Central East LHIN Community Crisis Service Review Project

Phase 2: Community Crisis Service Modelling

Final Report – Version 2

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1.0 Acknowledgements

The project could not have been completed without the expert knowledge and dedication of the following:

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- Faiza Khalid-Khan, Patient Care Director – Mental Health, The Scarborough Hospital

Working Group

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2.0 Background

In June 2015 the Central East Local Health Integration Network (LHIN) approved the Durham Mental Health Services, Canadian Mental Health Association – Haliburton, Kawartha, Pine Ridge (HKPR), and The Scarborough Hospital to continue as Project Leads on the next phase (Phase 2) of the Community Crisis Service Review Project. The crisis response services reviewed were those funded specifically under Multi-Sector Service Accountability Agreement (MSAA) Crisis Intervention Functional Centres. The Phase 2 work focused on the review and further definition of the recommendations made in the first phase, and to develop strategies for implementation, including costs and timeframes, to meet the proposed future state. It is anticipated that these operational changes will support the Central East LHIN's Strategic Aim *"To Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their home communities"* (Ontario Local Health Integration Network, 2014).

Over the course of the past year, the Project Leads and Working Group reviewed and revised the Phase 1 recommendations, to focus on the priority requirements necessary to meet the future state. The objectives of the second phase were to:

- Define a client-centred, community crisis service model for the Central East LHIN
- Define the cost, time commitment and impact of the strategies necessary to implement the defined services model across the Central East LHIN

In doing so, a defined client-centred model for the Central East LHIN is anticipated to close some of the gaps across the three clusters making up the LHIN's catchment area. The model will also align with the work being done around community-based crisis and withdrawal management services in the Greater Toronto Area (GTA).

3.0 Outcomes of Phase 1

3.1 Current and Future State

The current and future states were defined during the service review phase (Phase 1) of the project (Central East LHIN Community Crisis Project, 2015). The identification of gaps and areas for improvement helped to define the current state. The future state would see the gaps addressed through enhancements to services, collaboration with other providers, alignment to a set of standards and accountability, and improved communication.

Figure 1.0 – Comparison of Current and Future States of the Community-based Crisis Services

Current State	Future State
Access to community-based crisis services is not consistent across the three clusters	A defined, minimum, standard basket of services is available in each cluster. Additional services provided by each crisis response service provider meets the unique needs of the communities being served
Availability of specific community-based crisis response services differ across the clusters and across communities within the clusters	
Limited capacity of community crisis service providers to respond to clients within their catchment areas in a way that would meet the Ministry of Health and Long-Term Care (MOHLTC) crisis response standards	The Central East LHIN community crisis response system is clearly defined. The capacity of each community crisis service provider meets, at minimum, MOHLTC crisis response standards and client-based quality improvement measures
Community crisis service providers are autonomous and self-directed, without established protocols for standardized practice	
Formal and informal partnerships and collaborations vary across system service providers. There is no defined state of collaboration or standardized work process for crisis and other service providers involved in a client's care	A Community Crisis Knowledge Hub is developed to promote and inform all Central East LHIN service providers of community crisis response services, expectations, service guarantees, etc., as well as the services of other mental health and social services.
	New partnerships (formal and informal), which include data and information sharing protocols, between crisis response and other service providers are established to support clients with a variety of needs
Lack of formal mechanisms for performance evaluation of crisis program effectiveness, including quality improvement measures and accountability to service users and providers	Accountability of crisis service providers through the identification, standardization and reporting of indicators, outcomes, and targets
Limited awareness of community crisis response services available to MH&A clients, families and other service providers	Promotion of services is increased to the general public, other providers and targeted to specific groups

3.2 Client-based Quality Improvement Measures

Client-based Quality Improvement Measures were also defined in Phase 1, as specific components of community crisis response services identified as important or specifically requested by stakeholders during participation in focus groups and/or surveys (Central East LHIN Community Crisis Project, 2015). Stakeholder groups included service users, families, and other service providers. The measures for improvement include:

- Client should not have to leave a voicemail when contacting the 24/7 telephone crisis line (i.e., <90min response time).
- Same-day mobile crisis response visit (i.e., <24 hours) is available.
- All crisis response services should be 24/7 (mobile crisis response, MCIT, other alternatives to hospital).
- Availability/increased capacity of crisis/safe beds in the community, based on population and geographic need in each region.
- Staff of crisis service providers should reflect the populations they serve. Access to interpretation services or the hire of additional staff and collaboration with other providers is important to reflect different cultures and to the unique needs of clients.

3.3 Phase 1 Recommendations

The outcomes of Phase 1 were ten priority recommendations outlined in the final report (Central East LHIN Community Crisis Project, 2015). These recommendations were identified as a way to close the defined gaps and to move towards the future state:

1. Improve existing community crisis services by improving response times, increasing program capacity, and meeting (at minimum) MOHLTC Crisis Response Service Standards (2005)
2. As an alternative to hospital emergency departments (ED), establish 24/7 centres in each cluster, ideally in each community/sub-region, based on population and geographic need, either as a standalone or a co-location within existing agencies
3. Establish a standard “client-centred” crisis response service model, with a minimum expected level of service, standardized in each cluster by community need.
4. Extend after-hours supports to existing crisis services (e.g., mobile crisis response and MCIT)
5. Increase collaborations with youth crisis services
6. Establish a defined shared-care crisis model with other service providers (including hospitals) to include crisis response service providers, families, and caregivers as part of a client’s circle of care. Develop protocols for data and information sharing
7. Investigate and consider ongoing issues at the end of a crisis event and the transition to longer-term supports

8. Support collaboration with other health and social services through face-to-face meetings, shared reports and other new or existing platforms
9. Meet the needs of concurrent disorder clients by increasing addiction support capacity within community crisis response services through collaborations with addiction support agencies
10. Standardize promotional materials for community crisis response services across the Central East LHIN and look to add targeted promotion and new promotional tools

3.4 Phase 2 Focus

The scope of the second phase of work focused on the planning required for the implementation of recommendations 1, 3, 5, 6, 7, and 9 above. These recommendations were identified by the Project Leads and Working Group as priority, in order to address the highest needs/gaps identified in the service review. Recommendations 2, 4, 8 and 10 will be further reviewed and developed once the other priority recommendations are addressed.

- Recommendation 2 – The benefits of community alternatives to hospital visits and admission are known, but extensive planning and consultation with other service providers is required to develop such 24/7 sites consistently across the Central East LHIN. One example of such an alternative is the community hub model. Such a model provides individuals with access to mental health (including crisis), health and social services in a centralized location, and is valuable in densely populated areas where transportation is easily available. While challenges would exist in implementing such a model in rural areas (such as in the North East cluster), due primarily to the geography of the regions which could result in travel difficulties for residents to access the services, it is not to say it is not feasible. A proof of concept is a logical step prior to full implementation and standardization of this community hub model across the entire Central East LHIN, and is discussed further under Section 5.1 of this report.

- Recommendation 4 – Although service users and providers identified the importance of having 24/7 access to all community crisis response services (particularly mobile response and MCIT) in the first phase of the project, consultation with the community crisis service providers revealed that volumes for crisis response services decrease in the overnight hours (i.e. off-peak hours). It is unknown whether volumes decrease overnight as a result of decreased need, or because individuals find alternative supports knowing the mobile crisis services do not operate overnight. In addition to client volumes, the community crisis service providers identified safety risks of mobile response teams (without police) travelling in the late evening and early morning hours.

As such, this recommendation was determined to be out of scope for this phase of the project.

- Recommendation 8 – The focus of this recommendation was on the development of new, further-reaching networks that would include providers of mental health (including crisis), addictions, health and social services, to discuss local and regional trends, concerns, and how they can support each other. Many of these providers, including community crisis service providers, currently sit on committees and groups across the LHIN such as the Human Service Justice Coordinating Committees, Central East LHIN Mental Health and Addiction Network, local Situation Tables (e.g. HUB's, Durham Connect), Concurrent Disorder Committees and Hospital to Home Steering Committees, amongst others. As such, these existing platforms will be used to further share knowledge and information across providers.

