Development Of Community Psychiatric Crisis Management Indicators And Assessment Framework In Taiwan: A Focus Group Study

Shu-Fang Su, PhD Candidate
National Taipei University of Nursing and Health Sciences
/ Bali Psychiatric center, Taiwan
Jiin-Ru Rong, PhD
National Taipei University of Nursing and Health Sciences, Taiwan
Jin-Biau Li, PhD Candidate
National Yang Ming University/ Bali Psychiatric center, Taiwan

Abstract
          This study was to develop the Community Psychiatric Crisis Management (CPCM) Model for community-dwelling psychiatric patients of Taiwan. **Purposes** of this study were: 1. To develop psychiatric patients' community crisis management indictors; 2. To develop the psychiatric patients' community crisis management framework. **Methods**: Three focus group interviews involving a total of 42 experts, included psychiatrists, psychiatric nurses, social worker, and community mental health service providers were implemented. Interview data were analyzed with qualitative content analysis. **Results:** The model of CPCM concretized the objectives, crisis assessment indicators, and crisis intervention services for community psychiatric patients, and proved to be an important part of CPCM. The level of crisis severity and impact of patient can be assessed by the four indicators: medical care seeking behaviors, psychiatric symptom severity and impact, history of violence and substance abuse, and protective factors of family and social support system. In addition, the severity and impact of CPCM score could be implement to provide home visiting care and crisis management interventions. The recommended CPCM model enabled community mental health care professionals' assessment and management the patient's crisis problems in three stages, from crisis, acute and maintenance stage. **Conclusions:** The CPCM model was improved practically, and the contents of the intervention were constructed. It is important to integrate crisis management with the preventive intervention to the community psychiatric patient care.

Introduction

World Health Organization (WHO) classified mental illness as one of the serious threats faced by human beings in the 21st century. The prevention, treatment, rehabilitation, and continuous care of mental illness are imperative to promotion of mental health (World Health Organization [WHO], 2010). Mental Health Act in Taiwan (2007) is an important act for promotion of mental health, which stipulates that Ministry of Health and Welfare (MOHW) shall provide psychiatric patients with psychiatric treatment and community continuing care services. In order to help patients adapt to community life, continue receiving psychiatric treatment and rehabilitation therapy, MOHW in Taiwan (2008) promulgated "Guidelines of Home Visit for Community Psychiatric Patients (GHV)", which provides basis for home visits services and case management of psychiatric patients in communities. Moreover, it is necessary to assist patients and their family members in community crisis management and provide them with community medical services to reduce repeated relapse or readmission of irregular medication or reduce their self-harming and harming behaviors.

However, severe psychiatric patients in communities are more likely to experience adverse events and undermine safety, including violence and suffering injury. The Guidelines of Home Visits (GHV) provide psychiatric patients in communities with a general guidance for home visits , but it cannot be monitored or prevention possible crises by psychiatric patients in community. The GHV not only creates workload of visitors, but also undermines the safety of patients, their family members, and community residents (Li, Shiau, Lao, Li, & Liu, 2008). Therefore, there is a need to review the actual situations of crises occurring to psychiatric patients in communities and develop the community psychiatric crisis management indicators and assessment framework for psychiatric patients, in order to improve the quality and effectiveness of crisis management for psychiatric patients in communities.

Reform of community psychiatric home visit service delivery models in reducing the community crisis events and number of relapse or re-hospitalization is a critical issue of community psychiatric care and which should never be overlooked. Therefore, two purposes of this study were: 1. To develop psychiatric patients' community crisis management indictors; 2. To develop the psychiatric patients' community crisis management framework. This study intended to use focus group to investigate the essential requirements of home visit services for psychiatry patients in communities, as well as collect the domestic and foreign studies concerning

the meanings of community care services for psychiatric patients, in order to develop crisis management indicators and assessment framework for psychiatric patients in communities in Taiwan.

