



**Canadian Mental
Health Association**
Niagara
Mental health for all

**Mapping Mental Health Crisis Services
in the Niagara Region:
Towards Improved Integration and
Coordination of Services**

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Introduction

The Canadian Mental Health Association of Niagara (CMHA), in collaboration with mental health and addiction service providers of Niagara Region, acknowledged the need to conduct an overview of crisis services in Niagara Region. This type of work has never been completed before in Niagara Region. The main objective of the project was to develop a series of concise and understandable system maps accompanied with descriptive analysis of intersecting crisis services and urgent supports in Niagara Region. The new Mobile Crisis Rapid Response Team (MCRRT) has provided impetus for the project. This innovative mobile service will join mental health workers with specially trained Niagara Regional police officers. While Niagara has benefited from having the COAST program, the MCRRT will be a rapid response unit receiving calls via the 9-1-1 system. The goal of the MCRRT is to respond in real time to individuals in crisis, de-escalate the crisis and risk level, and to connect the individual to urgent and/or longer term supports. Evaluations of mobile crisis services across Canada provide evidence of reduced police and judicial services involvement, reduced admissions to hospital emergency services, and improved linkages to follow-up services. The current project will assist in integrating the MCRRT into the continuum of crisis services in Niagara. As such, this work will support where necessary the development of protocols and/or service agreements between the MCRRT and service providers.

An Overview of Crisis Services in the Niagara Region

Definition of Crisis Services, Service Standards and Frameworks

Crisis services refers to programs that provide immediate assistance for people who are currently experiencing severe emotional distress; for any situation that is life-threatening, or poses harm to someone; or for persons who are unable to cope with a problem that demands immediate attention. Generally accepted definitions of a crisis often cite the onset of emotional disturbance or situational distress and a person's inability to cope. A person may represent at risk to themselves or others (Making It Happen, p.28).

Crisis services help people deal with the immediate crisis, to restore them back to their original (or higher) level of function so that they can deal with their problems. Based on current standards (Ontario Ministry of Health, 2005) crisis services are a key part of the continuum of mental health and addiction services. Services must be integrated and coordinated within the broader mental health system. Crisis services can incorporate various modalities including telephone support, walk-in services, mobile crisis outreach, crisis residential services, and psychiatric emergency/medical crisis services. Their goal is to reduce unnecessary hospitalization and improve the quality of life for individuals experiencing a mental health crisis through symptom relief and access to on-going support to prevent a future crisis (p. 2).

Crisis services are considered a "core" service for Niagara's population of children and youth up to 16 years of age (MCYS, 2013). Crisis support services are immediate, time limited services delivered in response to a child or youth who is experiencing an imminent mental health crisis, or an urgent or crisis situation that places the child/youth at serious risk. Crisis services work to actively stabilize the

situation, ensure urgent access to services, and facilitate as required access to a range of longer-term resources and supports (p.20).

Continuum of Crisis Services in Niagara Region

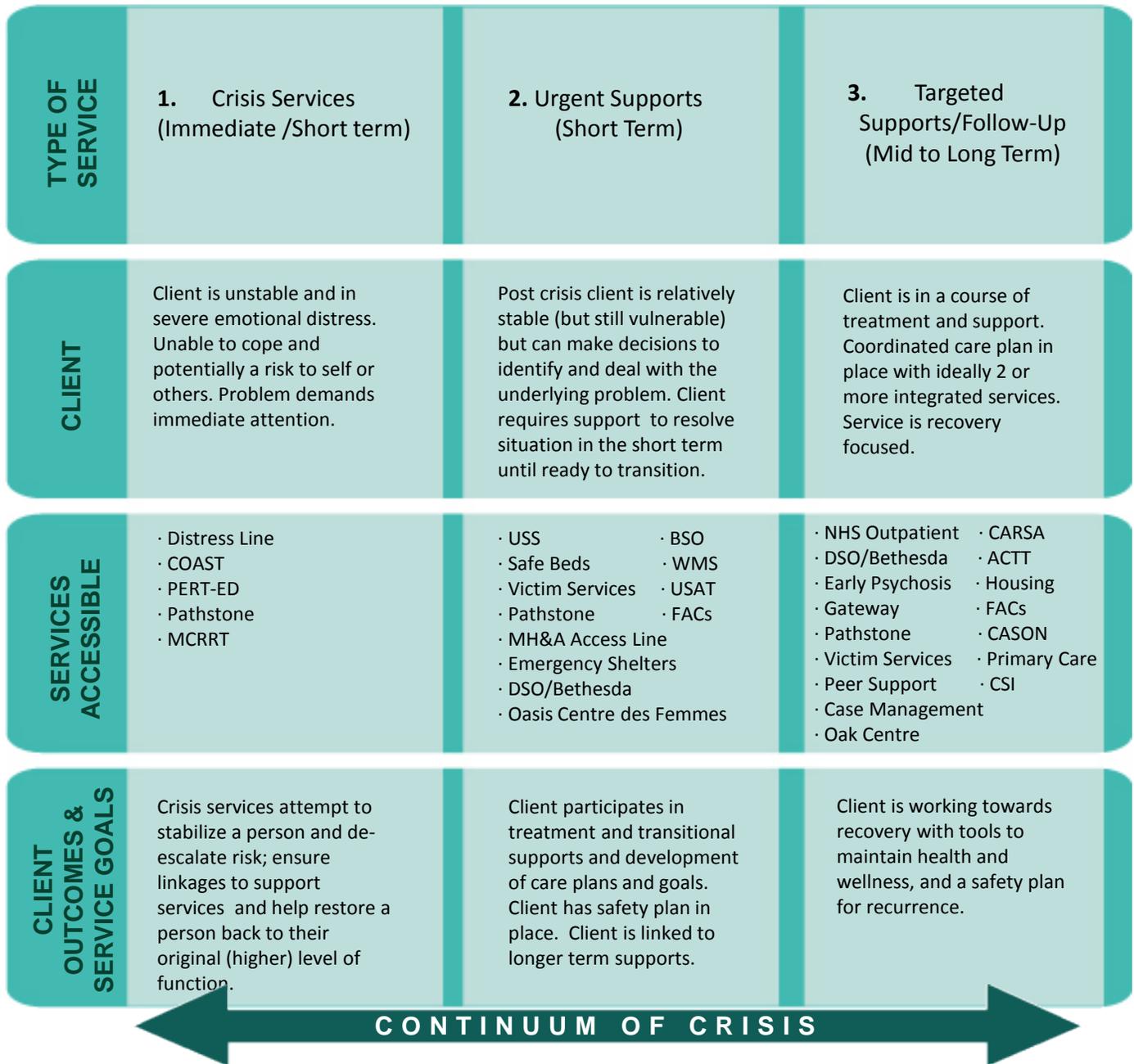
The spectrum of mental health and addiction services can vary significantly from one community to the next. Various frameworks have advanced the notion of a continuum of services effectively matched to a continuum of needs for any given population. MCYS (2013) presents a typology or continuum of needs based on the level of risk of the individual (Levels 1-4), with Level 1 matched to the least intensive services, and Level 4 matched to the most intensive services. Similarly, Making it Happen (1999) describes a continuum of services and supports that can respond to all aspects of a person's life situation (i.e., vocational, housing, crisis services). Crisis services are grouped into "First Line" services. The continuum progresses to more specialized intensive treatment services for persons with serious mental health challenges (e.g., ACTT, inpatient services). A person's needs will fluctuate at any given time. Within the continuum of needs and service, however, "...first line emergency and crisis services must be accessible to all people with symptoms of mental illness. Upon assessment within this level (First Line services), people will be directed to the service(s) which best meet their needs." (p. 13).

In 2008, the Government of Ontario commissioned an advisory group to assist in the development of a 10-year comprehensive plan for mental health and addiction services. The advisory group adopted a functional model originally developed by Dr. Brian Rush at the Centre for Addiction and Mental Health. The model "stratifies the functions of a comprehensive, multi-sectoral system in five tiers that correspond to the acuity, chronicity, and complexity of peoples' needs" (p.14). A depiction of the model appears in Appendix 1. The model supports the concept of a continuum of services that correspond to a continuum of needs. Crisis services appear in Tier 3 (crisis management and support functions) designed to provide necessary interventions related to "the timely and appropriate response to individuals in crisis including the provision of needed referrals to follow-up services and supports" (p. 20).

Newberry (2014) also differentiated mental health services along a continuum. Services were grouped as "First Contact" services, intermediate-mid/longer term services, or broader community or primary care services. Crisis services were further characterized as "Turning Point", providing an entry or linkage to other targeted or mid/long term mental health and addiction services.

To help with a general orientation to crisis and urgent services in Niagara, Figure 1 provides a view of these services in Niagara, presented along a continuum of services matched to client needs and outcomes. While the scope of services is not all-inclusive, the information gives the reader a basic orientation to the services that are featured in mapping crisis services and urgent supports.

Figure 1: Continuum of Crisis Supports in Niagara, 2015



Project Scope and Methodology

Purpose of System Mapping

The project was informed by previous system mapping work conducted by Taylor Newberry for the United Way of Peel Region (2014) and Peel CMHA (2008a, 2008b). System mapping provides a clearer understanding of both inflow and outflow to and from Niagara's crisis and urgent support services; illuminates issues and challenges in the current system for discussion; and supports recommendations to advance a more coordinated and integrated crisis system for Niagara. The goal of system mapping, according to Newberry, is to illustrate "the key junction points that people must go through in order to receive intended supports. (System Mapping)...provides a visual representation of different parts of the system in order to analyze common practices: where the system is working well, and where it is breaking down. System maps are an important first step in identifying system gaps and barriers, and opportunities for improved integration, coordination and access" (Peel Region, 2014, p.10).

Focus Groups and Key Informant Interviews

The scope of the project includes services for persons in crisis or with urgent needs as identified in Figure 1. The project excludes provincial and/or national crisis services and related supports. As well it is recognized that local mental health and addiction programs and services may provide some level of crisis support for clients of their programs. These services improve client access and integration and should be acknowledged.

The project methodology included a series of focus groups and/or one-on-one interviews with key informants; a review of program descriptions found in community information databases, web sites, brochures and protocols; frameworks/standards where available; system mapping; and a literature review of model ED diversion programs for mental health and addictions in Ontario.

Table 1 presents a summary of all participants that attended focus groups or an interview. Twenty-nine (N=29) individuals participated in ten one-on-one interviews or one of six focus groups during April/May 2015. Participants were identified through contact lists provided by CMHA Niagara. During the process, the sample was expanded beyond the initial list to include other individuals with key information about crisis services and urgent supports. The focus groups and interviews were instrumental in the development of system maps. In each session the facilitator worked with participants (mostly system managers and clinicians) to develop diagrams to illustrate common inflow and outflow to and from programs. Ten crisis maps were generated during the process. These maps were then circulated to all participants to ensure completeness and accuracy. Participants were fully knowledgeable about how the system operates on a day-to-day basis, and aware of system barriers, challenges, and opportunities for improvement.

Key Questions

The general questions brought forward to the interviews/focus groups were as follows:

1. Describe the role of your service for persons in crisis or at risk. What are the various components and how do they fit together?
2. How do persons typically get connected to your service/program? From whom do you typically receive referrals?
3. What are common issues, challenges or gaps experienced by your program/service upon receiving referrals or from your referral sources? How do you try to mitigate these issues?
4. What is the typical flow of persons through and out of your program/service? What are common discharge or referral destinations?
5. What are common issues, challenges or barriers to client disposition? Are there barriers to working with other services in the system? Problems getting people connected or working with the referral source? How do you try to mitigate these issues?
6. What are some suggested recommendations or options to improve access/referral/navigation to and from your program/service? What would improve connectedness and better flow?
7. What else can be done to improve system coordination and service levels in Niagara for people in crisis or at risk?

