

MENTAL HEALTH CRISIS BEDS IN THE CITY OF OTTAWA:

A Review and Roadmap for the Future

Final Report

September 2014

Table of Contents

Executive Summary 4

Project Background 7

 History of the Crisis Bed Program 7

 Review Activities..... 7

 Review Process 8

Context 8

 Making It Happen 8

 The Champlain District Crisis System 9

 Mental Health Crisis Line (Tier I) 9

 Local Mobile Crisis Teams (Tier II) 10

 Crisis Beds..... 10

 The Ottawa Hospital Crisis Bed Program..... 10

 System Context..... 12

 Deinstitutionalization and Hospital Diversion..... 12

Current approaches in crisis bed provision in Champlain 13

Challenges and Opportunities: Ottawa Crisis Bed Program 16

 Admission and Exclusion Criteria 16

 Location issues..... 17

 People with mental health and addictions issues 19

 Medication supply, administration, and supervision 19

 Length of Stay 19

 Linkages and Partnerships 20

 Capacity and Utilization..... 21

A broader paradigm shift 23

Outcome Indicators and Target Standards 26

Roadmap for Implementation and Proposed Timelines 28

Bibliography..... 30

Appendix A: Using Better Practice to Guide Next Steps 33

Appendix B: Physical Location(s) Criteria for Consideration 40

Executive Summary

The Ottawa Hospital has undertaken this review of its mental health crisis bed program (part of the Mobile Crisis Team) to identify:

- The level of satisfaction with the current program from the perspective of clients and family members,
- Opportunities to enhance the program from the perspective of better practices,
- How the crisis beds are currently operating within Ottawa, but also more broadly across the Champlain region,
- Key challenges and areas for improvement, and a short-, medium- and long-term set of recommendations for evolving the program.

To this end, focus groups were held with clients and families, the Ottawa Mobile Crisis Team was consulted, other crisis bed providers within the region were interviewed, and a scan of other crisis bed programs was conducted.

Overarching findings include:

- Clients and family members consulted are satisfied with the service and, in particular, spoke highly of crisis team staff, however, they reflected on the physical locations of the beds in an often negative way with respect to comfort, safety, and whether the environments of the current crisis beds was the best fit – this is consistent feedback with mobile crisis team members
- Regionally, a key area of concern for all crisis bed providers is the “fit” of the model for youth and young adults from a safety and supervision perspective, but also in relation to challenges faced in addressing the needs of transition-aged youth and engaging them in appropriate services to facilitate timely discharge,
- Additional work is needed to better reflect an inclusive set of admission criteria or operating procedures relating to who should be admitted to the crisis beds: the reality that there are very few resources available for respite and the current set of admission criteria for the crisis beds seriously impact the system’s ability to proactively work to avert a full-blown crisis.
- There are capacity issues, as well as issues related to target length of stay, across the region,
- The current number of physical sites used for the crisis beds in the City of Ottawa is too many, and creates inefficiencies related to staff travel time,
- The crisis bed program requires greater integration with key partners in the youth sector, addictions sector, and housing sector.

Key recommendations are as follows:

Regional Collaboration: Crisis Bed Objectives, Admission Criteria, Capacity and Evaluation

- That crisis bed providers incorporate specific objectives relating to crisis bed provision across the region, including identifying opportunities for consistency in inclusion criteria, regional reporting on utilization and issues, and ongoing identification of capacity issues and needs.
- That crisis bed providers use existing collaboration mechanisms for the regional crisis line and crisis teams to articulate common standards, guidelines or procedures for crisis beds across Champlain, including target length of stay, utilization of peer support, medication management, regional tracking of bed utilization and access processes, and other issues as identified
- In the context of a broader discussion with crisis bed partners, that current inclusion and exclusion criteria be reviewed and updated to reflect the following considerations and current practices, at a minimum

- That clients presenting in emergency or through Mental Health Court be considered high priority for admission to a crisis bed,
- That ability to administer their own medications be removed from the inclusion criteria,
- That willingness to abstain from substance use be removed from the inclusion criteria,
- That a significant history of violent or assaultive behaviour be removed from the exclusion criteria
- That exclusion criteria remove reference to developmental delay and housing-related crises
 - This type of revision to inclusion and exclusion criteria needs to reflect more on behaviour and capacity related issues of the person.
- That the target length of stay for crisis beds be articulated in collaboration with other crisis bed providers within the Champlain LHIN, and in collaboration with LHIN staff
- That TOH and the Champlain LHIN explore capacity-related issues of the crisis bed program and that mobile crisis teams across Champlain engage in a discussion about needs and capacity issues of mobile crisis teams.

Enhancing Partnerships: Emergency Services, Developmental Services, Addictions Services, and Youth Services

- That emergency department staff receive training on inclusion/exclusion criteria and procedures are developed to articulate the referral process when a client presents at the emergency department.
- That TOH engage with leaders in the dual diagnosis (mental health and developmental delay) field to outline a process that best meets the needs of people who are experiencing a mental health crisis, but also having varying degrees of developmental disabilities.
- That TOH engage with Withdrawal Management Services to effect a priority system for people presenting to the Emergency Room requiring WMS so as to ensure that these clients are not streamed to a crisis bed at an inappropriate time in their individual process. This engagement should include representation from the Champlain LHIN and should consider the following: priority access, communications among key partners (hospital emergency staff, OMCT and WMS staff), and collaborative treatment planning for people requiring and desiring both withdrawal management and crisis services.
- That the Mobile Crisis Team prepare a present a report on current issues with respect to housing and support options of crisis bed clients to :
 - Supportive Housing Network of Ottawa
 - Social Housing Network of Ottawa
 - Centralized Housing Registry of Ottawa
 - In an effort to explore how clients in the crisis bed program (and more broadly clients of the crisis team), can be given priority access to appropriate housing options.
 - That, as part of partner presentations to key housing partners, explore partnership opportunities, particularly in the context of upcoming capital RFPs expected to be issued by the City of Ottawa, to identify how future capital builds might incorporate a physical space to site the majority of the crisis beds in Ottawa.
- That TOH move immediately to submit a proposal to the LHIN, in partnership with key partners serving youth and young adults with mental health needs, to pilot a crisis bed site for youth and young adults. While this site would be located in the City of Ottawa, it would be accessible to youth and young adults throughout Champlain, and proposal planning should actively engage regional partners in how best to address transportation requirements, including exploring how this could be supported through a youth employment initiative. The youth and young adults crisis bed pilot should incorporate peer support, partner agency staff, and specifically target youth and young adults aged 16-24.

Crisis Bed Location: Short, Medium and Longer Term Planning

- That, on an interim basis, the crisis bed program be reduced to no more than three providers including 2 beds at Ottawa Inner City Health, 6-8 beds at Rothwell Heights retirement residence, and 2 at the YMCA. Remaining funding will be used for hotels or motels on an as-needed basis. Other existing contracted providers of beds will be provided with the requisite three months' notice for termination of the contracts by January 31, 2015.
- That the crisis bed program, in its movement towards reducing the number of locations, and incorporating hotel/motel options, define client profiles and needs most appropriate for each of the bed locations, reflecting a continuum of bedded crisis support options for a continuum of client needs.
- Beginning in the Fall 2014, negotiations will begin with the Youth Services Bureau to establish their potential to provide space for 2 beds for youth and young adults from the City of Ottawa and an additional 2 beds for residents from other areas of the Champlain LHIN area
- In Winter 2014, that TOH initiate a Request for Proposal process to secure a single site for 6-10 beds (assuming that 2 beds will be retained at Inner City Health, and 2 beds will be located at a Youth Services Bureau site).
- That the longer term goal will be to actively pursue a facility to locate all of the beds (discussed in further sections).
- That, over the next fiscal year, a proposal be developed for a single site for mental health crisis beds in Ottawa, incorporating physical plant requirements, options around co-locating staff from multiple agencies, and integration of peer support.

Medication Supply and Administration

- That TOH review policies related to provision of medication supply, specifically as this relates to clients coming through the hospital and being admitted to an Ottawa crisis bed, to ensure medication is packaged in ways that best meet the needs of the client and the program. Currently, discussions are underway to provide medication in bubble packs which is the ideal option.
- That the Mobile Crisis Team specifically identify which client profiles require assistance with medication administration and which don't, particularly given that this can dictate the type of crisis bed they need in terms of level of supervision. This is consistent with a core value of the crisis bed program (and crisis response in general) to provide the least intrusive approach when working with people in crisis.

