POLICEINTERVENTION IN EMERGENCYPSYCHIATRIC CARE

ABLUEPRINT FORCHANGE

British Columbia Schizophrenia Society

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Backgrounder, Executive Summary

Police Intervention in Emergency Psychiatric Care:
A Blueprint for Change

Excerpts

Full report available on request from British Columbia Schizophrenia Society *bcss.prov@telus.net www.bcss.org*

POLICE INTERVENTION IN EMERGENCY PSYCHIATRIC CARE: A BLUEPRINT FOR CHANGE

A couple of years ago I found myself at a dinner at Rideau Hall in honour of recipients of the Order of Canada. I found myself seated next to a police officer who was in charge of the police precinct in a downtown area of Toronto where people were poor and crime was high.

"What", I asked the officer, "is the biggest challenge you face?"

I expected him to reply that his biggest problem were all those defense-oriented Charter rulings the Supreme Court of Canada kept handing down. But he surprised me.

"Our biggest problem," the officer answered,"is mental illness."

– Chief Justice, Supreme Court of Canada (2005) [1]

BACKGROUND

One of the most common difficulties encountered by police who intervene in psychiatric emergencies is the lack of available hospital emergency room space and long waiting times for intake procedures. It is critical that people in a psychiatric crisis receive timely medical assessment and treatment and that British Columbia police officers are not made to wait for unacceptable lengths of time ─ often hours ─ to release the person to the hospital's care.

Early in 2005, Vancouver Police Chief Jamie Graham reported that his officers were experiencing substantial hospital emergency room waits, with 7 or 8 hours being the norm. Acting RCMP Commander Gary Forbes reported that his officers in Surrey were facing waits of 10 to 12 hours, and Ward Clapham, Officer in Charge of the Richmond RCMP concurred that this was a significant problem.

Not only is such a situation unacceptable in terms of timely access to appropriate medical care, it is unnecessarily costly in terms of salaries and benefits to deploy police the officers to stay with the patient. Police resources are invaluable. Having the police remain for lengthy times with psychiatric patients in hospital emergency is just one example of where police resources currently allocated to dealing with the mentally ill might be better utilized in other areas. For instance, there is an identified "capacity gap" for crime fighting and the prosecution of gang related crime in BC.[2]

In March 2005, a comprehensive report to the Attorney General of British Columbia[3] on street crime identified people with mental illness as a major

concern within the justice system. Consultations by the Justice Task Force's Working Group with a wide variety of stakeholders confirmed:

- The justice system is not the appropriate place to deal with mentally ill offenders.
- There are high numbers of mentally disordered offenders in the criminal justice system.
- There are a significant number of mentally ill residents and many of them are not receiving needed support in the community.

The Justice Working Group concluded that
Fundamental changes are required to the culture of the criminal justice system, and to the way that health, social and justice system agencies interact. This approach has attracted support within the health and justice system for the kind of collaboration recommended and demonstrated by the Working Group itself.

Among the key recommendations to the BC Attorney General is that the Provincial Government should establish a Community Health and Justice Committee to oversee the cross-agency implementation of recommendations contained in the Working Group's report.

To ensure more timely access to medical assessment and treatment for all people with mental illness, a *comprehensive provincial strategy* needs to be developed and implemented in British Columbia that includes services delivered by Regional Health Authorities, acute care hospitals, social services, justice officials, and the police. Otherwise, our jails will continue to become the default mental health system for people who are in a psychiatric crisis and needing care and treatment. The development of such a strategy will result in procedures that would both ensure timely medical care and shorten the wait times at hospital emergency facilities for police.

Focusing on a province-wide basis and working mainly with provincial agencies, efforts in preparing this report for the Provincial Health Services Authority also dovetailed with a Canadian Mental Health Association (CMHA) BC Division community project using six site-specific models in BC to improve interactions between police and people with mental illness.[4] Vancouver, Delta, Richmond, Nanaimo, Cranbrook, and Williams Lake were chosen for the project. One of the major goals was to share these communities' learnings provincially, which has resulted in a set of helpful *Fact Sheets* to provide information on various aspects of community interaction between police and mental health consumers.[5]

The CMHA project clearly identified three major priorities:

- Hospital emergency wait times
- Lack of communication and information sharing protocols and systems
- Need for systematic continuing education on mental illness and crisis response

Possible remedies have been explored for this report through the existing research and literature on these topics and provincially with the BC Association of Chiefs of Police, individual police officers, hospital administrators, psychiatrists, psychiatric nurses, emergency mental health service professionals, and mental health patients and their families.