All interviews and focus groups were audio-recorded. These recordings were subsequently transcribed into Microsoft Word files. These files were then reviewed for unique and common themes. Each service map is accompanied by a brief service description as well as pertinent issues with respect to inflow, flow through, and outflow for each individual service. Finally, common or generic system themes that cut across a number of agencies are presented along with system recommendations.

Next Page: *Table 1: Interview/Focus Group Participants*

Table 1: Interview/Focus Group Participants

Organization	Program-Service	Participants	Map Completed	Interviews	Focus Groups
Bethesda	CRM	1		yes	
Case Resolution Table	N/A	4			yes
CMHA	USS	1	yes	yes	
CMHA	MCRRT	1	yes***	yes	
CMHA	Safe Beds	1	yes	yes	
Contact Niagara	Access Line	1		yes**	
Distress Centre	COAST	1	yes		yes*
Distress Centre	BSO COT	2	yes	yes	yes*
Distress Centre	Distress Line	1	yes		yes*
DSO	URM	2			yes
NHS	PERT	4	yes		yes
NHS	WMS	1	yes	yes	
NRP	MCRRT	2	yes***	yes	yes*
Pathstone	Crisis Service	3	yes		yes
QUEST	USAT	2	yes		yes
Victim Services	Crisis Support	1		yes	
YWCA	Shelter Services	1		yes**	
TOTAL		29	10	10	6

*attended same focus group

**brief contact

***one map completed for CMHA MCRRT

Mapping the Crisis System in Niagara – Key Findings and Recommendations

This section presents a series of maps for crisis and urgent support services, beginning with crisis services that provide immediate/short term support intended to stabilize a crisis situation and reduce risk, and ensure the person is linked to other services including urgent supports.

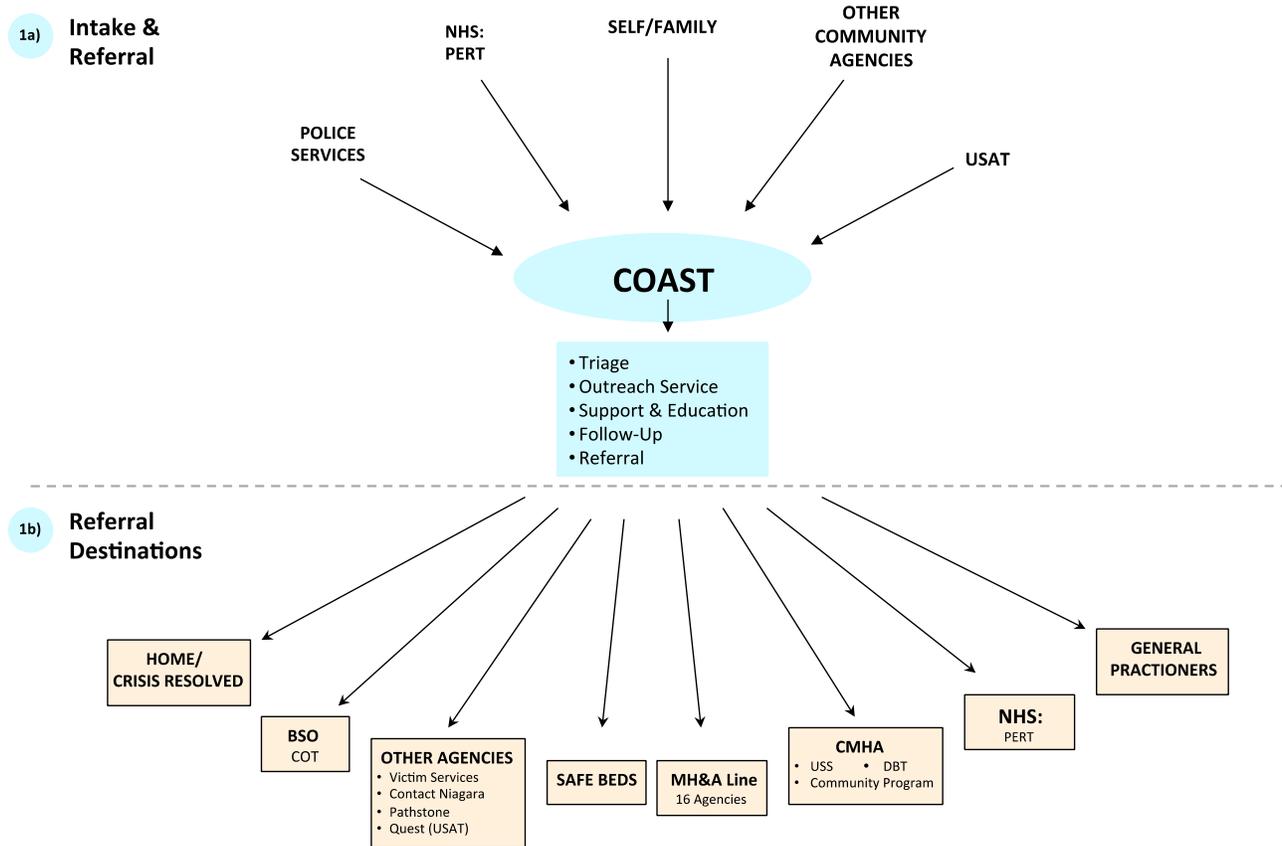
A. Crisis Services

COAST

The Niagara COAST program is a 24/7 crisis line and mobile team operated through the Niagara Distress Centre. The program is provided in partnership with CMHA Niagara and Niagara Regional Police Services. COAST is not a rapid response service – information is collected over the phone, cases are triaged, and often support and links to follow-up services are concluded over the phone. Should a situation warrant a mobile visit, the mobile team will assess the person experiencing the mental health crisis in their community. A mental health professional is teamed with a specially trained police officer using an unmarked cruiser. A plan will be implemented that best suits the needs of the

individual including a link to community programs if required. The service covers all of Niagara Region for persons 16 years and over. The mobile response team is accessible 7 days noon to midnight (Sunday noon to 8pm).

1. System Mapping for CRISIS OUTREACH & SUPPORT TEAM (COAST)



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Access to COAST is often direct with the individual/family making contact through the crisis line. Niagara Regional Police are a significant source of referrals – the NRP provides COAST with police reports from uniformed officers that have already been on scene, and COAST will follow-up with the individual by phone and if warranted through a mobile visit. A relationship is developed with the client and the client is advised to call COAST should the need arise. COAST also provides follow-up to individuals who went to hospital (based on a police report). Therefore COAST provides an alternative to and diversion from hospital for persons who do not present an immediate risk to themselves or others.

COAST referral destinations vary depending on the client needs. A significant outcome is “crisis resolved” at home with the individual linked to COAST follow-up services or other services. In this situation, COAST has successfully de-escalated the crisis and provided links to community-based resources. Although the client is provided with information about other services, COAST may not

know if the client has followed up with the referral. Feedback is provided back to COAST, for example from Safe Beds, when the client has followed through with referral. However, COAST will not have full knowledge of any barriers clients may have experienced. For example, COAST would not be aware of any barriers accessing psychiatry through a referral to a general practitioner. Similarly, any barriers to access addiction services through the MH&A Access Line may not be known. This is particularly problematic generally for the system and for more complex individuals that may have multiple needs such as primary medical care, housing and substance abuse.

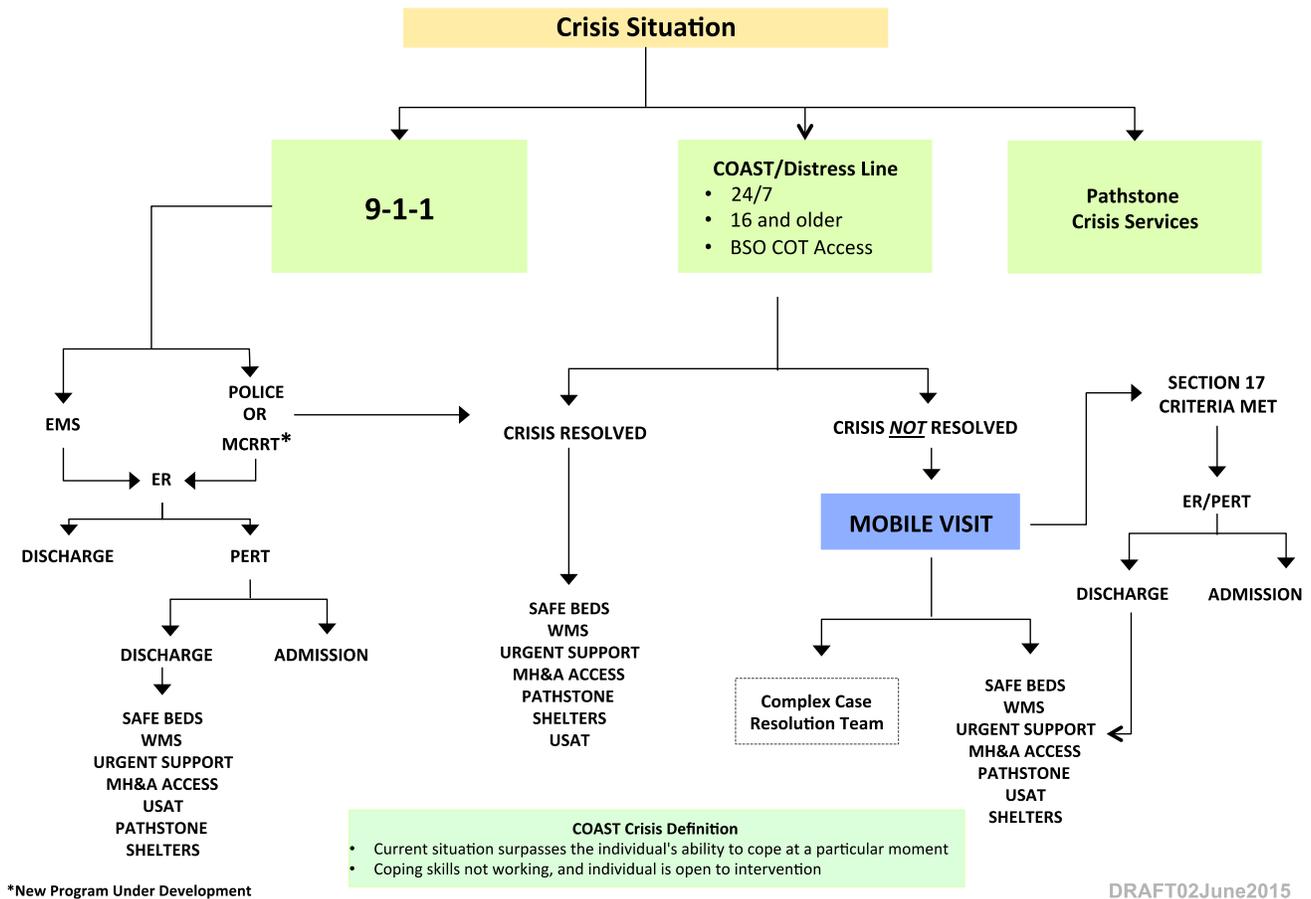
On occasion COAST will make a referral to the PERT team at the NHS emergency department. Currently the development of an appropriate referral form for inclusion in the PERT assessment is under development for all community agencies. The form will improve integration of community crisis information with assessments at the hospital. The two assessments occur at different times (from when the individual is first in crisis and when he/she arrives at the hospital). It is not uncommon for the individual's disposition to change. Community-based crisis assessments require appropriate weight. The development of the form for use by the community is, in part, a response to ensure community assessments are integrated into the process.

