access to psychiatrists and other mental health professionals • Access to primary care • Wait times for needed services • Denial of service
Appropriateness	• Hospital readmission rate • Involuntary committal rate • Length of stay in acute care • Time in community programs • Level of service and setting appropriate to needs of individual • Availability of community services • Criminal justice system involvement • Community/institutional balance • Treatment protocols for co-morbidity
Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Access to psychiatrists and other mental health professionals • Wait times for needed services • Availability of after hours care • Availability of transportation • Denial of service
Competence	• Resources available for on-the-job development and continuous learning
Appropriateness	• Best practices services/supports provided to persons with SMI • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Availability of community services • Criminal justice system involvement • Treatment protocols for co-morbidity
Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Access to psychiatrists and other mental health professionals • Access to primary care • Wait times for needed services • Consumer/family perception of accessibility • Access to continuum of mental health service • Criminal justice system involvement • Denial of service

Appendix E: *continued*

Function	Standard
Review/ Follow-up/ Referral	• The consumer must have the opportunity to review, discuss and comment on the service and its appropriateness.
	• A review process must be established that includes an assessment of consumer outcomes including status and stability (e.g., Did the consumer perceive return of control? Was the crisis stabilized?)
	• Written protocols must be established for providing referral and transition to post-crisis services. Referrals to post-crisis services must be based on consumer-articulated needs.
	• CRS must ensure that staff are provided with information about other relevant community resources.
	• A written follow-up plan must be developed upon completion of service, which will include criteria for follow-up, re-entry and linkage with other services.

	Domain	Indicators
	Appropriateness	• Consumer/family perception of appropriateness
	Acceptability	• Consumer/family satisfaction with service received • Formal complaints mechanisms in place • Cultural sensitivity
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Appropriateness	• Best practices services/supports provided to persons with SMI • Treatment protocols for co-morbidity • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Availability of community services
	Competence	• Resources available to train staff to meet required competencies for role • Resources available for on-the-job development and continuous learning
	Effectiveness	• Community tenure • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Acceptability	• Consumer/family involvement in service delivery and planning • Cultural sensitivity • Consumer/family choice of services

Appendix E: *continued*

Function	Standard	
Monitoring and Evaluation	• Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements.	
	• A consumer satisfaction survey will be developed and implemented on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS.	
	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.	

	Domain	Indicators
	Acceptability	• Consumer/family satisfaction with service received • Consumer/family involvement in treatment decisions • Formal complaints mechanisms in place • Patient bill of rights • Consumer/family involvement in service delivery and planning • Cultural sensitivity • Consumer/family choice of services
	Acceptability	• Consumer/family satisfaction with service received • Consumer/family involvement in treatment decisions • Formal complaints mechanisms in place • Patient bill of rights • Consumer/family involvement in service delivery and planning • Cultural sensitivity • Consumer/family choice of services
	Appropriateness Effectiveness	• Fidelity: adherence to best practices • Best practices services/supports provided to persons with SMI • Community tenure • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status • Mortality

Appendix E: *continued*

Function	Standard	
Information, Liaison, Advocacy, and Consultation/ Collaboration	• Service providers must identify gaps in service and develop means for collaborating with other relevant community resources in order to meet unmet needs.	
	• A plan must be developed and published that identifies community linkages.	
	• The crisis worker must be knowledgeable about services that are accessible and relevant to consumers' interests in order to provide up-to-date information.	
	• CRS must ensure that staff is provided with information about other relevant community resources.	

	Domain	Indicators
	Efficiency	• Mental health spending per capita • Proportion of staff funding spent on administration and support • Needs based allocation strategy • Resource intensity planning tool • Budget and tools for evaluation and performance monitoring
	Continuity	• Continuity mechanisms • Community follow-up after hospitalization
	Effectiveness	• Community tenure • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Competence	• Resources available to train staff to meet required competencies for role • Resources available for on-the-job development and continuous learning
	Appropriateness	• Fidelity: adherence to best practices • Treatment protocols for co-morbidity • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Availability of community services • Criminal justice system involvement • Community/institutional balance
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status

Appendix F: Literature Review – Summary of Key Research Findings on Crisis Response Services

Research literature on crisis response services (CRS) was reviewed to inform standard development. In general, there is limited research available in this area and it is under-studied compared with other areas in mental health. Of the research studies available, most were descriptive in nature and explored the approaches/components of crisis service delivery. Few studies used an experimental design to evaluate the effectiveness of CRS.

The following presents a summary of the findings of these literature reviews.

