Bridging the Gap Between Hospital and Community Mental Health Services for Frequent Emergency Department Visitors

Rebecca Cherner, Alexia Polillo, Jonathan Samosh, John Sylvestre, and Jennifer Rae
University of Ottawa

Donna Pettey
Canadian Mental Health Association, Ottawa Branch

Tim Aubry
University of Ottawa

ABSTRACT

Inappropriate emergency department (ED) use is costly. A system navigation service was developed to connect individuals with repeated ED presentations due to mental health or substance use to community services. Management, staff, and clients (n = 37) participated in interviews or focus groups to identify implementation challenges and associated solutions. Referrals were improved through ED staff support and automating the process. The outreach process, decreased service duration, and prompt support with connection to services facilitated program delivery. Two newly funded programs addressed the limited capacity of other services, and technology facilitated communication. Attention to partnerships and flexibility in the design were essential.

Rebecca Cherner, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario; Alexia Polillo, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario; Jonathan Samosh, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario; John Sylvestre, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario; Jennifer Rae, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario; Donna Pettey, Canadian Mental Health Association, Ottawa Branch, Ottawa, Ontario; Tim Aubry, School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario.

Rebecca Cherner is now at the Government of Canada, Ottawa, Ontario. Alexia Polillo is now at the Centre for Addiction and Mental Health, Toronto, Ontario. Jennifer Rae is now at the Social Research and Demonstration Corporation, Ottawa, Ontario.

This project was supported by funding from Mitacs.

Correspondence concerning this article should be addressed to Tim Aubry, Centre for Research on Educational and Community Services, University of Ottawa, 136 Jean-Jacques Lussier, Ottawa, Ontario, K1N 6N5. Email: Tim.Aubry@uottawa.ca

doi:10.7870/cjcmh-2022-001
Published by Canadian Periodical for Community Studies Inc.

Keywords: system navigation; emergency department; mental health; substance use

RÉSUMÉ

L'utilisation inappropriée du service des urgences est coûteuse. Un système de navigation a été conçu pour mettre les services communautaires en relation avec les personnes qui se présentent régulièrement au service des urgences en raison d'un problème de santé mentale ou de consommation de substances. La direction, les employés et les clients (n = 37) ont participé à des entrevues ou à des groupes de discussion afin de repérer les défis liés à la mise en œuvre du programme et les solutions qui y sont associées. Les recommandations liées au programme ont été enrichies grâce au soutien du personnel du service des urgences et à l'automatisation du processus. Le processus de sensibilisation, la réduction de la durée des services et la rapidité de l'accès aux services ont permis de mettre en œuvre le programme. Deux nouveaux programmes subventionnés ont été créés pour pallier les capacités limitées des autres services, et la technologie a permis de simplifier la communication à ce sujet. L'attention portée aux partenariats et à la souplesse des programmes conçus a été essentielle.

Mots clés : système de navigation; service des urgences; santé mentale; consommation de substances

Emergency department (ED) care is increasingly burdened by people presenting with mental health and substance use concerns (Moe et al., 2018; Theriault et al., 2020). ED visits due to mental health have increased over time among frequent ED visitors (Moe et al., 2021). Moreover, patients who visit the ED for reasons of mental health or substance use have high rates of return visits (Lee et al., 2017).

Increased ED use for mental health and substance use is problematic. ED care is focused on acute physical health symptoms and conditions and is ill-equipped to address the complex longer-term needs of this population (Jacobi, 2012), such as social, housing, financial, and medical concerns (Digel Vandyk et al., 2013; Jacobi, 2012; Sirotich et al., 2016). This mismatch between needs and available services increases the likelihood of return visits (Jacobi, 2012), as the underlying vulnerabilities are not addressed.

Barriers to the Use of Community Services

Community and primary care services may offer more effective, efficient, and cost-effective approaches to meet the needs of individuals with mental health and substance use difficulties. Yet, a study of individuals who had a psychiatric ED visit in Ontario found that 60% did not have a follow-up visit with a physician within 14 days (Barker et al., 2020). Several factors reduce the likelihood of this population accessing services. Barriers include the often decentralized nature of these services (Digel Vandyk et al., 2013); a perceived lack of community resources, particularly on evenings and weekends (Meehan et al., 2021; Parkman et al., 2017; Wise-Harris et al., 2017); the unavailability of a primary care provider (Parkman et al., 2017); patients' concerns about the immediate need for care (Digel Vandyk et al., 2018; Wise-Harris et al., 2017); lack of discharge planning prior to leaving hospital (Digel Vandyk et al., 2018); and difficulty scheduling appointments and long wait-times (Digel Vandyk et al., 2013; Parkman et al., 2017; Wise-Harris et al., 2017).

System Navigation to Support Community Service Use

System navigation has been used to address barriers and divert frequent visitors from hospital to community alternatives. It aims to connect patients to appropriate services and can improve access to community care by targeting communication, information, psychological, financial, social, and healthcare system barriers (Enard & Ganelin, 2013; Kelley et al., 2020). Navigators facilitate follow-up care and promote self-management, engagement, and self-advocacy (Kelly et al., 2014). This approach increases the use of primary care (Seaberg et al., 2017) and reduces repeat ED visits among frequent visitors (Enard & Ganelin, 2013; Kelley et al., 2020; Seaberg et al., 2017), as well as reduces hospitalizations (Kelley et al., 2020).

