Community Crisis Centre - Program Evaluation

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This program evaluation has been developed to outline the critical components and impacts of changes that were made in October 2012 to existing Crisis Services operating in the Sudbury Area. From 1988 to 2011 Health Sciences North operated a Crisis Intervention Service adjacent to the hospital’s emergency department, which evolved over the years and as funding enhancements were received. Prior to the most recent program changes in 2012, the Crisis Intervention service provided services to adults and youth through funding provided by the Northeast LHIN and Regional office of the Ministry of Child & Youth Services (MCYS). Services included:

- 24/7 emergency-based crisis care,
- 24/7 telephone crisis support that did not always have a live answering response; voice messaging was occasionally used during peak periods of activity,
- a mobile crisis team operating 5 days per week.
- a hospital-based office setting open weekdays until 8pm; after hours and on stat holidays all Crisis interviews were conducted in the ED.

With significant community input and collaborative planning, a proposal was put forward to the North East Local Health Integration Network to expand the program further by offering:

- A community-endorsed standard risk triage model which would drive decisions about who would get involved and how quickly
- 24/7 LIVE voice answering on the Crisis hotline
- A mobile crisis team operating 7 days per week, working in tandem with Police services
- Expanded community-based office hours until 10pm, 365 days per year
- A Crisis Support Navigator role in the local Emergency Department
- Access to an urgent care clinic to address needs outside of the Emergency department

In the two years since the enhanced funding was provided, the following impacts have been seen:

- **An 18% reduction in ED visits** by people presenting with mental health concerns to the Emergency Department in the first year; an annual **reduction of 314 Emergency Department visits** following implementation of the new model
- **More than 350 individuals** served for medical urgent care needs outside of the ED
- **Over 183 diversions from Police to the Crisis mobile team or community-based venue** vs. transport to the ED
- **A growing increase in community-based crisis visits** through relocation to a community setting and 24/7 LIVE voice answering of the Crisis hotline (2082 community-based visits in the first year and over 3700 visits in year 2, representing volume increases of 80% in just the past year alone)
- **A 39% increase in mobile visits**, in year 1
- **An 18% reduction in police waiting time** in the ED
- **A 95% “good catch/ retention” rate** with police calls (making the right decision in the client’s best interest)
- An ever-increasing number of ED diversions and ED support visits offered by the **Crisis navigator role** (72 diversions in the first year of operation and 344 support visits)
- High client satisfaction rates, **exceeding 93% satisfaction** in both service effectiveness and service satisfaction
- **Acceptable response times** (under 30 minutes) for the mobile crisis team to high risk situations
Table of Contents

Background and Case for Change 3
Program Evaluation Framework 5
Emergency Department Impact 6
Crisis Service Indicators 9
Police Service Indicators 14
CMHA Crisis support Navigator Impact 17
Conclusions 18
Background & the Case for Change

In the fall of 2011, Health Sciences North, the Greater Sudbury Police Services and the Canadian Mental Health- Sudbury/Manitoulin Branch put forward a proposal to the North East Local Health Integration Network, to enhance and expand the delivery model of the community’s existing Crisis Intervention service. The proposal put forth was deemed an improvement to the existing model which had been hospital-based and located adjacent to the Emergency department since the late 1980’s. Prior funding agreements with the North East Local Health Integration Network (NE-LHIN) and the Ministry of Children and Youth Services (MCYS) provided the resources to deliver 24/7 crisis services to people of all ages within the Sudbury Manitoulin catchment area, and this remained the focus during the planning of the new service model. Limitations to the existing service model included limited access to the mobile crisis team 5 days per week, and limited phone response during peak service times. The pre-existing model also drew people into the Emergency Department for care, when the environment of the ED was not always appropriate to meeting their needs.

The proposal laid out important improvements being considered:

- offering community-based care outside of the local Emergency Department and in an environment that could more sensitively address needs of clients with mental health concerns,
- reducing police waiting times for Crisis and Emergency Department services,
- enhancing the availability and profile of the Crisis mobile team to respond consistently to calls in the community for both youth and adults 7 days per week, rather than 5 days per week as per prior funding
- Offering crisis counselling through 24/7 LIVE voice answering of the existing Crisis Intervention hotline

In February 2012, at the invitation of the North East LHIN, a Community Crisis Steering Committee was formed to begin planning for the proposed changes that the NE LHIN supported in principle.

