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Nursing Best Practice Guideline
Shaping the future of Nursing

crisis
intervention



Registered Nurses
Association
of Ontario

L'Association des infirmières
et infirmiers autorisés de
l'Ontario



*Greetings from Doris Grinspun
Executive Director
Registered Nurses Association of Ontario*

It is with great excitement that the Registered Nurses Association of Ontario (RNAO) disseminates this nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice.

We offer our endless thanks to the many institutions and individuals that are making RNAO's vision for Nursing Best Practice Guidelines (NBPGs) a reality. The Ontario Ministry of Health and Long-Term Care recognized RNAO's ability to lead this project and is providing multi-year funding. Tazim Virani --NBPG project director-- with her fearless determination and skills, is moving the project forward faster and stronger than ever imagined. The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the creation and evaluation of each guideline. Employers have responded enthusiastically to the request for proposals (RFP), and are opening their organizations to pilot test the NBPGs.

Now comes the true test in this phenomenal journey: will nurses utilize the guidelines in their day-to-day practice?

Successful uptake of these NBPGs requires a concerted effort of four groups: nurses themselves, other health-care colleagues, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to life.

We ask that you share this NBPG, and others, with members of the interdisciplinary team. There is much to learn from one another. Together, we can ensure that Ontarians receive the best possible care every time they come in contact with us. Let's make them the real winners of this important effort!

RNAO will continue to work hard at developing and evaluating future guidelines. We wish you the best for a successful implementation!

Doris Grinspun, RN, MScN, PhD (candidate)



Executive Director
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How to Use this Document

This nursing best practice guideline is a comprehensive document providing resources necessary for the support of evidence-based nursing practice. The document needs to be reviewed and applied, based on the specific needs of the organization or practice setting, as well as the needs and wishes of the client. Guidelines should not be applied in a "cookbook" fashion but used as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Nurses, other health care professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools, etc. It is recommended that the nursing best practice guideline be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings adapt these guidelines in formats that would be user-friendly for daily use.



Organizations wishing to use the guideline may decide to do so in a number of ways:

- Assess current nursing and health care practices using the recommendations in the guideline.
- Identify recommendations that will address identified needs or gaps in services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

Implementation resources will be made available through the RNAO website to assist individuals and organizations to implement best practice guidelines. RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story.

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The nursing best practice
guideline: **Crisis Intervention**
is available on the RNAO
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Foreword

Crisis, as a normal life experience, has been occurring since the beginning of time. Likewise, caring for people in crisis is an enduring feature of family and community functioning. As a facet of professional health services, however, crisis intervention is very young in the annals of history. In the mental health arena, it is the third of three major phenomena affecting the course of service for the emotionally distressed and mentally ill: (1) Freud's discovery of the unconscious; (2) the discovery of psychotropic medications in the 1950's; and (3) the practice of crisis intervention in the 1960's and 1970's, as a formal body of knowledge, building on the experience with disaster survivors and soldiers injured during war.

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As recently as 1969, there was no crisis intervention textbook, only a rich collection of readings edited by Howard Parad and Gerald Caplan in 1965. Signifying the growth of crisis in health services, there are now many texts whose interdisciplinary authors represent a truism in crisis work: crisis intervention is everyone's business, not the specialty of a particular discipline. Extensive studies in the 1950's established this premise about crisis care. It is an essential element of comprehensive mental health services, and just as important as emergency medical treatment of acute physical injuries.

The RNAO nursing best practice guideline on *Crisis Intervention* is a major milestone in the development of the crisis field. In the late 1960's, I was privileged to attend the federally-funded interdisciplinary program in suicide and crisis studies at John Hopkins University. A key expectation of that program's graduates was to implement results of the students' crisis specialty studies and experience in our respective disciplines – in my case, in nursing education and practice. Despite the rich body of knowledge about crisis care now available, continuing bias against the mentally ill and inadequate funding of preventive intervention for people in crisis result in a prevailing “stepchild” status of crisis intervention in the mental health arena.



These barriers are compounded sometimes by the misplaced use of crisis intervention as an expedient “short-cut” for the longer-term service needed by some, with an increase in crime a frequent costly result. This guideline’s attention to organizational and administrative support contributes to avoiding such “penny-wise and pound-foolish” policy and practice. Burnout and other burdens are the further price paid by even the most skilled crisis workers, who lack institutional support of their work. Nurses and other appropriately trained health providers know when the crisis model is either misapplied or not supplemented by other needed services because of inadequate funds.

Funding of this guideline by the Ontario Ministry of Health and Long-Term Care clearly demonstrates that crisis care is defined by policy-makers as essential, but not sufficient, in the array of services needed by diverse populations. The document’s inclusion of a process for update, and the call for systematic reviews and randomized controlled trials is, I believe, a giant step forward in this important field. Also significant is the recognition that these guidelines do not substitute for nurses’ mastery of theory and practice strategies, gained through formal instruction and clinical supervision. This *Crisis Intervention* nursing best practice guideline is a great boon to my efforts and the work of many others over the past decades, to incorporate crisis intervention as standard content in nursing and other health professions’ curricula. I enthusiastically recommend the guideline to every nurse and administrator of health services.

July, 2002

Lee Ann Hoff, Ph.D., RN

Researcher, professor, and author of several books on Crisis Intervention.



summary of recommendations

Practice Recommendations

Recommendation 1

Crisis intervention is founded on a particular set of values and beliefs, and guiding principles.

Recommendation 2

Knowledge of the three core components of crisis intervention theory (a precipitating event, perception of the event, and the client's usual coping methods) is fundamental to identify clients in crisis.

Recommendation 3

The delivery of crisis intervention is based on an integrative framework.

Recommendation 4

A wide array of therapeutic communication skills is a pre-requisite to effective intervention with clients in crisis.

Recommendation 5

A comprehensive holistic assessment is performed prior to engaging in any plan to resolve crises.

Recommendation 6

Nurses are directly involved in all aspects of crisis intervention including assessment, intervention, referrals and linkages, and short-term follow up.

Recommendation 7

Teaching and educating clients, families, colleagues, and the community about crisis intervention and prevention are essential to promote mental health.

Education Recommendations

Recommendation 8

Education and ongoing learning opportunities are required for nurses to implement best practices in crisis intervention.

Recommendation 9

The core curriculum in nursing education includes the following key components:

- Crisis intervention theory and practice;
- Sound knowledge of the principles of the therapeutic relationship, and their application to crisis intervention; and
- The provision of regular clinical supervision.

To assist organizations, RNAO (through a panel of nurses, researchers and administrators) has developed the "Toolkit: Implementation of Clinical Practice Guidelines", based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on Crisis Intervention. To obtain, visit the RNAO website at www.rnao.org.



Organization & Policy Recommendations

Recommendation 10

Organizational commitment to providing quality crisis intervention services is reflected in its mission and vision statements, as well as through allocation of resources to develop, implement, and support the services.

Recommendation 11

To enhance the continuum of crisis care, the organization continuously strives to achieve a collaborative and integrative crisis intervention practice model within an interdisciplinary team.

Recommendation 12

The organization actively advocates for the provision of quality crisis intervention care on multiple levels (individual, family, and community).



Recommendation 13

Nursing best practice guidelines can be successfully implemented only when adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation, exist. An organizational plan for developing and implementing crisis intervention services includes:

- An assessment of organizational readiness and barriers to education;
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process;
- Dedication of a qualified individual to provide the support needed for the education and implementation process;
- Ongoing opportunities for discussion and education to reinforce the importance of best practices; and
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

Responsibility for Guideline Development

The Registered Nurses Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, has embarked on a multi-year project of nursing best practice guideline development, pilot implementation, evaluation, and dissemination. “Crisis Intervention” is one of seven (7) nursing best practice guidelines that were developed in the second cycle of the project. This guideline was developed by a panel of Registered Nurses and Registered Practical Nurses convened by the RNAO and conducting its work independent of any bias or influence from the Ontario Ministry of Health and Long-Term Care.

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Purpose and Scope

This guideline describes best practice in crisis intervention. While its primary focus is on mental health crises, its application has relevance to all settings and populations who experience developmental, situational, community or environmental crises.

The nursing best practice guideline focuses its recommendations on:

Practice Recommendations	directed at the nurse and nursing practice.
Education Recommendations	directed at the competencies required for practice.
Organization & Policy Recommendations	directed at the practice settings and the environment to facilitate nurses' practice.

It is intended that this guideline will enhance the understanding of crisis intervention and standardize its practice, as well as enhance professional nursing practice.

Guideline Development Process

A **panel of nurses** with expertise in practice, research and academic sectors was established by RNAO. The panel undertook the following steps in developing the guideline:

- Defined the scope of the guideline;
- Conducted an extensive literature search and reviewed relevant research, theoretical frameworks and discussion papers;
- Articulated the values underpinning crisis intervention;
- Identified an integrative framework built on the work of several crisis theorists within which to present the recommendations for best practice;
- Solicited formal feedback from relevant hospital and community-based stakeholders; and
- Consulted with Lee Ann Hoff, Ph.D., RN, author of *“People in Crisis: Understanding and Helping, 4th edition”*, *“Creating Excellence in Crisis Care”*, *“People in Crisis: Clinical and Public Health Perspectives, 5th edition”*, and several other major publications. A researcher and professor on this topic for the past 20 years, Hoff is founding director of the Life Crisis Institute based in Boston and Ottawa, and is professor at the University of Massachusetts Lowell, College of Health Professions, and adjunct professor at the University of Ottawa, Faculty of Health Sciences.

A draft guideline was reviewed by representative stakeholders, and the feedback received was incorporated into the final document. The draft nursing best practice guideline was also pilot implemented over an eight-month period in several organizations in Ontario that were identified through a “request for proposal” process conducted by RNAO. The guideline was further refined taking into consideration the pilot site feedback and evaluation results as well as current literature.



Definition of Terms

Client: Individuals, families, populations and communities who use crisis intervention services.

Client Centred Care: An approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting clients' autonomy, voice, self-determination, and participation in decision-making (Registered Nurses Association of Ontario, 2002a).

Clinical Practice Guidelines or Best Practice Guidelines: "Systematically developed statements (based on best available evidence) to assist practitioner and patient decisions about appropriate health care for specific clinical (practice) circumstances" (Field & Lohr, 1990, p.8).

Clinical supervision: The assignment of a person experienced in crisis intervention to help a novice practitioner, through the use of case material and regularly scheduled interaction, to develop or improve the supervisee's therapeutic effectiveness in practice.

Cognitive key: The perception the individual has about the precipitating events that led to the subjective distress (Caplan, 1964).

Collaboration: The mutual sharing and working together to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced (Stanhope & Lancaster, 2000).

Consensus: A process for making policy decisions, not a scientific method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al., 1999).

Coping methods: The behaviours, thinking, and emotional processes that an individual uses to deal with stress and continue to function (Caplan, 1964).

Crisis: An emotional upset, arising from situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors. This state of emotional distress results in a temporary inability to cope by means of one's usual resources and coping mechanisms. Unless the stressors that precipitated the crisis are alleviated and/or the coping mechanisms are bolstered, major disorganization may result. It is recognized that a crisis state is subjective and as such may be defined by the client, the family or other members of the community (Hoff, 1995; Ontario Ministry of Health and Long-Term Care, 1999ab).

Crisis Intervention: A process that focuses on resolution of the immediate problem through the use of personal, social and environmental resources (Hoff, 1995). The goals of crisis intervention are rapid resolution of the crisis to prevent further deterioration, to achieve at least a pre-crisis level of functioning, to promote growth and effective problem solving, and to recognize danger signs to prevent negative outcomes (Hoff, 1995).