Evaluation

- That the Mobile Crisis Team update its evaluation plan to ensure the following outcome indicators and target standards are incorporated in data collection and service user satisfaction surveys, and that mechanisms are in place to assess staff satisfaction.

A high-level roadmap has been included to outline next steps for The Ottawa Hospital's consideration.

Project Background

History of the Crisis Bed Program

In 2005, The Ottawa Hospital was provided with funding to support creation of a crisis bed program within the City of Ottawa, and to provide funding to other areas within Champlain to support implementation of crisis beds in those local areas (Renfrew County; Stormont, Dundas & Glengarry; and the United Counties of Prescott-Russell). Essentially, crisis beds are considered a community alternative to inpatient hospitalization. In each area, access to the crisis beds is through local Mobile Crisis Teams. At the time of inception, due to funding constraints, the Ottawa Mobile Crisis Team (a program of TOH) contracted with service providers who already had housing or treatment facilities providing 24/7 staffing for the beds, with daily or almost daily support from OMCT staff. As funding has increased, the model of operation has remained largely unchanged, and TOH contracts with shelters, addictions service providers, and retirement homes for the 11 beds now in operation. TOH pays a per-diem fee to these agencies and they, in turn, provide a private room in their facility.

In March 2014, The Ottawa Hospital undertook a review how the current crisis bed program is operating, and how resources might be redeveloped to better fit the needs of current and future clients. In addition, clinical staff from The Ottawa Hospital's Mobile Crisis Team provide mobile support to clients using these beds. This review also provided an opportunity to understand how other areas within Champlain are currently operating their crisis beds programs.

Review Activities

The report and recommendations were informed by the following activities:

- Conduct interviews and/or focus groups with clients and family members who have used, or chosen not to use, the crisis bed program
- Engage with content experts nationally and internationally to review existing practices in the context of evidence-based practices
- Conduct interviews and/or focus groups with current bed providers in the City of Ottawa and the mobile crisis team to assess current status, current practices, challenges and opportunities
- Identify opportunities to liaise and link with other programs or initiatives for specific population groups e.g. transition-aged youth
- Liaise with other crisis bed programs operating within the Champlain LHIN through key informant interviews to assess current status and practices
- Articulate the challenges and opportunities related to the residential crisis bed program. Specific issues to consider include:
 - Physical structure (congregate versus dispersed models),
 - Crisis bed functions and target population,
 - Skill mix required to support people using crisis beds,
 - Involvement/engagement of peer support and family peer support
 - Alignment opportunities with emergency department and hospital discharge planners (including communication and referral processes)

Review Process

This report summarizes findings from:

- Two client and family focus groups were undertaken with fifteen participants
- A meeting with the Family Advisory Committee of the Addictions and Mental Health Network
- Two meetings with Ottawa Mobile Crisis Team staff members
- Key informant interviews with crisis bed programs within Champlain
- A literature scan of existing / better practices in community crisis bed programs
- Liaison with content experts in other jurisdictions on key programs to profile and for assistance in client and family focus groups
 - Robyn Priest (former lead investigator, Mental Health Commission of Canada)
 - Fran Sylvestri (Executive Director, International Initiative for Mental Health Leadership)
 - Steve Lurie (Executive Director, CMHA Toronto)
 - Marion Wright (Director of Clinical Services, Frontenac Community Mental Health and Addictions Services; Accreditations Canada lead investigator)

This report is structured to incorporate better practices, issues and recommendations throughout the report, with a summary roadmap provided in conclusion.

Context

Making It Happen

Crisis response systems are one component of first line services, as defined by the MOHLTC in *Making It Happen* (the mental health policy framework):

- Prevention, assessment and treatment by front line health care providers this includes general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics;
- Priority population for mental health reform is people with severe mental illness (SMI). *First line emergency crisis services must be accessible to all people with symptoms of mental illness;*
- Services include information and referral, crisis telephone lines, mobile crisis teams, Schedule 1 hospital emergency services, holding/safe beds, primary care physicians, mental health counselling, community health centres, and health service organizations.

Local planning initiatives (Champlain District Mental Health Implementation Task Force, and, more recently, the regional three year mental health and addictions plan) draw a distinction across two types of beds:

- Respite beds: community-based beds that provide people with respite from their current living situation, or provide respite for caregivers,
- Community-based crisis beds: a community-based option where beds are focused on short-term crisis resolution and are not considered a placement for extended observation and assessment. This definition is consistent with that provided by the Ministry of Health & Long-Term Care.

The differentiation between these two types of beds is based on the person's needs, a risk assessment, and the core functions of the community crisis beds.

The Champlain District Crisis System

The crisis bed program sits within a broader crisis system with the Champlain region. More than ten years ago, the service providers funded to provide crisis services across the Champlain District¹ committed to working together to put in place a District-wide bilingual mental health crisis telephone response capability and, in their respective geographic areas, a local assessment and intervention response capability (including a mobile response). The Champlain District-wide mental health crisis line was initiated in July 2003.

To support the development and on-going operations of the integrated mental health crisis services system, the providers of mental health crisis services in the Champlain District formed a formal Management Committee. Through this structure the providers have set up a collaborative and supportive systems planning process to finalize service agreements; share information and resources; ensure on-going monitoring for quality improvements; and develop and implement an evaluation framework.

Recommendation: That the Management Committee incorporate specific objectives relating to crisis bed provision across the region, including identifying opportunities for consistency in inclusion criteria, regional reporting on utilization and issues, and ongoing identification of capacity issues and needs.

What follows is a brief description of the three core service components currently provided through crisis funding: the district-wide tier I mental health crisis line (tier I), the local mobile crisis teams (tier II), and the existing crisis bed constellation.

Mental Health Crisis Line (Tier I)

This Tier 1 line is a collaborative initiative across the Champlain District, including partners from the City of Ottawa (The Ottawa Hospital), and the counties of Renfrew (Pembroke General Hospital), Stormont-Dundas-Glengarry (Cornwall Community Hospital) and Prescott-Russell (Hawkesbury General Hospital). A partnership arrangement, through a formal service agreement, was entered into by all four mental health crisis services providers across the district with the Distress Centre of Ottawa. The total annual funding of \$240,000 is made up of equal contributions of \$50,000 by each of the three providers outside of Ottawa and a contribution of \$90,000 by the Ottawa service.

Key characteristics of the service include:

- The first point of public access to the mental health crisis response system.
- Serves people 16 years of age and over.
- Provides a single, district-wide, toll free, bilingual telephone line available 24 hours/7 days a week.
- Staffed by trained volunteers, supported by professional staff.

¹ City of Ottawa, Renfrew County, United Counties of Stormont, Dundas & Glengarry and the United Counties of Prescott-Russell.

- Provides screening, assessment, referrals, support in a crisis, suicide intervention and transfer to the Mobile Crisis Team or to emergency services when advisable.
- Access to Service - Public Access
 - Individuals, families or concerned friends can call the Mental Health Crisis Line at 722-6914 or toll free 1-866-996-0991. The volunteer will offer support and, if required, can make a direct transfer to the local Mobile Crisis Team.

Local Mobile Crisis Teams (Tier II)

A crisis team is operated by each of the partners in their respective geographic area.

- Mobile Crisis Teams work closely with hospital emergency rooms, community mental health and addictions service providers, psychiatrists, Mental Health Court and police to ensure a safe and comprehensive response.
- Services include crisis intervention, assessment, consultation, and links to community supports in a least intrusive approach to enable individuals in crisis to remain in their own environment.
- Consultation and advice can be provided to family members.
- Short-term follow-up and support can be provided for certain cases to help resolve the crisis. The Mobile Crisis Teams are composed of Crisis Counsellors, Registered Nurses and/or Social Workers.
- Access to Service - Professional Access
 - Professionals in the community including agencies, doctors, police, social workers, nurses and others are provided with a direct contact number to the Mobile Crisis Teams.

