

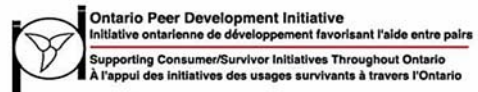


Addressing Emergency Department Wait Times

and

Enhancing Access to Community Mental Health & Addictions Services and Supports

July 2008^{*}



^{*} Originally submitted to the Honourable George Smitherman, (former) Minister of Health and Long-Term Care, May 2008.

July 2008

Background

In March 2008, the Minister of Health and Long-Term Care sought the advice of our partnership, comprising six provincial mental health and addictions organizations representing consumers and service providers. The Minister's office asked for suggestions on addressing emergency department wait times and improving access to mental health and addiction services.

The attached brief is the Partnership's submission to the Minister, '*Recommendations for Addressing Emergency Department Wait Times and Enhancing Access to Community Mental Health & Addictions Services and Supports, May 2008*'.[♦]

Ideally, our organizations would have had more time to develop a comprehensive position, and consult fully with consumers, health policy experts and providers. In this case, we took the opportunity to contribute to the government's attention on these important issues, and responded to the request within weeks.

We offer a series of suggestions that we believe will improve emergency department care for people with mental health and addiction problems, reduce demand on emergency departments, and strengthen the capacity of the community sector to address mental health and addiction problems before they become acute. Most of the suggestions are supported by a body of empirical evidence, in Canada and abroad; all are supported by the experience of consumers and service providers working to improve care for people with mental health and addiction problems.

Questions about this submission can be directed to any member of the Partnership

Addictions Ontario

Canadian Mental Health Association, Ontario

Centre for Addiction and Mental Health

Ontario Association of Patient Councils

Ontario Federation of Community Mental Health and Addiction Programs

Ontario Peer Development Initiative

[♦] Page 6 includes a revised paragraph from the original document, which clarifies Connex's current and potential role.

Executive Summary

The 2008 Ontario budget has committed \$80 million to community mental health and addiction services, and allocated \$180 million to address emergency department (ED) wait times.

Following a consultation with the Minister of Health and Long Term Care and a subsequent meeting with the Minister's policy advisor, our Partnership of six provincial mental health and addictions organizations has been asked to submit advice on two related health system issues.

The issues:

- how to reduce emergency department wait times
- how to improve access to community mental health and addiction services and supports

The Partnership recommends five initiatives to address emergency department wait times:

1. Develop and invest in a comprehensive 24-hour crisis response system in communities throughout Ontario. People with mental health and addiction needs require alternatives that are more appropriate in meeting their needs than the emergency department.
2. Invest in non-medical programs for alcohol and drug crisis management.
3. Invest in peer support warm lines, which are an upstream approach to reduce crisis escalation.
4. Support peer support workers involvement in discharge planning, to offer support and facilitate transitions from institutional to community care.
5. Invest in community mental health and addiction services that connect directly with hospitals, to facilitate appropriate diversion from emergency rooms; and support access to the most appropriate community based services and supports.

And, we recommend action be taken on two initiatives to improve access:

6. Expand and strengthen case management services, including the development of addiction-specific intensive case management teams; and a role for peer support.
7. Provide provincial funding to support integration strategies being organized in communities throughout Ontario, to facilitate access and coordination of community services for individuals with mental health and addiction needs.

Purpose

Following a consultation with the Minister of Health and Long Term Care and a subsequent meeting with his policy advisor, our Partnership was requested to submit advice on two related health system issues. Our Partnership represents six provincial mental health and addiction organizations that through our memberships include most community mental health and addiction service providers in Ontario.

The issues:

The Partnership was asked to consider and advise on actions that would address the following two issues:

- how to reduce emergency department wait times
- how to improve access and system navigation to community mental health and addiction services and supports

The advice contained in this brief represents our best advice given the limited time available to respond. We are prepared to follow-up with more detailed advice on these matters or others raised in our recommendations. The solutions identified are numerous and will take time to implement across the province. We therefore identify a number of recommendations for immediate action; and other considerations that we believe need attention over the course of a longer period of time.

