

**REDUCING EMERGENCY ROOM WAIT TIMES FOR  
PEOPLE IN PSYCHIATRIC DISTRESS:**

**RECOMMENDATIONS FROM THE  
SCHIZOPHRENIA SOCIETY OF ONTARIO**

**October 2008**



A REASON TO HOPE • THE MEANS TO COPE  
SCHIZOPHRENIA SOCIETY OF ONTARIO

SOCIÉTÉ ONTARIENNE DE LA SCHIZOPHRÉNIE  
UNE SOURCE D'ESPOIR • DE SOUTIEN ET D'ENTRAIDE

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## **Executive Summary**

The Schizophrenia Society of Ontario (SSO) is a non-profit organization with a mission to improve the quality of life for individuals and families affected by schizophrenia through education, support, awareness raising, public policy & research. The SSO has found that long wait times in emergency rooms are a major source of frustration for people living with schizophrenia and their families. Indeed, the factors associated with these long wait times, such as insufficient community-based services and a lack of capacity within hospitals to address emergency psychiatric issues, are a reality that its members have been coping with for years.

Accordingly, this paper provides feasible recommendations to the Ministry of Health and Long-Term Care on how to allocate funds in a way that will have a real impact on ER wait times for individuals in psychiatric distress. It does so by translating the grassroots experience of people who work within the mental health system into simple actions that would be relatively easy to implement.

To begin with, the Schizophrenia Society of Ontario urges the Government of Ontario to add a Psychiatric ER Wait Times component to its larger ER Wait Times Strategy, which would ideally focus on the enhancement of community-based mental health services while concurrently continuing to make improvements in hospital-based mental health care and access to care in the ER.

Three areas of focus are contemplated: Enhancements in the Community; Enhancements in Hospitals; and Enhancements in Hospital-Community Collaboration. More specifically, the Schizophrenia Society of Ontario recommends that the Government of Ontario should:

1. Increase the Number of Supportive Housing Units in Ontario;
2. Increase funding for intensive community-based treatment models such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM);
3. Increase Funding for 24/7 Crisis Response Services in the Community, Including Mobile Crisis Intervention Teams, Crisis Centres, and Short-term Residential Beds;
4. Increase Emphasis on Primary Care and Prevention;
5. Increase the Number of Acute Care Psychiatric Beds in Schedule 1 Facilities;
6. Implement Crisis Workers in Every ER in Ontario;
7. Promote Training in Mental Health De-Escalation Techniques for ER Staff, Including Security;
8. Implement More Extended-Observation or “Short Stay” Beds in High-Volume ERs;
9. Fund and Promote Collaborative Hospital-Community Programming;
10. Implement ER Diversion Programs/Community Mental Health Liaison Programs in High Volume ERs; and
11. Fund Effective Outpatient Programs for Patients Who Require Ongoing Treatment.

## FOREWORD

The Schizophrenia Society of Ontario (SSO) is a non-profit organization with a mission to improve the quality of life for individuals and families affected by schizophrenia through education, support, awareness raising, public policy & research. The SSO Ontario has a network of twenty chapters, eight regional offices and more than 500 active volunteers across the province. Reaching over 30,000 people each year, it is the largest organization representing people affected by schizophrenia in Ontario.

Advocacy on behalf of people with serious mental illness and their families is part of SSO's core mandate. In our strategic planning activities, our organization has chosen Access to Treatment as its three-year advocacy priority. For the year 2007-2008 in particular, our focus has been on the issue of psychiatric wait times, which includes wait times in hospital emergency rooms. In our pre-budget advocacy campaign, we called upon members of the public to write to their local government officials, advocating that emergency room (ER) wait times be added to the Ontario government's Wait Times Strategy. Our experience tells us that long wait times in emergency rooms are a major source of frustration for people living with schizophrenia and their families. Furthermore, the factors associated with these long wait times, such as insufficient community-based services and a lack of acute care psychiatric beds, are a reality that our members have been coping with for years.

We applaud the Ontario government for adding ER wait times to the provincial Wait Times Strategy. The \$180 million allocated over the next three years to provide incentives to make continuous improvements in emergency-department wait times and patient satisfaction will go a long way towards decreasing wait times in the ER for all Ontarians, including those who present to the ER in psychiatric distress. The \$80 million allocated towards the community mental health and addictions sector is also much needed during this time. As we will demonstrate in this paper, adequately-funded, comprehensive community-based mental health services are vital in decreasing pressure on emergency services.

The Ministry of Health and Long-Term Care has some important decisions to make regarding how to allocate these investments. For this reason, we have decided to focus our recommendations on **practical, feasible solutions which have shown to be effective at the front lines of mental health care**. These recommendations, though well-substantiated by the existing research and positions on this issue, are first and foremost rooted in the community, as they are informed by those working in the hospital and community sectors themselves. Over the course of our research, we interviewed over thirty individuals from small community mental health agencies, large mental health and addiction organizations, shelters, crisis intervention teams, and hospitals. Though the recommendations we discuss in this paper are those of our organization only, we are confident that they reflect the views of many in the hospital and community sectors.

Special thanks to all those who shared their thoughts with us over the course of our research:

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*Raymond Chung – Executive Director, Hong Fook Mental Health Association*  
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*Dr. Ashok Sharma – Common Chief of Staff, Grand River Hospital and St. Mary’s Hospital*  
*Paul Bruce – COTA Health, Saul Goodman – North York General Hospital, Rishika Williams – Toronto North Support Services, and Mary Compton – St. Elizabeth Health Care, North York General ER Diversion Project Team*  
*Alison Hunt – Manager of CTO Coordination Services, Centre for Addiction and Mental Health*  
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## **INTRODUCTION**

It is well known amongst the general public that patient wait times to access treatment in the Emergency Room (ER) can be quite lengthy. The Ministry of Health and Long-Term Care (MOHLTC) is to be lauded for its ongoing effort to reduce ER wait times, by adding this component to its Provincial Wait Times Strategy. This strategy will go a long way in ensuring that targets for wait times are met for people who present to the ER with a wide range of needs. Significantly, persons presenting to the ER in psychiatric distress account for a significant percentage of the overall number of persons who visit ERs, and continue as a group to experience unusually long ER wait times.

The Schizophrenia Society of Ontario (SSO) therefore recommends that the Ministry add a Psychiatric ER Wait Times sub-component to its larger ER Wait Times Strategy. In particular, the MOHLTC is urged to focus on the enhancement of community mental health services, while continuing to look at ways to make improvements within hospitals to reduce ER wait times for people with serious mental illness.

## **PURPOSE**

The purpose of this paper is to provide feasible recommendations to the Ministry of Health and Long-Term Care on how to allocate funds in a way that will have a real impact on ER wait times for individuals in psychiatric distress. It aims to accomplish this by translating the grassroots experience of people who work within the mental health system into simple actions that would be relatively easy to implement.

The Schizophrenia Society of Ontario's recommendations would be highly effective if adopted for several reasons. Chief among them is the fact that this paper is community-informed, evidence-based, and peer reviewed not only through a review of the existing literature, but the conduct of extensive key informant interviews and circulation of a working draft amongst various contacts in hospitals community organizations. Furthermore, our recommendations are patient-centred, and are consistent with the direction of the MOHLTC in that they focus on the needs of the individual patient and look to design systems around these needs. Specific treatment and service delivery approaches have been explored and due consideration has been given to both hospital-based and community-based roles in an effort to improve mental health service access. The cost-effectiveness and savings ramifications of particular options and models have also been taken into consideration in the recommendations we have made.

## **CONTEXT**

Emergency department overcrowding has been defined as "a situation in which the demand for emergency services exceeds the ability of an emergency department to provide quality care within acceptable time frames."<sup>1</sup> Indeed, there has been evidence of both an increased volume of people presenting to the ER with psychiatric issues and an increase in the complexity of these cases.<sup>2</sup> The result has been lengthy wait times in the ER for people presenting in psychiatric distress.

All of these factors have jointly created a clear disconnect between the needs of individuals suffering from mental illness who are presenting to the ER and the capacity of hospitals to

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<sup>1</sup> Improving Access to Emergency Care: Addressing System Issues - Physician Hospital Care Committee - OHA, OMA, MOHLTC.

<sup>2</sup> Emerging trends and training issues in the psychiatric emergency room. Canadian Psychiatric Association Position Paper.

address their needs. Indeed, it is clear that the health system which currently exists in Ontario does not have the capacity to meet the needs of people with mental illness. The process of deinstitutionalization which the province embarked on in the 1970s was never completed in that there was a failure to sufficiently invest in community support services for persons with serious mental illness. Moreover, there is evidence to show that while community-based care is the preferred approach for many individuals, there are still many people who, at varying points in their recovery, require hospital-based care. As such, a comprehensive continuum of care which meets the range of needs of individuals with mental illness is necessary to ensure that the right services are utilized for the right reasons at the right time. Until then, the emergency room will remain an over-utilized core service.

