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Community Emergency Psychiatric Service in Israel: A One-Year Experience

Razek Khawaled, MA,[1] Arie Bauer, MD,[1] Paola Rosca, MD,[1] Dafna Helman, MA,[2] Uzi Shai, MD,[2] Alexander Grinshpoon, MD, PhD,[3] and Alexander M. Ponizovsky, MD, PhD[1]

[1] *Mental Health Services, Ministry of Health, Jerusalem, Israel*
[2] *District Psychiatric Office, Tel Aviv, Israel*
[3] *Tirat Ha-Carmel Mental Health Center, Tirat Carmel, Israel*

Abstract: Background: In 2005 the Forensic Psychiatry Department of Mental Health Services at the Ministry of Health launched a pilot project: the Community Emergency Psychiatric Service (CEPS). The purpose was to offer community-based emergency response to acute psychiatric conditions during after-hours periods, including Saturdays and holidays. The project was implemented in the Tel Aviv, Central and Southern districts. *Method:* Advertisements were posted in mass circulating newspapers announcing the launching of the new program for the general public in the participating districts. The public was invited to call the hotline of the medical emergency service, Magen David Adom (MDA), in the event of psychiatric distress or emergency. MDA personnel were instructed to give the callers a telephone number of an on-call psychiatrist. The Ministry of Health engaged a pool of seven licensed psychiatrists to be available on-call one per shift. The psychiatrists offered crisis intervention over the phone or house visits when necessary. *Results:* Data were obtained from the Tel Aviv, Central and Southern Districts. The results show that there were 1,472 calls between May 2005 and June 2006. In 198 cases (13.5%) clients were referred for treatment and follow-up to local outpatient clinics, while in 116 of the cases (7.8%) a home visit by the on-call psychiatrist was carried out, resulting in 50 voluntary and 16 involuntary hospitalizations. An examination of records of calls received by the on-call psychiatrists (N=97) during August 2006 suggests that most callers fit the following profile: female, ranging in age 19–35, unmarried, with diagnosis of schizophrenia, with no previous psychiatric hospitalizations, and presenting no danger to herself or others. *Conclusions:* A limited response team, comprised of one on-call psychiatrist per shift, can provide a viable service for psychiatric emergencies in a population center of approximately 2.7 million. The findings also suggest that such a service may increase the number of referrals to outpatient clinics in the community as well as the number of voluntary and involuntary hospitalizations after working hours. The potential contribution of such a project to improving accessibility to outpatient psychiatric care and to reinforcing continuity of care among in- and out-patient facilities needs further investigation as is the important question of cost-effectiveness.

Introduction

In recent years, the growing sensitivity to human rights in general and to the rights of persons with mental illness or disorder in particular has led to a trend of limiting the use of compulsion in the management and treatment of those suffering from mental illness (1). At the same time awareness has been growing, both within the general public and among mental health professionals, of the need to invest resources in better management of acute and severe mental conditions, especially those likely to express themselves through violent behavior (2). According to prevailing approaches, the most effective response to such acute conditions is immediate intervention in the community, preferably as close to one's home environment as possible (3). It is assumed that such an approach is likely to reduce the need for involuntary hospitalization and may contribute to the prevention of decompensation and the development of intractable psychiatric conditions.

Address for Correspondence: Razek Khawaled, MA, Mental Health Services, Ministry of Health, 29 Rivka St., Jerusalem, 93461 Israel. E-mail: razek.haled@moh.health.gov.il

Emergency Psychiatric Services in Western Countries

The need for emergency psychiatric services has been recognized in many countries (4–11). Two main models of emergency response to acute psychiatric states and mental crisis can be identified: a) the model based on mental health ambulance services (5–10) and b) the model based on community care system, termed Community Emergency Psychiatric Services (CEPS) (3, 4, 11).

