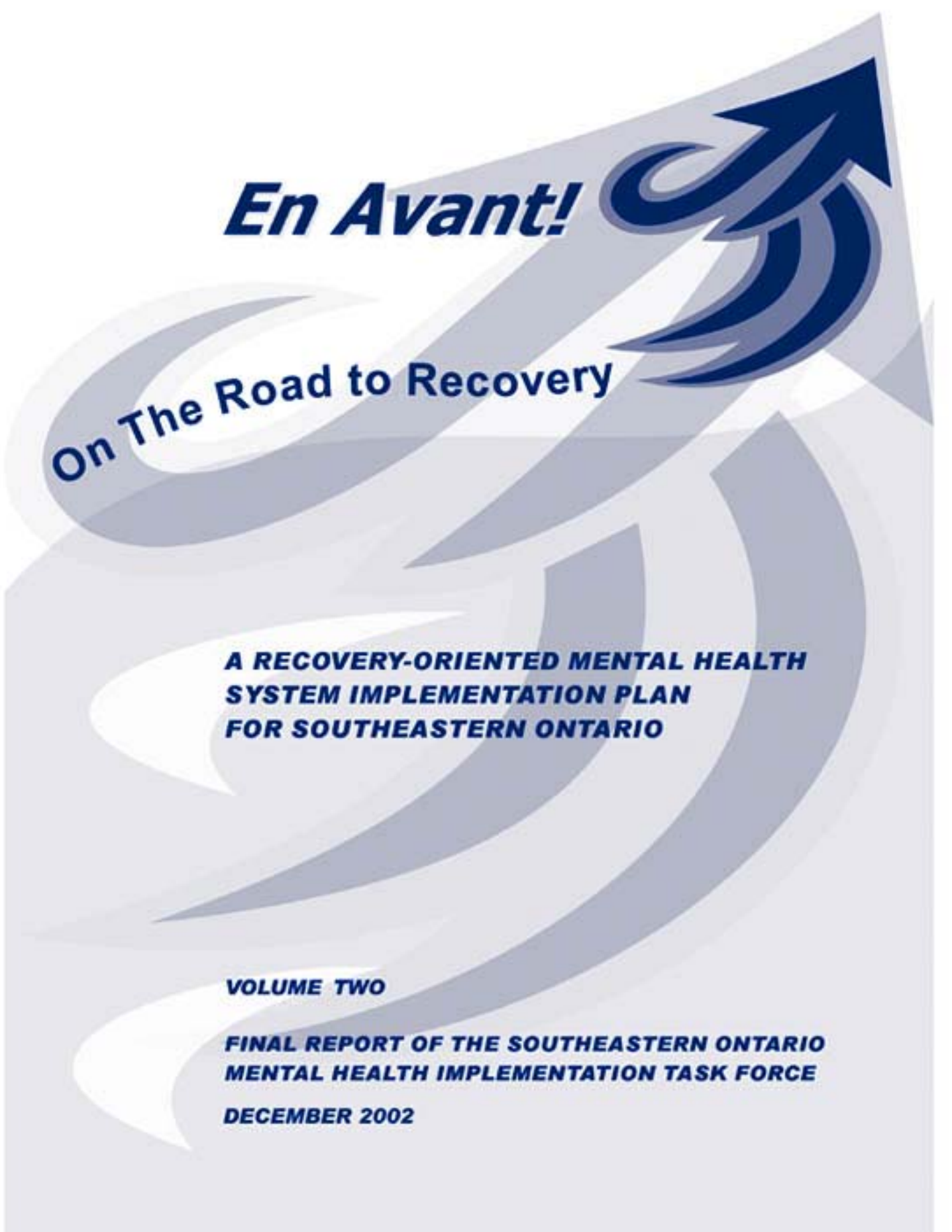




En Avant!

On The Road to Recovery

**A RECOVERY-ORIENTED MENTAL HEALTH
SYSTEM IMPLEMENTATION PLAN
FOR SOUTHEASTERN ONTARIO**

VOLUME TWO

**FINAL REPORT OF THE SOUTHEASTERN ONTARIO
MENTAL HEALTH IMPLEMENTATION TASK FORCE
DECEMBER 2002**

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Preface

The title of this report deserves some explanation. *En Avant* was chosen to reflect the fact that mental health reform is an evolutionary process of growth and change. It is not about getting it right, then stopping. It is about going forward, standing on the shoulders of those who have gone before, and moving into the future.

There are many ways to implement change. The Task Force was privileged to build upon the existing innovation and dedication of many people who cared deeply about making the best decisions possible.

In order to understand the different options available, the Task Force commissioned a number of reports from its advisory committees, work groups and advisors. **Volume II** contains these reports and their detailed recommendations as well as proceedings, research, and presentations. These were a valuable foundation for the work of the Task Force and provide a legacy fundamental to future improvements to the mental health system of Southeastern Ontario.



Albert Camus

Acknowledgements

The work completed under the auspices of the Southeastern Ontario District Mental Health Implementation Task Force and all of its committees, working groups, advisors, supporters and researchers may be the largest mental health planning effort ever undertaken in this district. Therefore, the effort reflected in Volumes I and II of this submission is the culmination of untold hours of work by people who share a common goal - to press on with the creation of an excellent mental health system in Southeastern Ontario.

Their work was often completed under difficult time lines, and over and above regular daily responsibilities. The quality and extent of the work completed attests to their commitment to this goal. This deserves our highest recognition and our grateful appreciation.

Of special note were the consumers who served on committees and working groups, who participated in community consultations and the comprehensive community assessment projects. They were an inspiration.

Sandra S. Lawn, Chair
Catherine Cleary, Administrative Coordinator



Community Action:

For Mental Health Promotion and Prevention

**Prepared by the Community Committee of the
Southeastern Ontario District Mental Health Implementation Task Force**

MENTAL HEALTH PROMOTION AND PREVENTION THROUGH

Community Action

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On Behalf Of:
The Community Committee

January 2002

Prepared By:

Heather Stuart, PhD
Queen's University
Kingston, Ontario

MEMBERS OF THE COMMUNITY COMMITTEE

The following members respectfully submit this report to the Southeastern Ontario Mental Health Implementation Task Force:

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Cathy Dunne (Vice-Chair), Seniors Champion

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Alia Hogben, Children and Youth Champion

Bob Napier, Forensic Champion

Marilyn Nicholson, Consumer Champion

Katie Rutledge, Family Champion

Colin Slack, General Public Champion

Nadia Zurba, Concurrent Disorders Champion

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Joanne Trew, Southeastern Ontario Mental Health Implementation Task
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(resource)

Summary of Recommendations

This report is submitted to the Mental Health Implementation Task Force and the Southeastern Ontario District Health Council on behalf of the Community Committee. This report outlines a conceptual framework for community action in the areas of health promotion and prevention. The report also recommends a program structure for activities aimed at community advocacy for healthier public policy relating to mental health and mental illness; promoting community integration of those with a serious mental illness through reduction of stigma and intolerance toward the severely mentally ill; supporting consumer advocacy; and promoting community awareness of mental health system functioning and reform.

In order to provide a fulcrum for leadership, and provide the resources necessary to mobilize health promotion and prevention activities in the Southeastern Ontario mental health planning district, the Community Committee recommends the development of a funded community based “Partnership Program” that is mandated to undertake mental health promotion and prevention activities in partnership with consumers, family members, and clinical care providers. This program should be built on notions of consumer empowerment and community action to foster working alliances between different sectors, agencies, groups, and individuals with the aim of mobilizing them toward well-defined promotion and prevention goals. The program should be accountable to the Southeastern Ontario Mental Health District Trust for the results obtained.

The main goals of the Partnership Program should be to:

- ❑ Monitor health, social welfare, and housing regulations to identify policies that discriminate against people with severe mental illness;
- ❑ Promote community integration of those with a serious mental illness through reduction of stigma and intolerance toward the severely mentally ill;
- ❑ Promote consumer advocacy;
- ❑ Promote community awareness of mental health system functioning and reform;
- ❑ Work with public health units, community health centres, district health councils, community agencies and professional associations to develop collaborative initiatives designed to improve public policy relating to mental illness, promote mental health, and prevent mental illness;
- ❑ Provide support and training to health and social service agencies to help them become more effective advocates for the mentally ill;

COMMUNITY ACTION FOR MENTAL HEALTH PROMOTION AND PREVENTION

- ❑ Work in collaboration with district programs to insure consumer and family member empowerment and involvement with respect to program planning, service delivery, and treatment;
- ❑ Work in collaboration with the District Planning, Research and Evaluation Unit to evaluate the effectiveness of advocacy initiatives;
- ❑ Provide support to District Trust Consumer and Family Advisory Councils for advocacy activities;
- ❑ Mobilize consumers, family members, and mental health professionals to work in partnership to reduce stigma and discrimination because of mental illness;
- ❑ Work with the District Trust to develop a complaint process including a fair and equitable means of resolving conflicts for consumers and their families;
- ❑ Through the use of tele-psychiatry, a dedicated web site and a toll free information line, provide valid, up-to-date information to the community about such things as:
 - early warning signs of mental disorders,
 - what to do and where to go in a mental health emergency,
 - best practice guidelines,
 - consumer rights and responsibilities,
 - services and supports available to consumers and their families,
 - how to navigate the mental health system,
 - mental health legislation,
 - self-help initiatives,
 - links to other web sites relevant to mental health services in Ontario (such as the Ontario's Drug and Alcohol Registry of Treatment or other provincial mental health services registries),
 - information on important mental health system initiatives, locally, provincially, nationally, and internationally.
- ❑ Undertake performance monitoring and accountability activities in accordance with District policies;

- ❑ Participate in research designed to evaluate the outcomes of mental health promotion and prevention.