Danger and Opportunity: A dichotomy is associated with a crisis. A crisis can be an opportunity when the individual grows from the crisis experience by developing new coping skills and altering perceptions. It can also be a danger when the individual does not seek help and rather comes out of the crisis state by use of defense mechanisms, resulting in a lowered functioning level and possibly psychosis or even death (Caplan, 1964).

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Ego Functions: Intact cognitive/perceptual abilities (i.e. thinking, problem-solving, decision-making processes). (J. LeGris, personal communication, Aug., 2000).

Emergency Psychiatry: A branch of medicine that deals with acute behavioural disturbances related to severe mental or emotional instability or dysfunction. It includes crisis intervention but also implies the need for distinct medical intervention such as medication or admission to an inpatient psychiatry facility. Elements of its practice are carried out by various members of the traditional mental health professions: psychiatry, psychiatric social work, psychiatric nursing, clinical psychology (Hoff & Adamowski, 1998).

Empowerment: An interpersonal process that encourages clients to take maximal control of their lives and builds on the strengths/talents of an actively involved client to solve problems (Arnold & Boggs, 1999).

Empathy: The ability of a person to perceive and understand another person's emotions accurately and to communicate the meanings of feelings to the other through verbal and non-verbal behaviours (Arnold & Boggs, 1999).

Evidence: "An observation or fact or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at issue" (Madjar & Walton, 2001, p.28).

Guiding principles: External indicators of one's values and beliefs involving knowledge and fact that guide one's actions. Principles often provide the rationale for one's critical actions (J. LeGris, personal communication, Aug., 2000).

Interdisciplinary: A process where health care professionals representing expertise from various health care disciplines participate in the process of supporting clients and their families in the care process.

Level of Functioning: The way an individual behaves socially, occupationally, academically, behaviourally and emotionally. Level of functioning is impaired when an individual is in crisis (Caplan, 1964).

Organization & Policy Recommendations: Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. 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.

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are ideally evidence-based.

Precipitating event: An actual event in a person's life that triggers a crisis state. It can arise from situational, developmental, socio-cultural, biological, psychological and/or spiritual sources (Caplan, 1964).

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters, and neutrals (Ontario Public Health Association, 1996).

Subjective distress: Painful and uncomfortable feelings an individual experiences when in a crisis (Caplan, 1964).

Systematic Review: Application of a rigorous scientific approach to the preparation of a review article (National Health and Medical Research Centre, 1998). Systematic reviews establish where the effects of health care are consistent and research results can be applied across populations, settings, and differences in treatment (e.g. dose); and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions (Clarke & Oxman, 1999).

Value/belief: Internalized, philosophical thoughts, convictions, assumptions or beliefs (cognitions) that underlie or drive one's behaviour or actions.



Background Context

Deinstitutionalization of the mentally ill, decreased health care funding for inpatient hospitalization, and a philosophical shift to community-based mental health service delivery have significantly influenced the growth of crisis intervention services in Ontario in the last several years. Originally highlighted in 1993 in the Ministry of Health document *“Putting People First: The Reform of Mental Health Services in Ontario”* (Ontario Ministry of Health, 1993), crisis services were identified as a key component of mental health reform in Ontario. Later in 1997, the *“Best Practices in Mental Health Reform”* document recommended crisis intervention as an effective approach to services for people in crisis (Health Canada, 1997). Most recently, in the two *“Making It Happen”* documents, the provincial government reaffirmed its commitment to the provision of crisis services and assumed a more proactive approach in supporting the increased need for crisis services in both the community and hospital sectors (Ontario Ministry of Health and Long-Term Care, 1999ab). As a consequence of these initiatives, this best practice guideline was developed to increase nurses’ awareness of their role to deliver effective crisis intervention to meet the needs of clients experiencing a crisis.



Interpretation of Evidence:

Evidence-based practice has been defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of patients” (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996, p.71). In order to ensure that current best evidence is used in the development of clinical guidelines, the methods of identification and interpretation of relevant evidence need to be critically appraised (Cluzeau, Littlejohns, Grimshaw, Feder & Moran, 1999). Generally, “the gold standard” is given to evidence derived from the randomized controlled trial (RCT), either in isolation or preferably in a systematic review or meta-analysis (Sweeney, 1998). In considering evidence, however, Berg (1997) cautions nurses to not deny the less quantifiable aspects of nursing work.

In developing this guideline, the guideline development panel drew their evidence from a variety of sources, including several quantitative and qualitative studies, anecdotal reports, and expert knowledge and experience. Expert consensus was also utilized in this guideline when no other more scientifically formalized knowledge was available. In this way, patterns of knowing, including empirics, ethics, personal knowing and aesthetics, were captured (Carper, 1978).

The application of evidence should lead to improvements in the delivery of crisis intervention by providing a sound theoretical basis for nurses who work with clients in crisis. Unfortunately, current mental health practice, including crisis intervention, falls short of evidence-based care despite the long standing literature on crisis theory (Baldwin, 1977; Sullivan, 1997). While there is a slowly growing body of empirical evidence of the effectiveness of crisis intervention, the existing literature supports the notion that crisis intervention is considered to be an effective approach in managing clients in crisis and can reduce hospital admissions.

The guideline development panel believes that this guideline is long overdue and is an essential first step in standardizing and enhancing the delivery of crisis intervention by nurses and other health care professionals. The panel also acknowledges the imperative need for further research to assess and evaluate the efficacy of crisis intervention approaches.



Practice Recommendations

Best practices in crisis intervention can be achieved by individual nurses, other health professionals, entire units, work groups, health care organizations, and by the mental health system as a whole. It is believed that nurses, through their actions and practices, can positively influence the practice of colleagues, health care organizations, and the health care system.

Recommendation 1

Crisis intervention is founded on a particular set of values and beliefs, and guiding principles.

The recommended values and beliefs, as well as the guiding principles identified in this document, while not all-inclusive, are:

Values and beliefs

- All clients perceive events uniquely and in keeping with their individualized needs and past experiences.
- All clients participate in care that is respectful and non-judgmental.
- Crisis intervention utilizes a client centred approach that takes into consideration the client's unique rights, feelings, values, perceptions and wishes (Registered Nurses Association of Ontario, 2002a).
- Client centred care, involving nurses' reflection and empathy is most effective in resolving crises (Registered Nurses Association of Ontario, 2002a).
- Psychic energy or ego strength is variable among individuals and is influenced by past experiences and social support.
- All clients and families are actively involved in collaboration and decision-making regarding their care.
- Stress is a normal part of existence and can foster self-development and growth.
- All clients are capable of assuming personal responsibility for their health, regardless of their unique abilities and challenges.
- All clients grow and change in an environment of acceptance, trust and empathic understanding.
- Sustained client change occurs when clients feel ready and supported to do so and not necessarily when the system expects it.

- All human beings have a need for self-mastery and control over their lives.
- Nurses believe in an individual's ongoing capacity for self-determination and growth and in their own abilities to foster this process with clients.

Guiding Principles

- Prevention is always the best form of crisis intervention and can be used at any stage to prevent further escalation of the crisis.
- Crises can be construed as danger or opportunity for growth (Aguilera, 1994): a danger in that the individual or family may be dramatically influenced by its negative effects on mental health, or an opportunity because, at times of crisis, individuals are more susceptible, more open to therapeutic intervention (Wooley, 1990).
- Crisis intervention is an active process that focuses on the immediate problem as perceived and identified by the client or client advocate.
- Crisis intervention is time-limited, and all interventions including assessment, treatment and follow-up usually occur within eight contacts (face-to-face or telephone) (Baldwin, 1977).
- Crisis intervention is employed in the least restrictive environment.
- Crisis intervention is timely, flexible and accessible 24 hours per day, seven days a week.
- Nurses work within an interdisciplinary team and in collaboration with the client, the family, physician, case manager or other community support agencies to stabilize the person in crisis.
- Client advocacy is an essential component of crisis intervention.
- The quality of the therapeutic relationship affects the outcome of crisis intervention (Registered Nurses Association of Ontario, 2002b).

Recommendation 2

Knowledge of the three core components of crisis intervention theory (a precipitating event, perception of the event, and the client's usual coping methods) is fundamental to identify clients in crisis.



The crisis theorists referenced in this guideline confirm that crises contain three (3) core components:

1. **A precipitating event occurs.** The experience of stressful events is not in itself a crisis, and is not always evident to the client. This first phase may or may not develop into a full-blown crisis, depending on personal and social circumstances.
2. **Perception of the event** leads to subjective distress. Subjective distress can take the form of many feelings or emotions that often feel overwhelming or confusing for the person in crisis. If subjective distress does not impair coping or functioning, one is experiencing manageable stress but is not in crisis.
3. The client's **usual coping methods** fail. As long as the client's ability to function emotionally, occupationally, and interpersonally is not impaired, he/she is not in crisis.

These three components must be recognized and identified by nurses as they work toward helping the client resolve the crisis.

Recommendation 3

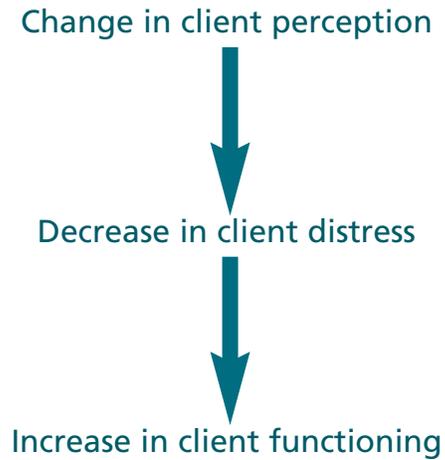
The delivery of crisis intervention is based on an integrative framework.

Many crisis models exist, and nurses should select a model that best suits their practice setting. This guideline has conceptualized an integrative framework in order to simplify, synthesize, and communicate the key concepts that crisis theorists espouse. The model described in this guideline builds upon the previous early works of Aguilera (1994), Caplan (1964), Hoff (1995, 2001), and Kanel (1999), and can be easily applied to a variety of settings and disciplines.

In crisis intervention the **focus** is always on **increasing** the client's level of social, occupational, cognitive and behavioural functioning.



Kanel (1999) describes a succinct formula to increase a client's functioning:

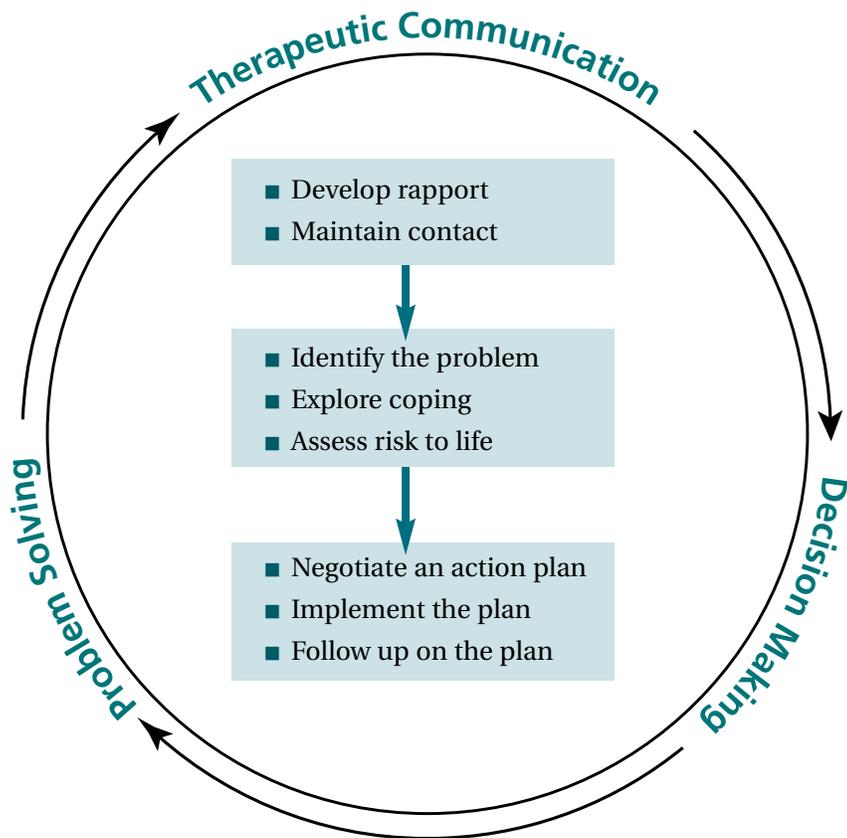


It is important to note that the method of change has to do with how the precipitant is perceived rather than with making a change in the precipitating event itself. The client's perception of the event is the factor most amenable to change and is the distinguishing feature of a crisis intervention approach. Whether a client emerges stronger or weaker from a crisis is usually based upon the access to and kind of immediate help received during the crisis (Kanel, 1999).



