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Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management

Third Edition

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

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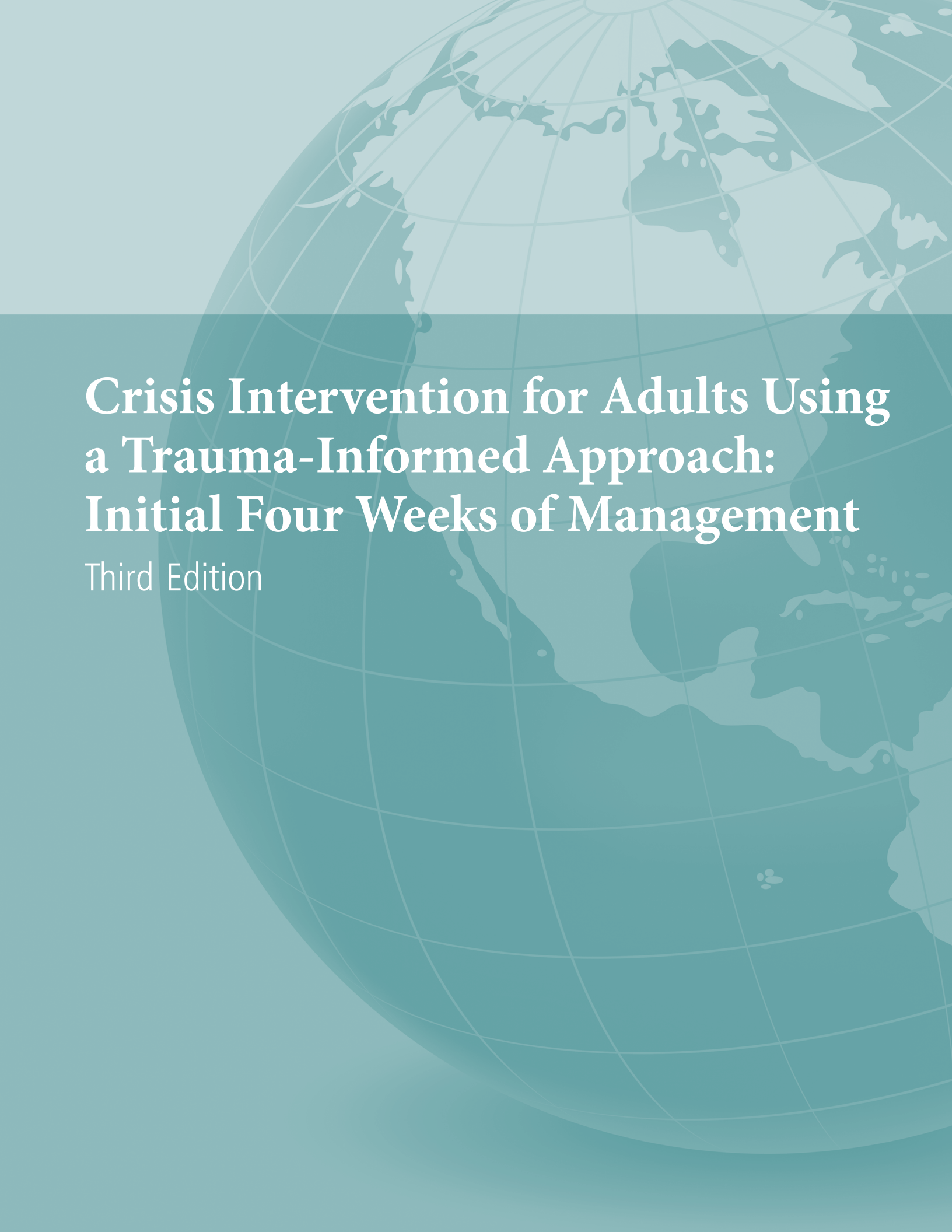
Contact Information

Registered Nurses' Association of Ontario
158 Pearl Street, Toronto, Ontario M5H 1L3

Website: www.RNAO.ca/bestpractices



Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management

Third Edition

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO) is delighted to present the clinical best practice guideline *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders who are making our vision for best practice guidelines a reality, starting with the Government of Ontario for recognizing RNAO's ability to lead the program and for providing multi-year funding. I want to thank the co-chairs of the expert panel, Dr. Nancy Poole (Director, Centre of Excellence for Women's Health) and Rosanra Yoon (Nurse Practitioner, The Jean Tweed Centre) for their expertise and stewardship of this Guideline. For their invaluable expertise and leadership, I also wish to thank Dr. Valerie Grdisa (Director of the RNAO International Affairs and Best Practice Guidelines Centre), Dr. Lucia Costantini (Associate Director, Guideline Development, Research & Evaluation), and Dr. Michelle Rey (the former Associate Director of Guideline Development). Thanks also to RNAO staff Sabrina Merali (Guideline Development Co-Lead), Nafsin Nizum (Guideline Development Co-Lead), Kyle Dieleman (Guideline Development Project Coordinator), Laura Ferreira-Legere (Senior Nursing Research Associate), Zainab Lulat (Nursing Research Associate), and the rest of the RNAO Best Practice Research and Development Team for their intense work in the production of this new Guideline. Special thanks to the members of the expert panel for generously providing their time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy-makers, and researchers. The nursing and health-care community, with its unwavering commitment and passion for excellence in patient care, has provided the expertise and countless hours of volunteer work essential to the development and revision of each best practice guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We invite you to share this Guideline with your colleagues from other professions and with the patient advisors who are partnering within organizations, because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us—making them the real winners in this important effort!

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O. ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario

Table of Contents

BACKGROUND

How to Use This Document 5
Purpose and Scope. 6
Interpretation of Evidence 9
Quality of Evidence 10
Summary of Recommendations 11
RNAO Best Practice Research and Development Team. 14
RNAO Expert Panel 15
Stakeholder Acknowledgment 17
Background Context 21

RECOMMENDATIONS

Practice Recommendations 28
Education Recommendations. 42
System, Organization, and Policy Recommendations 45
Research Gaps and Future Implications 53
Implementation Strategies. 55
Guideline Evaluation 57
Process for Update and Review of Best Practice Guidelines. 59

REFERENCES

Reference List 60

APPENDICES

Appendix A: Glossary of Terms 71
Appendix B: Concepts that Align with this Guideline 78
Appendix C: Guideline Development Process 79
Appendix D: Process for Systematic Review and Search Strategy 80
Appendix E: Critical Incident Stress Debriefing Steps 84
Appendix F: Crisis Plan Template 85
Appendix G: Community Resources for Persons Experiencing Crisis 87
Appendix H: Organizations Providing Peer Support 89
Appendix I: Telecommunication- and Technology-Based Resources 90
Appendix J: Long-Term Interventions to Mitigate Crisis 92
Appendix K: Training Resources 100
Appendix L: Critical Incident Stress Management Program Components 101

ENDORSEMENTS

Endorsements 102

NOTES

Notes 104

How to Use This Document

This best practice guideline (BPG)[G*] is a comprehensive document that provides resources for evidence-based practice[G]. It is not intended to be a manual or how-to guide; rather, it is a tool to guide best practices and enhance decision-making for nurses[G], other health-care providers[G], social service[G] providers, and police officers working with adults (18 years and older) who are experiencing or have experienced crisis[G]. This Guideline should be reviewed and applied in accordance with the needs of individual organizations or practice settings and with the needs and preferences of the persons experiencing crisis and their families[G] who are accessing the health system for care and services. In addition, this Guideline offers an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses, other health-care providers, social service providers, police officers, and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and assessments, interventions, and documentation tools. Furthermore, nurses and other health-care providers, social service providers, and police officers who provide direct response and/or care will benefit from reviewing the recommendations and the evidence that supports them. We particularly recommend that practice settings and police agencies adapt this Guideline in formats that are user-friendly for daily use.

If your organization is adopting this Guideline, we recommend you follow these steps:

1. Assess your existing crisis-related policies, procedures, protocols, and education programs in relation to the recommendations in this Guideline.
2. Identify existing needs or gaps in your crisis-related policies, procedures, protocols, and educational programs.
3. Note the recommendations that are applicable to your setting and that can be used to address your organization's existing needs or gaps.
4. Develop a plan for implementing or integrating recommendations, sustaining best practices, and evaluating outcomes.

Implementation resources, including the RNAO *Toolkit: Implementation of Best Practice Guidelines* (2012), are available at www.RNAO.ca.

For more information, see **Implementation Strategies**.

All of the RNAO best practice guidelines are available for download on the RNAO website at www.RNAO.ca/bpg. To locate particular best practice guidelines, search by keyword or browse by topic.

We are interested in hearing how you have implemented this Guideline. Share your story with us at www.RNAO.ca/contact.

* Throughout this document, terms that are marked with a superscript G ([G]) can be found in the Glossary of Terms (**Appendix A**).

Purpose and Scope

Best practice guidelines are systematically developed, evidence-based documents that include recommendations on specific clinical and healthy work environment topics for nurses, members of the interprofessional team[G], educators, leaders and policy-makers, and persons and their families. Members of the interprofessional team caring for persons experiencing crisis include nurses and other health-care providers (e.g., physicians, social workers, and counselors), first responders (e.g., police officers, paramedics, and firefighters), and peer support[G] workers. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people, communities, and the health-care system (RNAO, 2017).

This BPG is a new edition, and it replaces both the 2002 RNAO BPG Crisis Intervention and the 2006 supplement. This edition focuses on how nurses and the interprofessional team can provide effective trauma-informed crisis interventions[G] (immediately and to up to four weeks post-crisis) in adults (18 years and older) in order to optimize evidence-based practices and clinical outcomes.

In June 2016, RNAO convened an expert panel consisting of a person with lived experience and a multidisciplinary group of individuals with expertise in trauma-informed approaches and crisis intervention across a variety of health-care sectors (e.g., public health, primary care, acute care, and mental health[G] and addiction[G] settings), social services, academic institutions, and justice settings (including corrections, detention centres, and police services).

To determine the scope and organization of the Guideline, the RNAO Best Practice Research and Development Team took the following steps:

- It reviewed both of the 2002 RNAO BPGs *Crisis Intervention* and the 2006 supplement.
- It conducted a scoping review[G] of the literature to understand the relationship between trauma-informed care and crisis intervention, and to develop a better understanding from the existing literature of what is known about the role of nurses and the interprofessional team in crisis management and intervention.
- It conducted 15 key informant interviews with experts in the field, including those who actively implement the 2002 and 2006 guidelines.

The results of the analysis demonstrated that an expanded scope is required. As such, this Guideline provides evidence-based best practice recommendations[G] on effective crisis intervention using trauma-informed approaches for adults (18 years and older) experiencing crisis (i.e., developmental, situational, community, environmental, or mental health crisis) and to prevent future crises. The Guideline is applicable in all practice settings and promotes consistent, evidence-based response and care.

The Guideline is relevant for all domains of nursing practice (i.e., clinical practice, research, education, and policy and administration) and, social service, as well as for other members of the interprofessional team across all practice settings at the unit, organization, and system levels.

Intended Audience

Recommendations are provided at the following three levels:

1. Practice recommendations[G] are directed primarily toward nurses who provide direct clinical care to adults (18 years and older) across the spectrum of care, including (but not limited to) primary care, acute care, community and home-care settings, alternative level of care/complex continuing care, and long-term care. All practice recommendations are applicable to the scope of practice of registered nurses and nurse practitioners (general and extended class). The secondary audience of the practice recommendations includes other members of the interprofessional team who collaborate with nurses to provide response and comprehensive care.
2. Education recommendations[G] are directed to those responsible for the education of health-care providers (i.e., educators, quality improvement teams, managers, administrators, and academic and professional institutions). These recommendations outline core content and training strategies required for entry-level health-care programs, ongoing education, and professional development for all interprofessional team members.
3. System, organization, and policy recommendations[G] are directed to managers, administrators, regional planners, and policy-makers who are responsible for developing policy or securing supports within health-care organizations and other interprofessional organizations that enable the implementation of best practices.

Discussion of Evidence

After each recommendation statement, there is a discussion of evidence that has three main sections:

1. "The Evidence Summary" outlines the supporting research from the systematic review[G] that directly relates to the recommendation.
2. "Benefits and Harms" inform any aspect of care that promotes or deters from the person's health and well-being.
3. "Values and Preferences" denote the prioritization of approaches that facilitate health and the importance of consideration for desired support.

Content for "Benefits and Harms" and "Values and Preferences" may or may not include research from the systematic review. When applicable, the expert panel contributed to these areas.

For optimal effectiveness, recommendations in these three areas should be implemented together.

Concepts That Align with This Guideline

The following concepts may further inform nurses and the interprofessional team when implementing this Guideline. Refer to **Appendix B** for additional resources on these topics:

- cultural sensitivity[G,]
- Indigenous populations and trauma,
- substance use[G],
- interprofessional collaboration,
- person- and family-centred care[G], and
- social determinants of health[G].

Topics Outside the Scope of This Guideline

The following topics are not covered within this Guideline:

- in-depth recommendations beyond the fourth week of crisis interventions,
- crisis among children and youth (less than 18 years of age),
- screening and assessment criteria for crisis intervention, and
- pharmacological treatment options for crisis.

For guidance on topics outside the scope of this Guideline, please refer to **Appendix D**.

For more information regarding the Guideline development process, refer to **Appendix C**. For more information on the systematic review and search strategy, refer to **Appendix D**.

Use of the Term "Crisis" in This Guideline

The expert panel has chosen to use the term "crisis" as a time-limited response to a life event that overwhelms a person's usual coping mechanisms in response to situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors (Ontario Ministry of Health and Long-Term Care, 1999). For the purposes of this guideline, the term "crisis management" encompasses the steps of stabilization, intervention and resolution of a crisis. Key goals of crisis management are rapid resolution of the crisis to achieve at least a pre-crisis level of functioning, use and enhancement of coping skills, promotion of a sense of control and self-efficacy, and the provision of support for problem-solving and access to required services and supports (Hoff, 1995). This definition draws on early definitions from Caplan (1964), Hoff (1995), and the Ontario Ministry of Health and Long-Term Care (1999), and elements from motivational interviewing[G] and trauma-informed approach literature.

Interpretation of Evidence

Levels of evidence are assigned to study designs to rank how well they are able to eliminate alternate explanations of the phenomena under study. The higher the level of evidence, the more likely it is that there were fewer potential sources of bias influencing the research findings. However, levels of evidence do not reflect the quality[G] of individual studies or reviews.

In some cases, recommendations in this BPG are assigned more than one level of evidence. This reflects the varied study designs that support the recommendation. For transparency, the level of evidence for each component of the recommendation statement is identified in the discussion of evidence that follows the recommendation.

Table 1: Levels of Evidence

LEVEL	SOURCE OF EVIDENCE
Ia	Evidence obtained from meta-analysis[G] or systematic reviews of randomized controlled trials[G], and/or synthesis of multiple studies primarily of quantitative research.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study[G] without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study[G], without randomization.
III	Synthesis of multiple studies primarily of qualitative research[G].
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies[G] or descriptive studies[G], and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Adapted from the Scottish Intercollegiate Guidelines Network (Scottish Intercollegiate Guidelines Network [SIGN], 2011) and Pati (2011).

For information on the systematic review process and how studies are appraised for quality, see **Appendix D**.

Quality of Evidence

The quality of each study cited in the discussion of evidence that follows each recommendation was appraised and categorized as strong, moderate, or low based on its corresponding appraisal tool.

Quality appraisal tools were used based on study type. A Measurement Tool to Assess Systematic Reviews (AMSTAR) was used to appraise all reviews and meta-analyses. The Critical Appraisal Skills Program (CASP) tool was used to appraise randomized controlled trials, case-control studies, cohort studies, cross-sectional studies, and qualitative studies. The Mixed Methods Appraisal Tool (MMAT) was used to appraise mixed-methods studies.

The quality rating is calculated by converting the score on the tool into a percentage. When other guidelines informed the recommendation and its discussion of evidence, the AGREE II instrument was used to determine the quality rating. **Tables 2** and **3** highlight the quality scores required to achieve a quality rating of high, moderate, or low.

Table 2: Quality Rating for Studies Using the Quality Appraisal Tools (AMSTAR, CASP and MMAT)

QUALITY SCORE ON THE AMSTAR	OVERALL QUALITY RATING
Greater than, or equal to, a converted score of 82.4%	High
A converted score of 62.5–82.4%	Moderate
Less than, or equal to, a converted score of 62.4%	Low

Table 3: Quality Rating for Guidelines Using the AGREE II tool

QUALITY SCORE ON THE AGREE II	OVERALL QUALITY RATING
A score of 6 or 7 on the overall guideline quality	High
A score of 5 on the overall guideline quality	Moderate
A score of less than 4 on the overall guideline quality	Low (Not used to support recommendations)

For detailed explanation of the systematic review process and quality appraisal, please refer to **Appendix D**.

Summary of Recommendations

This Guideline BPG replaces both the 2002 RNAO BPG *Crisis Intervention* and the 2006 supplement.