Finally, the crisis services landscape in Niagara will soon change. New funding for a Mobile Crisis Rapid Response Team (MCRRT) has been approved, with rapid mobile response capability slated for St. Catharines. This service will be accessible through the 9-1-1 system and will comprise a uniformed officer teamed with a mental health worker. The service will significantly augment local crisis services. To date, the COAST program has generally played a secondary crisis role in follow-up by accessing police reports. It is intended that COAST will continue to play a similar follow-up role for the MCRRT. Figure 2 presents a flowchart of the basic flow of crisis services in Niagara Region inclusive of the 9-1-1 emergency response system and access to the MCRRT; clients who make contact with the COAST through the Distress Centre; and finally Pathstone Crisis Services for children and youth.

R1: That COAST develop protocols/service agreements with the new MCRRT.

R2: That agencies adopt both the PERT referral form to be integrated with PERT assessments, and the transitional discharge model/form developed by PERT to enable feedback from PERT to referral agencies.

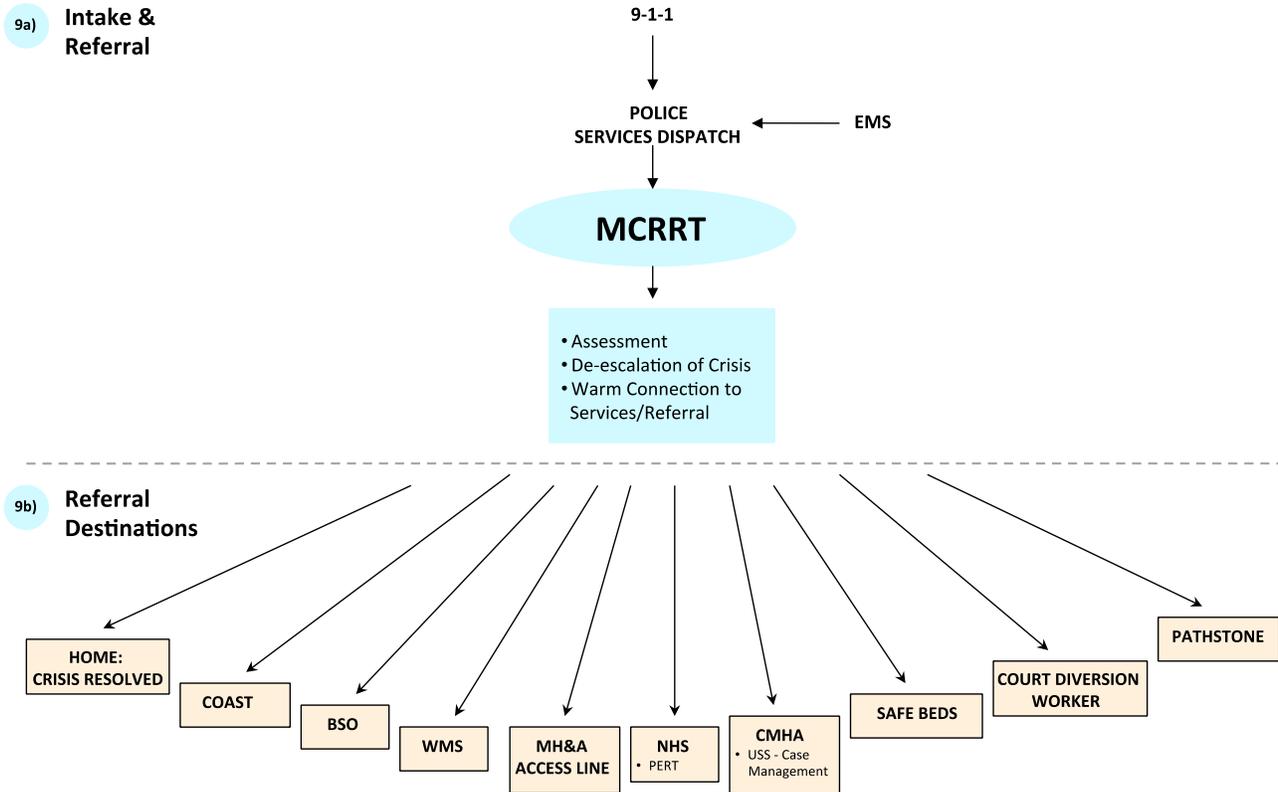
Figure 3: Basic Flowchart of Crisis Services and Urgent Supports – Current Status



Mobile Crisis Rapid Response Team (MCRRT)

The MCRRT will consist of a uniformed specially trained NRP officer teamed with a mental health professional. The service will comprise one unit, and be available 7 days per week, from 6pm to 1 am. St. Catharines will be the trial area. The role of the MCRRT will be to provide immediate access to mental health support in the community. Key goals will be to de-escalate the crisis; divert where appropriate persons from hospital admission and the criminal justice system; and to provide a warm connection to urgent support services. Unlike COAST, the MCRRT will be formally joined to the 9-1-1 emergency response system and NRP dispatch services. The service will respond to ALL age groups and will be linking to child and youth services.

2. System Mapping for MOBILE CRISIS RAPID RESPONSE TEAM (MCRRT)



Referral destinations will be similar to COAST. Formal protocols/service agreements are being developed with a number of agencies including Pathstone and COAST. Of interest, this will be the first time in Niagara’s history that CMHA will be serving individuals under age 16. Other key referral destinations include the MH&A Access Line, USS and Safe Beds provided by CMHA. Clients will be diverted from hospital if at all possible. As noted earlier, it will be a challenge for the MCRRT to determine if and when a client has been connected to services, particularly if the individual has complex needs, is transient and not linked to primary care. Unlike Hamilton COAST, crisis services in Niagara are operated by independent agencies. This requires stronger commitments to partnerships, the development of service agreements and protocols. In Hamilton mobile crisis services are integrated with St. Joseph’s Healthcare mental health programs. For example, when a mental health assessment is completed by St. Joseph’s COAST program, it is only required once. In Niagara the NHS PERT team will complete its own assessment. As noted above it is advisable to ensure that community assessments are integrated into the care plan for the patient.

- R3: Continue education and promotion activities for the MCRRT.*
- R4: That MCRRT develop protocols/service agreements with Pathstone for ongoing support for children and youth.*
- R5: That MCRRT develop protocols/service agreements with COAST/BSO for ongoing follow-up care and referral as necessary.*

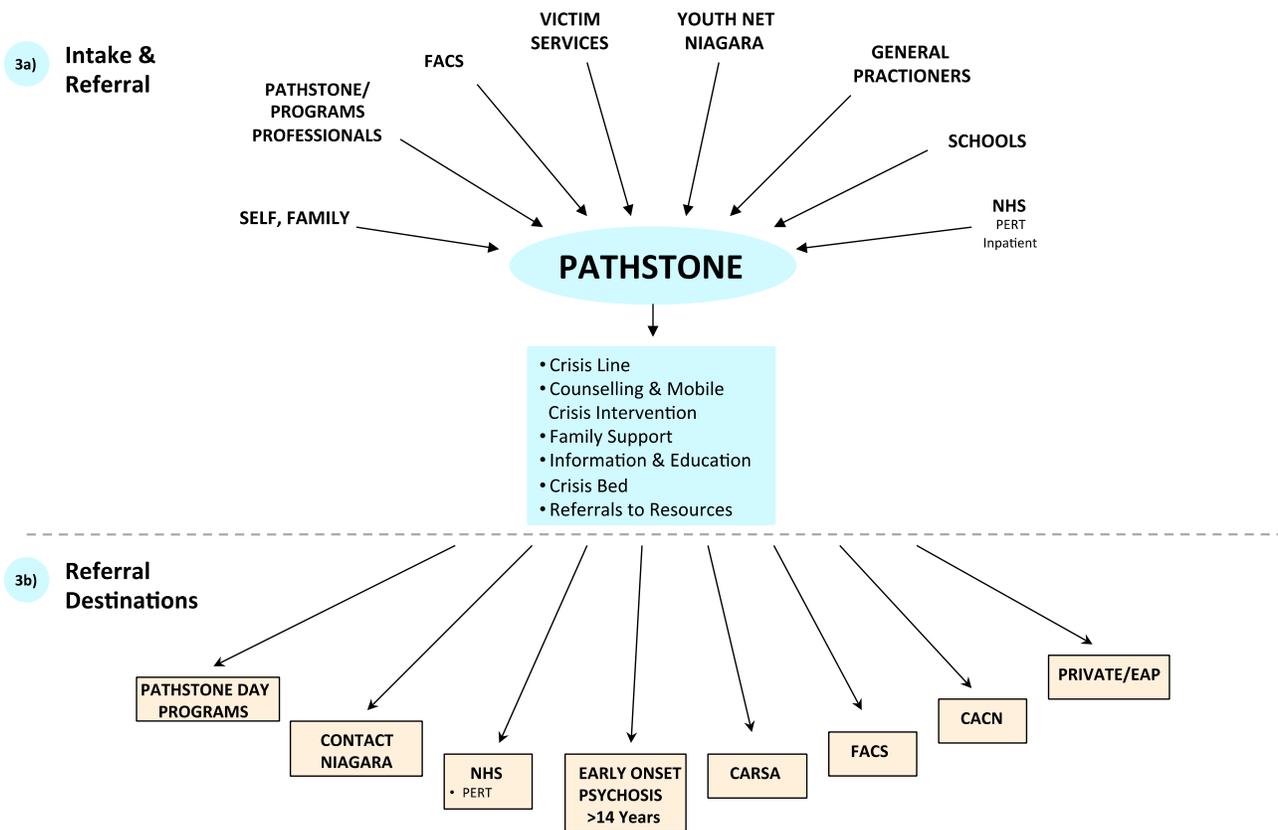
Pathstone Crisis Services

Crisis services are available for children and youth across Niagara Region (up to under age 18), 7 days per week, 24 hours per day. Providing immediate support to persons in crises or facing urgent situations aligns with Ontario's direction to provide a comprehensive continuum of supports for children and youth (MCYS, 2013). In the provision of crisis services, agencies should work towards coordination and integration of services through partnerships with hospitals, schools, crisis lines and other mental health crisis services in the community (p. 20). Pathstone crisis services comprises immediate telephone counselling via a crisis line and, if necessary, in person counselling with the individual/family at Pathstone's location or at the person's location (home, school). Supports include crisis counselling, family support, education and information, referrals to resources, access to psychiatric/psychologist consultation, and access to 1 crisis bed (located in Niagara Falls).

The majority (70%) of requests for service originate from parents (about 1/3 of individuals will be known to Pathstone). Significantly, a large proportion (40%) will represent new contacts for the crisis service. The process typically begins with a call to the 1-800 crisis line. A significant referral source however is Pathstone's own programs and professionals who refer individuals and families to the crisis service. This supports an integrated continuum of care between Pathstone's crisis services and day programs.

Next Page: *3. System Mapping for Pathstone Crisis Services*

3. System Mapping for PATHSTONE CRISIS SERVICES



Waiting lists for short and longer term support are a key challenge. Although the crisis service plays a key role addressing immediate needs and providing time limited support for families (and referral may not be necessary), waiting lists for ongoing care are lengthy and less than optimum for families. In May 2015 it had been reported that 40% of Ontario’s children and youth in need of therapy or counseling were not receiving the treatment they needed, and waiting lists could last over a year or more (The Standard, 2015). Pathstone has experienced a rise in demand for services in part due to increased public awareness. While progress had been made on wait times due to increased funding, there were still lengthy waits being reported in early 2015 (approximately 78 youth were waiting about 2.5 months for counselling, and 188 youth were waiting up to 6 months for longer term support).