Priorities for action

It is recommended that priorities for action should include the following:

- ❑ **Promotion:**

- Using community action principles, advocate for greater equity for mental health consumers with respect to housing, health, social welfare benefits, and other social services.

- ❑ **Primary Prevention:**

- Develop partnerships with public health and community health care centres in support of broader health initiatives promoting healthy family and school environments.

- ❑ **Secondary Prevention:**

- Advocate for youth mental health, specifically best practices in the early identification and treatment of youth with emotional and psychiatric problems, and policy changes necessary to smooth the transition between children and adult systems.
- Provide training and support to agencies, programs, and professionals so that they can come to see mental health promotion and prevention activities as integral to their own work.

- ❑ **Tertiary Prevention:**

- Actively undertake programs designed to reduce stigma and discrimination.
- Improve community awareness of mental health system functioning and services.



Introduction & Purpose

This report is submitted to the Mental Health Implementation Task Force and the Southeastern Ontario District Health Council on behalf of the Community Committee.

This report outlines a conceptual framework for community action in the areas of health promotion and prevention and recommends a program structure for activities aimed at:

- ❑ Community advocacy for healthier public policy relating to mental health and mental illness;
- ❑ Promoting community integration of those with a serious mental illness through reduction of stigma and intolerance toward the severely mentally ill;
- ❑ Supporting consumer advocacy; and
- ❑ Promoting community awareness of mental health system functioning and reform.

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Community Action for Mental Health

Health promotion and prevention are increasingly being viewed as core elements of health system reform.

In modern mental health systems, the role of community action in mental health promotion and prevention is often unclear, although there is agreement that we must begin to take an upstream view. Using a military analogy, we must not leave the enemy unchecked by concentrating on the treatment of war victims (Tsalikis, 1993).

Unfortunately, there are few concrete examples of community action programs that are fully integrated into mental health delivery systems and resourced in such a way as to make them sustainable and accountable. Some would argue that prevention activities have broken down due to a lack of commitment to promote health and prevent disease, and a lack of resources to do so (Bodenheimer and Grumbach, 1995). Yet, history shows that it is through effective promotion and prevention that we stand to make the greatest health gains. In the early part of the last century, syphilis related neuropsychiatric conditions such as general pareses of the insane or congenital syphilis were the ongoing concerns. At one time, mental hospitals were filled with people suffering the neuropsychiatric consequences of syphilis. Many causes of mental retardation, such as phenylketonuria, foetal rubella, have been controlled or eliminated (Wagenfeld, Lemkau, and Justice, 1982). Still others, such as conditions arising from the misuse of substances, ranging from foetal alcohol syndrome to interpersonal violence, remain eminently controllable, in the public health sense of the term.

The current emphasis on health promotion and prevention has emerged from our growing realization that we need to change in the way we view, achieve, and maintain

health. Thus, health promotion and prevention activities are increasingly being viewed as core elements of health system reform.

Health promotion & prevention reflect different but complementary philosophical traditions

Health promotion and prevention reflect different philosophical traditions. Health promotion focuses on community-wide action and is based on a consumer empowerment model that enables people to increase control over their lives. The view of health is largely positive, as a resource for daily living and it directs activities to the social and organizational policies that promote health. Health prevention is built on a public health model that recognizes the important role played by social and environmental factors as determinants of disease. In an attempt to reduce ill health, it directs activities to social and environmental risk factors. The two perspectives are complementary and work well together to form a comprehensive strategy.

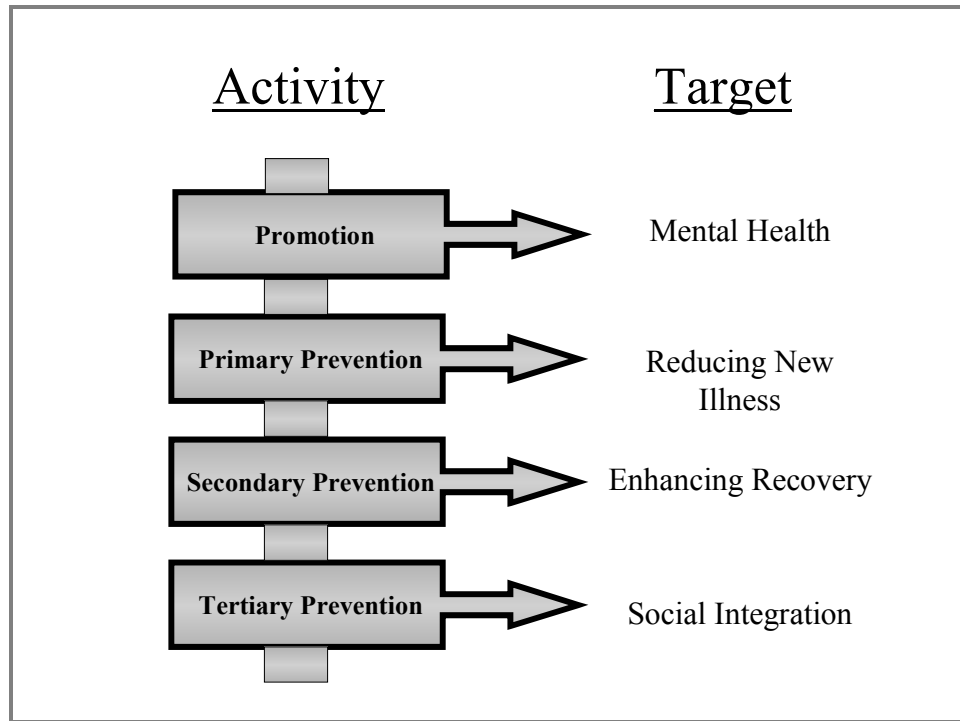
Both share the view that the health of the individual is qualitatively different from the health of a group. In both health promotion and prevention, the emphasis is on the health of the group, making them clearly distinguishable from clinical medicine, which focuses on health of the individual. At the population level, health may be defined as an adequate distribution of income, social benefits, healthy lifestyles, or community participation, whereas individual health may be viewed as a lack of symptoms or freedom from disability.

Both approaches view health from a balanced perspective recognizing the positive health promoting aspects, as well as the negative or illness producing aspects. Both place great emphasis on the potential of public policies to promote or impede health, and frequently ask the question of what policy options will nurture health? Therefore, advocacy for healthy public policy is a common goal. Toward this end, a range of strategies may be used including political lobbying for policy or legislative change, enlisting credible public figures to influence public opinion and health behaviours, or using mass media to create a favourable policy climate, gain public attention for issues, or advertise events (Badura and Kickbusch, 1991).

A framework for mental health promotion and prevention

Figure 1 integrates the various aspects of promotion and prevention into a single framework that could be used to conceptualize mental health promotion and prevention.

Figure 1: Framework for Mental Health Promotion and Prevention



Mental health promotion activities are aimed at improving mental health. Prevention activities are aimed at reducing mental illness or its consequences. For example, the goal of primary prevention is to prevent the occurrence of new illness from occurring. The goal of secondary prevention is to enhance recovery by eliminating or reducing symptoms and functional impairments (see Mazza and Sabo, 2001 for a description of a recovery philosophy). Therefore, secondary prevention adopts a recovery philosophy; is entirely service based; and involves intervention, diagnosis, effective treatment, and community supports for individuals who have an already identified illness. Finally, the goal of tertiary level prevention is to improve social connectedness and integration for individuals who have a severe or persistent mental disorder.

As it is the mandate of the Community Committee to take a broader community view, our emphasis will be on promotion and prevention activities that are not clinically based but those with a population health focus.

In mental health promotion, focus is key.

The concept of health promotion as it relates to *mental* health is relatively new, so there is much room for creativity. However, there is also much critical debate about what can be achieved and by whom in the broader social framework of health.

What we promote depends greatly on how we define mental health. While there is recognition that we must move beyond the tight illness-based conceptualizations of the medical model, broader quality of life views often seem too vast to provide a meaningful basis for community action. In staking a claim for promoting positive mental health, one runs the risk of becoming all things to all people. When virtually any realm of activity could impact mental health; when so little is known about the effectiveness of population-based mental health promotion activities; and when budgets for these activities are likely to remain small; maintaining focus will be key to success.

Canadians have pioneered our current concept of health. Dr. Bock Chisholm, a Canadian Psychiatrist and the first Director General of the World Health Organization is widely credited with having created the now famous definition of health as something more than the absence of disease—a state of physical, mental, and social well-being. Following in this tradition, Health Canada has defined mental health in the following broad terms as:

the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and relational), for the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Not surprisingly, notions of health promotion are as broad as definitions of health. For example, the first International Conference on Health Promotion held in Ottawa, defined health promotion as “the process of enabling people to create control over and to improve their health”. This is also the definition used by the World Health Organization (Green and Raeburn, 1990).

The mental health reform movement in the United Kingdom has adopted the following understanding of mental health promotion:

Mental health promotion is developing positive mental health both for and with the community in general and individuals who may have mental health problems. It includes self-help, service provision and organizational skills. The concept of mental health promotion recognizes that individual's mental health is inextricably linked with their relationship to others, their lifestyle, and the environmental factors that effect that, and the degree of power they can exert over their lives (McCulloch & Boxer, 1997).