Crisis Beds

First funded in 2004/05 by the Ministry of Health (through the Service Enhancement funding initiative), crisis beds are operated in each geographic area, with TOH flowing funding to each of the providers in local areas.

- Community crisis beds provide an alternative to hospitalization for people experiencing mental health crisis, including a focus on keeping people out of the criminal justice system.
- Services include crisis intervention, monitoring and assessment, and linking people to community supports.
- Generally, beds are provided through an agreement with organizations who already have staff available on a 24/7 basis, and crisis team staff regularly visit clients using the crisis beds.
- There is a strong emphasis on diversion from emergency rooms
- Access to Service – Mobile Crisis Teams
 - Crisis teams in each local area are the central point of access to local crisis beds although they work closely with emergency room staff in local hospitals when clients present in hospital settings.

The Ottawa Hospital Crisis Bed Program

The Ottawa Hospital Mobile Crisis Team has 11 community crisis beds at 6 different agencies located throughout Ottawa. These crisis beds are a voluntary, community based alternative for people experiencing mental health crises who do not require an acute inpatient hospitalization, but who would benefit from access to temporary housing and support. The community crisis bed program provides an opportunity for an individual to initiate

steps to resolve the current crisis through problem-solving, symptom stabilization, and reconnection to community supports.

Mobile Crisis Team staff meet daily with the client in the community crisis bed to assess mental status, medication response, symptom stabilization, and to begin a holistic approach to crisis resolution through connection to formal and informal supports, and enhancement of coping skills. The target length of stay is 5 days.

Staff within the community agencies provide clients with assistance in activities of daily living such as meal preparation, laundry, and, often, medication facilitation.

Referrals for the community crisis beds are made through the Mobile Crisis Team.

The Mobile Crisis Team will assess the client and respond to the referral source regarding whether the client has been accepted to the community crisis bed program.

Admission Criteria

- Clients must be 16 years of age and older for most crisis bed residences (18 years old to stay at specific agencies)
- Reside within the City of Ottawa
- Have serious mental health issues and are experiencing a mental health crisis (including psychosocial crises)
- Do not require inpatient admission** based on risk assessment (no imminent risk of suicidal, assaultive, self-harm or destructive behaviours) AND are willing to be voluntarily admitted to the crisis beds
- Are in stable physical health and have the ability to self-care for basic physical and personal needs
- Are able to administer own medications
- Willing to abstain from alcohol and/or substance use while in the crisis bed

Exclusion Criteria

- Risk assessment indicates that an inpatient admission or detox facility would be most appropriate treatment choice
- There is a significant history of violent or assaultive behaviour
- Client does not consent to admission to the beds
- Treatment recommendations require close medical or psychiatric supervision
- Are likely to wander and are incapable of returning to the Community Crisis Beds independently
- Are already living in a 24/7 mental health or long-term care supported bed
- Present with problems which are primarily caused by a developmental delay condition or dementia
- Primary crisis is housing related – no mental health concerns

System Context

Deinstitutionalization and Hospital Diversion

Consistent with a global movement towards deinstitutionalization of people living with serious mental illness, there have been significant community investments in community-based mental health services in Ontario over the last fifteen years which, at least in part, have been intended to coincide with closure of provincial psychiatric hospital beds. Community mental health providers first began receiving government funding in 1976: to contextualize the significant increases, between fiscal years 2001 and fiscal years 2007, funding to community mental health services in Ontario increased from \$390 million to \$647 million². By 2009, funding was at about \$683 million.

In 2011, Canada had one of the smallest numbers of psychiatric care beds per 100,000 population (33 beds/100,000 population) among all OECD countries³: the cautionary note, then, is that community-based services must correspondingly meet the needs of people in the community, however this has not been the experience of clients and family members. Indeed, the 2008 Auditor General's Report, while acknowledging that the Ministry of Health had nearly reached its interim goal of 35 psychiatric beds/100,000 population, noted that the system was still far from its target of investing 60% of mental health spending on community Based services. As of fiscal year 2006, the MOH spent about \$39 on community-based services for every \$61 spent on institutional services. Other findings included the dearth of availability of supportive housing (with wait times ranging from one year to six years across the province) and significant wait times for other community-based mental health services (averaging 180 days, with a range of eight weeks to a year or more for services). In a 2010 follow-up report by the Auditor General, the MOH noted it would be undertaking a review of short-term crisis beds and establishing standards for crisis beds in Ontario⁴. As of the date of this report, no such review has been published. Ultimately, these system pressures and lack of system capacity have a cascading effect, leading to increased utilization of emergency rooms, and inpatient services.

A central goal of the Champlain LHIN is to decrease utilization of emergency rooms and inpatient services where other appropriate alternatives are available, such as the community crisis beds. Most recently, the LHIN supported the development of a three-year community action plan for mental health and addictions services (Connecting the Circle). In particular, the value stream mapping exercise emphasized the need for integrated access to community crisis beds, as well as the need for respite bed options (which have been recommended but not funded through multiple system planning exercises).

² 2008 Annual Report of the Office of the Auditor General of Ontario, p.172.

³ Australia at the forefront of mental health care innovation but should remain attentive to population needs, says OECD . <http://www.oecd.org/els/health-systems/MMHC-Country-Press-Note-Australia.pdf>

⁴ 2010 Auditor General Follow-up Report to 2008 Annual Report. http://www.auditor.on.ca/en/reports_en/en10/406en10.pdf

Current approaches in crisis bed provision in Champlain

Partners reflected on a number of issues related to crisis bed provision outside of the City of Ottawa, including:

- Youth and young adults are one of the most challenging groups: they can require higher levels of supervision because of their age and should be kept separate from older clients where possible
- Length of stay is very challenging to meet, and this primarily relates to housing issues clients are experiencing
- A growing issue are co-occurring health issues clients have, and how best to ensure those are met: although all areas use retirement homes, some homes won't accept clients under the age of 65
- Tracking admissions and other service-level data can be complicated: where agencies are using CRMS, utilization of the crisis service versus the beds isn't tracked separately

The following table provides an overview of how crisis beds are organized across Champlain: The Ottawa Hospital is the transfer payment agency for all funding for the crisis beds in Champlain. Funding for the beds is for the purchase of the beds themselves and does not include additional costs related to administration, transportation, staffing, and physician consultation costs.

Recommendation:

That crisis bed providers use existing collaboration mechanisms for the regional crisis line and crisis teams to articulate common standards, guidelines or procedures for crisis beds across Champlain, including target length of stay, utilization of peer support, medication management, regional tracking of bed utilization and access processes, and other issues as identified

Local Area	Number of Beds	Physical structure / bed location	Funding	Support Levels	Target Length of Stay	Partnerships
Ottawa	11	In 6 locations: Rothwell Heights Retirement Home (4 beds, M or F) Ottawa Inner City Health – Salvation Army (2 M) The Oaks (2 beds, M or F) YMCA/YWCA Shenkman Residence (1 M bed and 1 F bed) Alexander House (1 bed, M or F)	\$276,960 for bed purchase + 4.2 FTE (social work and RN) equivalent to 12 hours coverage/day	Crisis team meets daily with clients (sometimes less depending on client need)	3-7 days but can be extended (in particular for housing-related issues)	Noted organizations Psychiatric Emergency Service – TOH Receive referrals from police as well as other community partners (including assertive community treatment teams and Canadian Mental Health Association), shelters
Renfrew County	3	In multiple locations (pay based on bed use): primarily using a hotel and motel, but have some arrangements with Carefor in Pembroke and Renfrew Victoria Hospital for their elder abuse program for people that require additional support Additionally, have an extra bedroom in their Semi-Independent Living home through Homes for Special Care (total of 3 beds) which is used occasionally	\$36,500	Crisis team may not go out on a daily basis to clients in beds – depends on level of need, also try to encourage clients to implement their plan themselves	Range of 3 days – week is the target – can extend for as long as a month (usually due to housing issues) Generally average 25 admissions annually – but significant range (e.g. last year was 40+)	Carefor Renfrew Victoria Elder Abuse Program Crisis team has agreement in place for all five hospitals within the County to go on-site to meet with people Receive referrals from police as well
Prescott-Russell	2-3	In multiple locations (pay based on bed use except for Residence McDonald in Van Kleek Hill where there is a contract for annual utilization) Will use another residence for a second bed capacity if needed, and	\$36,500	Crisis team may not go out on a daily basis to clients in beds – depends on level of need, availability of	Maximum 10 days – sometimes extends by 2-3 days to ensure person has place to go to Minimum 40 admissions annually	Residence McDonald Crisis beds/crisis team are a service of the Hawkesbury General Hospital Receive referrals from multiple sources