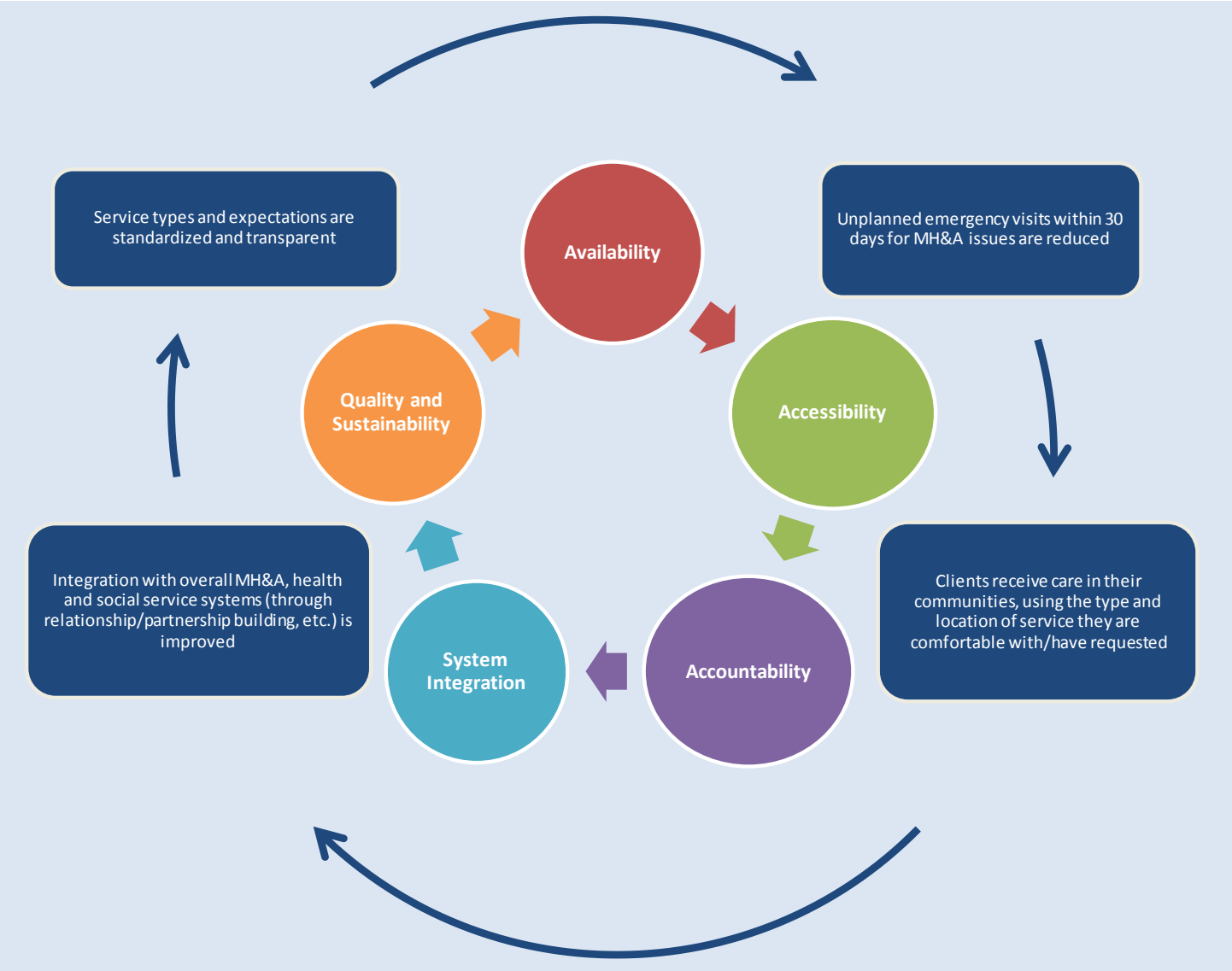
- Recommendation 10 – The promotion of community crisis services to the public and other service providers was identified as valuable by clients, families, and providers that participated in focus groups and surveys as part of Phase 1 (Central East LHIN Community Crisis Project, 2015). With the increased publicity of services, client volumes would also increase, which would cause further strain on the existing community crisis response services. This report highlights a new set of recommendations which include capacity improvements and the standardization of community crisis response services. As such, to prevent the promotion of rapidly outdated information and to prevent increased client volumes prior to preliminary service enhancements, promotion of community crisis response services was identified as out of scope for this phase of the project, but will be reviewed at a future time (post-implementation).

4.0 Central East LHIN Community Crisis Service Model

4.1 Model

As per recommendation 3 made in Phase 1, and feedback received from stakeholders participating in the focus groups and surveys during that phase, the following Model was developed as a standardized and integrated Community Crisis Service Model, for use by community-based MSAA-funded crisis service providers in the Central East LHIN. The purpose of the model is to ensure that the community crisis service providers operate in a consistent manner according to standardized practices, with consideration of client needs and accountability. The Model includes specific parameters and outcomes.

Figure 2.0 – Central East LHIN Client-Centred Community Crisis Service Model



The parameters of the Model are defined as follows:

- **Availability:** The crisis response service exists and is ready for use for any individual in the Central East LHIN (and in each cluster)
- **Accessibility:** An individual is able to obtain the crisis response service within their cluster, at a time and location suitable to them
- **Accountabilit**y: The community crisis service provider will ensure they are responsible to their clients and families/caregivers for decisions made as related to their care and for the provision of community crisis response services
- **System Integration:** An individual will receive seamless care with other mental health and addictions, health, or social services, according to their determined needs, when accessing services through community crisis service providers in the Central East LHIN
- **Quality and Sustainability**: A common set of standards is set and adhered to by community crisis service providers in the Central East LHIN, with established methods for ongoing evaluation and improvement

4.2 Core Basket of Services

The Model includes a core basket of crisis services that should be available to all residents of the Central East LHIN. These core services were determined through the Phase 1 literature search and defined in the final report (Central East LHIN Community Crisis Project, 2015). These services are:

- 24/7 Crisis Telephone Line
- Mobile Response
- Mobile Response with Police, such as Mobile Crisis Intervention Team (MCIT) or Integrated Outreach Program (IOP)
- Short-Term Crisis/Safe Beds

While all of the crisis response services above should be available in all regions of the Central East LHIN, they should be tailored based on the unique needs of the communities being served. Hours of operation should be based on identified peak periods for each of the providers, and should not necessarily be standardized across the entire LHIN. A minimum number of staff must be dedicated to both the 24/7 crisis telephone lines and the mobile response at any one time, based on client volumes at any particular time of day. Emphasis (i.e. additional staff) should be added to the service when additional support is required due to increased client volumes at any particular time.

4.3 Implementation

As part of the scope for Phase 2 of the project, the newly defined Model must also align with the Ministry of Health and Long Term Care's Crisis Response Standards (2005).

Each of the Ministry's 28 Standards was reviewed by the Working Group, who determined which of the Standards were being met, and where improvements could be made. These areas for improvement, along with the gaps and recommendations identified in Phase 1, were used to plan for enhancements across the community crisis response in the Central East LHIN.

Each of the community crisis service providers has agreed to incorporate the Model developed above to their service practices. The recommendations made in this report will assist each provider to further align with the Model.

5.0 Recommendations and Implementation Planning

The recommendations made as part of this planning and design phase build on the outcomes of Phase 1. They were developed in alignment to the key parameters of the new Crisis Model and are grouped under the categories of Availability and Accessibility, Accountability, Quality and Sustainability, and System Integration.

A total of 13 recommendations have been made as requirements to address the gaps and future state identified in Phase 1. To prepare for roll-out, each recommendation is accompanied by an overview of next steps for implementation.

5.1 Availability and Accessibility

Recommendation 1

1. Each one of the four identified crisis response services that are part of the core basket of services, as defined in the Central East LHIN Community Crisis Service Model, is available to every individual residing in the Central East LHIN.

Figure 3.0 – Recommendation 1

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
Lack of Central East LHIN-funded crisis/safe beds in the Scarborough cluster. Individuals rely on safe beds in the Greater Toronto Area through the Safe Bed Registry.	3	Scarborough	**1.a. i.** The addition of crisis/safe beds in the Scarborough cluster, operated by The Scarborough Hospital, functioning similarly to crisis/safe beds available in the Durham and North East clusters.	• To ensure standardization across the Central East LHIN, the new site in Scarborough will be modelled on the existing crisis/safe beds of Durham Mental Health Services and Four County Crisis. • A centrally located property will be selected, ensuring proximity to other amenities and services (e.g. public transit, grocery stores, health care providers, etc.). Zoning and safety requirements will be identified and the site will be updated to meet safety, accessibility and layout requirements. • With support from the Central East LHIN, community consultation will occur to inform area residents and to address any concerns. • Other local service providers will be consulted to build relationships and inform potential referral sources of the availability of beds, intake criteria, and the process for intake, care, and discharge. • New staff for the site will be hired and trained once the new sites have been upgraded. • A communication/promotion strategy for the new crisis/safe bed site will be developed in partnership with the Central East LHIN.