Review of Best Practices in Mental Health Reform (1997)

The 1997 *Review of Best Practices in Mental Health Reform* (*Goering et al.*) prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health found that:

- Compared to other service areas such as case management, the components of CRS have been poorly studied.
- Most of the literature on CRS has been descriptive in nature, lacking an experimental design. Only one study *(Merson et al., 1992)* conducted a clinical study comparing inpatient hospitalization to care in the community. Other studies evaluated components of CRS including mobile crisis units *(Fisher et al., 1990; Reding & Raphelson, 1995)*, crisis housing *(Leaman, 1987; Bond et al., 1989)* and hospital-based services *(Gillig et al., 1989; Lambert, 1995)*.
- There is almost no evidence supporting the efficacy of different crisis interventions. (*Geller et al., 1995)* surveyed mobile crisis services and found that, although the services had been accepted and implemented, no systematic evaluations have been carried out. However, the studies reviewed suggest:
  - Crisis housing provides a viable alternative to hospitalization for persons with serious mental illness,
  - Diversion programs are effective, and
  - Crisis centres can serve persons with psychosocial problems.
- Based on these findings, the following key elements of best practice for CRS were identified:
  - Use of minimally intrusive options,
  - Programs available to divert people from inpatient hospitalization, and
  - Evaluation/research protocols are incorporated into crisis programs.

Inter-jurisdictional Review

A literature review and an inter-jurisdictional scan were conducted to assess the state of CRS standards. Literature and documents were reviewed for service standards currently in place or being designed. The review revealed that:

- There is considerable on-going work within Canada and around the world. All Canadian jurisdictions reviewed had developed or were in the process of developing services and standards (*British Columbia Ministry of Health, 2003; Manitoba Department of Health, 1997; Nova Scotia Department of Health, 2003; Newfoundland Department of Health and Community Services, 2003*). Australia, the United Kingdom and the United States were at various points in developing standardized programs and services. Australia and the United Kingdom do not have standards specific to CRS but have developed national standards that are applied to all mental health services (*Commonwealth of Australia, 1996; National Health Service, 1999*).
- There is a lack of firm standards that are evidence-based, or that have been evaluated.
- Existing literature is limited and tends to evaluate services rather than evaluate the effectiveness of crisis interventions, although Cochrane et al. (1997) found that CRS are effective in diverting people from inpatient hospitalization and for minimizing the intrusiveness of the intervention.

- There is consensus that CRS are an essential component of the overall mental health system; however, it was found that definitions and implementation of services varied across jurisdictions.
- The Community Mental Health Evaluation Initiative conducted a series of evaluations involving various types of mental health programs, including a one-year evaluation of two mobile crisis programs. The findings from the evaluation of the two mobile crisis programs suggest the need for:
  - Integrating mobile crisis services with other mental health services
  - Clear lines of accountability and responsibility and attention to quality assurance
  - Close supervision and feedback to mobile crisis workers
  - A clear definition of the target population
  - Educational and communication opportunities among mobile crisis services and other agencies (i.e., policy, psychiatric services within a coordinated network of mental health services). (*Ferris et al., 2000*)

Literature Review: Standards Validation

A literature review was conducted to validate the service standards for CRS. Levels of Evidence were used to review the literature supporting the standards.

Levels of Evidence

- A four-level typology of evidence adapted from the typology developed by the Nova Scotia Department of Health (*Nova Scotia Department of Health, 2003*) was used to assess the literature against the proposed crisis response service standards.
- Level 1 involved direct evidence of effectiveness (i.e., specific standard evaluated as independent variable in a study and shown to produce positive outcomes).
- Level 2 considered indirect evidence of effectiveness (i.e., specific standard is one of the characteristics or ingredients of a program which has been shown to be effective).
- Level 3 involved studies based on expert opinion/consensus of effectiveness or correlational evidence of standards being associated with positive consumer outcomes.
- Level 4 involved expert opinion (i.e., defined by the working group or other Canadian jurisdictions in absence of empirical support in research literature).

Review Findings

Overall, there were limited experimental research studies supporting the development of standards. In general, the research tended to be descriptive but did not identify specific program components or best practices. Evidence for the proposed standards was largely based on expert stakeholder opinion. Other Canadian jurisdictions were found to have developed similar standards based on similar levels of evidence (i.e., Nova Scotia, British Columbia).