Local Area	Number of Beds	Physical structure / bed location	Funding	Support Levels	Target Length of Stay	Partnerships
		motel very occasionally		resources – also use phone calls as a method of staying in contact		
Stormont, Dundas and Glengarry	3	In multiple locations (pay based on bed use) in Cornwall Motel, residential home, residential retirement home Good working relationships with management at each of the locations	\$36,500	Crisis team does follow up with clients in beds – relationship with other services as well	Maximum 5 days	Crisis team, ACTT, Withdrawal Management Services and ER have access to beds

Challenges and Opportunities: Ottawa Crisis Bed Program

Admission and Exclusion Criteria

For a variety of reasons, people are sometimes admitted to the crisis bed program who don't "fit" within the existing inclusion criteria. These reasons include:

- Recognition that the current inclusion/exclusion criteria prevent appropriate admissions and are inconsistent with better practices: for example,
 - Clients who are admitted through the Mental health Court often have some history of violence
 - Adoption of a more harm reduction centred approach which recognizes that there are clients who use substances, but that substance use is only an issue if it is obstructing progress with respect to the client's treatment plan
- Current pressures in emergency and inpatient services, with pressure from emergency room staff to admit someone in order to prevent a hospital admission,
- Person-centred planning/clinical judgement/lack of housing options: staff recognize that there are some situations where a crisis bed admission is necessary to prevent continued escalation of the pressures the person is facing – predominantly, these can be attributed to housing crises, with the team recognizing that without pre-emptive intervention, the person will eventually experience escalating mental health issues
- Keeping strictly to inclusion criteria (as they currently stand) can substantively decrease utilization of the beds, and there is an acknowledgement that a community alternative to hospitalization and/or escalating crisis is necessary. For this reason, the lack of respite bed options within the community can lead to admissions which are more related to current living situation and/or pressures as opposed to meeting a rigorous definition of "crisis".

Recommendations:

In the context of a broader discussion with crisis bed partners, that current inclusion and exclusion criteria be reviewed and updated to reflect the following considerations and current practices, at a minimum

- *That clients presenting in emergency or through Mental Health Court be considered high priority for admission to a crisis bed,*
- *That ability to administer their own medications be removed from the inclusion criteria,*
- *That willingness to abstain from substance use be removed from the inclusion criteria,*
- *That a significant history of violent or assaultive behaviour be removed from the exclusion criteria*
- *That exclusion criteria remove reference to developmental delay and housing-related crises*

This type of revision to inclusion and exclusion criteria needs to reflect more on behaviour and capacity related issues of the person.

That emergency department staff receive training on inclusion/exclusion criteria and procedures are developed to articulate the referral process when a client presents at the emergency department.

That TOH engage with leaders in the dual diagnosis (mental health and developmental delay) field to outline a process that best meets the needs of people who are experiencing a mental health crisis, but also having varying degrees of developmental disabilities.

Quotes from Clients and Family:

We don't have access to respite like they do in dementia...part of the fatigue is, you try to get in and you're disappointed.

I much prefer to be told up-front, "I'm telling you, it's not a good match with what we do".

It was a very smooth transition...it was exactly what I needed.

There are doors closed all over the place [in the mental health system]... this is a door that needs to be open.

The Crisis Team – they saved my life. When I first walked in the place, I felt more depressed, but people were good to me and so what it looked like physically wasn't as important.

The doctor told me there was an alternative...I was extremely impressed by how efficient it was.

Location issues

Almost universally, mobile crisis team staff, clients and families have identified issues with the current locations of the crisis beds. Consistent with feedback from crisis bed programs across Champlain, Ottawa staff identified the challenges associated with youth and young adults, clients with middle or higher incomes, and clients with physical health needs. The current locations of the crisis beds are primarily retirement residence or shelter-based. While this provides some potential clients with an appropriate environment (such as older clients, as well as street-involved clients), they are mostly ineffective and inappropriate as a setting for younger clients, or clients who have middle or higher incomes.

Currently, these client groups are most often placed at the beds located at the YMCA, however, this is a location that has little ability for staff on-site to provide medication monitoring and supervision.

Multiple locations increase staff time spent in travel and liaison with multiple partners. It's clear that the number of locations needs to be reduced to increase efficiency, and also to identify additional options that better meet the needs of youth and young adults.

Quotes from Clients and Family:

The place I'm in right now – it's not physically accessible.

For me, it was really a respite. And it was absolutely incredible follow-up. If I called them today, they would take my call. But when I first walked into the place, I wanted to leave.

Recommendation:

- 1) That, on an interim basis, the crisis bed program be reduced to no more than three providers including 2 beds at Ottawa Inner City Health, 6-8 beds at Rothwell Heights retirement residence, and 2 at the YMCA. Remaining funding will be used for hotels or motels on an as-needed basis. Other existing contracted providers of beds will be provided with the requisite three months' notice for termination of the contracts by January 31, 2015.
- 2) Beginning in the Fall 2014, negotiations will begin with the Youth Services Bureau to establish their potential to provide space for 2 beds for youth and young adults from the City of Ottawa and an additional 2 beds for residents from other areas of the Champlain LHIN area
- 3) In Winter 2014, that TOH initiate a Request for Proposal process to secure a single site for 6-10 beds (assuming that 2 beds will be retained at Inner City Health, and 2 beds will be located at a Youth Services Bureau site).
- 4) That the longer term goal will be to actively pursue a facility to locate all of the beds (discussed in further sections).

In implementing these recommendations, The Ottawa Hospital will also review the considerations for the community crisis beds, as developed by Agnew Peckam as part of the functional program planning process. These considerations have been included below:

- **Organization of the beds** - How should the beds be organized? Should they be consolidated in one location or several locations? If the latter, how many beds should be in each location to ensure a critical mass.
- **Location of the beds** - Where should the beds be located to provide best access by clients? Do the beds need to be in proximity to the TOH Mobile Crisis Team? If the beds are not in a single location, should they be in close proximity or at a distance from each other?
- **Delivery of the services** - Should the beds be operated by one or multiple providers? How will quality standards be maintained?

Quotes from Clients and Family:

Once I was in the bed, it was very good care – I probably should have gone to a hospital and gotten help earlier.

Sometimes you need a place to get away to – a place that's away from the stressors in your life, where you have someone to talk to. But it should feel nice when you go there – you shouldn't feel like a second class citizen because you have a mental illness.

It was a godsend to know there would be someone that I was going to be able to talk to – and it was clear they really cared.

Detailed criteria for the physical location (s), have been included in Appendix B.

People with mental health and addictions issues

Additionally, crisis team staff spoke about their concerns relating to clients requiring detox services related to substance use problems. In theory, crisis beds are not to admit clients with these needs: the practical reality of pressures at the hospital level has sometimes impacted the application of this exclusion criteria.

Recommendation: That TOH engage with Withdrawal Management Services to effect a priority system for people presenting to the Emergency Room requiring WMS so as to ensure that these clients are not streamed to a crisis bed at an inappropriate time in their individual process. This engagement should include representation from the Champlain LHIN and should consider the following: priority access, communications among key partners (hospital emergency staff, OMCT and WMS staff), and collaborative treatment planning for people requiring and desiring both withdrawal management and crisis services.

Medication supply, administration, and supervision

“I find there are just always problems with medications and dosages” (mobile crisis team staff)

A number of crisis team staff identified the lack of It is unclear the extent to which medication administration is required for all clients and, given that most clients are being discharged to a home environment and will be taking their own medications, careful consideration is needed to identify which clients require close medication supervision (or assistance with administration) and which do not. This forms one part of a broader discussion about the philosophy of the crisis beds.

Recommendation: That TOH review policies related to provision of medication supply, specifically as this relates to clients coming through the hospital and being admitted to an Ottawa crisis bed, to ensure medication is packaged in ways that best meet the needs of the client and the program. Currently, discussions are underway to provide medication in bubble packs which is the ideal option.