I.
Medical behaviors of psychiatric patients in community

The one year follow-up study on psychiatric patients in communities in Taiwan found that, nearly 40% of patients, such as schizophrenia and affective disorder, were re-hospitalized in psychiatric hospitals due to relapse (Tseng, Chung, Chang, Chang, Lin, & Wu, 2014). Psychiatric patients living in communities face the distress caused by daily life management, psychiatric symptoms, poorly medication adherence, and multiple physical and psychological stresses (Shao, Chen, Chang, Lin, & Lin, 2013). It is important to assist psychiatric patients in regularly receiving psychiatric treatments and taking medicines, controlling psychiatric symptoms, quitting the use of substances, preventing them from hurting themselves or others, and implementing crisis management for them can effectively reduce the relapse of psychiatric patients (Armijo et al., 2013; Mellsop & Wilson, 2006; Olivares, Sermon, Hemels, & Schreiner, 2013; Killaspy et al.,2012). In particular, the assessment on occurrence of violence in patients, as well as crises and risks, is the core of crisis management, and its objective is to ensure the safety of patients, communities, and healthcare workers (Sands, 2012). Therefore, the work of community psychiatric care is not only to monitor the changes in patients' psychiatric symptoms, assess their regular medication treatment, prevent disease progression, and manage risk factors, but also to aggressively form an alliance among community, patients, and family members to reduce family members' stress of taking care of patients and strengthen community residents' understanding of psychiatric disorders (Kudless & White, 2007).

Risk Management of Psychiatric Patients in Communities

The relapse rate, readmission rate, suicide rate, and care cost of psychiatric patients living in communities and receiving case management all are lower than those of patients who do not receive case management (Simmonds, Coid, Joseph, Marriott, & Tyrer, 2001). In order to protect the safety of psychiatric patients and community residents or community healthcare workers, as well as prevent them from life, physical, or financial damages, there is an urgent need to include psychiatric patients in communities into crisis management system (Robert, Rebecca, David, Claire, &Andrew, 2009). Past studies showed that community crisis management can effectively reduce 75% of the chances of injuries of psychiatric patients or other personnel (Lewis, Taylor, & Parks, 2009). The

strategies of assessment on the risk factors and risk levels of community patients, control risk factors, change context of risk situation are core strategies of community crisis management (Buchanan, Binder, Norko, & Swartz, 2012).

Psychiatric patients living with supportive family members are more likely to maintain medication adherence behavior; however, when family members or patients hold an attitude of refusal, the risk of discontinuation of treatment is more likely to occur (Olfson, 1990; Shao, Chen, Chang, Lin, & Lin, 2013). Therefore, medication adherence has become an important indicator of relapse of psychiatric disorders or risk and crisis of occurrence of violence (Harris, Lovell, Day, & Roberts, 2009). The severity of psychiatric symptoms, occurrence of violence in patients, self-harming or harming behaviors, and social support are also important indicators for occurrence of crisis or disorder relapse in patients (Chatterjee, Patel, Chatterjee, & Weiss, 2003; Whitley, Gingerich, Lutz, & Mueser, 2009). In addition, the literature review on relapse of schizophrenia showed that, patients are associated with drug abuse have high rate of re-hospitalization and relapse (Olivares, Sermon, Hemels, & Schreiner, 2013). The risk factor of disease relapse appear alone or in combination of both risk factors above occur simultaneously, and the time of risk factor appears changes are the core indicators on community psychiatric patient crisis management (Skeem & Bibeau, 2008).

The home visit services in Taiwan for community psychiatric patients are mainly implemented by community health nurses and community mental health caregiving workers. Community home visitors bear a lot of intensive pressure, the effectiveness of home visits is usually limited by the manpower and competences of them. In addition, home visitors have not reached a consensus on crisis assessment indicators and classification of crisis levels. There is a lack of framework for community crisis management (Li,Shiau,Liao,Li,Liu,2008).This study intended to investigate the current status of home visits and care services for psychiatric patients in communities. In order to promote the community crisis management classification framework for psychiatric patients. Two research purposes of this study were: 1. To develop psychiatric patients' community crisis management indictors; 2. To develop the psychiatric patients' community crisis management framework.