In Germany, where the first model is commonly used, psychiatric emergencies account for 15% of all emergency medical interventions (visits or calls), the fourth place after internal medicine, neurology and surgery, respectively (9). One survey (1996) found that members of the emergency medical staff require specific training in psychiatric interventions as well as in addiction medicine in order to cope with this volume of emergency psychiatric referrals. A survey of London's general ambulance service in the late 1990s showed that 40% of calls for an ambulance were related to psychiatric emergencies and could have been better handled by mental health professionals (10). In Denmark, primary care physicians routinely offer certain services, including telephone advice and triage, outside normal working hours. The introduction of this expanded service (begun in 1991), in fact, reduced the frequency of emergency calls outside working hours while at the same time raising markedly the level of client satisfaction (12).

A review of the literature reveals many studies investigating the effectiveness of mental health "ambulance services." The findings generally indicate that such services often have the effect of encouraging the transfer of patients from hospital care to community care and of reducing the risk of involvement with the criminal justice system (5–7). Clients also prefer that emergency interventions take place in the community, rather than in hospital settings, and derive greater benefit from community-based services (8). The advantages reported in the U.S.A. where 39 of the states provided the CEPS (4) include: a) more persons with mental disorders found their way to treatment, b) rapid intervention had the effect of reducing the acuteness of the crisis, and c) more of the mentally ill individuals were removed from criminalization into care and rehabilitation.

The second model, emergency psychiatric service based on psychiatric community care, has operated in the London borough of Lewisham since 1982 (10). The team delivering the service consists of a psychiatric nurse, a social worker and a psychiatry intern supervised by a senior psychiatrist. Depending on the client's condition, the team provides telephone intervention or a direct referral (avoiding the usual waiting time) to an outpatient clinic. A home visit, which includes psychiatric assessment and treatment in the client's home, and immediate hospitalization, is often also provided. This model was found to be effective also in cases of psychological crises that involve a temporary decline in coping and problem solving mechanisms resulting in severe anxiety, disorganization and even a breakdown (13). Team intervention at an early stage in the crisis can shore up defenses, improve the overall response to the stress and thus prevent a breakdown. The model is also capable of handling emergency cases that have already passed the preliminary crisis stage and require high accessibility to a CEPS and immediate intervention (14, 15). Although the model is not specifically designed to prevent hospitalization, it may prove effective in averting major crises among the mentally ill. For example, in cases where a psychotic patient enters a dangerous state or his/her condition deteriorates during a home leave (during the weekend when community care services are closed), the CEPS team can intervene rapidly and prevent the patient from further deteriorating and from harming himself or others.

Several studies have compared the effectiveness of emergency psychiatric interventions in a hospital setting to similar interventions in a community facility or in the client's home. The findings suggest that a community-based intervention is preferable from both team and client perspectives because it reduces the percentage of persons hospitalized as well as those hospitalized within a month following the crisis, without increasing the risk of rehospitalization (16, 17).

The situation in Israel

The rationale for the introduction of the CEPS in Israel is that the public community-based mental

health care system provides no services outside working hours, so that the only points of service available are the emergency rooms of general and psychiatric hospitals. To access this service those in need have to be able to get there, either by themselves or with help from their family members. In cases where this does not happen, deterioration is likely to occur, increasing the risk for destructive behavior or for involuntary hospitalization. Alternatively, the family members of mentally ill persons in such acute states would often end up calling the police, which, lacking the appropriate training would often respond inappropriately or refuse to respond at all, on the grounds that mental illness is not a police responsibility. A similar response comes from the emergency teams of MDA which are neither equipped nor trained for emergency mental health interventions.

Although home visits are suppose to be part of the basket of services to be provided by public sector mental health outpatient clinics, such visits are seldom carried out because of chronic shortage of staff. Periodically, home visits are requested by the District Psychiatrists, usually involving crises situations that fall under the provisions of the Mental Health Act, 1991 (18). Although not obligated to execute, the staff of the mental health clinics generally honor the District Psychiatrists' requests and carry out the visits. The only exception is the Mobile Unit project operated out of Abarbanel Mental Health Center (MHC) (Dr. S. Pigersky, personal communication, 2004). This unit was designed as an outreach service for individuals diagnosed with mental illness (F20-F29 according to ICD-10 [19]) who evidence multiple and frequent psychiatric hospitalizations. Clients receive, in their homes, individually tailored support services, psychotropic and psychological treatment. The aim is to strengthen the clients' coping mechanisms, reinforcing their motivation to invest in their own rehabilitation thus reducing the chances of rehospitalization. Apart from the Abarbanel program, Tirat Ha-Carmel Mental Health Center also operates a home care unit, designed to treat its own discharged patients who fail to attend the outpatient clinic for follow-up care (Dr. A. Grinshpoon's personal communication, 2006).