Recommendation: That the Mobile Crisis Team specifically identify which client profiles require assistance with medication administration and which don't, particularly given that this can dictate the type of crisis bed they need in terms of level of supervision. This is consistent with a core value of the crisis bed program (and crisis response in general) to provide the least intrusive approach when working with people in crisis.

Length of Stay

When the crisis bed program was in its first planning stage ten years ago, partners clearly noted that success of these beds is dependent on appropriate and timely discharge with appropriate services in place: Partnerships are essential to effective implementation. Universally, programs across Champlain

have identified issues relating to meeting a target length of stay of around five days to being tremendously challenging to meet, particularly in relation to the availability of housing options in the community.

Recommendation:

That the Mobile Crisis Team prepare a present a report on current issues with respect to housing and support options of crisis bed clients to :

- Supportive Housing Network of Ottawa
- Social Housing Network of Ottawa
- Centralized Housing Registry of Ottawa

In an effort to explore how clients in the crisis bed program (and more broadly clients of the crisis team), can be given priority access to appropriate housing options.

That the target length of stay for crisis beds be articulated in collaboration with other crisis bed providers within the Champlain LHIN, and in collaboration with LHIN staff.

Linkages and Partnerships

One of the benefits of the multiple locations of the crisis beds has been the opportunity for mobile crisis team staff to build relationships with organizations across the city. At the same time, staff, clients and families talked about the potential of creating new partnerships that would enhance people’s experiences when they’re using the crisis beds, specifically in the area of programming and peer support. Crisis team staff also discussed the nature of the needs of clients that they see including social isolation, and a tendency to have had a lengthy involvement with the mental health system. They expressed concern about where their role “ends” because the needs of the clients can be so complex, that it can be difficult to disengage. While there is a role for system navigation or coordination of referrals within the mobile crisis team, and particularly in the context of working to address the client’s issues while they’re in the crisis beds, the team is keenly aware that they do not have an ongoing role with clients.

Quotes from Mobile Crisis Team Staff:

“It’s hard to stop, people need income, they need housing, it’s not good enough to just find them a rooming house....There have been miracles accomplished.”

“We get the people who have been hiding, living unimaginable lives, for years...”

Recommendation: There is a need to look at the development or enhancement of relationships with particular organizations. At a minimum, these should include:

- Housing providers – as noted previously, it’s crucial that key networks and the centralized housing registry be aware of the crisis bed program, and that high priority be given to housing people in the crisis beds.
- CMHA Ottawa – while there is an existing relationship with the Canadian Mental Health Association, the recent investment in Transitional Coordinators, targeting people at risk for use of emergency and inpatient services and often with multiple and complex needs, provides an opportunity to

engage with CMHA on how these new staff members could be involved in matching up with clients who are frequent users of crisis, emergency and hospital services.

- Psychiatric Survivors of Ottawa – there is a significant role that peer support can play when people are experiencing crisis and after. In addition to providing almost daily peer support, social or recreational opportunities, PSO has more recently implemented the Recovery Connections peer support and family peer support team within two hospitals within Ottawa, and is in the process of implementing the program at TOH as well, with an emphasis on clients transitioning back to community. There may be opportunities to provide a targeted approach to clients who are frequent users of crisis, emergency and hospital services and, at a minimum, to review how existing peer support groups could be made accessible to people using crisis beds.

Quotes from Clients and Family:

I was in a really bad place but no one ever offered a crisis bed option. Maybe they didn't know?

I do think education about the mobile crisis team is really important.

My family doctor told me about the bed.

This exercise needs to focus on leveraging organizations' areas of expertise: for example, in a 2012 review of various models of peer support in the United States, researchers found that about 8% of peer support groups or organizations provided respite care, 49% worked with people to secure services they wanted/needed, 34% engaged with people in their housing difficulties, in addition to provision of drop-in centres (34%), mentoring/matching (38%), telephone support (68%) and assisting people in getting jobs (21%)⁵. An extensive review from the U.S. Government's Substance Abuse and Mental Health Services Administration (SAMHSA) departmental review⁶ on consumer-operated programs found that they can and do provide concrete services such as safe shelters, and assistance with other basic needs, such as housing, employment, and education. The programs also may provide crisis response services, links to resources, social and recreational opportunities, information/education, and outreach.

Quotes from Mobile Crisis Team Staff:

"The longer we have them in the bed, the better the chance they won't be back."

"I know I did a better job last year, because there were fewer people with really high needs."

Capacity and Utilization

In general, this region has applied planning benchmarks for crisis beds based on common practices of 2 crisis beds/35 inpatient beds (equivalent to 1 bed/83,000 population).⁷ This isn't inconsistent with more recent planning and benchmarking exercises, however, shouldn't be viewed in isolation of the need for respite beds, which are a crucial option for people experiencing different stressors in their lives

⁵ National estimates for mental health, mutual support groups, self-help organizations and consumer-operated services, 2012, Goldstrom et al., <http://www.psychodyssey.net/wp-content/uploads/2012/02/National-estimates-for-mental-health-mutual-support-groups-self-help-organizations-and-consumer-operated-services.pdf>

⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Consumer-operated Services: The Evidence, 2008, <http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf>

⁷ See Champlain District Mental Health Implementation Task Force, First Line Services and Housing Reports, 2002.

and are identified as a need consistently by clients and family members. They may be used when the client needs respite from their current environment, their caregivers may require respite, or they could serve as a bridging mechanism, for example, if housing will not be available for a certain number of days. There has been little work to date on benchmarking of number of respite beds/100 000 population, although long term care facilities generally allocate 2-5% of their placements specifically for respite. Based on this benchmarking approach, the most recent planning exercise in Champlain identified the need for a minimum of 27 respite beds for people living with serious mental illness in the City of Ottawa⁸.

More recently, as part of a broad benchmarking exercise for one of the regions in Australia, Queensland estimated the need for crisis accommodation and residential respite as **3 beds/100,000 population**, with 3.5 FTE associated with these services⁹. According to the 2011 Census, there are approximately 724,000 aged 16 and over in the City of Ottawa, **equivalent to the need for 22 crisis/respite beds**. *The Ottawa Crisis Bed program has been operating at a 100% capacity over the Summer of 2014.*

Recommendation:

That the crisis bed program, in its movement towards reducing the number of locations, and incorporating hotel/motel options, define client profiles and needs most appropriate for each of the bed locations, reflecting a continuum of bedded crisis support options for a continuum of client needs.

That TOH and the Champlain LHIN explore capacity-related issues of the crisis bed program.

Feedback from the mobile crisis team staff clearly stated a need for more beds and some staff identified the need for a stand-alone facility.

More broadly, there is a need to better understand the capacity of the Mobile Crisis Team with respect to the needs within the City. The United Kingdom has a long history in articulating benchmarks and planning estimates for specific types of treatment teams (including crisis, community mental health and assertive outreach teams). In a 2007 review, the Sainsbury Centre for Mental Health reviewed planning estimates based on the National Health Service plan goals for mental health, and noted that there was one crisis resolution team per 119,796 adult population and extrapolated a staffing team of 23.8 per team (including administration and management) for a team with 24/7 capacity, and an ability to stay engaged with clients on a short-term (one month or less) basis¹⁰. While the intent of this review is to focus on the crisis bed program, the program relies on staffing support from the mobile crisis team, and can't be evaluated in a vacuum from other service pressures.

⁸ CDMHITF Housing Report, 2002

⁹ Planning estimates for the mental health community support sector, 2012, D. Siskind et al., <http://www.smhc.org.au/assets/Uploads/2012/August-2012/CMH-Planning-Targets-Journal-Article-2.pdf>

¹⁰ Delivering the government's mental health policies: services, staffing and costs. J. Boardman and M. Parsonage, 2007, Sainsbury Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/scmh_delivering_govt_mental_health_policy.pdf

Recommendation: That mobile crisis teams across Champlain engage in a discussion about needs and capacity issues of mobile crisis teams.