Research Method
Participants

In order to comprehensively understand the situation of crises occurring of community psychiatric patients, professional healthcare workers' application of community crisis management, classification of

crisis severity of community patients, and planning of crisis management, this study used focus group interviews, and invited the health bureau managers (14 people), public health nurses (8 people), psychiatrists (8 people), psychiatry nurses (10 people), and social workers (2 people) as the main research participants. A total of 42 people participated in this study. Their average age was 40 years old, and their average seniority of taking care of psychiatric patients was over 15 years. The invited research subjects participated in the focus group, and a total of 3 focus groups were held.

Research procedures

This study used focus group interviews to collect data, recorded the interview content, and used content analysis to perform data analysis. The group leader used semi-structured open-ended questions to guide the research themes of group for participants to discuss about them and exchange opinions. The open questions were: 1. What are the actual experiences regarding to crisis situation occurring in community psychiatric patients? 2. What are necessary community crisis assessment indicators? 3. How to classify the severity level of crisis? 4. How to provide the frequency of home visit to prevente and manage crisis situation?

The group leaders are clinical psychiatric nursing experts who have the professional capacity of community mental health nursing. In addition, the group leaders are familiar with the issues of clinical and community psychiatric patients, and are able to host the discussions of focus groups. Before the focus group was held, the group leader explained the research purposes and procedures first, and then obtained the consent of research participants to record the focus group interview content. The group leaders were responsible for catalyzing the group during focus groups, and did not provide any opinions. It was hoped that the participants could express their experiences and opinions, and provide more additional opinions after discussion with other participants.

Data analysis

Upon completion of each focus group interview, the recorded data were typed and converted into transcriptions. This study chose critical conversations according to the research questions discussed in focus groups, and then extracted data using the experiences/events described by the research particpants as the unit. This study classified the content of the extracted events, and confirmed the dimensions and content reflected in data through the consensus meetings of research participants. The researcher developed the community crisis assessment indicators, classified the severity of crisis of psychiatric patients, and planned the crisis management of home

visits according to the descriptions of various dimensions of the research participants.

For the rigor of the research data, this study used four standards: credibility, dependability, transferability, and cofirmability to inspect data analysis. The data of this study were collected from clinical and community professionals with abundant experiences in psychiatric treatment and care, the researchers summarized and analysis the data concerning the current status of crisis management of psychiatric patients in Taiwan communities to reflect the authenticity and trustworthiness of data. The discussions of focus group were performed according to the research procedures, and the recorded content was converted into transcriptions. The three researchers analyzed and coded the data according to the research questions discussed in focus group after reading the transcriptions to reduce the involvement of subjectivity and increase the dependability of data. The research data analysis was jointly inspected by three researchers. The three researchers compared, classified, and conceptualized the data, repeatedly discussed about and inspected data, and confirmed and concluded the research results after they reached consensuses.

Results

This study divided the data collected from focus groups into 3 dimensions as follows: (1) the objectives of crisis management for community psychiatric patients; (2) the assessment indicators of crisis management; (3) the crisis management framework. The content analysis on various themes is as follows:

Objectives of crisis management for community psychiatric patients

According to the participants' experiences of crisis management for community psychiatric patients, they mainly suggested that, the priority objects of crisis management for psychiatric patients discharged from psychiatric hospitals, and they were mainly patients diagnosed with schizophrenia and affective disorder. The primary objective of home visits is to prevent and control community crisis. The objectives of crisis management in home visits of community psychiatric patients are (1) to ensure that psychiatric patients regularly seek medical treatments and take medicines; (2) to instruct and help patients and their family members (caregivers) understand risk factors forming crisis and management principles. The main concepts reflected by the research participants are summarized as follows:

"Although it is necessary to assist patients with psychiatric disorders in communities in going to school, starting a career, and receiving home care, the application of home visits alone may not do it. The

concept of home visits is excessively comprehensive. The focuses of home visits start with the perspective of risks management…such as the control of psychiatric symptoms and the control of medication. Only when patients are free from risk factors, can their development of autonomous and independent ability be assisted."

"From the perspective of patients' needs to community contexts, have the original six objectives of home visits exceeded the needs of community patients? We should focus on the prevention and control of crisis, especially patients and their family members. It is necessary to strengthen the explanations of risk factors which may lead to patients' repeated relapse after they return to communities."

"It is very important to clarify the objectives of community home visits! The effectiveness of existing manpower is limited. Therefore, the important objective is to implement well crisis management."