AN INTEGRATIVE MODEL OF CRISIS INTERVENTION

The focus of the model below is to identify the precipitating event, the client's cognition or perceptions of the event, his or her degree of subjective distress, failed coping mechanisms, and impaired functioning. The goal is to return the client to his or her pre-crisis level of functioning emotionally, occupationally and interpersonally.



Adapted from: Guide to Crisis Intervention, 1 edition, by K. Kanel. ©1999. Reprinted with permission of Brooks/Cole, an imprint of the Wadsworth Group, a division of Thompson Learning; Hoff, L. (1995), People in Crisis: Understanding & Helping, Addison & Wesley Publishing; Hoff, L. (2001), People in Crisis: Clinical and Public Health Perspectives, (5th ed.), Jossey-Bass Publishing.

Phases of the Integrative Model of Crisis Intervention

The following three sequential phases incorporate the work of Kanel (1999), Hoff (1995, 2001), and other crisis theorists.

Develop Rapport and Maintain Contact

- Rapport, trust and active listening skills are foundational to the development of the therapeutic relationship. Contact with a nurse who is empathic, present, non-judgmental, respectful and genuine will permit the client to move into subsequent phases of the crisis resolution model. (See Registered Nurses Association of Ontario (2002b) best practice guideline “Establishing Therapeutic Relationships”, for additional therapeutic skill development).
- It is important to maintain ongoing contact with the client in crisis.
- Therapeutic communication skills are necessary to be successful with this phase of the model. Ensure that the client feels understood, accepted, and supported. Recognition and validation of the client’s personal meaning, feelings and perception of the event are the desired outcomes. One must consistently strive to make the client feel understood (Registered Nurses Association of Ontario, 2002b).
- Avoid dangerous assumptions based on non-factual or stereotypical data.
- Avoid asking “why” questions as these have connotations of a blaming, or accusatory stance, which is counterproductive to the therapeutic relationship.
- Verbal communication and empathic understanding are always implemented as a *first step* to de-escalate acute client distress, regardless of the degree of client disturbance.



Identify the Problem

It is essential to determine the reason the client is seeking help at this time. A clear focus on the immediate problem will prevent distracting issues from depleting the client's needed coping energy.

- Collect information that is relevant and aids in understanding the nature of the crisis, which often involves a theme of loss (loss of control, loss of nurturance, forced role adjustment, etc.). A mechanical or checklist approach is avoided as this is non-therapeutic. Rather, information is gathered in a coherent, caring manner, following the lead of the client as much as possible. Be client centred in your approach. (*See Registered Nurses Association of Ontario (2002a) best practice guideline on "Client Centred Care"*).
- Clinical judgment and expertise are utilized to obtain relevant information to accurately assess the problem and crisis situation. Hoff (2001) suggests that assessment should focus on client functioning (emotional, cognitive, and behavioural), including a history of coping with stressful and traumatic life events. Do not challenge the client's perception as this will only increase his/her frustration etc.
- Help the client gain an understanding of the crisis and curtail any client self-blame through thoughtful reflection of the event or problem. This will facilitate a more realistic perception of the crisis by the client.
- Be direct but not directive.
- Negotiate and collaborate with the client to discover new ways to think about, perceive and reappraise the situation using positive reframing techniques, empowering statements, educational and normalizing comments, support statements, validation and reflection (see Appendix A for examples of how to frame questions).
- Identifying perspective, subjective distress and current and previous functioning encompass most of this phase of the model. Impairments in behavioural, cognitive, social, academic and occupational functioning are assessed in relation to a client's pre-crisis level of functioning. Formal and informal mental status exams for individuals with a previous history of mental illness are particularly important. Identify legal and ethical issues involving suicidal/homicidal risk, abuse of all types, substance abuse and organic or physiological precipitants.

Explore Client Coping and Negotiate an Action Plan

- Once the therapeutic contact with the client is successfully achieved and the crisis identified, together the nurse and client explore new coping methodologies, which may involve new ways of *problem solving and decision-making*. These processes can foster greater personal growth and mastery.
- Encourage clients to consider alternative coping strategies. Trusting clients with their own ability to create solutions is imperative, as doing things to a person in crisis without his or her active participation can lead to failure (Hoff, 1995), and a lack of client commitment to the crisis resolution process.
- The plan must be problem-oriented, focus on the immediate problems that directly contributed to the crisis, and reflect the client's culture and functional level and personal commitment to the problem-solving process (Hoff, 1995).
- Avoid probing in-depth personality patterns or underlying psychological problems. If the client is so anxious or incapable of thinking clearly or able to make a decision, the nurse assumes a more active role temporarily. According to Hoff (1995), the client at this point, is allowed to borrow some of the ego functions of the counselor until adequate cognitive/emotional abilities to problem- solve are restored.
- If the client is highly emotional, allow sufficient time to express feelings. Provide the client with simple directions for action if the client's behaviour and thinking are very disturbed. This approach is based on the intrinsic belief in a person's ability to help himself or herself once the acute crisis is over (Hoff, 1995). Nurses need to know when to let go of the control so the client can once again take charge of his/her life. Experienced, self-aware and self-confident nurses can more easily do this through a process of ongoing clinical supervision, as described by Rolfe (1990).
- Mobilize client support networks to bolster renewed coping through referrals to appropriate community resources. Include significant others in the planning for a client, particularly if they are a future resource for the person. According to Hoff (1995), the plan should assess if the family or significant others are part of the problem or part of the solution. The nurse, in collaboration with the client (individual or family), may also suggest alternative options to assist with crisis resolution.



- The plan must be realistic, time-limited, concrete and flexible. The client needs to know that specific actions will be occurring at agreed-upon times and places. This structure will allow for the ongoing changes in the client's life, and will enhance hopefulness and coping.
- **Follow-up** is an essential component of best practices in crisis intervention. It involves assessing whether clients' coping strategies are effective, enhancing supports as needed, and evaluating the outcomes of crisis resolution. This follow-up is best planned and arranged by the professionals who help the client work through the crisis event.
- Areas of consideration during the follow-up phase include:
 - Did the client carry out the crisis plan, and what was the outcome?
 - Does the client have a plan to work towards meeting, through alternative actions, his/her goals?
 - Does the client require additional or alternative linkages to community resources and supports?



Recommendation 4

A wide array of therapeutic communication skills is a pre-requisite to effective intervention with clients in crisis.

It has been widely documented that the quality of the nurse-client relationship determines the successful resolution of crisis (Hoff, 1995). Also, see Registered Nurses Association of Ontario (2002b) best practice guideline on *Establishing Therapeutic Relationships*.

Despite agreement that therapeutic communication is important and valuable in nursing, a well documented body of knowledge suggests that nurses and other health care professionals do not communicate very well with patients and other colleagues (Ashworth, 1980; Brereton, 1995; Dickson, Hargie & Morrow, 1989; MacLeod, 1981; Macleod & Faulkner, 1987; Thies & Williams-

Burgess, 1992). It has been argued that nurses and health care professionals do not use these skills because they may lack understanding, do not believe or value them, may not perceive them as relevant, or are not given incentives to use them. Additionally, others (Graham, 1981; Greenwood 1984; Hunt 1991), suggest that therapeutic communication may be too anxiety-provoking for staff.

Dickson et al. (1989) identified four necessary components for the development of therapeutic/interpersonal communication competence:

1. An appropriate knowledge base;
2. A range of behaviours essential to effective performance;
3. A positive attitude and valuing of communication; and
4. Availability of opportunities to communicate.

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The purposes of therapeutic communication are to alleviate the person's distress and enhance the client's feelings of self-worth. Therapeutic communication is essential to the foundation of a positive working nurse-client relationship.

Therapeutic communication requires a seamless integration of multiple communication skills/strategies intermingled in a natural, comfortable and client-focused manner. As such, the concept of therapeutic communication has been described as combining elements of both art and science (Registered Nurses Association of Ontario, 2002b).



For some forms of crisis intervention involving changing conditions, rapid development of a therapeutic relationship requires a high level of skill/confidence.

Recommendation 5

A comprehensive holistic assessment is performed prior to engaging in any plan to resolve crises.

Misjudging a person in crisis as emotionally upset because of poor observation or inadequate assessment can have life-long, devastating effects. The literature on crisis intervention indicates that a thorough assessment and quick resolution of the crisis increases the likelihood for positive outcomes including the prevention of a hospital admission, and the

possible negative effects of institutionalization, labeling and succumbing to the patient role (Hoff, 1995).

Risk Assessment

The guideline development panel acknowledges that while there is a large body of literature on suicide and risk assessment, it is beyond the scope of this guideline to provide a comprehensive review of specific risk assessment studies or strategies. The panel does, however, consider suicide and homicide risk assessments to be an essential part of best practices in crisis intervention.

While the integrative model provides a general framework for the assessment and intervention processes, a more specific and comprehensive assessment guide is needed to enhance the practice of non-specialized nurses who are delivering crisis intervention. This includes assessment at two levels: 1) assessment of risk to life, a function of all health providers, and 2) identification of the client's strengths, coping mechanisms and current support systems (Hoff, 2001). A client with a new psychiatric disorder or a previous psychiatric history must also receive a mental status assessment. While it is not the intent of this guideline to provide skill development for mental status assessment, Appendix B offers suggested elements that should be considered during such an assessment.

For suggestions on how to assess coping skills and support systems, see Appendix C.

While tools (e.g. interview guides, mental status, risk assessment etc.) may aid in assessment by providing a structured approach to the process, they are not a substitute for empathy, knowledge, clinical judgement and expertise.

Recommendation 6

Nurses are directly involved in all aspects of crisis intervention including assessment, intervention, referrals and linkages, and short-term follow up.

Registered Nurses and Registered Practical Nurses are the largest health care provider group available to meet the holistic needs of clients across the lifespan.



Nurses, as cost-effective front-line workers, are in a strategic position to immediately respond to those in crisis. Crisis nurses must be used more in the roles of primary therapist, case manager, teacher and researcher (Haber, Krainovich-Miller & Price-Hoskins, 1996). Enhanced practice for crisis nurses will enable them to intervene more directly and autonomously in resolving crises with clients at the time of their crises, thus preventing further deterioration.

Experienced and trained nurses usually apply all phases of the crisis framework and move beyond assessment and referral to include creative problem-solving strategies even with severely disturbed clients. Too often nurses assume that disturbed clients are incapable of problem-solving and never proceed beyond risk assessment and referral. Crisis and problem-solving counseling with severely disturbed clients is holding increasing promise and hope (Hoff, 1995; Sensky, Turkington, Kingdon, Scott & Siddler, 2000).