Partners in the planning included:

- Health Science North’s Crisis Intervention team and Emergency Department staff (HSN)
- Greater Sudbury Police Services, (GSPS)
- Canadian Mental Health Association’s Sudbury-Manitoulin Branch, (CMHA)
- The Child & Family Centre (CFC)
- Northern Initiative for Social Action’s Warm-line staff (NISA is the local consumer organization)
- Family members

The Steering Committee recommended changes to the hours the Crisis service would operate in the community, the location of the services and how HSN’s Crisis Intervention staff would work more collaboratively with police and other front-line agencies providing crisis and pre-crisis care. Additional input was provided by consumers and community agencies regarding the benefit of having improved access to urgent primary care that would be more sensitive to the needs of the client group, outside of the ED environment. Planning continued through the spring and summer of 2012. Extensive community consultation was conducted, including focus groups with service users and family members from:

- Shkagamik-Kwe Health Centre, (aboriginal health centre)
- Sudbury Action Centre for Youth,
- The local chapter of the Schizophrenia Society of Ontario,
- The Rainbow District School Board,
- Mental Health consumers on Health Science North’s adult units and in NISA’s office sites
On October 1st, 2012 the new community-based crisis model was launched with pilot funding provided by the NE LHIN. The new model featured the following:

- A new downtown location for Crisis services at 127 Cedar St, in the existing Sudbury Mental Health & Addictions Centre operated by Health Sciences North
- Extended hours at 127 Cedar St, providing street-front access to adults and youth seeking crisis support until 10pm, 7 days per week, 365 days per year
- Development of a unified triage system for mobile calls by police, crisis workers and community partners
- Expanded hours for the Mobile Crisis team, who now respond to crisis calls in the community until 10pm, 7 days per week
- A comprehensive training program delivered by staff from CMHA and HSN to the Greater Sudbury Police services for responding to clients with mental health concerns
- The introduction of a CMHA staff member working in a Crisis support navigator role in the Emergency room at Health Sciences North
- An urgent primary care clinic using existing HSN resources (not new funding) for existing mental health clients of LHIN-funded agencies, as an alternative to seeking care in the ED and/or fragmented care in the community

The launch of the changes to the service was accompanied by significant communications and marketing efforts through distribution of posters to over 1000 locations in the community, and direct-to-consumer advertising through billboards spaced strategically in the community. Several sessions were held with community-based organizations, Emergency department staff, uniformed officers of GSPS and officials of all school boards to ensure they were well-informed of changes to the service delivery model. Additionally, a series of communiques were issued by the Steering committee co-chairs throughout the planning process. The communications strategy included inviting stakeholders and the general public into the Crisis centre to see for themselves what the centre would offer clients and how services would be delivered. The partners and funder hosted a media launch as the Crisis Centre opened. The broad array of tactics used were well-received by the community and helped move changes forward in the community.

A comprehensive 1st year review was developed, published and broadly circulated to keep the community informed of changes and progress-to-date.
Funding for enhancements of HSN’s existing Crisis service and the development of the Community Crisis Centre was provided on a pilot basis by the North East LHIN in November 2012. The LHIN also provided one-time funding to CMHA to pilot the role of the Crisis Support Navigator in the ED. This project funding was provided to HSN and CMHA, contingent on meeting certain performance targets.

This report will outline the targets established by the LHIN in consultation with the health service providers, and performance outcomes achieved between implementation of the new model in October 2012 and June 2014.

While there were targets set and agreed to by all parties, it was also understood that client choice would always be respected and that emergency department use, mobile crisis use, and urgent clinic use was not something that could be controlled by service providers, but changes in venue could be actively promoted; individuals would sometimes choose to seek care in certain locations for a variety of reasons, despite communication efforts and service availability in other locations.