PRACTICE RECOMMENDATIONS	LEVEL OF EVIDENCE
1.0 Research Question #1: What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team with adults experiencing crisis?	
Recommendation 1.1: Use brief intervention approaches with persons in crisis to reduce symptoms of crisis and increase motivation for change and other health improvements.	Ib
Recommendation 1.2: Support persons experiencing a crisis to engage meaningfully and safely in a critical incident stress debriefing process within 24 to 72 hours post-crisis in order to reduce distress and improve mental health.	Ib and V
Recommendation 1.3: Create crisis plans in collaboration with persons experiencing crisis using strength-based approaches.	Ib and IV
Recommendation 1.4: Facilitate access for persons experiencing crisis to community-based outreach support (including outreach visits and mobile crisis teams), as well as appropriate health-care providers, peer support workers, and mental health and substance use services.	Ia, IV and V
Recommendation 1.5: Engage peers trained in evidence-based approaches such as psychological first aid to provide comfort and support to persons experiencing crisis.	Ia, Ib and V
Recommendation 1.6: Encourage utilization of telecommunication- and technology-based solutions for people at risk for, or experiencing, crisis as a means for receiving: a) emergency assessment, triage, and support; and b) psycho-education and/or online skills and tools to support coping and self-management.	Ia, Ib and V

PRACTICE RECOMMENDATIONS	LEVEL OF EVIDENCE
2.0 Research Question #2: What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team to mitigate or prevent future crisis in adults?	
Recommendation 2.1: In collaboration with the person and when needed, provide or refer them to additional or continued supports and services.	Ia
EDUCATION RECOMMENDATIONS	**LEVEL OF EVIDENCE**
3.0 Research Question #3: What content and educational strategies are necessary to educate nurses and the interprofessional team effectively regarding crisis and trauma-informed approaches?	
Recommendation 3.1: Integrate interactive learning opportunities regarding trauma-informed approaches and support of persons experiencing crisis into curricula for all entry-level nursing and health-care programs.	Ia and IIb
Recommendation 3.2: Engage in continuing education to enhance knowledge and skill to support persons experiencing crisis through trauma-informed approaches.	Ia, IIb and IV

SYSTEM, ORGANIZATION, AND POLICY RECOMMENDATIONS	LEVEL OF EVIDENCE
4.0 Research Question #4: What organization- and system-level supports are needed by nurses and the interprofessional team to implement best practices effectively using trauma-informed approaches to crisis?	
Recommendation 4.1: Organizations identify and embed trauma-informed approaches directly within their policies and procedures to support: a) a framework for approaches to crisis intervention and service delivery, and b) a safe and supportive work environment for providers who have experienced critical incidents.	IV and V
Recommendation 4.2: Enhance collaboration between sectors through system-level integration between health systems, social services (e.g., housing and employment), education systems, the justice system, advocates, persons with lived experience, and families in order to improve system capacity to respond in a trauma-informed way to persons experiencing crisis.	V
Recommendation 4.3: Health, social service, and law enforcement organizations collaborate to ensure that crisis intervention services are accessible to persons experiencing crisis through the establishment of: a) mobile crisis teams, a) outreach visits, and b) telephone triage and helplines.	Ia, IIb, Ib, and IV
Recommendation 4.4: Police agencies integrate comprehensive crisis training: a) to enhance police officers' interaction with persons experiencing crisis, and b) to encourage police officers to make informed decisions about helping persons access appropriate services.	Ia, IIb, and IV

Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines Research and Development Team

Sabrina Merali, RN, MN
Guideline Development Co-Lead
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Nafsin Nizum, RN, MN
Guideline Development Co-Lead
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Kyle Dieleman, BA
Guideline Development Project Coordinator
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Laura Ferreira-Legere, RN, MScN
Senior Nursing Research Associate
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Zainab Lulat, RN, MN
Nursing Research Associate
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Lucia Costantini RN, PhD, CNeph(C)
Associate Director, Guideline Development, Research & Evaluation
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Valerie Grdisa, RN, MS, PhD
Director, International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Michelle Rey, MSc, PhD
Former Associate Director, Guideline Development
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Gurjit K. Toor, RN, MPH
Evaluation Manager
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines Expert Panel

Nancy Poole, PhD, MA, Dip.C.S., BA
Panel Co-Chair
Director
Centre of Excellence for Women's Health
Victoria, BC

Rosanra Yoon, NP, MN, PhD (cand.)
Panel Co-Chair
Nurse Practitioner
The Jean Tweed Centre
Toronto, ON

Oluremi Roseline Adewale, RN, MScN
Mental Health Nurse Consultant
Toronto Public Health
Toronto, ON

Jennifer Chambers, BSc (Hon)
Executive Director, Empowerment Council
Centre for Addiction and Mental Health
Toronto, ON

Aaron Clark, RN, BScN, CPMHN(C)
Registered Nurse, Parkwood Institute
St. Joseph's Health Care
Chair, Mental Health Nursing Interest Group
London, ON

Rosanna DiNunzio, RN, MSc, CPMHN(C)
Patient Care Manager
Sunnybrook Health Sciences Centre
Toronto, ON

Tanya Dion, RN, MA, CCHP
Health Care Manager
Quinte Detention Centre
Napanee, ON

Susan Engels, RN, MN, Phd (cand.)
Vice President, Quality and Professional Practice
Chief Nursing Executive
The Royal Health Care Group
Ottawa, ON

Elizabeth Harrison
BScN Year 4 Student
Ryerson University
Toronto, ON

Ron Hoffman, BA, MA, PhD
Assistant Professor
School of Criminology and Criminal Justice
interRAI Fellow
Nipissing University
North Bay, ON

Michelle Jubin, RN, MN
Mental Health Nurse Consultant
Toronto Public Health
Toronto, ON

Betty-Lou Kristy
Peer Support Substance Use System Lead
Consumer Survivor (CSI) Lead
Mississauga Halton LHIN Enhancing and Sustaining Peer Initiative
TEACH: Teach Empower Advocate Community Health
Support and Housing Halton
Oakville, ON

Elaine Mordoch, RN, PhD
Associate Professor
College of Nursing, Faculty of Health Sciences
University of Manitoba
Winnipeg, Manitoba

Kim Nash, RN, MN
Clinical Nurse Educator
Waypoint Centre for Mental Health Care
Penetanguishene, ON

Kathryn Ryan, RN, MSc(N), CPMHN(C)
Advanced Practice Clinical Leader (Nursing)
Complex Care and Recovery Program
Centre for Addiction and Mental Health
Toronto, ON

Mike Serr, BA
Deputy Chief Constable, Abbotsford Police Department
Abbotsford, BC

Vicky Stergiopoulos, MD, MHSc
Physician-in-Chief, Centre for Addiction and Mental Health
Professor, Faculty of Medicine, University of Toronto
Vice Chair, Clinical and Innovation, Department of Psychiatry, University of Toronto
Toronto, ON

Declarations of interest that might be construed as constituting an actual, potential, or apparent conflict were made by all members of the RNAO expert panel, and members were asked to update their disclosures throughout the guideline development process. Information was requested about financial, intellectual, personal, and other interests and documented for future reference. No limiting conflicts were identified. Details regarding disclosures are available at http://RNAO.ca/bpg/guidelines/crisis-intervention

Stakeholder Acknowledgment

As a component of the guideline development process, RNAO is committed to obtaining feedback from nurses from a wide range of practice settings and roles, knowledgeable administrators and funders of health-care services, and stakeholder[G] associations. Stakeholders representing diverse perspectives were solicited* for their feedback, and RNAO wishes to acknowledge the following individuals for their contribution in reviewing this Guideline.

Lori Adler, RN, MHSc, BScN
Consultant
LA Consulting
Toronto, ON

Najwa Alshammasi, RN, MN, CPMHN(C)
Mental Health Nurse
Health and Counselling Centre, University of Toronto Mississauga
Mississauga, ON

Brendan Bailey, RN, CPMHN(C)
Public Health Nurse
Toronto Public Health
Toronto, ON

Satinder Brar, RN, MScN
Clinical Nurse Specialist
Mississauga, ON

Emma Bingham, RN, BScN
Staff Nurse
Toronto Western Hospital
Toronto, ON

Marta Canesi, RN, MScN
Staff Nurse
Fondazione MBBM (Monza e Brianza per il Bambino e la sua Mamma)
Monza, Italy

Heather Dunlop-Witt, RN, MN, CPMHN(C)
Nurse Educator
St. Joseph's Healthcare Hamilton
Hamilton, ON

Tara Endeman, RN, BN, CPMHN(C)
Clinical Nurse Supervisor
Homewood Health
Guelph, ON

Beverly Faubert, RN, BScN, GNC(C), CHPCN(C)
Long-Term Care Best Practice Coordinator
RNAO
Tilbury, ON

Lisebeth Gatkowski, RN, BScN, CPMHN(C)
Educator
Mohawk College and Lisebeth Gatkowski & Associates
Hamilton, ON

Bettyann Goertz, RN, BScN, CPMHN(C)
Staff Nurse, Adult Acute Mental Health Inpatient Program
London Health Sciences Centre
London, ON

Kelly Holt, RN, BScN, MScN, CBSDip, CPMHN(C)
Clinical Nurse Specialist
St. Joseph's Healthcare Hamilton
Hamilton, ON

Roberto Iasci, Hon BA, RN, ACWD, CARN, CPMHN(C)
Mobile Crisis Intervention Team Nurse and Mental Health First Aid Instructor
North York, ON

Suman Iqbal, RN, MSN/MHA, GNC(C)
Senior Manager, Long-Term Care Best Practices Program
Registered Nurses' Association of Ontario
Toronto, ON

Elsabeth Jensen, RN, BA, PhD
Associate Professor
York University
Toronto, ON

Nicole Kambou, RN
Toronto, ON

Kelly Kokus, NP-PHC, FNP-BC, MScN, BScN (Hon)
Unilever
Simcoe, ON

Anthony Le Fuentes, BScN Student
Nipissing University
North Bay, ON

Amelia MacKinnon, RN
Staff Nurse
Casey House
Toronto, ON

Jane Mathews, RN, BScN, MSN, CPMHN(C)
Manager, Professional Practice
Bluewater Health
Sarnia, ON

Susan McDaid-Earl, RN
Counselor
The Wellness Collaborative
Guelph, ON

Joan McCollum, RN
Staff Nurse
William Osler Health System
Brampton, ON

Shirley McMillan, RN, MN
Clinical Nurse Specialist
Surrey Place Centre
Toronto, ON

Angelina Medjed, RN
Emergency Department Staff Nurse
Toronto Western Hospital
Toronto, ON

Joanne Menchions, RN, BScN, CPMHN(C)
Professor
Mohawk College
Hamilton, ON

Pat Nashef, RN, MHSc(N), CPMHN(C)
Guelph, ON

Noelle Ozog, RN, BHSc, BScN
Staff Nurse, Emergency Department
Halifax, NS

Darren Pace, BScN, MN, RN, CPMHN(C)
Mental Health Nurse
Calian/Department of National Defence
North Bay, ON

Barb Pizzingrilli, RN, BN, MN, CPMHN(C), MBA
Director, Patient Care Mental Health
and Addictions Program
Niagara Health
St. Catharines, ON

Stacey Roles, RN, MScN
Lecturer and Clinical Nurse Specialist
North ON School of Medicine and
Health Sciences North
Sudbury, ON

Cheryl Rolin-Gilman, RN, MN, CPMHN(C)
Advance Practice Clinical Leader (Nurse)
Centre for Addiction and Mental Health
Toronto, ON

Matthew Rico, RN
Staff Nurse
Assessment and Stabilization Unit, ON Shores Centre
for Mental Health Sciences
Whitby, ON

Susanne Sferrazza-Swayze, RPN, CMLC
Staff Nurse
St. Joseph's Healthcare Hamilton
Hamilton, ON

Shelley Sinyard, MSW, BEd, BA
Social Worker, Medicine Programs
Southlake Regional Health Centre
Newmarket, ON

Mary Smith, NP-PHC, PhD (cand.)
Nurse Practitioner
Queen's University
Kingston, ON

Liza Supang, RN, BScN
Staff Nurse
Kipling Acres Long-Term Care
Etobicoke, ON

Zohra Surani, RN, BScN, CPMHN(C)
Staff Nurse
Centre for Addiction and Mental Health
Toronto, ON

Sayanisa Suthanthirakaran, RN, BScN
Humber River Hospital
Toronto, ON

Raniya Syed, BSc (Hon), MACP
Graduate Practicum Counsellor
Health and Wellness Centre, University of Toronto
Toronto, ON

Grace Terry, RPN, BScN
Staff Nurse
Hamilton Health Sciences
Hamilton, ON

Tara Tourloukis, BScN, RN
Staff Nurse
Alexandra Marine and General Hospital
Goderich, ON

Dania Versailles, RN, MScN, MSc, PMHN, CPMHN(C)
Clinical Nurse Specialist
Hôpital Montfort
Ottawa, ON

Rebecca Welch, RN, CPMHN(C)
Staff Nurse, Child and Mental Health Program,
Emergency Mental Health Assessment Unit
McMaster Children's Hospital
Hamilton, ON

Patricia Woods, RN
Staff Nurse
Women's College Hospital
Toronto, ON

Shannon Wright, NP-PHC, MScN, CPMHN(C)
Nurse Practitioner, Psychiatric Emergency Service
Joseph Brant Hospital
Burlington, ON

*Stakeholder reviewers are individuals with subject matter expertise in the Guideline topic or those who may be affected by the implementation of the Guideline. Reviewers may be nurses and other point-of-care health-care providers, nurse executives, administrators, researchers, members of the interprofessional team, educators, nursing students, or persons and family. RNAO aims to solicit stakeholder expertise and perspectives representing diverse health-care sectors, roles within nursing and other professions (e.g., clinical practice, research, education, and policy), and geographic locations.

Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website (www.RNAO.ca/bpg/get-involved/stakeholder). Second, individuals and organizations with expertise in the Guideline topic area are identified by the RNAO Best Practice Research and Development Team and the expert panel, and they are directly invited to participate in the review.

Reviewers are asked to read a full draft of the Guideline and to participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

1. Is this recommendation clear?
2. Do you agree with this recommendation?
3. Is the discussion of evidence thorough and does the evidence support the recommendation?

The survey also provides an opportunity to include comments and feedback for each section of the Guideline. Survey submissions are compiled and feedback is summarized by the RNAO Best Practice Research and Development Team. Together with the expert panel, RNAO reviews and considers all feedback and, if necessary, modifies the Guideline content and recommendations prior to publication to address the feedback received.

Stakeholder reviewers have given consent to the publication of their names and relevant information in this Guideline.

Background Context

Crisis

A crisis is a time-limited response to a life event that overwhelms a person's usual coping mechanisms. It occurs as a response to situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors (Caplan, 1964; Ontario Ministry of Health and Long-Term Care, 1999). When individuals experience crisis, they may have intense feelings of personal distress (e.g., anxiety, depression, anger, panic, and hopelessness), exhibit changes in functioning (e.g., neglected personal hygiene or unusual behaviour), and/or have other negative life events that leads to ill effects (e.g., disruptions in personal relationships and living arrangements, loss of autonomy, and victimization) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Crisis may involve a loss or change that threatens and impacts an individual's sense of security, self-concept, self-efficacy, and self-esteem (Jakubec, 2014). Individuals who have experienced a crisis or multiple crises over their lives may have difficulty regulating emotions and navigating relationships, and they may have feelings of shame, hopelessness, and powerlessness (Canadian Centre on Substance Abuse, 2014).

Individuals who experience crisis are more open and amenable to interventions than they are during times of stable functioning (Caplan, 1964). A crisis situation can provide an opportunity for personal evolution and growth, allowing the individual to become resilient and positive, and to have a sense of hope for the future (da Silva, Siegmund, & Bredemeier, 2015). Nevertheless, timely crisis stabilization is needed to mitigate any further possible negative consequences for the person.

Types of Crises

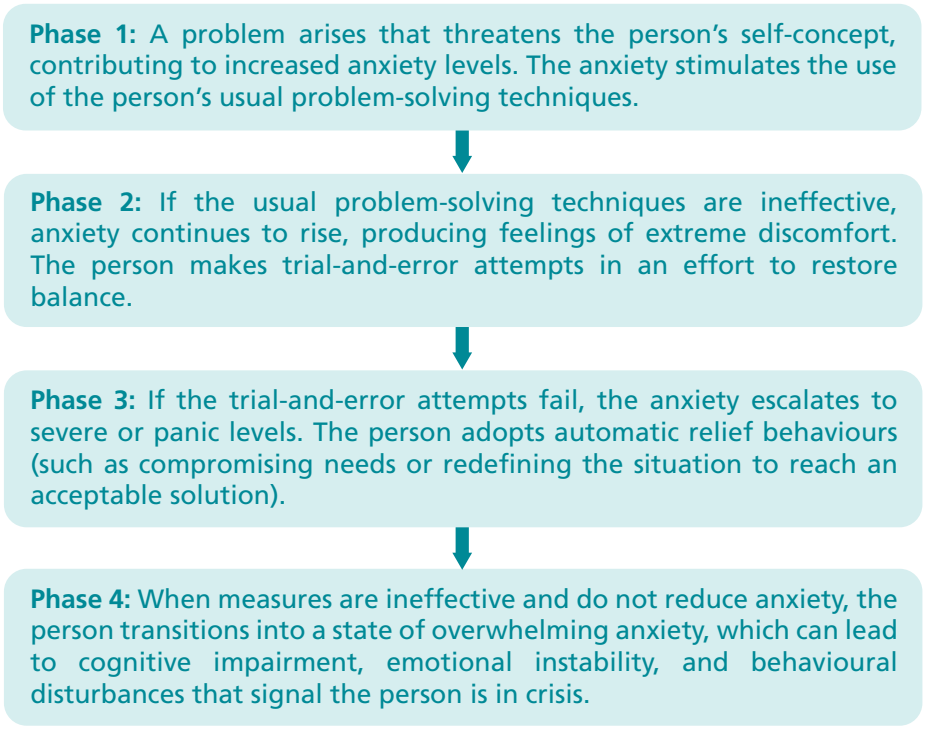
Crises can be classified in three categories: (1) developmental or maturation, (2) situational, and (3) disaster or adventitious. The event itself may not produce a crisis response: it is the alignment of circumstances, perceptions about the event, and the lack of resources to deal with it that has the ability to cause crisis (da Silva et al., 2015).

1. **Developmental or maturation crisis.** A developmental or maturation crisis may occur during a developmental stage in life where physical, cognitive, instinctual, and sexual changes create an internal conflict within a person that triggers a crisis. The response to this crisis can result in psychological growth or regression (Jakubec, 2014). Examples include major life events such as leaving home during late adolescence, marriage, birth of a child, retirement, and death of a parent (Jakubec, 2014). The developmental stage represents a period of increased vulnerability and an opportunity for growth and development. The development of new coping mechanisms and supports can strengthen a person's resilience for later in life.
2. **Situational crisis.** A situational crisis in response to events that are external and unanticipated, such as a loss or change of a job, death of a loved one, financial troubles, exacerbation of a chronic condition, or the experience of sudden illness (Jakubec, 2014). These stressful situational events have the potential to develop into a crisis if the person experiencing them lacks resources and supports. When individuals have adequate supports, positive emotional, mental and physical health, an ability to understand and cope with the meaning of the stressful event, and a sense of security, they may overcome this type of crisis.
3. **Disaster or adventitious crisis.** A disaster or adventitious (unexpected, unplanned, or random) crisis results from events that are not part of everyday life (such as natural disasters or violent crime). These crises may threaten survival. Experiencing or witnessing such events can also overwhelm a person's ability to cope. Such events have the potential to challenge a person's basic assumptions and world views, increase their vulnerability, and cause long-lasting psychological harm (Jakubec, 2014).

Phases of Crisis

The experience of a crisis occurs in four distinct phases, as identified by Caplan (1964).

Figure 1: Phases of Crisis



Sources: Adapted from Jakubec (2014) and Lasiuk, Hegadoren, and Austin (2015).

Signs and Symptoms of Crisis

The signs and symptoms of crisis are unique to each person. Some may report few problems while others report many. **Table 4** includes some of the signs and symptoms that are often reported when experiencing a crisis event. Traumatizing events that overwhelm the person's response and coping abilities can cause lasting psychological harm, including the potential for post-traumatic stress disorder (PTSD) (Goldner, Jenkins, Palma, & Bilsker, 2011; Poole, Urquhart, Jasiura, Smylie, & Schmidt, 2013). Others have prolonged reactions from acute symptoms to more severe or enduring mental health consequences, including anxiety disorders, substance use and mood disorders, and medical problems (such as arthritis, headaches, and chronic pain) (SAMHSA, 2014).

Table 4: Signs and Symptoms of Crisis

SIGNS AND SYMPTOMS OF CRISIS	
Inability to meet basic needs	Incoherence
Decreased use of social support	Depression
Inadequate problem-solving	Self-hatred
Inability to attend to information	Feels strange
Isolation	Perceived lack of control
Denial	Weeping
Exaggerated startle response	Grief/Sadness
Hypervigilence	Irritability
Panic attacks	Being on guard or jumpy
Feeling numb	Physical symptoms (shaking, headaches, fatigue, loss of appetite, and aches and pains)
Confusion	

Sources: Jakubec, 2014; World Health Organization (WHO), War Trauma Foundation, & World Vision International, 2013.