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
Lack of Central East LHIN-funded crisis/safe beds serving Durham Region; Gap in access to services in East Durham (Oshawa) and affiliated with the H2H Programs in that area.	3	Durham	**1.b.i**. Additional funding in order to operationalize a new 6 bed crisis unit in Oshawa to enhance the ability for vulnerable clients in the east region to obtain needed and acute crisis response services, as well as to work closely with the local Violence Against Women (VAW) shelters in the region.	• Durham Mental Health Services has received the capital funding for the new Oshawa crisis beds and is awaiting the approval of the remaining funding. A site for the new beds has been found and work is in progress on zoning and safety requirements. • With the ending of the VAW pilot, and the success seen by that initiative thus far, a recommendation is to sustain this initiative and link it closely to the Oshawa crisis beds location as a means of continuing to provide on-site, rotational support to vulnerable clients accessing the local VAW and crisis beds locations. This would act as a direct link to community-based crisis supports as a means of ED diversion.
Lack of Central East LHIN-funded crisis/safe beds serving Haliburton, Kawartha Lakes, and Northumberland regions resulting in a gap in access to services in the Four Counties.	3	North East	**1.c.i.** The addition of three new locations of crisis/safe beds, one location each in Haliburton, Kawartha Lakes and Northumberland, to cover the lack of beds in these regions.	• To standardize the operation of crisis/safe beds in the Central East LHIN, the new sites in the North East cluster will be modelled on building and operating standards of the existing crisis/safe beds of Durham Mental Health Services and Four County Crisis. • A centrally located property will be selected, ensuring proximity to other amenities and services (e.g. public transit, grocery stores, health care providers, etc.). Zoning and safety requirements will be identified and the site will be updated to meet safety, accessibility and layout requirements. • With support from the Central East LHIN, community consultation will occur to inform area residents and to address any concerns. • Other local service providers will be consulted to build relationships and inform potential referral sources of the availability of beds, intake criteria, and the process for intake, care, and discharge.

				• New staff for the site will be hired and trained once the new sites have been selected and upgraded. • A communication/promotion strategy for the new crisis/safe bed sites will be developed in partnership with the Central East LHIN.
Limited availability of mobile response to Haliburton, Kawartha Lakes and Northumberland regions due to long travel times of Four County Crisis mobile response teams (based out of Peterborough)	3	North East	**1.c.ii.** The addition of one dedicated mobile crisis response team to serve primarily the Haliburton and Kawartha Lakes regions, and the addition of one mobile crisis response team to service primarily the Northumberland region while providing additional support to Peterborough	• Four County Crisis is in the process of a preliminary collaboration with other service providers in the Haliburton, Kawartha Lakes and Northumberland regions to develop a Memorandum of Understanding (MOU) of service delivery and to refine the process of service delivery for new mobile response teams. • Upon approval of the new crisis/safe beds (see recommendation **1.c.i**.), the site of the new beds will house the mobile response team. Otherwise, a new location/co-location will be identified in the region. • Recruitment, hiring, and training of the new mobile response staff will follow, as per the standardized job descriptions/qualifications developed (see recommendation **7**)
Lack of mobile response with police programs that cover the North East cluster (beyond the City of Peterborough)	3	North East	**1.c.iii.** The creation of new partnerships with local/regional police services (including Ontario Provincial Police) and mental health providers to address the gaps with mobile response with police in the North East cluster (beyond Peterborough). Collaborations to include: • OPP (four divisions) • Cobourg Police Service	• Four County Crisis to connect with police services within the North East cluster to build relationships and identify active interests between partners in collaboration for mobile response with police in areas in the North East that currently do not have the service.

			• Kawartha Lakes Police Services • Hiawatha Police Service	
No dedicated peer support staff as part of Four County Crisis	3	North East	**1.c.iv.** The addition of one dedicated peer support worker in the Four County Crisis safe beds to support clients staying in those beds, and the integration of a dedicated peer support worker to support crisis staff on follow-up calls and non-urgent clients, and to assist with system navigation	• See Implementation Plan for **2.c.iv**.

Recommendation 2

2. To meet the response times set in the MOHLTC Crisis Response Standards (Government of Ontario, Ministry of Health and Long-Term Care, 2005) each community crisis response provider will a) increase capacity through the addition of crisis response staff for immediate and follow-up crisis response, and mobile crisis response, and b) investigate and develop partnerships with Distress Centres/Telecare for warm hand-off of clients.

Figure 4.0 – Recommendation 2

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
• Response times outlined in the MOHLTC Crisis Response Standards (2005) are not met due to capacity issues and geographic barriers • Overnight crisis line staff leave the phone lines to assist other programs when necessary (e.g. ED)	1	Scarborough	**2.a.i**. The addition of staff to the crisis telephone line at The Scarborough Hospital to ensure, at minimum, there are two dedicated crisis phone line staff during peak hours, and one dedicated crisis line staff member for off-peak hours	• The Scarborough Hospital will hire an additional crisis staff member to ensure there are, at minimum, two dedicated crisis line staff during peak hours, and one dedicated staff during off-peak hours. The Scarborough Hospital will also work with Durham Mental Health Services to follow Durham's operational model of the crisis lines.

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
• Response times outlined in the MOHLTC Crisis Response Standards (2005) are not met due to capacity issues and geographic barriers • Overnight crisis line staff leave the phone lines to assist other programs when necessary (e.g. crisis/safe beds)	1	Scarborough	**2.a.ii.** The Scarborough Hospital to remove the voicemail option from their 24/7 crisis telephone line and replace with live-answer phone system to improve live-answer response	• Durham Mental Health Services is piloting a live-answer response, through the removal of voicemail from their 24/7 crisis line. The pilot will be used as a model for The Scarborough Hospital and Four County Crisis Programs. An impact analysis will be performed to identify whether the removal of voicemail reduced response times and improved client volumes, and if so The Scarborough Hospital and Four County Crisis will also remove voicemail from their systems and implement a live-answer (queuing) system. Research into the new system is currently underway.
	1	Scarborough	**2.a.iii.** The addition of a second mobile crisis response team to The Scarborough Hospital Crisis Program, operating during peak hours	• As there may be overlap between services, The Scarborough Hospital will wait until the community hub pilot is approved by the Central East LHIN (see Implementation Plan for recommendation 12). In the meantime, consultation on the Durham Mental Health Service's model for mobile response is in progress.
	1	Scarborough	**2.a.iv.** The integration of a dedicated peer support worker at The Scarborough Hospital to support crisis staff on follow-up calls and non-urgent clients, and to assist clients with system navigation	• The peer support role, integrated within the crisis teams, will be standardized across all community crisis service providers in the Central East LHIN. An additional phone line specifically for the peer support role may be required to reduce the demands on the crisis phone lines. At the discretion of the crisis service provider, the role of the peer support worker will include: ○ Communicating by phone or mobile response with clients that are identified by the crisis workers as non-acute/urgent

				○ Acting as primary support for non-acute, repeat clients ○ Connecting with clients for follow-up ○ Assisting clients and families/caregivers with system navigation ○ Check-in calls with repeat clients • The peer support role within crisis response services will be modelled after the role within Durham Mental Health Services • Once the role is standardized, hiring and training will be underway, and include identifying best fit for the location of the peer support worker (e.g. crisis/safe beds, crisis line/mobile response office, etc.)
	6	Scarborough	**2.a.v**. Partnership established between The Scarborough Hospital and Toronto Distress Centres to develop protocols for shared client care, particularly for clients who don't require urgent crisis response	• See Implementation Plan **2.b.iii.** • Upon completion of the pilot with Durham Mental Health Services, The Scarborough Hospital will develop partnerships with their local Distress Centre(s), as per the pilot.

Gaps(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
• Response times outlined in the MOHLTC Crisis Response Standards are not met due to capacity issues and geographic barriers • Overnight crisis line staff leave the phone lines to assist other programs when necessary	1	Durham	**2.b.i.** The addition of a second mobile crisis response team to the Durham Mental Health Services Crisis Program, operating during peak hours	• Durham Mental Health Services will hire and train staff for a second mobile response team to operate during peak hours. • The position would be filled by an RPN to ensure consistency in support available via mobile response. • The aim is to provide a range of multi-disciplinary supports/ options to acute need clients in the least intrusive manner possible.
		Durham	**2.b.ii.** The integration of a peer support worker at Durham Mental Health Services to support crisis staff on follow-up calls and non-urgent clients, and assist clients with system navigation	• See Implementation Plan **2.a.iv.**
	6	Durham	**2.b.iii**. Partnership established between Durham Mental Health Services and Distress Centre Durham to develop protocols for shared client care, capacity building and in-house support particularly for clients who don't require urgent crisis response	• Durham Mental Health Services is developing a partnership (through a formal MOU) with Distress Centre Durham to collaborate on shared care of individuals who may or may not need urgent crisis support that call either Durham Mental Health or the Distress Centre. • The recommendation is to house a full time Durham Mental Health Services Crisis Intervention Worker at Distress Centre Durham as part of an enhanced partnership in order to provide cross-training initiatives, capacity building and an increase in direct linkage back to Durham Mental Health/ community-based crisis response services such as crisis beds for vulnerable persons.