THE CURRENT DILEMMA : POLICE PERSPECTIVES

In British Columbia, as well as throughout Canada and elsewhere in North America, there is agreement amongst all concerned that with deinstitutionalization and the movement of people with severe mental illness into the community, the police have become frontline professionals who manage these individuals when they are in crisis.

In our society, the police have a duty to assume responsibility for persons with mental illness under two major principles of law:
(i) Their power and authority to protect the safety and welfare of the community
(ii) Their *parens patriae* obligations to protect individuals with disabilities.

Therefore, it is often the police who are in the role of gatekeeper in deciding whether a person with mental illness ends up in the mental health system or the criminal justice system. Unfortunately, criminalization can and does result if this role is not performed appropriately.[6,7]

Research consistently shows that people with mental illness are frequently the subject of police calls and use a substantial proportion of their resources.[8] Furthermore, there is a growing national awareness in Canada of the both the ethical issues and the economic burdens arising from this situation.[9, 10] (See Appendix A, p. 41)

At the community level, a community resource base approach has progressively evolved to try and help people with mental illness. Beginning with the premise that people with a mental illness can live full and complete lives in the community, the theory puts them at the centre of a care and support system that engages them in partnerships amongst themselves, their families, mental health service providers and other community services.[11] In fact, this community resource base approach fits well within the tenets of community policing, which are prevention, community empowerment, partnership development and problem solving.[12] Fundamentals of the contemporary model of policing reflect community involvement and teamwork – all indispensable to police working with people with mental illness.[13]

Because provincial and community mental health initiatives are compatible with community policing principles[14], some communities in British Columbia have developed police liaison programs to try and increase support for people with mental illness. Recent research on such programs states that 47% to 80% of police officers rate their mental health liaison programs as effective in meeting the needs of people in crisis, which is significantly higher than police departments without specialized programs.[15]

Community awareness of the value of police/mental health liaison programs has greatly increased in recent years. How this awareness translates into actual services and programs appears to vary across the province. A fundamental issue

is that while mental health services in British Columbia are primarily community based, for the most part they do not interact in a coordinated manner with hospital inpatient services. Other studies have noted that this lack of integration is one peril of community initiated program coordination, and that further work to overcome the schism between hospital and community care is imperative.[16]

As 'first responders' and gatekeepers of our mental health system, the police have been dubbed *Psychiatrists in Blue*.[17] However, as noted in 2004 by the Canadian Mental Health Association study— police are being forced to play their role without the necessary resources or support to carry it out properly.

A 25-year member of the Vancouver Police Department, currently commander of District One, which comprises most of the downtown core of Vancouver, asks:

> *Shouldn't all people who suffer from mental disorders receive appropriate and timely treatment and services so they don't end up in situations that place them in contact with the justice system? Shouldn't we have systems in place that effectively deal with people who are continually involved in a cycle of crime due to mental disorders and addictions? Perhaps these seem like unattainable goals, but I believe they must be the goals to strive for. People who have an illness must receive the treatment they need, so they can live healthy and productive lives.*[18]

A true story highlighted by the above-cited BC Justice Review reveals the sad history of "Danny", a person with mental illness who revolves in and out of the justice system. In many instances, psychiatrists' assessments and the fact that the person had been a patient at Riverview Hospital in 2000 were unknown by the court. (See *Danny's Story*, attached). Psychiatrists are an important professional group with excellent training, skills and influence, and they provide essential services in a variety of community contexts, but they are often left out of the picture. It is vital that they become more integrated in partnerships with other caregivers and professionals. Partnerships and committees that include ties with psychiatry would lead to better patient outcomes, and would also greatly assist the ongoing development of community police/mental health liaison programs.

APPENDIX

DANNY'S STORY

On July 6, 2003 Danny was seen knocking over newspaper boxes and café tables in the West End. He was arrested and held overnight to attend at the provincial court in Vancouver the next morning. He was held in custody because of his lengthy criminal record, which is primarily for property offences. On July 7th, he was brought before the court for a bail hearing. In court, he began screaming so much that the judge adjourned the case overnight so he could be seen by a doctor.

If Danny had been assessed before court, the judge would have had the relevant medical information at his first appearance.