Moving out of one's comfort zone and making changes to one's clinical practice involves education, risk taking and an openness to change. Nurses need to assume initiative and responsibility for lifelong learning to maintain currency and competence within their multi-faceted crisis intervention roles.

Recommendation 7

Teaching and educating clients, families, colleagues, and the community about crisis intervention and prevention are essential to promote mental health.

Psychiatric bed shortages, budget constraints, economic factors, social problems, increased homelessness and increased drug use and abuse have generated an alarming increase in the numbers of people in crisis in the community (Gilliland & James, 1996). As front-line workers, hospital and community nurses are in a unique position to teach and educate colleagues, families, family practitioners, police, community leaders and the general public, regarding crisis prevention and intervention.



Education Recommendations

Recommendation 8

Education and ongoing learning opportunities are required for nurses to implement best practices in crisis intervention.

The complexity of working with clients in crisis and the skill set required by nurses necessitates the following education and training:

Short-term

Assess the staff's learning styles and provide learning opportunities as appropriate, including:

- Preceptorship/mentorship/internship programs;
- Role modeling;
- Books;
- Videos;
- In-house training/ workshops;
- Clinical supervision or guided practice opportunities;
- Crisis theory expert speakers;
- Train-the-trainer programs (develop expertise in a few staff to train others);
- Ongoing self awareness and reflection on current practices in crisis intervention; and
- Other educational materials identified by staff.

Long-term

- Basic educational preparation in university settings including mandatory courses on interviewing and crisis intervention;
- Mandatory field placements to role-model crisis intervention techniques;
- Education on legislation and standards that govern and direct practice;
- A culture that supports staff in learning about crisis theory, and provides opportunities for teams to work together and review/evaluate their practice;
- Regular communication, debriefing, and in-services on crisis intervention; and
- Access to adequate, current information and research for nurses to support crisis intervention learning.

Organizations can support education and training of nurses by:

1. Providing funding for professional development (i.e. conferences, workshops);
2. Creating and supporting a culture for interdisciplinary teamwork and evaluation/ follow-up debriefing in crisis intervention;
3. Including and maintaining a thorough crisis intervention training component in nursing orientation programs;
4. Mentoring of new staff by experienced staff to maintain organizational culture that is supportive of best practices in crisis intervention; and
5. Practices and policies to support caregivers.

Recommendation 9

The core curriculum in nursing education includes the following key components:

- Crisis intervention theory and practice;
- Sound knowledge of the principles of the therapeutic relationship, and their application to crisis intervention; and
- The provision of regular clinical supervision.

According to Baldwin (1977), experience in training and educating crisis counselors is most effectively learned at an advanced stage of professional training. In crisis intervention there is less time for student assessment and contemplation of therapeutic processes and an implicit demand of the crisis to facilitate resolution quickly and effectively. Without the core concepts related to therapy and training in the therapeutic processes, this will be more difficult. Through crisis training, nurses will assume increased responsibility for patients, become more self confident as counselors, and achieve more depth and perspective in assessing crises.

Clinical supervision involves the assignment of a person experienced in crisis intervention to help a novice practitioner, through the use of case material and regularly scheduled interaction, to develop or improve the supervisee's therapeutic effectiveness in practice. The creation of formal and informal learning environments that are conducive to ongoing professional growth and practice for adult learners is needed.



Organization & Policy Recommendations

The following recommendations reflect the conditions in organizations that will support the delivery of comprehensive and effective crisis intervention care.

Recommendation 10

Organizational commitment to providing quality crisis intervention services is reflected in its mission and vision statements, as well as through allocation of resources to develop, implement, and support the services.

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Traditionally, there has been inadequate allocation of resources in all health care sectors to meet the complex needs of individuals in emotional distress or crisis, including the mentally ill, in part due to the stigmatization of the mentally ill. Organizational environments must be established to develop human resources through ongoing education, preventive services and support, through the provision of safe working environments for their staff and clients. Despite an increase in funding allocation, clients in crisis are experiencing delays in emergency rooms prior to their intervention, with resulting danger to themselves and others. A multi-faceted, coordinated holistic approach can be provided through extensive linkages with all crisis service providers and community agencies delivering a broad spectrum of specialized crisis care.

Crisis programs must demonstrate clearly articulated philosophies, principles, purposes and processes of their services to ensure a high level of quality care and create easier access to appropriate linkages necessary for supporting clients in crisis. Cooperation and collaboration, rather than competition among service sectors for funds, must be client driven and be in the best interests of the clients and the community. A supportive, informed and coordinated organizational infrastructure is needed to ensure the comprehensive delivery of quality crisis care.

Recommendation 11

To enhance the continuum of crisis care, the organization continuously strives to achieve a collaborative and integrative crisis intervention practice model within an interdisciplinary team.

Recommendation 12

The organization actively advocates for the provision of quality crisis intervention care on multiple levels (individual, family, and community).

Nurses are in a strategic position as front-line workers to identify gaps and duplications in services and in the crisis care system. While nurses are familiar with advocacy at the individual level, they need to enhance their advocacy skills at the larger system's level.

Recommendation 13

Nursing best practice guidelines can be successfully implemented only when adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation, exist. An organizational plan for developing and implementing crisis intervention services includes:

- An assessment of organizational readiness and barriers to education;
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process;
- Dedication of a qualified individual to provide the support needed for the education and implementation process;
- Ongoing opportunities for discussion and education to reinforce the importance of best practices; and
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

To assist organizations, RNAO (through a panel of nurses, researchers and administrators) has developed the *“Toolkit: Implementation of Clinical Practice Guidelines”*, based on available evidence, theoretical perspectives and consensus.

The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on *Crisis Intervention*.



Evaluation & Monitoring

Organizations implementing the recommendations in this nursing best practice guideline are recommended to consider how the implementation and its impact will be monitored and evaluated. The following table, based on a framework outlined in the RNAO Toolkit: Implementation of Clinical Practice Guidelines (2002), illustrates some indicators for monitoring and evaluation:

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	Structure	Process	Outcome
Objectives	<i>To evaluate the supports available in the organization that allow for nurses to deliver crisis intervention practices.</i>	<i>To evaluate changes in practice that lead towards enhanced opportunity for crisis intervention.</i>	<i>To evaluate the impact of implementation of the recommendations.</i>
Organization/unit	<p>Review of guideline recommendations by organizational committee(s) responsible for crisis intervention policies and procedures.</p> <p>Organizational mission that supports crisis intervention and client centred care.</p>	Modification to policies and procedures consistent with the values of crisis intervention.	<p>Evidence of client centred focus in crisis intervention practice in organization.</p> <p>Staff satisfaction.</p>
Provider	<p>Per cent of nurses attending education sessions (orientation, professional development opportunities) on crisis theory, assessment and practice.</p> <p>Per cent of non-nursing staff attending education sessions (orientation, professional development activities) on value of crisis intervention.</p>	<p>Per cent of nurses self-reporting:</p> <ul style="list-style-type: none"> ■ Adequate assessment of the client's perception of events leading to the crisis. ■ Development and adequate documentation of the crisis intervention plan. ■ Sharing the clients' concerns with other members of the health care team. ■ Greater confidence in counseling role. 	<p>Nursing and non-nursing staff report being actively involved in the implementation process.</p> <p>Per cent of clients with a comprehensive assessment recorded on their chart.</p>
Client		Clients' self-assessed perception of appropriate crisis intervention care.	<p>Improved client/family satisfaction and involvement.</p> <p>Clients report being included as full partners in the program, feel they are being listened to.</p>
Financial costs	Provision of adequate financial resources for the level of staffing needed for a model of service based on crisis intervention practice.	Costs for education and other interventions.	Overall resource utilization.

Process For Update/Review of Guideline

The Registered Nurses Association of Ontario proposes to update the nursing best practice guidelines as follows:

1. Following dissemination, each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area, every three years following the last set of revisions.
2. During the three-year period between development and revision, RNAO Nursing Best Practice Guidelines project staff will regularly monitor for new research, systematic reviews and randomized controlled trials.
3. Based on the results of the monitor, project staff may recommend an earlier revision period. Appropriate consultation with a team of members comprised of original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the three-year milestone.
4. Three months prior to the three-year review milestone, the project staff will commence the planning of the review process as follows:
 - a) Invite specialists in the field to participate in the Review team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
 - b) Compile feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
 - c) Compile new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research, and other relevant literature.
 - d) Develop detailed work plan with target dates for deliverables.

The revised guideline will undergo dissemination based on established structures and processes.



References

- Aguilera, D. C. (1994). *Crisis intervention: Theory and methodology*. (7th ed.) St. Louis: Mosby - Year Book.
- American Psychiatric Association (1994). *Diagnostic & statistical manual of mental disorders*. (4th ed.) Washington: American Psychiatric Association.
- Arnold, E. & Boggs, K. (1999). *Interpersonal relationships: Professional communication skills for nurses*. Toronto: W.B. Saunders Company.
- Ashworth, P. (1980). Care to communicate: An investigation into problems of communication between patients and nurses in intensive care units. London: Royal College of Nursing.
- Baker, C., Ogden, S., Prapaipanich, W., Keith, C. K., Beattie, L. C., & Nickelson, L. (1999). Hospital consolidation: Applying stakeholder analysis to merger life cycle. *Journal of Nursing Administration*, 29(3), 11-20.
- Baldwin, B. A. (1977). Crisis intervention in professional practice: Implications for clinical training. *American Journal of Orthopsychiatry*, 47(4), 659-670.
- Berg, M. (1997). Problems and promises of the protocol. *Social Science and Medicine*, 44(8), 1081-1088.
- Black, N., Murphy, M., Lamping, D., McKee, M., Sanderson, C., Askham, J. et al. (1999). Consensus development methods: Review of best practice in creating clinical guidelines. *Journal of Health Services Research & Policy*, 4(4), 236-248.
- Brereton, M. L. (1995). Communications in nursing: The theory-practice relationship. *Journal of Advanced Nursing*, 21(2), 314-324.
- Caplan, G. K. (1964). *Principles of preventive psychiatry*. New York: Basic Books.
- Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13-23.
- Clarke, M. & Oxman, A. D. (1999). Cochrane Reviewers' Handbook 4.0 (updated July 1999) (Version 4.0) [Computer software]. Oxford: Review Manager (RevMan).
- Cluzeau, F., Littlejohns, P., Grimshaw, J., Feder, G., & Moran, S. (1999). Development and application of a generic methodology to assess the quality of clinical guidelines. *International Journal for Quality in Health Care*, 11(1), 21-28.
- Dickson, D. A., Hargie, O., & Morrow, N. C. (1989). *Communication skills training for health personnel*. London: Chapman & Hall.
- Field, M. J. & Lohr, K. N. (1990). *Guidelines for clinical practice: Directions for a new program*. Washington, DC: Institute of Medicine, National Academy Press.
- Gilliland, B. E. & James, R. K. (1996). *Crisis intervention strategies*. (3rd ed.). San Francisco: Brooks/Cole.
- Graham, R. J. (1981). Understanding the benefits of poor communication. *Interface*, 11, 80-82.
- Greenwood, B. (1984). When a neighbour collapses-Do you know what to do? *Nursing Life*, 4(4), 34-35.
- Haber, J., Krainovich-Miller, B., & Price-Hoskins, P. (1996). *Comprehensive psychiatric nursing*. Toronto, Ontario: Mosby Year Book.
- Health Canada (1997). *Best practices in mental health reform: Discussion paper*. Ottawa: Publications Health Canada.
- Hoff, L.A. (1995). *People in crisis: Understanding & helping*. (4th ed.) San Francisco: Wiley Trade Publishing.
- Hoff, L.A. & Adamowski, K. (1998). *Creating excellence in crisis care: A guide to effective training and program designs*. San Francisco: Jossey-Bass Publishing.
- Hoff, L.A. (2001). *People in crisis: Clinical and Public Health Perspectives*. (5th ed.) San Francisco: Jossey-Bass Publishing.