### **KEY QUESTIONS**

In coming to understand the crisis of excessive emergency room wait times for patients with psychiatric emergencies or in mental health crises, the SSO sought the answer to three key questions. Specifically, these questions are:

- Why are people with mental health issues presenting to the ER in psychiatric distress?
- Why are people with mental health issues waiting in the ER for assessment and treatment?
- Why do people with mental health issues return to the ER after receiving care in hospital?

#### **1. Why are People with Mental Health Issues Presenting to the ER in Psychiatric Distress?**

A significant number of people present to the ER with mental health issues, mainly because there are simply not enough comprehensive community-based mental health services to prevent psychiatric emergencies and mental health crises from occurring in the first place, as previously noted. This includes mental healthcare needs either through community-based mental health agencies or family physicians, as well as psychosocial needs such as housing, employment, and income support.

Furthermore, it has also been found that there are not enough alternative crisis services offered in the community setting, as opposed to the hospital setting in ERs. Worse still, even where alternate crisis services do exist, there tends to be a lack of awareness and understanding about them not only amongst the general public, but hospital staff members and even other community organizations. This is further exacerbated by the fact that many crisis response services do not operate on a 24/7 basis, and therefore are not available in the evenings and on weekends. Accordingly, persons in extreme mental or emotional duress are compelled to seek assistance in hospitals by default rather than choice.

#### **2. Why are Persons with Mental Health Issues Waiting in the ER for Assessment and Treatment?**

The first reason that many persons with mental illness are forced to wait for ER access and service is that initial patient screening and assessment is not conducted in a timely manner. Due to a lack of hospital human resources, and a general overcrowding of ERs, many individuals are forced to wait hours before they are initially assessed by an ER physician. In addition to this, psychiatric symptoms are often triaged too low and are accordingly given a low priority by some

ER physicians. However, triage guidelines for psychiatric emergencies clearly state that such cases be given high or top priority.<sup>3</sup>

Furthermore, many ERs do not have the capacity to manage difficult or aggressive patients: 45% of hospitals in Ontario do not have seclusion rooms, and 73% of them are forced to permit agitated patients to overflow into ERs with the use of physical and chemical restraints. The expertise to address the needs of persons in psychiatric crisis does not exist in many ERs in Ontario - indeed, only 31% of hospitals in Ontario have a crisis team in the ER, while a mere 21% have a mental health nurse or crisis worker to assist physicians and psychiatrists.<sup>4</sup> Complex psychological and psychiatric needs are difficult to address in the ER setting without staff who are experienced in and dedicated to handling such issues - this is undoubtedly another factor creating delays within the ER.

Beyond this, there seems to exist a bottleneck within ERs created by the lack of capacity in areas connected to this service. First, there are simply not enough psychiatric beds in the system to accommodate all who need them the moment they step into the ER. Accordingly, ERs must sometimes serve as places of temporary layover for persons in psychiatric distress or mental health crisis. 57% of hospitals in Ontario presently hold persons who require inpatient admission in the ER until beds become available.<sup>5</sup>

For those who do not need emergency medical care, many are “trapped” in the ER setting simply because there are no other safe and appropriate places to divert them to, especially in the evening and on weekends.

### **3. Why do People with Mental Health Issues Return to the ER after Receiving Care There?**

One of the factors leading to relapse and subsequent ER readmission is poor discharge planning. One of the biggest gaps in the system seems to be in this area. Those who receive care in the hospital are often discharged prematurely, which increases the risk of relapse. Even those who do receive the necessary level and length of care are often not properly transitioned into community-based care to maintain their treatment plan, as is evidenced by the fact that nearly 40% of patients hospitalized for schizophrenia are readmitted within one year of their discharge.<sup>6</sup> There are presently simply too few resources dedicated to discharge planning to ensure an effective continuum of care through referral to community mental health agencies and organizations.

Even when referrals are made, many consumers still fall through the cracks due to the fact that they are not directly connected to the services they require. A recognition must be made that many persons with serious mental illness have unique needs due to their cognitive symptoms, and as such require more support during their transition from hospital to community-based care.

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<sup>3</sup> Section 5 of “Revisions to the Canadian Emergency Department Triage and Acuity Scale” at the Canadian Association of Emergency Physicians Website at:

<http://www.caep.ca/template.asp?id=6211773f962e43b8ac1eab982b36b3ad>.

<sup>4</sup> Kelly K. Anderson and Jennifer Brasch, M.D. Emergency Psychiatric Services in Ontario. *Ontario Medical Review*, 72 (3) March 2005.

<sup>5</sup> See Anderson and Brasch above.

<sup>6</sup> Hospital Length of Stay and Readmission for Individuals Diagnosed with Schizophrenia: Are they Related? *Analysis in Brief* (April 17,2008). Canadian Institute for Health Information.

## **KEY FINDINGS**

During our consultation process, the Schizophrenia Society of Ontario learned a number of things about the state of mental health care in Ontario as it pertains to emergency room access. Our recommendations are therefore based on the following three key findings:

1. Not everyone who presents to the ER in psychiatric distress requires emergency medical care;
2. Improved access to appropriate supports in the community supports can decrease pressure on the ER; and
3. Hospital-community integration is essential to ensuring an effective mental health continuum of care.

### **1. Not Everyone Who Presents to the ER in Psychiatric Distress Requires Emergency Medical Care.**

A basic premise of this report is that not all those who are presenting to the ER in psychiatric distress actually require the emergency medical services that hospitals provide. While a certain percentage of patients do require round-the-clock observation and medical care, many others may pursue their treatment in the community with the assistance of mental health services and social support mechanisms.

There is a clear difference between psychiatric emergencies, which are medically based, and mental health crises which are psychosocial in their nature. A psychiatric emergency is defined as an “acute clinical situation in which there is imminent risk to harm to self or others unless there is some immediate intervention.”<sup>7</sup> A mental health crisis, on the other hand, is defined as a “serious disruption in the individual’s baseline functioning, such that coping strategies are inadequate to restore equilibrium.”<sup>8</sup>

Two other points should also be noted about the relationship between the different types of mental health issues. The first is that they are not necessarily mutually exclusive, since psychiatric emergencies may in some instances be prevented or at least mitigated through the amelioration of related psychosocial issues in consumers’ lives. Conversely, mental health crises can become psychiatric emergencies when the health and social support systems which consumers rely upon fail to provide them with a sufficient degree of psychosocial support to maintain health and well-being.

Nonetheless, it must be recognized that the health human resource requirements for responses to medical emergencies and psychosocial crises are not the same. Psychiatric emergencies may need to be addressed by medical personnel such as psychiatrists, ER physicians and nurses in a hospital setting not only because the administration of medication may be necessary in such cases, but because such patients may need to be admitted in order to prevent them from harming themselves or others. Mental health crises, on the other hand, do not necessarily require the same type of medical response. Therefore, guidance and support from mental health professionals and other social service workers in the community, such as social workers, case managers, and/or peer support specialists may be most appropriate.

Because a large subset of ER patients do require assistance in dealing with psychosocial crises rather than psychiatric emergencies, there is a clear need to develop more appropriate alternatives to treatment in the ER for this subset of individuals.

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<sup>7</sup> Alice Chan and Joseph Noone, Editors (2000) Emergency Mental Health Education Manual. University of British Columbia.

<sup>8</sup> See Chan and Noone above.

## **2. Improved Access to Appropriate Supports in the Community Supports can Decrease Pressure on the ER**

The deinstitutionalization policies of the Ontario government were based on the concept that people with mental illness could have their needs addressed in the community rather than in hospital. Indeed, it has been found that models of community-based mental health care are effective in meeting basic mental healthcare needs, thereby helping to decrease hospital usage by persons with serious mental illness. The Community Mental Health Evaluation Initiative (a 2004 collaborative effort between the Centre for Addiction and Mental Health, Canadian Mental Health Association, Ontario Mental Health Foundation, and Ministry of Health and Long-Term Care) has found that housing, income, and health care supports are essential to maintaining the health and well-being of people with serious mental illness.<sup>9</sup>

In particular, an emphasis on prevention of psychotic episodes and/or psychosocial crisis is clearly required. As Alan Hudson, the architect of Ontario's Wait Times Strategy has succinctly acknowledged, people with mental health issues "should be getting the help they need outside the ER to keep them from needing this service in the first place."<sup>10</sup> Another related problem, which will be discussed in detail later in this paper, is that there are presently few places where hospital patients with mental health issues may be safely discharged to in the community, which forces them to continue occupying beds and/or consuming ER services until acceptable discharge options may be found.