Guiding Framework

Trauma-Informed Approaches

Trauma-informed approaches are based on an understanding that many persons who access health and social services have had experiences of trauma in their lives (Poole et al., 2013). Trauma-informed approaches are not focused on treatment or disclosure of events; rather, the approach is applied universally to ensure that persons are not further traumatized in the course of accessing care, and that they are able to learn and grow in a positive, relational context (Poole et al., 2013). Trauma-informed approaches are based on principles of practice, including safety, trustworthiness, collaboration and choice, empowerment, and the building of strengths and skills. Application of the approaches requires consideration of cultural, historical, and gender issues. Furthermore, the involvement of people who have experienced trauma in decisions about the type, pace, and extent of the support they receive is valued and respected.

Trauma awareness[G] is an important component of trauma-informed approaches. It highlights the commonness of trauma experiences, how the impact of trauma can be central to one's development, the wide range of adaptations to cope and survive after trauma, and the relationship of trauma with substance use and physical and mental health (Poole et al., 2013).

Table 5 outlines the six key principles of trauma-informed approaches adopted from SAMHSA (2014a). Each recommendation in this Guideline is linked to these principles and supports organizations and health-care providers to provide trauma-informed services.

Table 5: Key Principles of a Trauma-Informed Approach

KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH	
1. Safety	Throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.
2. Trustworthiness and Transparency	Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with persons and family members, among staff, and others involved in the organization.
3. Peer Support	Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovering and healing. The term "peers" refers to individuals with lived experiences of trauma. Peers have also been referred to as "trauma survivors".
4. Collaboration and Mutuality	Importance is placed on partnering and the leveling of power differences between staff and persons and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach.

KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH	
5. Empowerment, Voice, and Choice	Throughout the organization and among the persons served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development, and services are organized to foster empowerment for staff and persons alike. Organizations understand the importance of power differentials and ways in which persons, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Persons are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovering rather than controllers of recovery. Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.
6. Cultural, Historical, and Gender Issues	The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography); offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served; and recognizes and addresses historical trauma.

Reprinted from SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach*, by SAMHSA, 2014, p. 11. Copyright 2014 by SAMHSA. Reprinted with permission.

Guiding Values

The following guiding values—which are adapted by the RNAO expert panel with permission from SAMHSA's *Core Elements in Responding to Mental Health Crises* (2009)—inform the recommendations within this Guideline. Adherence to these value and principles support the person in crisis and are an essential part of care. The following guiding values inform the recommendations within this Guideline.

1. **Avoiding harms.** Interprofessional team members work towards establishing physical and psychological safety for the person experiencing crisis, their family, and their nurse and/or health-care provider. The individual in crisis will be treated with respect at all times.
2. **Intervening in person-centered ways.** Interprofessional team members seek to understand the person and their circumstances, goals, and self-identified needs and preferences for support, and how these can be incorporated in the crisis response and used to provide interventions that best meet their needs.
3. **Shared responsibility.** Interprofessional team members collaborate with persons experiencing crisis to help them regain control over their life. They also work with persons experiencing crisis to engage them as active participants in their care.
4. **Trauma-informed.** Interprofessional team members recognize and understand the impact of trauma histories on the lives of people experiencing crisis.
5. **Establishing feelings of personal safety.** Interprofessional team members work with persons experiencing crisis to establish personal safety, a sense of security, and an understanding of what may increase feelings of vulnerability. The provider takes the time to understand the needs of the person experiencing crisis and works to address them.
6. **Strength-based.** Interprofessional team members work with a person experiencing crisis to develop plans that are based on individual skills and strengths. Ideally, the person is seen as the leader, but at the very least, the person is an active partner in the resolution of crisis through the use of a strength-based approach to build resilience and capacity to self-manage future crises.
7. **The whole person.** Interprofessional team members understand that a person in crisis is a whole person with multiple needs. The provider understands that crisis interventions are not limited to only health-care services, but that they can address other concerns as well, such as the social determinants of health.
8. **The person as a credible source.** Interprofessional team members are respectful of the person in crisis and view them as a credible source of information for understanding what is important to the person and to identifying their strengths and needs.
9. **Recovery, resilience, and natural supports.** Health-care providers work with persons on a journey of recovery and resilience, and they incorporate these values in their care. Interventions that preserve dignity, foster a sense of hope, and promote engagement are encouraged.
10. **Prevention.** Health-care providers work with persons to ensure that crises do not recur. They do this through evaluating and considering factors that contributed towards crisis and addressing the person's unmet needs.
11. **Services are provided in the least restrictive manner.** Crisis management is provided to persons in the least restrictive manner, avoiding use of coercion and preserving the person's connectedness to their world (i.e., the individual is not isolated from their routine networks of supports and is encouraged to make contact with outside professionals, family, and friends who can provide support).

12. **Rights are respected.** Interprofessional team members promote the person's "right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman, and the right to make informed decisions about medication" (SAMHSA, 2009, p. 11). Most importantly, they promote the person's right to be heard. The role of the provider is to serve as an advocate for persons and to ensure that their rights are upheld.

Practice Recommendations

RESEARCH QUESTION #1:

What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team with adults experiencing crisis?

RECOMMENDATION 1.1:

Use brief intervention approaches with persons in crisis to reduce symptoms of crisis and increase motivation for change and other health improvements.

Trauma-Informed Principles: Safety; Collaboration and Mutuality; and Empowerment, Voice, and Choice.

Level of Evidence for Summary: Ib

Quality of Evidence for Summary: High = 1 study; Moderate = 2 studies

Discussion of Evidence:

Evidence Summary

Brief intervention (BI)[G] focuses on communication between the person who has experienced crisis and the health-care provider. It can include elements of psycho-education[G], coping and skills enhancement training, and motivational interviewing[G] (Des Groseilliers, Marchand, Cordova, Ruzek, & Brunet, 2013). BI can be used effectively with persons to support the identification of problems and to provide the opportunity to co-create short- and long-term goals while engaging or referring the person to additional support with other providers and services (O'Connor et al., 2015). Research demonstrates that early BI provided by a nurse or social worker in hospital settings can be used to reduce symptoms of crisis in the weeks and months following trauma exposure (Brunet, Des Groseilliers, Cordova, & Ruzek, 2013; Des Groseilliers et al., 2013; O'Connor et al., 2015). For example, BI improves motivation and readiness for change, helping persons with suicidal ideation see more reasons for living (O'Connor et al., 2015). The literature further indicates BI improves functioning and decreases symptoms related to crisis for up to three months post-crisis episode (Brunet et al., 2013). The routine use of BI in emergency settings among trauma survivors with symptoms of PTSD demonstrates accelerated rates of recovery (Des Groseilliers et al., 2013).

Benefits and Harms

The benefits of BI are favourable for helping stabilize a person experiencing crisis. However, the urgency for follow-up and referral is heightened when enacting BI to manage crisis leading to or following a suicide attempt. The provider needs to screen for suicide risk, create safety plans, and connect the person to appropriate resources and/or providers. Further in-depth resources on suicide risk assessment and interventions are outlined in **Table 6**.

Values and Preferences

The RNAO expert panel places high value on the effective use of BI. Person-centred communication needs to be used by the provider when conducting BI. Some examples of effective communication techniques are outlined in **Table 6**. Nurses should seek appropriate education and training, and aim to incorporate BI into their clinical practice before using BI with persons. Furthermore, when discussing crises, the term "symptoms" is interchangeable with different

terms based on the person and provider point of view: for example, persons with lived experiences may recognize symptoms as "experiences" of crisis while police officers may recognize symptoms as "indicators" of crisis.

Table 6: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
FRAMES acronym *Source*: Miller, W. R, Sanchez, V.C. (1994). Motivating young adults for treatment and lifestyle change. In G. S. Howard & P. E. Nathan (Eds.), *Alcohol use and misuse by young adults* (pp. 55–81). Notre Dame, IN: University of Notre Dame Press.	The FRAMES acronym summarizes components of BI, and it reflects trauma-informed principles of safety, empowerment and choice, and collaboration: **F**eedback is given to the individual about personal risk/impairment. **R**esponsibility for making their own decisions is placed on the person. **A**dvice to change is given by the provider. **M**enu of coping options is offered to the participants. **E**mpathetic style is used in counseling. **S**elf-efficacy or optimistic empowerment is engendered in the person.
RNAO screening and brief intervention video	This online training video demonstrates interaction with a patient through the process of BI. Available from: https://www.youtube.com/watch?v=OpwkG2BXvuY&feature=youtu.be
Communication techniques *Source*: The Jean Tweed Centre. (2013). *Trauma matters: Guidelines for trauma-informed practices in women's substance use services.* Toronto: Author.	The Trauma Matters guideline outlines some key communication techniques for practicing BI in a trauma-informed way: ■ demonstrate empathy and respect; ■ talk openly; ■ be self-aware, including of body language and facial expressions; ■ feel comfortable with the unknown; ■ stay calm and demonstrate emotional regulation; and ■ show genuine interest by being a good listener.
Guidelines for the management of conditions specifically related to stress *Source*: WHO. (2013). *Guidelines for the management of conditions specifically related to stress.* Geneva, Switzerland: Author.	The recommendation is supported by this moderate-quality WHO guideline that also recommends early psychological intervention (including BI) in the first month after a potentially traumatic event for adults with acute traumatic stress symptoms and impaired daily functioning. Available from: http://apps.who.int/iris/bitstream/10665/85119/1/9789241505406_eng.pdf?ua=1

RECOMMENDATION 1.2:

Support persons experiencing a crisis to engage meaningfully and safely in a critical incident stress debriefing process within 24 to 72 hours post-crisis in order to reduce distress and improve mental health.

Trauma-Informed Principles: Empowerment, Voice, and Choice.

Level of Evidence for Summary: Ib and V

Quality of Evidence for Summary: Moderate = 1 study

Discussion of Evidence:

Evidence Summary

Critical incident stress debriefing (CISD)[G] is a short-term crisis intervention method to reduce distress and improve mental health for persons experiencing crisis (Li & Xu, 2012). The objectives of CISD are to mitigate the impact of the incident, facilitate recovery processes, and restore adaptive functions. CISD has been associated with a reduction in psychological distress and negative psychological symptoms, including somatization (having anxiety about physical symptoms), obsessive–compulsive behaviour, depression, and anxiety among family members who experienced the crisis of witnessing a loved one in a vegetative state (Li & Xu, 2012). CISD has been shown to be reproducible, easily implemented, and cost-effective for reducing psychological distress and the perception of stress (Li & Xu, 2012). Studies comparing CISD to other approaches were not found. Research is required to determine whether CISD is more effective than other forms of psychological interventions (Li & Xu, 2012).

The RNAO expert panel and the literature suggest that CISD should be facilitated by a health-care provider and occur anywhere from 24 to 72 hours after an incident (Li & Xu, 2012). CISD is typically conducted as a brief session that can last from one to five hours, and it is conducted with individuals or as a group intervention (Li & Xu, 2012). For more information on CISD as a process, refer to **Table 7**.

Benefits and Harms

The RNAO expert panel notes that debriefing a crisis situation may trigger negative emotional outcomes and temporarily impede a person's ability to reach a pre-crisis state. When this occurs, health-care providers should offer the person the choice to stop this intervention. Before using this approach, an evaluation of CISD specific to the person's situation is advisable in order to weigh the benefits and harms that may occur from debriefing.

Values and Preferences

Literature demonstrates that social workers who experienced a critical incident[G] at work viewed CISD as integral in healing (Pack, 2012). There was overwhelming support for an overarching critical incident stress management (CISM) model, which includes CISD and additional components, such as peer support (Pack, 2012). For more information on steps of CISM, please refer to **Appendix L**.

The expert panel emphasizes that the process for implementing CISD is flexible (i.e., it can be used in the form of narrative therapy). Furthermore, CISD requires specialized training, and nurses should obtain appropriate education and competency prior to incorporating this intervention into clinical practice.

Table 7: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Seminal article describing CISD as a process *Source:* Mitchell, J. T. (1983). When disaster strikes . . . the critical incident stress debriefing process. *JEMS: A Journal of Emergency Medical Services, 8*(1), 36–39.	The article describes the essentials of CISD, including how it must be used in combination with other crisis intervention, education, and support services. This includes referral to other health-care providers, when necessary. An overview of the seven stages of CISD used by providers can be found in **Appendix E**.
Justice Institute of British Columbia *Source:* Justice Institute of British Columbia. (2016). *Programs & courses*. Retrieved from http://www.jibc.ca/programs-courses	An example of a Canadian organization that provides CISD training and certification. Available from: http://www.jibc.ca/programs-courses

RECOMMENDATION 1.3:

Create crisis plans in collaboration with persons experiencing crisis using strength-based approaches.

Trauma-Informed Principles: Safety; Collaboration and Mutuality; and Empowerment, Voice, and Choice.

Level of Evidence for Summary: Ib and IV

Quality of Evidence for Summary: High = 1 study; Moderate = 3 studies

Discussion of Evidence:

Evidence Summary

Creation of crisis plans[G] (also known as "comfort" or "safety plans") in collaboration with persons experiencing crisis are effective for establishing safety, addressing fears, identifying coping mechanisms, and reducing rates of admissions for involuntary treatment (Ruchlewska et al., 2014; Tetterton & Farnsworth, 2011). Studies emphasize the importance of providers working collaboratively with persons to co-create crisis plans and be involved in future goal setting because it empowers persons and allows their active engagement, which echoes the principles of trauma-informed approaches (Gudde et al., 2013; Hootz, Mykot, & Fauchoux, 2016; Tetterton & Farnsworth, 2011). Other evidence suggests that collaborative crisis planning may decrease voluntary admissions, emergency visits and admissions, outpatient emergency visits, and involuntary treatment (Ruchlewska et al., 2014).

Establishing crisis plans during the first point of contact (e.g., during a first appointment or contact with emergency department) is critical, as the person experiencing crisis may not have the ability or choice to return for follow-up appointments due to personal circumstances (e.g., women who experience intimate partner violence[G] may have safety

issues accessing care) (Tetterton & Farnsworth, 2011). The crisis plan should identify the person's goals, strengths, barriers to achieving goals, triggers or warning signs that contribute to a crisis event, and coping mechanisms; it also should identify when and where the person needs to seek personal and professional support (Tetterton & Farnsworth, 2011). Other details of a crisis plan can vary and are determined by the person's needs.

Studies demonstrate the importance and impact of providers using strength-based approaches in care planning (Gudde et al., 2013; Hootz et al., 2016; Powell & Leytham, 2014). Using strength-based approaches allows active engagement in care and provides the opportunity to learn new methods of coping and of managing challenging situations that could induce crisis, thus building resilience (Hootz et al., 2016). Strength-based approaches utilize a person's strengths and work towards reducing their vulnerabilities, achieving optimal levels of independence, and promoting healthier lifestyles (Hootz et al., 2016). In these models, persons are encouraged to use their own strengths and hardships in order to move towards greater stability and independence in the problems they face (Hootz et al., 2016).

Benefits and Harms

In addition to the benefits of creating crisis plans outlined in the "Evidence Summary", are that health-care providers are able to understand the person's unique situation, can assess the person's risk more effectively and are able to provide early interventions to prevent future crisis (Tetterton & Farnsworth, 2011). Potential harms may be anxiety among persons who have experienced crisis that stems from being unable to meet expectations outlined in the crisis plan.

Values and Preferences

Among persons who have experienced crisis, the preferences for goal setting and planning include the following:

- the need to be empowered and active in placing measures to protect themselves;
- the importance of identifying strengths, current coping mechanisms, and increasing their tool box with positive strategies;
- the desire to meet familiar and trusted providers who know what the person needs in periods of crisis;
- the need to be taken seriously; and
- the significance of creating goals for change and recovery, rather than focusing on illness and diagnoses (Gudde et al., 2013; Tetterton & Farnsworth, 2011).

The RNAO expert panel placed high value on the following areas for supporting successful engagement with persons experiencing crisis and implementation of the recommendation:

- assessment and evaluation of the crisis plan and goals should be done with persons at every subsequent clinical visit as an ongoing process;
- crisis plans should be directed by the wishes of the persons who have experienced crisis, they should be written in their own words in order to support the person's commitment to enacting plans; and
- providers should explore contributing factors or potential triggers towards a crisis during the assessment, and they should utilize the person's strengths when developing individualized crisis plans. For example, a person may identify self-soothing strategies in collaboration with the provider in an effort to build awareness of trauma triggers.

The creation of the crisis plan in collaboration with the person is not exclusive to the health-care provider, and it may be adapted by members of the interprofessional team, as appropriate.

Table 8: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Practice questions to guide strength-based care *Source:* Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma- informed practice guide.* Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf	Providers may find these practice questions helpful to guide a crisis plan based on a person's strengths: ■ How have you managed to get through tough times in your life? ■ What/who are your supports? ■ What is your source of strength? ■ What would your friends say are your biggest strengths? ■ What keeps you going? What are your hopes for the future? What are some of your interests or passions? What are you already doing to look after yourself?
Explicit statements for collaboration and choice *Source:* Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma- informed practice guide.* Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf	Providers may use these statements to propel collaboration and allow the person who has experienced crisis to practise choice: ■ I'd like to understand your perspective. ■ Let's look at this together. ■ Let's figure out the plan that will work best for you. ■ What is most important for you that we should start with? ■ It is important to have your feedback every step of the way. ■ This may or may not work for you. You know yourself best. ■ Please let me know any time if you would like a break or if something feels uncomfortable for you.
Crisis plan template	**Appendix F** outlines an example of a crisis plan template that is intended to capture the perspective of the person who has experienced crisis.

RECOMMENDATION 1.4:

Facilitate access for persons experiencing crisis to community-based outreach support (including outreach visits and mobile crisis teams), as well as appropriate health-care providers, peer support workers, and mental health and substance use services.

Trauma-Informed Principles: Safety; Trustworthiness and Transparency; and Collaboration and Mutuality.

Level of Evidence for Summary: Ib, IV, and V

Quality of Evidence for Summary: High = 1 study; Moderate = 3 studies

Discussion of Evidence:

Evidence Summary

Access to community-based outreach support—either through outreach visits or mobile crisis team responses—has been associated with improved outcomes. Evidence demonstrates that early outreach visits are associated with further access to health-care providers (Boudreaux et al., 2015; Haga, S tene, Wentzel-Larsen, Thoresen, & Dyb, 2015). Access to outreach visits improved adherence to follow-up appointments with general practitioners or mental health clinics, and it reduced unnecessary visits to emergency departments for psychiatric crisis (Boudreaux et al., 2015; Haga et al., 2015).