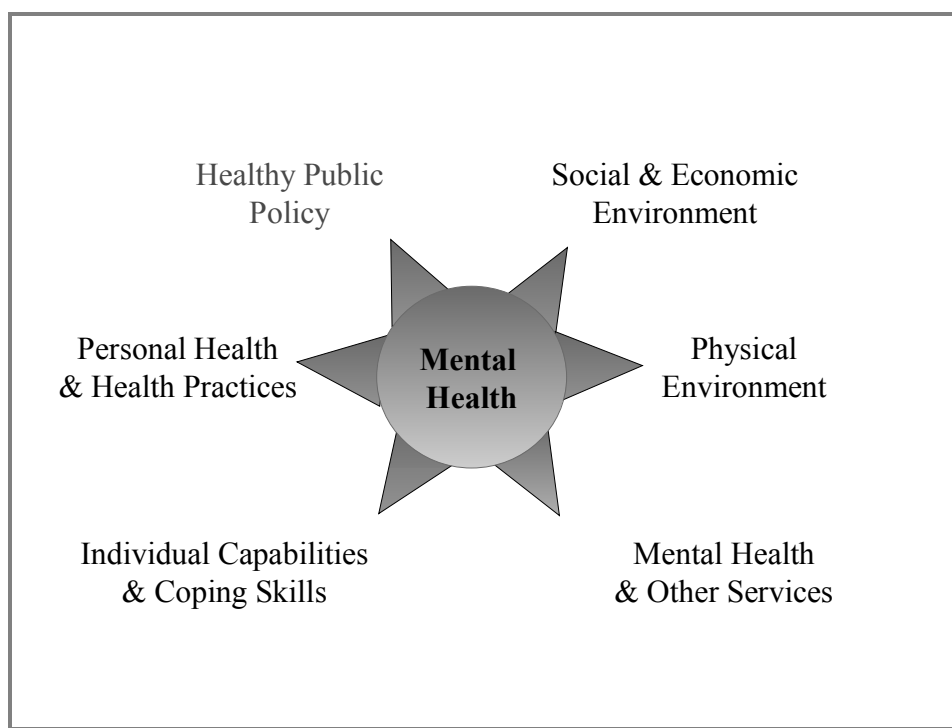
From these definitions it should be apparent that mental health promotion is as much an ideology as it is an activity, centred on beliefs about broader determinants of health, equity, social justice, and on ideals of social involvement that are based on notions of empowerment, participation and collaboration.

Traditionally, health promotion activities have focused on the general public—well people. More recently, the value of health promotion for people in ill health has been recognized. Consequently, the definition of health promotion has been extended to include such things as the maintenance and enhancement of existing levels of health through the implementation of effective policies, programs, and services (see McCulloch & Boxer, 1997, p. 4).

A focus on healthy public policy for mental health consumers

Figure 2 uses Canada’s population health framework to illustrate the broad array of social and environmental factors that are to be considered as determinants of mental health.

Figure 1: Determinants of Mental Health



An enduring feature of health promotion to date has been political advocacy for healthier public policies; often at a grass roots or consumer advocacy level. If we were to use the directions outlined in *Making it Happen* to circumscribe mental health promotion to the areas of greatest relevance for the mental health service system and for the severely mentally ill, we could strategically focus our efforts on improving public policies (such as health, housing or social benefits) that are known to be inequitable for mental health consumers. Mental health advocacy efforts in these areas have been diluted by a lack of coordinated leadership, meagre mobilization of resources, and a lack of ownership by public health agencies. This has slowed the progress of policy development with the result that major inequities in the socio-economic benefits and opportunities available to those with serious mental illness persist. Therefore, by focussing on the needs of the mental health consumer, mental health promotion can be used to further the goals of *Making it Happen*.

Prevention

Prevention activities may be viewed from two perspectives: the individual and the population. The medical model tries to identify high-risk individuals and provide them with treatment. The public health model tries to reduce illness in the population. Both approaches have merit, but the public health model offers greater opportunities for improving health. The goals of prevention at this level are to delay disability and death and to maximize healthy years of living through population-based interventions (Bodenheimer and Grumbach, 1995).

Until recently, infectious diseases caused the greatest amount of illness and death. Significant declines in infectious diseases were accomplished through prevention efforts that improved living conditions and sanitation and provided mass vaccination programs; not medical interventions aimed at treating infectious individuals. In fact it has been estimated that less than 5% of the decrease in mortality from infectious diseases over the last century has been due to medical interventions. These figures illustrate the power of prevention for improving population health.

By the middle of the last century, infectious diseases had declined and chronic, non-infectious diseases such as cancer or cardiovascular disease had begun to rise. Through epidemiology, we have learned that most of these illnesses share central causes that are modifiable through life style changes. Reduction in tobacco and alcohol use, improved diet, and greater exercise are among the lifestyle changes that can prevent or delay the major chronic illnesses of our time.

Primary prevention of mental disorders.

Epidemiologic studies have shown that the proportion of the population having a mental health problem that is sufficiently disabling to warrant treatment is much higher than first imagined. For example, studies of community populations show consistent results somewhere in the vicinity of 20%. Follow-up studies of people with major mental disorders demonstrate that brand new illnesses occur relatively rarely, but once they do occur, they often recur, and may result in longstanding disabilities. This has important implications for primary prevention, which has the goal of preventing new illness from occurring. Even if primary prevention were 100% successful in preventing mental disorders, there would be little appreciable difference in the prevalence of mental health related disability in the population for many years.

As a consequence, psychiatric epidemiologists have argued that primary prevention in mental health is somewhat over-rated. They suggest that effective treatments that reduce discomfort and disability; supports that maximizes self-healing and recovery; relapse prevention; and actions that reduce social disability will remain the primary elements for the control of mental disorders at the population level (Dalgard, Sørensen and Bjørk, 1991). Even when primary prevention is possible, if new disorders occur infrequently, secondary prevention is usually more cost-effective (McGorry, 2001). Perhaps for this reason, there are few advocates for large-scale primary prevention programs for the control of mental disorders, and there is no country in which there is a coherent primary prevention policy for achieving mental health (Sartorius, 2001).

Thus, while primary prevention may not be seen as a primary means of reducing mental disability, activities that support good nutrition, prenatal care, healthy beginnings, supportive family environments, and reduction of violence cannot help but have important mental health consequences. As these are largely functions of public health units and community health care centres, there is considerable room for collaboration between the mental health system and these more traditional primary prevention venues.

Issues in secondary prevention

Secondary prevention is devoted to enhancing the process of recovery. The World Health Organization defines recovery as the “sum of activities required to ensure patients the best possible physical, mental and social conditions so that they may, by their own efforts, resume as normal a place as possible in the life of the community” (Badura, 1991).

One in five individuals live with a disabling mental health problem during any given year. Increasing recognition of this has meant that the goals of reducing disability and promoting recovery from mental disorders are gaining priority on the agendas of health policy makers. Owing to an emphasis on illness recovery, secondary prevention falls within the mandate of health professionals and clinical services. Early identification and treatment, optimal interventions and best practices, targeting high risk groups, and relapse prevention are among the strategies used at this level.

Youth-centred mental health care an important secondary prevention strategy

Improving population health means extending healthy years of life lived. Younger age groups are often targeted because they have longer to live with a disability, so contribute more to the burden of illness in the population. Therefore, advocacy for earlier identification and treatment of mental disorders among youth may be a particularly powerful secondary prevention strategy.

Epidemiologic research shows that the onset for most psychiatric disorders is during adolescence or early adulthood. Indeed, some would argue that there has been a rise in the occurrence of psychosocial disorders among youth in recent decades, in part associated with a rise in substance misuse in these age groups (McGorry, 2001). In Ontario, it has been estimated that 24% of individuals between the age of 15 and 24 years have one or more psychiatric disorders during any given year. Substance abuse surveys report that 11% of students report hazardous drinking and of those, 40% report impaired mental health (Leavey, Goering, Macfarlane, Bradley, and Cochrane, 2000). Even mild mental health problems that emerge during youth and young adulthood can have life-long impacts. More serious disorders disrupt important psychosocial, educational, and vocational trajectories. Serious consequences include: increased risk of other psychiatric syndromes, substance abuse, suicide, unemployment, physical ill health, and homelessness. If the onset of psychiatric disorders could be delayed or the effects somehow cushioned, significant reductions in morbidity and socio-economic costs might be the result. McGorry (2001) believes:

this alarming scenario presents a major challenge to current service systems that typically have been seriously inaccessible and unresponsive to this age group. There is an urgent imperative rapidly to develop and disseminate effective mental health care models for this subcultural group [12-26 year olds], a process which would automatically create an opportunity to delivery effective secondary prevention under an early intervention banner. (p. 499)

Leavey and colleagues (2000) argue for youth-centred mental health care in Ontario, particularly focussed on smoothing the transition for youth who must move from the child and adolescent service system to the adult psychiatric system, as well as school based programs to deal with the identification and early treatment of symptoms of depression and anxiety, and substance misuse.

Current planning for children and youth is haphazard, fragmented and fraught with jurisdictional issues. These authors argue that it is clear that system integration must occur at every level, but particularly at the inter-ministerial level. Inter-ministerial and inter-sectoral activities are required in order to develop common service standards, smooth the transition across systems, and implement best identification and treatment practices.