Context

The issues we were asked to consider are multi-layered, and not easily resolved. But actions can be taken to make a significant difference. It is also important to point out that these issues being addressed are not exclusive to persons with a mental illness or addiction. Inappropriate emergency department utilization and effective system access and navigation are the subject of many health care reports in Ontario and elsewhere. There are also factors contributing to these issues that are specific to the experience of people with a mental illness and/or addiction. These circumstances require unique and targeted actions of system solutions are to be effective.

The issues raised by the Minister cannot be solved without increased resources. It is our understanding, as a result of a briefing with the Minister's staff, that our advice will help inform decisions to be made regarding how to invest much of the \$80 million allocated in the 2008 Ontario provincial budget for the community mental health and addictions sector; and, in addition that there are opportunities for the sector to receive additional investments from another portion of the provincial budget allocated to reducing emergency department wait times.

Reducing Emergency Department Wait Times

Emergency department wait times constitute a fundamental challenge to the public's confidence in the health care system. Yet the problem of emergency department (ED) overcrowding is not strictly (or even primarily) an emergency department failure. Throughout this brief, actions for addressing the ED problems involve solutions outside of the ED. These actions create alternatives to going to the ED in the first place. Not only are wait times reduced but more appropriate and responsive care is provided.

Emergency Department (ED) wait times can be symptomatic of a variety of pressures being experienced within the hospital or elsewhere in the health system. Lack of community capacity to respond is

particularly the case with respect to unmet needs in mental health and addictions services. The ED is an appropriate point of entry for some people experiencing a medical emergency, psychiatric emergency or addictions crisis and requiring immediate attention and/or inpatient admission. However, a significant cohort of individuals who present to the ED do not require institutional emergency services or hospital admission. They are retained in the ED or are admitted due to a lack of available community-based services and supports.

The ED is often an inappropriate point of access into the health care and social service system. A London, Ontario study found that up to 13% of people with mental health and addictions needs presenting to the ED were seeking care for social-structural stressors such as housing, financial issues, and the legal system.¹ During 2002-2004, on an annualized basis there were over 115,000 visits to Ontario hospital emergency departments for mental health reasons, representing a provincial average of 1,400 per 100,000 adults. In 2005, this rate increased to 1,485 visits per 100,000.² It has been suggested that these increases may be attributed to increased case finding, arising from new investments in court diversion and crisis intervention programs. These new and expanded programs have exceeded local communities' capacity and ability to respond.³

A significant percentage of emergency visits by individuals with mental health and addiction needs could be more appropriately served through alternative, more appropriate programs and services. There is promising evidence suggesting a range of initiatives that can reduce the number of mental health and addictions clients in the emergency department, and more importantly, improve quality of care.

Key Challenges

Solutions to reduce inappropriate use of the ED must address several system challenges. Emergency department use and repeat ED visits are oftentimes the result of little or no communication between hospitals and community-based services, resulting in hospitals having insufficient information to provide necessary care and/or refer to the community for optimal treatment. Hospital readmissions are often a consequence of lack of referral to more appropriate community services. This also leads to interruptions in community-based follow-up and care. The "treat 'em and street 'em" approach is a missed opportunity for continuity of care.

Lack of access to primary health care and community-based psychiatric care are two other reasons for unnecessary emergency department visits. Even persons with access to physicians and psychiatrists are likely to be confronted by telephone messages advising them to go to their nearest emergency department, should they require services outside of regular business hours.

Lastly, the lack of 24-hour crisis alternatives in most communities directly contributes to increased emergency department use. Options for crisis services on evenings and weekends are limited in many communities to emergency departments or the police.

¹ Coristine, R., K. Hartford, E. Vingilis, and D. White. (2007). Mental Health Triage in the ER: a qualitative study. *Journal of Evaluation in Clinical Practices* 13(2): 303-309.