Mobile crisis teams (also known as crisis resolution teams[G]) are most often comprised of multiple professions that provide interprofessional care. Evidence demonstrates that teams specifically comprised of mental health-care providers and police officers are more engaged and supportive over a short period of time, and that they are able to hand over information to hospital services efficiently and smoothly (Evangelista et al., 2016). Mobile crisis teams have demonstrated high degrees of satisfaction among those experiencing crisis due to the multidisciplinary nature of the team (Evangelista et al., 2016). The health-care provider's presence has allowed for effective de-escalation, identification of potential warning signs, and communication in a nurturing and empathetic manner; the police presence maintained physical safety for the person and the health-care provider(s) (Evangelista et al., 2016). Outreach providers may include peer support workers: peer support workers providing home visits for bereaved fathers demonstrated impact in supporting individual coping with loss and recovery (Aho, Tarkka, Åstedt-Kurki, Sorvari, & Kaunonen, 2011). The RNAO expert panel recommends that providers facilitate access not only to community-based outreach support, but also to other appropriate health-care providers and mental health and substance use services, as needed.

Benefits and Harms

In addition to the benefits of outreach teams outlined in the "Evidence Summary", outreach teams also have the potential to reduce visits to the emergency department for psychiatric crisis situations (Boudreaux et al., 2015). There were no harms identified in the literature, although the expert panel notes that police presence may trigger negative emotions in some persons due to perceived or past experiences with police involvement.

Values and Preferences

Persons who were approached by mobile crisis teams have described teams as valuable, flexible, effective, and considerate of their needs (Evangelista et al., 2016; Gudde et al., 2013). In terms of mobile crisis teams, persons also desired more coherence, continuity of services, and services to be readily available (persons expressed hours of operation of teams are limited) (Gudde et al., 2013). Finally, meeting familiar and trusted providers who knew what persons needed in period of crisis was valued (Gudde et al., 2013).

The expert panel recommends that providers working in community-based outreach support services should learn about the impacts of trauma on crisis and utilize a trauma-informed approach. They should also maintain an active inventory/partnership with peer support, mental health, and substance use services. The expert panel also highlights that referral to outreach support should be offered to persons, recognizing that access or use of these services may not occur until the person is ready, as every person experiences crisis differently and may have different coping abilities and strategies, and that underlying mental health needs often warrant support for accessing resources (such as housing or employment).

Table 9: Supporting Resources

RESOURCES	DESCRIPTION/EXCERPT
Community resources for persons experiencing crisis	**Appendix G** outlines some peer-run services and community- and hospital-based outreach mental health and substance use services. Providers can refer persons experiencing crisis to these services.

RECOMMENDATION 1.5:

Engage peers trained in evidence-based approaches such as psychological first aid to provide comfort and support to persons experiencing crisis.

Trauma-Informed Principles: Peer Support

Level of Evidence for Summary: Ia, Ib, and V

Quality of Evidence for Summary: High = 2 studies; Moderate = 2 studies

Discussion of Evidence:

Evidence Summary

Peer support[G] is effective for persons after a crisis experience. Research on bereaved fathers demonstrates that peer support improves coping with loss, recovery, and personal growth (Aho et al., 2011; Paton et al., 2016). Peer support has been associated with increases in self-rated recovery and functional disability, increased likelihood of contacting health care and other services and supports, and satisfaction with care (Paton et al., 2016). Although Paton et al. (2016) identified low-quality evidence in their systematic review, the RNAO expert panel strongly supports the training of peer support workers as an effective intervention as part of holistic care planning to provide comfort and support recovery.

Psychological first aid (PFA)[G] (or mental health first aid) training is recommended for peer support workers. PFA provides skills training in listening, comforting, and helping people connect with others, and in providing information and practical support to address basic needs (Dieltjens, Moonens, Praet, Buck, & Vandekerckhove, 2014; Fox et al., 2012). Although PFA is used internationally, research indicates mixed results regarding its effectiveness (Dieltjens et al., 2014; Fox et al., 2012). Experts contend that PFA is beneficial and an acceptable intervention provided by peer support workers, but the literature also cautions that because PFA does not provide training for treatment of mental health problems or mental illness[G], these interventions must remain the responsibility of trained mental health professionals (Fox et al., 2012). Other training approaches not found in the systematic review may be valuable for peer support workers. Regardless of the approach, an evidence-based training process should be used.

Benefits and Harms

Peer support workers trained in PFA should only assist in the provision of basic care, comfort, and support to persons experiencing crisis. Exceeding these boundaries may cause clear harm to persons experiencing crisis. Organizations should create clear distinctions of roles and develop policies that support distinction between roles (Fox et al., 2012).

Values and Preferences

Peer support is a popular choice among persons experiencing crisis, with many preferring early peer support after a crisis incident, and calling for further availability of the service; some, however, favour the continuation of contact by peer support workers after they establish a relationship and receive support (Aho et al., 2011; Paton et al., 2016).

Table 10: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Peer support organizations	**Appendix H** outlines existing organizations that provide crisis peer support.
Psychological first aid: Guide for field workers *Source:* WHO et al. (2011). *Psychological first aid: Guide for field workers.* Geneva: Author.	The guide covers PFA, and it is written for people in a position to help others who have experienced an extremely distressing event. It provides a framework for supporting people in ways that respect their dignity, culture, and abilities. Available from: http://www.who.int/mental_health/publications/guide_field_workers/en/
Making the case for peer support: Report to the peer support project committee of Mental Health Commission of Canada *Source:* Cyr, C., Mckee, H., O'Hagan, M., & Priest, R. (2016). *Making the case for peer support: Report to the peer support project committee of Mental Health Commission of Canada*. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Making_the_Case_for_Peer_Support_2016_Eng.pdf	The report advocates for peer support as a core service available to everyone. Available from: https://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Making_the_Case_for_Peer_Support_2016_Eng.pdf

RESOURCE	DESCRIPTION/EXCERPT
Ontario Peer Development Initiative	The Ontario Peer Development Initiative is an organization representing several organizations. Its members are mental health consumer/survivor initiatives and peer support organizations across Ontario. These organizations are run by and for people with lived experience of a mental health or addiction issue. http://www.opdi.org/ (416) 484-8785

RECOMMENDATION 1.6:

Encourage utilization of telecommunication- and technology-based solutions for people at risk for, or experiencing, crisis as a means for receiving:

a) emergency assessment, triage, and support; and

b) psycho-education and/or online skills and tools to support coping and self-management.

Trauma-Informed Principles: Safety; and Empowerment, Voice, and Choice.

Level of Evidence for Summary: Ia, Ib, and IV

Quality of Evidence for Summary: High = 1 study; Moderate = 4 studies; Low = 1 study

Discussion of Evidence:

Evidence Summary

A. Emergency Assessment, Triage, and Support

Access and utilization of telecommunication- (e.g., community-based helplines) and technology-based solutions (e.g., Internet-based services and mobile applications) has been proven to be supportive for persons who are experiencing crisis. Telephone supports help minimize harm to persons experiencing crisis, reduce posttraumatic stress symptoms, and improve functioning (Gelkopf, Haimov, & Lapid, 2015; Paton et al., 2016). Telephone supports (e.g., 24-hour helplines) are staffed by professionally trained specialists that triage callers to provide support, offer strategies, and give information about services in the community, including quick access to crisis intervention programs and/or emergency services (Chavan, Garg, & Bhargava, 2012; Paton et al., 2016). Internet-based outreach programs are effective in increasing access to immediate screening, assessments, therapist-guided treatment, and referral to emergency services or local mental health services (Nielssen et al., 2015).

Telecommunication- and technology-based solutions (including telephone-based and Internet-based services) can provide a range of services to support persons in crisis. These include performing a mental status exam or risk assessment, developing safety plans or plans of care, conducting a brief intervention to avert crisis situations, developing a plan of care, and providing further referrals and supports (Chavan et al., 2012; Nielssen et al., 2015; Paton et al., 2016). Telephone supports have demonstrated effectiveness by decreasing both the number of suicide attempts and the problems affecting a person's overall functioning (Chavan et al., 2012).

B. Psycho-Education and/or Online Skills and Tools to Support Coping and Self-Management

Telecommunication- and technology-based solutions—which include Internet-based services and mobile applications—demonstrate effectiveness in providing psycho-education and building skills to support coping and self-management among persons who experience crisis (da Silva et al., 2015; Miner et al., 2016; Wang, Wang, & Maercker, 2013). The literature supports the use of Internet-based psycho-education and skill development for short-term effectiveness in reducing PTSD symptoms, post-traumatic cognitive changes, functional impairment, and depression (Wang et al., 2013). The use of the PTSD Coach mobile application, which provides self-management and psycho-education, was helpful for persons in terms of learning new skills and using tools to manage their symptoms and emotions, and it demonstrated a significant effect on symptom reduction from baseline to follow-up assessment (Miner et al., 2016). Furthermore, reduction in post-traumatic cognitive changes, functional impairment, and depression were evident (Miner et al., 2016).

There is limited research available examining the effectiveness of text messaging between the person and provider in the context of crisis services. To date, studies have not shown improved outcomes when using text-based interventions, although positive feedback from participants and therapists was reported (Furber, Jones, Healey, & Bidargaddi, 2014). For this reason, text or SMS-based technology should be used with caution.

Benefits and Harms

Additional benefits of utilizing telecommunication- and technology-based solutions with people at risk for, or experiencing, crisis include working with media to avoid sensationalization of the crisis event (e.g., natural disaster or mass suicide event) among the wider public (Chavan et al., 2012). It also allows coordination with police in high-risk areas to provide around-the-clock vigilance and support and to create awareness campaigns for the wider public (e.g., raising awareness of signs and symptoms of crisis, and creating early identification messaging and media campaigns to promote awareness of the telephone service) (Chavan et al., 2012). Telecommunication- and technology-based solutions are also less stigmatizing than seeking help in person, more cost-effective, less time-consuming, not limited to business hours or geographical boundaries, and more likely to maintain person–provider confidentiality (Chavan et al., 2012; da Silva et al., 2015; Nielssen et al., 2015)

The literature has demonstrated that telecommunication- and technology-based solutions used as part of psycho-education and/or skill development may pose harm to those who live in geographically remote or isolated areas (such as rural and remote regions or areas where telecommunications are inoperative or limited) when those persons need urgent post-conflict or post-disaster face-to-face treatment but are some distance from their care providers (da Silva et al., 2015; Wang et al., 2013). As such, health-care providers and other interprofessional team members must be cognizant that these strategies are not exclusive treatment forms, and that they do not replace face-to-face interventions, but that they can provide a first step into the health-care system (da Silva et al., 2015).

Values and Preferences

The expert panel placed high value on the following areas to support successful engagement with persons experiencing crisis and implementation of the recommendation:

- Providers should understand the person's preferences, abilities for treatment, and access to information and telecommunication technologies. Some persons may not be suitable candidates for technology-based interventions due to factors such as a lack of comfort or skill in the use of technology, lack of access to technology, and limitations related to socio-economic status.

- Health-care providers should familiarize themselves with technology-based solutions, telecommunication-based solutions, and resources available in their local communities in order to support optimal care. It is expected that the provider will use critical judgment to ensure that the recommended resources and/or referrals are current and evidence-based. These services should be made available to family and friends who support persons experiencing crisis to prevent vicarious trauma[G] and provide follow-up support.

Table 11: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Telecommunication- and technology-based solution resources	**Appendix I** outlines a list of telecommunication- and technology-based resources (including community-based telephone, Internet and mobile application services) that a person experiencing crisis can access.

RESEARCH QUESTION #2:

What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team to mitigate or prevent future crisis in adults?

RECOMMENDATION 2.1:

In collaboration with the person and when needed, provide or refer them to additional or continued supports and services.

Trauma-Informed Principles: Safety; Empowerment, Voice, and Choice; Cultural, Historical, and Gender Issues; and Collaboration and Mutuality.

Level of Evidence for Summary: Ia

Quality of Evidence for Summary: High = 1 study

Discussion of Evidence:

Evidence Summary

Access to long-term supports can be effective in promoting recovery and preventing future crisis (Paton et al., 2016). Long-term interventions are beneficial when crisis stabilization has occurred which may be within the first 4 weeks or later. Pharmacological interventions—such as the use of anxiolytics, antidepressants, or antipsychotics—have demonstrated effectiveness in short- and long-term crisis management (Paton et al., 2016). Additional information regarding pharmacology is beyond the scope of this Guideline.

Non-pharmacological interventions with varying degrees of effectiveness include trauma-specific interventions (treating the consequences of trauma), psychotherapy (cognitive behavioural therapy and other modalities), group therapy, technology-based solutions, and complementary therapies[G]. The purposes of these interventions range from skill-building to reduce or manage stressful situations, preventing PTSD, and treating crisis symptoms and consequences. These interventions can be delivered in multiple settings, such as hospitals and community-based services. Decisions regarding long-term supports and access should be made collaboratively by the nurse or health-care provider and the person.

Interventions four weeks post-crisis are beyond the scope of this Guideline. For further information and supporting research on trauma-specific interventions, psychotherapy, group therapy, technology-based solutions, and complementary therapies used once crisis stabilization occurs, please refer to **Appendix J**.

Benefits and Harms

The benefit of receiving services four weeks post-crisis is mitigation of future crises and/or other associated mental and physical harms (Paton et al., 2016). Research demonstrates that persons living with mental illness that receive long-term interventions recover from the crisis (Paton et al., 2016).

Values and Preferences

The RNAO expert panel highlights that not all persons may require access to long-term supports, particularly when they have returned to pre-crisis functioning and have developed new, healthy coping skills and resilience. The expert panel recommends that health-care providers be knowledgeable of different long-term interventions and facilitate

access to referral taking into consideration effectiveness, accessibility, and personal preferences. The expert panel recognizes that continued supports are not limited to the aforementioned interventions, but other services and supports specific to social determinants of health such as housing and employment may be required to address underlying factors associated with crisis experiences.

Education Recommendations

RESEARCH QUESTION #3:

What content and educational strategies are necessary to educate nurses and the interprofessional team effectively regarding crisis and trauma-informed approaches?

RECOMMENDATION 3.1:

Integrate interactive learning opportunities regarding trauma-informed approaches and support of persons experiencing crisis into curricula for all entry-level nursing and health-care programs.

Trauma-Informed Principles: All trauma-informed principles

Level of Evidence for Summary: Ia and IIb

Quality of Evidence for Summary: Moderate = 2 studies

Discussion of Evidence:

Evidence Summary

It is essential that health-care providers learn and apply relevant trauma-informed approaches to care for persons experiencing crisis during their entry-level education; this will facilitate knowledge update and integration with their ongoing practice. The literature indicates that consideration must be made in terms of *how* education is delivered and that interactive teaching modalities are integral and effective (Raja et al., 2015; Xie et al., 2015). Non-traditional methods of teaching health-care students were more effective than traditional lecture style methods for the delivery of the mental status examination (Xie et al., 2015). Non-traditional teaching modalities included the use of film, simulation, standardized patients, reflection, and discussion (Xie et al., 2015; Raja et al., 2015).

Benefits and Harms

There were no harms identified in the literature regarding integrating interactive learning opportunities for students. Overall, the benefits of this recommendation are favourable.

Values and Preferences

Evidence suggests that students want interaction with patient simulations and survivor panels, online tutorials, and follow-up sessions on trauma-informed care (Raja et al., 2015). The RNAO expert panel emphasizes that students should be taught relevant skills outlining trauma-informed principles and trauma awareness[G], and that they should be taught specific evidence-informed approaches on how to engage with persons experiencing a crisis in a therapeutic manner (e.g., learning brief intervention skills or engaging in psychological first aid [also known as mental health first aid]). Furthermore, the expert panel highlights that education regarding crisis and trauma-informed practice is not limited to entry-level professional programs, and that it should include first responder training (such as for police officers and firefighters).

Table 12: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Nurse educator: Mental health and addiction resource *Source:* Registered Nurses' Association of Ontario. (2016). *Nurse educator: Mental health and addiction resource.* Toronto, ON: Author.	The primary purpose of RNAO's *Nurse Educator: Mental Health and Addiction Resource* is to support educators to integrate mental health and addiction knowledge and skills into undergraduate nursing curricula. Available from: http://RNAO.ca/sites/rnao-ca/files/MHR_WEB_FINAL_0.pdf
Practice education in nursing *Source:* Registered Nurses' Association of Ontario. (2016). *Practice education in nursing.* Toronto, ON: Author.	This BPG aims to promote and sustain the undergraduate nursing students' application of knowledge to practice in a variety of clinical learning environments. Information on how to structure interactive learning opportunities are provided (such as simulation and reflective practice). Available from: http://RNAO.ca/sites/rnao-ca/files/SHWE_Practice_Education_BPG_WEB_0.pdf

RECOMMENDATION 3.2:

Engage in continuing education to enhance knowledge and skill to support persons experiencing crisis through trauma-informed approaches.

Trauma-Informed Principles: All trauma-informed principles

Level of Evidence for Summary: Ia, IIb, and IV

Quality of Evidence for Summary: High = 1 study; Moderate = 5 studies

Discussion of Evidence:

Evidence Summary

It is essential that the interprofessional team participate in training on trauma-informed approaches and crisis interventions. It is important to generate trauma awareness[G] through education across health-care services (acute care, community, and so on) among all members of the interprofessional team who are directly or indirectly involved with persons who have experienced crisis (Poole et al., 2013). This can include administrative and admission personnel who engage with persons for the first time in an agency (Poole et al., 2013).

Research demonstrates that continuing education in the form of in-house training for staff has positive outcomes on staff knowledge (Choi & Seng, 2015; Everly, Lee McCabe, Semon, Thompson, & Links, 2014). Specifically, psychological first aid for health personnel without a mental health background (such as administrative staff, managers, health-care providers, and volunteers) improved self-confidence (Everly et al., 2014), while trauma-informed perinatal care for staff in a perinatal care agency (including health-care providers, administrative personnel, and doulas) improved attitudes and

skill level (Choi & Seng, 2015). Studies on the training of health-care professionals working with people who self-harm found positive effects on knowledge, skills, and attitudes regarding suicide (Paton et al., 2016). Crisis intervention team training[G] for police officers contributed to increased knowledge of mental illness and changes in perception and attitude towards person living with mental illness among those trained; it also led to more frequent use of salient de-escalation techniques and the use of less force (Canada, Angell, & Watson, 2012; Compton et al., 2014a; Ellis, 2014).

Benefits and Harms

There were no harms identified in the literature regarding the interprofessional team engaging in continuing education. Overall, the benefits of this recommendation make it appropriate to adopt.

Values and Preferences

Some preferences for training among participants included requests for trauma-informed training to be more in-depth and for more interprofessional training involving both nurses and police officers (as they had limited understanding of each other's professional cultures) (Choi & Seng, 2015; Kirst et al., 2015). The expert panel highly values components such as mentorship opportunities (i.e., learning from colleagues through clinical supervision[G] and coaching) and the involvement of persons with lived experience. This ensures a rich learning environment.

Table 13: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Trauma-informed and crisis training resources	**Appendix K** outlines some organizations that provide crisis intervention and trauma-informed practice training and resources for independent learning.