"We hope that we can also instruct and help family members manage relevant crises. We hope that we can instruct them in the focuses of how to manage crisis when they encounter it. It is necessary to prioritize the confirmation of content of critical indicator."

This study obtained the dimensions and critical items of crisis management indicators, such as "medical care seeking behavior", "psychiatric symptoms severity and impact", "risk factors of history of violence and substance abuse", and "protective factors of family and social support system" of communities psychiatric patients. These indicators could be used to assess and confirm the situation of community patients' crisis. The main concept of 4-indicators reflected by participants are summarized as follows:

Medical care seeking behavior

According to suggestions from empirical studies, important assessment factors were included, and whether patients regularly attend outpatient visits and regularly take medicines within the past month are the assessment focuses.

"At present, the most important focus of community care is risk factors. Communities will understand the changes in community patients through monthly supervision meetings. In fact, the workload is heavy. For example, we (a regional health authority) have to convene monthly meetings where public health nurses in 38 regions will attend. The workload (of reviewing the changes in every patient) is very heavy. If critical indicators can be established to assess the situation of patients' crisis, it will be more feasible to undertake the workload."

"In fact, it is very important for patients to regularly attend outpatient visits and take medicines on time. Medical compliance is imperative. In

terms of psychiatric patients, approximately 90% of patients will experience relapse if they do not take medicines for 3 months."

"Regular medical seeking refers to patients attending outpatient visits as scheduled. Some patients may attend outpatient visits monthly, bimonthly, or biweekly. It is important for them to attend outpatient visits according to the frequency. For medication, if patients are prescribed with drugs by psychiatrists, home visitors or family members have to check how the drugs should be taken. Some drugs may have to be taken in the morning, in the evening or at night. Home visitors should check whether patients take drugs on time according to their conditions."

Psychiatric symptoms severity and impact

The influence of psychiatric symptoms or disruptive behaviors on patients themselves or others and whether patients need other people's provision of assistance in life due to symptom distress were used as the assessment indicators of crisis management .

"As a matter of fact, many community patients still experience active symptoms. In order to understand whether patients will experience risks, it is very important to observe their psychiatric symptoms. However, it is still necessary to take into account whether the scores of risk factors are divided into the so-called high risks, moderate risks, and low risks."

"For example, if active symptoms affect daily life, there will be risks! Moreover, repeated hospitalization, other drug abuse or alcoholism issues, and violent or self-harming behaviors of patients are all crisis factors."

"Classification of risks should be in line with active psychiatric symptoms. However, classification of risks is not simply determined by psychiatric symptoms, and other factors should be taken into account."

Risk factors of history of violence and substance abuse

Some of the crisis management indicators and criteria for patients were summarized from important risk factors. Community patients experiencing the following situations are exposed to risks: (a). a history of violence (doing harm to self and others) within 1 year; (b). drug abuse or alcoholism. The patients experiencing the situations as above have a higher chance to experience crisis.

"During the first enrollment in communities, it is necessary to collect the risks factors in the past medical history of patients. We have noticed that a patient with a history of violence is likely to engage in violent behavior again. In addition, patients' paranoia, alcoholism, drug abuse, and caregiver's attitude (if caregiver may easily enrage patients) are also risk factors."

Protective factors of family and social support system:

Participants in focus groups suggested that community crisis management should take into account protective factors for community patients, which include (a). the family and social support functions (i.e. primary caregivers are over the age of 65); (b). whether there are other family members suffering from psychiatric disorders in patients' family (i.e. two people are psychiatric patients in the same family). The above showed that patients with poor functions of family or social support system have a higher chance of crisis in community.

"Whether patients are able to stably continue attending outpatient visits and taking medications in communities is also associated with family because whether family can provide supportive care also affects the occurrence of crisis in patients. Relations between the two are very strongly correlated."

"Moreover, the primary caregivers of some of the patients at home are family members over the age of 65 or there are two psychiatric patients living in the same family. It is necessary to consider that the chance of risks under such situations is higher."

"Community patient management is advised to include risk factors and protection factors of patients and their family members, as well as classify the levels of crisis for community patients."