² Durbin, J., E. Lin, B. Rush, K. Thibault and B. Smith. Impact of Targeted Community Mental Health Funding on Utilization of Hospital and Corrections Services by Persons with Mental Illness: Mid-Term Study Report. Systems Enhancement Evaluation Initiative. 2007.

³ Systems Enhancement Evaluation Initiative. Seeing a Difference: Demonstrating the Impact of New Investments in our Community Mental Health System: Interim Report. 2007.

Solutions to address emergency department visits should focus on two key strategies:

Support Initiatives which Locate Community Supports within Hospitals

Place community-based mental health and addictions diversion and triage services in emergency departments

The placement of *community-based* workers in emergency departments has been shown to reduce inappropriate usage. An expanded hospital-based health triage system, combined with mental health crisis counsellors, improved ED wait times for people seeking psychiatric care and assistance with social/population health needs at the London Health Sciences Centre.¹ Preliminary results from a community-based emergency diversion program at a North York hospital found a 50% reduction in repeat visits to the emergency room within 6 months of program participation. Following medical clearance, the hospital crisis nurse refers a client to the community-based crisis worker who meets with the client at the hospital and develops a community-based crisis intervention plan.⁴

Place community-based mental health and addictions discharge workers within hospitals

Community-based discharge workers, assigned from the local service sector, located in inpatient settings can improve access to community services following discharge, as they have direct knowledge and working relationships with a broad array of community services. Return visits to the ED could be reduced if appropriate community discharge plans are arranged the first time. Preliminary results from a community-based discharge planning program in Sarnia indicate a significant decrease in the rate of readmissions occurring within one month of discharge and overall readmission to hospital.⁵

Increase the Role of Peer Support

Peer support improves the quality of care provided to mental health and addiction clients. Peer support workers play a different role than health professionals, and can effectively inspire hope and support recovery, as well as provide practical advice, through their lived experience in manoeuvring through the system. The involvement of peer support workers in discharge planning has also been shown to reduce ED visits. A recent Ontario study found that peer support at discharge reduced subsequent use of hospital services, including emergency care. The study recommended that consumers be recognized as part of the hospital team.⁶ In Australia, direct hospital and ED referrals to peer support, which provided psychosocial, emotional and practical support through telephone and in-person contact, information about services, assistance in developing self-care strategies, accompanying individuals to appointments and activities, and support to families resulted in fewer days in hospital and fewer self-reported emergency visits by individuals. Based on its success, this peer support program has continued to grow.⁷

⁴ Goodman, S. The Emergency Department Diversion Program at North York General Hospital: An Integrated Response to Mental Health Clients in Crisis. Poster Presentation: Celebrating Innovations in Health Care Expo. Toronto, 2008.

⁵ Jensen, E., et al. An Evaluation of Community-Based Discharge Planning. Poster Presentation: Celebrating Innovations in Health Care Expo. Toronto, 2008

⁶ Forchuk C, et al. Therapeutic Relationships: From Hospital to Community. Canadian Health Services Research Foundation. 2002.

⁷ Lawn S, Smith A, Hunter K. (2007). Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. Journal of Mental Health. Nov 2007 Available online: <http://www.informaworld.com/smpp/content-content=a785021916?words=lawn&hash=859892899>.

Increase Community Alternatives to Emergency Services

While the previous recommendations address what to do once a person has presented to the hospital, the following recommended strategies look at avoiding unnecessary visits in the first place. The emergency department will serve as the point of entry for health care (and social care) emergencies when alternatives are not available. As the ED is often the only 24/7 access point, it is the default entry point. For individuals living with a mental health or addiction, there are better alternatives that can result in more timely and appropriate care.

Expand Community Based Services for Crisis and Distress

Expand Warm Lines

Linking peer-monitored warm lines to crisis response services can help to ensure that callers experiencing distress (as opposed to crisis) will receive active listening and support. This will help to keep crisis lines open for true crisis calls, while helping distressed callers resolve issues before they may escalate into crisis and an ED visit. Consumer/survivor initiatives (CSI's) routinely provide distress support. Relatively small investments could expand their capacity to provide after-hours warm lines, as is beginning to take place in some communities in Ontario.