## **3. Hospital Community Integration is Essential to Ensuring an Effective Mental Health Continuum of Care.**

Another key requirement for addressing mental health issues is that health care must be patient-centred. Ideally, it would be best for people with mental health issues if they could be served by an array of integrated health services both within hospitals and the wider communities in which they live. As previously noted, however, this is not presently the case. Accordingly, consumers of the mental health system are left on their own (or in some instances, with the assistance of family and friends) to navigate the complex health care system and find appropriate treatment options outside of the hospital setting - either upon discharge from the ER or longer-term mandatory hospital care, or as a precursor to utilizing this option. This is not only inconvenient to the people using the system, it also results in increased costs to the system as people turn to more costly services because they are not aware of the other options available to them.

The previously noted occurrence of poor discharge planning does not serve the best interests of patients either. Ideally, individuals presenting to the ER should be directed to the services they require - whether these be within the hospital or in the community. This includes services for housing and income support as well as mental health care, as previously observed. The unfortunate reality at this time, however, is that hospital and community-based services operate in so-called "silos" in isolation from one another, which makes it difficult for patients to move seamlessly through the health care system without discontinuity or outright disruption in their care. Consequently, they fail to communicate with one another or do so in a limited fashion at best, which impairs or precludes efficient referral and transmission of health status information.

Ultimately, because the mental health system is fragmented in the ways described, and therefore is not yet geared to operate in a manner which serves the best interests of consumers at present,

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<sup>9</sup> Canadian Mental Health Association, Centre for Addiction and Mental Health, Ministry of Health and Long-Term Care, and Ontario Mental Health Foundation (2004). Making a Difference. *Community Mental Health Evaluation Initiative*.

<sup>10</sup> Julie DeBruin (April 14, 2008). "Province Promises to Reduce ER Wait Times." The Mirror.com at: <http://www.midlandmirror.com/MidlandMirror/article/71496>.

many people are figuratively falling through the cracks and are not receiving the best care possible.

## **RECOMMENDATIONS**

Based on our community consultations and the available evidence, we have developed the following recommendations on how allocations can be made towards specific models in order to effectively reduce ER wait times. These are separated into three categories:

1. Enhancements in the Community
2. Enhancements in Hospitals
3. Recommendations which require hospital-community collaboration

### **Recommendations for Enhancements in the Community Sector**

The following four recommendations concerning the community sector are expected to demonstrate the following outcomes;

- Better management of psychiatric symptoms in the community;
- Increased adherence to treatment;
- Fewer episodes of mental health crisis;
- Decreased pressure on ER for service;
- Decreased admissions to hospital;
- More appropriate use of medical and non-medical resources;
- Better connections made with the necessary psychosocial supports;
- More comprehensive care to address related co-morbidities such as medical; and problems, substance use, and social determinants of health.

#### **1. Increase the Number of Supportive Housing Units in Ontario.**

Housing is a major concern for many people with serious mental illness, and a lack of adequate housing contributes to the type of psychosocial distress that can lead a person to the ER. Supportive housing contributes to quality of life and can be more cost effective than institutional care, making it a viable housing option for governments seeking to decrease health expenditures.<sup>11</sup> In fact, the existence of supportive housing and community mental health services has been shown to reduce hospitalization by up to 80%.<sup>12</sup> Supportive housing provides not only a place to live but comprehensive mental health support to meet the needs of tenants.

The key informants who contributed their knowledge and experience to this paper listed supportive housing as the number one community resource that could cause a decrease in ER usage by individuals with serious mental illness. Despite significant investments in supportive housing made by the provincial government, this type of support is out of reach for many people who need it. Up to one-third of people who have indicated a need for supportive housing are not able to access it when necessary.<sup>13</sup>

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<sup>11</sup> Please see Page 4 of the Canadian Research Network for Care's *In Focus Supportive Housing Fact Sheet* (2006).

<sup>12</sup> As stated at [http://www.thedreamteam.ca/dreamteam\\_facts.htm](http://www.thedreamteam.ca/dreamteam_facts.htm).

<sup>13</sup> Koegl C, Durbin J, Goering P. "Mental Health Services in Ontario: How well is the province meeting the needs of people with serious mental illness?" Health Systems Research and Consulting Unit & Centre for Addiction and Mental Health, 2004.

Individuals living with mental illness have a wide range of needs; therefore, different variations of housing should be made available to meet them all. Specifically, there is a need for:

- **Custodial housing** to provide room-and-board, 24-hour on-site supervision, basic assistance with the activities of daily living such as bathing and dressing, and medication supervision. Indeed, custodial beds are used in the MOHLTC's Homes for Special Care and the Habitat Services model (which is described in a case study in Appendix A).
- **Supportive (a.k.a. alternative) housing** to focus on on-site rehabilitation and community integration - in group home or low-support self-contained apartments - through the provision of a variety of different types of linked housing and living support services by staff who are specifically trained in social work or psychiatric rehabilitation.
- **Supported housing** arrangements that operate on the premise that housing and support to are separate functions. Accordingly, there are no staff members on-site. Support services are provided from outside the home, therefore, usually in the form of case management. Supported housing usually consists of independent apartments, housing co-operatives, or other government-funded social housing for people with low incomes.<sup>14</sup> This type of housing is most suitable for psychiatric consumers with relatively high levels of functioning.

In order to ensure efficient use of this resource, it is essential that the level of support offered be matched to the individual's needs, and that the transition from more-supported to less-supported housing (or vice versa) be easily facilitated. This in turn would open up highly-supportive housing arrangements to those who need it the most.

## **2. Increase funding for intensive community-based treatment models such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM).**

Efforts to reduce pressure on the ER should focus on management of mental health issues in the community as a way of preventing crises. Two intensive community-based treatment models that are already used to great success are Assertive Community Treatment (ACT) and Intensive Case Management (ICM). Both approaches are targeted at persons with serious mental illness. While they differ somewhat in their methods, wider employment of the two approaches is recommended because they are client-centred and provide coordinated continuity of care, and have therefore been empirically shown to promote community living among mental health service consumers and decrease hospitalization.

### ***Assertive Community Treatment***

Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service intended to facilitate psychosocial rehabilitation for persons who have the most serious mental illnesses. More specifically, this approach provides comprehensive, community-based:

- Treatment (psychiatric treatment, medication service, individual therapy, crisis intervention, and substance abuse service);
- Rehabilitation (education-vocational-recreational services, skill teaching, and activities of daily living); and
- Support (family services, medical/dental services, housing support, transportation, criminal justice services and advocacy).

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<sup>14</sup> Canadian Mental Health Association website:  
[http://www.ontario.cmha.ca/services\\_and\\_supports.asp?cID=7585](http://www.ontario.cmha.ca/services_and_supports.asp?cID=7585).

In this model of mental health service, care is delivered by ACT Teams which are comprised of health professionals from a variety of disciplines (e.g. psychiatry, nursing, medicine, therapy, and rehabilitation) who work together in a collaborative manner to address the mental health issues of individual patients whom they share in common. Ideally, they also:

- Employ at least one peer specialist;
- Offer low staff-to-client ratios and intensive services;
- Make staff available to patients at all times;
- Provide up-to-date, individually-tailored treatment, rehabilitation, and support services;
- Conduct client-centred, individualized assessment and treatment/service planning (a.k.a. recovery or care planning); and
- Employ a sufficient number of support staff to provide service 24 hours per day, seven days a week.

This form of case management has proven to be extremely effective in improving the lives of people with serious mental illness and reducing hospitalizations. An 18-month study on ACT clients demonstrated significant improvements in the areas of housing, employment, quality of life, and symptoms of distress. Moreover, all clients showed a reduction in visits to the ER and admissions to hospital.<sup>15</sup> Indeed, it has also been found that clients of ACT teams are more likely to adhere to treatment and experience fewer crises than non-ACT clients.

Clearly, this model of treatment has proven to be effective for high-needs clients and should be made widely available to those who require this level of care. The 24/7 availability of supports through this team is a major factor in their ability to reduce pressure on the ER, as the ACT team has the capacity to address mental health crisis at any time day or night. As is the case with supportive housing, efforts would also have to be made to transfer higher functioning clients to lower levels of care so that more disabled clients could access this specialized service.<sup>16</sup> (Please see Appendix B for a case example on how ACT teams can help reduce pressure on the ER.)