Danny was seen by a psychiatric nurse overnight, and reappeared in court on July 8th. The medical report indicated he was "mentally fit" to understand the proceedings. So he was released on bail with conditions including that he report to the Forensic Outpatients Clinic, and take his medications as prescribed for as long as he consented to.

His conditions also required that he report to his probation officer if he withdrew his consent to take the medications prescribed. Upon hearing this, Danny said to the judge, "If you think I am going to follow these conditions, you're crazy". He was then released, and ordered to return to court on July 16 for another appearance before a judge.

The law in Canada requires offenders to consent to taking medical treatment when courts make this a condition of their release on bail.

The Provincial Court and probation office are located at the corner of Cordova and Main Streets. The Vancouver Forensic Commission and Outpatient Clinic is located in the 300 block of West Broadway, some thirty blocks away, directly through the heart of the skid row area. No arrangements were made to ensure he got to the clinic.

On July 16th, Danny did not come to court as required by the judge on the last court date. The judge issued a warrant for his arrest. On August 3rd, witnesses phoned the police with reports of Danny masturbating on a busy commercial street in the West End.

The police arrested him and he was held in custody overnight. The police report indicated he had no fixed address. At court, he refused to talk to a lawyer or a doctor, and spoke nonsense. Observing this behaviour, the judge ordered that he be held in custody so that a psychiatric assessment could be done within the next 30 days.

The location of these offences is significant because street crime and disorderly conduct, which used to be more concentrated in the Downtown Eastside, have spread across the Downtown area.

On September 2nd, Danny was brought back to court. The psychiatrist's assessment had uncovered a long history of psychoactive substance abuse, drug-induced psychosis and mild mental retardation, and that he had been an inpatient at Riverview Hospital in 2000. Once again, he met the definition of mental fitness for court purposes. He pleaded guilty to the disturbance charge from July 6th. The judge imposed a

suspended sentence and followed the psychiatrist's recommendation and ordered Danny to report to the Forensic Psychiatric Outpatient Clinic and take treatment as prescribed as long as he consented.

This was Danny's second identical order to attend the Psychiatric Outpatient Clinic. There was no information before this judge to show whether he had ever actually attended the outpatient clinic, or if he had any place to live. No attempt was made to specifically address his addiction problems either.

Back in the West End, Danny was sitting in an Internet café after midnight on September 18th. He appeared to be falling asleep, and an employee asked him to leave. He punched the employee in the face a destroyed a computer printer by pushing it off a table. He was once again arrested by the police and held in jail for court.

The next day, the information before the court made reference to Danny's addiction to crystal methamphetamine, but made no mention of his psychiatric history or assessments. Crown Counsel knew there had been a probation order made recently, but did not know its precise conditions. This time, Danny was released on bail on the condition he stay away from the café where the latest incident had occurred.

There was no built-in mechanism to alert justice system personnel to the fact that Danny had recently undergone a psychiatric assessment.

Given sufficient time, case histories could be assembled by each relevant component of the justice system, but there is currently little interface between systems to exchange information. The heavy volume and fast pace of remand courts in Vancouver allows little time to assemble background information.

The two most recent files were not correlated, so the judge on the September 2nd sentencing dealt only with the mental health issues, and the judge on the September 19th bail hearing was not aware of the mental health issues, and although aware of the addiction, did not address that issue. Neither attempted to address the homelessness issue.

On September 22nd, Danny was arrested for being in the vicinity of the Internet Café, contrary to the terms the judge placed on him when he was released the last time. He was annoying customers and staff at another coffee shop in the same area. He was charged with a new offence of breaching the conditions of his release on bail. When he was arrested, he had a glass pipe and several needles in his pockets, and admitted he was addicted to crystal methamphetamine.

When he was brought to court on September 24th, the duty counsel assigned to represent Danny told the court he could not get clear instructions from him. An overnight psychiatric assessment was ordered. The psychiatrist who saw him recommended that the judge order a futher, 30 day in custody assessment, which was completed on September 27th.

This order was made with no knowledge by the court of the previous court-ordered psychiatric assessment approximately one month before.

On October 18th the Forensic Psychiatric Services Commission notified the Court that Danny was still on their waiting list to be assessed and they had no report prepared for the hearing on mental fitness. At that point the judge conducted the fitness hearing by making her own inquiries of Danny and decided he met the legal test for mental fitness.

Crown Counsel asked the court to keep him in custody this time, but he was released and ordered not to go near either of the cafes in the West End, and once again to report to the Forensic Outpatient Clinic and to take his medication.