Issues in tertiary prevention

The aim of tertiary prevention is to reduce social handicap and improve community integration for people with a serious mental illness. At the clinical and service level, this is accomplished through provision of rehabilitation services (Gittelman, 2000). At the community level, this is accomplished by reducing stigma and discrimination against those with a mental disorder and improving community tolerance for community-based care.

Public attitudes toward the mentally ill have been the topic of research since the early days of the community mental health movement. Surveys conducted in the 1950's showed extremely negative attitudes. While the public may have improved knowledge of the biological basis of mental illness, and even have come to appreciate a community mental health philosophy, attitudes toward those with a mental illness remain highly stigmatizing.

Stigmatizing attitudes often translate into discriminatory behaviours and examples abound (see Warner 2000). In one 1991 US survey, 40% of landlords surveyed immediately rejected applicants who were known to have a psychiatric disorder. Citizen groups fight vociferously to exclude community based mental health treatment facilities from their neighbourhoods. Even when they demonstrated half a decade of stable housing, normal living, and employment, ex-mental patients were still rated as less acceptable than ex-convicts. All those who come into close association with individuals with mentally illness are equally tainted: their families, mental health professionals, mental health agencies, and mental health researchers. Even the mentally ill, themselves, come to view themselves in negative and self-stigmatizing terms.

Three types of interventions have been demonstrated to be effective in the fight against stigma (Corrigan, et al., 2001; Wolf, 1997):

- ❑ Advocacy for policy change,
- ❑ Neighbourhood interventions in areas planned to receive deinstitutionalized patients,

- ❑ Positive personal contacts with persons who have experienced mental illness.

Community action is a preferred means of undertaking mental health promotion and prevention in the Southeastern Ontario mental health planning district.

While community action is rooted in health promotion and public health philosophies, its tools are much more eclectic. It borrows strategies and intervention concepts from a wide array of disciplines ranging from communications and social marketing to policy analysis and lobbying to bring about social change. It is built on community development principles and the belief that individuals are influenced by their social environments; that permanent, population-wide change can best be realized by altering the standards of acceptable behaviour; and that this can best be done at the policy or system level.

Community action is cooperative action. The aim is to mobilize community resources, consumer and citizen energy to build partnerships for system-level change in social, economic, institutional, cultural, legislative, industrial, and other milieus that affect individual's behaviours (Bracht, 1990). Therefore, community action can be understood as the process by which community resources, such as people, goods, services, time, and money are mobilized. Community mobilization engages governments, voluntary and special interest groups, coalitions, networks, and provider agencies. The aim is to galvanize these energies and interests to form a coordinated, collective response. Bracht and Kingsbury (1990) describe community action as:

a planned process to activate a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organized by individuals, groups, or organizations from within the community to attain and then sustain community improvements and/or new opportunities (p. 67)

Community action is a preferred means of implementing mental health promotion and prevention in the Southeastern Ontario Mental Health Planning District for the following reasons:

- ❑ Its population-wide focus provides a comprehensive framework for addressing mental health promotion and prevention across the life span and within special populations;
- ❑ The importance of consumer empowerment and involvement will help put the consumer first;

- ❑ An emphasis on change through partnerships and consumer involvement will channel the experiences, knowledge, skills and resources of mental health consumers, their family members, mental health providers, and others, to work toward common advocacy goals;
- ❑ The emphasis on system-level change will guide inter-sectoral initiatives necessary to bring about reforms in social, housing, and economic sectors;
- ❑ The recognition that community norms and sanctions are a powerful influences on individual behaviours will support efforts to reduce stigma and discrimination through policy-level interventions and social activism;
- ❑ Given the importance of mobilizing networks, coalitions, and volunteers, community action principles will encourage cooperation with existing initiatives and structures within the Southeastern Ontario Mental Health Planning District and provide a forum for multi-agency, inter-sectoral initiatives.

Barriers to community action for mental health

The first step in the process of community mobilization is to increase awareness that a problem exists. Second, the problem must come to be seen as a priority for action. Third, steps must be taken to bring about change, and fourth, structures must be established in order to bring about the change.

In most areas of health promotion and prevention (such as smoking or substance misuse) it is possible to count on significant support from government and community leaders. Momentum for change may be easily established and programs may be sustained on the basis of volunteer spirit alone. This is unlikely to be the case for mental health promotion and prevention programs where:

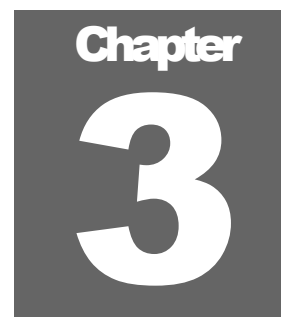
- ❑ The aspirations of many mental health consumers for “a home, a friend, and a job” reflects the fact that traditional government and community health allies may be a source of stigma and discrimination and so objects of community action, rather than agents of change;
- ❑ Public fear and intolerance of the mentally ill and sometimes hostile reactions to community-based program initiatives (a) makes it difficult to find influential community personalities that will serve as spokesperson for the cause, (b) reduces the pool of volunteer resources required to sustain promotion and prevention activities, and (c) makes it difficult to attract external funds;
- ❑ Mental health issues have been marginalized in the broader health and public health realms, with the result that traditional promotion and public health

agencies often lack the expertise, capacity or the interest to undertake mental health promotion and prevention;

- ❑ Negative images in the entertainment and news media fuel public fears and may overtly contradict positive program messages;
- ❑ Lack of professional support for mental health promotion and prevention activities requires stronger system-level leadership and protected resources for mental health promotion and prevention activities;
- ❑ Health promotion and prevention efforts may be given low priority because their outcomes are not immediately obvious. Not only are they complex and difficult to measure they may only be realized over extended periods of time. In an evidence-based environment that emphasizes immediate outcomes, it can be difficult to protect budgets for these activities.

The considerable barriers to mental health promotion and prevention make it necessary for the mental health system to establish a separate profile in this area in order to:

- ❑ provide leadership for mental health promotion and prevention activities at the community level;
- ❑ actively support the efforts of other public health agencies to incorporate mental health promotion, prevention, and consumer advocacy initiatives into their regular portfolios; and
- ❑ develop collaborative initiatives in support of policy change.



Chapter 3

Infrastructure Requirements

Recommendation

In order to provide a fulcrum for leadership, and provide the resources necessary to mobilize health promotion and prevention activities in the Southeastern Ontario mental health planning district, that are comprehensive, sustainable, and accountable, the Community Committee recommends the development of a funded community based “Partnership Program” that is mandated to undertake mental health promotion and prevention activities in partnership with consumers, family members, and clinical care providers. This program should be built on notions of consumer empowerment and community action to foster working alliances between different sectors, agencies, groups, and individuals with the aim of mobilizing them toward well-defined promotion and prevention goals. The program should be accountable to the Southeastern Ontario Mental Health District Trust for the results obtained.

The main goals of the Partnership Program should be to:

- ❑ Monitor health, social welfare, and housing regulations to identify policies that discriminate against people with severe mental illness;
- ❑ Promote community integration of those with a serious mental illness through reduction of stigma and intolerance toward the severely mentally ill;
- ❑ Promote consumer advocacy;
- ❑ Promote community awareness of mental health system functioning and reform;

- ❑ Work with public health units, community health centres, district health councils, community agencies and professional associations to develop collaborative initiatives designed to improve public policy relating to mental illness, promote mental health, and prevent mental illness;
- ❑ Provide support and training to health and social service agencies to help them become more effective advocates for individuals with mental illness;
- ❑ Work in collaboration with district programs to insure consumer and family member empowerment and involvement with respect to program planning, service delivery, and treatment;
- ❑ Work in collaboration with the District Planning, Research and Evaluation Unit to evaluate the effectiveness of advocacy initiatives;
- ❑ Provide support to District Trust Consumer and Family Advisory Councils for advocacy activities;
- ❑ Mobilize consumers, family members, and mental health professionals to work in partnership reduce stigma and discrimination because of mental illness;
- ❑ Work with the District Trust to develop a complaint process including a fair and equitable means of resolving conflicts for consumers and their families;
- ❑ Through the use of tele-psychiatry, a dedicated web site and a toll free information line, provide valid, up-to-date information to the community about such things as:
 - early warning signs of mental disorders,
 - what to do and where to go in a mental health emergency,
 - best practices in such things as treatment, capacity building, community development, and evaluation, to name a few,
 - consumer rights and responsibilities,
 - services and supports available to consumers and their families,
 - how to navigate the mental health system,
 - mental health legislation,
 - self-help initiatives,

- links to other web sites relevant to mental health services in Ontario (such as the Ontario's Drug and Alcohol Registry of Treatment or other provincial mental health services registries),
 - information on important mental health system initiatives, locally, provincially, and internationally;
- Undertake performance monitoring and accountability activities in accordance with District policies;
- Participate in research designed to evaluate the outcomes of mental health promotion and prevention;

Priorities for action

It is recommended that priorities for action should include the following:

- **Promotion:**
 - Using community action principles, advocate for greater equity for mental health consumers with respect to housing, health, and social welfare benefits.
- **Primary Prevention:**
 - Develop partnerships with public health and community health care centres in support of broader health initiatives promoting healthy family and school environments.
- **Secondary Prevention:**
 - Advocate for youth mental health, specifically best practices in the early identification and treatment of youth with emotional and psychiatric problems, and policy changes necessary to smooth the transition between children and adult systems.
 - Provide training and support to agencies, programs, and professionals so that they can come to see mental health promotion and prevention activities as integral to their own work

□ **Tertiary Prevention:**

- Actively undertake programs designed to reduce stigma and discrimination.
- Improve community awareness of mental health system functioning and services.