### ***Intensive Case Management***

Intensive Case Management (ICM) is the other model which should be more widely funded. As set out in the key 2001 Ontario Health Document, *Making it Happen: Operation Framework for the Delivery of Mental Health Service and Supports*, ICM is a brokered service delivery model which improves clients' integration with their communities through:

- Outreach and Consumer Identification;
- Case Assessment and Planning;
- Monitoring, Evaluation, and Follow-Up; and
- Information, Liaison, Advocacy, Consultation, and Collaboration, with
- Direct Service Provision/Intervention when necessary.

In this model of mental health service – which is sometimes also referred to as “clinical case management” because it not only brokers service, but also provides direct interventions when necessary – a single case manager:

- Conducts proactive outreach to prospective clients;
- Holds caseloads of no more than twenty clients at most if possible;

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<sup>15</sup> Ontario Mental Health Foundation, The Centre for Addiction and Mental Health, The Canadian Mental Health Association, Ontario, and the Ministry of Health and Long-Term Care. *The Community Mental Health Evaluation Initiative*. 2004

<sup>16</sup> Koegl C, Durbin J, Goering P. “Mental Health Services in Ontario: How well is the province meeting the needs of people with serious mental illness?” Health Systems Research and Consulting Unit & Centre for Addiction and Mental Health, 2004.

- Meets at least twice per week with 20% of his/her clients;
- Attends at least 50% of his/her meeting outside of the office setting; and
- Ensures 24 hour access to brokered services within the system.

In regards to the matter of 24 hour access, this does not mean that intensive case management itself must always be available. In fact, the Ministry of Health and Long-Term Care only stipulates that they must be offered to consumers eight hours per day, five days a week. However, written protocols must be established and communicated which allow clients to access emergency and crisis service and support at times when case managers are not available.<sup>17</sup>

### **Comparative Advantages**

A comparative study of the ACT and ICM has examined six key considerations about the effectiveness of these models in addressing six key areas of concern:

- Psychiatric admissions to hospital;
- Emergency Room visitations;
- Stabilization of housing situations;
- Improvement of employment rates;
- Self-perceptions of quality of life; and
- Experience of moderate to extreme symptoms of illness.

Both models have shown to be effective in all six areas. Where ACT Teams' effectiveness is concerned, improvement in consumers' rate of employment and (self-assessed) quality of life of has been especially notable.<sup>18</sup> In comparison, the ICM approach has also been found to be very effective, although progress produced in the particular areas of employment and quality of life is slight. While ICM clients are less likely to complete their recovery programs than ACT ones (it is not known whether this is due to client or program specific reasons), ICM clients are less likely than ACT clients are to be readmitted to hospital, and tend to spend fewer days there if admitted.<sup>19</sup>

Beyond this, the findings of the cited study notwithstanding, the Intensive Case Management approach has the virtue of encompassing a range of service delivery practices that are less intensive and not as standardized as ones offered by ACT teams. Among other things, this means that it can more flexibly adapt itself and function according to local needs and resource availabilities. Moreover, because it only employs case managers as opposed to a whole team of specialists, it is the more cost effective option. However, it should also be noted that an American study has indicated that ICM may be best suited to communities that have ample pre-existing mental health treatment and support services.<sup>20</sup> Accordingly, the Assertive Community Treatment approach may be better suited for rural communities.

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<sup>17</sup> The Ministry of Health and Long-Term Care. Intensive Case Management Service Standards for Mental Health Services and Supports (2005).

<sup>18</sup> Canadian Mental Health Evaluation Initiative. Making a Difference: Ontario's Community Mental Health Evaluation Initiative (2004). Pages 19 and 20.

<sup>19</sup> See Canadian Mental Health Evaluation Initiative (2004) above, Page 20.

<sup>20</sup> Piper S. Meyer, Ph.D, and Joseph P. Morrissey, Ph.D (January 2007). A comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. *Psychiatric Services*, 58: 121-127.

### **3. Increase Funding for 24/7 Crisis Response Services in the Community, Including Mobile Crisis Intervention Teams, Crisis Centres, and Short-term Residential Beds.**

Crisis response services are an integral part of a comprehensive mental health system which provides timely access to a wide range of options on a twenty-four hour basis. This type of service is an ideal response for people experiencing non-medical, psychosocial crisis. The primary role of crisis response services is to provide immediate relief of symptoms and rapidly stabilize patients' conditions so that they do not worsen. Their secondary role is to connect the individual to services which can meet their more long term needs, such as treatment and social supports.

Key elements of a diversion crisis system include: mobile crisis units, walk-in crisis programs, telephone crisis lines, and safe beds (i.e. temporary housing where people in crisis can stay for several days).<sup>21</sup> In order to effectively divert those who do not require emergency medical services from the ER, it is recommended that the MOHLTC ensure that the appropriate combination of the three following models of alternative crisis response service are available in every community 24 hours per day, seven days a week:

- **Mobile crisis intervention teams (MCITs):** Teams made up of police officers and mental health workers have proven to be effective both in meeting the crisis needs of high-risk individuals in the community, and reducing unnecessary hospital usage. 80% of individuals seen by St. Michael's Hospital MCIT, for example, are cared for in the community and are not brought to the ER.<sup>22</sup> Various models of mobile crisis intervention exist and may be employed, which means that such factors as size of the police service, available mental health resources, and scope of geographic area served should be taken into account when choosing the most appropriate model. (Please refer to Appendix C for a case example on COAST, a mobile crisis team in Hamilton.)
- **Crisis centres:** Crisis centres provide supportive counselling to address immediate crisis issues. These centres, open 24 hours a day, 7 days a week, can include various components such as telephone crisis lines, peer support on-site, and even mobile crisis response teams. They provide a safe and supportive environment in which persons in complex mental health crisis can stabilize, and be connected with longer-term supports to prevent future psychosocial crises from occurring. (Please see Appendix D for a case example on Gerstein Centre, a crisis centre in Toronto.)
- **Short-term residential crisis services:** Short-term residential crisis support beds, which are often referred to as "safe beds," can be used as an alternative to hospital admission. The province has implemented several safe bed initiatives in the area of mental health and justice. These programs, which offer both temporary housing and intensive case management for a short period of time (on average, thirty days), are well-suited to high-risk, high-needs individuals in crisis who do not have adequate housing, and should be expanded beyond those who have had contact with the criminal justice system.

### **4. Increase Emphasis on Primary Care and Prevention.**

The high volume of psychiatric patients in the ER is partly due to barriers in accessing primary care. Many individuals with serious mental illness use the ER to satisfy their primary treatment needs because they do not have access to a family physician. Fortunately, the dual goals of reducing ER wait times and improving access to family health care, announced by the provincial government in April 2008, go hand in hand.

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<sup>21</sup> Public Health Agency of Canada (2003). Review of Best Practices in Mental Health Reform.

<sup>22</sup> Key informant interview, June 26 2008

Individuals who do not have access to a family physician or other primary care provider are more likely to use the ER to meet their healthcare needs than those who do. This includes the homeless population, one third of which does not have access to primary care services.<sup>23</sup> Significantly, approximately 35% of these individuals who present to the ER are treated for mental health problems.<sup>24</sup>

In addition to this, it must also be kept in mind that treatment of these segments of the population requires more time and attention because they also not only tend to suffer co-morbidities such as substance abuse problems more than the general population, but because their physical health concerns are often overlooked. Consequently, any future models or adaptations for primary health care which hope to prevent ER visitations and re-visitations should take these complexities into account. A fusion of social and health services would create a more holistic primary health care system that could more effectively address the needs of individuals with serious mental illness.

Fortunately, patient centred and regular follow-up services, when coupled with health promotion services, are effective in preventing mental health crises from occurring. Family Health Teams, in particular, are well-equipped to provide this level of service. Consequently, they are a key component of the government's plan to build a health care system that delivers on three priorities: keeping Ontarians healthy, reducing wait times, and providing better access to doctors and nurses. We encourage the Ontario government to continue the expansion of the Family Health Team program. (Please see Appendix E for a case example on Family Health Teams at Sherbourne Health Centre and Seaton House in Toronto.)

### **Recommendations for Enhancements in the Hospital Sector**

The following four recommendations are expected to demonstrate the following outcomes:

- Increased access to acute psychiatric care for those who need it;
- Decreased wait times for assessment;
- Decreased Length of Stay (LOS) for admission;
- Fewer premature discharges from ER and from psychiatric units due to bed shortages;
- More efficient flow through ER as a result of efficient use of resources and effective information exchange processes between ER staff;
- More appropriate use of medical and non-medical resources;
- More appropriate use resources within the hospital;
- Better connections made with community services for post-discharge support;
- Reduced risk of physical harm of ER staff or other patients;
- Reduced use of police resources for patients apprehended under the *Mental Health Act*;
- Fewer relapses in the community because mental health needs were not met in hospital; and
- Decreased pressure on the ER as a result of fewer readmissions.