Access to the single crisis bed for children and youth is problematic. The crisis bed is only funded for 30 days per fiscal year – any excess beyond the 30 days to staff the bed (24/7) must come from Pathstone’s budget. Access is difficult particularly when there is limited access to alternative residential or foster placements in Niagara. Reduced access also creates flow issues for NHS that will

attempt to discharge a youth to the crisis bed. Other pressure on residential services was the closure of the House of Hope (8 beds were closed in 2014).

R6: That Pathstone Crisis Services establish a protocol/service agreement with the MCRRT for crisis support, ongoing care and follow-up for children and youth.

R7: That a proposal/business case be developed for the expansion of crisis beds for children and youth in Niagara, beyond the single (1 bed) in Niagara Falls, and that it incorporate best practice models for short term respite and crisis services.

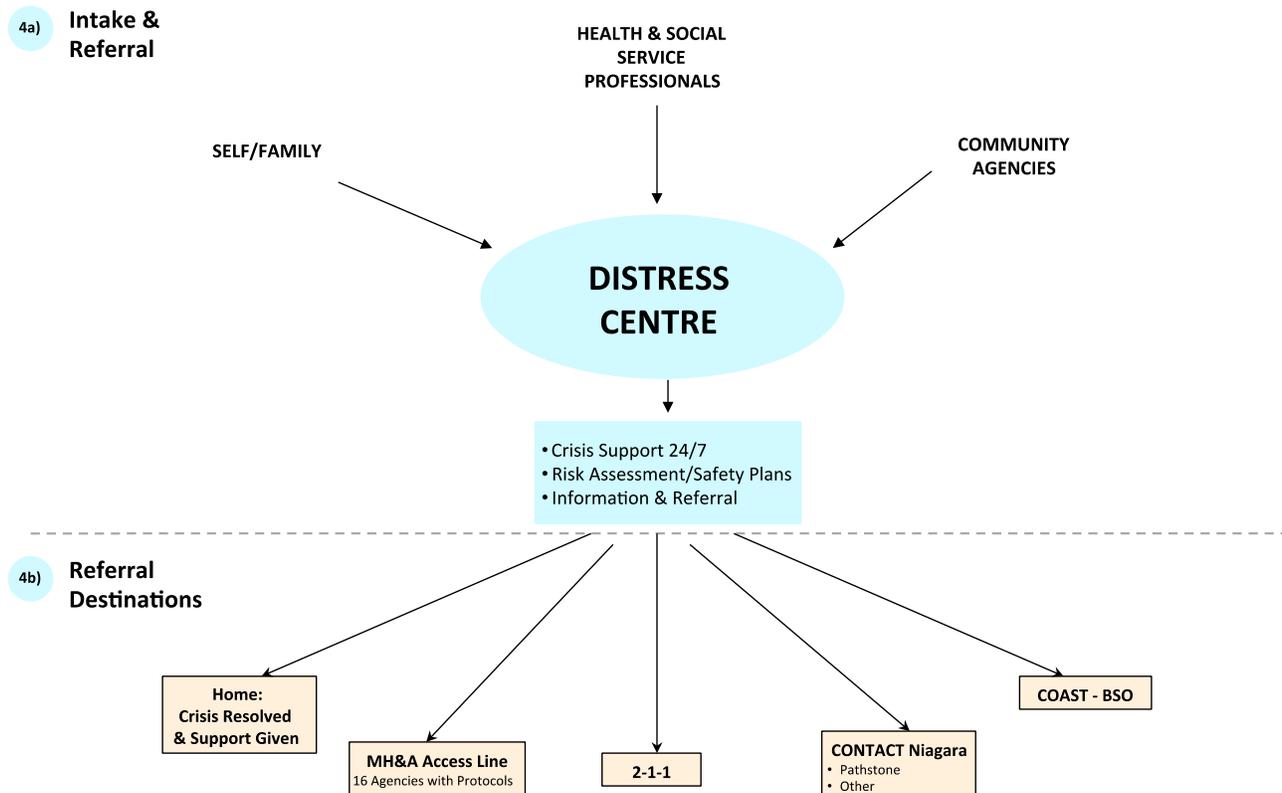
Niagara Distress Centre

The Distress Centre provides a confidential distress line staffed by trained volunteers (24/7). Volunteers provide emotional support, risk assessment, de-escalation of a crisis (e.g., suicide risk), safety planning, and information and referral. It is a personal “choice” oriented service that emphasizes crisis support and empowerment. Individuals are mostly self-referred, with a smaller proportion of referrals from professionals and community agencies. Once a crisis is abated the Distress Centre will link the person to other services. Often the crisis is resolved and there is no need for follow-up. Referral areas include 2-1-1 for information, the MH&A Access Line, COAST, BSO COT, and Contact Niagara. The Distress Centre also operates the MH&A Access Line and COAST, which is co-located with the BSO Community Outreach Team.

There are approximately 12,000 calls to the Distress Centre annually. For this reason a caller may experience a busy signal and be asked to call back. Busy signals have always been a challenge as call surges are always unpredictable.

Next Page: *4. System Mapping for Distress Centre*

4. System Mapping for DISTRESS CENTRE (Distress Line)



Psychiatric Emergency Response Team (PERT)

Psychiatric emergency services at NHS have become regionalized with all psychiatric services located at the St. Catharines site. The PERT team comprises specially trained professionals based in the emergency department (ED) whose function is to assess all persons with mental health and addiction issues. Team members consist of psychiatric emergency response nurses, an addictions counselor, and a psychiatrist who is on call 24 hours a day. PERT will coordinate admissions or develops a care plan to transition an individual back to the community with follow-up supports. PERT manages a separate four-bed unit in the ED. The unit is a private space for patients with psychiatric or addictions issues. Referral sources vary considerably, as the ED is accessible to the broader community across Niagara Region. Referrals are also common from other NHS sites (that formerly provided psychiatric services).

High occupancy of PERT’s crisis beds is an ongoing issue. Demand often exceeds capacity. When this occurs the team is forced to use other beds in the ED, thus encroaching into other areas. A protocol is

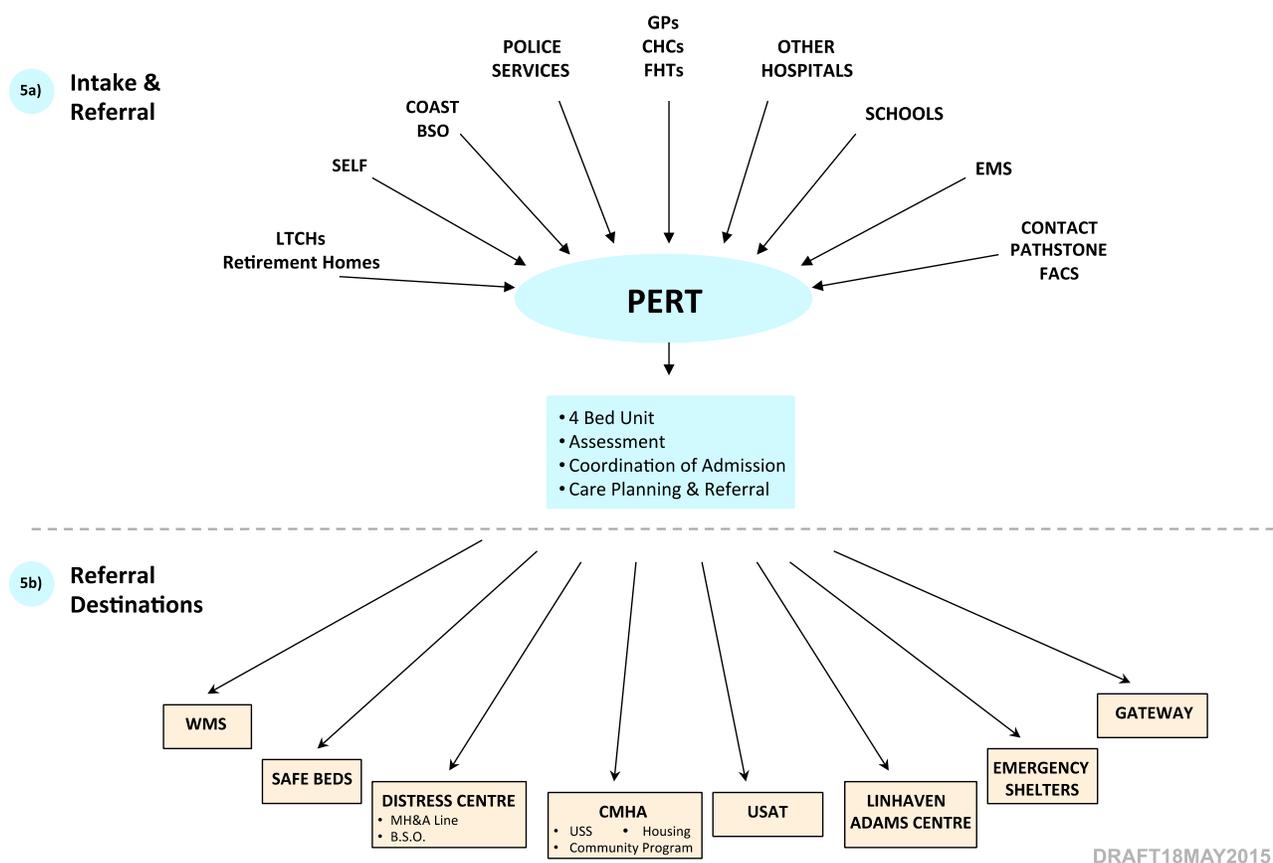
in place for use of overflow beds, however, this exceeds PERT resources and the situation is never optimal. The situation may be exasperated by alternate level of care (ALC) patients, where inpatients are holding up beds that no longer require them and are awaiting discharge to the community.

Other challenges include high rates of readmission within 30 days of discharge – NHS is one of the highest across the province (14.7% overall). Another concern is repeat visits to the ED within 30 days for persons with mental health and substance abuse problems (about 20% and 27% respectively). Although the ED is a primary access point for emergency care, some hospitals in Ontario have had significant success reducing ED repeat visits through processes/programs developed and provided in collaboration with community mental health and addiction services (Jodoin, 2010). Some of these processes include expanded peer support; Safe Beds; better synergies between hospital and community; expanded mobile crisis services; supportive housing; formal ED diversion programs; enhanced primary care; effective discharge planning; and coordinators located in the ED. Some of these initiatives are being reviewed jointly by the NHS and community agencies.

A transitional discharge form has been developed to provide more effective information at discharge to community agencies (e.g., MH&A Access Line). Protocols have also been developed to “flag” repeat visitors for linkage to primary care and addiction services (USAT program and MH&A Access Line). Two programs (USAT and USS) located on-site at NHS provide an opportunity to formalize ED diversion and community linkages in partnership with NHS inpatients and PERT. Another opportunity is to formalize access to “surge beds” off site at CMHA Safe Beds. A protocol however is required to ensure that patients are appropriately matched to the Safe Bed program in terms of program goals.