"Our care experiences find that, it is necessary to observe family members' sensitivity to the care for patients. If family members deal with the problems of patients as early as possible, patients are more likely to live stably in communities."

"Family members are very important. If the functions of family members can be fulfilled, community patients can be taken care of and managed."

"Crisis management items should include the assessment items for primary caregivers over the age of 65. Crises are likely to take place when patients' condition is unstable or when there are at least two psychiatric patients in a family."

Crisis management framework for community psychiatric patients

Many scholars emphasized that managers make decision to manage crisis event, most of the manager will faced the challenge of uncertainty related to risk factors (Dervishi & Kadriu, 2014). In this study, the participants in focus groups suggested that, it is necessary to classify the levels of crises occurring to community patients, as well as provide different crisis prevention and management care according to their severe levels of crisis. This study integrated the concepts of participants of focus groups, and found that the severe levels of crisis of community patients can be defined from two axes, as well as the planning of crisis management services. One

axis is timeline, it takes into account the time frame setting of patients after they are discharged from psychiatric hospitals. The other axis is crisis management indicators and their critical items, such as "medical care seeking behaviors", "psychiatric symptoms severity and impact", "risk factors of history of violence and substance abuse" and "protective factors of family and social support system" . Each item was assigned 2 points, with a total score of 8 points. The higher score means the more unstable of patients' condition and the higher risk for crisis take place. This study concurrently assessed these two axes to define the classification of crisis management of community patients and the frequency of home visits.

Our current crisis management model identifies three severe level of crisis and manage stages, which are crisis, acute and maintenance stage. The three stages reflect the patients' adaptive or crisis responses. Moreover, the study results suggest a set of crisis management framework. For each stage, the health professionals should focus on the crisis indicators, identifies the severe level of crisis, and the nature of crisis intervention, and the expected outcome of crisis management. In addition, this study arranged and planned the time and frequency of home visits according to the levels of crisis of community patients. The classification of levels of crisis and management are as follows (see Table 1):

1. Level 3 –During the maintenance stage of crisis management, the assessment score is 0-2 points, patients can stable life in the community. Low intensity of home visits should be provided, and the recommended frequency of home visit is once annually.

2. Level 2 –During the acute stage of crisis management, the assessment score is 3-5 points, patients' have psychiatric symptoms and maladaptive mild responses in the community. For the intensity of home visits, the recommended frequency of home visit is once every 2-3 months.

3. Level 1 –During the crisis stage of crisis management, the assessment score is 3-5 points, patients' have psychiatric symptoms, live an unstable life and maladaptive responses in community. The recommended frequency of home visit is once every 2 weeks. Professional psychiatric team will be contacted to assist in mandatory psychiatric treatment, if necessary.

4. For patients who are recently discharged from psychiatric hospitals and returning to community, home visit should be implemented once each month. Six months after the continuous visits, it is necessary to assess the stability of patients' condition to re-adjust the frequency of home visits.

5. Case closure: this study suggested that, for patients living at home in communities who are able to maintain level 3 for 2 years, the termination of regular home visits may be considered since their condition is stable".

"For the classification of crisis management, both active symptoms and risk-related factors should be taken into account. However, for

risk factors, is there a definition for the scores of high risk, moderate risk, and low risk?"

"Patients' condition is dynamic. I feel that the classification should be simple to facilitate the assessment and arrangement of home visits or contact of psychiatric medical resources."

"Classification of community crisis is necessary. However, there are also difficulties in implementation. We actually encounter some people with psychiatric problems who do not view themselves as psychiatric patients. They ask you the reason why you (home visitors) send them to hospitals. It's a very tricky issue."

"It's simpler to use an assessment for to perform assessments. The assessment form should not be overly complicated to increase the difficulties of assessment and handling. In addition, relevant risk factors should be taken into account."

"For patients who are recently discharged from psychiatric hospitals, the first 3 months after discharge is the prime time for maintaining community care. Patients should be in a stable state when they are discharged from hospital. However, if they stop taking medicines again after discharge, the stability of their disease control will be affected. If they do not take medicines for three consecutive months, the change of relapse may be higher. Therefore, it is necessary to implement community home visits to patients who are recently discharged from hospital and follow-up their condition."