System, Organization, and Policy Recommendations

RESEARCH QUESTION # 4:

What organization- and system-level supports are needed by nurses and the interprofessional team to implement best practices effectively using trauma-informed approaches to crisis?

RECOMMENDATION 4.1:

Organizations identify and embed trauma-informed approaches directly within their policies and procedures to support:

a) a framework for approaches to crisis intervention and service delivery, and

b) a safe and supportive work environment for providers who have experienced critical incidents.

Trauma-Informed Principles: All trauma-informed principles

Level of Evidence for Summary: IV and V

Quality of Evidence for Summary: Moderate = 3 studies

Discussion of Evidence:

Evidence Summary

A. Framework for Approaches to Crisis Intervention and Service Delivery

Literature demonstrates that a person's health and preferences are favored when organizations embed trauma-informed approaches into their policies and practices (Hootz et al., 2016; Lewis-O'Connor & Chadwick, 2015). For example, research indicates that trauma-informed services that include strength-based crisis management help persons to develop better self-support mechanisms, determination of independent living goals, and greater autonomy (Hootz et al., 2016). People experiencing crisis appreciate strength-based strategies and being involved in creating active problem-solving, and they expressed a strong desire to help themselves (Gudde et al., 2013; Roller, 2012; Tetterton & Farnsworth, 2011). The partnering relationship with health providers supported a satisfactory care experience that respected personal choices and created safety (Roller, 2012; Tetterton & Farnsworth, 2011).

Research examining gender-based violence[G] found that trauma-informed practices improved quality of care and safety. However, the effect on follow-up services following the acute care visit was unclear (Lewis-O'Connor & Chadwick, 2015). Research on evidence collection related to a crisis incident showed that explicit consent is mandatory. Some persons declined consent without regret and others indicated further harm and distress related to evidence collection (Lewis-O'Connor & Chadwick, 2015). It is important for persons to understand the benefits and limitations of evidence collection to support trauma-informed principles of safety and collaboration in decision making (Lewis-O'Connor & Chadwick, 2015).

B. Safe and Supportive Work Environment for Providers who Have Experienced Critical Incidents

It is important to recognize that health-care providers and members of the interprofessional team may experience traumatic events in their professional or personal life. Critical incidents[G] at work (e.g., witnessing the serious injury of a co-worker or responding to a fatal accident) may cause significant distress that negatively affects performance and mental well-being. Research indicates that it was important to build strength-based principles into a critical incident stress management (CISM) policy for social workers (Pack, 2012). CISM focuses on providing support, assistance, and follow-up services to those involved in critical incidents (Pack, 2012). **Appendix L** outlines the components of a CISM program. Although the literature demonstrates evidence for this recommendation for social workers, the expert panel recognizes the need for a safe and supportive work environment for all members of the interprofessional team who are susceptible to critical incidents.

Benefits and Harms

There were no harms identified in the literature. Overall, the benefit of organizational implementation of trauma-informed approaches to crisis interventions is appropriate for service delivery.

Values and Preferences

Incorporating clinical supervision[G] is an example of providing a safe and supportive work environment for health-care providers in particular who have experienced critical incidents. Clinical supervision is an essential part of an integrated CISM policy, and evidence demonstrates that social workers who experienced critical incidents at work valued the opportunity to have a supervisor to facilitate reflective practice and professional growth (Pack 2012). The expert panel recognizes that safe and supportive work environments are important for health-care providers who experience vicarious trauma[G], which can lead to decreased productivity, low motivation, and exhaustion. The expert panel therefore places high value on providers engaging in clinical supervision and self-care strategies to promote knowledge development, introspection, coping, and mental health.

Table 14: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Organizational checklist *Source:* Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf	This source contains a checklist that is intended to support the translation of trauma-informed principles into practice at the organizational level. The checklist can be found on page 45. Available from: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
Organizational self-assessment *Source:* Manitoba Trauma Information Centre. (2017). *Organizational self-assessment*. Retrieved from http://trauma-informed.ca/trauma-informed-organizationssystems/organizational-self-assessment/	This self-assessment provides organizational criteria in the provision of trauma-informed practice, policy and program mandates, hiring practices, procedures, and evaluation and monitoring. Available from: http://trauma-informed.ca/trauma-informed-organizationssystems/organizational-self-assessment/

RESOURCE	DESCRIPTION/EXCERPT
Preventing and managing violence in the workplace *Source:* Registered Nurses' Association of Ontario. (2009). *Preventing and managing violence in the workplace.* Toronto, ON: Author.	This nursing BPG identifies strategies for planning, implementing, and evaluating outcomes related to recognizing and assessing the risk of violence in the workplace. Available from: http://RNAO.ca/sites/rnao-ca/files/Preventing_and_Managing_Violence_in_the_Workplace.pdf
Clinical supervision handbook *Source:* Centre for Addiction and Mental Health. (2008). *Clinical supervision handbook*. Toronto, ON: Author.	A guide for clinical supervisors in the area of substance use and mental health, including frameworks and components of clinical supervision. Available from: https://www.yumpu.com/en/document/view/6331450/clinical-supervision-handbook-camh-knowledge-exchange-
Organizational support for clinical supervision *Source:* The Bouverie Centre. (2013). *Organizational support for clinical supervision*. Retrieved from http://www.clinicalsupervisionguidelines.com.au/role-of-the-organisation	Online resource that provides steps for building a clinical supervision framework within an organization. Available from: http://www.clinicalsupervisionguidelines.com.au/role-of-the-organisation
Self-care starter kit *Source:* University of Buffalo. (2017). *Our self-care starter kit*. Retrieved from http://socialwork.buffalo.edu/resources/self-care-starter-kit.html	An online resource providing tools to develop a self-care plan, a self-care assessment, and additional exercises and activities. Available from: http://socialwork.buffalo.edu/resources/self-care-starter-kit.html
Self-care resources *Source:* Mindcheck.ca. (2017). *Stress self-care resources.* Retrieved from https://mindcheck.ca/stress/stress-self-care-resources	Online resources and tools that can help build skills and develop ways to manage stress. Includes apps, interactive activities, and worksheets. Available from: https://mindcheck.ca/stress/stress-self-care-resources

RECOMMENDATION 4.2:

Enhance collaboration between sectors through system-level integration between health systems, social services (e.g., housing and employment), education systems, the justice system, advocates, persons with lived experience, and families in order to improve system capacity to respond in a trauma-informed way to persons experiencing crisis.

Trauma-Informed Principles: All trauma-informed principles

Level of Evidence for Summary: V

Quality of Evidence for Summary: Expert panel with supporting grey and peer-reviewed literature

Discussion and Summary from Expert Panel:

The RNAO expert panel recommends system-level integration between various health, social services (such as housing and employment agencies), education, and justice sectors to support shared principals of trauma-informed care. System integration refers to a formalized coordinated approach to planning, service delivery, and management at a macro level (Canadian Observatory on Homelessness, 2017). The purpose of system integration is to align services, avoid duplication, improve information sharing, increase efficiency (i.e., decrease first response times), the right level of care in response to a person's needs, and provide a seamless care experience for individuals and families (Canadian Observatory on Homelessness, 2017; Durbin, Goering, Streiner, & Pink, 2006). Specifically, horizontal integration is a centralized approach to planning, management, and service delivery between sectors. It involves creating a network of organizations that provides a coordinated continuum of services to a defined population (Durbin et al., 2006).

Persons who experience crisis access multiple sectors—such as social services (including homeless shelters and crisis centres) and the justice system—when their underlying issues are not adequately addressed. The expert panel highlights that sectors often operate in silos, with a lack of communication, fragmentation between services, and inconsistencies in approaches to crisis intervention. Effective system integration requires active participation and collaboration among representatives from these sectors, including those with lived experience.

The expert panel recommends the involvement of persons with lived experience in the planning and processes of integrating trauma-informed approaches across sectors. The expert panel does note, however, that improved integrated care will not necessarily result in effective services. To improve organizational effectiveness, the panel emphasizes that standalone organizations and the different sectors need to focus on adopting trauma-informed approaches. For example, workflow processes ultimately need to be informed by the person (i.e., the person must define the crisis/safety plans), while practices are evidence-informed and outcome-based. For more information on how a trauma-informed approaches can be adopted at the organizational level, refer to **Recommendation 4.1**.

Benefits and Harms

The expert panel did not note any harms associated with the recommendation. Overall, the proposed benefits make this recommendation appropriate for implementation.

Values and Preferences

There were no additional values or preferences indicated by the expert panel.

Table 15: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Systems approach workbook: Valuing people with lived experience *Source:* Canadian Centre of Substance Abuse. (2013). *Systems approach workbook: Valuing people with lived experience*. Ottawa, ON: Author.	This report describes the importance of persons with lived experience and how to involve them in system change. Available from: http://www.ccsa.ca/Resource%20Library/nts-systems-approach-lived-experience-2013-en.pdf
Patients Canada *Source:* Patients Canada. (2014). *Patients Canada*. Retrieved from http://www.patientscanada.ca/	"A national, independent organization that champions health care change that matters to patients with a commitment to share health care policy and improve the delivery of health care at all levels. Patients Canada provides several avenues for patient engagement including but not limited to education and training and collaborative partnerships with health care stakeholders (including governments, health care providers and like-minded organizations)." Available from: http://www.patientscanada.ca/

RECOMMENDATION 4.3:

Health, social service, and law enforcement organizations collaborate to ensure that crisis intervention services are accessible to persons experiencing crisis through the establishment of:

a) mobile crisis teams;

b) outreach visits; and

c) telephone triage and helplines.

Trauma-Informed Principles: Collaboration and Mutuality; and Peer Support.

Level of Evidence for Summary: Ia, IIb, Ib, and IV

Quality of Evidence for Summary: High = 4 studies; Moderate = 5 studies

Discussion of Evidence:

Evidence Summary

The literature demonstrates the effectiveness of critical resources required in the health system to support persons experiencing crisis: access to timely and appropriate crisis intervention services is essential in aiding a person to achieve the pre-crisis state. This includes mobile crisis teams, outreach visits, and telephone triage and helplines.

A. Mobile Crisis Teams

Mobile crisis teams (also referred to as "crisis resolution teams[G]") are multidisciplinary teams that offer rapid, short-term emergency services in the community as an alternative to inpatient admission (Hasselberg, Grawe, Johnson, & Ruud, 2011a, 2011b). Mobile crisis teams are meant to reduce the use of coercion, collaborate with the wider mental health system and with families/networks, and to offer referrals and links to community agencies for ongoing, longer-term support (Hasselberg et al., 2011b).

Research indicates that the overall outcomes of symptom severity and level of functioning among persons receiving support from a mobile crisis team is positive (Hasselberg et al., 2011b). Findings have demonstrated the effectiveness of mobile crisis teams in diverting persons away from hospitals and the criminal justice system, and in improving access to services such as home, family health team, or other community supports (Evangelista et al., 2016; Kirst et al., 2015; McKenna, Furness, Oakes, & Brown, 2015). With the addition of home-based interventions (such as home-based delivery and administration of medication, practical help with activities of daily living, family and caregiver support, a range of interpersonal therapies, planning for crisis prevention, and referral to other services), mobile crisis teams were associated with substantial reductions in hospital admissions for persons experiencing crisis (Paton et al., 2016).

B. Outreach Visits

Outreach visits by multidisciplinary crisis teams, designated contact persons, and peer support workers provide effective support for persons in crisis. The establishment of outreach visits improves access to follow-up services and mental health. Research on early intervention outreach programs (e.g., following a violent event and follow-up of psychiatric patients in emergency departments) found increased referral and improved access to general practitioners and mental health clinics (Boudreaux et al., 2015; Haga et al., 2015). Fathers that experienced the loss of a child benefited from outreach visits with improved personal growth and reduced self-blame and anger (Aho et al., 2011).

C. Telephone Triage and Helplines

Telephone triage and helplines are resources designed to improve access to services for persons experiencing crisis. Helplines often are the first line of communication for persons experiencing crisis prior to a mobile crisis team being dispatched. Research demonstrates that the establishment of 24-hour suicide prevention helplines has improved access to appropriate health services and reduced the number of suicides (Chavan et al., 2012; Sands, Elsom, Keppich-Arnold, Henderson, & Thomas, 2016). Furthermore, persons have described 24-hour telephone-based mental health triage services as life-saving because they provide immediate support and crisis interventions (Sands et al., 2016). The establishment of helplines ensures easy, accessible, and immediate support.

Benefits and Harms

There were no harms identified in the literature. Overall, the benefits of these resources are favourable.

Values and Preferences

When working with mobile crisis teams, persons who experienced crisis valued accessible services, continuity of care, counseling support with time to talk, and home-based interventions (Wheeler et al., 2015). They did, however, desire more coherence and continuity of services than was readily available at the time required, and they expressed concerns about the limited hours of operation of mobile crisis teams (Gudde et al., 2013). For telephone-based triage, some persons indicated that being offered choices while in crisis was not perceived as helpful, particularly during periods of crisis, when the ability to make decisions was difficult (Sands et al., 2016).

RECOMMENDATION 4.4:

Police agencies integrate comprehensive crisis training:

a) to enhance police officers' interaction with persons experiencing crisis, and

b) to encourage police officers to make informed decisions about helping persons access appropriate services.

Trauma-Informed Principles: All trauma-informed principles

Level of Evidence for Summary: Ia, IIb, and IV

Quality of Evidence for Summary: High =1 study; Moderate = 5 studies

Discussion of Evidence

Evidence Summary

A. To Enhance Police Officers' Interaction with Persons Experiencing Crisis

A person experiencing crisis often has first contact with police officers, either alone or as part of a larger mobile crisis team. Crisis intervention training[G] for police officers has been shown to be effective. It guides officers in assessing the likely presence of mental health problems or mental illness using communication and de-escalation techniques (Ellis, 2014; Tyuse, 2012). The goals of training include improving officer and person safety and redirecting individuals with mental illness from the judicial system to the health-care system (Dupont, Cochran, & Pilsbury, 2007).

Crisis intervention training for police has been shown to improve knowledge of mental illness and treatment, decrease stigma towards persons living with mental illness, improve self-efficacy for interacting with individuals experiencing psychosis or suicidal ideation, and improve de-escalation skills and decision making in connecting the person with appropriate supports (Canada et al., 2012; Compton et al., 2014a; Compton et al., 2014b; Ellis, 2014). Police officers who had received crisis intervention training resolved encounters with less use of force (Canada et al., 2012). Based on their encounters, mental health consumers echoed the need for training and education in mental health for police officers (Evangelista et al., 2016).

For more information on crisis intervention training and other forms of mental health training, please refer to **Table 16**.

B. To Encourage Police Officers to Make Informed Decisions About Helping Persons Access Appropriate Services

Evidence demonstrates that crisis intervention training for police officers supports informed decision making and access to community-based mental health services. Officers who received crisis intervention training were more likely to connect persons to mental health services or take them to a treatment facility for a psychiatric evaluation (Compton et al., 2014b; Paton et al., 2016; Tyuse, 2012). They also were less likely to execute an arrest (Compton et al., 2014b; Paton et al., 2016), and they reported knowing more options when deciding the outcome of a crisis assessment in the community (Canada et al., 2012).

Benefits and Harms

Although there are benefits of police presence in ensuring safety and stabilization for persons experiencing crisis, the panel also recognizes that a police presence during a crisis intervention may trigger negative emotional outcomes in some persons. Considerations (such as not wearing a police uniform) should be taken for reducing the potential for emotional harm.

Values and Preferences

Police officers and health-care providers in an inteprofessional mobile crisis team expressed the need for more cross-sector training because they had limited understanding of each other's professional cultures (Kirst et al., 2015). The RNAO expert panel places high value on interprofessional training, incorporating theory regarding trauma-informed approaches into existing training methods, and having persons with lived experience inform the development of training.

Table 16: Supporting Resources

RESOURCE	DESCRIPTION/EXCERPT
Crisis intervention training website *Source:* International Crisis Intervention Team. (2017). *Welcome to CIT International*. Retrieved from http://www.citinternational.org/	CIT International is an organization that works to facilitate understanding, development, and implementation of crisis intervention training programs throughout the world. Available from: http://www.citinternational.org/
TEMPO: Police interactions —a report towards improving interactions between police and people living with mental health problem. *Source:* Coleman, T., & Cotton, D. (2014). *TEMPO: Police interactions —a report towards improving interactions between police and people living with mental health problem*. Canada: Mental Health Commission of Canada.	This report provides information on different formats of mental health training currently being used within Canada and around the world. It also highlights specific key training and education recommendations that aim to improve interaction between police officers and persons with mental illness. Available from: http://www.ciddd.ca/documents/phasetwo/Tempo_Police_Interactions.pdf

Research Gaps and Future Implications

The RNAO Best Practice Research and Development Team and RNAO expert panel identified the priority areas for future research outlined in **Table 17**. Studies conducted in these areas would provide further evidence to support trauma-informed crisis interventions in adults. The list is not exhaustive; other areas of research may be required.

Table 17: Priority Research Areas for Each Research Question

RESEARCH QUESTION	PRIORITY RESEARCH AREA
Research question #1: What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team with adults experiencing crisis?	■ Examining effective crisis interventions for those with severe mental illness and addictions. ■ Exploring the needs and preferences for crisis support of diverse women, men, transgender and Indigenous populations. ■ Identifying assessment processes to be conducted immediately after a crisis incident/event. ■ Determining the effectiveness of text messaging alongside telephone counselling in improving outcomes.
Research question #2: What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team to mitigate or prevent future crisis in adults?	■ Decision-making pathways for appropriate referrals to follow-up care. ■ Long-term effectiveness and efficacy of virtual care and/or web-based interventions. ■ Utilization and cost-effectiveness of crisis plans. ■ Effects of long-term psycho-education in providing long-term recovery.
Research question #3: What content and educational strategies are necessary to educate nurses and the interprofessional team effectively regarding crisis and trauma-informed approaches?	■ Effectiveness of interprofessional educational strategies. ■ Effective models for educating providers on trauma-informed crisis interventions. ■ Effects of trauma-informed training for providers on patient outcomes (e.g., lowers anxiety or improves self- perception regarding safety). ■ Long-term effects of trauma-informed training on provider knowledge and skill.

RESEARCH QUESTION	PRIORITY RESEARCH AREA
Research question #4: What organization- and system-level supports are needed by nurses and the interprofessional team to implement best practices effectively using trauma-informed approaches to crisis	■ Identification of systemic (organizational and societal) factors that contribute to crisis. ■ Identification of impact of system integration on persons experiencing crisis outcomes. ■ Determination of feasibility of crisis resolution teams, outreach visits, and telephone helplines implemented in areas with vast geographic distances and/or limited resources (i.e., rural and remote locations). ■ Development of performance measures and public data repositories to support quality improvement and funding resources for crisis services.