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan (Upon approval and funding from the Central East LHIN)
• Response times outlined in the MOHLTC Crisis Response Standards are not met due to capacity issues and geographic barriers • Overnight crisis line staff leave the phone lines to assist other programs when necessary	1	North East	**2.c.i.** Four County Crisis to remove the voicemail option from their 24/7 crisis telephone line and replace with live-answer phone system to improve live-answer response	• See Implementation Plan **2.a.ii.**
		North East	**2.c.ii.** The addition of one crisis worker at Four County Crisis to assist crisis staff	• Four County Crisis to hire and train a crisis worker to support the existing crisis response services available.
		North East	**2.c.iii.** The integration of a dedicated peer support worker at Four County Crisis to support crisis staff on follow-up calls and non-urgent clients, and assist with system navigation	• See Implementation Plan for **2.a.iv.**
	3	North East	**2.c.iv.** Partnership established between Four County Crisis and Telecare Distress Centre of Peterborough, to develop protocols for shared client care, particularly for clients who don't require urgent crisis response	• See Implementation Plan **2.b.iii.** • Upon completion of the pilot with Durham Mental Health Services, Four County Crisis will develop partnerships with their local Distress Centres, based on the model developed from the pilot.

5.2 Accountability, Quality and Sustainability

Figure 5.0 – Recommendations 3-10

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
Community Crisis Service Providers do not align to all of the MOHLTC Crisis Response Standards (2005)	1	All	**3.** As per the MOHLTC Crisis Response Standard whereby services offered by community crisis service providers will be consumer-directed and provided in the least intrusive manner possible, the providers will develop or improve upon existing tools currently in use. This includes assessments (see recommendations **6** and **9**) that will be guided/developed with consultation of clients and family/caregivers. Integration of peer support workers (see recommendation **2**) in crisis response will allow clients the opportunity to work with someone with lived experience if preferred (when appropriate)	• Recommendations 3-10 require ongoing inter-cluster work to implement and achieve alignment to the MOHLTC Standards and to ensure quality and accountability across the LHIN. To continue the progress of previous phases, new Working Groups will be established to perform the tasks required to further develop and implement recommendations **3-10**.
	1	All	**4.** To align with the MOHLTC Crisis Response Standard whereby short-term crisis support/counselling is available to provide risk assessment, de-escalation and safety planning for clients, each community crisis service provider will develop and utilize consistent tools (see Recommendation **9**) across the LHIN	

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
Community Crisis Service Providers do not align to all of the MOHLTC Crisis Response Standards (2005)	1	All	**5.** To align with the MOHLTC Crisis Response Standards, clients will have the opportunity to review, discuss and comment on services, through the implementation of a standardized quality improvement tool, being the Ontario Perception of Care (OPOC) Tool for Mental Health and Addictions (Centre for Addiction and Mental Health, 2015), implemented by community crisis service providers across the Central East LHIN	• Recommendations 3-10 require ongoing inter-cluster work to implement and achieve alignment to the MOHLTC Standards and to ensure quality and accountability across the LHIN. To continue the progress of previous phases, new Working Groups will be established to perform the tasks required to further develop and implement recommendations **3-10**.
	1, 6	All	**6**. To align with the MOHLTC Crisis Response Standard whereby written protocols are established for providing referral and transition to post-crisis services, community crisis service providers will: **a.** Develop and incorporate specific statements to the referral and transition process to other services, within their policy manuals b. When appropriate, initiate and/or participate in Coordinated Care Plans (CCP), through regional Health Links (Ontario Ministry of Health and Long-Term Care, 2016), for high-needs clients that have high repeat	

			rates to crisis services. The result will be a multi-disciplinary, longer-term provision of care beyond, but including, crisis services	
Community Crisis Service Providers do not align to all of the MOHLTC Crisis Response Standards (2005)	1	All	**7.** As per the MOHLTC Crisis Response Standard of staff training and core competencies, the community crisis response providers will implement minimum staffing requirements/ qualifications as per newly standardized elements of job descriptions	• Recommendations 3-10 require ongoing inter-cluster work to implement and achieve alignment to the MOHLTC Standards and to ensure quality and accountability across the LHIN. To continue the progress of previous phases, new Working Groups will be established to perform the tasks required to further develop and implement recommendations **3-10**.
Discrepancies exist in the collection and reporting of client/volume data across providers, leading to inconsistencies and difficulties comparing data	6	All	**8.** Data collection and reporting across all community crisis service providers in the Central East LHIN will be standardized through the following: **a.** Community crisis service providers to implement data collection reporting requirements as per the Multi-Sector Service Accountability Agreement and Ontario Healthcare Reporting Standards (OHRS) definitions **b.** Micro-collaboration between the three community crisis service providers to standardize crisis/safe bed and MCIT/IOP data collection and reporting (beyond the above)	

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
Assessment, intake and post crisis/coping strategies are not standardized across the Central East LHIN community crisis service providers, and information is not always readily available or shared with other providers	3, 6	All	**9.** Community crisis service providers will develop and implement the following standardized items: • An assessment, risk, and post-crisis tool, based on the Ontario Common Assessment of Need (OCAN), for use when appropriate, during the provision of crisis services through 24/7 telephone line, mobile response, and crisis/safe bed stays. This tool will be developed by and receive input from front-line crisis workers, clients and families to ensure ease-of-use and appropriateness. The tool will be implemented electronically for each provider, to reduce redundancy of paper-work and be shared with other providers, with a client's consent, through OneMail (as appropriate)	• Recommendations 3-10 require ongoing inter-cluster work to implement and achieve alignment to the MOHLTC Standards and to ensure quality and accountability across the LHIN. To continue the progress of previous phases, new Working Groups will be established to perform the tasks required to further develop and implement recommendations **3-10**.
Limited longer-term supports available for both mental health, health, and social services, result in difficulty transitioning clients to post-crisis services	7	All	**10.** As per the outcomes of Phase 1, a living document of gaps, for yearly analysis, will be developed. Community crisis response providers, other mental health and addiction providers, and the Central East LHIN will have access to the list and identify ways to address and add to the gaps where possible	

5.3 System Integration

Figure 6.0 – Recommendations 11-13

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
Variation across the Central East LHIN exists in mental health training and partnerships with local and regional police services	3	All	**11.** Minimum content for police training is standardized across the Central East LHIN community crisis response providers, for provider-led police training programs, including (but not limited to) topics related to: a. Personal Health Information Protection Act (PHIPA) and health information sharing regulations b. Differences in the roles of police service and crisis/mental health providers for better understanding of each providers' services and mandates	• This Recommendation requires a phased approach to implement. • The community crisis service providers in the Central East LHIN will develop standardized training materials to ensure the curriculum presented to any police service in the LHIN on the topic of mental health is consistent. • Each provider will work with local and regional police services in their clusters to request co-leadership of police training. Providers will begin by requesting that all road officers be trained, followed by all other officers. • Four County Crisis will lead a "train the trainer" session, as appropriate, for the other providers on delivery of the curriculum. Trainers from the other providers will be invited to attend the Four County Crisis police training sessions. • It is also recommended that, to provide additional context and benefits of police training on mental health, a trainer from Four County Crisis, along with a trained police officer from the Four Counties region, will support police training in the Durham and Scarborough areas.

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
Limited crisis resources/services exist within the existing community crisis response providers for specific populations	5, 6, 9	All	**12.** Each community crisis service provider will look at potential partnerships/best fit with other providers to plan for further ED avoidance improvements for specific populations, such as youth, concurrent disorders, dual diagnosis, homelessness, etc. Formal and informal partnerships will be developed to improve collaboration with other community agencies (e.g. shelters, youth service providers, etc.)	• Currently each provider has partnerships, both formal and informal, with agencies that support children and youth, individuals with concurrent disorders, dual diagnosis, homeless persons, etc. For example: ○ Durham Mental Health Services works with Kinark Child and Youth Services, Chimo Youth and Family Services and Frontenac Youth Services to support children and youth requiring crisis services and their families. ○ The Scarborough Hospital and Four County Crisis Teams have access to addiction specialists to support individuals in crisis that have concurrent disorders. ○ Four County Crisis has partnerships with the CE Specialized Network of Care and Tri-County Behavioral Services. ○ Durham Mental Health Services has completed a pilot with a local Violence Against Women (VAW) shelter whereby a crisis worker was housed within the shelter to support women needing crisis and mental health services. ○ The Scarborough Hospital is currently in the process of researching the benefits and

				implications of piloting a community hub model within Scarborough, by expanding an existing shared-care plan with a local health centre. A component of this model would include the co-location of crisis staff at the existing health centre, to improve access to urgent mental health services, while remaining integrated within the community. Upon further direction from the Central East LHIN, a detailed analysis will be performed and findings will be presented by The Scarborough Hospital on piloting an integrated community hub model in the Scarborough region. This analysis will also include research into whether the hub should operate 24/7. • The community crisis service providers will work together to further the adoption and implementation of partnerships similar to those above within each cluster, to achieve further consistency across the Central East LHIN.