Chapter 4

Estimated Budget

The following protected annualized budget is offered on the assumption that a more detailed operational budget would be required if the recommendations in this report are accepted. It is based on a number of assumptions:

- Resources for tele-psychiatry support for cross-training initiatives would be factored into the tele-psychiatry operating budget and that any expansion of the tele-psychiatry program to other sites would enhance district-wide health promotion and prevention efforts.
- Resources necessary to fund network administration would be factored into the governance costs and reflected in that operating budget,
- Resources necessary to fund accountability monitoring, information management, and analyses would be factored into the accountability costs and reflected in that budget.
- A detailed budget based on a clearly delineated operational plan would be required should the recommendations in this report be acceptable to the Task Force and the Ministry of Health and Long Term Care.
- Staffing costs have been estimated using university scales. In order to account for discrepancies may exist between across agencies with respect to salaries and benefits so salary ranges (minimum and maximum) are provided.

Table 1: Estimated Protected Annualized Budget – Partnership Program

Budget Item	Description	Estimated Cost
Program Coordinator	Masters trained in a field relevant to health promotion and prevention	\$50,000-65,000
Community Health Promotion Worker	Masters trained in a field relevant to health promotion and prevention to undertake program activities and provide professional support for the 1-800 line	\$49,000-62,000
Administrative Support	1 FTE to provide support to all aspects of the program and maintain the web site and the 1-800 line.	\$30,000-38,000
Computer Support	Computer programming services to develop and maintain the WEB site. Estimated at 0.5 FTE Technician salary.	\$17,000-21,000
Honoraria	Honoraria for consumers and family members who undertake advocacy activities on behalf of the program (such as community consultations, public speaking, training initiatives, etc.) Estimated to be equivalent to 1.0 FTE Community Health Promotion Worker.	\$49,000-62,000
Operating Budget	To include outreach travel, the costs of the 1-800 line, the costs of the Web Site, production of health promotion materials, professional development and training costs.	\$100,000
Total (maximum)		\$348,000

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References consulted in writing this report

Badura B. (1991) Health Promotion for Chronically Ill People. In Badura B, Kickbusch I. (Eds.) Health Promotion Research: Towards a New Social Epidemiology. (pp. 365-392) World Health Organization Regional Publications, European Series No. 37.

Bodenheimer TS, Grumbach K. (1995) Understanding Health Policy. Norwalk, Connecticut: Appleton & Lange.

Bracht N (Ed.) (1990) Health Promotion at the Community Level. Newbury Park: Sage Publications.

Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K, Campion J, Mathisen J, Gagnon C, Bergman M, Goldstein H, Kubiak MA. (2001) Three Strategies for Changing Attributions About Severe Mental Illness. Schizophrenia Bulletin, 27(2): 187-195.

Dalgard OS, Sørensen T, Bjørk S. (1991) Community Psychiatry and Health Promotion Research. In Badura B, Kickbusch I.. (Eds.) Health Promotion Research: Towards a New Social Epidemiology. (pp. 421-439) World Health Organization Regional Publications, European Series No. 37.

Green LW, and Raeburn J. (1990) Contemporary Developments in Health Promotion: Definitions and Challenges. In Bracht N (Ed.) Health Promotion at the Community Level. (pp. 29-44) Newbury Park: Sage Publications.

Health and Welfare Canada (1988) Mental Health for Canadians: Striking a Balance. Ottawa: Ministry of Supply and Services.

Leavey J, Goering P, Macfarlane D, Bradley S, Cochrane J. (2000) *The Gap: Moving Toward Youth-centred Mental Health Care for Transitional Aged Youth (16-24)*. Toronto: Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

Mazza G, Sabo R. (2001) *Continuing to Meet the Challenge: Facilitating Recovery*. Ontario Medical Association: The Coalition of Ontario Psychiatrists.

McCulloch G, and Boxer J. (1997) *Mental Health Promotion: Policy, Practice, & Partnerships*. Toronto: Baillière Tindall.

McGorry P. (2001) Secondary Prevention of Mental Disorders. In Thornicroft G, and Szmukler G. (Eds.) *Textbook of Community Psychiatry*. (pp. 495-508) Oxford: Oxford University Press.

Sartorius N. (2001) Primary Prevention of Mental Disorders. In Thornicroft G, and Szmukler G. (Eds.) *Textbook of Community Psychiatry*. (pp. 487-494) Oxford: Oxford University Press.

Tsalikis G. (1993) Ontario's Health Strategy of 'Muddling Through' to the Millenium. *Health and Canadian Society*, 1(2): 395-413.

Wagenfeld MO, Lemkau PV, Justifce B. (1982) *Public Mental Health: Perspectives and Prospects*. Beverly Hills: Sage Publications.

Warner R. (2001) Community Attitudes Towards Mental Disorder. In Thornicroft G, and Szmukler G. (Eds.) *Textbook of Community Psychiatry*. (pp. 453-464) Oxford: Oxford University Press.

Wolf G. (1997) Attitudes of the Media and The Public. In Leff J. (Ed.) *Care in the Community: Illusion or Realty?* (p. 144-163) Toronto: John Wiley and Sons.



A Framework for District-level Governance For Mental Health System Delivery

**Prepared by the Research Committee of the
Southeastern Ontario District Mental Health Implementation Task Force**

SOUTHEASTERN ONTARIO MENTAL HEALTH IMPLEMENTATION TASK
FORCE

A Framework for District-level Governance for Mental Health System Delivery

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On behalf of:
The Research Committee

February 2002

Prepared By:

Heather Stuart, PhD
Queen's University
Kingston, Ontario

MEMBERS OF THE RESEARCH COMMITTEE

The following members respectfully submit this report to the Southeastern Ontario Mental Health Implementation Task Force:

Dr. Charles Gardner, Chair, General Public Champion

Carol Wannamaker, Vice-Chair, Seriously Mentally Ill Champion

Dr. Nick Delva, Forensic Champion
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Nancy Sears, Senior Champion
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Sandra Lawn, Chair, Southeastern Ontario District Mental Health Implementation Task Force (ex-officio)

Jane Banbury, Coordinator, Southeastern Ontario District Mental Health Implementation Task Force (ex-officio)

Dr. Heather Stuart, Research Coordinator, Mental Health Implementation Task Force (resource)

Maryanne Takala, Southeastern Ontario District Mental Health Implementation Task Force (resource)

Gail Lock, Southeastern Ontario District Mental Health Implementation Task Force (resource)

Executive Summary

The Southeastern Ontario Mental Health Implementation Task force has benefited from broad representation from district level mental health care providers, community leaders, consumers, family members, and academic researchers. Through its activities, important planning alliances have been built and district mental health providers have come to view smooth system functioning and accountability as district-level responsibilities. The Southeastern Ontario Mental Health Implementation Task Force now wishes to build on this emerging district culture as well as capitalize on existing service networks.

In recommending a governance structure our goals were to:

- ensure accountability to the Ministry of Health and Long Term Care for mental health system functioning at the district level,
- formalize structures to support consumer and family involvement in all aspects of service delivery including system level planning, program monitoring and evaluation, research, and community mental health promotion,
- respect local cultures and informal working relationships, but build on these to formalize existing alliances and create new working partnerships with clearly articulated goals and objectives, and
- support agency autonomy and diversity, but harmonize activities through service networks to provide integrated system functioning at the district level.

This report describes our preferred structure for district-level governance—a Mental Health Trust. This report does not provide a detailed operational plan for the implementation of a Trust, however, if approved in principle, this would be the next step.

For the Trust to work effectively, the Ministry of Health and Long Term Care would have to delegate authority and responsibility to the Trust for providing oversight and district-level management of the mental health system according to the principles and outcomes identified in *Making it Happen*. We suggest that the Trust not directly control the district funding envelope but advise the Ministry on funding issues.

The Trust offers our district a mid-range solution between the status quo (which is unacceptable) and our understanding of a fully fledged regional authority. Based on a networking philosophy, the Trust would maximize the benefits of district-level coordination

by creating opportunities for shared care networks, while respecting agency autonomy by maintaining existing agency Boards and structures. Because it would harmonize agency activities, rather than change existing agency structures, it could be more easily implemented. While the Trust would advise the Ministry on resource issues, separation of resource allocation from the Trust's activities would foster clearer strategic thinking and system planning. As a result, the Trust would be a strong step forward toward mental health reform in the Southeastern Ontario district.

Toward this end, The Southeastern Ontario Mental Health Implementation Task Force recommends that:

1. The Ministry of Health and Long Term Care create a Southeastern Ontario District Mental Health Trust to be accountable to the Ministry of Health and Long Term Care.
2. The geographic boundaries of the Trust be made co-terminus with county boundaries
3. The Ministry of Health and Long Term Care clearly mandate local mental health agencies to be accountable to the Ministry through the Mental Health Trust.
4. The Trust create three Advisory Councils—a Consumer Advisory Council, a Family Advisory Council, and a Programs and Services Advisory Council.
5. The Trust create integrated service networks through explicit shared care agreements between agencies, to be clearly accountable to the Trust for the joint outcomes achieved.
6. Membership on the Southeastern Ontario District Mental Health Trust be defined by the Ministry of Health and Long Term Care but be kept small, workable, and strike balance between the differing perspectives offered by the:
 - The Ministry of Health and Long Term Care,
 - Consumer Advisory Council,
 - Family Advisory Council,
 - Programs and Services Council,
 - Southeastern Ontario District Health Council,
 - Academic Health Sciences Centre of Queen's University, and
 - the general public.