Context in Ontario

When the program was designed, the mental health and addictions strategy of the Ontario Ministry of Health and Long-Term Care included a focus on reducing repeat ED visits for mental health and substance use (Ministry of Health and Long-term Care, 2011). This complex issue called for an approach involving diverse partners, including hospitals and community agencies. For example, a link was needed between the hospital and the community so discharged patients could be supported in the community. Community services required communication with the hospital to identify individuals requiring services and to coordinate care when needed. Developing connections between these service settings was important as the mental health system in Ontario lacked integration (Mental Health and Addictions Leadership Advisory Council, 2015).

Program Description

To reduce repeat ED visits, the Familiar Faces program was launched in 2014 to serve individuals with frequent visits to the ED for mental health or substance use in Ottawa. The Familiar Faces program included two components situated at the Ottawa Branch of the Canadian Mental Health Association (CMHA): (1) System Navigation services and (2) Transitional Case Management for higher-need clients. An additional support Quick Response Counselling service was funded to serve Familiar Faces clients and was delivered by another community mental health agency.

Four[1] Ottawa-area hospitals referred patients to Familiar Faces who were (1) between 16 and 64 years old, (2) residents of Ontario, and (3) had two ED visits for mental health and/or substance use within 30 days. The upper age limit of 64 years is the cut-off for *adults* as defined by the Ministry of Health and Long-Term Care. Two ED visits in 30 days for mental health and/or substance use was a Ministry-defined metric. Referrals, called *e-triggers*, from three of the hospitals were made through an automated process. Handwritten referrals from the fourth hospital were faxed by staff. After receiving the referrals, system navigators reviewed the electronic medical records of the patients of three of the hospitals to ensure eligibility. Then, navigators contacted the referred individuals by phone. Outreach could also involve mailed letters and visits in the community. System navigators conducted in-person intake assessments and evaluated clients' needs, considering factors such as mental health, substance use, use of services, support systems, and psychosocial variables. System navigators then referred clients to appropriate community resources, including those within

1. One hospital had two campuses involved in the program. These campuses were considered as two separate hospitals.

CMHA. Clients could receive additional services from system navigators, for example, assistance with psychosocial needs and crisis intervention. System navigators could serve a client for up to three months. Thus, the Familiar Faces program provided an opportunity to bridge hospital EDs and community care. Figure 1 illustrates the referral and service delivery process.

A study of the outcomes of the System Navigation and Transitional Case Management services has been conducted. The preliminary findings demonstrated a significant improvement in overall functioning (including mental health, substance use, and crime/violence) and internalizing mental disorders (including depression, anxiety, trauma, and suicidality) between program entry and a six-month follow-up (Samosh et al., 2019). No changes were observed in externalizing mental disorders (including inattentiveness, hyperactivity, conduct problems, gambling, and other impulse control problems), alcohol use, or substance use. In a qualitative study, clients and staff described a reduction in client ED use as a result of program participation (Samosh et all., 2021), suggesting that the program met its primary goal of reducing ED use.

Prior to undertaking the outcome studies, a formative evaluation was conducted to examine and improve program delivery. It was intended to refine the program prior to studying the outcomes. Although there is evidence about the relevance of system navigation, there is limited literature that describes the challenges faced by community-based system navigators when supporting individuals who are frequent ED visitors for mental health or substance use. The current study used findings from the formative evaluation to answer three questions: (1) What challenges were encountered by the Familiar Faces System Navigation service? (2) How did the program address these challenges? and (3) What were the demographic, clinical, and service use characteristics of program clients? Although this article focuses on Ottawa, Canada, repeat ED use is observed internationally (Lee et al., 2017; Meehan et al., 2021). Thus, these findings may be relevant to other jurisdictions considering similar programs.

METHODS

Data were collected through a review of program documents, interviews, focus groups, administrative data, and participant and program observation.

Participants and Measures

Review of program documents. Documents included a letter from the regional health authority outlining Familiar Faces funding and program expectations, a memorandum of understanding between CMHA and a partner organization, and other program documents (e.g., internal training documents, program flow charts).

Qualitative interviews and focus groups. Data were collected from 37 stakeholders. One individual participated in an interview as a key informant and then joined a focus group conducted with a team to which this person belonged. Nine key informants, 14 staff members, and 15 clients completed interviews and focus groups in-person or over the phone. Nine key informant interviews were completed with representatives from the Champlain Local Health Integration Network, stakeholders from partner agencies, and staff, managers, and directors from CMHA. Two focus groups were conducted with staff members, including five system navigators and the intake coordinator, as well as seven transitional case managers and their team manager. Sociodemographic characteristics of the 15 clients who participated in interviews are presented in Table 1.