Appendix F: *continued*

Function	Standard	Evidence for Standard
Assessment and Planning	• Upon identification of a crisis, the first contact with the consumer by the crisis response service (CRS) must be established within 90 minutes.	• Level 4 – Based on expert opinion. British Columbia (BC) – Standard for mobile crisis units requires immediate response to crisis.
	• A crisis requiring in-person contact will be responded to as soon as possible. Response time should be within 24 hours, with consideration for travel time, weather, etc.	• Level 4 – Based on expert opinion. BC – Standard for mobile crisis units requires the development of guidelines for the prompt determination of a response strategy to crisis calls.
	• Crisis support telephone lines must be configured to include a queuing system that lasts no longer than 15 minutes. During the wait time, voice instructions for alternative crisis management options must be provided (e.g., 911, local emergency number, another crisis line).	• Level 4 – Based on expert opinion.
	• Protocols must be in place with related service providers (e.g., case management services, psychiatrists, hospitals, primary care teams, etc.) in order to ensure access to necessary medical, psychiatric and psychological/social assessments and existing crisis management protocols. If access to other health records will assist in planning with the consumer, documented consent is required.	• Level 2 – Three studies. Found participation of psychiatrist (*Reding & Raphelson, 1995*) and the ability to prescribe medication (*Tufnell et al., 1985; Reynolds et al., 1990*) critical to mobile crisis teams in reducing hospitalization. • Level 4 – Based on expert opinion. Nova Scotia (NS) – Standard for the availability of timely consultation to various service providers to assist in identifying and intervening in emergencies. Manitoba – Identifies multidisciplinary service delivery as a key value of the mental health system as a whole (including crisis response services). Newfoundland – Identifies the provision of CRS through partnership of primary care health teams and mobile crisis teams as a key Strategic Direction.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Assessment and Planning (continued)		BC – Standards were developed based on the principle that CRS require members to function as interdisciplinary teams and develop and maintain service links with other CRS providers. Defines assessments that identify and integrate range of factors (biological, psychological and/or social) as a key principle of CRS. Also has a standard for its mobile crisis units and walk-in crisis stabilization services that require guidelines to assess risk, presence of mental illness, stressors and the need for medical evaluation.
	• Services must be provided in the consumer's place of choice wherever possible.	• Level 4 – Based on expert opinion. Manitoba – Identifies this as a key value of the mental health system as a whole (including crisis response services).
	• The CRS will ensure that staff have training and core competencies in a variety of areas, to the best extent possible, (e.g., risk assessment; suicide assessment; crisis intervention; safety standards; conflict resolution; anti-racism training; psychiatric symptomatology and psychiatric medications).	• Level 4 – Based on expert opinion. NS – Requires CRS providers to have core competencies in risk assessment. Manitoba – Recognizes training as a key policy direction to strengthen the mental health system. BC – Requires staff to be trained to assess risk, mental illness, stressors and the need for medical evaluation. Also identifies CRS staff skills including: knowledge of psychiatric illness and range of psychiatric conditions, suicide assessment and management, assaultive behaviour and acute psychosis, crisis intervention skills, comprehensive mental status exam, etc. Risk management is identified as a key principle of CRS.
	• The CRS must ensure that workers are provided with information regarding relevant legislative reporting requirements.	• Level 4 – Based on expert opinion. BC – Requires mobile and hospital based crisis teams to have training in the *Mental Health Act* and relevant legislation.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Crisis Support/ Counseling	• Services are consumer directed and will be provided in the least intrusive manner possible.	• Level 4 – Based on expert opinion. Manitoba – Recognizes consumer centredness as a key policy direction to strengthen the mental health system. Newfoundland – Defines the involvement of the individual and caregiver in planning and decision making as a Strategic Direction.
	• Written protocols for consumer and service provider safety must be established.	• Level 4 – Based on expert opinion. BC – Defines risk management as a key principle of CRS and sets standards to address the safety of consumers and staff.
	• Written protocols must be developed to ensure that timely consultation is available with various service providers (e.g., physicians, guidance counsellors, CAS workers) to assist in identifying and intervening in actual emergencies; documented consent is required.	• Level 4 – Based on expert opinion. NS – Identifies this as standard for its CRS. Manitoba – Identifies multidisciplinary service delivery as a key value of the mental health system as a whole (includes CRS).
	• Short-term crisis support/counseling will be available to provide risk assessment, de-escalation and safety planning, to the best extent possible, given the mandate of the CRS.	• Level 4 – Based on expert opinion. BC – Requires walk-in crisis services to provide crisis intervention to help consumers make sense of the crisis, mobilize personal coping resources and formulate a plan to cope more effectively.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Medical Intervention	• The CRS must have written protocols for initiating and accessing medical interventions in a timely manner.	• Level 4 – Based on expert opinion. NS – Set the standard that a policy will identify situations and circumstances where medical clearance/assessment is required. BC – Has a standard requiring consultation regarding medical/ medication issues.
	• The CRS will have procedures/ guidelines for responding to emergency and non-emergency medical situations.	• Level 4 – Based on expert opinion. BC – Requires staff to consult regarding medical/medication issues and receive training in assessing for the need for medical evaluation.