- R8: That NHS and Community Mental and Addiction programs/services review the key features of the Transitional Discharge Planning model, including the role of peer support, and adopt/adapt key features through service agreements and/or protocols for enhanced quality of care and effective use of resources.*
- R9: That NHS establish more formalized emergency department (PERT) diversion programs in partnership with CMHA Safe Beds, Quest USAT, CMHA USS, COAST and MCRRT and other agencies as appropriate.*
- R10: That Safe Beds designate 2-3 beds for PERT referrals, and that PERT enhance support to Safe Beds to reduce unnecessary referrals to the ED (e.g., psychiatric support via OTN, other).*
- R11: That PERT provide more timely and effective referrals to the USAT program.*
- R12: Based on patient consent, that PERT and NHS Inpatient Units consider referring complex cases with recurring admissions and ED visits to the Complex Case Resolution Table for review and community care plans.*

5. System Mapping for PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT)



Another challenge is the ability for referral agencies in the community to advise the psychiatrist and PERT what is really happening with the client. An unintended consequence is that a patient may be prematurely discharged back to the community (Safe Beds for example). To enhance the level of information accessible to PERT, as well as to provide more effective information back to community agencies, protocols and forms have been developed to give PERT a more comprehensive picture for consideration in their assessment.

The NHS is a strong advocate of the “transitional discharge” model (TDM) which is intended to create better partnerships between the hospital and the community. It implies a stronger joint effort between community and hospital for a successful discharge and concomitant accountability for client outcomes. The model has proven its effectiveness – it has been shown to reduce visits to the ED and the risk of re-admission, while enhancing the patient’s functioning, quality of life and reduction of symptoms (Reynolds et al, 2004; Victoria Hospital, 2013). The model incorporates peer support and strong partnerships between the hospital and community agencies.

B. Urgent Supports

Urgent supports are provided to persons who have experienced a crisis but no longer need immediate support, nor do they pose imminent danger to themselves or others. The person has stabilized to a degree where he/she can now understand their crisis situation and is able to participate in short term treatment before transitioning to longer term supports.

Safe Beds

The Safe Bed program provides a short-term residential service with 7 beds (and 1 flex bed) in St. Catharines. Clients who have been referred (or self-referred) require crisis counselling in a safe therapeutic environment. The program is 24-7 and is open to males and females, 16 years of age and older. Safe Beds as originally conceived by the Province is an alternative to hospitalization. Persons may be experiencing an episode of crisis however they are not an immediate risk to warrant hospitalization. Eligibility requirements include not being impaired and not a health and safety risk to themselves or others. Therapeutic activities include goal setting, planning and coping skills, and promoting confidence and independence. The client is provided with information about other community services and assistance with connecting to services.

The NHS is a main referral source, in particular the PERT team. CMHA programs such as USS and community programs also refer their clients. Currently one bed is dedicated for dual diagnosis clients. A high referral source is justice services. CMHA court support staff will refer clients with mental health issues who have been released on bail or just released from jail.

Safe Beds is experiencing a number of challenges. Capacity often fluctuates leading to some level of frustration among referral agencies. At times Safe Beds are fully occupied, and at other times they are empty and not meeting performance targets. One solution would be to create a web based bed registry to allow referral agencies immediate access to Safe Bed occupancy information in real time.

A second challenge is variation across community stakeholders regarding the types of persons eligible for Safe Beds. Safe Beds should not be considered a shelter – it is not just a place to stay. Secondly, Safe Beds is not a mental health crisis service for persons with severe mental health concerns or unstable behaviors. Similar referral challenges have been noted in Peel Region (CMHA Peel, 2008a, 2008b). Safe Beds often receive persons who are still in severe crisis. For example, a person may not meet the criteria for hospital admission, but may not be eligible for shelter programs based on their disposition and history. Neither client would be appropriate for Safe Beds. One extra flex bed has been used to help resolve the situation. Safe Bed clients, who have become more complex while at Safe Beds, will be referred to PERT. A new referral form developed by PERT (discussed earlier) will enable PERT to receive a better history on the client, and thus avoid inappropriate referrals back to Safe Beds for clients who require admission.

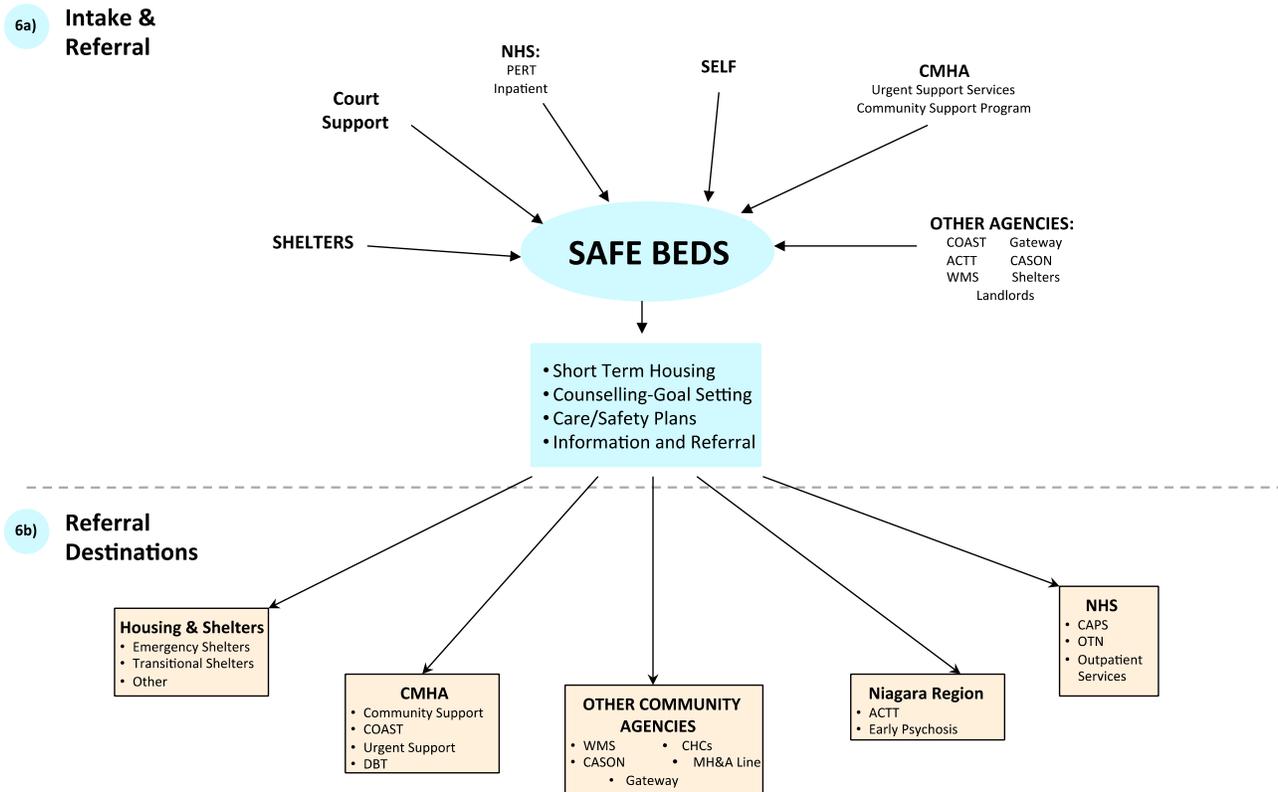
Finally the distinction must be made between a “mental health crisis” versus a “housing crisis”. Safe Beds should be envisioned as short term recovery for persons in crisis who can participate in counselling and in decisions regarding services and supports. To help support retention of clients at

shelters the CMHA Mental Health Coach Program has been initiated to provide services to clients and shelter staff. There is a gap in the community for persons that need places to stay, particularly with supports in place.

CMHA Niagara is committed to expanding Safe Beds. In so doing, CMHA should consider a tiered approach for Safe Beds – some beds designated for persons with more intense needs (single rooms and isolation rooms), and step down beds for persons who have advanced through the program and are in transition. Safe Bed expansion would support more flexible use of beds between WMS, NHS, PERT and Safe Beds, and improve flow across the system. Again in Niagara there are limited places to send people in need of accommodation with supports. “Permanent housing options are few...Safe Beds may be effective at stabilizing crisis but this is undone by a lack of supports when they leave, representing a cycle of disadvantage” (CMHA Peel, 2008b).

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6. System Mapping for SAFE BEDS



As noted earlier PERT has implemented the transitional discharge model which will help alleviate inappropriate referrals to Safe Beds. Across the broader community however, there is a general lack of information that accompanies a referral to Safe Beds. A form has been developed for community

referrals to Safe Beds to provide more comprehensive information about the client's history. In Ontario there is lack of standards and guidelines for Safe Beds although there is information sharing across the various programs through the Safe Beds OTN network.

Persons will transition through Safe Beds to shelter programs and other housing alternatives once the crisis has abated. The continuum of longer term supports includes housing, ACTT, WMS (relapse prevention) and follow-up services such as COAST and USS. The latter forms part of the individual's crisis or safety plan. Clients banned from shelters are a barrier to discharge – the ban will last for 30 days based on health and safety protocols.

The Safe Beds program and the system in general could benefit by accessing primary care and psychiatry on a more immediate basis. One option is designate 2-3 beds for urgent referrals from NHS and PERT. Providing some level of support to the site could help maintain clients at Safe Beds and avoid unnecessary visits back to the ED. Immediate or short term access to primary care and psychiatry for Safe Beds would improve flow and provide service at the right time, with use of fewer resources.

- R.13: That CMHA Niagara in partnership with shelter services and other agencies develop a web based bed registry to provide information to referral stakeholders on bed availability across the system.*
- R14: That CMHA Niagara continues efforts to educate the community on the role and eligibility for Safe Beds, and pursue all protocols and service agreements as needed.*
- R15: That Safe Beds designate 2-3 beds for NHS and PERT, and negotiate enhanced support to Safe Beds for psychiatry and primary care.*
- R16: That Safe Beds promote the use of Safe Beds with Pathstone for individuals 16 and over.*
- R17: That Safe Beds work closely with NHS PERT to formalize with other agencies a more formalized system of ED diversion.*
- R18: That CMHA Niagara expand and re-locate Safe Beds and consider a tiered model with beds dedicated to persons with more intense needs (use of single rooms, isolation rooms), and step down beds for persons who are at the point of transition to other supports.*

Withdrawal Management Services (WMS)