This Program Evaluation Report is outlined in 4 sections, according to the LHIN funding letters:
Part 1 - Emergency Department Diversion Impact
Part 2 - Crisis Program Indicators
Part 3 - Police Service Indicators
Part 4 - CMHA Crisis Support Navigator Impact
Performance Target #1:
Reduction in total volume of visits to ED for Mental Health and Addictions issues by 25%
Baseline visits: 2600 annual (650/quarter) Target: 1950 annual (487/quarter)

In its first year of operation, the performance target of <487 visits per quarter (25% reduction) was achieved in all 4 quarters, dipping well below the established target, particularly in the summer of 2013-14. The significant rise in ED visits encountered in the latter part of 2013-14 can be explained by a small number of unique individuals with a dual diagnosis of mental illness and a developmental disability using the ED on a daily and sometimes twice daily basis and also consuming a tremendous amount of time from community-based developmental services, police, EMS and Crisis services. Inter-agency diversion plans of care have been put in place for these frequent users bringing the numbers back to the level of ED use, prior to the crisis model change. Despite these efforts, there continue to be increases in ED use by our community. Additional details about appropriateness of ED use will be provided below in the section dealing with police encounters.

Figure 1: Mental Health visits in the ED

While ED use had an initial decline, achieving the targeted reduction, and then a subsequent rise, this is not providing a full picture of Mental Health service use in our community, it merely represents ED visit rates (see next section). When considering case reviews with police that have been carried out monthly (see performance target #10), most of these ED visits are appropriate and non-deferrable, or related to client choice. Since the community crisis model was funded, Crisis data has been tracked to identify where clients are being seen and these graphs below reflect that the community-based crisis model is reaching more adults and youth than ever before via its community-based offices downtown, the 24/7 Live-voice Crisis line, as well as through mobile outreach visits in the community. In summary, while the target of reduced ED use has not necessarily been sustained, it is not an accurate depiction of the service capacity that has increased as a result of the community-based model reaching more clients than ever. Feedback provided to Steering Committee members is that the marketing campaign has increased people’s awareness to get help. The good stories of positive outcomes associated with Crisis visits spread through the community, increasing service use in the community. When you compare Crisis visits from 2012-13 (baseline year) to 2013-14 (first year of full implementation), the Crisis service has provided 185% more client contacts/visits (1819 vs. 5200) overall, in large part due to its presence in the community and availability of services 7 days/week. In summary, service use overall has increased significantly in the past
two years, and the move downtown saw increases in office-based and mobile visits, taking considerable volume away from the ED. In year 1, 2082 client visits occurred in the community, while in year 2, this number increased to nearly 3700 community visits. This alternative way of providing crisis services has enhanced service access to people in our community.

Figures 2a &b: Crisis volume over period of 2011-12 to 2013-14 by fiscal quarter
Performance Target #2:
Increased number of MD assessments outside of the ED
Baseline visits: 0  Target: 576 visits to Urgent Care Clinic annually

Although there were not additional funds provided for this service, as part of the plan to divert clients from the ED, HSN allocated some of its sessional dollars to a local primary care physician so that an urgent care clinic could be provided 2 afternoons per week at HSN’s downtown Mental Health & Addictions Centre. This clinic was intended to support clients of the existing Mental Health & Addictions services that the NE LHIN funds (HSN, CMHA, Monarch Recovery Services clients). The clinic’s function is to enhance mental health and addictions recovery by providing episodic urgent care to those clients who do not have access to a primary care provider, from having to use the ED for physical care issues and medical concerns. The consistent primary care physician works collaboratively with psychiatrists and other clinicians to ensure continuity of the care being delivered within the mental health and addictions system locally. In its first fiscal year of operation (2013-14) a total of 309 visits occurred (avg. 25 visits/month), supporting 184 unique individuals. This fell short of the initial performance target in the first year of start-up. However monthly visits in 2014-15 are tracking at an average of 37 visits per month with a projected service level of 350 unique individuals and 444 visits by year-end. This clinic is meeting the needs of hundreds of clients who lack access to primary care, diverting them from ED use, and is a service which is completely integrated with LHIN-funded Community-based mental health & addictions services, so that client visits and physician notes appear in the integrated electronic medical record.

Figure 3: Urgent Care clinic volumes

Individuals are referred into the clinic by an existing LHIN-funded service provider. Generally there is no wait time to access services.