Environmental Intervention and Crisis Stabilization	• All CRS will have access to other services 24 hours a day, seven days a week.	• Level 4 – Based on expert opinion. Saskatchewan, Quebec and Nova Scotia have set the standard of 24/7 access to crisis services. Newfoundland requires the 24-hour availability of crisis services provided through its primary care team. All view CRS as part of a continuum of mental health services.
	• All CRS will have access to current community contact information.	• Level 4 – Based on expert opinion.
	• Protocols are in place for providing referral and support (i.e., income support, dealing with employers, access to long/short-term housing, addressing family issues) based on consumer-articulated needs.	• Level 4 – Based on expert opinion. BC – Identified access to a range of follow-up services as a key principle of CRS. Set standard that crisis team is engaged until links with appropriate services are made and that a clear, well-documented care plan and discharge plan must be developed.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Review/ Follow-up/ Referral	• The consumer must have the opportunity to review, discuss and comment on the service and its appropriateness.	• Level 4 – Based on expert opinion. Newfoundland, Nova Scotia and Manitoba all identified the inclusion of the consumer in evaluating services.
	• A review process must be established that includes an assessment of consumer outcomes including status and stability (e.g., Did the consumer perceive return of control? Was the crisis stabilized?)	• Level 4 – Based on expert opinion. BC – Standard for its Community Crisis Stabilization Services that discharge planning will include family and key supports. NS – Generic standards for all mental health services includes mutually determining goals/outcomes and revising and evaluating the treatment plan and services.
	• Written protocols must be established for providing referral and transition to post-crisis services. Referrals to post-crisis services must be based on consumer-articulated needs.	• Level 4 – Based on expert opinion. BC – Identified access to a range of follow-up services as a key principle of CRS. Set standard that crisis team is engaged until links with appropriate services are made and a clear, well-documented care plan and discharge plan is developed. NS – Generic standards for all mental health services includes developing treatment and discharge plans that include appropriate linkage and coordination with other services and resources.
	• CRS must ensure that staff are provided with information about other relevant community resources.	• Level 4 – Based on expert opinion. NS – Standard for providing continuity of services through coordination with other community crisis services. Manitoba – Defines a key value of the mental health system as working in partnership with consumers, service providers and government in the planning and delivery of service.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Review/ Follow-up/ Referral (continued)		Newfoundland – One of its strategic directions is to ensure there are connections to the community services people need.
	• A written follow-up plan must be developed upon completion of service, which will include criteria for follow-up, re-entry and linkage with other services.	• Level 4 – Based on expert opinion. BC – Access to a range of follow-up services is a key principle of CRS. Set standard that crisis team is engaged until links with appropriate services are made and that a clear, well-documented discharge plan must be developed. NS – Generic standards for all mental health services include development and monitoring of individualized follow-up plan.
Monitoring and Evaluation	• Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements.	• Level 4 – Based on expert opinion. Newfoundland – Key strategic direction for entire mental health system considers accountability and requires the inclusion of consumers and families in service evaluation.
	• A consumer satisfaction survey will be developed and implemented on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS.	• Level 4 – Based on expert opinion. Newfoundland – Key strategic direction for entire mental health system considers accountability and requires the inclusion of consumers and families in service evaluation.
	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.	• Level 4 – Based on expert opinion. NS – Generic standards for all mental health services includes annual monitoring of compliance with standards and utilization of services. Newfoundland – Key strategic direction for entire mental health system considers accountability and requires the inclusion of consumers and families in service evaluation.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Information, Liaison, Advocacy, and Consultation/ Collaboration	• Service providers must identify gaps in service and develop means for collaborating with other relevant community resources in order to meet unmet needs.	• Level 4 – Based on expert opinion. NS – Standard for providing continuity of services through coordination with other crisis services in the community. Manitoba – Defines a key value of the mental health system as working in partnership with consumers, service providers and government in the planning and delivery of service. Newfoundland – Identifies a strategic direction of establishing a continuum of mental health services (including crisis services) linked with primary care teams.
	• A plan must be developed and published that identifies community linkages.	• Level 4 – Based on expert opinion. NS – Generic standards for all mental health services includes the development of a treatment and discharge plan that incorporates other services and resources. BC – Identified access to a range of follow-up services as a key principle of CRS. Set standard that crisis team is engaged until links with appropriate services are made and that a clear, well-documented treatment and discharge plan is made.
	• The crisis worker must be knowledgeable about services that are accessible and relevant to consumers' interests in order to provide up-to-date information.	• Level 4 – Based on expert opinion. Manitoba and Newfoundland identified the inclusion of family and their access to supports as key. BC – Requires the communication of pertinent information to consumers and family members.
	• CRS must ensure that staff is provided with information about other relevant community resources.	• Level 4 – Based on expert opinion.

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Catalogue No. 7610-2243054 0.8M May/05

Ontario