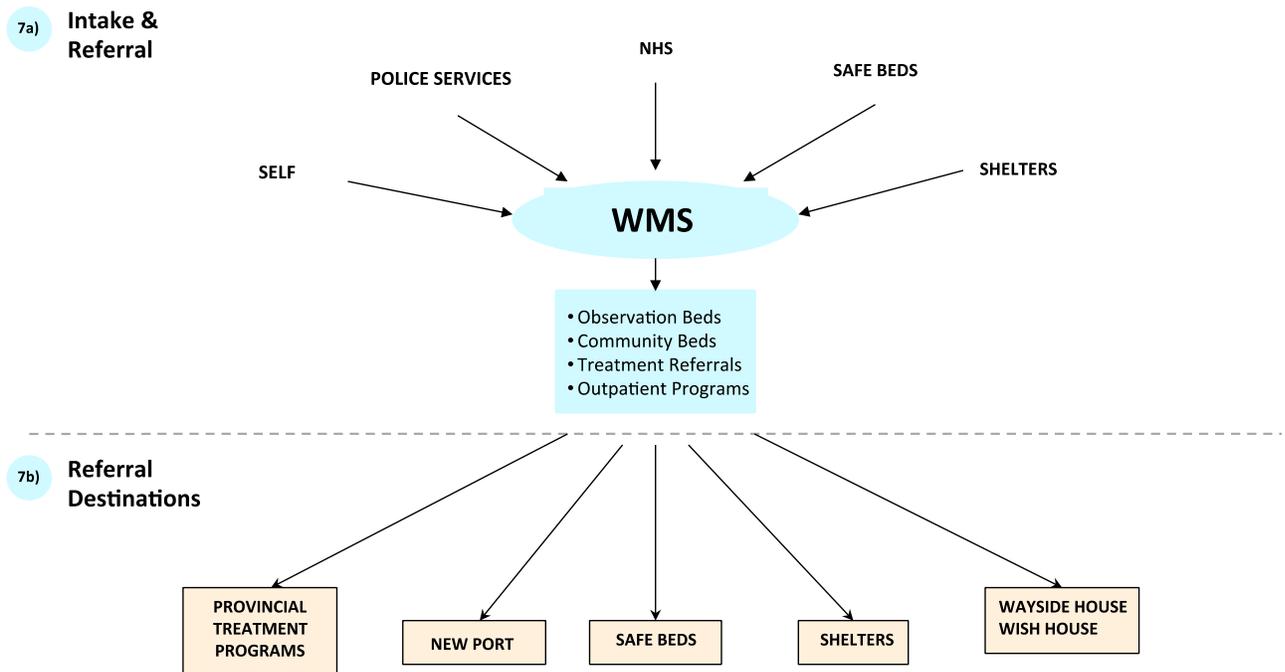
The Niagara Health System operates addiction recovery centres in St. Catharines and Port Colborne. WMS are provided for men and women 24-7 in two residential locations in St. Catharines (18-bed centre and 12-bed centre for men and women respectively). Services include crisis intervention,

withdrawal management, assessment, supportive counseling and self-help groups, consultation, treatment referrals and discharge planning. Inpatient and outpatient supports are also available (Out and About Clinic, Better Choice/ABC, Gambling).

WMS is not a formal crisis service, however being in a crisis directly related to one’s alcohol or drug use is one admission criteria for WMS across Ontario. As an example if a client was facing jail for public intoxication, they could be considered in crisis and admitted to WMS if a bed were available. However, persons who are suicidal will be asked to call 9-1-1 or WMS will call on their behalf. Similarly, persons with significant medical issues will be sent to the hospital. WMS is non-medical based and should the need arise after close monitoring a referral will be made to the hospital. Overall a person does not need to be in a crisis to require WMS.

WMS has a variety of referral sources the most common being self-referral (sometimes a parent or spouse will call). Most crisis-oriented referrals will involve Niagara Regional Police. This will be on an informal basis and would not involve 9-1-1. Small proportions of referrals come from COAST, Safe Beds, and shelters.

7. System Mapping for WITHDRAWAL MANAGEMENT SERVICES (WMS)



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The referral process mandates that WMS staff make direct contact with the client to ensure appropriate admission to the program. There are two types of WMS beds – observation beds and community beds (7 and 4 observation beds for males and females respectively). All incoming referrals must be admitted to an observation bed for higher monitoring (4 hours minimum). Afterwards when the individual is stable he/she can transfer to a community bed. Often observation beds are at maximum capacity and therefore new referrals cannot be accepted. This is a recurring problem. Another issue is the need for a medical detox unit for Niagara. This service would apply mostly to persons that are going through alcohol or opiate withdrawal that require closer medical monitoring.

NHS has a re-admission challenge for persons with addiction issues. WMS tracks persons who are frequent visitors to the ED. Often a person visits the ED with the goal of being admitted to WMS. Although they can self-refer, the centre might be at capacity and unable to accept new referrals. A visit to the ED, or call to 9-1-1 for EMS, is thought to expedite the process. However this is not the case and clients are educated on the WMS process.

New Port is a large referral centre for alcohol and drugs. Other options include supported recovery based residential programs such as Wayside House and Wish House (Arid Group Homes). Safe Beds and shelters are also common referral destinations. A key concern is the lack of shelter capacity in Niagara. Shelters may have wait lists and have strict protocols that disallow drugs and alcohol (a 30 day ban may be imposed on violators).

R19: That WMS review its capacity for short-term assessment beds.

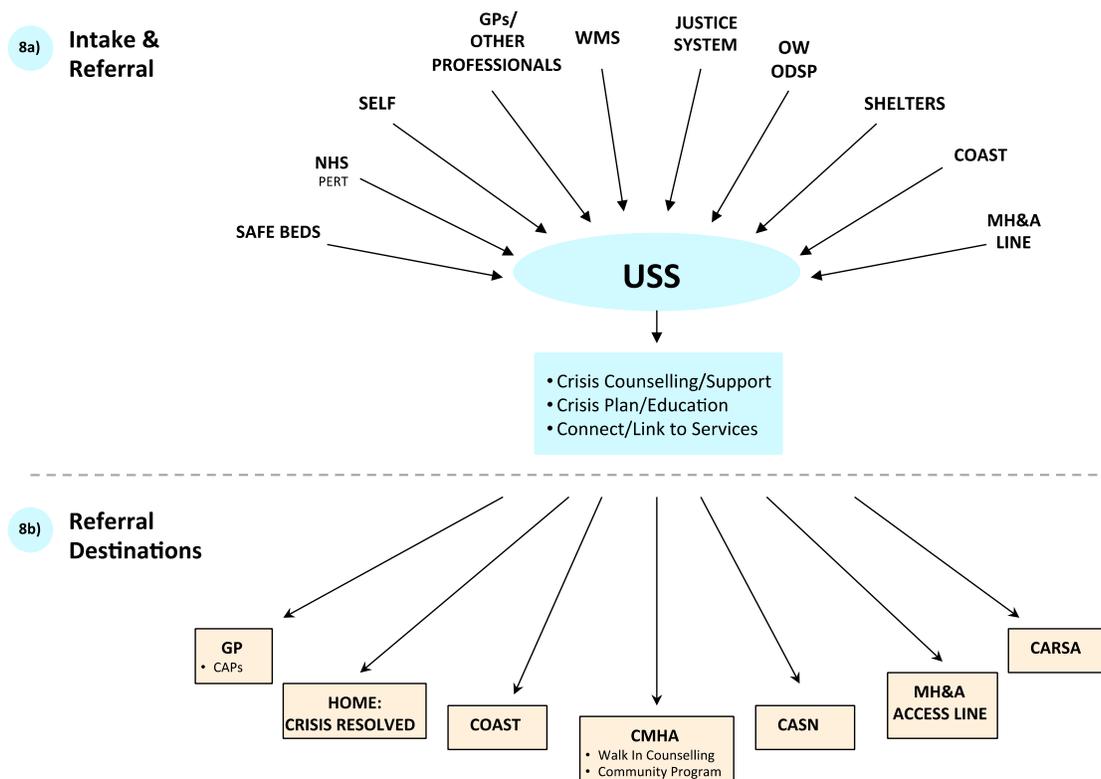
R20: That WMS consider participating in a secure web based bed registry to enable ready access to information for referral stakeholders.

Urgent Support Services (USS)

USS is a community-based “walk-in” service for people in crisis. Service locations include St. Catharines (co-located with Safe Beds), Niagara Falls and the NHS (St. Catharines site). The service is M-F (11:30am to 7pm). Mental health counsellors are available to assist individuals (16 years and older) with non-emergency, non-medical needs with problem solving, goal setting, and linking to appropriate community supports. Follow-up services may include brief solution-based counselling, telephone counselling, safety planning and bridging to longer term services. Individuals can self-refer by visiting any USS location or be referred by mental health and addiction programs/services. The hospital based program provides support to individuals who have been seen in the ED by PERT or as an inpatient preparing for discharge. A key goal is to inform the individual of services provided through USS and to possibly avoid a future visit to the ED.

A key function of USS is to help individuals manage a personal crisis and to help them get stabilized. Situations may include relationship breakup, conflict, loss of job, change in personal health and any situation where the person has trouble coping.

8. System Mapping for URGENT SUPPORT SERVICES (USS)



USS identifies a wide variety of referral sources. A separate protocol has been set up with the MH&A Access Line.

The majority of clients are able to resolve their crisis with USS support. CMHA “walk-in” counselling situated in Niagara Falls is a major referral destination as it provides more intensive therapeutic counselling. CMHA case management (community program) is also a significant referral destination.

It is recommended that the role of USS on-site at the hospital be revisited. In earlier times, CMHA mental health workers and hospital nursing staff were integrated into the EDs across Niagara Region (“Community Crisis Care”). The main focus was crisis care but also ED diversion. CMHA workers were able to avoid admissions by identifying alternatives (Plan B). Post regionalization of all mental health services, PERT was created and has since continued to make referrals to USS. However, these referrals are now more downstream as follow-up care. USS no longer participates in assessments in the ED and plays less of a proactive role in diversion. With more pressures being placed on EDs across the province, more formalized diversion programs are being put in place (Jodoin, 2010).

Currently there are logistical problems for USS based at the hospital. When the ED process is complete, it might be 6-8 hours before USS has an opportunity to meet with the client. USS counselling sessions for persons in crisis may take more than 1 hour, so there is often a lack of

interest on the part of the client to participate after a long day. Combined with the lack of space, time constraints and seemingly lack of integration, there has been less than optimal utilization of USS at the hospital. For example, the USS worker at the hospital may be pulled to help deal with surge capacity at the other two sites and in the early evening hours. However, at the same time, 20-30% of persons with mental health and/or addiction issues will re-visit the ED within 30 days of their previous visit.

R21: That NHS/CMHA review the role of USS at the NHS, with the goal to reframe the program with a service agreement for a more formalized role in ED diversion at the point of entry.

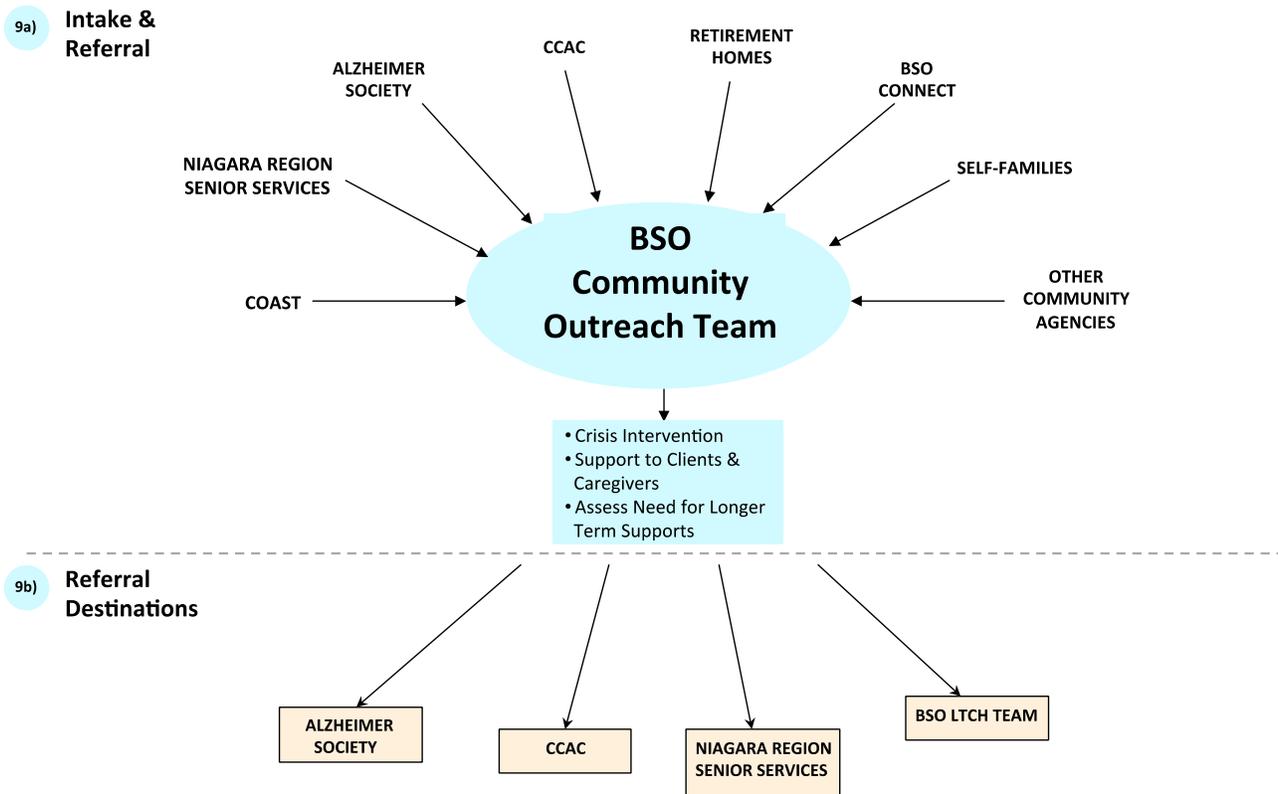
Behavioural Supports Ontario (BSO) Community Outreach Team (COT)

The BSO Community Outreach Team (COT) provides support to caregivers and older adults with cognitive impairments due to mental health problems, addictions, dementia, or other neurological conditions. The crises encountered relate to responsive behaviours such as exit seeking, verbal/physical aggression, and repetitive actions. Responsive behaviours refer to behaviours that could respond to appropriate and timely interventions.