There are a variety of community based crisis services available in Ontario, including telephone crisis response, walk-in services, mobile crisis outreach, residential crisis services and safe beds. The availability of a comprehensive range of coordinated community based crisis services can more appropriately meet individual needs for crisis stabilization and recovery support.⁸ However, these services require 24 hour accessibility to be effective alternatives to ED use.

Develop a 24/7 Crisis Response System

A comprehensive and coordinated crisis response system should include the following components:

- crisis response lines
- safe beds
- mobile teams
- direct links to emergency departments
- direct links to community-based case management

These services must be accessible to all mental health and addiction clients, including intoxicated individuals.

Offer Non-Medical Programs for Alcohol and Drug Crisis Management

The exclusion of intoxicated persons from certain crisis services contributes to emergency department overcrowding, and wait times. There must be sufficient options available to individuals experiencing an alcohol or drug related crisis to meet their unique needs, philosophy (harm reduction or abstinence) and readiness for change. Withdrawal management programs were developed to keep people out of hospitals and jails; and offer non-medical settings for detoxification with support. Currently in Ontario, capacity for

⁸ Ontario. Crisis Response Service Standards for Mental Health Services and Supports. Ministry of Health and Long-Term Care (Queen's Printer for Ontario, 2005), no. 7610-2243054, http://www.health.gov.on.ca/english/public/pub/ministry_reports/mentalhealth/cris_resp.pdf

withdrawal management is limited; and some communities lack any residential and community withdrawal management programs.

Additional System Issues Requiring Provincial Leadership

There are a number of other health system issues that require provincial leadership to address emergency department use by people with mental health and addictions:

- More valid and reliable indicators need to be developed that can better identify and monitor the extent of ED wait times for people with mental health and addictions needs. Visits are oftentimes inaccurately reported due to protocols that force coding to either a psychiatric or medical diagnosis.
- ED strategies for people with serious mental illness or addiction needs are not the same as for individuals presenting in the emergency department with behavioural issues. Better data on the latter would be the first step in identifying the extent of the problem and developing an appropriate response.
- Consistent information from the field indicates that people presenting to the ED with mental health and addiction needs routinely experience stigma, leading to delays in receiving services and increased wait times. This can occur regardless of whether they are seeking medical or psychiatric care. Anti-discrimination in-service training should be implemented across the province to ensure that people with mental health and addictions needs are treated by health care professionals in the emergency department with dignity and respect, and in a timely manner.
- Medical clearance and triage protocols need to be reviewed for persons presenting to the Emergency Department with mental health and addictions needs. The Canadian Triage and Acuity Scale identifies 'psychiatric complaints' with the exception of suicidal ideation/ attempts as a level V category response – the very lowest level. The implications of this on wait times and quality of care needs to be reviewed and remedied.
- Some individuals and circumstances will still require a referral to the emergency department for medical reasons. Agreed upon protocols for hospitals to receive and accept community based crisis and case management service referrals need to be developed and implemented.
- Many community mental health and addiction agencies are already working with Community Health Centres and Family Health Teams – from client information sharing to formalized service agreements providing intake, case management and group work. In many locations, community mental health agencies are co-locating staff within Family Health Teams, and in a few areas, satellite clinics of CHCs are being set up by community mental health agencies themselves.⁹ The Ministry should build on these initiatives and allocate future rounds of funding specifically to initiatives that support the availability of primary health care for people with mental illness and addictions.

⁹ Reville D. On Becoming New Best Friends: Integrating Front and Back Offices in Community Mental Health and Addictions. Final Report. March 2006.