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging; it takes more than awareness and distribution of guidelines for practice to change. Guidelines must be adapted for each practice setting in a systematic and participatory way in order to ensure recommendations fit the local context (Harrison, Graham, Fervers, & van den Hoek, 2013). The RNAO *Toolkit: Implementation of Best Practice Guidelines* (2012) provides an evidence-informed process for doing this. It can be downloaded at www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health-care is more likely when:

- leaders at all levels are committed to supporting guideline implementation;
- guidelines are selected for implementation through a systematic, participatory process;
- stakeholders for whom the guidelines are relevant are identified and engaged in the implementation;
- environmental readiness for implementing guidelines is assessed;
- the guideline is tailored to the local context;
- barriers and facilitators to using the guideline are assessed and addressed;
- interventions to promote use of the guideline are selected;
- use of the guideline is systematically monitored and sustained;
- evaluation of the guideline's impact is embedded in the process; and
- there are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the "Knowledge-to-Action" framework (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis (see **Figure 2**). It also guides the adaptation of the new knowledge to the local context and its implementation. This framework suggests identifying and using knowledge tools, such as guidelines, to identify gaps and begin the process of tailoring the new knowledge to local settings.

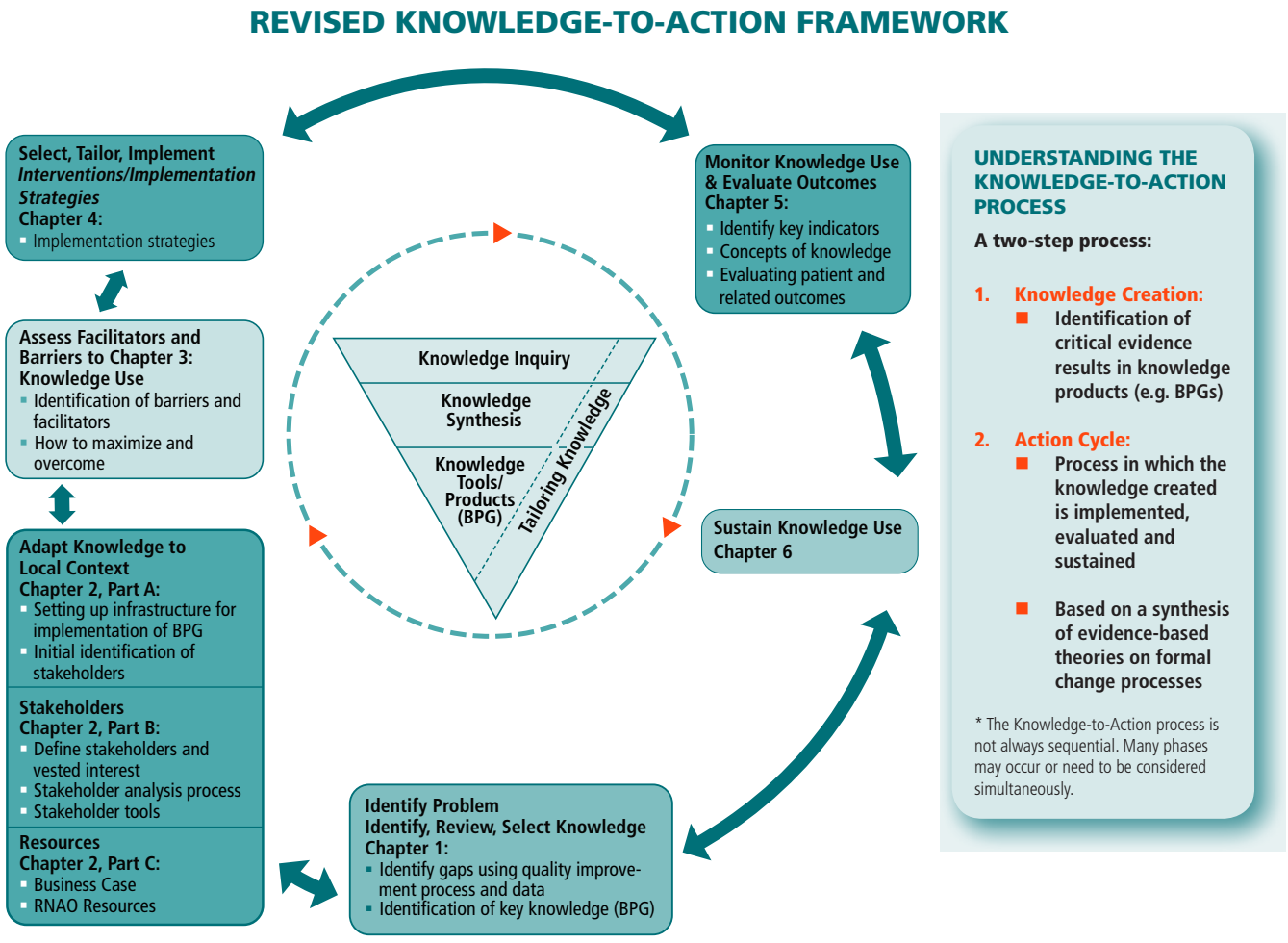
RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination that incorporates a variety of strategies, including:

1. The Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs;
2. Nursing order sets[G], which provide clear, concise, and actionable intervention statements derived from the BPGs' practice recommendations that can be readily embedded within electronic medical records (although they may also be used in paper-based or hybrid environments); and
3. The Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs® focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation. Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network®: RNAO.ca/bpg/get-involved/champions
- RNAO Nursing Order Sets: RNAO.ca/bpg/initiatives/nursing-order-sets
- RNAO Best Practice Spotlight Organizations®: RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: RNAO.ca/events

Figure 2: Knowledge-to-Action Framework



Adapted from "Knowledge Translation in Health Care: Moving from Evidence to Practice". S. Straus, J. Tetroe, and I. Graham. Copyright 2009 by the Blackwell Publishing Ltd. Adapted with permission.

Guideline Evaluation

Table 18 provides potential evaluation measures to assess overall Guideline success. It is important to evaluate evidence-based practice changes when implementing a guideline. Measures are identified using established health information data libraries or repositories, such as those from Canadian Institute of Health Information (CIHI), Health Quality Ontario (HQO), and others. The listed data repositories are legislated mandatory reporting for Ontario and Canada. The instruments listed are used to collect the data for the respective measures (e.g. interRAI). Select the measure most relevant to the practice setting.

Table 18: Evaluation Measures for Overall Guideline Success

EVALUATION MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
Percentage of persons reporting crisis (i.e., serious psychological distress) in the last 30 days	CAMH Monitor Report[1]
Percentage of persons reporting more than 14 days of crisis (i.e., mental distress) in the last 30 days	
Risk of Harm to Other Scale or violent or aggressive behaviours in the last seven days	interRAI-MH[2]
Age-standardized rate of hospitalization in a general hospital due to self-injury (per 100,000 population)	CIHI DAD[3], Statistics Canada, CIHI HMDB[4], CIHI NACRS[5], CIHI OMHRS[6], interRAI-MH
Percentage of persons in crisis provided with access to: ■ mobile crisis teams ■ outreach visits ■ appropriate health-care providers[G] ■ telephone triage and helplines	New
Number of providers who have experienced critical incidents who then accessed available supports and services	New
Percentage of satisfaction for persons that received crisis interventions (brief intervention, critical incident stress debriefing approach, psychological first aid)	New

1 Centre for Addiction and Mental Health Monitor Report (CAMH Monitor Report)
2 interRAI Mental Health (interRAI-MH)
3 Canadian Institute for Health Information Discharge Abstract Database (CIHI DAD)
4 Canadian Institute for Health Information Hospital Morbidity Database (CIHI HMDB)
5 Canadian Institute for Health Information National Ambulatory Care Reporting System (CIHI NACRS)
6 Canadian Institute for Health Information Ontario Mental Health Reporting System (CIHI OMHRS)

Table 19 supports evaluation of practice changes during implementation. The measures are directly associated with the recommendation statements and support process improvement.

Table 19: Implementation Measures for Overall Guideline Success

RECOMMENDATION	IMPLEMENTATION MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
1.1	Percentage of persons in crisis who received brief intervention as part of routine care	New
1.2	Percentage of persons experiencing crisis who were engaged in critical incident stress debriefing approach within 24 to 72 hours of crisis event	New
1.3	Percentage of persons in crisis for whom crisis plans were developed upon initial contact	New
1.4	Percentage of persons who attend follow-up appointments following outreach by mobile crisis teams/visitors	New
1.5	Percentage of persons in crisis provided PFA by peer support workers	New

Other RNAO resources for the evaluation and monitoring of BPGs:

- Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®), a unique nursing data system housed in the International Affairs and Best Practice Guideline Centre, allows Best Practice Spotlight Organizations® (BPSOs®) to measure the impact of BPG implementation by BPSOs worldwide. The NQuIRE data system collects, compares, and reports data on guideline-based nursing-sensitive process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing performance measures wherever possible, adhering to a 'collect once, use many times' principle. By complementing other established and emerging performance measurement systems, NQulRE strives to leverage reliable and valid measures, minimize reporting burden and align evaluation measures to enable comparative analyses. The international NQuIRE data system was launched in August 2012 to: (i) create and sustain evidence-based practice cultures, (ii) optimize patient safety, (iii) improve patient outcomes, and (iv) engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (VanDeVelde-Coke et al., 2012). Please visit RNAO.ca/bpg/initiatives/nquire for more information.
- Nursing order sets embedded within electronic medical records provide a mechanism for electronic data capture of process indicators. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific client health outcomes. Please visit RNAO.ca/ehealth/nursingordersets for more information.

Process for Update and Review of Best Practice Guidelines

The Registered Nurses' Association of Ontario commits to updating its BPGs as follows:

1. Each nursing BPG will be reviewed by a team of specialists in the topic area every five years after the publication of the previous edition.
2. RNAO International Affairs and Best Practice Guideline Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, the staff commences planning of the review by doing the following:
   a) Inviting specialists in the field to participate on the expert panel. The expert panel will be comprised of members from the original panel as well as other recommended specialists and experts.
   b) Compiling feedback received and questions encountered during the implementation, including comments of BPSOs® and other implementation sites about their experiences.
   c) Compiling a list of new clinical practice guidelines in the field and refining the purpose and scope.
   d) Developing a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
5. New editions of BPGs will be disseminated based on established structures and processes.

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Appendix A: Glossary of Terms

Addiction: The persistent dependence on or use of a substance or behaviour despite its negative consequences and the increasing frequency of those consequences (Halter, Pollard, Ray & Haase, 2014).

Analytical studies: Analytical studies test hypotheses about exposure–outcome relationships. The investigators do not assign an intervention, exposure, or treatment, but they do measure the association between exposure and outcome over time using a comparison group (Centres for Disease Control and Prevention [CDC], 2013). Analytical study designs include case-control studies and cohort studies.

Case-control study: A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (The Cochrane Collaboration, 2017).

Cohort study: An observational study in which a defined group of people (the cohort) is followed either prospectively or retrospectively over time (The Cochrane Collaboration, 2017).

Best practice guideline (BPG): Systematically developed, evidence-based documents that include recommendations on specific clinical and healthy work environment topics for nurses, interprofessional team members, educators, leaders and policy-makers, and persons and their families. BPGs promote consistency and excellence in clinical care, health policies, and health education, ultimately leading to optimal health outcomes for people, communities, and the health-care system.

Brief intervention (BI): A technique used by health-care providers to express empathy for the client and offer feedback in order to increase the client's motivation to make changes (RNAO, 2015).

Clinical supervision: Clinical supervision focuses on the provision of empathetic support from a supervisor to improve therapeutic skills, the transmission of knowledge, and the facilitation of reflective practice (RNAO, 2002; Winstanley & White, 2003). It is an opportunity for personal and professional growth and does not involve penalties or judgment (RNAO, 2002).

The principal aims of clinical supervision include the following: enhancing supervisees' skills, competence, and confidence; providing a reflective space and emotional support; providing assistance with professional development; ensuring that services to persons are safe, ethical, and competent; and ensuring compliance with professional and organizational treatment standards (Victorian Alcohol & Drug Association, 2013).

Complementary therapies: Complementary therapies refer to practices and products that are non-mainstream in origin. Complementary therapies can be either natural products (e.g., dietary supplements such as vitamins and probiotics) or mind/body practices (e.g., yoga, chiropractors, meditation, massage, and acupuncture). Other traditional healers—such as Ayurvedic medicine, traditional Chinese medicine, homeopathy, and naturopathy—also can be considered complementary therapies (National Centre for Complementary and Integrative Health, 2016).

The RNAO expert panel recommends that complementary therapies be used as an adjunct to traditional therapy, and that they should never be the sole type of therapy for persons who have experienced or are experiencing crisis.

Consensus: A process used to reach agreement among a group or panel during a Delphi or modified Delphi technique (Avella, 2016). For example, a consensus of 70 per cent agreement from all panel members was needed for the recommendations within this Guideline.

See modified Delphi technique

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who have not been randomly allocated to the experimental and comparison or control groups (The Cochrane Collaboration, 2005).

Cultural sensitivity: Awareness, understanding, and attitudes toward culture and place the focus on self-awareness and insight (RNAO, 2007).

Crisis: A crisis is a time-limited response to a life event that overwhelms a person's usual coping mechanisms in response to situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors (Caplan, 1964; Ontario Ministry of Health and Long-Term Care, 1999).

It is important to note that this Guideline intends to provide evidence-based interventions immediately and up to four weeks post-crisis.

Crisis interventions: Crisis interventions are the methods used to offer immediate short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioural distress. They are designed to ensure safety and recovery, and to last no longer than one month (Borschmann, Henderson, Hogg, Phillips, & Moran, 2012; Li & Xu, 2012).

Crisis intervention team training: Crisis intervention team training (sometimes known as "CIT training") is a first-responder model of police-based crisis intervention. It requires training that results in the utilization of specialized skills by police when responding to calls involving persons with mental illness. These skills may include assessing the likely presence of mental illness, using communication and de-escalation techniques, and communicating with mental health providers (Ellis, 2014; Tyuse, 2012). The goals of crisis intervention team training include improving officer and consumer safety and redirecting individuals with mental illness away from the judicial system to the health-care system (Dupont et al., 2007).

Crisis plan: A written plan to outline preferred ways of managing and preventing crisis in the future. Crisis plans may include information on early warning signs of a crisis, medications, supports that help manage the person with crisis, preferences for care, contact details for family members, and information about 24-hour services (Mind, 2013).

Crisis resolution teams: Crisis resolution teams are multidisciplinary mobile teams offering rapid, short-term emergency services in the community as an alternative to inpatient admission (Hasselberg et al., 2011a, 2011b; Wheeler et al., 2015).

Critical incident: A critical incident is a traumatic event (which could happen in an institution or in the community) that causes a strong emotional reaction with the potential to affect one's ability to cope with the after-effects. Examples of critical incidents can include, but are not limited to, witnessing the death of another person, being a victim of physical violence, or the suicide of a colleague (Correctional Service Canada, 2007).

Critical incident stress debriefing (CISD): A type of crisis intervention that can occur in an individual or group setting with persons who have experienced acute crisis. It is a seven-step model used for short-term crisis intervention that can occur anywhere from 24 to 72 hours post-incident and last anywhere from one to five hours in length (Mitchell, 1983).

Descriptive study: A study that generates a hypothesis and describes characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but instead merely describes the characteristics of a sample from a defined population (CDC, 2013; The Cochrane Collaboration, 2017). Descriptive study designs include cross-sectional studies.

Cross-sectional study: A descriptive study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called a "survey") (The Cochrane Collaboration, 2017).

Education recommendations: Statements of educational requirements and educational approaches or strategies for the introduction, implementation, and sustainability of the BPG.

Evidence-based practice: The integration of the methodologically strongest research evidence with clinical expertise and patient values. Evidence-based practice unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (Stevens, 2013).

Family: A term used to refer to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person receiving health care. A person's family may include all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on his or her capacity (RNAO, 2015b).

Gender-based violence: Violence that targets individuals or groups on the basis of their gender (Lewis-O'Connor & Chadwick, 2015).

Health-care provider: In this Guideline, the term health-care provider refers to regulated health-care providers or professionals and, in some cases, to unregulated health-care providers who provide care and services to persons in any setting.

Interprofessional team: Teams made up of individuals from different professions who work together to reach a common goal and share decision making to achieve that goal.

For the purposes of this Guideline, the interprofessional team is comprised of multiple health-care providers (regulated and unregulated), first responders (such as police officers), and peer support workers who all work collaboratively to deliver comprehensive and quality responses, care, and services to people within, between, and across health-care and community settings. The goal is collaborate with persons to provide care that reflects their goals and values (Ferris et al., 2002).

Intimate partner violence: Behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm. This includes physical aggression, sexual coercion, psychological abuse, and controlling behaviour (WHO, 2016).

Meta-analysis: A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (The Cochrane Collaboration, 2017).

Mental health: A state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. This definition emphasizes that mental health is more than the absence of mental illness. Knowledge about the prevalence and determinants of mental health is important for informing promotion and intervention programs (Gilmour, 2015; WHO, 2014).

Mental illness: "Mental illness is a collection of disorders such as depression, bipolar disorder, depression, and anxiety. The symptoms can range from loss of motivation and energy, changed sleep patterns, extreme mood swings, disturbances in thought or perception, or overwhelming obsessions or fears. Mental illness interferes with relationships and affects a person's ability to function on a day-to-day basis, often leading to social isolation" (Canadian Mental Health Association, 2017, para 2).

Modified Delphi technique: The modified Delphi technique is a process whereby the initial recommendations, which were formulated to answer the research questions, are carefully created before being provided to the panel for a consensus-seeking process (Avella, 2016).

A modified Delphi technique was used during the Guideline development process. Whereas the identity of the panel members was not concealed, their individual responses to the survey questionnaires used to capture their opinion were concealed from the other members of the group.

Motivational interviewing: An evidence-based, person-centered, and non-directive counseling method for enhancing a person's intrinsic motivation to change (Smedslund et al., 2011).

Nurses: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses, in Ontario), registered psychiatric nurses, and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists (RNAO, 2013).

Nursing order sets: A group of evidence-based interventions specific to the domain of nursing. Nursing order sets are ordered independently by nurses (i.e., without a physician's signature) to standardize the care provided for a specific clinical condition or situation. Nursing order sets are derived from the practice recommendations within a guideline.

Peer support: Defined as a supportive relationship between individuals who have a common lived experience (Cyr et al., 2016). Its purpose is to provide individuals who have experienced adverse events such as a crisis with emotional and social support, encouragement, and hope, and it is meant to complement traditional clinical care (Cyr et al., 2016; Mental Health Commission of Canada, 2017). Peer support workers play an important role in advocating for persons with lived experience.

Person- and family-centred care: A person- and family-centred approach to care demonstrates certain practices that put the person and their family members at the centre of health care and services. Person- and family-centred care respects and empowers individuals to be genuine partners with health-care providers for their health. The approach includes the following common themes and attributes:

- Fostering relationships and trust;
- Empowering the person to be actively involved in making decisions regarding their health care (independence and autonomy, right to self-determination);
- Sharing of evidence-based options for care, education, and information that is unbiased, clear, and comprehensive to support the person in making decisions;
- Respecting the person and personalizing care by promoting the person's strengths, self-knowledge, preferences, and goals for care based on their beliefs, values, culture, and their experience of health;
- Providing physical comfort within an environment that is conducive to healing;
- Offering emotional support and sympathetic presence;
- Ensuring continuity of care during transitions;
- Ensuring the person's ability to access care and services when needed;
- Partnering with the person and their family in health system reform to improve the quality, delivery, and design of health care and services at all levels (micro, meso, and macro);
- Communicating effectively within a therapeutic relationship to promote true health-care partnerships; and
- Caring for individuals, their families, and communities by addressing determinants of health (health promotion and disease prevention) (RNAO, 2015b).