Clients and caregivers are connected with COT primarily through COAST. Referrals can originate from clients/caregivers themselves, agency staff, hospital emergency department staff, EMS, police etc. BSO Connect located at the CCAC is also a referral source. Once a referral is received, the COT will either respond through a telephone call or conduct a face to face outreach visit (mobile visit). An attempt is made to contact the client within 24 hours. Key interventions include crisis intervention, practical support and education to clients and caregivers, advocacy, and coordination of services (longer term supports).

Next Page: *9. System Mapping for BSO Community Outreach Team*

9. System Mapping for BSO Community Outreach Team (COT)



Referral destinations for longer term supports include Alzheimer Society, CCAC and Seniors Community Programs (Niagara Region). A separate BSO team is designated for the LTCH sector. The COT does support clients in retirement homes, or in transition from home to retirement home. Persons that are transitioning to a LTCH will be referred to the BSO LTCH Team.

The BSO COT continues to develop promotional material. The team is strictly community-based, is not an emergency response and does not provide service at the hospital. As noted, the team endeavours to follow-up referrals within 24 hours. It is anticipated that the COT will have some involvement for the new MCRRT as a referral source.

The COT plays a key role in hospital diversion by providing key supports to clients and caregivers. Should the client warrant a hospital visit the team will be part of the transitional discharge model and receive discharge information to assist with their care plans. In the past little information was provided back to COAST and the COT when a client was hospitalized.

R22: That the BSO COT continue its efforts to inform the community of its role in providing crisis intervention and urgent support.

R23: That the BSO COT participate in the NHS transitional discharge model, adopting its key features, and participate in related service agreements/protocols with NHS and community providers.

R24: That the BSO COT establish a new working relationship with the MCRRT.

Urgent Service Access Team (USAT)

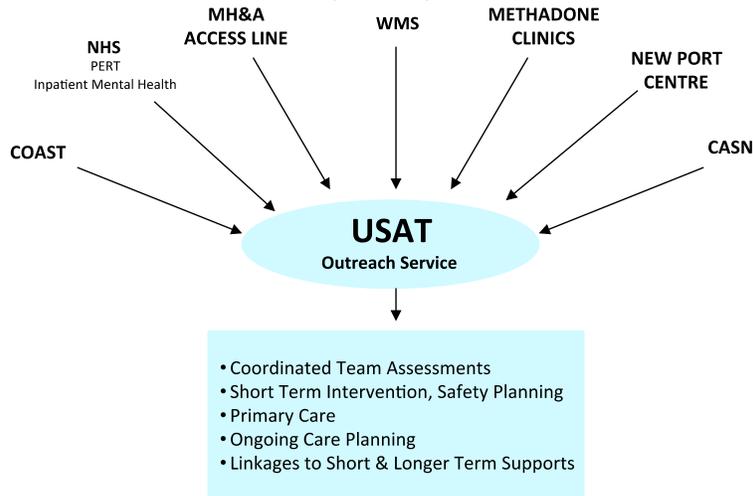
The USAT is a mobile outreach program provided by QUEST CHC in collaboration with Niagara CMHA, Community Addiction Services of Niagara and the NHS. USAT provides short-term support and health care to people experiencing opioid dependency or individuals who frequently use emergency departments for mental health/addiction issues. While providing episodic care the team will make connections to longer-term services including medical care, addiction services, housing, mental health services and other programs.

The outreach/home visit service is provided 11:30am -730pm daily. Other direct points of service include NHS, methadone clinics and WMS. The service is provided in St. Catharines and Port Colborne only, with intent of becoming region-wide. The team consists of an outreach social worker, RPN, nurse practitioner and a client coordinator. Working collaboratively, the team will do a thorough assessment, and will establish goals and develop a plan of care to meet the client's specific needs. The team will do joint complex case resolution to ensure the client connects to services. A key outcome is diversion from hospital.

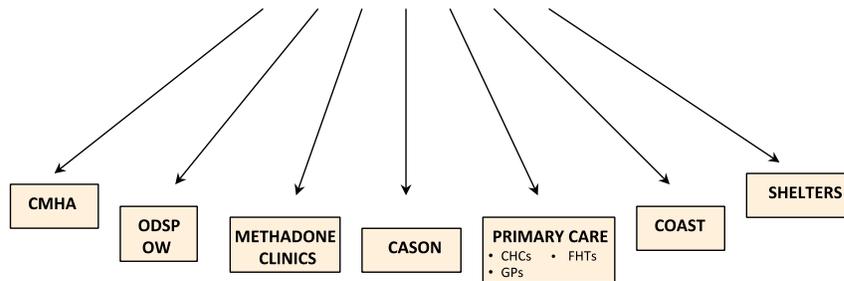
Next Page: *10. System Mapping for Urgent Service Access Team*

10. System Mapping for URGENT SERVICE ACCESS TEAM (USAT)

10a) Intake & Referral



10b) Referral Destinations



USAT receives referrals from a variety of sources. NHS PERT has developed referral protocols with USAT, QUEST and the MH&A Access Line. Clients who have high visits to the ED for mental health and/or addiction issues (5 or more visits in the past year and/or the client is flagged in the Meditech system), will be referred to USAT. Clients with a current opioid addiction will also be referred to USAT. If a client only requires primary care and is not eligible for USAT, QUEST will be contacted directly.

Experience dictates that the more direct the referral, the better able the USAT can respond. The real time scenario makes a difference, as it is possible for the client to become lost to the system. Although there is a protocol to flag clients who make 5 or more visits to the ED, and USAT is on-site for certain days, the PERT team does not necessarily identify or flag clients and notify USAT. This results in less effective use of USAT.

A significant challenge for USAT is being able to receive client information with respect to ED visits, housing situation, health care issues, etc. Client consent is secured to help obtain information from other services. To ensure that referrals from primary care are appropriately considered PERT has developed a referral form for use by community agencies. The intent is to ensure that PERT receives

the necessary background information and gives ample weight to the information provided by community agencies in decision making.

USAT as originally proposed was designed to be two teams -- funding was received for half of what was submitted. The USAT is reviewing the need for similar services in other population centres such as Niagara Falls and Welland. About 75% of all clients seen by USAT are not connected to primary care, and this scenario would be similar region-wide.

R25: That USAT work with PERT along with other community agencies to establish a more formalized diversion program for the ED, inclusive of transitional discharge planning, based on service agreements, protocols, shared accountability.

R26: That PERT review its capability to flag persons that are eligible for referral to USAT, and work towards more effective flagging and referral in real time to avoid losing the opportunity to connect the client to immediate services and ongoing care.

R27: That USAT review service needs across Niagara Region with the goal to expand to other population centres with similar needs.

C. Summary of Other Supports

This section provides a brief summary of services that provide urgent supports for special needs groups, and/or play a supportive role in linking persons in crisis to longer term supports.

Mental Health and Addictions Access Line (MH&A Access Line)

The Access Line is provided by Distress Centre Niagara. It is a free 24 hour confidential telephone support service with highly trained volunteers that provide immediate support and explore with the caller a range of services to find the most appropriate fit. It is the first point of access to mental health and addictions services for adults in Niagara. A total of sixteen (16) mental health addiction services participate with standard protocols. Key activities include information, support, connection to local services and follow-up. PERT has established a protocol with the MH&A Access Line for direct referral.

Developmental Services Ontario (DSO) – Urgent Response Mechanism (URM)

Serving adults with developmental disabilities, the DSO URM is a provincial urgent response process of coordinating short term, temporary services for individuals with imminent and significant risks. The DSO located in Hamilton is the central access point for assessment and determination of eligibility. The DOS works with a local urgent response committee comprised of developmental service agencies in Niagara to determine what service options may already be available to respond to an urgent need, and any additional resources that may be required. Persons in need may reside at home or within an existing agency. A DSO access coordinator is assigned to each case. Emergency situations are referred to 9-1-1 system, as well as COAST or Safe Beds. Examples of urgent needs are as follows: 1) the

primary care giver is not able to care for the person; 2) the person in need is homeless or displaced; 3) the person's needs have changed so much that their caregiver can't look after the person; 4) a person's accommodation situation has broken down. The role of the URM is not to find a permanent solution but to provide an interim measure (such as temporary respite). Bethesda is a key provider of in-home support through the DSO (see below).

Bethesda Community Response Program (CRP)

Bethesda's community response program assists adults with developmental disabilities and their caregivers who are dealing with significant behavioral issues. The CRP works collaboratively with local behaviour providers and relevant professionals to enhance treatment and stabilization. Referrals are coordinated through the DSO. The program consists of outreach to the home or facility where the individual resides; short term access to additional funding or a stabilization bed for an individual who needs care outside the home; and finally residential treatment – Bethesda provides a six bed residential treatment home in Vineland.

Victim Services Niagara (VSN)

Victim Services Niagara (VSN) is a community-based, non-profit organization made up of over 100 volunteer crisis responders. Its key goal is to help victims cope with the impact of crime and/or a tragic circumstance. VSN mitigates the trauma through personal support and assists individuals to access other community services. Accessed through an emergency referral line, VSN provides crisis intervention through its trained staff and volunteers 24 /7. The service provides short term emotional support and practical support in cooperation with local fire, police, hospital and emergency medical services. VSN provides the following key functions: 1) on-scene crisis intervention and bridging to other community services for long term support; 2) timely financial assistance for emergency, funeral and counseling expenses and compensation for certain crimes; 3) safety planning; and 4) free personal alarms and wireless cell phones for victims of domestic violence.

Mental Health and Addictions Complex Case Resolution Team

The committee represents a cross section of mental health and addiction programs and services set up to review referred cases that represent challenges to individual services and with transitions between services. Persons may be at higher level of risk without supports in the community and/or have become frequent users of Emergency Departments or Emergency Medical Services. Through a collaborative approach it is hoped that the multiagency review will result in a more responsive and customized approach involving two or more agencies. Eligibility includes:

- Persons 16 years of age and older
- Have a mental health and/or addiction issue
- Have complex needs and require multiagency consultation
- Have current or emergent needs and would benefit from consultation within to two week window (i.e., not crisis situation).