Hunt, M. (1991). Being friendly and informal: Reflected in nurses', terminally ill patients', and relatives' conversations at home. *Journal of Advanced Nursing*, 16(8), 929-938.

Kanel, K. (1999). *Guide to crisis intervention*. (1st ed.). Pacific Grove, CA: Brooks/Cole.

Macleod, C. J. (1981). Communication in nursing. *Nursing Times*, 77(1), 12-18.

Macleod, C. J. & Faulkner, A. (1987). Communication skills teaching in nurse education. In B. Davis (Ed.), *Nursing education: Research and developments*. London: Croom Helm.

Madjar, I. & Walton, J. A. (2001). What is problematic about evidence? In M.J. Morse, J. M. Swanson, & A. J. Kuzel (Eds.), *The nature of qualitative evidence* (pp. 28-45). Thousand Oaks: Sage.

National Health and Medical Research Centre (1998). A guide to the development, implementation and evaluation of clinical practice guidelines. Info Access Network [On-line]. Available: www.dcita.gov.au/infoaccess

Ontario Ministry of Health (1993). *Putting people first: The reform of mental health services in Ontario*. Toronto, Ontario: Ontario Ministry of Health.

Ontario Ministry of Health and Long-Term Care (1999a). *Making it happen: Implementation plan for mental health reform*. Toronto, Ontario: Queen's Printer for Ontario.

Ontario Ministry of Health and Long-Term Care (1999b). *Making it happen: Operational framework for the delivery of mental health services and supports*. Toronto, Ontario: Queen's Printer for Ontario.

Ontario Public Health Association (OPHA) (1996). *Making a difference! A workshop on the basics of policy change*. Toronto, Ontario: Government of Ontario.

Registered Nurses Association of Ontario (2002a). *Client centred care*. Toronto, Canada: Registered Nurses Association of Ontario. [On-line]. Available: <http://www.rnao.org/bestpractices>

Registered Nurses Association of Ontario (2002b). *Establishing therapeutic relationships*. Toronto, Canada: Registered Nurses Association of Ontario. [On-line]. Available: <http://www.rnao.org/bestpractices>

Robinson, D. J. (2000). *The mental status exam explained*. Port Huron, MI: Rapid Psychler Press.

Rolfe, G. (1990). The role of clinical supervision in the education of student psychiatric nurses: A theoretical approach. *Nurse Education Today*, 10(3), 193-197.

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence. *British Medical Journal*, 312(7023), 71-72.

Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., & Siddie, R. (2000). A randomized controlled trial of cognitive-behavioural therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, 57(2), 165-172.

Stanhope, M. & Lancaster, J. (2000). *Community and public health nursing*. St. Louis: Mosby.

Suillian, P. (1997). *Developing evidence-based care in mental health nursing*. Nursing Standard [On-line]. Retrieved 5-29-2000. Available: <http://www.nursing-standard.co.uk/vol12-31/research.htm>

Sweeney, K. G. (1998). The information paradox. In M. Evans & K. Sweeney (Eds.), *The human side of medicine* (pp. 17-25). London: The Royal College of General Practitioners.

Thies, K. M. & Williams-Burgess, C. (1992). Communication as a progressive curriculum concept. *Nurse Educator*, 17(2), 39-41.

Trzepacz, P. T. & Baker, R. W. (1993). *The psychiatric mental status examination*. Oxford: University Press.

Voineskos, G. (1974). Psychiatric emergencies: The crisis intervention approach. *The University of Toronto Medical Journal*, 60, 43-50, 83-89.

Wooley, N. (1990). Crisis theory: A paradigm of effective intervention with families of critically ill patients. *Journal of Advanced Nursing*, 15(12), 1402-1408.

Bibliography

Austin, W., Douglas, P., Gallop, R., Harris, D., & Spencer, E. (1996). A 'domains of practice' approach to the standards of psychiatric and mental health nursing standards. *Journal of Psychiatric and Mental Health Nursing*, 3(2), 111-115.

Bengelsdorf, H. & Alden, C. D. (1987). A mobile crisis unit in the psychiatric emergency room. *Hospital and Community Psychiatry*, 38(6), 662-666.

Bengelsdorf, H., Church, J. O., Kaye, R. A., Orłowski, B., & Alden, C. D. (1993). The cost effectiveness of crisis intervention. Admission diversion savings can offset the high cost of service. *Journal of Nervous and Mental Disease*, 181(12), 757-762.

Boomsma, J., Dingemans, C. A., & Dassen, T. W. (1997). The nursing process in crisis-oriented psychiatric home care. *Journal of Psychiatric and Mental Health Nursing*, 4(1), 295-301.

Bressi, C., Amadei, G., Caparrelli, S., Cattaneo, C., Cova, F., & Crespi, S. (2000). A clinical and psychodynamic follow-up study of crisis intervention and brief psychotherapy in psychiatric emergency. *New Trends in Experimental & Clinical Psychiatry*, 16(1-4), 31-37.

Bressi, C., Colombo, E., Coppola, M. T., Cattaneo, C., Cova, F., & Guggeri, G. (1999). Crisis intervention in psychiatric emergencies: Effectiveness and limitations. *New Trends in Experimental & Clinical Psychiatry*, 15(2-3), 163-167.

Burnard, P. (1989). *Counseling skills for health professionals*. London: Chapman & Hall.

Canadian Nurses Association (1992). *Family violence - Clinical guidelines for nurses*. National Clearinghouse on Family Violence [On-line]. Retrieved 8-21-2000. Available: <http://www.hc-sc.gc.ca/hppb/familyviolence/html/nurses/1nurses.htm>

Canadian Nurses Association (1996). *Policy statement - Interpersonal violence*. Canadian Nurses Association [On-line]. Retrieved 8-16-2000. Available: http://206.191.29.104/pages/policies/interpersonal_violence.html

Carson, V. & Arnold, E. (1996). *Mental health nursing: The nurse patient journey*. Philadelphia: W.B. Saunders Company.

Clarke Institute of Psychiatry: Health Systems Research Unit (1997). *Best practices in mental health reform*. Toronto, Ontario: Clarke Institute of Psychiatry.

Corey, M. & Grey, G. (1998). *Becoming a helper*. Pacific Grove, CA: Brooks/Cole Publishing Co.

Crawford, M. J., Turnball, G., & Wessely, S. (1998). Deliberate self-harm assessment by accident and emergency staff - An intervention study. *Journal of Accident & Emergency Medicine*, 15(1), 18-22.

Eastwood, C. M. (1985). Role of communication in nursing. *Journal of Advanced Nursing*, 10(3), 245-250.

Engleman, N. B., Jobes, D. A., Berman, A. L., & Langbein, L. I. (1998). Clinicians' decision making about involuntary commitment. *Psychiatric Services*, 49(7), 941-945.

Eppard, J. & Anderson, J. (1995). Emergency psychiatric assessment: The nurse, psychiatrist, and counselor roles during the process. *Journal of Psychosocial Nursing*, 33(10), 17-23.

Fielding, R. & Llewellyn, S. P. (1987). Communication training in nursing. *Journal of Advanced Nursing*, 12(3), 281-290.

- Geller, J. L., Fisher, W. H., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services, 46*(9), 893-897.
- Goosen, R., Berry, P., Marshall, C., McAdams, J., Renaud, R., Hodge, S. et al. (2000). Program of assertive community treatment (PACT). Elgin Pact Team [On-line]. Retrieved 5-15-2000a Available: <http://www.psychiatry.med.uwo.ca/pact/elgin/>
- Hansburg, F. L., Nelson, L., Connors, C., Gill, K., Grande, P., & Paley, N. L. (1996). Two sides of a crisis: Consumer and professional views of screening services. *Psychiatric Rehabilitation Journal, 20*(1), 19-23.
- Heath, H. & Freshwater, D. (2000). Clinical supervision as an emancipatory process: Avoiding inappropriate intent. *Journal of Advanced Nursing, 32*(5), 1298-1306.
- Hoff, L. A. & Ross, M. M. (1993). *Curriculum guide for nursing: Violence against women and children*. Ottawa: University of Ottawa.
- Joy, C. B., Adams, C. E., & Rice, K. (1999). Crisis intervention for people with severe mental illnesses. *The Cochrane Library, 2*(2), 1-23.
- Karshmer, J. F. & Hales, A. (1997). Role of the psychiatric clinical nurse specialist in the emergency department. *Clinical Nurse Specialist, 11*(6), 264-268.
- Larsen, J. H. & Rissor, O. (1997). Telephone consultations at the emergency service, Copenhagen County: Analysis of doctor-patient communication patterns. *Family Practice, 14*(5), 387-393.
- LeGris, J., Weir, R., Browne, G., Gafni, A., Steward, L., & Easton, S. (2000). Developing a model of collaborative research: The complexities and challenges of implementation. *International Journal of Nursing Studies, 37*(1), 65-79.
- McClarey, M. & Duff, L. (1997). *Clinical effectiveness and evidence-based practice*. Nursing Standard [On-line]. Retrieved 5-25-2000. Available: <http://www.nursing-standard.co.uk/vol11-52/research.thm>
- McIndoe, K., Harwood, G., & Olmstead, C. (1994). Psychiatric crisis in emergency. *The Canadian Nurse, 90*(5), 26-29.
- Murdach, A. D. (1995). Decision-making situations in health care. *Health & Social Work, 20*(3), 187-191.
- Nelson, Z. & Mowry, D. (1976). Contracting in crisis intervention. *Community Mental Health Journal, 12*(1), 37-44.
- National Health Service Centre for Review and Dissemination - University of York (1997a). *Bulletin on the effectiveness of health service interventions of decision makers*. Effective Health Care [On-line]. Retrieved 3-29-2000a Available: <http://www.york.ac.uk/inst/crd/ehc33.htm>
- National Health Service Centre for Review and Dissemination - University of York (1997b). *Mental health promotion in high risk groups*. *Effective Health Care, 3*(3), 2-11.
- Ploeg, J., Ciliska, D., Brunton, G., MacDonnell, J., & O'Brien, M. A. (1999a). *Crisis intervention*. Ottawa: Ontario Ministry of Health.
- Ploeg, J., Ciliska, D., Brunton, G., MacDonnell, J., & O'Brien, M. A. (1999b). *The effectiveness of school-based curriculum suicide prevention programs of adolescents*. Ottawa: Ontario Ministry of Health.
- Puryear, D. A. (1992). Proposed standards in emergency psychiatry. *Hospital and Community Psychiatry, 43*(1), 14-15.
- Reding, G. R. & Raphelson, M. (1995). Around-the-clock mobile psychiatric crisis intervention: Another effective alternative to psychiatric hospitalization. *Community Mental Health Journal, 31*(2), 179-187.
- Reynolds, I., Jones, J. E., Berry, D. W., & Houlst, J. E. (1990). A crisis team for the mentally ill: The effect on patients, relatives and admissions. *The Medical Journal of Australia, 152*, 646-652.

Rice, M. E., Harris, G. T., & Varney, G. W. (1989). *Violence in institutions - Understanding, prevention and control*. Toronto, Ontario: Hogrefe & Huber Publications.