Person-centred care: *See person- and family-centered care*

Practice recommendations: Statements of best practice directed at health-care providers that enable the successful implementation of a BPG.

Psycho-education: The provision of information about the nature of a mental disorder and its symptoms, and what to do about them (WHO, 2013).

Psychological first aid (PFA): Humane, supportive response to a fellow human being who is suffering and may need support. It entails basic, non-intrusive pragmatic care with a focus on listening (but not forcing talk), assessing needs and concerns, ensuring that basic needs are met, encouraging social support from significant others, and protecting from further harm. It centres on five key principles: (1) safety, (2) connectedness, (3) self and collective efficacy, (4) calm, and (5) hope. It is not restricted to mental health professionals; it can also be applied by lay people (Dieltjens et al., 2014; WHO et al., 2013).

System, organization, and policy recommendations: Statements of conditions required for a practice setting that enable the successful implementation of the BPG. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Qualitative research: An approach to research that seeks to convey how human behaviour and experiences can be explained within the context of social structures. Qualitative research uses an interactive and subjective approach to investigate and describe phenomena (Austin & Sutton, 2014).

Quality: The degree to which health-care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (WHO, 2009).

Quasi-experimental study: Quasi-experimental studies are those that estimate causal effects by observing the exposure of interest, but the experiments are not directly controlled by the researcher and lack randomization (e.g., before-and-after designs) (Rockers, Rottingen, Shemilt, Tugwell, & Barnighausen, 2015).

Randomized controlled trials: An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (which receives the experimental intervention) or the comparison group (receiving conventional treatment) or control group (receiving no intervention or placebo) (The Cochrane Collaboration, 2017).

Scoping review: Scoping reviews are used to present a broad overview of the evidence on a specific topic in order to examine areas that are emerging or to clarify key concepts or questions that a researcher may have, irrespective of study quality. Scoping reviews are often a hypothesis-generating process, whereas systematic reviews are hypothesis-testing (Tricco et al., 2016).

Social determinants of health: The social determinants of health are "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (WHO, 2017, para. 1).

Social service: Social services are community-based services and supports that help people recover from hardship and regain control of their lives. These services may include, but are not limited to, crisis centres, case management services, and homeless shelters (Ministry of Child and Youth Services, 2016).

Stakeholder: An individual, group, or organization that has a vested interest in the decisions and actions of organizations, and may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all of the individuals and groups who will be directly or indirectly affected by a change or solution to a problem.

Substance use: Substance use exists on a continuum, with addiction at one end of that continuum. However, not all substance use is problematic, and even when substance use is problematic or addictive in nature, it may be perceived as beneficial by the person. It is important to understand both perceived benefits and drawbacks (SAMHSA, n.d).

Systematic review: A comprehensive review of the literature that uses a clearly formulated question and systematic and explicit methods to identify, select, and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (The Cochrane Collaboration, 2017).

See meta-analysis

Trauma awareness: Having an understanding of how the impact of trauma can be central to one's development, of the wide range of adaptations people make to cope and survive after trauma, and of the relation of trauma with substance use, physical health, and mental health concerns (Poole et al., 2013).

Vicarious trauma: The traumatization of service providers after hearing stories and witnessing the suffering of persons who have experienced trauma (Klinic Community Health Centre, 2013).

Appendix B: Concepts that Align with this Guideline

Table B1: Concepts that Align with this Guideline and Suggested Resources

TOPIC	RESOURCES
Cultural sensitivity[G]	College of Nurses of Ontario. (2009). *Culturally sensitive care*. Toronto, ON: Author. Retrieved from http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf Registered Nurses' Association of Ontario. (2007). *Embracing cultural diversity in health care: Developing cultural competence*. Toronto, ON: Author. Retrieved from RNAO.ca/bpg/guidelines/embracing-cultural-diversity-health-care-developing-cultural-competence
Indigenous populations and trauma	Aguiar W., & Halseth R. (2015). *Aboriginal peoples and historic trauma: The process of intergenerational transmission*. Prince George, BC: National Collaborating Centre for Aboriginal Health. Retrieved from https://www.ccnsa-nccah.ca/docs/context/RPT-HistoricTrauma-IntergenTransmission-Aguiar-Halseth-EN.pdf Aboriginal Healing Foundation. (2004). *Historic trauma and Aboriginal healing*. Ottawa, ON: Author. Retrieved from http://www.ahf.ca/downloads/historic-trauma.pdf
Substance use[G]	Registered Nurses' Association of Ontario. (2015). *Engaging clients who use substances*. Toronto, ON: Author. Retrieved from http://RNAO.ca/bpg/guidelines/engaging-clients-who-use-substances
Interprofessional collaboration	Registered Nurses' Association of Ontario. (2013). *Developing and sustaining interprofessional health care: Optimizing patients/clients, organizational, and system outcomes*. Toronto, ON: Author. Retrieved from RNAO.ca/bpg/guidelines/interprofessional-team-work-healthcare
Person- and family-centred care; person-centred care[G]	Registered Nurses' Association of Ontario. (2015). *Person- and family-centred care*. Toronto, ON: Author. Retrieved from RNAO.ca/bpg/guidelines/person-and-family-centred-care
Social determinants of health[G]	World Health Organization. (2017). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/ Registered Nurses' Association of Ontario. *Nursing towards equity: Applying the social determinants of health in practice*. RNAO eLearning course. Retrieved from http://elearning.RNAO.ca

Appendix C: Guideline Development Process

The Registered Nurses' Association of Ontario has made a commitment to ensure that every BPG is based on the best available evidence. To meet this commitment, a monitoring and revision process has been established for each Guideline every five years.

For this Guideline, RNAO assembled a panel of experts who represent a range of sectors and practice areas (see "RNAO Expert Panel" on page 15). A systematic review of the evidence was based on the purpose and scope of this Guideline, supported by the four research questions listed below. The systematic review captured relevant peer-reviewed literature published between January 2011 and November 2016. The following research questions were established to guide the systematic review:

1. What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team with adults experiencing crisis?
2. What are effective and trauma-informed interventions that can be utilized by nurses and the interprofessional team to mitigate or prevent future crisis in adults?
3. What content and educational strategies are necessary to educate nurses and the interprofessional team effectively regarding crisis and trauma-informed approaches?
4. What organization- and system-level supports are needed by nurses and the interprofessional team to implement best practices effectively using trauma-informed approaches to crisis?

The RNAO Best Practice Research and Development Team and expert panel worked to integrate the most current and best evidence, and to ensure the appropriateness and safety of the Guideline recommendations with supporting evidence and/or expert panel consensus[G].

A modified Delphi technique[G] was employed to obtain panel consensus on the recommendations.

Appendix D: Process for Systematic Review and Search Strategy

Guideline Review

The RNAO Best Practice Research and Development Team's Project Coordinator searched an established list of websites for guidelines and other relevant content published between January 2011 and June 2016. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. Expert panel members were also asked to suggest additional guidelines (see **Figure D1**, **Guidelines Review Process Flow Diagram** below). Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria, is available at http://RNAO.ca/bpg/guidelines/crisis-intervention

The Guideline Development Co-Leads appraised seven international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010). Guidelines with an overall score of four or below were considered to be weak and were excluded. Guidelines with an overall score of five was considered to be moderate, and guidelines with a score of six or seven were considered to be strong. The following guideline, rated moderate was selected to inform the recommendations and discussions of evidence:

World Health Organization. (2013). *Guidelines for the management of conditions specficially related to stress*. Geneva, Switzerland: Author.

Systematic Review

A comprehensive search strategy was developed by RNAO's Best Practice Research and Development Team and a health sciences librarian based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant articles published in English between January 2011 and November 2016 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), MEDLINE, MEDLINE In-Process, Cochrane Library (Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Trials), Embase, and PsycINFO. Education Resources Information Centre (ERIC) was only used for Question Three. In addition to this systematic search, panel members were asked to review personal libraries for key articles not found through the above search strategies.

Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria and search terms, is available at http://RNAO.ca/bpg/guidelines/crisis-intervention

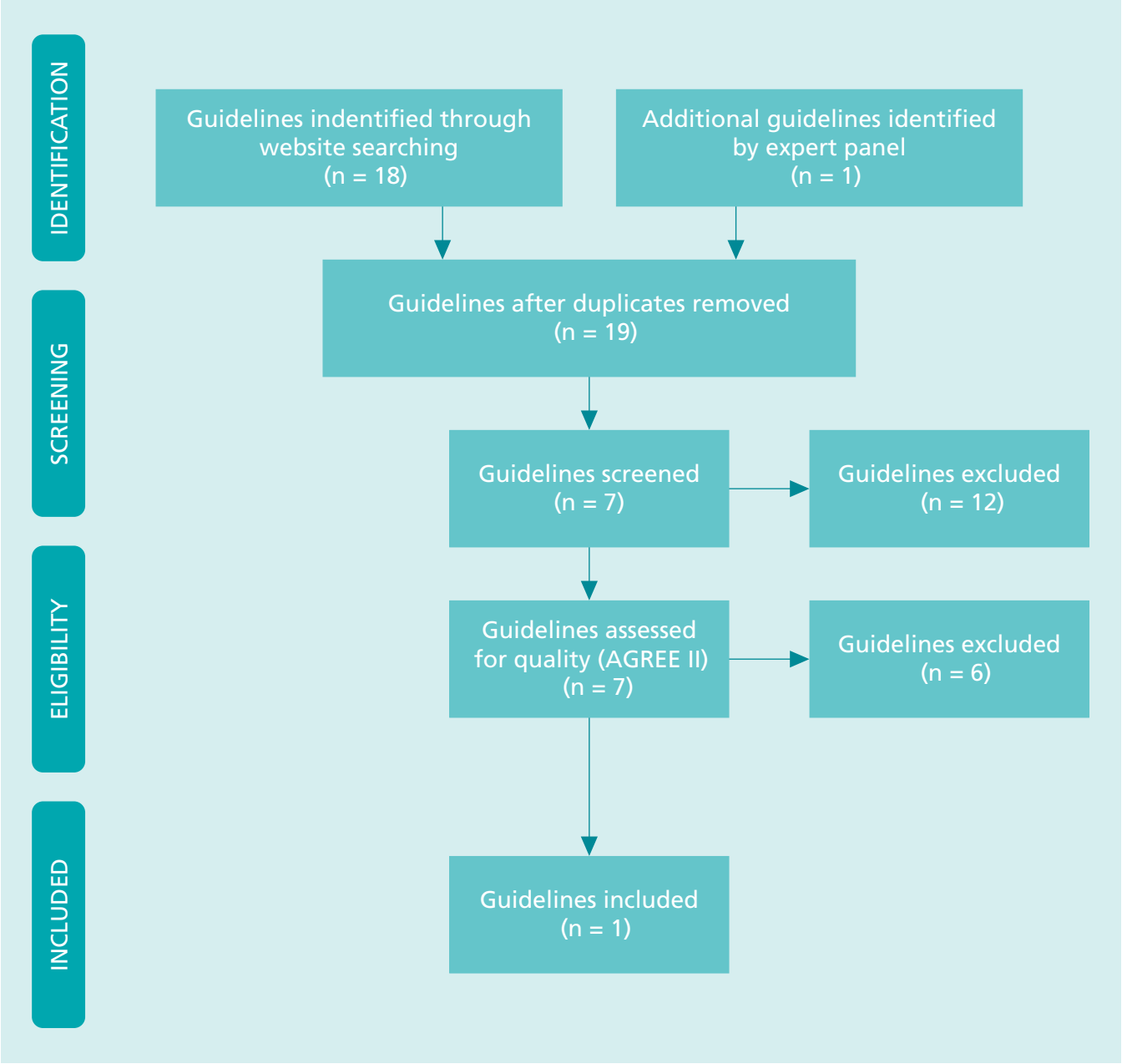
Once articles were retrieved, two RNAO nursing research associates (registered nurses holding master's degrees) independently assessed the eligibility of the studies according to established inclusion and exclusion criteria. Any disagreements at this stage were resolved through tie-breaking by a guideline development co-lead.

Quality appraisal scores for 27 articles (a random sample of approximately 20 per cent of the total articles eligible for data extraction and quality appraisal) were independently assessed by RNAO nursing research associates. Quality appraisal was assessed using AMSTAR (A Measurement Tool to Assess Systematic Reviews) and RNAO's scoring system, which rates reviews as low, moderate, or high (see **Table 2**). The nursing research associates reached acceptable inter-rater agreement (kappa statistic, K = 0.855), which justified proceeding with quality appraisal and data extraction for the remaining studies. The remaining studies were divided equally between the two research

associates for quality appraisal and data extraction (Fleiss, Levin, & Paik, 2003). A final narrative summary of literature findings was completed. The comprehensive data tables and narrative summaries were provided to all expert panel members for review and discussion.

A complete bibliography of all full screened for inclusion and their quality appraisal scores is available at http://RNAO.ca/bpg/guidelines/crisis-intervention

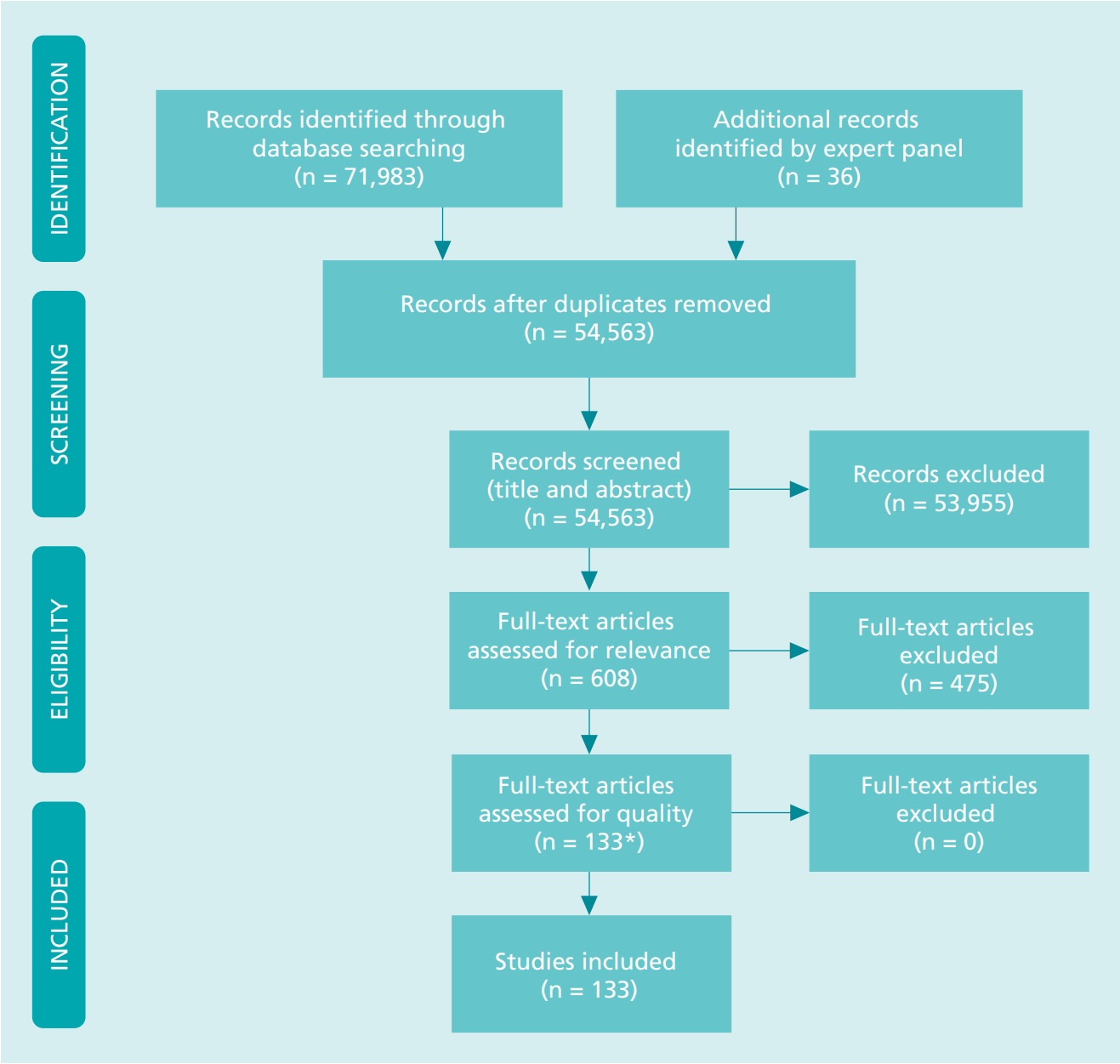
Figure D1: Guidelines Review Process Flow Diagram



Included guidelines had an overall AGREE II score of five or greater (out of seven).

Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Figure D2: Article Review Process Flow Diagram



*133 articles were included for all four research questions, however 3 studies were duplicates and included for separate questions. Therefore, the final number of included studies that were unique were 130.

Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Appendix E: Critical Incident Stress Debriefing Steps

The following table outlines the seven phases of the formal Critical Incident Stress Debriefing (CISD) designed to promote the emotional processing of crisis events and support positive coping mechanisms for future experiences.

Table E1: CISD Steps

CISD STEPS
Phase 1: Introductory Phase. Facilitator introduces themselves, confidentiality is carefully explained, and the person is urged to talk if they wish.
Phase 2: Facts Phase. The person is asked to describe what happened during the incident from their own perspective. This may include stating who they are, where they were, and what they heard, saw, smelled, and did. This helps to give a total picture of what happened.
Phase 3: Feeling and Thoughts Phase. The person describes their first thoughts about the event. The discussion becomes more personal.
Phase 4: Emotions. The person discusses their emotional reactions. This phase can be combined with Phase 3 (Feeling and Thought Phase).
Phase 5: Assessment and Symptom Phase. The physical and psychological symptoms are noted and discussed.
Phase 6: Teaching Phase. The facilitator and person discuss stress reaction and responses and coping strategies.
Phase 7: Re-entry Phase. The person asks questions, wraps up any loose ends, answers outstanding questions, provides final reassurances, and makes a plan of action. Team leaders summarize what has occurred, provide team members contact information, and draw the debriefing to a close.
Sources: Li & Xu, 2012; Mitchell, 1983

Appendix F: Crisis Plan Template

The following is reprinted with permission from Safety and Comfort Plan by the Professional Practice Office, 2016, Centre for Addiction and Mental Health (CAMH).

The form is intended to capture the person's perspective.