Clients have provided very positive feedback regarding the amount of time the primary care physician spends with them to address their physical and emotional needs, unlike some of the fee-for-service walk-in-clinics elsewhere in the community, where limited time is spent for more transactional service. The location of the clinic and the sense of safety and familiarity it provides have been well articulated by clients using the service. The ability to expand hours, actively advertise and promote the clinic’s use is limited by its unfunded status. There is potential to explore expansion of this valued service in partnership with other community agencies who do receive primary care funding.
As part of the pilot funding, the LHIN also identified the following performance requirements specific to the Crisis service:

**Performance Target #3:**
Increase in mobile crisis visits in community by 30%
Baseline visits: 582  
Target: 756 annually

- Note that the baseline visits in the performance target above reflected a different reporting period (different 12 months in the calculation) and is not the most accurate pre-post comparator. For the purpose of analysis, the 12 month period considered for baseline is Oct 1-Sept 30. The Oct 1-Sept 30 baseline (pre-implementation was 477, so a 30% target would equal 620 visits.

**Increased Mobile Crisis Growth**
In the previous model, the mobile team operated 5 days per week (statutory holidays excepted) which often created some confusion with police and community in terms of the team’s availability. With the model expanding to 7 days week, inclusive of holidays, there was a 39% increase in mobile visits in the community by the Crisis Intervention team in the first year of operation, increasing from 477 visits in the pre-implementation baseline year (Oct. 2011 to Sept 2012), to 663 visits in the same period, one year later. The performance target of 30% increase in the first year of operation was exceeded.

In the second full year of operation, we have seen a decline in mobile visits from year 1, although visits are still above baseline. This can be explained by in-school supports that were put in place (CCAC nurses) who now manage some crises independent of the mobile crisis service. Additionally, the local Child & Family centre piloted a new walk-in clinic in the summer of 2014 which also may be impacting the use of the mobile team by youth. The mobile team remains available 7 days per week to provide support directly in the community, including private residences, schools, or wherever the client and family wish to meet. They also respond to issues arising through discussion at the Rapid Mobilization Initiative; a recent LHIN-funded initiative.

**Figure 4: Mobile Crisis visit volume**

When the mobile team is not out on calls, as part of the integrated Crisis Service team, they assist with coverage within the service responding to phone calls, picking up waiting clients and supporting the ED when help is needed by the Crisis staff there. In essence, helping to relieve the pressures of increased community-based referrals, and mitigating for the >240% increase in crisis visit volume the past 2 years.
Manual data collection for the period of January to June 2014 reflects the following activity and support provided by the Mobile team:

**Figure 5: Mobile team workload**

<table>
<thead>
<tr>
<th>Month</th>
<th>Mobile call-outs</th>
<th>Mobile support to office/ phone/ ED visits</th>
<th>Total mobile visits</th>
<th>Daily average</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2014</td>
<td>23</td>
<td>40</td>
<td>63</td>
<td>2.0</td>
</tr>
<tr>
<td>February 2014</td>
<td>31</td>
<td>35</td>
<td>66</td>
<td>2.4</td>
</tr>
<tr>
<td>March 2014</td>
<td>49</td>
<td>49</td>
<td>98</td>
<td>3.2</td>
</tr>
<tr>
<td>April 2014</td>
<td>42</td>
<td>76</td>
<td>118</td>
<td>3.9</td>
</tr>
<tr>
<td>May 2014</td>
<td>60</td>
<td>54</td>
<td>114</td>
<td>3.7</td>
</tr>
<tr>
<td>June 2014</td>
<td>42</td>
<td>51</td>
<td>93</td>
<td>3.1</td>
</tr>
<tr>
<td>6 month total</td>
<td>247</td>
<td>305</td>
<td>552</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*note the mobile team (1 vehicle) generally spend 1 hour in direct visit with adults and on average 1.5 hours with direct visit with youth/family. In addition to direct visits, the mobile team’s efficiency is affected by travel distances and documentation requirements.