7. The Trust designate a Planning, Research & Evaluation Unit to provide necessary infrastructure support and that this unit have a formal affiliation with the Academic Health Sciences Centre of Queen's University.
8. The Ministry of Health and Long Term Care accept responsibility as the lead Ministry for purposes of coordinating inter-ministerial initiatives required to improve integration of services across sectors (such as housing, education, social services, justice, or corrections) and actively advocate for the needs of mental health consumers and the mental health system in these areas.

District-level Governance For Mental Health System Delivery

Introduction & purpose:

A key aspect of mental health system reform has been the creation of district-level task forces. Appointed by the Minister of Health and Long Term Care, task forces have developed an implementation strategy for mental health reform in their respective districts.

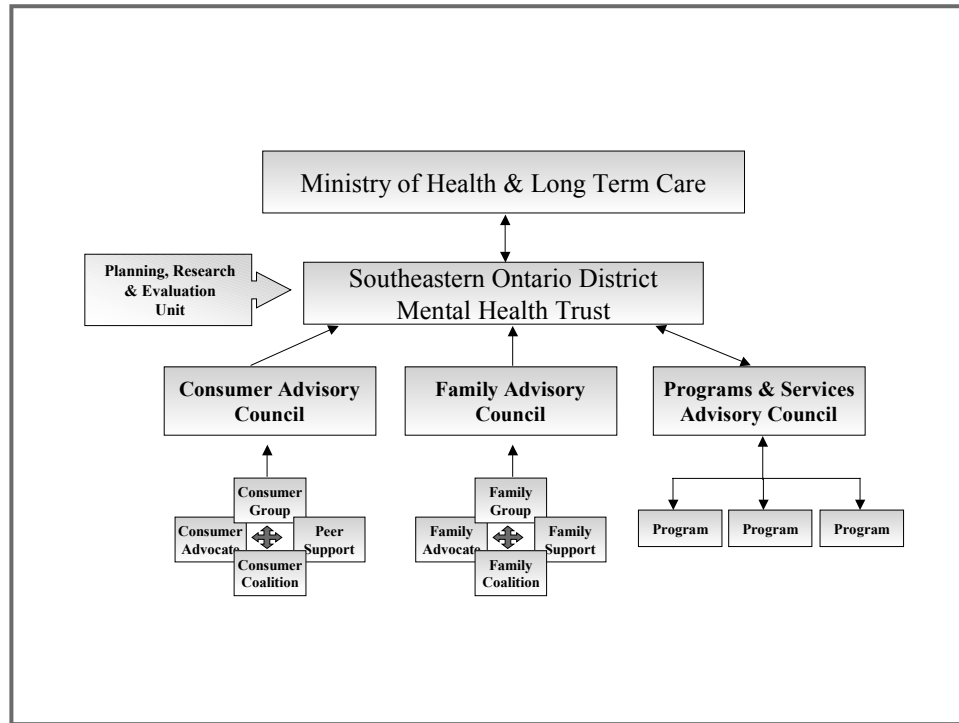
The Southeastern Ontario Mental Health Implementation Task force has benefited from broad representation from district level mental health care providers, community leaders, consumers, family members, and academic researchers. Through its activities, important planning alliances have been built and district mental health providers have come to view smooth system functioning and accountability as a district-level responsibilities.

The Southeastern Ontario Mental Health Implementation Task Force now wishes to build on these interactions to create a governance structure responsible for district-level oversight, system integration, service delivery and accountability. In recommending a governance structure Task Force members wish to:

- ensure accountability to the Ministry of Health and Long Term Care for mental health system functioning at the district level;
- formalize structures that support consumer and family involvement in all aspects of service delivery including system level planning, program monitoring and evaluation, research, and community mental health promotion;
- respect local traditions and informal working relationships, but build on these to formalize existing alliances and create new working partnerships with clearly articulated goals and objectives; and
- support agency autonomy and diversity, but harmonize activities to provide integrated system functioning at the district level.

Proposed governance structure:

Toward this end, we propose that the Ministry of Health and Long Term Care create a Southeastern Ontario District **Mental Health Trust** to be accountable to the Ministry of Health and Long Term Care for district-level mental health system functioning. As outlined in the figure below, it is further proposed that the Trust will work with three Advisory Councils and a Planning, Research & Evaluation Unit to create a more responsive, consumer-friendly, system of mental health services in Southeastern Ontario.



Roles and Responsibilities:

The Ministry of Health and Long Term Care:

The Ministry of Health and Long Term Care will:

- delegate responsibility to the Southeastern Ontario District Trust to oversee and be accountable for mental health system delivery in the Southeastern Ontario mental health planning region;
- clearly mandate local mental health agencies to be accountable to the Ministry through the Mental Health Trust;

- function as the lead Ministry for purposes of inter-ministerial issues, particularly in areas of children and youth, forensic populations, and addictions;
- coordinate inter-ministerial initiatives required to improve integration of service delivery across ministries, and actively advocate for the needs of mental health consumers and the mental health system;
- maintain transparency in funding decisions and with advice from the District Trust, fund district-level programs and support structures;
- monitor the performance of the Trust in meeting its district mandate;
- actively support capacity building for mental health services research and evaluation at the district level; and
- lead province-wide initiatives designed to educate the public about mental health reform.

The Southeastern Ontario Mental Health Trust:

The Trust will be responsible to the Ministry of Health and Long Term Care for all aspects of mental health system functioning in the Southeastern Ontario mental health district. With the support of an Executive Director and appropriate administrative staff the Trust will be responsible for:

- implementing mental health reform and system functioning in the Southeastern Ontario district;
- advancing inter-agency cooperation and service integration by creating district-wide programs and service networks based on formal inter-agency partnerships and service agreements, mandated to meet the needs and be held accountable for clearly defined population groups;
- advancing community mental health by developing district-wide mental health promotion, prevention, and advocacy initiatives built on partnerships between consumers, family members, and mental health professionals;
- setting strategic directions for system functioning;
- maintaining accountability for all aspects of system-functioning and service delivery within the district;
- conducting strategic, system-level planning;
- advising the Government, through the Ministry of Health and Long Term Care regarding all aspects of system functioning ranging from strategic planning to funding to service delivery in the District, including how new and existing funds may be reallocated to support system functioning activities;
- promoting greater visibility of the needs of those with a mental disorder;
- coordinate opportunities for skill development and training across district-level service networks and programs;

- foster excellence in service delivery by identifying and setting program and service standards and ensuring that mechanisms are in place to meet and monitor these;
- participating in regional and provincial initiatives;
- supporting the ongoing development and funding of the three Advisory Councils;
- fostering a culture of cooperation and excellence through participation in research, education, and inter-agency initiatives; and
- creating other relevant advisory mechanisms, as needed, to support smooth system functioning or decision-making.

In recognition of the complexity of mental health systems, and the requirement to effectively link together a variety of groups in order to best meet the needs of consumers, we recommend that membership on the Southeastern Ontario District Mental Health Trust be kept small and workable, and strike balance between different perspectives and types of expertise; that the Ministry of Health and Long Term Care define membership to include the following perspectives:

- The Ministry of Health and Long Term Care,
- Consumer Advisory Council,
- Family Advisory Council,
- Programs and Services Council,
- Southeastern Ontario District Health Council,
- Academic Health Sciences Centre, Queen's University, and
- the general public.

Planning, Research & Evaluation Unit:

The Planning, Research & Evaluation Unit will be composed of researchers, planners, and research support staff. It will provide administrative and evaluation support to the District Trust in order to promote greater system accountability. More specifically, the Planning and Evaluation Unit will:

- through a Director of Research, advise Trustees on all aspects of system accountability and research in the District;
- work collaboratively with District-level programs to develop a culture of self-assessment and performance monitoring and implement district accountability processes;
- develop and implement standards for data collection for performance monitoring and outcome assessment;
- oversee district data collection and the creation of linked performance monitoring data;

- function as custodian of district-level evaluation and performance monitoring data;
- plan and conduct research and evaluation studies designed to address specific mental health system or program outcome questions;
- analyze and interpret performance monitoring and evaluation data;
- build capacity for district-level mental health research and evaluation;
- develop and implement information brokerage models to synthesize and communicate the literature on best practices to key decision makers within the region;
- actively communicate with accountability partners regarding the results and outcomes of local accountability processes; and
- collaborate with other systems-based accountability units in multi-centred or provincial evaluation initiatives.

Members of the planning and evaluation unit should be individuals with research and planning experience. As much of the work will be in the analysis of large district-level datasets, epidemiologic and statistical expertise is necessary. In order to promote excellence in mental health systems research and evaluation, University-based researchers should play an active role in developing research methods and analytic strategies through joint appointments and formal arrangements with Queen's University.

Consumer Advisory Council:

The Consumer Advisory Council will be composed of existing consumer coalitions, consumer initiatives, peer-support and self-help groups for current and past mental health system users, and consumer advocacy groups such as patient/consumer councils. It will provide a system-level mechanism to bring forward the views of consumers and assist Trustees in maintaining a consumer-focussed system of mental health care as described in *Making it Happen*. More specifically, the Consumer Advisory Council will:

- through a Council Director (or delegate), actively participate in the District Trust;
- identify issues that consumers wish to have placed before the Trust for discussion or resolution;
- bring forward consumer perspectives on system functioning and priorities;
- communicate with consumer groups concerning Trust activities and decisions; and
- help strengthen the presence of consumers in all aspects of mental health system functioning.