Gap(s) Addressed	Phase 1 Recommend-ation(s)	Cluster	Recommendation	Implementation Plan
• Limited knowledge of Indigenous cultures and safety by community crisis service provider staff serving First Nations Communities • Lack of access and availability of community crisis service providers to Indigenous clients	6	All	**13.** With further direction from the Central East LHIN, community crisis service providers will: **a.** Continue Indigenous cultural safety training, and building relationships and collaborating with First Nations Elders, community leaders, and service providers, to better serve the Indigenous communities **b.** Identify other cultural training needs specific to their cluster to ensure staff are supporting the populations they serve in a culturally safe manner	• As per the Business Case approved by the Central East LHIN in late 2015, community crisis service provider staff have been educated on the beginning concepts (i.e., history and culture) of Indigenous Peoples in Canada, and are able to use this information, along with the guidance of the trainers, to better support Aboriginal clients, their families and communities. • Four County Crisis has begun collaboration with First Nation communities in the North East cluster, to further build on the relationships between the crisis, health and mental health providers within the First Nations communities, and the communities themselves. • To build and maintain a collaborative air between providers and the communities, the community crisis service providers will look to the Central East LHIN and the Health Advisory Circles and First Nations for further direction/leadership. Using similar approaches as Four County Crisis, the crisis service providers will work with the Aboriginal communities in the clusters they serve to further develop relationships with Indigenous Communities in order to collaborate on care to support the needs of the individual communities they serve. • The community crisis service providers are investigating new staff training opportunities

				specific to different cultures in their catchment areas. For example, The Scarborough Hospital's catchment area includes high Tamil and Chinese populations, and as such, the crisis provider will research and reach out to community leaders (health or otherwise) for education and training opportunities

6.0 Priorities and Resource Requirements

To implement the recommendation above, the following resource requirements are being requested from the Central East LHIN, broken down by priority and implementation schedule. A detailed cost breakdown for each provider is found in Appendix B. The issues of availability, access, and capacity of community crisis response services (i.e. priorities one and two) were determined to be the highest priority, to ensure residents across the Central East LHIN had available to them a standardized basket of services.

Definitions:

- The Scarborough Hospital: TSH
- Durham Mental Health Services: DMHS
- CMHA-HKPR, Four County Crisis: 4CC

Priority 1: To improve the Availability of community crisis response services in high-need areas across the Central East LHIN. This will be accomplished by implementing a standardized basket of crisis response services to address a lack of these services within specific clusters of the LHIN.

Figure 7.1 - Priority 1 Resource Requirements

Cluster: Scarborough	Implementation Schedule - One-Time Costs				Annualized
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
1.a.i. New Scarborough Crisis/Safe Beds		$150,000			$953,700
Rationale To meet the minimum standard basket of services across the Central East LHIN, the Scarborough cluster requires the implementation of new crisis/safe beds, to ensure these Central East LHIN-funded short-term residential beds are available in the Scarborough region, and operating similarly to other crisis/safe beds in the LHIN. Planning would begin in Year 1 (i.e. consultation with DMHS and 4CC on best practices, costs and scoping locations), but funding would not begin until Year 2 once planning was complete.					
Cluster: Durham	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
1.b.i. New Oshawa Crisis/Safe Beds	$61,500				$218,400
Rationale Additional funding for the new Oshawa crisis/safe beds is required beyond funding already provided by the Central East LHIN for Oshawa Beds. This will support and increase the number of available crisis beds, but to also enhance partnerships with the Hospital to Home program and assist with hospital diversion and community rapport. Funding is required in Year 1 to support the Oshawa beds that are currently in development.					
Cluster: North East	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
1.c.i. New Haliburton Crisis/Safe Beds	$160,000				$1,456,700
1.c.i. New Northumberland Crisis/Safe Beds		$160,000			$1,030,068

1.c.i. New Kawartha Lakes Crisis/Safe Beds			$160,000		$1,023,468
1.c.ii. New Kawartha Lakes-Haliburton Mobile Response	$41,000				$391,613
1.c.ii. New Northumberland Mobile Response		$41,000			$391,613
1.c.iii. New Police Partnerships	$5,000				$513,494
1.c.iii. New Police Partnerships		$4,500			$317,625
10. Longer Term Supports - STCM (4CC only)	$2,000				$191,457

Rationale

To meet the minimum standard basket of services across the entire Central East LHIN, crisis/safe beds, mobile response, MCIT/IOP and case management services are further needed in the North East cluster. The addition of these services will not only meet the standard basket of services, but will also reduce travel times for service users and crisis providers, and improve the availability of the service in rural, high-need regions (e.g.: Haliburton, Kawartha Lakes, and Northumberland). Implementation of these services will be staggered over a three year implementation schedule to allow for appropriate time to plan, implement and evaluate. Services scheduled for Year 1 are in areas and with organizations where high needs and strong partnerships are established. Cost discrepancies: i) Year 1 crisis/safe beds include 5 FTEs for the Peterborough program, to bring up to same standard of double coverage for all programs in the Central East LHIN, also, occupancy costs vary geographically, ii) Year 1 MCIT plan includes the MCIT Educator to provide ongoing Police/4CC joint training programs with seven forces. 10) STCM Short Term Case Management is essential to address bottleneck in client flow through 4CC with expected new volumes.

Priority 2: To meet the minimum response times outlined in the MOHLTC Crisis Response Standards (2005), and the Client-based Quality Improvement Measures (as outlined in the Phase 1 Report). This will be accomplished by increasing the capacity of existing community crisis response services in the Central East LHIN and improving Access to services for residents.

Figure 7.2 - Priority 2 Resource Requirements

Cluster: Scarborough	Implementation Schedule - One-Time Costs				Annualized
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
2.a.i Addition of Crisis Line Staff to TSH	$2,000				$323,662
2.a.ii Removal of Voicemail to TSH Crisis Line	$15,000				
2.a.iii. Second Mobile Response to TSH Crisis	$2,000				$200,000
2.a. iv. Peer Support Integration to TSH Crisis					$159,000
Rationale					
To improve access to community crisis services, and to reduce the response times to within the MOHLTC Crisis Response Standards (2005), the addition of staff to improve capacity is required for existing community crisis response services in the Scarborough cluster. The request is being made in Year 1 of the implementation schedule as it will have an almost immediate impact on outcomes, and assist with standardization of services across the Central East LHIN, primarily with respect to the number and type of dedicated staff to each service, so that it aligns with the other clusters. The addition of a dedicated Peer Support Worker was identified in Phase 1 as a clear need and will generate on-site capacity for live-answer response. Removal of voicemail will also improve live-answer response and will follow upon the DMHS pilot.					
Cluster: Durham	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
2.b.i Second Mobile Response to DMHS Crisis	$9,000				$171,000
2.b.ii. Peer Support Integration to DMHS Crisis	See 2.b.i				See 2.b.i
Rationale					
To improve access to community crisis services, and to reduce the response times to within the MOHLTC Crisis Response Standards (2005), the addition of staff to improve capacity is required to existing community crisis response services in the Durham cluster. The request is being made in Year 1 of the implementation schedule as it will have an almost immediate impact on outcomes, and assist with standardization of services across the Central East LHIN, primarily with respect to the number and type of dedicated staff to each service, so that it aligns with the other clusters. The addition of a dedicated Peer Support Worker was identified in Phase 1 as a clear need and will generate on-site capacity for live-answer response.					
Cluster: North East	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
1.c.iv Addition of Peer Support to 4CC Crisis Beds	See 1.c.i				See 1.c.i
2.c.i. Conversion from Voicemail to live 4CC Crisis Lines	15,000				$15,000
2.c.ii. Addition of Crisis Line Staff to 4CC	$2,000				$200, 838
2.c.iii. Peer Support Worker Integration to 4CC					
Rationale					
To improve access to community crisis services, and to reduce the response times to within the MOHLTC Crisis Response					

Standards (2005), the addition of staff to improve capacity is required to existing community crisis response services in the North East cluster. The request is being made in Year 1 of the implementation schedule as it will have an almost immediate impact on outcomes, and assist with standardization of services across the Central East LHIN, primarily with respect to the number and type of dedicated staff to each service, so that it aligns with the other clusters. The addition of a dedicated Peer Support Worker was identified in Phase 1 as a clear need. Removal of voicemail will improve live-answer response and will follow upon the DMHS pilot.
Changes required to convert from voice mail system and low response rates to live call response with high response rates include:

Addition of Peer Supports to 4CC Crisis Beds – will improve access to services, similar to the DMHS model, via peer outreach and support to clients coming in and preparing to transition out of crisis/safe beds. Costs are included in total crisis/safe beds budgets ($42,000 salary each, plus benefits, travel, training etc.) in 1.c.i.