It is not uncommon for the waiting lists to be too long for assessments to be completed by the date ordered by the court. Judges can be reluctant to detain a person longer for this reason alone.

Danny failed to appear at his next court date on October 22. Warrants for his arrest were issued. The same day the police were called back to the coffee shop in the West End because Danny was refusing to leave. He was arrested on the outstanding warrants. He told the police he didn't care about the criminal charges and would continue to do what he pleased. He was taken to jail over the weekend.

When he appeared in custody in court on the 25th of October, with the assistance of a lawyer, he pleaded guilty to the assault, mischief and breach of bail charges. The judge gave credit for the time Danny had already spent in custody and sentenced him to 15 days total in jail on all charges. When he was released he would be on probation for one year with the same terms he had on bail, requiring him to stay away from the cafes, report to a probation officer and take treatment and prescribed.

These were exactly the same terms he was released on when sentenced on September 6th. Over the four month period, there were four separate police reports filed with Crown Counsel, 10 different Crown Counsel handled the files and Danny appeared before 4 different judges and an unknown number of Justices of the Peace. Each time he came to court, he appeared as one on a list of numerous persons charged with crimes (sometimes up to 50 a day in Bail Court, and up to 150 in Remand Court), many charged with much more serious offences. Up to 40 mentally ill offenders may appear in the courts at Main Street in Vancouver on any day.

Danny was just one of many. The situation facing him upon his release from the October 25th sentence would be no different than it was on July 6th when this story began, despite having appeared before the court 9 times. He would still be homeless, with an untreated mental disorder and drug addiction and he would be right back on the street in the West End.

This is a true story and Danny is a real person (Danny is not his real name).

POLICE INTERVENTION IN EMERGENCY PSYCHIATRIC CARE: A BLUEPRINT FOR CHANGE

EXECUTIVE SUMMARY

The purpose of this project was to examine factors influencing long wait times for police accompanying psychiatric patients in emergency wards in British Columbia hospitals, and to propose possible solutions to alleviate the problem.

To begin, it must be said that there is certainly hope to be found in some excellent police/mental health liaison programs that developed over the last few years through community initiatives. However, one of the major conclusions reached through our research and consultation is that systemic changes are required in the health care system and other systems that provide services for people with mental illness. Without such changes, it is unlikely that any specific recommendations for reducing police wait times can be wholly successful.

There is growing recognition and acknowledgement of our failure as a society to provide basic care for people with serious and persistent mental illness. Police are acutely aware of this fact, since they have the ultimate responsibility of attending when individuals and families find themselves in crisis situations in the community.

Most people consulted during this project noted that police duties to *serve and protect* people with mental illness have increased, contributing to resource shortages in other areas of police responsibility. Police data show that "street crime" offences and disorderly behaviour both represent a continual demand on police resources. There is a perceived lack of effective response to offences such as property theft and cars broken into, and there is an identified "capacity gap" for crime fighting and the prosecution of gang related crime in BC.

In addition to a chronic shortage of mental health and police resources, consultations with BC police, health care providers and justice workers consistently articulate the same theme – lack of coordination between systems that deal with the mentally ill.

In an attempt to overcome the numerous barriers caused by "stove pipe" budgets, overlapping jurisdictional authority, confidentiality concerns, plus a myriad of other challenges—clinicians and others have come together with the police to develop police/mental health liaison strategies within their own communities. In some areas, innovative approaches to helping people with mental illness and their families are becoming part of the fabric of the care system. It is evident that principles of contemporary community policing—prevention, community empowerment, partnership development and problem solving—fit well with the dedicated work of other agencies that support people with mental illness within the community.

But despite innovative efforts by some police and other professionals in our communities, there is dissatisfaction everywhere at the large number of seriously ill individuals who continue to fall through the cracks. While resource limitations are an obvious concern, the *lack of coordination and information sharing* between government ministries,

regional authorities, and community agencies is just as often identified as the culprit. Everyone is aware that, to some extent, results are typical of a system that is bifurcated with so many separate lines of accountability.

For many years, family and community advocacy groups have criticized "the mental health system" for its lack of resources and poor quality of care. Their complaints are finally now being echoed at the national and provincial levels of government, as well as by professional groups and policy, planning and administration officials.