A broader paradigm shift

When the crisis bed program first initiated in 2004/05, the program was designed to provide a total of 3 crisis beds for the City of Ottawa: with the resources available, there were few options for implementation aside from contracting with existing providers for provision of the beds. Over time, while the funding has increased, this model has continued. While this report has focused on some immediate steps towards addressing program issues, a broader discussion needs to occur to better understand the options for moving forward. The current model focuses on an individual crisis residential option, but there are a range of options to consider in looking to the future of the crisis bed program within the City of Ottawa¹¹, and recognizing that there are examples of peer-run models for each (or examples where peer support plays a significant role). Appendix A provides an overview of individual crisis options in family homes, crisis apartments, crisis homes, crisis stabilization units, and 24-hour beds.

Ultimately, what clients and families have stated as being needed, is a place to “get away” from the pressures and struggles in their lives, and to have an opportunity to be in a safe place, with people who are there to hear them, and work with them on the barriers they’re encountering. The feedback from the small number of clients and families spoken to through this process is very consistent with the findings from a much larger-scale project undertaken in 2012, where over 200 clients and families shared their experience about crisis, emergency and hospitalization. In outlining a broader shift for the crisis bed program in the future, there are two main considerations:

- **Integration of peer support as a central component of the service, together with**
- **Development of a true continuum of crisis residential services (including respite).**

Examples of programs:

- Tupu Ake is a New Zealand-based, peer-driven service that provides a “time out” when people are struggling, and is considered an alternative to hospitalization. Staff are available 24/7 and provide support in different ways including therapeutic programs, but also a physical environment where people can exercise, read, paint and so on. They have the capacity to have

¹¹ Drawn from Crisis manual, 2008, Technical Assistance Collaborative, <http://www.tacinc.org/media/13106/Crisis%20Manual.pdf>

up to ten people overnight, with an additional five people during the day, and length of stay is around a week. Staff have a variety of backgrounds including registered nurses, peer support specialists and counsellors. Tupu Ake is one component of Pathways, New Zealand's largest provider of community-based mental health and wellness services.

- The Living Room (Illinois) opened in 2011, and is part of an existing outpatient community mental health centre near Chicago. It's open 5 days/week and is staffed by an RN, a licensed counsellor and three trained peer counselors. The physical space is designed as a living room in a home, and has office space as well. It's intended to be a quiet, peaceful place for people to go when they're experiencing struggles/issues with their mental health. Service users describe it as a calming, relaxing, healing environment¹².
- Soteria model: an approach that has been evolved and replicated since the 1970s, it is alternative to hospitalization, and has been implemented in a number of different locations (by various organizations) and focuses on authentic interpersonal relationships and limited use of neuroleptic medication. Soteria Vermont is a project in the implementation stages, operated by Pathways Vermont, and is premised loosely on Soteria principles, providing an alternative to hospitalization for people experiencing an early episode of psychosis. Some key features include¹³:
 - An integrated setting in the community, where the residence is indistinguishable from other residences
 - Space for no more than 10 people to sleep
 - Admission procedures are individualized
 - Principles of service provision include: understanding the precipitating factors to the

Quotes from Clients and Family:

For me, having someone to be a sounding board meant a lot – I had a friend I would speak to after I was discharged. That's what you need, when you're in the bed and when you leave – someone to hear you and be around.

I'm really involved at [peer support groups] – I found them by accident by searching online – that's something people need to know about.

They [crisis team staff] really involved my family – that was important to me.

When you're in a crisis, you just want a mental break...and you need to be in a safe place with safe people.

There's more ways to deal with crisis than medication and staff visits – that's part of it, but having someone to talk to about other things you can try, like exercising, meditation, stuff like that. That's really important too.

The places the beds are in – kids can't go there. And we wouldn't send someone with cancer for respite in a shelter, so we shouldn't do that to people with mental illness.

¹² <http://www.power2u.org/downloads/Shatell-et%20al-2014-TLR.pdf>

¹³ Soteria and other alternatives to acute psychiatric hospitalization, 1999, L. Mosher <http://manitoba.cmha.ca/files/2012/03/SoteriaAndOtherAlternativesToAcutePsychiatricHospitalization.pdf>

crisis; staff working in partnership with the client; minimizing dependency on staff and encouraging autonomy; clients can maintain their connection to the program in a number of ways (including periodic group meetings)

- Recovery Innovations Arizona: formerly known as META services, the organization has a broad array of services and 70% of their 275 staff are peer support specialists. The organization provides crisis support, peer support and self-help, recovery education, peer training and employment, and community living. The crisis support service is oriented towards diverting people from inpatient hospitalization, and has approximately 5,000 admissions annually. The center is staffed by a multi-disciplinary team (physicians, RNs, community support specialists, peer support specialists). The “Living Room” component of the service is fully operated by peers and is
- Appendix A contains a number of other examples of programs, including those from within Ontario such as the Gerstein Centre.

Recommendation:

- That TOH move immediately to submit a proposal to the LHIN, in partnership with key partners serving youth and young adults with mental health needs, to pilot a crisis bed site for youth and young adults. While this site would be located in the City of Ottawa, it would be accessible to youth and young adults throughout Champlain, and proposal planning should actively engage regional partners in how best to address transportation requirements, including exploring how this could be supported through a youth employment initiative. The youth and young adults crisis bed pilot should incorporate peer support, partner agency staff, and specifically target youth and young adults aged 16-24.
- That, as part of partner presentations to key housing partners, explore partnership opportunities, particularly in the context of upcoming capital RFPs expected to be issued by the City of Ottawa, to identify how future capital builds might incorporate a physical space to site the majority of the crisis beds in Ottawa.
- That, over the next fiscal year, a proposal be developed for a single site for mental health crisis beds in Ottawa, incorporating physical plant requirements, options around co-locating staff from multiple agencies, and integration of peer support.

Outcome Indicators and Target Standards¹⁴

Recommendation:

That the Mobile Crisis Team update its evaluation plan to ensure the following outcome indicators and target standards are incorporated in data collection and service user satisfaction surveys, and that mechanisms are in place to assess staff satisfaction.

Key outcome indicators to consider including in the Mobile Crisis Team’s evaluation plan include:

- Person’s satisfaction
- Staff satisfaction
- Person’s level of involvement in crisis plan development
- Efficacy of model in alleviating crisis
- Resource utilization: length of stay, number of admissions, number of unique individuals served on an annual basis
- Inpatient admissions measured pre and post implementation of crisis beds

These target standards are intended to inform the development of the evaluation framework.

Function	Standard
Screens and prioritizes referrals according to established criteria based on risk factors, severity and degree of availability of other options	Mobile Crisis Team staff are responsible for determining admission
Provides support and stabilization	Staff are trained in assessment of risk, mental health issues, stressors, need for medical evaluation Milieu is designed in line with research on effective environments
Provides crisis intervention	Provides intervention to help make sense of the crisis, mobilize personal coping resources, formulate a plan to cope more effectively Staff are trained in evidence based group and individual interventions
Ensures safety of clients and staff	Protocols are in place concerning management of aggressive behaviour and other safety issues
Provides an alternative to hospitalization	Referral agents in the community are aware of the criteria for appropriate referrals Clients stay a relatively short time to allow turnover 24 hour staff coverage
Plans actively for a viable discharge to the community where one did not exist previously	Discharge planning begins with admission Family and other supportive others as identified by the person are involved in this planning Other partners are involved in planning as identified by

¹⁴ From Best Practices for B.C.’s Mental Health Reform: Crisis Response and Emergency Services p.32-3.

Function	Standard
	the person
Teaches clients to handle stress more effectively and thus prevent future crises	Provides a program of coping skills enhancement and psychoeducation
Care planning is done in a systematic manner, integrating collateral and assessment data	There is a clear, well-documented care plan

Roadmap for Implementation and Proposed Timelines

The following outlines proposed next steps for this review process, to be undertaken by TOH leadership unless otherwise noted.