Table 1. Crisis Assessment and Management Framework for Patients with Psychiatric Disorders in Communities

Indicator	Mild level		Severe level
Medical care seeking behaviors	1. Regular seeking medical care within recent one month 2. Regular medicine taking within recent one month	1. Regular seeking medical care within recent one month 2. Irregular medicine taking within recent one month (1 point)	1. Irregular seeking medical care within recent one month (1 point) 2. Irregular medicine taking within recent one month (1 point)
Psychiatric symptoms severity and impact	1. Symptoms no impact to self and others 2.Daily living functioning independently	1. Symptoms impact to self and others (1 point) 2.Daily living functioning independently	1. Symptoms impact to self and others (1 point) 2.Daily living functioning dependently (1 point)
Risk factors	1. No history of violence 2. No substance or alcohol addiction	1. Has history of violence 2. No substance or alcohol addiction	1. Has history of violence (1 point) 2. Has history substance or alcohol addiction (1 point)

Protective factors	1. Proper family /social support system and functioning 2. No family member with mental illness		1. Weak family/social support system (1 point) 2. No family member with mental illness	1. Weak family/social support system (1 point) 2. Family member(s) with mental illness (1 point)
Crisis Level and stages	Newly discharged patients	Level 3 Maintenace stage	Level 2 Acute stage	Level 1 Crisis stage
The Score of crisis level	0-2 point		3-5 point	6-8 point
Home Visiting frequency	Once per month for newly discharged patients Once per Year after monthly visit for six consecutive months		Once every two or three months	Once per 2 weeks
Closed case	After visit for 2Year			

Discussion

The patients with psychiatric disorders receiving the service of home visits in communities investigated in this study are patients diagnosed with psychiatric disorder by psychiatrist, and they reflect abnormalities in psychiatric conditions, such as thinking, emotions, perception, cognition, and behavior, which lead to barriers in their adaptation to life functions. These patients are those with psychiatric patients who need medical treatment and care (Lai, 2015). However, those with antisocial personality disorder were not included. The disorders and problems of psychiatric patients may vary with whether they regularly receive treatments and the status of their life contexts. It is difficult to implement disease prevention and management for crises of community patients. Moreover, the standards for termination of management of community patients are different. The moving or death of patients are usually used as case closure indicators, leading to the constant accumulation of number of patients receiving home visits in communities. The workload of home visitors is heavy, so it is more difficult for them to properly implement crisis management.

For the prevention of disease relapse and crisis management for psychiatric patients in communities, it is necessary to pay attention to changes in patients' psychiatric symptoms, as well as to consider patients' medication management (whether patients regularly take medicines), regular outpatient visits, participation in rehabilitation therapy activities, violent behavior, and social support, which all are important factors affecting stable control of disease and relapse of psychiatric patients in communities (Olivares, Sermon, Hemels, & Schreiner, 2013). For psychiatric patients who are recently discharged from hospital, 6 months to 1 year after discharge is

the critical period for implementation of case management for psychiatric patients in communities (Shao, Chen, Chang, Lin, & Lin, 2013; Ucok, Polat, Cakir & Genc, 2006). If case management can be implemented within 6 months after patients are discharged from hospitals, relapse rate can be reduced. Therefore, it is necessary to plan multiple home visits and case management services for psychiatric patients who are recently discharged from hospital to ensure that psychiatric patients can continue receiving treatment after they are discharged from hospital.

This study set up the objectives, indicators, and critical assessment items of crisis management for psychiatric patients in communities according to the discussions of experts in psychiatric treatment and care and actual community workers. This study used patients' medical seeking behavior, change and interference of psychiatric symptoms, risk factors, and protective factors as important indicators, and developed critical assessment items. The indicators and factors of the framework leading to relapse of psychiatric disorders are associated with the content emphasized in literature of crisis management. Moreover, psychiatric patients in communities in Taiwan usually live with family members or live in the same community with their family members (Lin, Wen, Chai, & Huseh, 2010). Family support is an important protective factor for psychiatric patients to live in communities. After the discussions in focus groups, this study suggested that, the potential protective factors of community patients should be included as crisis assessment indicators. The protective factors defined in this study mainly refer to the supportive functions fulfilled by patients' family and social support systems. Sufficient protective factors can reduce the influence of risk factors. However, if the supportive functions of protection factors are weak, it is necessary to take into account the negative impact of crisis occurring to psychiatric patients in communities.