Figure 1

The Process of the System Navigation Service

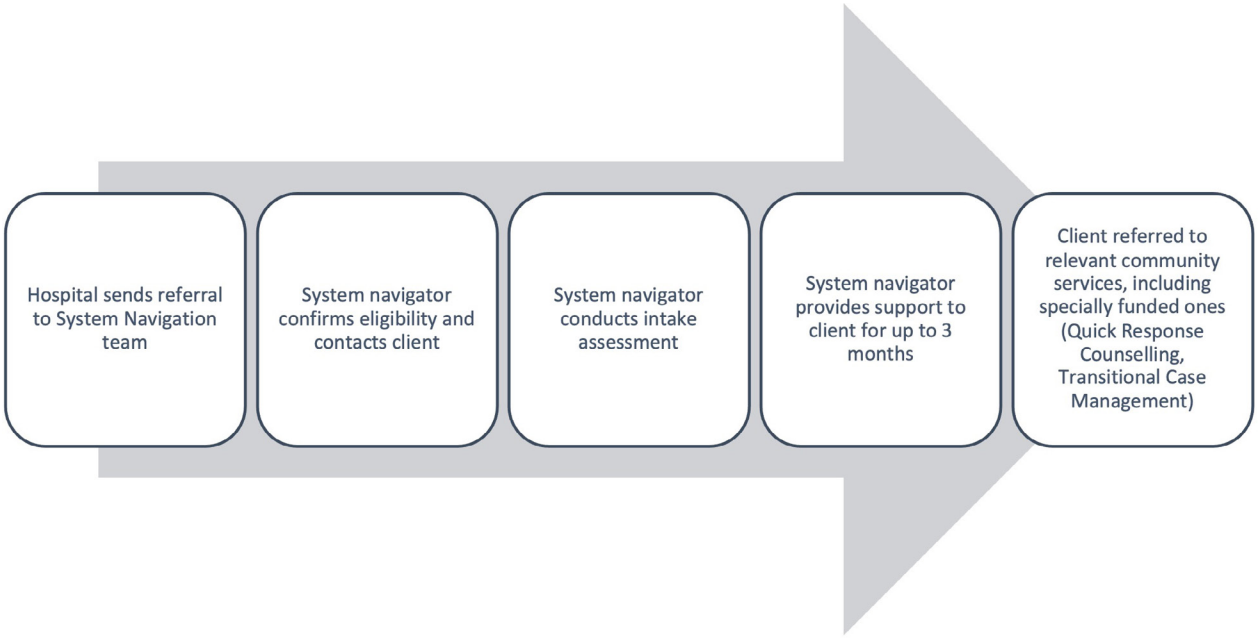

Table 1

Sociodemographic Characteristics of Program Client Interviewees

Characteristic	Number	%
Gender		
Female	8	53.3
Male	7	46.7
Age		
18–24	2	13.3
25–34	1	6.7
35–44	3	20.0
45–54	3	20.0
55–64	6	40.0
Indigenous		
Yes	2	13.3
No	13	86.7
Primary Diagnostic Category		
Mood disorder	5	33.3
Schizophrenia or other psychotic disorder	5	33.3
Personality disorder	2	13.3
Anxiety disorder	1	6.7
Substance related disorder	1	6.7
Unknown	1	6.7
Employment		
Employed	1	6.7
Not employed	12	80.0
Unknown	2	13.3
Highest Education Level		
Completed college/university	6	40.0
Some college/university	6	40.0
Completed secondary school	2	13.3
Some secondary school	1	6.7

Note. N = 15.

Administrative data. De-identified administrative data of all 1,232 individuals who were referred to System Navigation and 325 clients who received System Navigation between April 1, 2016, and March 31, 2017, were reviewed, as were referral data from October 1, 2016, to May 31, 2017. Administrative data were used to describe the demographic, clinical, and service use characteristics of program clients. Data from the following standardized measures are reported:

Alcohol Use Disorders Identification Test (AUDIT). The AUDIT is a 10-item self-report measure to screen for harmful or hazardous alcohol use (Babor et al., 2001). A review of research on the AUDIT reported that the measure has been shown to be valid and reliable in a range of samples (Reinart & Allen, 2002).

Drug Abuse Screening Test (DAST-10). The DAST-10 is a 10-item self-report measure to screen for level of problematic drug use (Cucco & Carey, 1998). The DAST-10 has been found to have good internal consistency (alpha = .86) and good test-retest reliability (intraclass correlation = .71; Cucco & Carey, 1998).

Observation. Four research team members observed the System Navigation team. Researchers attended weekly team meetings, observed client intake interviews, and shadowed outreach activities.

Procedure

Key informants and staff were recruited in-person or through email by researchers. Clients were contacted by system navigators and further recruited by researchers who provided study details to interested clients. Clients were informed that their decision to participate would not affect the services that they received. All participants provided written, informed consent. Clients were compensated $20. Key informant interviews occurred between July 2016 and March 2017 and lasted approximately 60 minutes. Focus groups with staff were held November 2016 and April 2017 and lasted approximately 60 minutes. Client interviews were completed between January and April 2017 and lasted 20 to 60 minutes.

Questions to key informants and staff addressed program goals, client population characteristics, program implementation, and organizational partnerships. Focus group questions also inquired about the referral and intake processes. Questions to clients addressed their understanding of the program, services received, and helpful or challenging experiences. All participants were asked about program strengths, weaknesses, and suggested improvements.

Data Analysis

De-identified administrative data were extracted and analyzed by a program analyst. Focus groups and interviews were audio recorded, transcribed verbatim, and analyzed. Three team members were involved in qualitative data analysis, which was conducted in pairs using a general inductive approach (Saldaña, 2009). In step one, all team members independently searched a few transcripts for statements related to the first two evaluation questions (program challenges and how these challenges were resolved) and then grouped the statements into codes. In step two, team members discussed codes that emerged from the findings to develop a preliminary coding framework. When there were inconsistencies between team members, the codes were discussed until a consensus was reached. In step three, one team member coded the remaining transcripts using the coding framework and the other team members reviewed the codes and transcripts for accuracy and reliability.