Task	Start Date	End Date
Development of HSIP for youth and young adults crisis beds	September	October 10
Review report findings with key partners (mobile crisis team providers in the region, current contracted providers for crisis beds, housing and mental health services, and others as appropriate) as well as specific planning networks as appropriate (including following up with the Addictions and Mental Health Network Family Advisory Committee)	October	December
Refine criteria for physical location requirements for RFP with Agnew Peckham and develop detailed Request for Proposal	October	December
Review and update admission criteria for crisis beds	October	December
Begin engagement process with peer support to identify linkages with crisis beds and peer support		By December
Engage with Champlain LHIN and other Champlain crisis bed providers on capacity issues and to discuss target length of stay		By December
Identify specific hotels and motels that can be accessed for utilization by people not appropriate for current crisis bed locations	Immediate	By January, confirm options to be used
Confirm with current contracted providers how beds will be consolidated and provide notice (recognizing that there are three phases to location changes – 1. Consolidate existing number of locations and establish small pool of funds for use of hotel rooms; 2. Issue RFP for beds and select contracted provider (s) through this formalized process; 3. Longer-term planning goal reflects the need for a stand-alone facility requiring capital dollars)	November	By January
Confirm timelines for issuing RFP	November	January
Address recommendations relating to medication management	Ongoing	By January
Continue discussion with Withdrawal Management Services and Emergency Department to establish appropriate client flow pathways for admission to crisis beds	Ongoing	By February
Update crisis bed evaluation plan to reflect outcome indicators and target standards	November	By March
Consolidate beds to identified three locations and begin utilization of hotels/motels as appropriate		By April
Issue RFP for crisis bed location (s)		Target Spring 2015

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Appendix A: Using Better Practice to Guide Next Steps

The following summarizes the Better Practice Documents (Review of Best Practices and B.C. Best Practices), Identified Innovative Practices, and programs within the province (Gerstein, St. Michael's, CMHA Niagara)

Landeem et al., Delineating the Population Served by a Mobile Crisis Team: Organizing Diversity (January 2004, p.45-50):

- Retrospective analysis (n=401) of people served by COAST (Hamilton), a hospital-sponsored, community-based crisis service reflecting an integrated model with police – analysis identified distinct clusters of people based on presenting symptoms
- Symptoms disturbing others-general – referrals are from people other than the person experiencing the symptoms – represents symptomatic actions and behaviours that cause others to worry about the safety of the client, as well as themselves, and possibly others in the community (there is a threat/harm to others rather than self) **30%**,
 - People often have a serious and persistent mental illness, are just under the criteria of the Mental Health Act for apprehension, are repeatedly seen by COAST until they meet the criteria – in approximately 75% of COAST apprehensions under the MHA, people are admitted to a hospital bed ***people do not always pose a serious threat to the community, but they do stretch community tolerance as a result of bizarre or frightening behaviours
- Symptoms disturbing others-suicide – referrals are from people other than the person experiencing the symptoms which are characterized by threats, plans, or actions specific to self-harm or suicidal behaviours **19%**,
- Symptoms disturbing self – as identified directly by the person who is self-referring – experiencing some form of distress, either physical or emotional, **32%** (used to be about 15% 5 years ago)
 - Provided with an array of interventions, including assessment, support and referral, can be discharged to other services for the longer term
- Information seeking – individuals who are calling the agency in search of information or direction related to connecting relatives to the mental health system – often referrals by family members (non-crisis situations) **2%**,
- For your information – agencies forewarn the program that they might hear from, or about, a person who has recently been having a difficult time (agencies assess the necessity of breaching client confidentiality based on perceived risks for violence) **10%**
- Other – could include substance use or housing concerns (miscellaneous) **7%**

Best Practices in Crisis Response/Emergency Services: February 2002 (BC)

- People with serious mental illness who are willing to accept treatment voluntarily and are stable enough to function within a setting that does not provide constant security or monitoring
- People may be suicidal

Crisis Manual, Technical Assistance Collaborative (2008): Describing a continuum of crisis residential options

Individual Residential Supports: Individual approaches serve one or two persons in a particular setting.

- Can include family-based crisis homes where the person in crisis lives with a screened and trained “professional family.” In addition to practical and emotional support from “family” members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services.
- A crisis apartment is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports. In a peer support model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere.

Group Residential Supports : Group respite/residential approaches have the capacity to serve more than two consumers at a time. These services are generally provided through crisis residences that offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a step-down resource upon hospital discharge.

Crisis Stabilization Units (CSUs) : Crisis Stabilization Unit services are provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. For people who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multi-disciplinary teams of mental health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay

23-Hour Beds : Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

Gerstein Centre (Toronto, Ontario)

Service Overview

- Provides crisis (warm) line, mobile crisis service and safe beds (24/7)

- Beds co-located in large home with crisis service (all single bedrooms)
- Purchase of Service for 15 additional beds through Salvation Army for people who are homeless
- Provide locked location for medication
- Created second home through service enhancement funding with 9 beds for men, and 5 beds for women

Target Population/Referral

- Focus is on voluntary self-referral and self-assessment
- No danger to self or others, not formable
- People asked to detox prior to self-referring

Peer Support

- Preferential hiring for consumer/survivors
- Training program

Discharge

- 3-7 day ALOS
- Discharge planning including crisis prevention begins on admission

Resources

- Shared staffing across crisis service and crisis beds
- Four staff 'on' at any given time (two through Crisis service, two through crisis bed funding)

Partnerships

- Close working partnership with St. Michael's Mobile Crisis Team and other community partners facilitates psychiatric assessments as required

January 2005 focus groups with people who have used the service

- less stigmatizing than hospital stay
- Emphasis on recovery and self-determination, equal power relationships
- Ability to choose own bed times, to eat when they were hungry, to use the computer or the smoking room without asking permission were praised
- Different degrees of wellness/illness, and that this made it easier to work on their issues
- Currently identifying more opportunities for involvement through volunteer staffing, pooling resources with other agencies

St. Michael's Hospital Crisis Stabilization Unit

St. Michael's Hospital: Crisis Stabilization Unit (Hospital) – one component of crisis services (mobile team, psychiatric emergency service and CSU)

- 5 bed unit located adjacent to emergency department providing 24/7 crisis assessment and intervention for up to 72 hours
- Major objectives:
 - Stabilize the person and at the least return them to their pre-crisis level of functioning using the least intrusive methods possible
 - Provide a safe and supportive environment for clients to work through their crisis situation
 - Link/reconnect clients to available and appropriate personal, professional, and community resources for ongoing follow up and support
 - Developing and/or implementing a crisis plan is a core best practice function of the unit
- Works in close partnership with Gerstein Centre which directly operates 10 community crisis beds and contracts with Salvation Army hostel for an additional 15 beds

Staffing

- Experienced mental health nurses
- Developed comprehensive selection and recruitment process based on years of experience, mental health nursing certification, attitude and commitment to best practice

Evaluation: Two Core Components

- Person's satisfaction
 - Do people feel they are involved in developing their crisis plan?
 - Is the CSU helping them to deal with their crisis?
- Resource utilization
 - Length of Stay
 - Inpatient Admissions
 - Occupancy

Quesnel Unit Emergency Short Stay Treatment (QUESST)

- Five bed crisis stabilization unit in GR Baker Hospital – average 5 day LOS but up to 14 days
- Trained mental health personnel including Registered Psychiatric Nurses
- Referral through variety of sources including self – all admissions require physician's assessment
- Also manages a crisis line
- Groups are flexible
- Follow-up phone call 14 days post discharge
- Drop-in support group for people waiting for outpatient counselling

Josephine Centre (United States)

Community-based secure facility with 3-5 day ALOS crisis beds – team includes psychiatrist: exclusions include

- People needing seclusion/restraint because of assaultive behaviour
- People needing skilled or semi-skilled nursing care or who aren't ambulatory
- Persons who are intoxicated and/or need medical detoxification

Miller House (Riverbend Community Mental health)

- Provides therapeutic environment for people whose symptoms have exacerbated and who are having psychological or emotional distress
- 24 hour, non-hospital based program for voluntary and involuntary psychiatric care to people over 18 experiencing acute symptoms – actively works with local Schedule 1 (New Hampshire) to provide less restrictive, community-based and secure treatment environment.