Improving Access to Community Mental Health & Addiction Services

Concerns have also been raised that people in Ontario are having difficulty accessing community mental health and addiction services. We agree that both needs and demands are great, and the system is complex. In 2002, the Ministry of Health and Long-Term Care prepared 'A Guide to Developing Recommendations on Streamlining Access to Mental Health Services and Support'. Key features include access to psychiatric consultations, centralized information and referral functions, standardized assessment tools, and formalized service provider agreements to coordinate entry into local systems of care. We believe that progress is being made in implementing all but the first strategy; and that these developing initiatives will demonstrate results, if they continue to be supported and resourced. We also identify other issues that will need to be addressed to ensure that an integrated and responsive mental health and addictions system be enabled to proceed.

Information and Referral Through Every Door

The organization known as ConnexOntario is providing through a toll-free number 24 hour, 7 day a week information and referral services through the Drug and Alcohol Registry of Treatment (DART) and the Ontario Problem Gambling Helpline (OPGH). And, since 2005 it has provided information on all Ministry funded mental health programs through Mental Health Service Information Ontario (MHSIO). Connex is currently piloting direct booking of appointments to problem gambling services for callers into OPGH. Given positive results, Connex indicates that with validation from the sector, they would be willing to expand this service to book appointments to other addictions and mental health services in their database.

However, it is essential to appreciate that people with serious mental illness and/or addictions can never be expected to enter the system through just one door. *No wrong door* is a realistic and feasible strategy for persons with serious mental illness and addictions, who are often identified through the police, jails and shelters. Forcing a single entry point can lead to the unintended consequence of eliminating options for persons who are already marginalized.¹⁰

ConnexOntario is mandated by the Ministry of Health and Long-Term Care (MOHLTC) to collect key information on all of the substance abuse, mental health, and problem gambling programs funded by the MOHLTC in Ontario. Connex reports that their provincial database is available for use by mental health and addiction services providing information and referral services in their local community; and that they can and do refer to community-based centralized intake and access services located at the LHIN level.¹¹

Standardized Tools and Information Systems are Underway

Every door can lead to the right services when there are standardized assessment tools, common information systems and electronic access to client information. Enhancing access to service is supported when every individual is assessed in a common and coordinated way. Again, we believe there is progress being made in Ontario.

The community mental health common assessment project is currently being implemented in Ontario to enhance the sector's capacity to streamline and standardize the assessment process. The common assessment process will ensure each consumer is assessed using a standardized, consumer-led

¹⁰ Health Canada. Organizational Models in Community-Based Health Care: A Review of the Literature. Ottawa. 1995.

¹¹ This is a revised paragraph from the original document, which clarifies Connex's current and potential role.

decision-making tool that allows key information to be electronically gathered in a quick and secure manner. The tool being implemented is a customized version of the Camberwell Assessment of Need (CAN-C). The assessment tool is currently being piloted in 11 sites by 16 organizations. Based on the findings the tool will be rolled out and broadly implemented with all community mental health agencies across the province.

The provincial eReferrals and Access Tracking Project will enable community mental health and addiction agencies, hospitals, community care access centres, long-term care homes, and community support services to electronically share client information safely and securely. Data collected through the access tracking component should support wait time measurement and resource planning. The eReferrals system is currently being piloted for the community mental health sector through agreements between the Scarborough Hospital Short Term Case Management Crisis team and Canadian Mental Health Association, Toronto Branch. Hong Fook Mental Health Association will soon be joining the pilot, and an addictions pilot is being developed. Planning for a provincial rollout is underway.

Addiction agencies have utilized a package of assessment tools for all inter-agency referrals. These tools have been required for referral to residential services for the past eight years. Training has been conducted for all workers and ongoing training is available. The Drug and Alcohol Treatment Information System (DATIS) is a comprehensive, province-wide client information system that collects and report client demographic and data from addiction and problem gambling treatment services across the province.