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<sup>23</sup> Street Health Research Bulletin: Fall 2005. Available at:  
<http://www.streethealth.ca/Downloads/ResearchBulletin1005.pdf>.

<sup>24</sup> Canadian Institute for Health Information (2007). Improving the Health of Canadians: Mental Health and Homelessness.

## 5. Increase the Number of Acute Care Psychiatric Beds in Schedule 1 Facilities.

Though there are many individuals who can be safely diverted from the ER and effectively served by alternative services, some people presenting to the ER in psychiatric distress do require admission for the purposes of assessment and/or treatment. A significant factor contributing to ER wait times for this population is that the number of patients requiring admission exceeds the number of beds available. Clearly, an increase in the number of mental health beds is required to meet current needs.<sup>25</sup> This was substantiated by many of the key informants who contributed their knowledge and experience to this paper.

The number of psychiatric beds in Ontario has decreased dramatically in the last 40 years. Through the process of deinstitutionalization, the number of beds has been cut by over 80%, from 23,968 in 1965 to 4,577 in 2004.<sup>26</sup> Consequently, in cases of the most acute psychiatric need where community-based services cannot meet the requirements of such patients, there is no other choice but to temporarily “warehouse” patients in ERs until beds can be found for them. This in turn causes significant bottlenecks in the ER as patients wait for a bed to become available. Ultimately, this increases ER Length of Stays (LOS), which refer to the time spent waiting for admission, for psychiatric patients. For example, as was previously mentioned, at St. Joseph’s Health Care in Toronto, the average LOS for mental health visits was 19.65 hours: 2.9 times higher than the LOS for all other ER visits.<sup>27</sup>

Moreover, the lack of acute care psychiatric beds also impacts the volume of mental health patients presenting to the ER. Firstly, discharge from ER due to a lack of acute care beds has immediate repercussions, including further exacerbation of symptoms in the community. Furthermore, a lack of acute care beds puts pressure on hospital staff to discharge psychiatric inpatients early, in order to make room for the next patient ‘on the list’. Early discharge from inpatient psychiatric units has been directly linked to unplanned readmissions via the ER, as both the readmission rate and time to readmission are shown to be higher for shorter hospital length of stays.<sup>28</sup> Clearly, individuals who are not able to access acute psychiatric care because of a lack of hospital resources are likely to present back to the ER, producing a “revolving door” phenomenon.

Accordingly, it is recommended at minimum that the government should refrain from closing any more psychiatric beds in Ontario. Beyond this, we recommend that the Ontario government re-examine the recommendations of the Duncan Commission with the view that community investments were not made at the level that were expected to coincide with the recommendations provided in this document, and that an increase in hospital beds might be required in at least the short term in order to meet current demand for acute care services.

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<sup>25</sup> Physician Hospital Care Committee - OHA, OMA, MOHLTC (August 2006). Improving Access to Emergency Care: Addressing System Issues. (August 2006).

<sup>26</sup> These figures were derived by comparing totaled 2004 figures from the Ontario Mental Health Reporting System and 1965 ones from Statistics Canada that were cited by Patricia Sealy and Paul Whitehead in “Forty Years of Deinstitutionalization of Psychiatric Services in Canada: an Empirical Assessment,” in *The Canadian Journal of Psychiatry*, Vol. 49, No. 4, in April of 2004.

<sup>27</sup> Presentation by Dr. Marko Duic, Chief, Department of Emergency Medicine, St. Joseph’s Health Centre, Toronto. July 4 2008.

<sup>28</sup> Canadian Institute for Health Information (April 2008). Hospital Stay and Length of Readmission for Individuals Diagnosed with Schizophrenia: Are They Related?

## **6. Implement Crisis Workers in Every ER in Ontario.**

Crisis workers play a vital role in the ER and can go a long way in helping to decrease wait times for psychiatric assessment and treatment. ER Crisis Workers support individuals and families in crisis by:

- Explaining the process and procedures in the ER to them;
- Conducting an initial mental status examination to assess the presence and/or extent of an individual's mental impairment;
- Providing the ER physician and/or psychiatrist with an overview of the situation and a summary of recommendations on how to move forward; and
- Liaising with community supports to implement a post-discharge plan for the patient.

In the absence of crisis workers, ER physicians must take on these roles, resulting in an inefficient use of health human resources, and bottlenecks in the ER. For this reason alone, crisis workers play a vital function in improving flow through the ER.

In addition to this, the function of crisis workers has the potential to be expanded to include that of ER diversion. At St. Mary's General Hospital in Kitchener, for example, a separate office was established for Crisis Workers in the ER in 1998. This office, which is open from 10am to 10pm, enables crisis workers to see both patients who come through the ER, as well as ones who are direct referrals from the community. Essentially, they serve as a screening tool, doing initial assessments to determine whether the person has medical needs that require further assessment or treatment in the ER. Because this screening occurs as soon as patients walk into or are referred to the office, they do not have to go through lengthy triage processes in the ER, and can consequently be referred directly to ER physicians. In the alternative, those patients who do not require medical attention can be assisted solely by crisis workers in the office and subsequently connected with community-based services as necessary.<sup>29</sup>

Accordingly, for all of these reasons, the funding and placement of crisis workers in the ER setting would undoubtedly have a significant impact of ER wait times for psychiatric patients.

## **7. Promote Training in Mental Health De-Escalation Techniques for ER Staff, Including Security.**

The psychotic symptoms that individuals in psychiatric crisis experience do have the ability to manifest in behaviour which could be perceived as aggressive. In fact, even severe psychosocial crisis can cause a person to become agitated, which in some cases makes it difficult for ER staff to manage their care. Yet most hospitals have limited capacity to deal with patients who are agitated or aggressive. This poses a risk for hospitals, as they have a duty to protect both their staff and their patients. Moreover, it contributes to the problem of extended wait times, as already limited resources are spent restraining the individual, or time is spent waiting for the individual to become more manageable.

Indeed, one survey of Ontario hospitals has found that 73% of hospitals do not have effective strategies for managing agitated patients, and therefore, must allow these patients to overflow into the ER with the use of security personnel and/or physical/chemical restraints as the only means of maintaining safety.<sup>30</sup> Data on seclusion rooms provides additional evidence that most facilities have limited resources to manage patients in a psychotic or aggressive state.<sup>31</sup>

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<sup>29</sup> Key Informant Interview, June 16, 2008

<sup>30</sup> See Anderson and Brasch (March 2005). "Emergency Psychiatric Services in Ontario." *Ontario Medical Review*, 72 (3).

<sup>31</sup> See Anderson and Brasch above.

Nonetheless, relatively low-cost models for addressing agitated or aggressive persons within the ER are available. Interviews with medical staff at St. Joseph's Health Care in Toronto highlight how the use of trained security staff have improved patient flow through the ER. Security staff who are trained in mental health de-escalation and are available 24 hours per day, seven days a week, are able to maintain the safety of all patients in the ER. Just as importantly, the resultant reduction in time spent managing aggressive patients allows them to be assessed more quickly, and makes ER staff more comfortable in seeing such patients. Accordingly, the St. Joseph's medical staff maintains that the minimal resources spent on hiring and training security personnel demonstrate a high return.

## **8. Implement More Extended-Observation or "Short Stay" Beds in High-Volume ERs.**

While community-based programs are effective in addressing individuals who do not require medical intervention, and admission to a psychiatric bed is necessary for certain people who do require this level of intervention, there also appears to be a subset of the population of psychiatric patients presenting to the ER who fall somewhere in between these two Levels of care. Specifically, these patients do not require the extensive resources that come with a long-stay admission, but do need to be kept in hospital for a short period of time for monitoring. Nevertheless, they are often discharged from the ER because they do not meet the criteria for long-term admission. Accordingly, this subset of individuals is at a high risk of relapsing in the community and presenting back to the ER, which results in the occurrence of a "revolving door" type of situation.