Research Ethics Approval

The University of Ottawa Research Ethics Board approved this study.

RESULTS

Clients, staff, and key informants described challenges encountered with the System Navigation service of Familiar Faces, from referral to the program to the delivery of the service and referral to other service providers. These challenges and the steps taken to address them are outlined below.

Establishing an Efficient Referral System

Establishing an effective referral mechanism that ensured that eligible individuals were referred was a challenge and a key component of the Familiar Faces program. Initially, system navigators visited the hospitals to educate staff regarding the program and the referral process. However, this education was time-consuming and the number of referrals remained low. Relying on busy ED staff was deemed inefficient.

Addressing the challenge. Through collaboration, the hospitals and the System Navigation team improved the referral process. Two key approaches included support from ED employees and establishing an automatic referral process.

ED staff support. To increase hospital staff awareness of Familiar Faces, two ED social workers worked with system navigators to support the implementation of the program, for example, training staff. While the e-trigger was being established and refined, one social worker identified eligible patients who had not been referred, and then referred them. This follow-up facilitated and solidified the hospital-System Navigation relationship.

Automatic referral. Quick and appropriate referrals are key. After experimenting with staff-initiated referrals, three hospitals created an automated referral process whereby an e-trigger would be sent automatically by fax to the system navigators when a patient was eligible. The e-trigger reduced the burden on ED staff by automating the referral process. Between October 2016 and May 2017, the three hospitals using e-triggers referred more individuals (n = 590, 510, and 208) than the hospital that used handwritten referrals (n = 9). Key informants overwhelmingly praised the automated referral system as a major strength. As described by a key informant:

> I think this e-trigger is really the key to creating a mutually beneficial arrangement because if there is no e-trigger, it takes time and effort on both sides…The e-trigger takes no thought, it's automatic and then the hospital recognizes that this is going to be taken care of, so I can have more comfort discharging this individual knowing somebody is going to be following up.

Delivering System Navigation Services

Service delivery challenges included contacting people who were unaware of their referral to System Navigation, a limited capacity to serve many clients, and the complexity of client presentations.

Contacting potential clients. As the e-trigger was generated via an automatic referral, ED patients were not specifically informed of their referral to System Navigation. Some clients were confused as to why

they were contacted by the program, how the program received their personal information, and were unsure of what services were available. A system navigator spoke about the reaction of some clients:

> [S]ome people are surprised, I mean in rare occasions they will even be upset that we are reaching out to them and, "How did you get the information?" and we do have a memorandum that, you know, that we have that understanding, we have that uh collaborative partnership with the [hospital], but some people for them this is too intense. How do we get to connect to them? How do we reach out with them?

Consequently, system navigators were trying to locate and engage individuals who were unfamiliar with the program. The lack of client awareness of the program may have led to some reluctance among clients with respect to engaging in the program.

Addressing the challenge. Informing referred individuals of System Navigation was the first step in engaging them. To ensure that referred individuals were aware of the program, the outreach process involved up to two phone calls by a system navigator and a mailed letter that listed community resources. Initially, the navigators attempted in-person outreach with individuals not contacted by phone, which involved locating individuals in the community. A system navigator explained: "You have to be able to outreach clients either over the phone, face-to-face, and at home, the community, OCDC [local detention centre], shelters… wherever."

This extensive outreach was thought to engage clients who might otherwise be reluctant. A client agreed that outreach was important:

> [B]ig strengths would be it was offered almost immediately after leaving the emergency room, so that was really good. Um and then, not just that, but they were proactive about contacting me and setting things up because after I left the emergency room, like, I wasn't, I wasn't motivated to do anything anyways… So them reaching out to me made that difference. So that's a huge positive there.

Capacity. The program's capacity was negatively affected by many referrals. Additionally, the extensive outreach, while helpful in engaging clients, was time-consuming, as described by a system navigator:

> There's files for people that come in that are repeats. […] if you go in that file there could be every single one of us that has tried to outreach that client over the last few months so there's a huge piece to that outreach that a lot of people are putting time into doing.

With considerable time devoted to contacting referred individuals, plus delivering services, many key informants and staff believed that the numerous referrals created what was described as an overwhelming workload. This busy workload had implications for the duration and intensity of services.

Addressing the challenge. To serve all clients, the program reportedly reduced service intensity and duration. Due to the time-consuming nature of outreach, in-person outreach had been limited to individuals with no fixed address or phone number, those who revisited the ED, or those whose hospital records indicated a history of opioid use.

The typical length of services was decreased due to limited capacity, according to system navigators and case managers. Although clients could receive up to three months of the System Navigation service, as the number of referrals increased, the program shifted to a shorter service duration with an emphasis on rapidly referring clients. Although this emphasis on short-term service was necessary due to resource constraints, some key informants were concerned that the length of services was too short to address complex needs.

Complex needs of clients. Another challenge identified by key informants concerned clients' complex needs. Stakeholders described clients as having high levels of acute mental health difficulties, substance use, and suicidality. The data collected by navigators through the hospital charts, referral forms, and client self-report also spoke to the complexity of the client population (see Table 2).