Support Community Planning to Implement Integrated Approaches to Access

A range of initiatives exist or are in development across Ontario to improve coordinated access to community mental health and addiction services. This addresses the last recommendation, to create formalized service provider agreements, to streamline access. A review of best practices indicates that *one size does not fit all* and models of coordination and integration require 'correct sizing to the community'.¹² Criteria should include consideration of system characteristics, such as service capacity, history of collaboration and partnerships. Options for improving service integration and access need to be relevant and appropriate for each community to ensure acceptability, responsiveness, and accountability. This is why there are different models going forward in Ontario to improve access. The two most common models for coordinated access being developed by community mental health and addiction providers in Ontario are:

- *Coordinated/Joint* access approaches - where partnering agencies share intake procedures and jointly review assessments to determine the most appropriate placement of clients into services across their organizations.
- *Centralized* access approaches - where one service provider agency or dedicated intake worker performs the functions of assessment, intake, and placement on behalf of the partnering agencies.

Mental health and addiction service providers are committed and already involved, working with others in their community both within and beyond the sector, preparing service inventories, mapping how individuals move about the system; and designing system level plans to improve access into and through the system to meet the needs of local Ontarians with mental illness and addictions. This is not surprising, given that mental health and addictions was identified as an integration priority in 13 of 14 LHINs.

¹² Durbin J et al. Strategies for Mental Health System Integration: A Review. Final Report. Health Systems Research and Consulting Unit. Centre for Addiction and Mental Health. August 2001.

Lessons learned about the process of integrating from other jurisdictions include:^{11, 13, 14}

- it takes time to achieve integration, and it usually involves incremental steps and continuous adjustments to respond to community need
- providers, consumers and other stakeholders must come to the table as partners, with no one party being allowed to dominate the process based on power differentials due to size or status
- there must be mechanisms to communicate formally and informally among members, including how to build consensus and resolve conflict; and a neutral skilled facilitator is useful to assist in the process of integration
- dedicated resources are needed to sustain the process of integration
- there are costs involved in harmonizing and coordinating services.

Evidence also indicates that service integration does not save money¹¹ – the majority of costs are incurred in human resources and unless downsizing of services is contemplated, service demands will remain static or are more likely increase as communities create new approaches to be more responsive and accessible to local population needs.

Despite the impressive number of integration initiatives underway, the majority of consumer/survivor initiatives and mental health and addiction agencies are indicating that their desire to engage in new ways of working will be severely restricted in the absence of adequate funds for enabling the implementation of integration to proceed. Currently, there have been some one-off decisions by individual LHINs to support mental health and addiction integration projects in their areas. Given the large number of mental health and addiction integration initiatives underway in the LHINs, we recommend that the Ministry initiate an innovation fund, similar to the Aging at Home strategy – that will enable mental health and addiction initiatives that foster integration to be adequately resourced. Criteria for funding should be provincially determined to communicate opportunities to implement integration in an equitable and transparent manner.

Invest in Case Management & Peer Support

Many people with serious mental illness and/or addictions live in disadvantaged and impoverished circumstances, further compounded by stigmatizing attitudes that heighten their distress. The complex needs of people with mental illness and addiction means that a different type of case management is required, than the one designed for people with physical conditions.

Intensive case management for people with serious mental illness is based on a supportive, proactive relationship between case manager and consumer. A key function of intensive case management (ICM) is to facilitate access and coordination of services for persons who are marginalized and at-risk of falling through the cracks. Intensive case management has been shown to significantly improve housing stability, community functioning and reduce both visits to the emergency department and hospital admissions among people with a serious mental illness. Individuals receiving intensive case management also report increased satisfaction with family relations, finances, and day-to-day activities.¹⁵ In 2005, Ontario identified standards for the intensive case management function in community mental health services and supports.

¹³ The Whole Picture: A provincial framework for redesigning the Ontario mental health system. Canadian Mental Health Association, Ontario and the Ontario Federation of Community Mental Health and Addiction Programs. 2001.

¹⁴ Health Canada. Sharing the Learning. the Health Transition Fund Synthesis Series: Integrated Service Delivery. 2002.

¹⁵ Making a Difference. Ontario's Community Mental Health Evaluation Initiative. Government of Ontario. 2004.