Extended-observation beds, however, provide a useful short-term alternative to outpatient referral or to longer-term hospitalization. These units, located in close proximity to the ER, provide extra time for the continuing assessment and management of complicated-crisis patients in a safe, structured environment. In addition to this, the concept allows patients respite and time to mobilize defences and community service providers to adjust to treatment strategies; both of which allow patients to return to the community more rapidly with a decreased risk of relapse.<sup>32</sup>

St. Joseph's Health Care has benefited from a 6-bed Mental Health Short Stay Unit. This unit is intended to meet the crisis needs of individuals who are requiring hospitalization but for whom the goals of hospital stay can be met within a short period of time with intensive intervention. Approximately one-third of all patients admitted through the ER at St. Joseph's go to this unit, and stay an average of three to four days - allowing for a quick bed turnover.<sup>33</sup> This leaves psychiatric beds open to people who require long-term admission. Another example may be found at St. Michael's Hospital, which has a similar crisis stabilization unit that holds patients for 24 hours so that they may stabilize while hospital staff secures the necessary community supports that will prevent them from suffering relapse or at least mitigate their chances of doing so.

## **Recommendations for Community-Hospital Collaboration**

The following three recommendations are expected to demonstrate the following outcomes:

- More appropriate use of medical and non-medical resources;
- Decreased pressure on the ER;
- Decreased wait time in the ER for those who do present to that department;
- Improved discharge planning;

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<sup>32</sup> Canadian Psychiatric Association (2003). Emerging Trends and Training Issues in the Psychiatric Emergency Room.

<sup>33</sup> Key Informant Interview, May 30 2008.

- Strong connections made with community-based services and supports;
- More effective crisis management;
- Increased adherence to treatment plans; and
- Reduced rates of relapse.

## **9. Fund and Promote Collaborative Hospital-Community Programming.**

In general, the community sector and the hospital sector tend to operate in silos. Therefore, when a person who is receiving services in the community goes into psychiatric crisis, their gateway to acute care services is typically through the ER. Connections between hospitals and community agencies which could facilitate more efficient pathways to care are currently not being leveraged. Moreover, the lack of coordination between hospitals and community agencies is not patient-centred, and makes it difficult for people with serious mental illness to access the care they need.

Collaborative programming would allow for a more efficient referral of patients from community agencies to hospitals, thereby avoiding the lengthy triage and waiting stage. Hospital-community partnerships such as the one between St. Michael's Hospital and Seaton House (as described in Appendix E) are effective in facilitating discharge, as the hospital physician can communicate the patient's treatment plan directly to the community agency, thereby allowing more stable continuity of care.

These partnerships also work in the other direction, as community mental health workers can contact the hospital psychiatrist directly to initiate a referral for admission, thereby bypassing the lengthy ER waiting stage. This process is particularly applicable and useful for people with serious mental illness as their relapses often manifest in the same symptoms. (A truly unique example of such hospital-community collaboration may be found at Lanark County Mental Health, which is discussed in Appendix F.)

It is crucial to note that this level of collaboration is difficult to initiate, and cannot be achieved through partnership in name alone. Key elements of meaningful hospital-community partnership include:

- Community mental health workers situated on-site in hospitals;
- Funded coordinators to facilitate ongoing communication and collaborative programming; and
- Organizational culture which supports these partnerships and values the contribution of both partnering sectors.

## **10. Implement ER Diversion Programs/Community Mental Health Liaison Programs in High-Volume ERs.**

It is clear that many individuals who present to the ER in psychiatric distress do not require emergency medical attention. Mental health crisis can result from severe psychosocial distress, and require a type of response that hospitals are not well-equipped to provide. Often, individuals in psychosocial or non-medical distress are retained in the ER or admitted to a bed simply because there is no one to direct them towards the necessary community supports. In the case of severe bed shortages, these individuals must wait in the ER for extended periods of time until access to these supports can be provided.<sup>34</sup>

ER diversion programs can intercept these individuals at the ER and connect them to the service and supports necessary to address the root of their crisis including short-term crisis

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<sup>34</sup> (NYGH ER diversion project).

support, long-term case management, and housing. These services are not resource-intensive; in fact, evidence from ER diversion programs has demonstrated that most clients do not require long-term case management, and are sufficiently stabilized through short-term crisis management. For example, the fact that the North York General Hospital (NYGH) Emergency Department Diversion Project only had to refer 10% of its patients in crisis to long term case management services shows the strength of the crisis stabilization model of care.<sup>35</sup>

ER diversion programming is made possible through strong ties between hospitals and community agencies. This, too, is evidenced in the success of the NYGH Emergency Department Diversion Project, which involved strong partnerships between North York General Hospital and Saint Elizabeth Health Care, Toronto North Support Services, Bayview Community Services, COTA Health, and the Ontario Association of Patient Councils. Community mental health workers based in the hospital are able to take direct referrals from the ER and connect the individual to the necessary services. Experience has shown that simply discharging individuals from the ER and providing them with the name of a community agency does not adequately ensure good continuity of care, since the cognitive symptoms associated with serious mental illness can make it difficult for these patients to follow through. A direct “handoff” to community workers situated in the ER, however, does prevent individuals from falling through the cracks.

Beyond this, it must also be recognized that access to 24/7 community services is an integral component of any ER diversion program’s success. The two examples studied for this report were the NYGH Emergency Department Diversion Project and the Community Mental Health Liaison program out of the Centre for Addiction and Mental Health and the Canadian Mental Health Association. Ultimately, the NYGH Emergency Department Diversion Project model seems to be more effective because it provides 24/7 access to community-based crisis workers who can therefore meet patients in the ER at any time of day, and ensure that any necessary connections with community-based services are made. In other settings where staff are only available during daytime working hours (not on evenings or weekends), connections with community-based services are not as secure, since patients must assume some responsibility for accessing the recommended services on their own. Accordingly, it should be noted that Recommendation 9 of this paper is linked to Recommendation 3.

## **11. Fund Effective Outpatient Programs for Patients Who Require Ongoing Treatment.**

Many individuals with serious mental illness experience an exacerbation of their symptoms following discharge from hospital. Certain high-needs patients may require more comprehensive care post-discharge to maintain adherence to their treatment plan. Whether situated in the hospital or in the community, services for this population are necessary in order to prevent unnecessary re-admission to hospital.

Effective maintenance of a high-need patient's treatment plan requires communication between hospital staff and outpatient treatment program about what the patient’s needs are and how the patient should be monitored. Record sharing is essential to ensuring that the treatment plan is maintained.

For example, the Day Hospital at St. Joseph’s Health Centre provides assessment and treatment for up to three weeks to ensure that clients are stable and have suitable follow-up care. The Depot Clinic at the Day Hospital administers anti-psychotic medication to patients who have been discharged or are part of the outpatient Mental Health and Addiction program. This clinic has shown a 90% attendance rate, and has the capacity to follow-up with patients

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<sup>35</sup> Goodman, S. The Emergency Department Diversion Program at North York General Hospital: An Integrated Response to Mental Health Clients in Crisis. Poster Presentation: Celebrating Innovations in Health Care Expo. Toronto, 2008.

who did not come in for the administration of their medication. Regular attendance at the Depot Clinic has reduced the risk of relapse in many clients, and ER visits are estimated to have been reduced by 60%.<sup>36</sup>

### **COMMON THREADS**

A number of common threads run throughout our recommendations regarding the ER Psychiatric Wait Times issue. Specifically, they include:

- **Culture:** The organizational or professional culture of any mental health service is essential to the delivery of effective care and assistance. First and foremost the needs of clients must be given top priority. This is true both where these parties work alone, and where they work together collaboratively. Logically, if hospital-based and community-based mental health service providers wish to work together to provide seamless continuity of care to their clients, they must also instill a culture of collaboration and mutual trust in their respective workplaces. The most important cultural value of all, however, is respect: respect for both internal and external colleagues, and respect for the clients that all mutually serve.
- **Education:** All parties involved in mental health care must have adequate knowledge to respond to issues that pertain to their role and therefore must be educated accordingly if they lack this knowledge. Service providers must know about services outside of their own organization which can benefit their clients as well as how to respond to clients in an effective manner. In addition, efforts should be made to provide more education to individuals with mental health issues themselves as well as their families, about the services that are available in their communities and how best to access care that will meet their needs.
- **Diversity:** Organizations that hope to provide effective mental health service must take diversity into account. Attention to the linguistic and cultural needs of both staff and patients enables the delivery of culturally appropriate care because it induces a sense of cultural safety which is conducive to healing and constructive cooperation. On a wider level of consideration, in planning improvement to the mental health care system, government must address the diverse needs of both urban and rural communities.
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- **Stigma:** Persons with mental illness are often stigmatized even by ER staff. The stigma related to mental illness is felt by many individuals presenting to the ER in psychiatric distress, who report that they are not treated with respect or compassion by the staff in hospitals. This stigma manifests in discrimination as these individuals are triaged at much too low a level, as their health concerns are not seen as being as grave as someone presenting with a physical health issue. Accordingly, feelings of stigma pertaining to persons with mental illness must be vigorously guarded against and eliminated.
- **Peer Support:** It must be recognized by all parties that peer support can play a vital role in recovery. Though not specifically mentioned in any one of our recommendations, we do insist that peer support be utilized in all the models and approaches discussed above, wherever possible.
- **Continuum of Care:** This concept is the key to understanding many of the recommendations put forward in this paper. Simply put, it must be realized that health and wellness can be dependent upon many different types of service; some medical in

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<sup>36</sup> Key Informant Interview, June 4, 2008

nature and others more psychosocial. Ideally, all elements work smoothly together, rather than working alone in so-called “silos,” to ensure that all aspects of peoples’ health and wellness are addressed.