On the other hand, for the failure to effectively implement crisis management for community patients, this study suggested that it is necessary to specifically develop the classification framework of severe levels of crisis for community patients. Apart from critical factors for crisis, crisis items should be scored to distinguish the levels of crisis occurring to community patients, and different crisis prevention and management care should be provided. Moreover, patients' medical seeking behaviors, symptomatic impact, risk factors, and protection factors should be classified and assessed to determine the stable or unstable conditions of disorders and life of patients, as well as to develop a quantitative standard for classification of patients' crisis. Furthermore, the frequency of home visits and case management should be determined and implemented according to such a classification standard. For the meanings of management and care services, prevention and control of crisis in communities should be assisted using the

confirmation of regular outpatient visits and medication of patients with psychiatric disorders, as well as the instruction and assistance in patients or family members (caregivers) in understanding the formation of crisis factors and handling principles.

The participants in focus groups all indicated that, competent health authorities should be advised to include crisis prevention and management framework into the system of case management for psychiatric disorders in communities. Therefore, future community psychiatry management is advised to refer to this study's suggestions on community crisis control to include actual implementation items and continue collecting data to understand implementation status in communities, community workers' implementation of case management for psychiatric patients in communities, and difficulties encountered during actual implementation, in order to continuously review and improve them. It is also necessary to include crisis management for psychiatric patients in communities into educational training for community workers.

Conclusion:

This study referred to "Guidelines for Community Home Visits for Psychiatric Patients" promulgated by Ministry of Health and Welfare (2008) to perform reviews and propose suggestions on revisions. Moreover, this study suggested that the development of primary objectives of home visits is the consensus for prevention and control community crisis. Psychiatric patients who are recently discharged from psychiatric hospitals should be the priority objects of crisis management for community psychiatric disorders crisis. This study selected patients' medical seeking behavior, psychiatric symptoms and disruptive behaviors, risk factors, and protection factors as the critical indicators for crisis management for community psychiatric disorders. In addition, the levels of crisis of patients were managed and classified according to the stability or instability of disease and life, which is also used as the basis for determining frequency of home visits and providing services of case management.

References:

Armijo, J., Mendez, E., Morales, R., Schilling, S., Castro, A., Alvarado, R., et al. (2013). Efficacy of community treatments for schizophrenia and other psychotic disorders: A literature review. *Front Psychiatry, 4*, 116. doi: 10.3389/fpsyt.2013.00116

Buchanan,A.,Binder,R., Norko,M**.,** Swartz,M**. (2012).** Psychiatric violence risk assessment. *The American Journal Of Psychiatry , 169* (3), 340.

Chatterjee, S., Patel, V., Chatterjee, A., & Weiss, H. A. (2003). Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *The British Journal of Psychiatry, 182*, 57-62.

Dervishi, A,& Kadriu,i. (2014). Decision making under the conditions of risk and uncertainty in some enterprises of prishitina and ferzajc, *European Scientific Journal, 1*(1)224-228.

Harris, N., Lovell, K., Day, J., & Roberts, C. (2009). An evaluation of a medication management training programme for community mental health professionals; service user level outcomes: A cluster randomised contr olled trial. *International Journal Of Nursing Studies, 46*(5), 645-652. doi:10.1016/j.ijnurstu.2008.10.010

Killaspy, H., White, S., Wright, C., Taylor, T. L., Turton, P., et al. (2012). Quality of longer term mental health facilities in Europe: Validation of the quality indicator for rehabilitative care against service users' views. *PLoS One, 7*(6), e38070. doi:10.1371/journal.pone.0038070

Kudless, M. W. & White, J.H. (2007). Competencies and roles of community mental health nurses. *Journal of Psychosocial Nursing and Mental Health Services. 45* (5), 36-44

Lai, S.L. (2015). Mental illness prevention and control work instructions and discussion. Retrieved from http://www.mohw.gov.tw/MOHW_Upload/doc/%E7%B2%BE%E7%A5%9E%E7%96%BE%E7%97%85%E9%98%B2%E6%B2%BB%E7%A7%91_0050202002.pdf

Li, J. B., Shiau, S. J., Liao, S. C., Li, I. L., & Liu, W. I.. (2008). The exploration of the services offered for psychiatric patients though the continuing community care services. *The Journal of Psychiatric Mental Health Nursing, 3*(1), 20-27.