Schnyder, U., Klaghofer, R., Leuthold, A., & Buddeberg, C. (1999). Characteristics of psychiatric emergencies and the choice of intervention strategies. *Acta psychiatrica Scandinavica*, 99, 179-187.

Segal, S. P., Egly, L., Watson, M. A., Miller, L., & Goldfinger, S. M. (1995). Factors in the quality of patient evaluations in general hospital psychiatric emergency services. *Psychiatric Services*, 46(11), 1144-1148.

Simington, A. J., Cargill, L., & Hill, W. (1996). Crisis intervention: Program evaluation. *Clinical Nursing Research*, 5(4), 376.

Slaby, A. E. (1981). Emergency psychiatry: An update. *Hospital and Community Psychiatry*, 32(10), 687-698.

Smith, M. (1994). Nurses' response to patient anger: From disconnecting to connecting. *Journal of Advanced Nursing*, 20(4), 643-653.

Theinhaus, O. J., Ford, J., & Hillard, J. R. (1995). Factors related to patients' decisions to visit the psychiatric emergency service. *Psychiatric Services*, 46(12), 1227-1228.

van der Sande, R., Buskens, E., Allart, E., van der Graaf, Y., & van Engeland, H. (1997). Psychosocial intervention following suicide attempt: A systematic review of treatment interventions. *Acta psychiatrica Scandinavica*, 96(1), 43-50.

Velamoor, V. R. & Mendonca, J. D. (1997). Psychiatric crisis: a community response. *The Canadian Journal of Diagnosis*, 14(9), 95-101.

Wessely, S., Rose, S., & Bisson, J. (2000). Brief psychological interventions ("debriefing") for trauma-related symptoms and the prevention of posttraumatic stress disorder. *The Cochrane Library*, (2), 1-18.

York Central Hospital. (2000). Mental health program multidisciplinary assessment form. Richmond Hill, Ontario: York Central Hospital.

Zametkin, A., Alter, M., & Yemini, T. (2001). Suicide in teenagers. *The Journal of the American Medical Association*, 286(24), 3120-3127.

Zun, L. S., Leikin, J. B., Stotland, N. L., Blade, L., & Marks, R. C. (1996). A tool for the emergency medicine evaluation of psychiatric patients. *American Journal of Emergency Medicine*, 14(3), 329-331.



Appendix A

AN APPLICATION OF A MODEL OF CRISIS INTERVENTION

From *Guide to Crisis Intervention*, 1st edition, by K. Kanel. © 1999. Adapted with permission of Brooks/Cole, an imprint of the Wadsworth Group, a division of Thomson Learning (pp. 81-84).

The ABC Model of Crisis Intervention

Note: Numerous examples (*in italics*) have been cited to provide choices for clinicians, in framing questions. It is not intended that all questions should be posed to all clients in question.

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A: BASIC ATTENDING SKILLS

Introduce yourself and your role in a respectful, friendly and *CALM* manner. Use ice-breakers as needed to relieve the tension. Extend your hand if possible in a handshake.

I can see that you are very distressed/ upset. I am concerned about you. Can you tell me what is upsetting /bothering you? I'd like to understand your situation from your point of view. Have you had an opportunity to talk to anyone about this? Please tell me what is happening with you. Can I help you get started by asking you...??? (*Listen actively, and paraphrase in the client's own words re his/her description of the current situation*).

How can I help you today, Mr. or Mrs ___? You seem to be having a little trouble getting started. Can I help by ___? (*Offer a drink of water, or whatever may be needed*). *I am so pleased you could meet with me today, as I can see it must have been very difficult for you to make it in today.*



B: IDENTIFYING THE PROBLEM AND THERAPEUTIC INTERACTION

Identify the precipitating event.

What specifically brings you here today? Is what is happening unusual or different from the way you normally think (behave or feel)? How is this different from your usual norm? I know you have had problems with this in the past, so something must be different about what is happening now. Can you try and put your finger on what is different, for you now? Did something happen recently, something different? Try and recall to the best of your ability. It will make it easier for you and I to tackle the problem together.

Explore meanings, cognitions, and perceptions.

What do you think about all this? (may have already been provided by the client, so may not be necessary to ask). What does it mean to you? What thoughts go through your mind when you picture or relive the event/experience? How do you make sense of all of this? What specifically do you mean? Can you tell me more about this, so I can better understand? I appreciate your ability to try to help me understand this further. Take a couple of deep breaths - it may help you to collect your thoughts.

Identify subjective distress (emotional distress).

Am I correct in understanding that you feel really (sad, anxious, afraid, angry, guilty, helpless, depressed etc.?). Have you ever felt this badly before? Under similar or different circumstances? What other feelings are going on inside you? You seem sad, angry, ambivalent, in pain. How have you been feeling since this occurred (the precipitating event)? Have these feelings worsened since the event?

Identify impairments in functioning in the following areas:

1. Behavioural

How has this been affecting your life? For example, How are you sleeping? How is your appetite? Have you been carrying on with your normal activities? Kindly elaborate. How is this different from before the event occurred?

2. Social

Are your relationships with your friends and family different since this happened? How would your friends or family describe the change in your relationships with them? Are you still able to maintain your usual social contacts with the important people in your life? Please explain. How do you usually feel or act around people? Would you describe yourself as a sociable person normally? Is this different for you now?



3. Academic

Are you going to school? How are your grades lately? Is this a change from normal? Have you been able to study and concentrate in classes? How are you getting along with classmates? Are you more withdrawn, irritable, or absent from class?

4. Occupational

How are you coping or functioning at work? Has your work performance changed since (the precipitating event)? Have you been able to function adequately at work? Have co-workers observed a change in you. If so, in what way?

Identify pre-crisis level of functioning in 1-4 above. If not already employed as above, ensure that current assessment is compared with a person's normal functioning.

How has your ability to function socially, at school, and at work changed since (the precipitating event)? What was it like for you before (the precipitating event)? What were your relationships like before and after (the precipitating event)?

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Identify any ethical concerns:

1. Suicide/homicide assessment

Do you ever think that life is no longer worth living? Have these feelings intensified lately? Do you think of joining loved ones who have passed on? Are you more preoccupied with thoughts of death lately? Do you ever think of taking loved ones with you? Have you been thinking about hurting yourself or others? Do you have a specific plan? Can you tell me about it? Do you have the means to follow through with your plan? Is there anything or anyone stopping you from killing yourself or others? Are your children/wife/husband or others in imminent danger? Are you in imminent danger? Although I realize this is painful to talk about, I am grateful that you are able to share these thoughts with me. It took a lot of strength and courage for you to ask for help today, and I (we) are here to help. I can better understand why you are feeling the way you are (validate and state the specific emotion being communicated by the client). You are coping with a great deal now. Together we can work on establishing a different course. Would you be willing to work with me on this? Despite your intense feelings now, I have helped others like you AND I KNOW there are other solutions/options/choices for you to lessen your distress. I'd like to work with you on this. Are these feelings interfering with your everyday functioning? Can you tell me more about this?



2. Organic or other medical concerns

How is your physical health status? What treatments or conditions are you coping with? How are these conditions affecting your everyday functioning (i.e. sleep, appetite, work or school attendance, relationship with others)? Do you know the medications you are currently on?

Are you able to get up in the morning and feed yourself? Are you independent in your ability to carry on your activities of daily living? Please elaborate if you can. (How many hours do you sleep? Can you dress yourself every day?)

Do you ever hear voices/sounds that others cannot hear? Does it ever feel like the phone wires are talking to you? Do you ever believe you have special powers? Can people read your mind or put thoughts into your head? Do you think people are out to harm you in anyway? Do you ever smell, taste, feel or see things that are unusual or that others don't understand? Over what period of time have you been experiencing these sensations? Often people experiencing high degrees of stress report these unusual sensations.

Identify substance use/abuse issues.

Are you currently using any non-prescription drugs? Have you used these in the past? For what period of time? Has alcohol consumption been a problem for you lately? How much alcohol do you normally drink per week/month/day? Has this changed since the precipitating event (use the patient's own words here re his/her description of the crisis event)? What if any drugs do you use recreationally? Is your drinking/drug use a problem in your view?



Use therapeutic interactions:

1. Educational comments

Although you feel as though you are the only woman who stays in a battering relationship, it is estimated that about 30% of women in the United States and Canada live in ongoing battering relationships for a variety of reasons.

Going through a period of intense anger is quite normal and to be expected after the death of a loved one.

Actually, it is not uncommon to be raped by someone you know. Date rape is extremely common for women ages 15 to 24.

Studies to date do not show that one can catch HIV by shaking hands.

It is not uncommon for the spouse of an alcoholic to be highly anxious about the spouse's drinking.

2. Empowerment statements

It is true that you did not have a choice about being raped, but you do have choices now, including whether to press charges, get a medical exam, or drop the whole matter.

Unfortunately, you cannot control your wife's drug use, but you can control your own behaviour, or responses to/ with her.

True, you are HIV infected and cannot change that. You can, however, choose how to live the rest of your life in a way that is most meaningful for you.

3. Support statements

This is an extremely difficult situation, and I don't take it lightly. I can only imagine the pain you are going through. I am so sorry this happened to you. Please, let me be there for you: I do care. It must feel pretty terrible if you want to kill yourself. These kinds of traumas often make people feel like giving up.

4. Positive Reframes

I think it takes a lot of strength to cry, and I don't see crying as a sign of weakness.

While painful emotionally, this crisis will help you become a stronger, more insightful person.

Have you ever considered that perhaps your children /wife were trying to help you rather than harm you when they? I can't see how anything you may have done would have prevented your friend's death. From what you have described, you were there for your friend every step of the way.



C: COPING

Identify client's current coping attempts.

What have you done in the past to cope with similar feelings or behaviours? Did this work for you? Why or why not? What have you done recently to try to feel better? What else have you done? Anything else? Why do you think this is not working for you now? Do you have any ideas on what might be more helpful for you at present? Perhaps together we can explore some alternatives that might be worth trying to help you feel more in control of the situation. You seem to be doing a good job of the situation, but perhaps there are other things that you haven't considered, that you might find more helpful. I would like to work on this with you. What do you think? Would you be willing to give it a try over the next couple of visits? (Specify how many). People in crisis often learn more about themselves and think of ways to overcome their distress. This is my hope for you. In the process of exploring your own solutions to this crisis you will become stronger and healthier. Crises are often a normal part of life. We all experience crises at some point in our lives. You, more than anyone, know yourself best and what may or may not work for you. I will follow your lead and provide encouragement for you along the way.

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Encourage client to think of other creative coping strategies.

What else can you think of to try to get through this? What have you done in the past to get through difficult times? What would you tell a friend to do in this case?

1. Present alternative coping idea/ Develop a Plan.

Contract to come in for additional sessions with yourself. Negotiate the number of sessions. Set up the next appointment - time, date, location. Offer homework as needed for the next session.

Our focus will be..... I'd like you to bring in your ideas on what solutions we may consider to help you solve the problem. Would you find this helpful? I am looking forward to our next session. Thank you for helping me understand this with you. I know it took a lot of courage on your part and I know that strength will carry you through this difficult period.



2. Refer to a medical doctor or psychiatrist

I would feel more comfortable if you see a physician. Your symptoms are treatable and you may need medication or a change in your medication as well as a thorough physical workup. Do you know of a doctor; or shall I refer you to one that I really respect and work with?

3. Refer to a lawyer

I would recommend you get legal advice from an attorney. These matters are beyond my scope of clinical expertise. A visit with a public defender, justice of the peace or lawyer will help you consider or exercise your legal options. I will set this up for you before you leave today, as I can see that you are coping with a great deal right now. Are you aware of restraining orders? This legal appointment will offer you additional information and options that I feel you need to address to maintain your safety or the safety of your family. Would you agree to this? I would like to meet with you again following the visit with the lawyer if you are in agreement. Shall we set this up now?