Conversion from voicemail – equipment cost includes additional phone line and purchase/operation of automated live –call forwarding to multiple sites (e.g. Haterus line) – operations cost includes annual long distance and fees related to this service.

Priority 3: To improve System Integration across the Central East LHIN. This will be accomplished by creating new, and building upon existing, relationships and partnerships between community crisis response and other stakeholders (including regional Health Links within each cluster) to address the limited and inconsistent collaboration across the system.

Figure 7.3 - Priority 3 Resource Requirements

Cluster: Scarborough	Implementation Schedule - One-Time Costs				Annualized
Recommendation	Year 1	Year 2	Year 3		Ongoing
2.a.v - Distress Centre-TSH Crisis Partnership		$4,160			
Rationale Discussion for collaboration with Toronto Distress Centre is currently underway. Funding requested includes staff cross-training between the Distress Centre and TSH Crisis Team, as well as MOU development and a computer and workstation to be set up at the Distress Centre for TSH staff (on-site staff).					
Cluster: Durham	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
2.b.iii. Distress Centre-DMHS Crisis Partnership		$4,160			$103,600
Rationale Discussion for collaboration with Distress Centre Durham is currently underway. Funding requested includes staff cross-training between the Distress Centre and DMHS Crisis Team, as well as MOU development and a computer and workstation to be set up at the Distress Centre for DMHS staff (on-site staff). The Distress Centre-DMHS Crisis Partnership will be a pilot for the TSH and 4CC partnerships with their respective Distress Centres.					
Cluster: North East	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
2.c.iv - Distress Centre-4CC Partnership		In-Kind			In-Kind
Rationale Discussion for collaboration with Telecare Distress Centre Peterborough is currently underway. Any costs will be covered in-kind by 4CC.					
Cluster: All	**Implementation Schedule - One-Time Costs**				**Annualized**
Recommendation	**Year 1**	**Year 2**	**Year 3**		**Ongoing**
6. Transition Process and CCP Initiation		N/A			
11. MH/Crisis Training for Police		In-Kind			
12. Partnerships with Other Providers		N/A			
13. Cultural Competency		In-Kind			
Rationale Partnerships with health, mental health, social service and other cultural-specific providers will build on existing relationships and create new ones. Collaboration will improve within each cluster, and hopefully across the system. The expectation is to review existing relationships and begin discussion with new providers in late year 1, with the creation of new relationships/partnerships in Year 2 of the implementation schedule. Any costs associated with these recommendations will be provided in-kind by the community crisis service providers.					

Priority 4: To promote Quality, Accountability and Sustainability of services as well as transparency and collaboration with both service users and other service providers. This will be accomplished by standardizing tools (assessment, post-crisis, patient satisfaction, etc.) and data collection methods of community crisis service providers in the Central East LHIN.

Figure 7.4 - Priority 4 Resource Requirements

Cluster: All	Implementation Schedule - One-Time Costs				Annualized
Recommendation	Year 1	Year 2	Year 3		Ongoing
3. Standard - Client-Directed Care			N/A		
4. Standard - Standardized Tool Development			N/A		
5. Standard - Patient Satisfaction Tool (OPOC)	N/A				
7. Standard - Crisis Staff Job Descriptions			N/A		
8. Standard - Data Collection			N/A		
9. Standard - Standardized OCAN Tool			N/A		
10. Longer-Term Supports - Annual Gaps Analysis			N/A		

Rationale

Recommendations associated with standardized tools and processes will begin in Year 3 of the implementation schedule, with the exception of the implementation of the OPOC tool. While these recommendations have been identified as Priority 4, and scheduled for Year 3, they may be implemented sooner, should the need and opportunity arise.

7.0 Evaluation

Planning for post-implementation evaluation will assist in forecasting the potential impact of implementing the recommendations and service enhancements. Assumptions have been made on the impact increases to capacity, alignment to Standards, etc., could have on current client volumes, response times, client satisfaction, etc. The three main elements of the evaluation will include: client-centred outcomes (e.g. volumes, response times, etc.), patient satisfaction, and fidelity to both the Community Crisis Service Model and the MOHLTC Crisis Response Standards (self-evaluation).

Definitions:

- The Scarborough Hospital: TSH
- Durham Mental Health Services: DMHS
- CMHA-HKPR, Four County Crisis: 4CC
- Domain: Alignment with the parameters of the Community Crisis Service Model
- Baseline: Baseline data provided was identified in the Phase 2 Final Report (Central East LHIN Community Crisis Project, 2015)

Figure 8.0 – Evaluation Framework

Question	Assumptions	Domain	Indicators	Method	Baseline (FY 2013/2014)	Target (1 year post-implementation)
1. Has the number of live-answer responses increased?	Telephone response times will decrease, and live-answer response will increase as a result of: • The addition of crisis line staff • Removal of voicemail • Partnerships with Distress Centres/Telecare • The use of mobile team staff between mobile visits to add capacity for live answer • Peer Support for non-urgent clients	• Access and Availability • Accountability • Quality and Sustainability	Response Times	• Manual data collection and/or system count • Client surveys • Durham Mental Health Services Live Answer Pilot	• As per the November 2014 pilot, the % of calls that did not result in voicemail: - TSH: 84.74% - DMHS: 59.0% - 4CC: 87.33%	TSH: Increase in calls answered in 'real time" by 20% DMHS: Increase in calls answered in 'real time' by 10% 4CC: Upon impact analysis of live-answer responses pilot with DMHS, 4CC will identify targets specific to them
2. Have in-person contact response times decreased?	In-person contact response times (i.e. mobile response) will decrease as a result of: • The addition of mobile response teams • Addition of staff at TSH to the crisis line (to free up staff for mobile response)	• Access and Availability • Accountability • Quality and Sustainability	Response Times	• Manual Data Collection	• >24hours • As per November 2014 pilot, the % of visits needed but unavailable: - TSH: N/A - DMHS: 29.56% - 4CC: 13.16%	All: Equal to or <24 hours as per MOHLTC Crisis Response Standards (2005)

Question	Assumptions	Domain	Indicators	Method	Baseline (FY 2013/2014)	Target (1 year post-implementation)
3. Have client volumes increased?	Client volumes to community crisis response services will increase due to: • Increased capacity through the addition of dedicated crisis line staff, mobile teams, crisis/safe beds , as well as partnerships with Distress Centres/Telecare	• Access and Availability • System Integration	Client Volumes	• Manage-ment Information System (MIS) Data	Service Provider Interactions: - TSH: 15,640 - DMHS: 17,348 - 4CC: 14,420	TSH: Increase in calls answered in real time by 20% and mobile visits to increase by 15-20%, thereby overall client volumes to increase DMHS: Increase in calls answered in 'real time' by 10% therefore an increase in clients receiving phone support. Increase in mobile visits provided by 10% 4CC: Increase in call volume by 5%. Increase in mobile response volume by 50%. Increase in safe bed volume by 50%

Question	Assumptions	Domain	Indicators	Method	Baseline (FY 2013/2014)	Target (1 year post-implementation)
4. Have unscheduled return visits to ED within 30 days for mental health and addictions issues decreased?	30-day unscheduled ED return rates will decrease for repeat crisis response service clients as a result of: • The addition of crisis/safe beds which will improve capacity and divert individuals from the ED • New partnerships/addition of mobile response with police will assist police in identifying and providing alternatives to the ED for individuals	• Access and Availability • Quality and Sustainability • System Integration	Unscheduled return visits to ED within 30 days for mental health and addictions issues	• Central East LHIN Data • Crisis Response Service Intake/ Exit Survey	**Mental Health:** 3,183 repeat visits **Substance Abuse:** 1,018 repeat visits	All: 50% of clients receiving a mobile visit will be asked: "Did this visit prevent you from seeking support at a hospital?" TSH: Currently unable to meet the targets set by the LHIN. Decrease in unscheduled return rates to the ED for MH&A to enable TSH to meet the LHIN targets DMHS: TBD 4CC: 10% of crisis calls will be ED diversions, 5% mobiles will be ED diversions, 10% safe bed admissions from community will be ED diversions, and 25% of safe bed admissions directly from hospital will be ED diversions

Question	Assumptions	Domain	Indicators	Method	Baseline (FY 2013/2014)	Target (1 year post-implementation)
5. Have the number of hospital days decreased in the Central East LHIN for individuals with mental health and addictions issues?	Hospital days are expected to decrease as a result of: • Individuals will be diverted from the ED, and hospital admissions and/or length of stay will decrease due to the availability of additional crisis/safe beds, especially in the North East cluster • With the addition of crisis/safe beds in Scarborough, hospital days should decrease, due to the new short-term residential stay option as an alternative to hospital stays	• Access and Availability	Hospital days for repeat crisis service clients	• Common Data Sets (CDS)	N/A	TSH: TBD once new crisis/safe beds are implemented. DMHS: An increase of 25-35% of beds admissions directly from one of the local hospitals. 4CC: Admissions from Hospital - 50 x 2days= 100 days • Year 1- 200 days saved • Year 2- 300 days saved • Year 3 - 400 days saved • Years 1-3 -50% overall volume increase in safe beds admissions from local hospitals
6. Have client satisfaction ratings improved?	Client satisfaction ratings for community crisis response services will improve as a result of: • Availability of more peer support workers • Increased capacity of crisis response services overall • Reduced response times	• Access and Availability • Quality and Sustainability	Improved client satisfaction	• Client satisfaction Surveys, including OPOC	N/A	All: Peer support facilitate client satisfaction surveys. DMHS: Client satisfaction ratings increase by 25% (300 clients surveyed yearly). TSH and 4CC: Targets set in Year 2.