Significant effort has been made to directly market Mobile Crisis services directly to the public, however some of the feedback received includes people preferring the privacy of an office vs. the venue of a kitchen table or family living room. There continue to be concerns expressed about “what the neighbours might say/think”. Despite this, direct-to-public advertising will continue to market all community-based options of service delivery.
Performance Target #4:
Wait time for mobile crisis
Baseline: to be established in 2012-13 Target: 1 hour

In consultation with the LHIN staff and the Community Crisis Steering committee, wait time targets were established based on client acuity and level of risk as per the Crisis Triage Rating Scale (the unified triage scale being developed and adopted by Crisis, police and all community partners). Level B clients (very high risk) were assigned a mobile crisis wait time target of 60 minutes (inclusive of travel to the scene) and Level C clients (high risk but in the presence of a capable adult) were assigned a wait time target of 120 minutes (inclusive of travel to the scene). Mobile Crisis wait times are an important indicator, as the mobile team presents an attractive option for clients compared to wait times in the ED and an attraction option to police in terms of wait times that police experience handing off to the mobile crisis team vs. wait times as part of apprehending someone under the Mental Health Act and bringing them to ED.

Over the past 15 months of tracking wait times according to triage scores, the team has met its wait time targets in all months for level B clients; where the average wait is below 30 minutes. For level C clients, the mobile team has met its target of 120 minutes in 11 of the past 15 months.

The chart below shows results for the period of April 2013 to June 2014.

Figure 6: Mobile Crisis wait times

![Mobile Crisis wait times chart](chart.png)
**Performance Target #5:**
Increase in overall office & phone-based program visits by 30% (adult & youth visits excluding mobile & ED visits)

Baseline*: 1626 individuals
Target*: 2114 individuals
3297 visits
4286 visits

*note the baseline year statistics in the LHIN funding letter were determined based on previous years’ crisis visits inclusive of ED visits. For the purpose of this report, chart reviews were conducted of the baseline year to distinguish office based-visits (Crisis office suite) from ED visits (crisis response) so an accurate baseline could be used for comparing pre-post implementation statistics. The chart below reflects the period of Oct 1-Sept 30th in the pre-implementation year (baseline) and post implementation period, specific to community and phone visits.

Since moving to the Sudbury Mental Health & Addictions Centre on October 1, 2012 and expanding service hours until 10pm, 7 days per week, the Crisis Intervention team has seen a tremendous increase in the number of individuals seeking crisis care in the community. **Overall, there was a 140% increase in the volume of visits to the Crisis Intervention service in the community in the first year of the new model** (from 704 office & phone visits to 1691 office and phone visits); well exceeding the 30% target and making up the majority of service volume increases compared to other venues (ED or mobile). This increase in community visits has continued to grow in the second year, where 9 months into the year (October to June) **we have already exceeded last year’s numbers, showing a nearly 240% increase over the pre-implementation year**. The graph below indicates how Crisis care in the community has expanded with increased capacity of our 24-7 Live Voice crisis hotline and services operating at our downtown location until 10pm, 365 days per year. (phone and in person visits)

**Figure 7: Community-based office and 24/7 Hotline visits**
Performance Target #6:
Overall Crisis Services Effectiveness (defined as helpful/ very helpful in CSQ8 survey- question #6)
Baseline: 91% Target: maintain >80%

Client perceptions of care are captured using a standardized and validated 8-item survey called the CSQ8. In the first year, following implementation of the new model, clients perceived the effectiveness of crisis service as helpful or very helpful 93% of the time (above baseline and above target). This indicator has risen to 94% in the current year (9 months of data to end of June 2014).

Additionally the Community Crisis Steering Committee has reviewed anecdotal data written on client surveys by consumers and families of the service. Key stakeholders sitting at the steering committee continue to hold the program changes in high regard.

Performance Target #7
Overall Client Satisfaction (defined as satisfied/ very satisfied in CSQ 8 survey- question #7)
Baseline: 86% Target: maintain >80%

Using the same standardized and validated 8-item survey, CSQ8, clients were also surveyed regarding their overall satisfaction with Crisis services. In the first year, following implementation of the new model, clients were satisfied or highly satisfied 94% of the time (above baseline and above target. This indicator has remained positive at 90% in the current year (9 months of data to end of June 2014).
Given the inter-agency collaboration in the development and support of the proposal and some of the issues front-line police staff were experiencing, the LHIN’s original funding letter also contained some targets regarding measuring impacts on police services.