Although budgets have not been provided outlining the costs of the proposed Governance structure, it is expected that key consumer positions within the Trust be paid positions so that consumers are appropriately reimbursed for their time.

Family Advisory Council:

The Family Advisory Council, composed of existing coalitions and peer-support groups for family members and family advocates of current and past mental health system users will represent the views of family members and assist the Trustees in maintaining a consumer-focussed system of mental health care as described in *Making it Happen*. More specifically, the Family Advisory Council will:

- through a Council Director (or delegate), actively participate in the District Trust,
- Identify issues that family members wish to have placed before the Trust for discussion or resolution;
- bring forward family perspectives on system functioning and priorities;
- communicate with family groups concerning Trust activities and decisions; and
- help strengthen the presence of families in all aspects of mental health system functioning.

Family members who occupy key positions with the Trust should be reimbursed for their time.

Programs and Services Advisory Council:

It is recommended that the basic building blocks of an integrated mental health system delivery are considered to be district programs. Each district program will be formed through explicit shared care agreements from a network of relevant programs and supports that are formally mandated to be responsible for delivering services to a particular client group and are accountable to the Southeastern Ontario District Mental Health Trust for the outcomes achieved. Each program will have a Director and a well-defined leadership structure. Directors of programs will form a Programs and Services Advisory Council with the following functions:

- through a Council Director (or delegate), actively participate in the District Trust,
- identify issues that Program Directors wish to have placed before the Trust for discussion or resolution, and
- bring forward provider perspectives on system functioning and priorities, and

- communicate with provider groups concerning Trust activities and decisions.

The Trust will define programs in diverse ways so that each has the best potential to maximize efficiency and effectiveness. In cases of highly specialized tertiary services, for example, a single district-wide program may be the most cost-effective approach. At the level of intensive or first line care, several service networks may be defined on the basis of smaller geographic catchment areas and span various components of the mental health and addictions service sectors. Where training or evaluation are concerned, network participation may be much broader, involving agencies and providers outside of the district (such as the Centre for Addictions and Mental Health in Toronto) who have a provincial mandate. In all cases, programs will be defined by the District Mental Health Trust based on a formal proposal with:

- clearly defined terms of reference and appointment;
- clearly defined goals;
- measurable objectives;
- a geographically defined target population;
- services based on best practices;
- formal inter-agency agreements or service contracts; and
- a performance monitoring plan that is consistent with District-level requirements for data sharing and accountability.

Agencies with multi-level services may be members of several different district programs or networks, provided they have clearly articulated contributions and measurable outcomes.

When creating district-level programs and networks in accordance with the Implementation Plan of the Southeastern Ontario District Mental Health Implementation Task Force, the Trust will give careful consideration to matching services to individual needs, eliminating system-level gaps, and providing adequate coverage for rural outlying areas.

Programs Directors:

Appointed by the Trust, program directors will provide program leadership and will be held accountable for:

- ensuring the integration of services and supports across the District within their respective programs to ensure that the needs of consumers and their families for coordinated care are met;
- ensuring the collection of standardized data for performance monitoring,

- ensuring the regular evaluation of program outcomes and the use of these to improve service delivery and system functioning;
- participating in mental health evaluation and research to ensure that services are based on best practices;
- actively communicating the results of accountability processes to the Trust, consumers, and network partners;
- creating and supporting a culture of cooperation across programs and services; and
- fostering excellence through active participation in education, research, and clinical training initiatives.

Mental health and addictions service providers in the Southeastern Ontario Mental Health planning district have already developed considerable experience in creating viable service delivery, data sharing, educational, and research networks and coalitions. The development of district-wide programs builds on this expertise, but formalizes these structures to provide clear accountability and service delivery expectations.

Catchment area for programs:

The Southeastern Ontario Mental Health Implementation Task Force has been responsible for the counties of Lennox, Addington, Hastings, Prince Edward, Frontenac, Leeds, Grenville, and **South** Lanark. North Lanark has participated in the Champlain District Mental Health Implementation Task Force, effectively splitting the county for mental health planning purposes. This has posed a number of logistical problems, not only for collection of planning data (which is typically available on a county-basis) but for key mental health program personnel who have had to double their planning burden.

Recommendations:

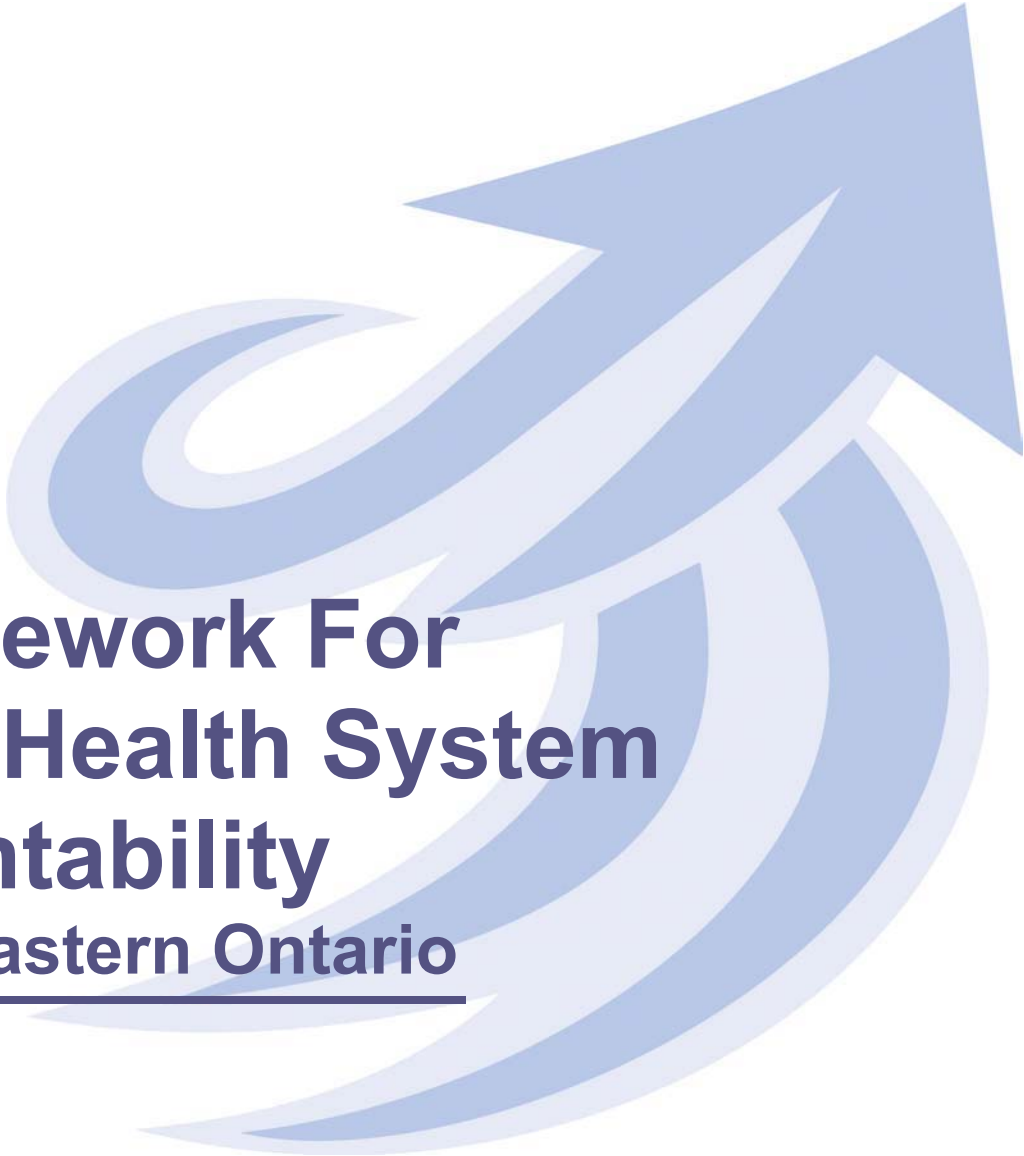
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Bibliography

Durbin J, Rogers J, Macrarlane D, Baranek P, Goering P. (2001) Strategies for Mental Health System Integration: A Review. Ontario Ministry of Health and Long Term Care.



A Framework For Mental Health System Accountability in Southeastern Ontario

**Prepared by the Research Committee of the
Southeastern Ontario District Mental Health Implementation Task Force**

SOUTHEASTERN ONTARIO MENTAL HEALTH IMPLEMENTATION TASK
FORCE

A Framework for Mental Health System Accountability

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On behalf of:
The Research Committee

December 2001

Prepared By:

Heather Stuart, PhD
Queen's University
Kingston, Ontario

MEMBERS OF THE RESEARCH COMMITTEE

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Dr. Heather Stuart, Research Coordinator, Mental Health Implementation Task Force (resource)

Maryanne Takala, Southeastern Ontario District Mental Health Implementation Task Force (resource)

Gail Lock, Southeastern Ontario District Mental Health Implementation Task Force (resource)

Executive Summary

This report recommends an accountability framework for the Southeastern Ontario mental health planning district. The focus of this report is on accountability for mental health *system* functioning, rather than on accountability for individuals working within the system. System functioning refers to the extent to which agencies work together through formal partnerships to provide integrated care that meets the needs of consumers and their families. The goal of the accountability framework is to provide a district-level mechanism to monitor and improve consumer focus, fortify inter-agency linkages for shared care, support system functioning, and improve the quality of care.