4. Refer to a shelter or other community other agency

How would you feel about going to a battered woman's or homeless shelter in the meantime? Particularly since you do not feel safe in returning home tonight. You will be safe there and it will give you some time to explore your options. I will continue to maintain contact with you until this crisis is resolved even though there might be other agencies and people involved.

5. Recommend books

Do you like to read? I know some really good books that help explain more about what you are going through. Here are some suggestions that might make it easier for you to talk about and understand your situation.

6. Obtain commitment; do follow-up

When can you make another appointment with me? Call me when you set up your appointment with Dr. Jones. I am going to call you tomorrow at 9 am. Will you promise not to act impulsively or harm yourself until then? Do you give me your word? Let's shake on it. Can you have a friend stay with you tonight just so you are not alone? Let me call this person on your behalf. I will also leave you my card. If you need to call at any time of the night or day, there is always a person at this number 24 hours per day. I will return your call as soon as I possibly can. I am looking forward to seeing you or speaking with you on our next visit (or phone call). Has talking about this helped you in some way? Can you describe this for me?

Appendix B

OUTLINE OF A MENTAL STATUS ASSESSMENT

The following elements may be included in a mental status assessment:

APPEARANCE:

Age (*chronological age and whether person looks this age*)

Sex, Race

Body build (*thin, obese, athletic, medium*)

Position (*lying, sitting, standing, kneeling*)

Posture (*rigid, slumped, slouched, comfortable, threatening*)

Eye contact (*eyes closed, good contact, avoids contact, stares*)

Dress (*what individual is wearing, cleanliness, condition of clothes, neatness, appropriateness of garments*)

Grooming (*malodorous, unkempt, dirty, unshaven, overly meticulous, hairstyle, disheveled, makeup*)

Manner (*cooperative, guarded, pleasant, suspicious, glib, angry, seductive, ingratiating, evasive, friendly, hostile*)

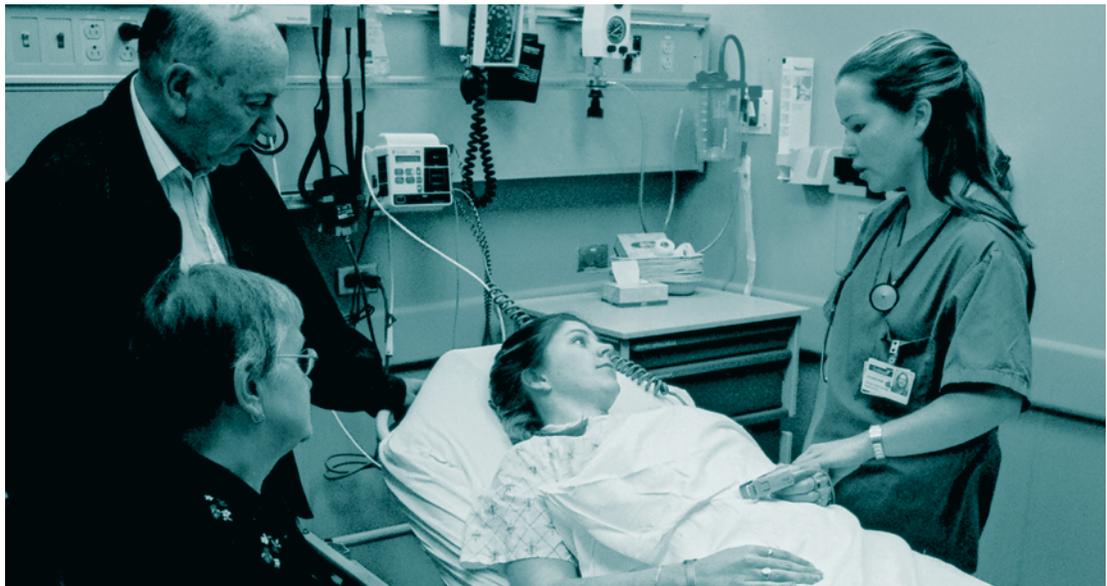
Attentiveness to examiner (*disinterested, bored, internally preoccupied, distractible, attentive*)

Distinguishing features (*scars, tattoos, bandages, bloodstains, missing teeth, tobacco-stained fingers*)

Prominent physical irregularity (*missing limb, jaundice, profuse sweating, goiter, wheezing, coughing*)

Emotional facial expression (*crying, calm, perplexed, stressed, tense, screaming, tremulous, furrowed brow*)

Alertness (*alert, drowsy, stupor, confused*)



MOTOR

Retardation (*slowed movements*)

Agitation (*unable to sit still, wringing hands, rocking, picking at skin or clothing, pacing, excessive movement, compulsive*)

Unusual movements (*tremor, lip smacking, tongue thrust, mannerisms, grimaces, tics*)

Gait (*shuffling, broad-based, limping, stumbling, hesitation*)

Catatonia (*stupor, excitement*)

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SPEECH

Rate (*slowed, long pauses before answering questions, hesitant, rapid, pressured*)

Rhythm (*monotonous, stuttering*)

Volume (*loud, soft, whispered*)

Amount (*monosyllabic, hyper-talkative, mute*)

Articulation (*clear, mumbled, slurred*)

Spontaneity

AFFECT

Stability (*stable, fixed, labile*)

Range (*constricted, full*)

Appropriateness (*to content of speech & circumstance*)

Intensity (*flat, blunted, exaggerated*)

Affect (*depressed, sad, happy, euphoric, irritable, anxious, neutral, fearful, angry, pleasant*)

Mood (*reported by patient/client*)



THOUGHT CONTENT

Coherence (*coherent, incoherent*)

Logic (*logical, illogical*)

Stream (*goal-directed, circumstantial, tangential {diverges suddenly from a train of thought}, loose, flight of ideas, rambling, word salad*)

Perseveration (*pathological repetition of a sentence or word*)

Neologism (*use of new expressions, phrases, words*)

Blocking (*sudden cessation of flow of thinking & speech related to strong emotions*)

Attention (*distractibility, concentration*)

PERCEPTION

Hallucinations (*auditory, visual, olfactory [smelling], gustatory [taste], tactile*)

Illusions (*misinterpretation of actual external stimuli*)

Depersonalization

Déjà vu, Jamais vu

INTELLECT

Global evaluation (*average, above or below average*)

INSIGHT

Awareness of illness

Adapted from: American Psychiatric Association (1994). Diagnostic & Statistical Manual of Mental Disorders. 4th Edition. American Psychiatric Association, Washington D.C.; Trzepacz, P.T. & Baker. R.W. (1993). The Psychiatric Mental Status Examination. Oxford University Press; Robinson, D.J. (2000). The Mental Status Exam Explained. Rapid Psychler Press.



Appendix C

Assessment of Coping Skills and Support Systems

Coping Skills

Individuals use a variety of coping mechanisms. These may include such things as withdrawing, trying to think it out, crying, physically acting out their distress, use of defense mechanisms, direct action, that is, taking action intended to solve the problem directly, or indirect action, putting things on hold or dealing with the problem through tension reduction.

Signs of maladaptive coping are difficulty in managing one's feelings, suicidal or homicidal tendencies, alcohol or other drug abuse/misuse, encounters with the law and inability to effectively use available help (Hoff, 1995).

Some questions for assessing coping mechanisms are:

- How does the client usually cope with stress?
- What helped/what didn't help in the past?
- What is the client's degree of coping now?

Support Systems

Almost two thirds of mental health crises have been found to be the result of social factors; family conflicts, marital discord, impending divorce, desertion and conflicts with parent's account for approximately 50 per cent of crises (Voineskos, 1974). Support systems must be assessed and accessed for every person in crisis. These include family support and accessibility, financial resources, and community and professional support networks. The strength of the client's support systems significantly influences the outcomes of successful crisis resolution. Do not assume that families are always supportive of clients.

Some questions for assessing the client's support systems include:

- Does the client live alone or with others?
- Who is the client close to?
- Who is important for the client?
- What supports have been helpful in the past and are these supports available now?

Because multiple studies have shown that what appear to be psychiatric symptoms are often caused by medical problems, best practice recommends a medical/psychiatric history that includes a mental status exam to be implemented by nurses. (See Appendix B for example of a mental status assessment).

Appendix D

Toolkit: Implementation of Clinical Practice Guidelines

Best practice guidelines can only be successfully implemented if there are: adequate planning, resources, organizational and administrative support as well as appropriate facilitation. In this light, RNAO, through a panel of nurses, researchers and administrators has developed a “Toolkit: Implementation of Clinical Practice Guidelines” based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

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The “Toolkit” provides step-by-step directions to individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. Specifically, the “Toolkit” addresses the following key steps in implementing a guideline:

1. Identifying a well-developed, evidence-based clinical practice guideline.
2. Identification, assessment and engagement of stakeholders.
3. Assessment of environmental readiness for guideline implementation.
4. Identifying and planning evidence-based implementation strategies.
5. Planning and implementing evaluation.
6. Identifying and securing required resources for implementation.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The “Toolkit” is one key resource for managing this process.

The “Toolkit” is available through the Registered Nurses Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge off the RNAO website. For more information, an order form or to download the “Toolkit”, please visit the RNAO website at www.rnao.org.



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**Nursing Best
Practice Guideline**
Shaping the future of Nursing



crisis intervention
supplement

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Supplement Integration

This supplement to the nursing best practice guideline *Crisis Intervention* is the result of a three year scheduled revision of the guideline. Additional material has been provided in an attempt to provide the reader with current evidence to support practice. Similar to the original guideline publication, this document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. This supplement should be used in conjunction with the guideline as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Crisis intervention must be responsive to clients and families in community and institutional settings. While accessibility of services in the client's environment is ideal; it does not preclude the provision of effective crisis intervention approaches in multiple settings, delivered in a timely and responsive manner.

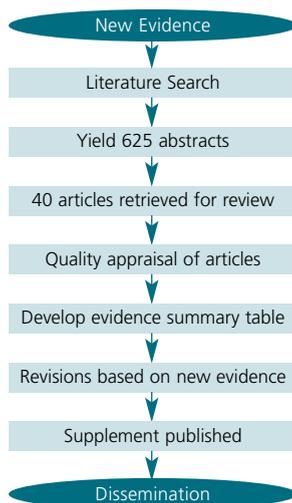
It is noteworthy that crisis intervention is but one level of care within a continuum of health care services and should not be

viewed as a panacea for the absolute reduction of emergency room visits or as a replacement for ongoing ambulatory care services (Hoff 2001), particularly for patients experiencing chronic illnesses. As with any illness, it is important to recognize that chronically ill patients also experience episodes of crisis that may or may not be directly related to their specific diagnoses. Crisis interventions can therefore be provided informally with individuals and families and more systematically via organized crisis response teams and delivery systems; the latter often based upon a community's particular needs and provincial standards (Ontario Ministry of Health and Long Term Care, 2005).

Nurses are ideally positioned within the healthcare system, having timely opportunities for rapid recognition and responsiveness to clients, families and groups experiencing crisis. This guideline has been reviewed to further equip nurses to refine, develop and monitor their crisis care skills in order to effectively work with clients in crisis and to mitigate future crises. A recent review of the current evidence to support these recommendations has been completed, and indicates ongoing support for this guideline to enhance the delivery of best practices in crisis intervention.

Revision Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this practice guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each guideline every three years. The revision panel members (experts from a variety of practice settings) are given a mandate to review the guideline focusing on the recommendations and the original scope of the guideline.



Summary of Evidence

The following content reflects the changes made to the original publication (2002) based on the consensus of the review panel.