Table 2

Mental Health and Substance Use of System Navigation Clients

Variable	Number	%
Primary Diagnostic Category[a]	325	
Mood disorder	108	33.2
Schizophrenia and other psychotic disorders	68	20.9
Substance-related disorder	52	16.0
Anxiety disorder	39	12.0
Unknown	26	8.0
Personality disorder	23	7.1
Developmental handicap	3	0.9
Adjustment disorder	2	0.6
Dissociative disorder	1	0.3
Mental disorder due to general medical conditions	1	0.3
Sleep disorder	1	0.3
Somatoform disorder	1	0.3
Problematic Alcohol Use (AUDIT)	250	
Harmful or hazardous use	87	34.8
Problems Associated with Drug Use (DAST)	249	
No problems reported	97	39.0
Low level	66	26.5
Moderate level	32	12.9
Substantial level	29	11.6
Severe level	25	10.0
Risk Factors	264	
Harm to self	108	40.9

Note. [a] Diagnostic categories were identified from referral forms, hospital charts, and client self-report. Note that the diagnostic category may not be related to the reason for presentation at an ED.

Clients had limited financial means, despite 58.7% having partially or fully completed college or university. The primary income source of over half (56.8%) of the clients was government financial assistance, and employment was a primary source of income for only 11.5%. Eighty percent of clients were unemployed.

Clients' complex needs reportedly impacted their readiness to access and engage with services. Other implications of the complexity of clients' needs were that they required a substantial amount of outreach to engage with the program, service delivery and referral involved coordination among numerous agencies, and the program required more time and staff to support clients than could be provided. The intensity of clients' needs and the large number of referrals combined to create pressure on system navigators.

Addressing the challenge. Providing quick access to services and connection to appropriate referrals were important to address complex client needs.

Promptness. To best meet the needs of clients with significant mental health and substance use issues, rapid access to services, in contrast to the typically long waitlist, was perceived as vital. With rapid access, key informants hoped to prevent deterioration in client functioning and avoid the need for intense, long-term service. As described by a key informant:

> Unlike those services where you're put on a waitlist and we will give you a call when we can, this was only going to work if it could be offered rapidly. We would just have to stop the program. So, that is first and foremost, rapid connection to the client and then exploring exactly what they need and as much as possible, meet that need with the lowest amount of intervention as possible.

Connection to services. Given the clients' complex needs, it was important for navigators to support clients in accessing services and to refer them to a range of services. Most interviewed clients reported receiving a referral to services within CMHA or in the community. One client spoke about the importance of support in accessing services, having:

> Somebody to talk to, belief that there is somebody there to kind of manage and navigate the system for you, point you in the right direction… There's a lot of things I've come to discover just by word of mouth from [system navigator] and people she's reached out to for me…

Working with Partners to Ensure Clients' Access to Services

The program's primary objective was to refer clients to community services, including the Transitional Case Management and Quick Response Counselling programs that were created to serve Familiar Faces clients. However, the capacity of other services to accept clients and communication with these service providers proved to be challenging.

Availability of programs to accept referrals. System navigators described the limited capacity of other programs to accept clients as a barrier. Despite clients' interest in accessing other services, these services did not always have the capacity to accept clients. For example, although Transitional Case Management could serve 100 people, the numerous System Navigation clients with complex needs meant that there was insufficient capacity to refer all clients requiring that program. As a result, the navigators maintained clients on their caseload until they could be transferred, which was a challenge, as reported by a navigator:

> [W]e are maybe being very successful in reaching out to many people, but then there is like we're not met on the other end when we have to, let's say, transfer files to TCM [Transitional Case Management] and or

> to other programs. So that's where we get kind of stuck and then we end up overwhelmed with our case 'cause now we have all these case management things that we have to do or outreach and all that.

Addressing the challenge. To ensure that there were programs to which clients could be referred, it was crucial to develop partnerships with other agencies and individual service providers. Several services were created for Familiar Faces clients and these programs were the primary recipients of referrals from System Navigation due to their capacity to accept clients. For example, the Quick Response Counselling program was developed in partnership with another community agency to offer short-term counselling for clients with acute mental health difficulties, and approximately half (46.5%) of System Navigation clients received this service. In addition, Transitional Case Management services were created by CMHA for clients requiring longer-term services and served 43.4% of clients. Other CMHA programming designed to serve Familiar Faces clients included groups to treat anxiety or concurrent disorders (23.4% of clients) and a dialectical behaviour therapy group (7.7% of clients). The System Navigation team also maintained contact with other agencies, such as those serving Indigenous individuals, a peer support organization, and other programs designed for frequent ED visitors. Access to these other services was key to delivering System Navigation. Despite an effort to create relevant services, some stakeholders reported that clients would benefit from longer-term services.

Communication between organizational partners. Communication with referring partners and organizations that received referrals was important to continuity of care. Hospital partners were interested in further information about individuals whom they had referred to System Navigation and the services received to better serve them if they revisited the ED. Organizations that received referrals from System Navigation wanted client information in order to facilitate and improve the care that they offered. However, the time required to communicate by writing in different electronic record systems or having telephone or in-person discussions was a barrier.