Crisis Resolution/Home Treatment Teams (North Birmingham, United Kingdom)

Target Population:

- Adults (16 to 65 years old) with severe mental illness with an acute psychiatric crisis of such severity that without the involvement of a crisis resolution/home treatment team, hospitalization would be necessary
- Note that the area it serves has both rural and urban components

- This service is not usually appropriate for individuals with Mild anxiety disorders, Primary diagnosis of alcohol or other substance misuse, Brain damage or other organic disorders including dementia, Learning disabilities, Exclusive diagnosis of personality disorder, Recent history of self harm but not suffering from a psychotic illness or severe depressive illness, Crisis related solely to relationship issues

Functions:

- 'gatekeeper ' to mental health services rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week
- Ensure that individuals experiencing acute severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
- If hospitalization is necessary be actively involved in discharge planning and provide intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximize their resilience
- Experience indicates that the following principles of care are important:
- A 24 hour 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs

Staffing:

- Adequate skill mix within the team to provide all the interventions listed above
- Total 14 members per team (team leader plus up to 13 others)
- Medical staff: Active members of the team, 24 hour access to senior psychiatrists
- able to do home visits is vital, Involvement from both consultant and
- middle grade psychiatrists, Level of psychiatric input to be determined
- by local need and service configuration
- Specialist skills: These skills should be available within the team either by employing a fully qualified practitioner or by training other team members

Meta Services (Arizona)

- Comprehensive multi-service organization with programs organized based on recovery principles
- Differentiates between psychiatric crisis services and crisis recovery services. Living room program (as part of crisis recovery), offers a homelike alternative to hospitalization in crises
- Staffed by 24-hour peer support team
- LOS is approximately 24 hours

Brunswick House (United Kingdom)

- Operational in January 1999 – normal housing stock with four bedrooms, kitchen, lounge and dining area
- 6 FTE complement with two on at any time – recreational and therapeutic activities
- open 1PM Friday to 1PM Monday – emphasis that this is not respite, it is for crisis and service users indicated that weekend can be most difficult time to cope with if in crisis

- Target population: people with mental health problems who are known to social or health services and who are in acute crisis
- professional keyworkers normally make referrals, self-referrals are generally only accepted from people who have previously used the unit
- staff and service users take meals together
- Patients with schizophrenia and personality disorder accounted for most admissions
- mean occupancy of 10.7 days
- people were banned for persistent substance misuse
- absence of serious self-harming behaviour and violence to others – have developed a self-help group for this
- Always fully occupied, increasing number of people can't be accommodated – restrictions have been placed on number of times used per year (average 3.7 per person in first year) also developed telephone support

Sherbrook Partial Hospitalization Unit (United Kingdom)

- Created in 1994: formation of two crisis beds (for a population of 120,000) with additional day unit places
- Close proximity to acute ward allows for staff cross-over
- Staffed by a clinical team leader, 8 registered mental health nurses, 5 nursing assistants, and two part-time night staff (8:45PM to 7:30AM)
- Provides 24 hour assessment and treatment for people with mental health problems, maximum length of stay is 72 hours
- Referrals from local general practitioners, members of community mental health teams or self referral
- Separate entrance from hospital
- Comprehensive risk and needs assessment done and outcome can be short-term admission to a crisis bed, support in the community or not accepted. If person cannot be safely managed in the crisis beds, admission to the inpatient unit is an option
- Close working linkages with community mental health staff, inpatient unit, social services and voluntary sector
- People are reviewed on a daily basis
- Unit can serve people with serious mental illness or people with less severe mental health problems
- Functions as a transitional step for people leaving the inpatient unit, allows assessment of people with first episode psychosis and a safe environment to start medication treatments
- Average occupancy over a 12-month period was 10.8 people per month with ALOS in first year of 2.9 days
- Number of admissions to the acute unit fell by 15% despite the fact that monthly admissions, % bed occupancy and mean duration of stay had remained relatively constant in the preceding 3 years – ALOS has increased while reduction in acute admissions has continued
- Unit has proved viable with just two beds because of its close geographical and functional links with acute unit and other elements of the mental health services

Crisis Assessment and Treatment Service: Grampians Psychiatric Services, Victoria, Australia

- CAT Team of Grampians Psychiatric Services, at Ballarat Base Hospital, Ballarat, was formed in October, 1994

- Grampians Psychiatric Services (GPS) is one of 8 regions providing psychiatric care for patients with serious mental illness in Victoria: 45,000 sq. km., with a population of 182,000 and has a population density of 4.1 per sq. km
- Functions include: Assessment and diagnosis, crisis intervention and resolution, intensive support
- As an alternative to hospitalization or to decrease length of hospitalization, the team may engage in intensive follow up: this could mean visiting a person up to four times a day to monitor medications and provide counseling and support to both patients and their families
- Also engage in Early Discharge Management—as soon as an individual’s discharge plan is in place, they are discharged from hospital and followed by the CAT team; once the individual is stabilized, they are linked to community services for longer term follow up (facilitates integration from hospital to community)
- Because 25% of referrals come from the ER department, a CAP community psychiatric nurse is posted at the department to provide assessments

Target population:

- People aged 16-64 years in acute phase of mental illness or crisis
- People in psychiatric crisis whose community living arrangements are breaking down;
- People under 18 years or over 64 years in acute phase of mental illness for urgent out-of hours assessment in order to determine whether an intensive intervention can prevent a hospital admission
- Particular emphasis on people with personality disorders (50% of referrals)

Staffing:

- The team comprises of a Consultant psychiatrist, a psychiatric registrar, community/registered psychiatric nurses, psychologist and social worker
- Referral through general practitioners, emergency departments, police, families, private psychiatrist, continuing care service, self

Outcomes:

- Of the patients referred to the CAT team till now, 4/5th were managed in the community
- Since the formation of CAT, admission rates for personality disorders have decreased significantly

Leaman et al.(1987)

- Evaluated a foster home program for patients referred by community mental health agencies and by the hospital Crisis Intervention Center
- Target population: patients able to function in an open psychiatric unit, who did not have a history of violence, arson or theft and who were determined by staff to be able to live safely in a family’s private home were accepted into the program
- Foster care providers were families living in the community who responded to advertisements in the newspaper
- Orientation included four-week clinical orientation which covered medications, communication issues, patient characteristics, suicide assessment and community resources
- Nurse meets with patients on a daily basis
- One-year evaluation: 80% of patients considered for inpatient treatment were diverted to the foster home program at considerable savings (approximately \$224,000 in 1984-85). Patient satisfaction with the program was high (94% were satisfied) and 77% thought that the stay in the crisis home helped them avoid hospitalization. In addition the staff and patients reported significant improvement in clinical status as measured by a psychiatric rating scale.

Appendix B: Physical Location(s) Criteria for Consideration

As developed by Agnew Peckham, the following criteria were created to identify minimum requirements for the organization, location and delivery of the community crisis bed services that will inform the preferred operational model. These will be considerations as TOH moves to implement a) a streamlined number of locations for existing crisis beds; b) an RFP to co-locate as many beds as possible in one location; and ultimately c) capital planning for a stand-alone facility in the longer-term future.

A facility that houses the community crisis beds must be able to accommodate:

- A minimum of eight beds on not more than two levels
- All single bedrooms of at least 120 NSF (i.e., private accommodation) with a window providing a pleasant view to the outdoors
- A 3-pc. washroom of at least 50 NSF ensuite to each bedroom
- A minimum of two bedrooms/ensuite washrooms that provide wheelchair accessibility within the bedroom and washroom areas
- A wheelchair accessible lounge in proximity to the bedrooms, able to comfortably accommodate seating for up to eight persons, a television and a window providing a pleasant view to the outdoors
- A staff workroom including a locked medication cupboard on the same level as the bedrooms
- A wheelchair accessible laundry room that accommodates a washer and dryer
- the wheelchair accessible bedrooms/ensuite washrooms, lounge and laundry room on the ground level (if a multiple level building)
- Wheelchair accessible client entrance into the facility building

The facility(ies) that house the beds must be located

- In the downtown core of Ottawa
- On a public transit line
- In walking distance to community amenities (e.g., stores, community health centre, entertainment, community recreational facilities etc.)
- Within a 10 minute driving distance to the mobile community crisis team office

Operation of the beds requires

- Twenty four hour on site supervision, provided by support service workers, 24 hours per day, 7 days per week
- A staffing ratio consistent with similar models
- Three nutritious meals provided daily to clients
- Access by both female and male clients, with appropriate privacy provided to each
- Daily nursing support
- Access to case management services
- Access to peer support
- Evidence that quality standards exist and are monitored regularly