When considering specific things that can help us move forward in BC, one encouraging fact is that British Columbia is fortunate in having good mental health legislation—although some professionals in the mental health field do not know the Mental Health Act well and therefore misinterpret it or underutilize it. The BC Mental Health Act for a type of conditional leave (*extended leave*) that should be helpful in dealing with the *revolving door* syndrome, whereby people with untreated mental illness continually rotate in and out of our health care and justice systems. In addition, the BC government provides concise guidelines that clarify the Freedom of Information and Protection of Privacy Act and specify how information may be shared for the purposes of continuity of care or if a person's health or safety is at risk. Again, many professionals working in mental health are unaware of these provisions. Knowledge of both these tools – the BC Mental Health Act *and* the guidelines for sharing personal health information – should be essential for all professionals involved in service delivery to the mentally ill.

A comprehensive provincial strategy is needed to (i) improve information-sharing between health, justice and social services; (ii) increase professional education and training; and (iii) standardize treatment guidelines and hospital discharge planning procedures for people with serious mental illness. Some key approaches suggested are:

- A high-level inter-ministry committee with representation from all ministries responsible for health care, social services, police and justice services to examine current provincial resource utilization for people with mental illness. A common observation in the literature and in consultation with professionals is that, ethics aside, not providing appropriate medical treatment, accommodation and rehabilitation for people who are ill to live with dignity in the community appears to be expensive when high use of hospital emergency, ambulance, police, and the courts are considered.

- Support for community police/mental health liaison programs, including resources for police/hospital protocol development, information management and evaluation. Promising community partnerships have been developed in British Columbia. However, many arrangements depend solely on courtesies extended by individual professionals to each other. Written protocols and ongoing evaluation models would not only help existing programs; they would foster similar program development throughout the province.

- Strategies for increasing awareness of BC's *Guide to the Mental Health Act.* Wider knowledge and distribution of this document would greatly improve communication not only between police and hospitals, but also at many levels of service delivery for people with mental illness in British Columbia.

- Support for Early Psychosis Intervention (EPI) programs. The age of onset for serious mental illness is usually mid teens to early twenties. The longer a mental illness is left untreated, the greater the risk that the young person's life will be permanently derailed. Research shows that a significant time period often separates the onset of psychotic symptoms and the initiation of appropriate treatment. The longer the illness goes untreated, the longer it takes for remission of symptoms, the lesser the degree of remission, and the greater the chance of early relapse. BC has led the way in developing a provincial initiative that has resulted in some excellent Early Psychosis programs – but some regions still lag woefully behind. To help prevent chronic mental illness from derailing young people's lives to point where police intervention is frequently required, BC must continue to create and sustain effective Early Psychosis Intervention programs that are inter-regional and can be accessed from anywhere in the province.

- Timely access to clinical care. Police are aware of the many people suffering from severe and persistent mental illness who live in a state of continuous psychosis, with no pattern of care or medical help. Untreated psychosis is associated with slower and less complete recovery, an inability to function in the community, increased risk of relapse, and substantial treatment resistance. Treatment is essential at the onset of chronic mental illness, so hospital or hospital-like care is particularly important for patients in the early phases of the illness. Access to hospital care is also important for individuals who are treatment-resistant, and for those who, from time to time in the course of their disease, need the extra care that only a hospital setting can provide.

- Mandated case management for people with severe and persistent mental illness would go a long way towards alleviating many of the difficulties faced by police. Ill people who are at risk for harms should be recognized and supported in treatment regimes for their own safety and for that of the general public.

- Chronic disease management strategies are needed for people with schizophrenia. The British Columbia Schizophrenia Society has asked that schizophrenia be added to the government's Chronic Disease Management list. Inclusion in the Chronic Disease Management program would help clear pathways to care and standardize treatment practices for this patient population, and improve population health outcomes and functional clinical outcomes.

THINGS WE CAN DO NOW

The *Blueprint for Change* report concludes by identifying three steps that can be taken immediately by police and regional health authorities to help reduce police wait times wait times with psychiatric patients in BC's hospital emergency rooms.

(1) Development of written protocols between individual police departments and the hospitals they attend while escorting psychiatric patients. Written protocols have proven to be extremely useful in several jurisdictions across Canada. This report's Appendix F offers a number of protocols developed between police and hospital emergency departments in Montreal, Winnipeg, Cornwall, and Vancouver, which might be adapted for use by communities in British Columbia.