- **Continuity of Service:** Continuity of service is a duty owed by service providers to their clients. While the concept of a continuum of care is the realization that health and wellness cannot necessarily be maintained in isolation, continuity of services is the deliberate attempt on service providers’ part to ensure that ill persons receive any additional help they may need from other ones who provide different but complimentary services. Also inherent in this concept is the notion that transition from or between one service to another should not disrupt clients treatment and recovery process.

## **BENCHMARKS**

The Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines should be kept in mind when considering the problem of excessive ER wait times for persons in psychiatric emergency or mental health crisis. Originally developed in 1998 by the Canadian Association of Emergency Physicians (CAEP), they have been since revised in 2008 to more closely correspond to physical symptoms. In summary, they state that all cases of psychiatric emergency or mental health crisis that are presented to the ER must be taken very seriously and given top priority for treatment.

However, as noted above, this standard is sometimes not adhered to by ER staff members who stigmatize persons with mental illness. In addition to this, adherence has also been hindered in the past by a lack of clear definitions in the protocol. Despite the recent revisions to the CTAS guidelines, they continue not to be enforced in many ERs. In particular, this is attributed in part to the fact that triage nurses generally seem not to know that mental health complaints are ones that need to be treated with great urgency. Education in this area is key.

## **INDICATORS**

The *Mental Health Accountability Framework* which was created in 2006 by the Ministry of Health and Long Term Care sets out eight performance domains/indicators which impact upon and indicate the effectiveness of the mental health system. The mental health system (including ERs) must achieve the following objectives if it is to properly serve those with mental illness or who are in psychosocial distress:

- **Acceptability:** Services provided must meet the expectations of service users such as consumer-survivors and their family members, community, providers and government. Furthermore, they must be involved in treatment decisions and in service delivery and planning, and have recourse to formal complaint mechanisms when they are dissatisfied. Cultural sensitivity and adherence to client rights are also crucial to ensuring acceptability.
- **Accessibility:** People must be able to obtain the services they need - including access to psychiatrists, other health care professionals, and primary care in general - at the right place and right time. Such factors as access to transportation, early intervention, and after hours services must be considered as well. Beyond this, human resource gaps which reduce accessibility must also be identified and addressed.
- **Appropriateness:** Services and supports provided to persons with serious mental illness must be relevant to service user needs and based on established standards of best practice, and also include treatment protocols for co-morbidities. Appropriateness is also

dependent upon the availability of community services and good balance between them and institutional services. Ultimately, all of these things must serve to create a belief amongst consumer-survivors and their family members that services provided are appropriate because they are acceptable, accessible, effective, efficient, and safe since they provide good continuity of care that is delivered by competent service providers.

- **Competence:** Knowledge, skills and actions of the individuals who provide mental health services must be appropriate to the specific services provided. Accordingly, they must meet provincial certification and professional standards (where applicable), and be given access to resources that allow them to pursue on-the-job development and continuous learning throughout their careers. Although the *Framework* does not specifically state this, knowledge of and discipline to adhere to Canadian Emergency Department Triage and Acuity Scale Guidelines should logically also be considered to be a mark of professional competence.
- **Continuity:** The mental health care system must be sustainable, comprehensive, and have the capacity to provide seamless and coordinated service provision across programs, practitioners, organizations, and levels of service, in accordance with individuals' specific needs. Consequently, appropriate mechanisms with clear, visible, and available points of accountability must be put into place to ensure community-based follow-up service subsequent to hospitalization or ER presentations, including the negotiation or stipulation of discharge plans for each and every patient who requires one.
- **Effectiveness:** It must be insured that services, intervention or actions actually achieve the desired results. Effectiveness is manifested in the form of:
  - Enhanced community tenure;
  - Lowered mortality rates;
  - Decreased involvements with the criminal justice system;
  - Progression in patients' clinical status;
  - Improvement in patients' functionality;
  - Heightened patient involvement in meaningful daytime activity;
  - Stabilization of patients' housing status;
  - Betterment of patients' self-reported quality of life; and
  - Maintenance of good physical health status.
- **Efficiency:** Mental health service organizations and programs must achieve desired results with the most cost-effective use of resources. Among other things, this means that the proportion of staffing funds spent on administration and support must be kept as low as possible without sacrificing any effectiveness. This may be achieved by:
  - Implementing needs-based allocation strategies;
  - Striking a good balance between institutional and community-based care;
  - Creating a resource intensity planning tool; and
  - Ensuring that budget and tools for evaluation and performance monitoring are available.
- **Safety:** Mental health service organizations and programs must avoid or minimize potential risks or harms to consumers, families, staff members, and communities that are associated with the mental health interventions (or lack thereof). Accordingly, risk management must be insisted upon and practiced at all levels, and research and practices pertaining to the reduction of adverse events and errors identified and employed. Safety is manifested in the form acceptable rates of incident for:
  - Medication errors;

- Medication side-effects;
- Critical incidents;
- Suicide;
- Homicide; and
- Involuntary commitment to psychiatric facilities.

## **CONCLUSION**

The Schizophrenia Society of Ontario urges the Ministry of Health and Long-Term Care to add a Psychiatric ER Wait Times component to its larger ER Wait Times Strategy. Ideally, it would focus on the enhancement of community-based mental health services while concurrently continuing to make improvements in institutional mental health care and access to care in the ER.

The combination of evidence-based knowledge and grassroots experience which informs the eleven recommendations discussed previously and restated below makes a strong case for their potential effectiveness. In particular, it is crucial that community-hospital collaboration become more deliberately and consciously cooperative and well-informed. However, no matter what type of sector or cross-sector consideration or improvement is pursued, culture, education, diversity, stigma, peer support, continuum of care, and continuity of service must all be taken into account.

In summary, the Schizophrenia Society of Ontario is confident that if the following steps are taken, all of these things will be achieved and ER wait times for persons in psychiatric emergency or mental health crisis will thereby be reduced (which in turn should contribute to the reduction of ER wait times in general):

1. Increase the Number of Supportive Housing Units in Ontario;
2. Increase funding for intensive community-based treatment models such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM);
3. Increase Funding for 24/7 Crisis Response Services in the Community, Including Mobile Crisis Intervention Teams, Crisis Centres, and Short-term Residential Beds;
4. Increase Emphasis on Primary Care and Prevention;
5. Increase the Number of Acute Care Psychiatric Beds in Schedule 1 Facilities;
6. Implement Crisis Workers in Every ER in Ontario;
7. Promote Training in Mental Health De-Escalation Techniques for ER Staff, Including Security;
8. Implement More Extended-Observation or “Short Stay” Beds in High-Volume ERs;
9. Fund and Promote Collaborative Hospital-Community Programming;
10. Implement ER Diversion Programs/Community Mental Health Liaison Programs in High Volume ERs; and
11. Fund Effective Outpatient Programs for Patients Who Require Ongoing Treatment.

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## Appendix A

### **Case Example: Supportive Housing Habitat Services, Toronto, Ontario**

Habitat Services plays a significant role in reducing the pressure on ERs by providing supportive housing to persons with serious psychiatric disorders who are not able to live independently. The Habitat model was established in 1987 to address community concerns about the living conditions of consumer/survivors housed in boarding homes. This model of supportive housing provides a viable housing solution with a home-like atmosphere for individuals with serious mental health issues who may not possess the life skills to conduct everyday tasks such as doing their own shopping, preparing meals or doing laundry.

Habitat Services provides permanent accommodations to up to 931 adults with mental illnesses at 48 different locations across Toronto by signing commercial contracts with the home owners. The average Habitat home has 20 rooms, single or double occupancy. Eligibility is restricted to persons who are consumers of or require the services of the mental health system and are defined as ‘an adult who is currently limited in activities pertaining to normal living, and whose disability has been verified by hospital or other referral source personnel.’ More than 100 referral services have access to Habitat funded beds.