Addressing the challenge. Partners viewed the program as an important service for frequent ED visitors and were motivated to maintain communication to support service delivery and ensure continuity of care. Communication strategies supported inter-organizational collaboration. Particularly important were technological solutions that facilitated communication with external partners. For example, three hospitals allowed the system navigators to access and write notes in patients' electronic medical records. Access to the medical records facilitated the referral process and permitted hospital staff to be aware of the system navigators' involvement in client care.

Technology also facilitated communication with the agency providing Quick Response Counselling. System navigators and counsellors shared a calendar, so that the system navigators could schedule counselling appointments for clients. The counsellors also accessed and wrote clinical notes in the electronic client record system used by Familiar Faces.

In-person meetings were intended to happen during the transition from System Navigation to Transitional Case Management. Ideally, the two service providers were also to meet with the client to discuss the transfer of care. While these meetings did not always happen, a regular schedule and process for the staff to meet and transfer client files was established. Later, the two services began to work as one team.

DISCUSSION

The System Navigation service of Familiar Faces connected individuals with repeat ED visits for mental health and substance use concerns to community services by bridging the gap between the hospital and community. This approach to linking hospital and community mental health services was a new strategy within Ottawa and has encountered challenges, which the program and its partners have attempted to address. There were differences between the clients who were interviewed and the larger set of clients (e.g., 16% of the overall clients and 7% of the interviewed clients had a substance related disorder). Thus, some of the findings may be less applicable to the overall group of clients.

Referral Process

Given the busy and demanding ED environment, having ED staff make referrals was ineffective. This finding is unsurprising as researchers have previously reported the challenges in transitioning individuals from the ED to the community with a lack of referral to community services and limited discharge planning (Digel Vandyk et al., 2018; Meehan et al., 2021). As described above, an electronic referral system was created in collaboration with the hospitals to automate the process. The importance of using an automatic, electronic referral system is supported by previous studies. Specifically, electronic referral systems were rated by primary care physicians as improving clinical care (Kim et al., 2009) and surgical electronic referrals were deemed less likely to be inappropriate than paper referrals (Kim-Hwang et al., 2010). For Familiar Faces, the hospitals using automatic referrals referred more patients than the hospital that did not have automatic processes. This is consistent with the low referral rates observed in a case management program that lacked an automated system to flag potential clients (Kahan et al., 2016). Thus, the use of an automatic referral may be integral to the success of programs designed to connect hospital and community services and should be given careful consideration by those developing similar programs.

Client Needs and Service Delivery

The complexity of the clients' needs is consistent with what has been observed in other studies with individuals with multiple ED visits for mental health (Sirotich et al., 2016; Wise-Harris et al., 2017). The similarity in the level of complexity and multiple clients' needs to those of other research suggests that the findings may apply to other programs serving similar populations.

Sirotich and colleagues (2016) posited that repeat ED users may comprise different subgroups defined by mental health conditions with corresponding differences in needs and understanding these differences may help tailor interventions to clients. The present study did not explore the differing needs of clinical subpopulations, but system navigators linked clients to a range of services based on clients' needs.

The large number of referrals necessitated a reduction in service intensity and duration, which was a concern for some stakeholders. This concern fits with the finding of short service duration as a barrier to continuity of care for a case management program (Poremski et al., 2016). This short service duration highlights the need to ensure that clients can transition successfully to other services so that needs requiring longer term services can be met. Although the service intensity was limited, the system navigators engaged in extensive

outreach efforts that were described as appreciated and may address the feeling of abandonment that some patients experience when required to organize support for themselves post-ED visit (Meehan et al., 2021).

Partnerships

Partnerships were central to the success of the program, whether in the provision of services to clients, or in terms of communication. Partnerships and multi-agency collaboration were also noted as strengths in a multiagency case management program (Kahan et al., 2016).

When referring clients to other services, their limited capacity to accept referrals was a barrier, one that was observed in a case management program that relied on other agencies to provide mental health and substance use services (Kahan et al., 2016). As such, partnerships were essential for accessing and creating services for clients. Access to Transitional Case Management was particularly relevant as case management interventions have been associated with reductions in service use and cost for individuals with frequent ED use for mental health and substance use (Kolbasovsky et al., 2007; Kolbasovsky et al., 2010). It should be noted that case management programs are not always associated with significant improvements in ED-related outcomes in this population (Stergiopoulos et al., 2017).

Communication was key, given the central role of the partners in program implementation and the importance of information-sharing to ensure continuity of care (Digel Vandyk et al., 2013). Continued attention to smooth transitions between services is vital to continuity of care (Poremski et al., 2016). System navigators communicate with other service providers, hold in-person meetings with the client and new case manager, and accompany clients to appointments, all strategies previously noted to facilitate continuity of care (Poremski et al., 2016). Poremski and colleagues also described a period of service overlap prior to terminating services as enabling continuity of care.

Ongoing Challenges

System integration has been proposed as a means to improve continuity of care for mental health (Durbin et al., 2006). Yet, Ontario lacks an integrated system for mental health and substance use, with fragmentation identified as a challenge of the healthcare system (Mental Health and Addictions Leadership Advisory Council, 2015). Familiar Faces was designed to increase the connection between the hospital and community services. While the program provides greater integration at the service level for individual clients, further steps would be required to increase system level integration. A strategy to improve the integration of a system involves having organizations coordinate a continuum of care to serve specific groups of patients (Durbin et al., 2006). Collective impact principles such as standard measurement, mutually reinforcing activities, continuing communication, and backbone support (Kania & Kramer, 2011) could provide guidance for activities and conditions that could enhance the capacity of stakeholders to address their common agenda of reducing repeat ED visits for mental health and substance use.