The Committee attempts to coordinate services for individual clients, where any when one agency on its own is not succeeding. The Committee also has a broader role in reviewing systemic concerns in terms of gaps, issues and opportunities within Niagara’s mental health and addiction system. These gaps and issues once identified can be included in action plans to advocate for service changes, funding and/or program expansion where appropriate. The Committee is addressing its role in identifying systems issues, and envisions some role to help address repeat users of emergency departments (based on client consent to have his/her case reviewed).

R28: That the Mental Health & Addictions Complex Case Resolution Team play a broader role in local and regional systemic issues, and bring forward proposals to the MH&A managers’ group.

R29: That the Case Resolution Team, in collaboration with PERT on a trial basis, have a role in reviewing individuals known to make repeat visits to the ED.

Emergency Shelters

Emergency shelters are places for people to live temporarily when they do not have a place to stay. They are primarily meant for persons who have fallen into certain circumstances and find themselves homeless with few options in the short term. In the case of women’s shelters for example, individuals may be fleeing an abusive relationship, sexual abuse or domestic violence. Based on an inventory conducted by Niagara Regional Housing, there are twelve emergency shelters in Niagara Region:

Emergency Shelter	Location
Chez Marie Refugee Assistance Centre	St. Catharines
Salvation Army Booth Centre	St. Catharines (men)
Southridge Community Church	St. Catharines (adults over 18)
The Raft Youth Shelter	St. Catharines (youth)
Hope Centre Emergency Shelter	Welland (adults over 16)
Night Light Youth Services	Niagara Falls (youth 16-30)
Gillian’s’ Place	St. Catharines (women and children)
Women’s Place of South Niagara	Niagara Falls Nova House (women and children)
Women’s Place of South Niagara	Welland Serenity Place (women and children)
YWCA Niagara Region	Niagara Falls Culp Street (women and children)
YWCA Niagara Region	St. Catharines King Street (family Shelter)
YWCA Niagara Region*	Niagara Falls (men)

*temporary only. YMCA also operates 6 family units across the Region (4 St. Catharines, 2 Niagara Falls).

Hope House was a men's emergency shelter in Welland however it ceased operations in early 2015. Approximately 12-14 beds were lost to the system with a small uptake of remaining shelter beds at other shelters. Only a smaller 5-bed emergency shelter is available at a local hotel in Welland for a maximum 30-day stay. There is now a small 10-bed temporary emergency shelter for men in Niagara Falls. The program is situated at a local hotel and is only staffed Monday to Friday (9am-5pm).

Persons with mental health and/or addiction issues may depend on emergency shelters for accommodation. Persons, who are abusing substances, are violent or represent a threat to themselves or others are generally not eligible to stay at emergency shelters. For health and safety reasons, shelters may impose a 30 day ban on individuals. In January 2015 CMHA Niagara in collaboration with the YWCA started the Mental Health Coach Program. The program supports women and staff at the YWCA shelter. Women are provided with support (information, crisis intervention and referrals) and shelter staff receives coaching about working with clients with mental health and addiction issues. The project has proved very successful and has been extended for one year.

R30: That the Mental Health Coach Program be extended to other shelters.

R31: That the status of the temporary emergency men's shelter in Niagara Falls be reviewed with the goal for it to become permanent and to provide a minimum of 15-20 shelter beds.

Summary

CMHA Niagara commissioned the crisis services mapping project to help identify intersecting crisis services and urgent supports in Niagara Region and any challenges and opportunities related to access, integration and coordination of services. Ten system flow diagrams were developed with key stakeholders, providing a comprehensive view of system properties and relationships with referral partners. A key impetus for the project was the establishment of the Mobile Crisis Rapid Response Team (MCRRT); its introduction into the system and its relationship with the continuum of crisis services and urgent supports. The MCRRT will join mental health workers with specially trained Niagara Regional police officers that will provide a rapid mobile response through the 9-1-1 system. This service change has promoted a broader review of the system in its entirety. Interviews and focus groups were held with twenty-nine (N=29) individuals that provide crisis services and urgent supports (Table 1). Throughout the report key recommendations are presented to help guide the development of the system over the next 3-5 years. Key themes emanating from the recommendations include:

- The need to establish new and/or enhanced protocols and service agreements across referral partners to enhance integration, coordination and use of resources
- The need for continued education and promotion of individual services, to clarify with referral sources service eligibility and types of services provided

- The need to enhance access to a number of services including
 - Crisis beds for children and youth
 - Emergency shelter capacity across Niagara Region
 - Primary care and psychiatric support to community based services
 - Expansion and re-location of Safe Beds
- The need to establish more formalized ED diversion programs on-site within the hospital and within the community
- The adoption of the Transitional Discharge Planning model signifying broader accountability for hospital and community-based agencies for integration, coordination and client outcomes.
- The need for improved referral information flow to and from referral partners (hospital and community-based programs).

During the project a number of positive initiatives took place concurrently such as the development of new referral protocols to improve client flow, the development of new referral forms to support information exchange, and the integration of mobile crisis services with services for children and youth. Several agencies are forging new relationships and are determined to work together and adopt appropriate changes.

The context for moving forward is supported, in part, by the new Mental Health and Addictions Charter for Niagara (Niagara Connects, 2014). In developing the charter 65 agencies committed to work together to address systems development. Key among them (Principle #3) is the need to work towards effective integration and coordination of services, and sharing ownership and accountability for both client and system outcomes. The notable directives to mention here include:

- Improving transition points between programs and services
- Enhance inter-agency relationships
- Provide information to assist agencies to conduct their work.
- Improve navigation across the continuum
- Open exchange of ideas and best practices to improve the system
- A ongoing commitment to evaluation for program and system improvement

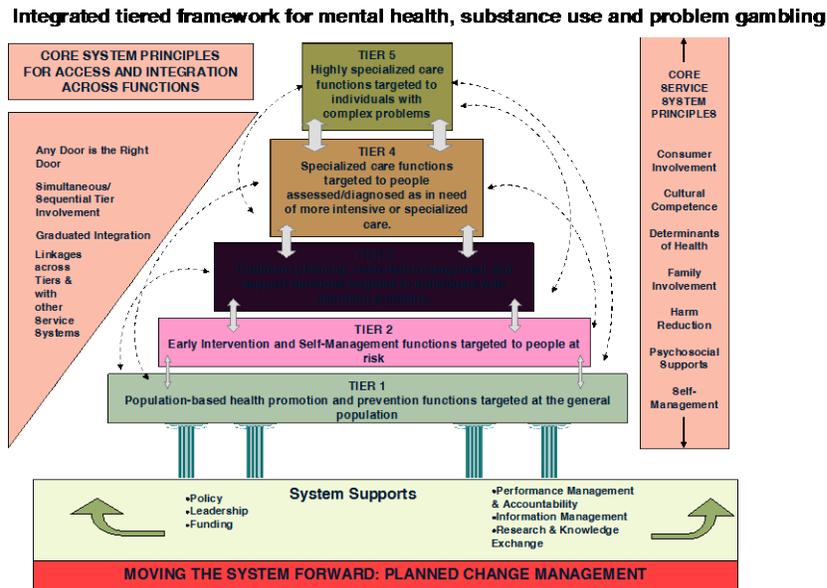
To support the current momentum to improve crisis services in the Niagara Region, and, to recognize the continued importance of the Niagara Charter, the following additional recommendations are provided:

R32: That the NHS and Community-Based Mental Health and Addiction programs/services continue to explore new partnerships, agreements and accountability mechanisms to improve integration, coordination and outcomes for clients within the system.

R33: That a model evaluation framework for mental health and addiction programs and services be developed region-wide.

R34: That a 3-5 Year Strategic Plan be developed for Mental Health and Addiction programs/services, and services for Children and Youth, to include a population needs based approach, with a framework for decision-making for establishing priorities for new and/or expanded services, integration of services, and capital projects.

Appendix A – Integrated Tiered Framework



Tier 1: Population-based health promotion and prevention functions targeted at the general population

This tier is comprised of functions that are designed to enhance natural systems and networks of support for individuals, families and communities. This includes an emphasis on the social determinants of health as well as education and policy functions aimed at the general public with the objective of promoting healthy lifestyles and preventing the development of mental health, substance use or gambling problems.

Tier 2: Early intervention & self-management functions targeted to people at risk

This tier is comprised of functions targeted to people with emerging or unidentified problems. The functions include screening/identification, information & referral, brief interventions, brief psychotherapy, psychopharmacy, self-management, motivational and peer support functions.

Tier 3: Treatment planning, risk/crisis management and support functions targeted to individuals with identified problems

This tier is comprised of functions targeted to people with identified problems who are not engaged in, or have completed specialized treatment. These functions may serve as a doorway to higher tier, specialized care functions and lower tier, self-management and mutual aid functions. Examples of these Tier 3 functions include comprehensive assessment/diagnosis, outreach/engagement, and case management. They also include general support functions (e.g., continuing care, supportive counseling, support groups, walk-in services) as well as functions designed to reduce the risks and consequences associated with the identified problems (e.g., emergency/acute medical care, psychosocial crisis intervention, and needle exchange).

Tier 4: Specialized-care functions targeted to people assessed/diagnosed as in need of more intensive or specialized care

This tier is comprised of, but not limited to, most of the functions generally considered to be part of the specialized mental health, substance use and problem gambling treatment systems. The functions include ambulatory and structured residential interventions, including pharmacotherapy, psychotherapy, and may involve multidisciplinary teams (e.g., ACT). These are specialized treatment functions intended to be delivered by individuals with special training to people who have been assessed/diagnosed as requiring this level of specialization. The function is unrelated to setting (e.g., a primary care physician providing pharmacotherapy for alcohol dependence or depressive disorders is providing a Tier 4 function).

Tier 5: Highly specialized-care functions targeted to individuals with complex problems

These are functions designed for people with particularly complex or severe mental health, substance use or gambling problems or combinations of these problems (e.g., inpatient medical withdrawal management; comprehensive inpatient/residential concurrent disorder services; inpatient forensic services; long-term inpatient psychiatric care).

Appendix B – List of Acronyms

Acronym	Definition
ACTT	Assertive Community Treatment Team
BSO COT	Behavioural Supports Ontario Community Outreach Team
CACN	Kristen French Child Advocacy Centre Niagara
CAPS	Central Access to Psychiatric Services
CARSA	Niagara Region Sexual Assault Centre (CARSA)
CASON	Community Addiction Services of Niagara
CCAC	Community Care Access Centre
CHC	Community Health Centre
CMHA	Canadian Mental Health Association
COAST	Crisis Outreach and Support Team
DBT	Dialectical Behaviour Therapy
DSO	Developmental Services Ontario
EMS	Emergency Medical Services
FACS	Family and Children’s Services
FHT	Family Health Team
LTCH	Long Term Care Home
MCRRT	Mobile Crisis Rapid Response Team
MCYS	Ministry of Youth and Children’s Services
MH&A Access	Mental Health and Addictions Access Line
NHS	Niagara Health System
NRP	Niagara Regional Police
ODSP	Ontario Disability Support Program
OTN	Ontario Telemedicine Network
OW	Ontario Works
PERT	Psychiatric Emergency Response Team
TDM	Transitional Discharge Model
URM	Urgent Response Mechanism
USAT	Urgent Service Access Team
USS	Urgent Support Services
WMS	Withdrawal Management Services

Appendix C - References

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