The addictions sector has also identified an important role and need for case management. A provincial advisory committee to the former Ontario Substance Abuse Bureau recommended that a system case management function be developed for persons with addictions.¹⁶ System case managers can provide primary and on-going contact with individuals across services and locations, as long as the individual is involved with the service system. There is no analogous service to intensive case management within the spectrum of addiction services. While many intensive case management teams will serve clients with co-occurring addiction and mental health problems, there is a strong need for addictions-specific intensive case management services and broader system-based case management.

In addition, peer support has an important role to play in case management. Mental health consumers served by peer specialists within case management teams have demonstrated greater gains in several areas of quality of life and overall reduction in the number of major life problems. They also report more frequent contact with their case managers and greater overall social support.¹⁷ An interesting pilot project http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2038 underway in Hamilton, whereby peer support workers are seconded from local consumer/survivor initiatives to work in case management agencies, is showing that this integrated approach can strengthen both case management agency services and CSI's, while providing peer workers with employment support.¹⁸

Additional System Issues Requiring Provincial Leadership

- System navigation cannot guarantee an effective and responsive mental health and addictions system in communities that lack capacity. Without adequate resources to deliver a comprehensive and coordinated continuum of services and supports, streamlining access will be an entry point down a limited 'road'. Over the past several years, Ontario has increased its funding to the community mental health and addictions sector, but the need is still great.
- A provincially led population needs-based planning approach to design and fund Ontario's directions for mental health and addictions is the next step in creating a true mental health and addictions system. The Health Based Allocation Model (HBAM) being developed to allocate funds to LHINs for the sector does not at this time address issues of unmet needs. Additional, parallel provincial strategies are necessary to solve this gap.
- There are significant shortages in affordable, supportive and supported housing in Ontario. For people with serious mental illnesses and addictions, a safe and affordable home can be a place to live in dignity and move toward recovery. Individuals with serious mental illness and addictions frequently identify housing as an important factor in achieving and maintaining their health. Ontarians with mental illness and addictions are disproportionately affected by homelessness. Visits to the emergency room and hospital stays are greater for people with mental illness and addictions who are homeless, than the population as a whole.¹⁹ Increasing the stock of affordable housing to meet the needs of individuals with serious mental illness and addictions can therefore also decrease the need for emergency and hospital services.

¹⁶ System Case Management in the Ontario Addictions Treatment System. Substance Abuse Bureau. Government of Ontario. 2002.

¹⁷ CJ Felton, P Stastny, DL Shern, A Blanch, SA Donahue, E Knight and C Brown. Consumers as peer specialists on intensive case management teams: impact on client outcomes Bureau of Evaluation and Services Research, New York State Office of Mental Health, Albany. NY.

¹⁸ Moll S, Sherman D. Psychiatric Disability and Peer Support: Final Report. McMaster University and Mental Health Rights Coalition, Hamilton. 2007.

¹⁹ Canadian Institute for Health Information. Improving the Health of the Population: Mental Health and Homelessness. Ottawa: 2007.

Recommendations

The Partnership recommends five initiatives to address emergency department wait times:

1. Develop and invest in a comprehensive 24-hour crisis response system in communities throughout Ontario. People with mental health and addiction needs require alternatives that are more appropriate in meeting their needs than the emergency department.
2. Invest in non-medical programs for alcohol and drug crisis management.
3. Invest in peer support warm lines, which are an upstream approach to reduce crisis escalation.
4. Support peer support workers involvement in discharge planning, to offer support and facilitate transitions from institutional to community care.
5. Invest in community mental health and addiction services that connect directly with hospitals, to facilitate appropriate diversion from emergency rooms; and support access to the most appropriate community based services and supports.

And, we recommend action be taken on two initiatives to improve access:

6. Expand and strengthen case management services, including the development of addiction-specific intensive case management teams; and a role for peer support.
7. Provide provincial funding to support integration strategies being organized in communities throughout Ontario, to facilitate access and coordination of community services for individuals with mental health and addiction needs.

We look forward to discussing our recommendations for immediate strategies and longer term needs. And continue to offer ourselves as available and knowledgeable provincial representatives from the sector, who wish to work with the Minister and Ministry, to enhance services to meet the needs of Ontarians.