Client name: **Date:**

1. Who participated in developing this safety plan?

__ Client __ Family	__ Significant Other __ Substitute Decision Maker	__ Clinical Staff __ Friend/Peer Support Worker	__ Other

2. What makes me feel safe?

3. What makes me feel unsafe?

Some things that make me angry, afraid, very upset, or cause me to go into crisis:

4. How do I know when I am becoming, or in, distress/crisis?

My warning signals:

5. What does it look like when I am in distress or losing control?

What would others see?

6. When I'm in distress/crisis, I need:

7. What activities or coping strategies can I try to calm and comfort myself?

Activities that have helped me feel better when I'm having a hard time:

8. What can others do to help?

Identify who can help and how they can help. Are there other resources that can help?

9. What gets in the way of me using my strategy?

Barriers, obstacles, or situations that impact my ability to apply this safety plan:

10. What would others notice about me when I'm coping effectively?

Things others may notice about me when I am no longer in distress/crisis:

Appendix G: Community Resources for Persons Experiencing Crisis

The RNAO expert panel, with input from external reviewers and other key stakeholders, compiled a list of community resources available in Ontario and Canada for individuals experiencing crisis (**Table G1**). This list is not exhaustive.

Links to websites that are external to RNAO are provided for information purposes only. RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Furthermore, RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

Table G1: Community Resources for Persons Experiencing Crisis

ORGANIZATION/RESOURCE	DESCRIPTION	LINK
ConnexOntario	"ConnexOntario provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness or gambling." *Source:* "About Us," ConnexOntario website.	http://www.connexontario.ca/
Mental Health Helpline	"The Mental Health Helpline provides information about mental health services in Ontario." *Source:* "About Us," Mental Health Helpline website.	http://www.mentalhealthhelpline.ca/ Phone number: 1-866-531-2600
Sistering	Sistering is a women's organization that offers practical and emotional support (including crisis intervention and prevention support for those dealing with trauma and abuse) that enables them to take greater control over their lives.	http://www.sistering.org/

ORGANIZATION/RESOURCE	DESCRIPTION	LINK
Progress Place	"Progress Place is a recovering centre for people living with mental illness such as Schizophrenia, Bipolar, Depression, and Anxiety." It combines a comprehensive network of services that includes employment, education, recreation, and housing. *Source:* Progress Place website.	http://www.progressplace.org/
The Toronto Mental Health and Addictions Access Point (The Access Point)	"The Access Point is a centralized organization where one can apply for individual mental health and addictions support services and supportive housing." *Source:* "About," The Access Point website.	http://theaccesspoint.ca/
ShelterSafe.ca	"ShelterSafe.ca is an online resource outlining shelters throughout Canada that help women and their children seeking safety from violence and abuse." *Source:* "About," ShelterSafe.ca website.	http://www.sheltersafe.ca/
Distress Centres of Ontario	Distress Centres of Ontario provides lists of agencies, websites, and resources related to mental health, suicide prevention, and community support services.	http://dcontario.org/links.html

Appendix H: Organizations Providing Peer Support

The RNAO expert panel, with input from external reviewers and other key stakeholders, compiled a list of peer support organizations (**Table H1**) available in Ontario and Canada for individuals who are experiencing crisis. This list is not exhaustive.

Links to websites that are external to RNAO are provided for information purposes only. RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Furthermore, RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

Table H1: Organizations Providing Peer Support

ORGANIZATION	LINK
Peer Support South East Ontario	http://psseo.ca/
Ontario Peer Development Initiative	http://www.opdi.org/
Progress Place—Warm Line	http://www.progressplace.org/approach.html#warm
Mood Disorders Association of Ontario—Family Matters Peer Support and Recovery Program	https://www.mooddisorders.ca/program/family-matters-peer-support-and-recovery-program
Psychiatric Survivors of Ottawa	http://www.pso-ottawa.ca/peer-support-groups
Peer Support Worker Program (British Columbia)	http://www.vch.ca/locations-services/result?res_id=340

Appendix I: Telecommunication- and Technology-Based Resources

The expert panel, with input from external reviewers and other key stakeholders, has compiled a list of crisis helplines (**Table I1**) and mobile apps (**Table I2**). This list is not exhaustive.

Links to websites that are external to RNAO are provided for information purposes only. RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Furthermore, RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

Table I1: Crisis Helplines

RESOURCE	TELEPHONE NUMBER
Mental Health Helpline	1-866-531-2600
Here to Help (British Columbia)	310-6789 *(do not add 604, 778 or 250 before the number). It's free and available 24 hours a day.*
Distress and Crisis Ontario	http://dcontario.org/centres.html (crisis line phone numbers are provided by area)
Assaulted Women's Helpline	1-866-863-0511 1-866-863-7868 (toll free TTY)
Talk4Healing: A Help Line for Aboriginal Women	1-855-554-HEAL
LGBTQ-friendly Crisis Lines	http://www.saravyc.ubc.ca/reports-resources/links/resources-for-trans-youth-allies/crisis-lines-for-lgbtq-youth/ (crisis line phone numbers provided by area)
Anishnawbe Health Toronto—Mental Health Crisis Management Service	416-891-8606

Table I2: Mobile Apps

RESOURCE	APP LINK
SAMHSA Behavioural Health Disaster Response App (for responders)	http://store.samhsa.gov/product/SAMHSA-Behavioral-Health-Disaster-Response-Mobile-App/PEP13-DKAPP-1
Calm in the Storm	http://calminthestormapp.com/
Measure Workplace Stress App	http://www.ohcow.on.ca/measure-workplace-stress.html
The LifeLine App	https://thelifelinecanada.ca/lifeline-canada-foundation/lifeline-app/
Stop Panic & Anxiety Self-Help	https://play.google.com/store/apps/details?id=com.excelatlife.panic&hl=en

Appendix J: Long-Term Interventions to Mitigate Crisis

This appendix includes a summary table (**Table J1**) of interventions from the systematic review to support persons four weeks post-crisis or when crisis stabilization occurs. The purposes of these interventions vary, ranging from continuing skill-building, reducing or managing stressful situations, preventing development of PTSD, and treating the symptoms or consequences of crisis. These interventions help mitigate or better manage crisis events in the future.

Table J1: Long-Term Crisis Interventions (as Informed by the Systematic Review)

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Trauma-specific Interventions	Trauma-specific interventions are focused on treating the consequences of trauma through therapeutic interventions involving practitioners with specialized skills (Poole et al., 2013). They are offered with considerations of trauma-informed approaches and are based on detailed assessment of persons with trauma, mental health, and substance use concerns that seek and consent to integrated treatment (Poole et al., 2013). Articles in the systematic review were related to trauma-specific programs such as Seeking Safety, Helping to Overcome PTSD Through Empowerment, Male Trauma Recovery and Empowerment Model, Helping Women Recover & Beyond Trauma, Esuba, and Beyond Violence (Anderson & Najavits, 2014; Johnson, Zlotnick, & Perez, 2011; Kaiser et al., 2015; Kubiak, Kim, Fedock, & Bybee, 2012).	Research indicates that most trauma-specific interventions were effective in reducing negative outcomes. A study that used the Seeking Safety program found that persons with disabilities experienced sustained reductions in PTSD symptoms (Anderson & Najavits, 2014). Other studies examining the effectiveness of a group-based integrated treatment for PTSD and addiction disorders among incarcerated men, participants in Seeking Safety or Male Trauma Recovery and Empowerment Model showed statistically and clinically significant improvement in PTSD symptom severity over time, although the difference in improvement was not statistically significant compared to that experienced by the wait list (control) group (Wolff et al., 2015). Participants in the Seeking Safety program also expressed treatment satisfaction in an end-of-treatment questionnaire used in another study (Kaiser et al., 2015).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Psychotherapy	Psychotherapy involves a range of approaches based on personal interaction aimed at improving mental health and well-being. The systematic review included psychotherapy interventions delivered in individual, group-based, and brief-intervention formats that varied in duration, components, and target populations. Overall, psychotherapy interventions consistently included skill-building and psycho-education. Cognitive behavioural therapy is a short-term, time-limited form of psychotherapy that focuses on the present. Cognitive behavioural therapy is meant to help people examine how they make sense of what is happening around them and how these perceptions affect the way they feel (Centre for Addiction and Mental Health, 2012).	Research examining the effectiveness of psychotherapy demonstrated mixed results. Some studies indicated positive outcomes, and others showed no effect or were incomplete. Individual-based psychotherapy interventions (e.g., behavioural activation treatment for depression, cognitive processing therapy, dietary education for the treatment of PTSD symptoms, or problem-solving therapy) demonstrated moderate to strong effectiveness on depression and dysfunction (Bolton et al., 2014) and PTSD symptom improvement (Kasckow et al., 2014). Another individual-based cognitive behavioural therapy study found no significant differences post-treatment in PTSD symptoms (Roberts, Roberts, Jones, & Bisson, 2016). Other research focusing on brief cognitive behavioural therapy intervention for active duty military personnel with current suicidal ideation or a recent suicide attempt found that in the intervention group, the intervention was effective in preventing suicide attempts after a two-year follow-up (Rudd et al., 2015). However there were no significant differences between groups in PTSD, depression, anxiety, and hopelessness (Rudd et al., 2015). One group-based psychotherapy intervention that promoted skill-building for self-regulation included aspects of narrative therapy, cognitive behavioural therapy, interpersonal therapy, psycho-education, and expressive techniques. Results indicated that it was effective at reducing symptoms of PTSD, depression, anxiety, and feelings of stigma and isolation (Sayin, Candansayar, & Welkin, 2013).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Psychotherapy		The evidence on cognitive behavioral therapy is mixed. Four studies explored the overall impact of cognitive behavioural therapy and within specific subgroups, reported reductions in PTSD and trauma-related symptoms, depression, and anxiety (Echeburua, Sarasua, & Zubizarreta, 2014; Mueser et al., 2015; Murphy et al., 2015; Zalta et al., 2016). An individual-based cognitive behavioural therapy study involving tailored cognitive behavioural resilience training, was found to be feasible and acceptable and associated with psychological resilience, reduced anxiety, and improved quality of life (Zalta et al., 2016).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Group Therapy	Group therapy involves delivering the intervention in a group format. The specific components may vary.	Group interventions demonstrated positive outcomes. All studies included a trauma-informed approach for teaching skills for self-regulation. For example, learning how to appraise stressors accurately (Ford, Chang, Levine, & Zhang, 2013; Sikkema et al., 2013), learning positive coping skills (Ford et al., 2013; Sikkema et al., 2013), taking a skill-building approach to addressing spiritual struggles in recovery (Bowland, Edmond, & Fallot, 2012), and providing psycho-education (e.g., encouraging medication compliance to promote relapse prevention) (Bowland et al., 2012; Ford et al., 2013). In a spiritually focused group intervention with older women survivors of interpersonal trauma, the women in the experimental group session experienced significantly lower depressive symptoms, anxiety, and physical symptoms than those in the control group; these were maintained in the three-month follow-up (Bowland et al., 2012). A randomized controlled trial examining the effect of the program Living in the Face of Trauma (LIFT), a group intervention to address coping with HIV and childhood sexual abuse, found that the intervention led to a reduction in traumatic stress over time (Sikkema et al., 2013).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Group Therapy		A study of incarcerated women with full or partial PTSD were randomized to two different types of group therapy approaches (Trauma Affect Regulation: Guide for Education and Therapy [TARGET] and supportive group therapy) found that both interventions achieved statistically significant reductions in PTSD and associated symptom severity and increased self-efficacy (Ford et al., 2013). Group cognitive analytic therapy was found to be effective intervention on reducing distress for fe male survivors of childhood sexual abuse (Calvert, Kellett, & Hagan, 2015). One study compared the effectiveness of an individual-based therapy to group therapy in females who had been newly diagnosed with breast cancer and self-reported cancer-related traumatic stress symptoms. The stress management intervention did not reduce cancer-related traumatic stress symptoms, and there were no benefits in delivering the intervention in a group setting compared to an individual setting (Rissanen, Nordin, Ahlgren, & Arving, 2015).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Technology-based solutions	Technology-based solutions involved the use of telecommunications, computers, and personal assistive devices in providing care. In the systematic review, these interventions involved skill-building, and the majority included an education component.	Research suggests that technology-based solutions are effective. Internet-based interventions (including Internet-delivered cognitive behavioural therapy and nurse-guided online intervention for veterans with PTSD) were found to be associated with reductions in PTSD symptoms and were generally of value to patients (Engel et al., 2015; Spence et al., 2011). One study compared cognitive processing therapy for women with PTSD delivered through video teleconferencing versus in-person therapy (Morland et al., 2015). The intervention included psycho-education and skill-building. The results indicated that psychotherapy via video teleconferencing was effective at reducing symptoms of PTSD and was comparable to in-person treatment (Morland et al., 2015).

INTERVENTION	DESCRIPTION	SUMMARY OF FINDINGS ON EFFECTIVENESS
Complementary therapies	Complementary therapies for the treatment of crisis symptoms included art therapy, mindfulness-based stress reduction, healing touch, mindful meditation, and music therapy.	Overall, mindfulness-based stress reduction was the most commonly researched approach for treating trauma. Mindfulness-based stress reduction was found to be effective in improving PTSD symptom severity in a veteran population (Polusny et al., 2015). In a group of adults with PTSD, seven out of nine participants had reductions in PTSD symptom scores from pre- to post-treatment with a mindfulness-based stress reduction intervention (Goldsmith et al., 2014). Mindfulness-based stress reduction was associated with reductions in PTSD and depression symptoms in women who had experienced interpersonal violence (Kelly & Garland, 2016). Four studies examined the use of art therapy to treat symptoms of trauma or crisis and demonstrated mixed effectiveness (Kopytin & Lebedev, 2013; Schouten, de Niet, Knipscheer, Kleber, & Hutschemaekers, 2015; Wang et al., 2015). A randomized controlled trial comparing art therapy to standard treatment found an improvement in depression, hostility, and anxiety scores (Kopytin & Lebedev, 2013). Another randomized controlled trial found that a creative arts therapy program had no effect on PTSD symptoms in a group of motor vehicle accident survivors (Wang et al., 2015). One review of six small, methodologically weak studies found that art therapy interventions are effective in reducing trauma symptom severity and anxiety in traumatized adults (Schouten et al., 2015). Healing touch (Jain et al., 2012), music therapy (Carr et al., 2012), and mindful meditation (Pence, Katz, Huffman, & Cojucar, 2014) were found to be effective in reducing PTSD symptoms and other mental health measures. However, the strength of this evidence was low.

Appendix K: Training Resources

The RNAO expert panel, with input from external reviewers and other key stakeholders, has compiled a list of training resources for providers (**Table K1**).

Links to websites that are external to RNAO are provided for information purposes only. RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Furthermore, RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

Table K1: Education and Training Resources for Providers

ORGANIZATION	DESCRIPTION	LINK
Manitoba Trauma Information and Education Centre	The Manitoba Trauma Information and Education Centre provides online training opportunities and webinars on how to be more trauma-informed in one's practice.	http://trauma-informed.ca/on-line-trauma-training/
Alberta Health Services	Alberta Health Services has compiled an e-learning module on trauma-informed care.	https://www.albertahealthservices.ca/webapps/elearning/TIC/Mod01/story_html5.html
The Crisis Prevention Institute	The Crisis Prevention Institute provides training programs, particularly in non-violent crisis interventions.	https://www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention
Applied Suicide Intervention Skills Training (ASIST)	ASIST is an interactive workshop in suicide first aid.	https://www.livingworks.net/programs/asist/

Appendix L: Critical Incident Stress Management Program Components

Table L1 outlines the components of a Critical Incident Stress Management (CISM) program.

Table L1: Components of a CISM program

COMPONENTS OF A CISM PROGRAM
CISM is an integrated work-based program that is designed to assist emergency service workers. The program has 11 components and spans the complete crisis continuum, from preparedness training and promoting resiliency, to addressing human resource considerations in the organization and providing mechanisms for follow-up, formal assessment, and intervention. It includes: 1. Pre-incident education and preparedness training. 2. One-on-one crisis intervention. 3. Critical Incident Stress Debriefing (CISD). 4. Defusing (an abbreviated form of debriefing). 5. Demobilizations. 6. Family and significant other support programs. 7. Stress management and trauma management education programs. 8. Peer support programs. 9. On-scene support processes. 10. Follow-up programs. 11. Other programs as required. *Sources:* Mithchell, 1998; Pack, 2012

Endorsements

November 29, 2017

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Dr. Grinspun,

On behalf of the Canadian Centre on Substance Use and Addiction (CCSA), I am pleased to provide endorsement of the Registered Nurses' Association of Ontario's (RNAO's) evidence-based clinical best practice guideline, *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management (3rd Edition)*.

Informed by evidence from research and other sources and developed in partnership with a multi-disciplinary focus, this guideline on *Crisis Intervention* will serve as a valuable resource for many of our partners and networks across the country. It will be useful for nurses as well as their colleagues who are invested in providing effective, evidence-based services to Canadians who have experienced, and are at risk for, experiencing crisis.

By way of background, CCSA is a national, not-for-profit organization created by a federal Act of Parliament in 1988. For almost 30 years, we have provided national leadership and advanced knowledge and solutions to address alcohol and other drug-related harms by working collaboratively with all orders of government, the not-for-profit and private sectors. Similar to RNAO, we recognize and stress the important link between mental health and substance use; and to responding in a non-judgmental and compassionate manner to those we serve.

Thank you for reaching out to CCSA to endorse this important resource. Congratulations and many thanks for developing *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management (3rd Edition)*, an important contribution to reducing the mental health issues associated with substance use among Canadians.

Warm regards,

Rita Notarandrea, M.H.Sc.,C.H.E.
Chief Executive Officer
Canadian Centre on Substance Use and Addiction (CCSA)

500-75 rue Albert Street
Ottawa ON K1P 5E7

Tel./Tél. : 613-235-4048
Fax/Téléc. : 613-235-8101

www.ccsa.ca
www.ccdus.ca

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GLOBAL NURSING EXCELLENCE

16 January 2018

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Doris,

The Sigma Theta Tau International (Sigma) Honor Society of Nursing is delighted to endorse the Registered Nurses' Association of Ontario's (RNAO) Clinical Best Practice Guideline – *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management (3rd Edition)*. I congratulate RNAO on this very important work to enhance the leadership capacity of nurses and other crisis care providers to effectively care for persons who have experienced a crisis, in health-care settings across Canada and internationally.

As you know, Sigma is dedicated to advancing world health and celebrating nursing excellence in scholarship, leadership, and service. With more than 135,000 active members from over 90 countries, we promote products and services that focus on education, leadership, career development, evidence-based nursing, research, and scholarship. RNAO's new edition of the guideline on the topic of crisis intervention using a trauma-informed approach will support nurses in all roles as they lead implementation of evidence-based, high-quality care, across all sectors.

Thank you for your leadership in developing this impressive work.

Sincerely,

Beth Baldwin Tigges

Beth Baldwin Tigges, PhD, RN, PNP, BC
2017-2019 President

Elizabeth A. Madigan

Elizabeth A. Madigan, PhD, RN, FAAN
Chief Executive Officer

SigmaNursing.org

550 W. North Street, Indianapolis, IN 46202

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