The purpose of this report is to describe the introduction of another preventive care approach (Emergency Psychiatric Services-CEPS) in the form of a limited response team, bringing together staff from the national MDA, serving as a screening hotline, and a one-person psychiatric intervention team.

Method

The CEPS project was developed as an initiative of the Mental Health Services at the Ministry of Health along with the Forensic Psychiatry Unit. The project's implementation began in May 2005 in the Tel Aviv and Central Districts with a pool of seven licensed psychiatrists. Another project, using a different model, was run in the Southern District where the emergency room team at Beersheba MHC acted as the emergency call center.

Table 1. *Summary of results of the program's first year of activity (May 2005–June 2006).*

	N	%
Overall Calls	1,472	100
Referrals to outpatient clinics	198	13.5
Home visits	116	7.9
Voluntary admission	50	3.4
Involuntary admission	16	1.1

At the start of the pilot project advertisements in Hebrew, Arabic and Russian were posted in mass circulating newspapers announcing the launching of the new program to the general public in the participating districts. The public was invited to call the hotline of MDA in the event of a psychiatric distress or emergency. The key actors in the service were the MDA dispatcher, the psychiatrist on-call and the District Psychiatrist. The main function of the MDA dispatchers is to take emergency 101 calls from the public and decide what MDA vehicle is **a**ppropriate to dispatch. Under the new project they also responded to calls occasioned by mental health emergencies. The Ministry of Health engaged a pool of seven licensed psychiatrists to be available on-call, one per shift. By the 25th of each month, the MDA dispatchers were given a list, drawn up by the District Psychiatrist, of the

names and telephone numbers of the next month's on-call psychiatrists. The dispatchers gave "mental health" callers the name and telephone number of that day's on-call psychiatrist.

Once the on-call psychiatrist received the call the following options for intervention were employed: a) counseling the caller over the phone, suggesting ways to resolve the crisis, including applying to public services in the community (hospital emergency room, outpatient clinic, etc.), and b) making a home visit, taking with him a medical treatment kit, including drugs for emergency administration. If the identified patient agrees to be examined and treated, the psychiatrist makes a provisional diagnosis and decides what further care and treatment measures are required, which may include giving the client a letter of referral to an appropriate agency. If the client does not consent to be examined and treated, then the on-call psychiatrist records the case and from the impression he had gained decides if the case meets the criteria established in the Mental Health Act, 1991 (18) for submitting a request to the District Psychiatrist for a Compulsory Examination Order. Payments for home visits are collected by the psychiatrist who conducts the visit, except for special cases according to a fee-waiver policy.

Results

Table 1 presents summary of results of the program's first year of activity between May 31, 2005 and June 1, 2006. As can be seen, a total of 1,472 calls were made to the on-call psychiatrists, of which 198 (13.5%) resulted in a referral to ambulatory care, 116 (7.8%) resulted in a home visit, 50 (3.4%) resulted (after the psychiatrist's examination) in voluntary hospitalization and 16 (1.1%) resulted in compulsory hospitalization.

Table 2 presents selected characteristics of all callers during August 2006 (N=97). An analysis of these characteristics suggests the following profile: female, ranging in age between 19 and 35 years old, unmarried, diagnosed with schizophrenia, having no history of psychiatric hospitalizations and presenting no danger to herself or others. The majority of the calls came from family members (61.2%), suggesting the close involvement of family members in the treatment process and a real concern for the health and safety for the identified patient. The family members were clearly worried that any deterioration in the family member's state might endanger the rest. The vast majority (90%) of the calls were not considered as requiring a home visit and a recommendation for ambulatory care was considered sufficient for 37.3% of the patients. Only 14.9% were referred to inpatient care and in most of these cases hospitalization was voluntary. In those cases where the on-call psychiatrist made no home visit, he followed up the case until the client began to turn to the care recommended. Forty-five cases (46.4% of callers) were related to a preliminary diagnosis of psychosis and involved crisis intervention or administration of psychotropic medication.