Question	Assumptions	Domain	Indicators	Method	Baseline (FY 2013/2014)	Target (1 year post-implementation)
7. Has alignment to MOHLTC Standards (2005) improved?	All community crisis service providers will align more closely with the MOHLTC Standards (2005) as a result of: • Increased capacity • Use of standardized tools to support data collection • Partner collaborations	• System Integration • Accountability	Alignment to Standards	• Yearly review of Standards	N/A	Increase in mobile visit response time as well as the ability to respond in 'real time' to callers.
8. Is there standardization of certain practices across community crisis response?	Community crisis response services across the Central East LHIN will be standardized as a result of: • Implementation of Community Crisis Model • Approval and implementation of Phase 2 recommendations	• Accountability • Quality and Sustainability	TBD	TBD	No measurement	Model is implemented across all community crisis service providers in the Central East LHIN. Phase 2 Recommendation implementation is underway.

8.0 Conclusion

Phase 2 of the Community Crisis Service Review Project saw the development of a Client-Centred Community Crisis Service Model with clearly defined parameters and outcomes. This Model includes a minimum basket of services that should be available and accessible to all residents of the Central East LHIN, regardless of where they live. The Model also aligns with the MOHLTC Crisis Response Standards (2005), to ensure support and accountability of the services to identified best practices. The expectation is that all community-based crisis service providers in the Central East LHIN that are M-SAA funded for crisis services will implement the Model within their own practices.

Recommendations have been put forward in this report to implement the new Model across the Central East LHIN, and to provide the resources necessary to ensure crisis service providers are meeting the MOHLTC Crisis Response Standards (2005). The expectation is that access to services will improve, response times will decrease, and there will be enhanced accountability and transparency in the provision of crisis response services. Clients and their families/caregivers will be given the opportunity to truly make the provision of services "client-centred", as regular input on tools, operations and satisfaction of services will be requested from these stakeholder groups.

Upon approval from the Central East LHIN to move forward, new Working Groups will be established to oversee and perform the work required to implement the recommendations identified above. The Project Leads continue to look to the Central East LHIN for direction on stakeholder engagement, particularly on communication planning and ongoing engagement with Indigenous Communities across the LHIN.

The Project Leads look forward to the ongoing progress of the project, and the continued work and enhancements required to close the identified gaps and meet the future state.

Appendix A – References

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Appendix B – Detailed Cost Breakdown of Recommendations by Provider

The Scarborough Hospital
Crisis Enhancements - Phase 2
Budget

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding		
The Scarborough Hospital	**1.a.i. Crisis/Safe Beds in Scarborough**	Year 2	**Retro-fit**		**Staff**		
			Accessibility	$20,000	Wages and Benefits (double coverage 10 FTE Crisis Staff)		$600,000
			Entrances	$5,000	Wages and Benefits (1.0 FTE Peer Support Worker)		$53,700
			Kitchen	$30,000	Training and Travel (11 FTE)		$41,500
			Bathrooms	$40,000	Occupancy, Supplies, Equipment, Admin		$93,000
			Offices	$5,000		Total	$788,200
				Total $100,000			
			Supplies		**Housing**		
			Furniture, appliances, other supplies	$50,000	Rental ($6,000/month)		$72,000
				Total $50,000	Utilities (Heat, Hydro, Water -$1,500/month)		$36,000
					Insurance		$2,500
					Cable, TV, Internet, Phone ($1,250/month)		$15,000
					Food and Toiletries ($300/week)		$15,000
					Building Maintenance (Cleaning, Repairs, Lawn Care)		$15,000
					Other Program Supplies		$10,000
						Total	**$165,500**
			TOTAL ONE-TIME FUNDING	**$150,000**	**TOTAL ANNUALIZED FUNDING**		**$953,700**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
The Scarborough Hospital	**2.a.i Addition of Crisis Line Staff to TSH**	Year 1	**Supplies**		**Staff**	
			Computers, Phones, etc. (2)	$2,000	Wages and Benefits (2.0 FTE Crisis Staff)	$184,000
			Total	$2,000	Wages and Benefits (Crisis Manager oversees 15 FTE)	$126,000
					Backfill for 10% of FTEs (Relief)	$13,662
					Total	$323,662
			TOTAL ONE-TIME FUNDING	**$2,000**	**TOTAL ANNUALIZED FUNDING**	**$323,662**
	2.a.ii. Removal of Voicemail to TSH Crisis Line	Year 1	**Supplies**			
			Purchase and Implementation of Haterus Call Queuing System	$15,000		
			Total	$15,000		
			TOTAL ONE-TIME FUNDING	**$15,000**		
	2.a.iii. Second Mobile Response Team to TSH Crisis	Year 1	**Supplies**		**Staff**	
			Computers (4)	$3,000	Wages, Benefits and Training (2.0 FTE Crisis Staff)	$200,000
			Work Stations (4)	$3,000	Total	$200,000
			Total	$6,000		
			TOTAL ONE-TIME FUNDING	**$6,000**	**TOTAL ANNUALIZED FUNDING**	**$200,000**

Provider	Recommendation	Implement-ation	One-Time Funding	Annualized Funding
The Scarborough Hospital	**2.a.iv. Peer Support Integration to TSH Crisis**	Year 1		**Staff** Wages, Benefits and Training (2.0 FTE Peer Support) $159,000 Total $159,000 **TOTAL ANNUALIZED FUNDING $159,000**
	2.a.v. Distress Centre-TSH Crisis Partnership	Year 2	**Staff** Staff Hours (Cross-Training, MOU Development - 2x40hrs) Total $1,280 **Supplies** Computer (1) $1,600 Workstation (1) $1,280 Total $2,880 **TOTAL ONE-TIME FUNDING $4,160**	

Durham Mental Health Services
Crisis Enhancements - Phase 2
Budget

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Durham Mental Health Services	**1.b.i.** **New Oshawa Crisis/Safe Beds**	Year 1	**Supplies**		**Staff**	
			Start-up Costs	$61,500	Wages and Benefits (1.0 FTE VAW Crisis Worker)	$77,900
			Total	$61,500	Travel and Training (1.0 FTE VAW Crisis Worker)	$1,500
					Communication and IT	$1,000
					Administration	$138,000
					Total	$218,400
			TOTAL ONE-TIME FUNDING	$61,500	**TOTAL ANNUALIZED FUNDING**	**$218,400**
	2.b.i **Second Mobile Mobile Response Team to DMHS Crisis**	Year 1	**Supplies**		**Staff**	
			Start-up Costs	$9,000	Wages 1.0 FTE RPN)	$64,400
			Total	$9,000	Wages (1.0 FTE Peer Support)	$57,000
					Benefits (1.0 FTE PRN and 1.0 FTE Peer Support)	$27,600
					Admin Support (0.2 FTE)	$10,000
					Training and Travel	$3,000
					Supplies	$4,000
					Communication and IT	$5,000
					Total	$171,000
			TOTAL ONE-TIME FUNDING	**$9,000**	**TOTAL ANNUALIZED FUNDING**	**$171,000**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Durham Mental Health Services	**2.b.ii. Peer Support Integration to DMHS Crisis**	Year 1	Costs have been integrated with 2.b.i as a result of the role of Peer Support			
	2.b.iii. Distress Centre-DMHS Crisis Partnership	Year 1	**Staff** Staff Hours (Cross-Training, MOU Development - 2x40hrs)		**Staff** Wages and Benefits (1.0 FTE Crisis Worker) Wages and Benefits (0.25 FTE Program Coordinator) Training and Travel Supplies Communication and IT	 $1,500 $2,000 $1,000
			Total	$2,560	Total	$103,600
			Supplies DMHS Workstation at Distress Centre (1) DMHS Computer with CRMS software at Distress Centre (1)	 $500 $1,100		
			Total	$1,600		
			TOTAL ONE-TIME FUNDING	**$4,160**	**TOTAL ANNUALIZED FUNDING**	**$103,600**