(2) Ensure that hospital and community psychiatrists, nurses and all other professionals in British Columbia who work regularly with people with mental illness know of and have access to the BC *Guide to the Mental Health Act.* The *Guide to the Mental Health Act:*

- Clearly explains the meaning and use of the *Act*
- Offers advice specifically for police, doctors, other professionals and families
- Includes all pertinent legal forms, which may be copied for use
- Contains the BC government's *Freedom of Information and Protection of Privacy* (FOIPPA) *Fact Sheet,* which clarifies when—lacking patient consent— professionals can and should share information with other public bodies, family members and other caregivers for the purposes of continuity of care.

Despite government efforts to make this information widely known and easily available, consultation for the report revealed that there is still extensive misinterpretation of the *Mental Health Act,* and many misconceptions regarding "confidentiality". The BC *Guide to the Mental Health Act* contains important knowledge that should be transferred to where it is most needed in the health care regions. The *Guide* is available online at www.health.gov.bc.ca/mhd/mentalhealthact.html

(3) Evaluation of existing and new police/mental health liaison programs in British Columbia, with resources specifically allocated for this process. There is no doubt that police/mental health liaison programs will continue to grow as both police and regional health authorities advance the principles and practices of community mental health liaison services. Evaluation is critical to understanding outcomes, furthering our knowledge of how such programs are successful, and improving accountability. A generic *logic model* is highlighted in the *Blueprint for Change* report to help facilitate evaluation of police/mental health liaison programs. In addition, a concrete evaluation example of Victoria's police/mental health liaison program is provided. Both the logic model and the Victoria example of a successful evaluation from an already-existing BC program should prove useful templates for helping other communities design their own program evaluations.

Beginning with the above three steps and working together with the police, BC Regional Health Authorities can help alleviate some of the long wait times police experience in British Columbia's hospital psychiatric emergency departments.

At the same time, the larger communication and systems issues mentioned in this report must also be addressed in order to bring about meaningful change.

♦ ♦ ♦

RECOMMENDATIONS

This Report makes the following recommendations:

1. That the provincial government undertake the development of a high level inter-ministry committee to try to determine real costs of service delivery to people with mental illness and their families. Input from all ministries responsible for service delivery – most particularly health care, social services, and police and justice services – is required, although information from the Regional Health Authorities and the Ministry of Children and Family Development would also be critical to obtaining an accurate picture of current spending.

2. That Regional Health Authorities continue to encourage the development of community police/mental health liaisons in their regions, with an emphasis on:
    - Encouraging the development of written protocols for police and hospitals to establish agreed upon procedures and reasonable wait times with psychiatric patients in emergency departments. Where they exist, written protocols help reduce police wait times in hospital emergency departments by clarifying roles and responsibilities of police and hospital emergency staff.
    - Requesting that resources for evaluating police/mental health liaison initiatives be built in as a component of individual programs. Knowing whether program goals are being met and having access to data from evaluations can improve future planning for mental health service delivery by Regional Health Authorities.

3. That an educational initiative be undertaken to improve knowledge about British Columbia's *Guide to the Mental Health Act* among individuals who deliver mental health services to people with mental illness and their families. Targets should include the following professionals and university faculties that provide professional training:
    - Health care professionals in acute and community settings, with special focus on hospital emergency staff and community mental health workers
    - Social workers, particularly front-line Financial Aid Workers and professionals working with dysfunctional families
    - Justice and court officials at all levels of the legal system

4. That BC Regional Health Authorities continue to fund, encourage and monitor the development of Early Psychosis Intervention programs. This will help prevent chronic mental illness from derailing young people's lives to the point where families and others are forced to resort to the police and the criminal justice system as a means of accessing treatment for the young person.

5. That the provincial government consider mandated assertive case management (ACT) for people with severe and persistent mental illness who have accompanying functional disabilities and who are intensive users of the health care and justice systems. Assertive case management was defined as a BC *Best Practice* because controlled research studies link this approach to positive client outcomes, a feature that is missing from other case management models. Consistent with research evidence, it is expected that ACT will decrease hospital

utilization, improve individuals' level of functioning and decrease caregiver burden.

6. That the provincial government through the Ministry of Health add schizophrenia to BC's Chronic Disease Management list. Schizophrenia is a chronic life long illness that usually starts between ages 15-24. Modern treatment is available, and it works. Inclusion in the Chronic Disease Management program will assist the medical profession by clarifying pathways to care and standardized treatment practices. It will also assist people with schizophrenia by helping them find the best tools to manage their illness so that they can live with dignity in their communities. In addition, population health outcomes and functional clinical outcomes in British Columbia will be greatly improved.

Endnotes

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