**Performance Target #8:**
Direct dispatches of Crisis team from 911 vs. deployment of police
Baseline: 0  Target: 250 annualized

In the fall of 2012, extensive training was provided by CMHA and HSN staff to 296 members of the Greater Sudbury Police service, including communications centre (911) personnel. The training included content and simulations for effective response to people with serious mental illness. It also highlighted changes to the Crisis service, promoting diversion of individuals to the Crisis Centre downtown, or by calling out the mobile team to attend on scene.

**In the first year of operation (Oct 2012 to Sept 2013) a total of 72 diversions occurred** where the caller was either referred to the downtown Crisis Centre or the mobile team was called out to the scene to relieve officers. In prior years, these would have been automatic transfers to the local ED.

**In our second full year of operating, this number of diversions has increased from 72 to 111 (9 months data to date).** Although the target of 250 direct dispatches/diversions has not been achieved there are monthly case reviews conducted regarding appropriateness of police apprehensions/use of ED. More analysis follows below, raising the question of whether the target is realistic or appropriate.

**Performance Target #9:**
Reduction in police MHA apprehensions by 25%
Baseline: 455  Target: 341 annualized

**Performance Target #10:**
Increase in retention rate of apprehensions at the ED
Baseline: 46%  Target: 65%

- Note that the baseline apprehensions in the performance target above reflected a different reporting period (different 12 months in the calculation) and is not the most accurate pre-post comparator. For the purpose of analysis, the 12 month period considered for baseline is Oct 1-Sept 30. The Oct 1-Sept 30 baseline (pre-implementation was 373, so a 25 target would equal 280 apprehensions.

The number of Mental Health Act apprehensions decreased by 22% in the first year of implementation, from 373 to 290. It appears as though this significant decline will not be sustained based on year-to-date data in year 2. Greater Sudbury Police services share their MHA apprehension data with the HSN Program Director on a monthly basis, and each month these apprehensions are reviewed collaboratively with the GSPS administrative staff sergeant for clinical appropriateness. What has been learned over the course of the past two years of conducting these clinical/administrative reviews is that **95% of the time, front-line officers are making the appropriate choice in terms of use of the ED** and clients brought in for
assessment are retained as appropriate for emergency department intervention (target of 65% exceeded). Such factors as drug/alcohol intoxication, presence of weapons, assault of officers, out-of-control behaviours and the time of day when police are intervening limit the diversions to the Community Crisis centre located downtown. The clinical reviews have been helpful in continuous improvement efforts; reinforcing options with officers, reminding officers of available options and troubleshooting on clients who are frequent service users to discuss diversion plans. **We are confident the training investment has paid off and the Police services are diverting where appropriate 95% of the time.**

![Figure 8: Mental Health Act Apprehensions by police](image)

**Figure 8: Mental Health Act Apprehensions by police**

**Performance Target #11:**
Increase in number of uniformed officers attending core mental health training.
Baseline: 0 Target: 80%

In October through December 2012, CMHA and HSN partnered in delivering 2 types of workshops for Greater Sudbury Police Service staff. The first offering was a ½ day intensive training workshop for 245 front-line officers and all ranks of uniformed and non-uniformed personnel, dealing with effective response to people with a variety of mental health and addictions issues. Simulated exercises were offered, as well as first-person accounts from Mental Health consumers to raise awareness of those strategies which can be helpful and harmful in intervening in a mental health call. This session was repeated for 18 special constables and 33 communications (911) officers. In essence, 100% of the police force received this specialized training. Evaluations from the attendees were extremely positive.

The second offering was “line-up” training, lasting under 30 minutes which briefed 80 uniformed officers on the changes to the model as changes were being implemented in October 2012. It contained factual information such as where services were located, hours of operation and how to apply the triage rating scale to aid in decision-making about best venue for service. Again, 100% of officers were reached through this approach.
Performance Target #12:
Average wait time for police in ED (reduce by 50%)
Baseline: 3.0 hours Target: 1.5 hours

The average wait time for police at the Emergency room has declined steadily from the baseline year of 2.8 hours per patient (equating to 5.6 hours of office time for each call) to 2.3 hours per patient (or 4.6 hours of officer time). To date an 18% reduction in patient waiting/officer time has been achieved. The leadership team of the ED and crisis staff in the ED remain engaged in process improvements to ensure all attempts are made to relieve officers as quickly as possible. Some of the current volume and space pressures of the ED prevent full achievement of the target of 50% improvement; however this remains an indicator being tracked monthly with steady improvement towards the goal.