Canadian Mental Health Association – Haliburton, Kawartha, Pine Ridge
Crisis Enhancements - Phase 2
Budget

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis	**1.c.i.** **New Haliburton Crisis/Safe Beds** **10 FTE Haliburton - New Team** **5 FTE Peterborough - Double Coverage**	Year 1	**Retro-fit** Accessibility, Entrances, Rooms	$100,000	**Staff** Wages (15 FTE Workers) Wages (1.64 Relief) Wages (1 FTE Manager) Wages (1.4 FTE Peer Support) Benefits Training and Travel	$712,500 $77,144 $75,000 $58,940 $222,490 $63,100
			Total	$100,000	Total	$1,209,174
			Supplies Beds, Furniture, Appliances Offices (Furniture, Workstation)	$50,000 $10,000	**Housing** Supplies (Food, Toiletries, Linen, etc.) Equipment Lease & Service (Phone, Internet, Cable, Haterus) Occupancy (Rent, Utilities, Maintenance) Administration	$25,000 $18,600 $71,500 $132,426
			Total	$60,000	Total	$247,526
			TOTAL ONE-TIME FUNDING	**$160,000**	**TOTAL ANNUALIZED FUNDING**	**$1,456,700**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis	**1.c.i New Northumberland Crisis/Safe Beds**	Year 2	**Retro-fit**		**Staff**	
			Accessibility, Entrances, Rooms	$100,000	Wages (10 FTE Workers)	$475,000
			Total	$100,000	Wages (1.10 Relief)	$51,710
					Wages (0.67 FTE Manager)	$50,250
			Supplies		Wages (1.0 FTE Peer Support)	$42,100
			Beds, Furniture, Appliances	$50,000	Benefits	$154,765
			Offices (Furniture, Workstation)	$10,000	Training and Travel	$41,500
			Total	$60,000	Total	$815,325
					Housing	
					Supplies (Food, Toiletries, Linen, etc.)	$25,000
					Equipment Lease & Service (Phone, Internet, Cable, Haterus)	$18,600
					Occupancy (Rent, Utilities, Maintenance)	$77,500
					Administration	$93,643
					Total	$214,743
			TOTAL ONE-TIME FUNDING	**$160,000**	**TOTAL ANNUALIZED FUNDING**	**$1,030,068**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis	**1.c.i New Kawartha Lakes Crisis/Safe Beds**	Year 3	**Retro-fit**		**Staff**	
			Accessibility, Entrances, Rooms	$100,000	Wages (10 FTE Workers)	$475,000
			Total	$100,000	Wages (1.10 Relief)	$51,710
					Wages (0.67 FTE Manager)	$50,250
			Supplies		Wages (1.0 FTE Peer Support)	$42,100
			Beds, Furniture, Appliances	$50,000	Benefits	$154,765
			Offices (Furniture, Workstation)	$10,000	Training and Travel	$41,500
			Total	$60,000	Total	$815,325
					Housing	
					Supplies (Food, Toiletries, Linen, etc.)	$25,000
					Equipment Lease & Service (Phone, Internet, Cable, Haterus)	$18,600
					Occupancy (Rent, Utilities, Maintenance)	$71,500
					Administration	$93,043
					Total	$208,143
			TOTAL ONE-TIME FUNDING	**$160,000**	**TOTAL ANNUALIZED FUNDING**	**$1,023,468**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding		
Canadian Mental Health Association – HKPR (Four County Crisis	**1.c.ii. New Kawartha Lakes-Haliburton Mobile Response**	Year 1	Vehicle	$35,000	**Staff**		
			Office (Furniture, Workstation)	$6,000	Wages (4.0 FTE Workers)		$213,600
			Total	$41,000	Wages (0.4 Relief)		$21,360
					Wages (0.27 FTE Manager)		$20,250
					Benefits		$63,803
					Training and Travel		$26,000
						Total	$345,013
					Program		
					Supplies		$2,000
					Equipment Lease & Service		$3,000
					Occupancy (Rent)		$6,000
					Adminstration		$35,600
						Total	$46,600
			TOTAL ONE-TIME FUNDING	**$41,000**	**TOTAL ANNUALIZED FUNDING**		**$391,613**
	1.c.ii. New Northumberland Mobile Response	Year 2	Vehicle	$35,000	**Staff**		
			Office (Furniture, Workstation)	$6,000	Wages (4.0 FTE Workers)		$213,600
			Total	$41,000	Wages (0.4 Relief)		$21,360
					Wages (0.27 FTE Manager)		$20,250
					Benefits		$63,803
					Training and Travel		$26,000
						Total	$345,013

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis					**Program**	
					Supplies	$2,000
					Equipment Lease & Service	$3,000
					Occupancy (Rent)	$6,000
					Administration	$35,600
					Total	$46,600
			TOTAL ONE-TIME FUNDING	**$41,000**	**TOTAL ANNUALIZED FUNDING**	**$391,613**
	1.c.iii. New Police Partnerships	Year 1	Office (Furniture, Workstation)	$5,000		
			Total	$5,000	**Staff**	
					Wages (4.0 FTE Workers)	$232,000
					Wages (1.0 FTE Trainer)	$59,700
					Wages (0.4 Relief)	$23,200
					Wages (0.33 FTE Manager)	$24,750
					Benefits	$84,913
					Training and Travel	$27,500
					Total	$452,063
					Program	
					Supplies	$5,000
					Equipment Lease & Service	$3,750
					Occupancy (Rent)	$6,000
					Administration	$46,681
					Total	$61,431
			TOTAL ONE-TIME FUNDING	**$5,000**	**TOTAL ANNUALIZED FUNDING**	**$513,494**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding		
Canadian Mental Health Association – HKPR (Four County Crisis	**1.c.iii. New Police Partnerships**	Year 1	Office (Furniture, Workstation)	$4,500	**Staff**		
			Total	$4,500	Wages (3.0 FTE Workers)		$174,000
					Wages (0.3 Relief)		$17,400
					Wages (0.2 FTE Manager)		$15,000
					Benefits		$51,600
					Training and Travel		$19,500
						Total	$277,500
					Program		
					Supplies		$3,000
					Equipment Lease & Service		$2,250
					Occupancy (Rent)		$6,000
					Administration		$28,875
						Total	$40,125
			TOTAL ONE-TIME FUNDING	**$4,500**	**TOTAL ANNUALIZED FUNDING**		**$317,625**
	1.c.iv. Addition of Peer Support to 4CC Crisis/Safe Beds	Year 1	Costs have been integrated with 1.c.i as a result of the role of Peer Support				

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis	**2.c.i Conversion from Voicemail to live 4CC Crisis Lines**	Year 1	**System** Purchase and Implementation of Haterus Call Queuing System	$15,000		
			Total	$15,000		
			TOTAL ONE-TIME FUNDING	**$15,000**		
	2.c.ii. Addition of Crisis Line Staff to 4CC **2.c.iii. Peer Support Worker Integration to 4CC**	Year 1	Office (Furniture, Workstation)	$2,000	**Staff**	
			Total	$2,000	Wages (1.0 FTE Worker)	$53,400
					Wages (0.25 Relief)	$11,655
					Wages (0.17 FTE Manager)	$12,750
					Wages (1.5 Peer Support Worker)	$63,150
					Benefits	$35,239
					Training and Travel	$4,750
					Total	$180,944
					Program	
					Supplies (Phone Line, Long Distance, etc.)	$18,000
					Administration	$19,894
					Total	$37,894
			TOTAL ONE-TIME FUNDING	**$2,000**	**TOTAL ANNUALIZED FUNDING**	**$218,838**

Provider	Recommendation	Implement-ation	One-Time Funding		Annualized Funding	
Canadian Mental Health Association – HKPR (Four County Crisis	**10. Longer Term Supports – STCM (4CC Only)**	Year 1	Office (Furniture, Workstation)	$2,000	**Staff**	
			Total	$2,000	Wages (2.0 FTE STCM)	$116,400
					Wages (0.13 FTE Manager)	$9,750
					Benefits	$31,538
					Training and Travel	$13,000
					Total	$170,688
					Program	
					Supplies	$2,000
					Equipment Lease and Service	$1,500
					Administration	$17,269
					Total	$20,769
			TOTAL ONE-TIME FUNDING	**$2,000**	**TOTAL ANNUALIZED FUNDING**	**$191,457**