Discussion

The profile to which most callers fit in this study, an unmarried female diagnosed with schizophrenia, having no history of psychiatric hospitalizations and presenting no danger to herself or others, is very different from the one reported in other related studies, where most of the applicants for emergency mental care are men displaying signs of violence and dangerousness (2, 20, 21). Although, consistent with previous studies (21), most calls for intervention in this project concerned persons diagnosed with schizophrenia or with a psychotic state both constituting major risk factors for violent behavior (22), only 20% of the cases were assessed by the psychiatrists as dangerous to self or others and only 1% were hospitalized involuntarily. These figures belie the concerns expressed by some of the participating psychiatrists about being compelled to go out unescorted to home visits. The suggested profile also should dispel apprehensions, expressed by the professionals involved, of having to deal with individuals presenting with multiple and high risk medical and psychiatric pathologies.

The findings of this study suggest a number of research questions for future study. The first involves health economics and can be simply put: Is this service likely to prove cost-effective when all costs involved are factored in? It should be noted here that there is some evidence that CEPS models

Table 2. *Selected characteristics of all 97 callers during August 2006*

Characteristic	N	%
Gender		
Male	42	43.3
Female	55	56.7
Age group (yrs.)		
19–35	39	40.2
36–55	35	36.1
55 and older	17	17.5
Unknown	6	6.2
Marital status		
Single	42	43.3
Married	16	16.5
Divorced	25	25.8
Widowed	4	4.1
Unknown	10	10.3
Caller		
Family member	60	61.9
Patient	25	25.8
Carer	8	8.2
Other	4	4.1
Home visit		
Yes	10	10.3
No	87	89.7
Recommended care		
Outpatient clinic	36	37.1
Psychiatric hospitalization	14	14.4
Family doctor	12	12.4
Social services	4	4.1
No need	31	32.0
Violence risk for self/others		
Yes	20	20.6
No	77	79.4
Previous psychiatric hospitalization		
Yes	31	32.0
No	66	68.0
Diagnostic category		
Schizophrenia/psychosis	45	46.4
Depression/anxiety disorder	28	28.9
Personality disorder	10	10.3
No diagnosis	14	14.4

employing mobile units were found to be particularly cost-effective in the United States (4) and the cost of such an emergency service was found to be 23% less than the regular services available (3). The following are some other questions of interest to those involved in planning of services: Are the differing socio-economic characteristics and demographics of the various districts relevant for the design and implementation of such an emergency service and are they likely to affect its chances for success; what are the relative advantages and disadvantages of the two models used, the Tel Aviv/Central districts model where services were rendered by privately-contracted physicians as compared with the Southern model employing personnel of the government-owned regional psychiatric center. Alternately, it is worth considering and studying one of the existing overseas models taking into account the conclusion of Scott (3) that CEPS was a particularly important strategy for reducing expenditure both for psychiatric inpatient care and those relating to the criminal system, and for reducing the burden on families.

We suggest that in many cases CEPS plays a role in early detection and the treatment of emerging mental illness, thus contributing to prevention of further deterioration and hospitalization. Among those with known mental illness who are already receiving treatment the new community service may contribute to their sense of empowerment, increase the level of cooperation between them and their family members, improve adherence and otherwise improve the continuity of their care.

Finally, considering the anticipated reform in the mental health field in Israel which is set to transfer responsibility for mental health services to the health funds, the way the proposed psychiatric emergency service is funded should be reconsidered. Specifically, ways should be explored to include this service in the Basket of Services or at least to the list of service included in the complementary insurance.

In conclusion, the findings of this pilot project suggest that a one-person psychiatric team can provide a useful home-based service for individuals in crisis situation as well as to mentally ill individuals and their families. The project shows that a collaborative relationship between the office of

the District Psychiatrist and the national medical emergency service could be established and maintained. The potential contribution of such a project to increasing access to outpatient care, continuity of psychiatric care, linking various community – and inpatient-based services, as well as the important consideration of cost-effectiveness need further investigation.

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