-  changed
-  unchanged
-  additional information

<p>Recommendation 1</p> <p>Crisis intervention is founded on a particular set of values and beliefs, and guiding principles.</p>	✓
<p><i>Additional Literature Supports</i> Clark & Hughes, 2002; De Leo, 2002; Ferris, De Siato, Sandercock, Williams & Shulman, 2003; Hoff, 2001; Liken, 2001; Mead & Hilton, 2003; Mitchell, 2003; Sturis, 2002</p>	
<p>Recommendation 2</p> <p>Knowledge of the three core components of crisis intervention theory (a precipitating event, client perception of the event, and the client's usual coping methods) is fundamental to identify clients in crisis.</p>	
<p>The wording of this recommendation has been revised for further clarification. The following content is to be included immediately under the recommendation on page 21.</p>	
<p>Crisis care should be incorporated into all areas and units of healthcare where nurses and other healthcare disciplines work with clients. It is important for nurses to recognize that crisis intervention is integral for all environments and contexts where care is provided, including hospital and community settings.</p>	
<p><i>Additional Literature Supports</i> Antai-Otong, 2003; Mead & Hilton, 2003</p>	
<p>Recommendation 3</p> <p>The delivery of crisis intervention is based on an integrative framework.</p>	✓
<p><i>Additional Literature Supports</i> Antai-Otong, 2003; Evans, Boothroyd, Armstrong, Greenbaum, Brown & Kuppinger, 2003; Liken, 2001; Mitchell, 2003; Roberts, 2002; Stone & Conley, 2004; Sturis, 2002</p>	
<p>Recommendation 4</p> <p>A wide array of therapeutic communication skills is a pre-requisite to effective intervention with clients in crisis.</p>	✓
<p><i>Additional Literature Supports</i> Barker, 2001; Hendin, Maltzberger, Lipschitz, Pollinger Haas & Kyle, 2001; Mead & Hilton, 2003; Sturis, 2002</p>	

<p>Recommendation 5</p> <p>A comprehensive holistic assessment is performed prior to engaging in any plan to resolve crises.</p>	✓
<p>The following sentence is to be incorporated after the first paragraph under Risk Assessment page 30.</p> <p>When considering a client’s potential for suicide, nurses must also examine both protective factors and risk factors for suicide.</p>	+
<p><i>Additional Literature Supports</i> Antai-Otong, 2003; De Leo, 2002; Hendin et al., 2001; Hoff & Brown, 2005; Sturis, 2002; Neeleman, 2002</p>	
<p>Recommendation 6</p> <p>Nurses are directly involved in all aspects of crisis intervention including assessment, intervention, referrals and linkages, and short-term follow up.</p>	✓
<p>The following sentence is to be added at the end of the second paragraph on page 31</p> <p>Nurses ensure that there is appropriate follow up and linkages to services and resources when necessary.</p>	+
<p><i>Additional Literature Supports</i> Antai-Otong, 2003; Clarke & Hughes, 2002; Mariano, 2002</p>	
<p>Recommendation 7</p> <p>Teaching and educating clients, families, colleagues, and the community about crisis intervention and prevention are essential to promote mental health.</p>	✓
<p><i>Additional Literature Supports</i> Campbell, Cataldie, McIntosh & Millet, 2004; Evans et al., 2003; Mitchell, 2003; Sturis, 2002</p>	
<p>Recommendation 8</p> <p>Education and ongoing learning opportunities are required for nurses to implement best practices in crisis intervention.</p>	✓
<p><i>Additional Literature Supports</i> Boscarino et al., 2005; Cowin et al., 2003. Mitchell, 2003</p>	
<p>Recommendation 9</p> <p>The core curriculum in nursing education includes the following key components:</p> <ul style="list-style-type: none"> ■ Crisis intervention theory and practice; ■ Sound knowledge of the principles of the therapeutic relationship, and their application to crisis intervention; and ■ The provision of regular clinical supervision. 	✓
<p>The following sentence is to be added at the end of the first paragraph page 33.</p> <p>Nurses educated in crisis theory and intervention can improve outcomes for clients in crisis.</p>	+
<p><i>Additional Literature Supports</i> Boscarino, Adams & Figley, 2005; Cowin et al., 2003. Mitchell, 2003; Hoff & Adamowski, 1998; Mariano, 2002</p>	
<p>Recommendation 10</p> <p>Organizational commitment to providing quality crisis intervention services is reflected in its mission and vision statements, as well as through allocation of resources to develop, implement, and support the services.</p>	✓
<p><i>Additional Literature Supports</i> Hoff, 2001; Ontario Ministry of Health and Long-Term Care, 2005</p>	

<p>Recommendation 11</p> <p>To enhance the continuum of crisis care, the organization continuously strives to achieve a collaborative and integrative crisis intervention practice model within an interdisciplinary team.</p>	✓
<p><i>Additional Literature Supports</i></p> <p>Clarke & Hughes, 2002; Campbell et al., 2004; Hoff, 2001</p>	
<p>Recommendation 12</p> <p>The organization actively advocates for the provision of quality crisis intervention care on multiple levels (individual, family, and community).</p>	✓
<p><i>Additional Literature Supports</i></p> <p>Campbell et al., 2004</p>	
<p>Recommendation 13</p> <p>Nursing best practice guidelines can be optimally implemented when adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation, exist. An organizational plan for developing and implementing crisis intervention services includes:</p> <ul style="list-style-type: none"> ■ An assessment of organizational readiness and barriers to education; ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process; ■ Dedication of a qualified individual to provide the support needed for the education and implementation process; ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices; and ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. 	
<p>The wording of this recommendation has been revised for further clarification.</p>	
<p><i>Additional Literature Supports</i></p> <p>Boscarino et al., 2005; Campbell et al., 2004; Hoff & Adamowski, 1998</p>	

Implementation Strategies

There are several key strategies organizations can utilize to implement the *Crisis Intervention* guideline. These strategies are comprised of the following:

- Identification of an individual to lead the project that will dedicate time to implementation of the *Crisis Intervention* guideline. This nurse will provide support, clinical expertise and leadership to all nurses involved in implementation.
- Utilization of a systematic approach to planning, implementation and evaluation of the guideline initiative. A work plan is helpful to keep track of activities and timelines.
- Provide opportunities for staff to attend interactive, adult-learning programs which incorporate the key recommendation from the guideline.
- Teamwork and collaboration through an interdisciplinary approach is essential.
- Consider establishing an implementation team that includes not only the organization implementing the guideline, but others such as community partners (referral sources) and support groups.

In addition to the tips mentioned above, RNAO has published implementation resources that are available on the website. A *Toolkit* for implementing guidelines can be helpful, if used appropriately. It is available for free download at www.rnao.org/bestpractices.

Research Gaps & Implications

In reviewing the evidence for the revision of this guideline, it is clear that future research opportunities involve the process and outcomes related to crisis intervention with a focus on assessment tools.

The following is a correction to the *Mental Health Status Assessment* on p.52. The remaining content in the appendix is unchanged.

Appendix B (Revised)

Outline of a Mental Health Status Assessment

THOUGHT CONTENT:

- Suicidal or homicidal ideations
- Depressive cognition (guilt, worthlessness, hopelessness)
- Obsessions (persistent, unwanted, recurring thought)
- Ruminations
- Phobias (strong, persistent, fear of object or situation)
- Ideas of reference
- Paranoid ideation
- Magical ideation
- Delusions (false belief kept despite no supportive evidence)
- Overvalued ideas
- Other major themes discussed by patient/client

THOUGHT PROCESS:

- Coherence (coherent, incoherent)
- Logic (logical, illogical)
- Stream (goal-directed, circumstantial, tangential [diverges suddenly from a train of thought], looseness of associations, flight of ideas, rambling, word salad)
- Perseveration (pathological repetition of a sentence or word)
- Neologism (use of new expressions, phrases, words)
- Blocking (sudden cessation of flow of thinking & speech related to strong emotions)
- Attention (distractibility, concentration)

Additional Literature Supports

Hoff & Brown, 2005

References

- Antai-Otong, D. (2003). Psychiatric mental health nursing. *Nursing Clinics of North America*, 38(1), 111-122.
- Barker, P. (2001). The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8, 233-240.
- Boscarino, J., Adams, R., & Figley, C. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health*, 7(1), 9-22.
- Campbell, F., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis*, 25(1), 30-32.
- Clarke, D. & Hughes, L. (2002). Psychiatric nurses in hospital emergency departments. *Canadian Nurse*, 98(10), 23-26.
- Cowin, L., Davies, R., Estall, G., Berlin, T., Fitzgerald, M., & Hoot, S. (2003). De-escalating aggression and violence in the mental health setting. *International Journal of Mental Health Nursing*, 12, 64-73.
- De Leo, D. (2002). Struggling against suicide: The need for an integrative approach. *Crisis*, 23(1), 23-31.
- Evans, M., Boothroyd, R., Armstrong, M., Greenbaum, P., Brown, E., & Kuppinger, A. (2003). An experimental study of the effectiveness of intensive in-home crisis services for children and their families: Program outcomes. *Journal of Emotional and Behavioral Disorders*, 11(2), 92-121.
- Ferris, L., De Siato, C., Sandercock, J., Williams, J., & Shulman, K. (2003). A descriptive analysis of two mobile crisis programs for clients with severe mental illness. *Canadian Journal of Public Health*, 94(3), 233-237.
- Hendin, H., Maltsberger, J., Lipschitz, A., Pollinger Haas, A., & Kyle, J. (2001). Recognizing and responding to a suicide crisis. *Suicide and Life-Threatening Behavior*, 31(2), 115-128.
- Hoff, L. & Adamowski, K. (1998). *Comprehensive mental health assessment: An integrated approach*. Sudbury, MA: Jones and Bartlett Publishers.
- Hoff, L., & Brown, L. (2005). *Comprehensive mental health assessment: An integrated approach*. In K. Devereaux Melillo & S. Crocker Houde, Geropsychiatric and mental health nursing (pp. 45-66). Sudbury, MA: Jones and Bartlett Publishers.
- Hoff, L. (2001). *People in crisis: Clinical and public health perspective*. San Francisco, CA: Jossey-Bass Publishers.
- Liken, M. (2001). Caregivers in crisis. *Clinical Nursing Research*, 10(1), 52-68.
- Mariano, C. (2002). Crisis theory and intervention: A critical component of nursing education. *Journal of the New York State Nurses Association*. 33(1) 19-24.
- Mead, S. & Hilton, D. (2003). Speaking out. *Psychiatric Rehabilitation Journal*, 27(1), 87-94.
- Mitchell, J. (2003). Major misconceptions in crisis intervention. *International Journal of Emergency Mental Health*, 5(4), 185-197.
- Neeleman, J. (2002). Beyond risk theory: Suicidal behavior in its social and epidemiological context. *Crisis*, 23(3), 114-120.
- Ontario Ministry of Health and Long-Term Care (2005). Crisis Response Service Standards for Mental Health Services and Supports. [On-line]. Available: http://www.health.gov.on.ca/english/public/pub/ministry_reports/psychosis/cris_resp.pdf
- Roberts, A. R. (2002). *Crisis Intervention Handbook: Assessment, treatment and research, 3rd Edition*. New York, New York: Oxford Press.
- Stone, D. & Conley, J. (2004). A partnership between Roberts' crisis intervention model and multicultural competencies. *Brief Treatment and Crisis Intervention*, 4(4), 367-375.
- Sturis, I. (2002). Nursing intervention and treatment of the acutely psychotic patient in the emergency department. *Journal of the American Psychiatric Nurses Association*, 8(6), S36-S39.

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