Lin, E.C.L., Wen, W.C., Chai,. Q.H., Huseh, C.H. (2010). Barriers to reintegrate to community for psychiatric outpatients. *J. of Hungkung University, 61*, 26-39

Lewis, M., Taylor, K., & Parks, J. (2009). Crisis prevention management: A program to reduce the use of seclusion and restraint in an inpatient mental health setting . *Mental Health Nursing, 30* (3), 159-64 .

Mellsop, G., & Wilson, J. (2006). Outcome measures in mental health services: Humpty Dumpty is alive and well. *Australasian Psychiatry, 14*(2), 137-140.

Ministry of Health and Welfare, Taiwan, ROC. (2007). *Mental Health Act*. Retrieved from http://law.moj.gov.tw/Eng/LawClass/LawAll.aspx?PCode=L0020030

Ministry of Health and Welfare, Taiwan, ROC. (2008). Practices of severe mental illness patient mandatory community treatment. Retrieved from http://dohlaw.doh.gov.tw/Chi/FLAW/FLAWDAT01.asp?lsid=FL013543

Olfson, M. (1990). Assertive community treatment: An evaluation of the experimental evidence. *Hosp Community Psychiatry, 41*(6), 634-641; discussion 649-651.

Olivares, J. M., Sermon, J., Hemels, M., & Schreiner, A. (2013). Definitions and drivers of relapse in patients with schizophrenia: A systematic literature review. *Ann Gen Psychiatry, 12*(1), 32. doi:10.1186/1744-8 59X-12-32

Robert,L., Becca,H., David ,D., Claire, N., & Andrew, C. (2009). Application of a Model for the Development of a Mental Health Service Delivery Collaboration Between Police and the Health Service. *Mental Health Nursing*, *30*, 337–341.

Sands, N., Elsom, S., Gerdtz, M., & Khaw, D. (2012). Mental health-related risk factors for violence: using the evidence to guide mental health triage decision making. *Journal of Psychiatric and Mental Health Nursing, 19* (8), 690-701.

Shao, W. C., Chen, H., Chang, Y. F., Lin, W. C., & Lin, C. L. (2013). The relation ship between medication adherence and rehospitalization: A prospective study of schizophrenia patients discharged from psychiatric acute wards. *The Journal of Nursing*, *60*(5), 31-40. doi:10.6224/JN.60.5.31

Simmonds, S., Coid, J., Joseph, P., Marriott, S., & Tyrer, P. (2001). Community mental health team management in severe mental illness: a systematic review. *Br J Psychiatry, 178*, 497-502; discussion 503-495.

Skeem, J. & Bibeau. L. (2008). How does violence potential relate to crisis intervention team responses to emergencies? *Psychiatric Services, 59* (2), 201-204.

Tseng, P. T., Chung, W. L., Chang, C. H., Chang, Y. C., Lin, P. Y., & Wu, C. K. (2014). Re-hospitalization rates and associated risk factors in schizophrenia and affective disorder patients at a local mental hospital in Taiwan. *Taiwanese Journal of Psychiatry*, *28*(4), 258-265.

Uçok, A., Polat, **A.,** Cakir, **S**., & Genç, A. (2006). One year outcome in first episode schizophrenia. Predictors of relapse. *European Archives Of Psychiatry And Clinical Neuroscience, 256* (1), 37-43.

Whitley, R., Gingerich, S., Lutz, W. J., & Mueser, K. T. (2009). Implementing the illness management and recovery program in community mental health settings: Facilitators and barriers. *Psychiatric Services, 60*(2), 202-209. doi: 10.1176/appi.ps.60.2.202

World Health Organization. (2010). *Mental health: Strengthening our response*. Retrieved from http://www.who.int/mediacentre/factsheets/fs220/en/