Support Services to tenants in Habitat funded boarding homes are provided by COTA Health and Habitat Services Site Support. Habitat Services Site Support workers provide the following on-site support services for tenants using a community development model of support which involves:

- Providing opportunities for tenants to interact and socialize with one another and build a sense of community in their housing;
- Supporting tenants to acquire and practice skills which will enable them to participate in the community;
- Supporting tenants to assert themselves and exercise their rights in housing and other areas; and
- Advocating on behalf of the tenant when dealing with income supports, community and healthcare services, and/or the operator of the home.

Many tenants also have their own case managers, workers, or nurses who visit them in their homes.

## Appendix B

### **Case Example: ACT Teams Typical Client Scenario - Janice**

Janice was a 45 year old woman with a diagnosis of bipolar disorder and diabetes. She would regularly discontinue her medications resulting in mania and psychosis. Her poor adherence with medications led her to forget to take her diabetes medications resulting in cellulitis of the foot (an infection which could result in amputation if not treated). The pain of these infections was usually what prompted her ER visits as she would not seek help for her mental health concerns. She was difficult to treat in the ER due to her mental status; she would scream and yell obscenities, remove her clothing, and behave inappropriately with other patients. She was also homeless or under-housed most of the time, and had been banned from the local soup kitchen and shelter. Janice rejected case management each time it was offered to her so that she would be stabilized in hospital and discharged, then fail to follow up with community agencies. Although she was reluctant, the ACT team was able to meet during an admission to hospital to establish a relationship and assist her with finding adequate housing to prepare her for discharge. After this relationship was established, the ACT team made daily visits to Janice, administering and observing her medications each day. Through nursing support and psycho-education the team was able to provide health teaching on nutrition and diabetes and its effect on her mood. The occupational therapist engaged her in a volunteer program so that she would have meaningful activity. Together these comprehensive services lead to her recovery after many years of cycling through “the system”, and reduced her ER visits and hospital admissions.

## Appendix C

### **Case Study: Mobile Crisis Intervention Team Hamilton Crisis Outreach and Support Team (COAST), Hamilton, Ontario**

The Hamilton Crisis Outreach and Support Team (COAST) program serves residents of Hamilton-Wentworth who have serious mental health issues and are in crisis. COAST is a multidisciplinary team consisting of child and youth crisis workers, mental health workers, nurses, social workers and plain-clothes police officers. The goal of the COAST is to help individuals and/or their families to deal with reported crisis situations in an environment where they feel safe and comfortable. This model supports clients in managing acute psychiatric problems and crisis through the uses of education and problem solving approaches.

Initially, a Mental Health Triage Worker responds to calls on the COAST crisis line and makes preliminary assessments regarding the reported mental health concern to determine whether to respond with further telephone support, or to dispatch a mobile crisis team to visit the caller. The outreach mobile unit, which consists of a mental health worker and a police officer, can visit callers daily between 8:00 a.m. and 1:00 a.m. anywhere in Hamilton. Psychiatric consultation, assessment and/or treatment are negotiated on an individual case-by-case basis.

Clients requiring further support or follow-up receive assistance from the support team within 24 hours of the crisis situation. Follow-up plans may involve linkage to additional community agencies or support networks. COAST support or follow-up continues until either reported difficulties have been resolved or clients have been linked to appropriate community resources.

The Hamilton COAST Model has been so successful that it has been adopted in both the Peel and Halton Regions.

## Appendix D

### **Case Example: Crisis Centre Gerstein Centre, Toronto, Ontario**

The Gerstein Centre, established in 1990, provides 24/7 community-based, non-medical crisis intervention to adults in Toronto with mental health issues through telephone support, community visits, and its short-stay residences. Community-based treatment offered by the centre is based upon the assumption that administration of anti-psychotic medication alone cannot successfully address mental health issues. If the centre receives a crisis call of a medical nature, such as psychiatric assessment, severe self-harm or suicide attempts, or cases where medical attention is necessary, they will refer the client to hospital.

The Gerstein Centre believes that a crisis occurs when an individual experiences a change that leaves them feeling uncomfortable and unable to cope in their usual way. It employs a crisis intervention model which pursues the following path of treatment: Initial Contact, Build Rapport, Listen, Identify Choices, and Closure. Clients are encouraged to explore and consider internal and external resources that are available to them. In its own words, the Centre's "environment and support...are individualized, responsive to the needs and wishes expressed by the service user, and respectful of the autonomy, dignity and ability of the service user."

The Gerstein Centre provides a supportive, home-like atmosphere for people in crisis to help them become sufficiently stabilized to return to the community. Their short-term supportive counselling uses a first-steps approach deals with immediate issues and small manageable goals. The centre also plays a strong role in connecting individuals in crisis to the long-term supports necessary to prevent future crises from happening. Their strong links with hospitals and community agencies make them well positioned to establish these connections.

Although the Gerstein Centre is still limited to the 10 beds it had when it opened, its approach has been so successful that a second site has been opened. Gerstein's newer Bloor Street location has 9 "Mental Health and Justice" beds for men and women with mental health issues who are concurrently involved with the criminal justice system

The Gerstein Centre also provides training in crisis intervention, suicide prevention and mental health awareness to other groups and organizations.

## Appendix E

### **Case Example: Primary Care**

#### **Sherbourne Health Centre and Seaton House Family Health Teams, Toronto, Ontario**

The Family Health Team at Sherbourne Health Centre allows for access to routine care for clients with mental health needs. This team offers a mix of acute episodic care, chronic disease management/health promotion, and system navigation support. This means that in addition to addressing immediate health care needs, these teams contribute to their clients' overall well being by helping them access supports such as ODSP, or facilitating admissions to hospital or community services. Proactive follow-up calls to the client to check-in on their mental health status helps to prevent a situation from escalating to the point of crisis. In addition, the hourly rate paid to physicians as independent contractors allows them to spend sufficient time with each client to address complex concerns. Team psychiatrists are also on site part-time for consultations and to provide in-depth psychiatric care.

At Seaton House, the largest shelter in Toronto, the Family Health Team is an excellent example of community health care. The clients of Seaton House are some of the most vulnerable in society, and their burden of illness is profound. Clients of this team require extensive guidance and support in meeting their own healthcare needs. While the traditional healthcare system is focused on meeting immediate or acute needs, the Family Health Team at Seaton House uses an approach that is centred on prevention. Addressing health concerns before they turn into crisis and require hospitalization saves the system a great deal of money and saves patients a great deal of distress.

Family Health Teams are an excellent model for meeting the complex needs of individuals suffering from serious and persistent mental illness. The impact on cognitive functioning that many of these illnesses have requires a more hands-on, comprehensive and holistic approach to care which requires that the wide range of an individual's needs are met.

## Appendix F

### **Case Example: Hospital-Community Partnership Lanark County Mental Health (LCMH), Smith Falls, Ontario**

Lanark County Mental Health (LCMH) is a truly unique network of services for adults with severe and moderate mental health concerns. Established in 1981, LCMH is fully funded by the Ministry of Health and Long-Term Care. Although LCMH is not referred to as a “one-stop shopping model for mental health care,” that is essentially what it is. LCMH provides patient-centered care and a collaborative team approach where the patients and family members are very much engaged in the recovery process.

LCMH works in collaboration with local hospitals to ensure high quality services and timely treatment for the 62,000 residents in Lanark County - a rural area near Ottawa. The LCMH team model also encourages shared care between the four psychiatrists who practice in the region and the patient’s family doctor.

Support is available for primary mental health problems such as depression and anxiety as well as more chronic illness such as schizophrenia and manic-depressive illness. Services provided by LCMH include: assessment and referral, crisis stabilization, counselling, psychiatric consultation, community outreach, linkage to hospital resources, education and training. In 2007 alone, LCMH received 1,100 referrals for services from hospitals, doctors, family members and individuals themselves.

Hospital-community collaboration is facilitated partly through the presence of community workers on-site at the hospital. Four LCMH psychiatric nurses are dedicated to spend 15 to 20 hours per week in one of three regional hospitals (Almonte General Hospital, Carleton Place & District Memorial Hospital and Perth & Smith Falls District Hospital) where they have their own office in the ER to conduct psychiatric assessments. When an LCMH nurse is on duty at the hospital, there is essentially no wait time in the hospital ER for assessment for someone is in psychiatric distress. Decisions regarding care are made in collaboration with the ER physician, who usually relies heavily on the assessment conducted by the LCMH nurse. Discharge planning from the regional hospitals includes LCMH staff.

LCMH is active in the area of education as well. Staff provide regular training sessions on mental health to all hospital and ambulance staff as well as the police in the region. LCMH also provides an on-call consultation service from 8 p.m. to 8 a.m. and weekends for hospitals and police.