Limitations

One limitation was that many of the interviewed clients had a significant amount of contact with the program. Thus, their experiences might not be representative of all service users. Also, we were unable to

interview a stakeholder from the hospital that did not use an automated referral, so there was no feedback on the hospital's experience with the handwritten referral process. The distribution of the primary diagnostic categories differed between the clients who were interviewed and the larger population of clients. Thus, the findings may not fully represent the experiences of the larger group of clients. Additionally, the age cut-off of 64 years for the program means that these findings may be less applicable to programs that serve seniors.

CONCLUSION

This study described the perspectives of key informants, front-line staff, and clients regarding the challenges encountered by a community-based program designed to reduce frequent ED use for mental health and substance use, as well as how those difficulties were addressed. The findings highlight the importance of partnerships to delivering a program that spans organizations, which is also supported by observations made in a multi-organization program intended to support the same client population in Toronto (Kahan et al., 2016). The willingness of hospitals to commit staff and technological resources to support the program facilitated its success. These findings suggest that attention to partnership factors is key in the development of inter-organizational programs to address frequent ED use for mental health difficulties, whether for establishing efficient referral systems, ensuring continuity of care, or having appropriate services available to clients. The developers of similar programs should pay particular attention to the creation and maintenance of such partnerships, as well as to establishing an efficient, and preferably automated, referral process. Future studies need to examine the effects of system navigation services on system-level outcomes, including reductions in ED visits and in-patient admissions.

REFERENCES

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care (2nd ed.)*. World Health Organization.

Barker, L. C., Sunderji, N., Kurdyak, P., Stergiopoulos, V., Gonzalez, A., Kopp, A., & Vigod, S. N. (2020). Urgent outpatient care following mental health ED visits: A population-based study. *Psychiatric Services, 71*(6), 616–619. doi: 10.1176/appi.ps.201900466

Cucco, K. M., & Carey, K. B. (1998). Psychometric properties of the Drug Abuse Screening Test in psychiatric outpatients. *Psychological Assessment, 10*(4), 408–414. doi: 10.1037/1040-3590.10.4.408

Digel Vandyk, A., Harrison, M. B., VanDenKerkhof, E. G., Graham I. D., & Ross-White, A. (2013). Frequent emergency department use by individuals seeking mental healthcare: A systematic search and review. *Archives of Psychiatric Nursing, 27*(4), 171–178. doi: 10.1016/j.apnu.2013.03.001

Digel Vandyk, A., Young, L., MacPhee, C., & Gillis, K. (2018). Exploring the experiences of persons who frequently visit the emergency department for mental health-related reasons. *Qualitative Health Research, 28*(4), 587–599, doi: 10.1177/1049732317746382

Durbin, J., Goering, P., Streiner, D. L., & Pink, G. (2006). Does systems integration affect continuity of mental health care? *Administration and Policy in Mental Health and Mental Health Services Research, 33*(6), 705–717. doi: 10.1007/s10488-006-0087-6

Enard, K. R., & Ganelin, D. M. (2013). Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *Journal of Healthcare Management, 58*(6), 412–427.

Jacobi, J. V. (2012). High utilizers of ED services: Lessons for system reform. *Annals of Health Law, 21*(1), 35–44.

Kahan, D., Leszcz, M., O'Campo, P., Hwang, S. W., Wasylenki, D. A., Kurdyak, P., Wise Harris, D., Gozdzik, A., & Stergiopoulos, V. (2016). Integrating care for frequent users of emergency departments: Implementation evaluation of a brief multi-organizational intensive case management intervention. *BMC Health Services Research, 16*, 156–164. https://doi.org/10.1186/s12913-016-1407-5

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review, 9*(1), 36–41.

Kelley, L., Capp, R., Carmona, J. F., D'Onofrio, G., Mei, H., Cobbs-Lomax, D., & Ellis, P. (2020). Patient navigation to reduce emergency department (ED) utilization among Medicaid insured, frequent ED users: A randomized controlled trial. *The Journal of Emergency Medicine, 58*(6), 967–977. doi: 10.1016/j.jemermed.2019.12.001

Kelly, E., Fulginiti, A., Pahwa, R., Tallen, L., Duan, L., & Brekke, J. S. (2014). A pilot test of a peer navigator intervention for improving the health of individuals with serious mental illness. *Community Mental Health Journal, 50*(4), 435–446. doi: 10.1007/s10597-013-9616-4

Kim, Y., Chen, A. H., Keith, E., Yee Jr, H. F., & Kushel, M. B. (2009). Not perfect, but better: Primary care providers' experiences with electronic referrals in a safety net health system. *Journal of General Internal Medicine, 24*(5), 614–619. doi: 10.1007/s11606-009-0955-3

Kim-Hwang, J. E., Chen, A. H., Bell, D. S., Guzman, D., Yee Jr., H. F., & Kushel, M. B. (2010). Evaluating electronic referrals for specialty care at a public hospital. *Journal of General Internal Medicine, 25*(10), 1123–1128. doi: 10.1007/s11606-010-1402-1

Kolbasovsky, A., Reich, L., Futterman, R., & Meyerkopf, N. (2007). Reducing the number of emergency department visits and costs associated with anxiety: A randomized controlled study. *American Journal of Managed Care, 13*(2), 95–102.