To provide some additional context in terms of expediting police wait times, patients arriving in ED for mental health concerns in the past year, unaccompanied by police, waited on average 3.8 hours before a decision could be made to accept for admission or discharge to community (compared to 2.3 hours with police). In terms of all patients arriving in ED, the average wait time to treatment disposition was 4.7 hours in the past year.

Figure 9: Police wait times in ED (in hours per patient visit)
Performance Target #14:
CMHA Crisis Navigator impacts
Baseline: 0  Target: 780 visits and 450 individuals served annually

As part of the collaborative funding proposal, The Canadian Mental Health Association’s Crisis Support Navigator has been situated at HSN’s Emergency Room since the spring of 2013. This was a pilot project to assess need. The Crisis Navigator role supports and accompanies clients who present in the ED, while they wait to see a physician or Crisis worker. Following the triage process, the navigator also offers the option of accompaniment or diversion to the downtown location if the client was unaware of that service option. Where warranted and acceptable to the client, the Crisis Support Navigator will accompany the client to be seen by the Crisis team downtown (diversion function), or when called upon, support a client who needs to transition from the downtown location to the ED for possible admission or further medical treatment (support function). In the first full year of operation (April 2013 to March 2014) the Crisis Navigator has supported nearly 344 individuals and diverted over 72 people to be seen elsewhere in the community. The role is now in operation 7 days per week from 12p.m. to 8p.m.

The partnership between CMHA and HSN has been strengthened considerably in the last year and grows stronger as the System Navigator role becomes embedded in standard work of the ED and Crisis service. New screening tools and processes have been implemented to ensure patients in the ED get reliable and consistent service and access to supports.

The HSN Emergency Department is currently undergoing a LEAN review to examine improvements in the flow and quality of care of Mental Health patients being seen in the ED. As part of this review, role optimization and process improvements are being fully explored, which will in all likelihood positively impact and fully optimize the Support Navigator’s role in the patients’ care experience. It is recommended that pilot funding for this role continue until fiscal year-end 2014-15 in order to implement and realize flow improvements and care standards. Rapid improvement events, involving the Crisis Support Navigator, ED and Crisis staff will take place between October 2014 and March 2015.

Figure 10: CMHA crisis support navigator

![Figure 10: CMHA crisis support navigator](chart)
Overall, the changes to the Crisis Intervention model seems to be meeting the community’s needs, and preferences.

Fewer people are using the Emergency Department as the first point of access for Mental Health services. When police do apprehend someone under the Mental Health Act, or transport them to ED, they are doing so with solid rationale, and are experiencing shorter wait-times in handing off care to clinicians.

The service has seen tremendous growth in volumes of client activity these past 2 years in all venues (mobile, ED and community) which has only been sustainable because of effective working relationships with our partners. Fears of shifting wait times from the ED to the community have not been realized. People are being assessed and interventions are taking place in a timely manner in the community, and certainly in less time on average, than if clients present to the Emergency Department on an average day.

The service has been well-received by service users. High satisfaction ratings and anecdotes of high quality care are being received and reviewed on a continuous basis. All feedback is taken constructively and addressed in ED and Crisis team huddles to ensure the focus remains on providing high quality, reliable care.

The Community Crisis Steering committee remains engaged in fostering collaborative relationships and promoting the use of crisis services which are most appropriate to meet client needs. We will begin to extend our reach of direct-to-consumer advertising through targeted radio ads in the coming year.

The Crisis Intervention team is moving into new frontiers, offering Crisis assessment over the Ontario Telemedicine Network (OTN) to clients presenting to hospitals and community health centres outside of Sudbury. The team is currently involved in a pilot program with Espanola Hospital, Manitoulin Health Centre and two aboriginal health and social service organizations to offer face-to-face crisis intervention using OTN. A proposal has also been put forward to expand direct crisis service delivery in the Espanola area, to meet community needs and preferences.