Kolbasovsky, A., Reich, L., & Meyerkopf, N. (2010). Reducing six-month inpatient psychiatric recidivism and costs through case management. *Case Management Journals, 11*(1), 2–10. doi: 10.1891/1521-0987.11.1.2

Lee, S., Herrin, J., Bobo, W. V., Johnson, R., Sangaralingham, L. R., & Campbell, R. L. (2017). Predictors of return visits among insured emergency department mental health and substance abuse patients 2005–2013. *Western Journal of Emergency Medicine, 18*(5), 884–893. doi: 10.5811/westjem.2017.6.33850

Meehan, T., Baker, D., Blyth, D., & Stedman, T. (2021). Repeat presentations to the emergency department for non-fatal suicidal behaviour: Perceptions of patients. *International Journal of Mental Health Nursing, 30,* 200–207. doi: 10.1111/inm.12773

Mental Health & Addictions Leadership Advisory Council. (2015). *Better mental health means better health.* Annual report of the Ontario's Mental Health & Addictions Leadership Advisory Council. http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh/mental_health_adv_council.pdf

Ministry of Health and Long-term Care (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Additions Strategy*. http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf

Moe, J., Camargo, C. A., Jelinski, S., Erdelyi, S., Brubacher, J., & Rowe, B. H. (2018). Epidemiologic trends in substance and opioid misuse-related emergency department visits in Alberta: A cross-sectional time-series analysis. *Canadian Journal of Public Health, 109*(2), 164–173. doi: 10.17269/s41997-018-0053-6

Moe, J., O'Sullivan, F., McGregor, M. J., Schull, M. J., Dong, K., Holroyd, B. R., Grafstein, E., Hohl, C. M., Trimble, J., & McGrail, K. M. (2021). Characteristics of frequent emergency department users in British Columbia, Canada: A retrospective analysis. *Canadian Medical Association Journal Open, 9*(1), E134–E121. doi: 10.9778/cmajo.20200168

Parkman, T., Neale, J., Day, E., & Drummond, C. (2017). Qualitative exploration of why people repeatedly attend emergency departments for alcohol-related reasons. *BMC Health Services Research, 17*, 140. doi: 10.1186/s12913-017-2091-9

Poremski, D., Wise Harris, D., Kahan, D., Pauly, D., Leszcz, M., O'Campo, P., Wasylenki, D., & Stergiopoulos, V. (2016). Improving continuity of care for frequent users of emergency departments: Service user and provider perspectives. *General Hospital Psychiatry, 40*, 55-59. doi: 10.1016/j.genhosppsych.2016.01.004

Reinart, D. F., & Allen, J. P. (2002). The Alcohol Use Disorders Identification Test (AUDIT): A review of recent research. *Alcoholism: Clinical and Experimental Research, 26*(2), 272–279. doi: 0145-6008/02/2602-0272$03.00/0

Saldaña, J. (2009). *The coding manual for qualitative researchers*. SAGE Publications Inc.

Samosh, J., Polillo, A., Matroud, Z., Sylvestre, J., & Aubry, T. (2019, June 26–29). *Evaluating the mental health and substance use outcomes of frequent emergency department users participating in a community-based case management service* [Poster presentation]. 2019 Society for Community Research and Action Biennial, Chicago, IL, United States.

Samosh, J., Sylvestre, J., & Aubry, T. (2021, June 7–25). *Exploring the mechanisms of change in a community-based case management program for frequent emergency department users with mental health or substance use issues* [Paper presentation]. Canadian Psychological Association 82nd Annual Convention, Online Conference.

Seaberg, D., Elseroad, S., Dumas, M., Mendiratta, S., Whittle, J., Hyatte, C., & Keys, J. (2017). Patient navigation for patients frequently visiting the emergency department: A randomized, controlled trial. *Academic Emergency Medicine, 24*(11), 1327–1333. doi: 10.1111/acem.13280.

Sirotich, F., Durbin, A., & Durbin, J. (2016). Examining the need profiles of patients with multiple emergency department visits for mental health reasons: A cross-sectional study. *Social Psychiatry and Psychiatric Epidemiology, 51*(5), 777–786. doi: 10.1007/s00127-016-1188-5

Stergiopoulos, V., Gozdzik, A., Cohen, A., Guimond, T., Hwang, S. W., Kurdyak, P., Leszcz, M., & Wasylenki, D. (2017). The effect of brief case management on emergency department use of frequent users in mental health: Findings of a randomized controlled trial. *PLoS One, 12*(8), e0182157. doi: 10.1371/journal.pone.0182157

Theriault, K. M., Rosenheck, R. A., & Rhee, T. G. (2020). Increasing emergency department visits for mental health conditions in the United States. *The Journal of Clinicial Psychiatry, 81*(5), 20m13241. doi: 10.4088/JCP.20m13241

Wise-Harris, D., Pauly, D., Kahan, D., de Bibiana, J. T., Hwang, S. W., & Stergiopoulos, V. (2017). "Hospital was the only option": Experiences of frequent emergency department users in mental health. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(3), 405–412. doi: 10.1007/s10488-016-0728-3