No attempt has been made to flesh out the myriad of operational details that would need to be considered for such a framework to be implemented, including such things as the cost, funding options, or the extent to which existing structures and resources could be redirected or mandated toward these ends. Rather, our focus is on presenting an idea for a framework recognizing that, if approved, a detailed operational plan would be the next logical step in its development.

It should also be noted that this document distinguishes accountability from governance (with governance issues being addressed separately). This is based on the conviction that district-level accountability must occur regardless of whatever governance structure is in place. Within this context, accountability is understood as the force that binds us to answer for moral and legal obligations: to consumers and their families; to other agencies within the continuum of care; and to our funders.

In order to promote greater accountability for mental health system functioning in Southeastern Ontario, the Research Committee of the Southeastern Ontario Mental Health Implementation Task Force recommends that:

- 1.0 The planning and evaluation research unit proposed in the Governance document be commissioned to develop a district-wide accountability process designed to:
 - create an operational plan (including an budget) for the collection of standardized, linked performance monitoring data;
 - harmonize data demands across different agencies;
 - develop and implement information brokerage models to synthesize and communicate the literature on best practices to key participants within the district;
 - actively communicate with accountability partners regarding the results and outcomes of local accountability processes; and
 - collaborate with other systems-based accountability units in multi-centred or provincial evaluation initiatives.
- 2.0 Wherever appropriate, infrastructure funding be provided to agencies to support the costs of standardized data collection, to support staff orientation and training, and to offset the costs of harmonizing data and computer requirements across agencies.

Wherever possible, standardized data collection should build on existing systems and structures.

- 3.0 A formal relationship between Queen's University Academic Health Sciences Centre and the local planning and research evaluation unit be developed to supersede any direct relationships that may exist with individual Queen's researchers. This will better coordinate scarce expertise and build research capacity needed to:
- support appropriate analysis and interpretation of accountability data,
 - foster local mental health system research and the dissemination of results,
 - create local research capacity and promote external critical appraisal of system functioning.
- 4.0 Program-specific data dealing with service volumes, workload measurements, and clinical outcomes be standardized to support the collection and analysis of district-wide system indicators to assess performance, but that every effort be made to minimize data collection burden on front line staff by implementing a **minimum** dataset.
- 5.0 With strong consumer involvement, performance indicators be developed to monitor district-wide system functioning for outcomes such as:
- consumer focus,
 - consumer autonomy (and use of least restrictive alternatives),
 - integrated and coordinated care,
 - accessibility,
 - equity in matching services to needs,
 - safety,
 - effectiveness in achieving system outcomes, and
 - efficiency or value for money.

A Framework for Mental Health System Accountability

A key feature of Ontario's mental health reform is the need to improve accountability for system functioning. *Making it Happen*, the Government's operational framework for the delivery of mental health services and supports, recommends that local accountability structures be created to monitor system functioning and insure that reform goals are met.

This report follows from a separate governance report to recommend an accountability structure for the Southeastern Ontario mental health planning district. The focus of this report is on accountability for mental health *system* functioning. System functioning refers to the extent to which organizations work in concert to provide integrated care that meets the needs of consumers and their families. By mental health system, we mean the formal mental health system that is composed of agencies specifically funded to provide first line, intensive, or specialty mental health services. However, we recognize that considerable mental health care is provided outside of the formal mental health system and identify networking strategies that should be used to ensure coordination of services across health and social service sectors.

This document distinguishes accountability relationships for purposes of collecting, analyzing, and reporting performance data, from the manner in which the mental health system will be governed. This is based on the conviction that accountability is a continuous process of self-monitoring and self-assessment. It involves making judgments about system functioning and a process for making improvements. As, continuous quality improvement must be a central goal of any and all governance models, accountability must be considered separately from governance. Therefore, this report addresses issues of accountability and governance issues are addressed in a separate report.

The current context of accountability

Restructuring of health care systems is underway in most jurisdictions in Canada. The trend has been to decentralize authority and transfer responsibilities from provincial governments to local governing bodies. This is intended to make services more responsive to local needs, improve coordination of care and increase efficiency.

Against this broader backdrop, the mental health community has experienced a number of trends which have culminated in the current emphasis on public accountability for the provision of adequate community mental health care:

- erosion of base budgets for mental health services and geographic inequities in access to care,
- inadequate community services and supports for those with serious or persistent mental illnesses,
- growing complexity and fragmentation of mental health and addictions services,
- increasing marginalization of mental health care and care providers from main stream health systems and health system trends, particularly the marginalization of mental health clients from current shifts toward primary care and health promotion/prevention,
- increasing visibility of social problems such as substance abuse, homelessness, criminalization of the mentally ill, and community violence, and
- renewed emphasis on downsizing and deinstitutionalization of remaining psychiatric hospitals.

At the same time, and in part prompted by these forces, there has been an exponential growth in epidemiologic information about the frequency and distribution of mental disorders and psychiatric disabilities. For example, although definitions vary, it has been estimated that 2-3% of Canadians (over 700,000 people) have a serious or persistent mental illness that causes significant suffering and results in socio-economic disability. Using this estimate, almost 300,000 Ontarians (approximately one in every 35), and 10,000-15,000 residents of the Southeastern Ontario Mental Health district may have a mental illness that is associated with serious socio-economic disability. An additional 9% will have a mental illness that is associated with moderate disability, and an additional ten percent will suffer from a mental illness that is associated with mild or intermittent disability. These figures are daunting.

Awareness of the pervasiveness of mental health and behavioural disorders has increased at a time when health and social service budgets are under stress. This has prompted a re-evaluation of value-for-money measures across a wide range of mental health interventions, and a call for greater system accountability. It is within this broad context that Ontario is proceeding with mental health reform and in which Ministry-appointed Mental Health Implementation Task Forces must make recommendations for system-wide accountability frameworks.

What the literature says about accountability

In 1997, the Corporate Policy Branch of the Government of Ontario issued an Accountability Directive for all public servants. In it, accountability was defined as “the obligation to answer for results and the manner in which responsibilities are discharged”. Responsibility was defined as the “obligation to assume a role or take a specific action(s)”. Authority was defined as the “legitimate power to make decisions or take action”.

This report noted that multiple accountability relationships were possible, but it did not provide direction on how the resulting systems of accountability could be operationalized. Nevertheless, it noted that accountability could be encompassed in traditional hierarchical relationships within ministries; through horizontal, cross-ministry relationships stemming from integrated operations or shared administrative services, or relationships with components in the broader public or private sectors. At the core of all accountability relationships is a contract, formed through legislation, obligations within an organizational hierarchy, negotiated agreements, service contracts, or any combination of these.

The research and policy literature dealing with accountability structures in health and mental health care is sparse and of variable quality. Operational examples of local-level accountability structures are lacking. Throughout the last decade, the trend has been to decentralize responsibility by creating regional health (and even mental health) authorities. While they seem to offer a single point of accountability, there is yet no evidence that regional authorities improve health outcomes and some would argue that regional authorities increase bureaucracy and cost. A mental health authority may reinforce social stigma and marginalization by segregating mental health from mainstream health functions. However, these and other important issues cannot be resolved with reference to the literature so must await future evaluation. Therefore, our approach is to suggest a model that is feasible to implement with a minimum of disruption, acceptable to local stakeholders, and builds on existing structures and cultures.

In 1999, a comprehensive literature review on accountability practices in the Canadian health care system was conducted by the Queen’s Health Policy Unit. After an extensive search of multiple databases, they identified only 14 published works that were relevant to the Canadian context out of a total of 109 unique citations. While these publications gave some direction with respect to theoretical concepts, the authors could not develop a literature-based consensus for an accountability framework for the Canadian health care system. Provincial accountability practices were also reviewed, only to reveal a bewildering array of approaches, mechanisms, and tools, with no information on their relative effectiveness (Macdonald & Shortt, 1999). An Internet search of international government sites conducted for this report was similarly disappointing. Nothing substantive was identified in the World Health Organization or in the US Surgeon General’s web sites. Many countries with publicly funded health systems, such as Australia or Canada, had information on financial accountability only. Scandinavian websites were not presented in English, so were inaccessible.

In January 2001, the Federal/Provincial/Territorial Advisory Network on Mental Health released a document entitled “Accountability and Performance Indicators for Mental Health

Services and Supports” (McEwan and Goldner, 2001). This was the only document found relating to accountability processes and performance indicators for mental health in Canada. It outlines the components of an accountability model and provides examples of performance indicators that could be used in mental health. It emphasizes the importance of tracking indicators relating to acceptability, accessibility, appropriateness, competence, continuity effectiveness, efficiency, and safety, to develop a culture of self-assessment and continuous quality improvement. We have relied heavily on this document in constructing our accountability framework.

How we understand accountability

Simply stated, we understand accountability as the force that binds us to answer for moral and legal obligations. In the context of mental health service delivery, this would include answering for (a) responsibilities conferred by the Ministry of Health & Long Term Care (or other funder), (b) legal and ethical codes of conduct embodied in professional practice standards and best practices; and (c) formal agreements and partnerships between mental health agencies. Our understanding of accountability supports a system that incorporates multiple points of accountability.

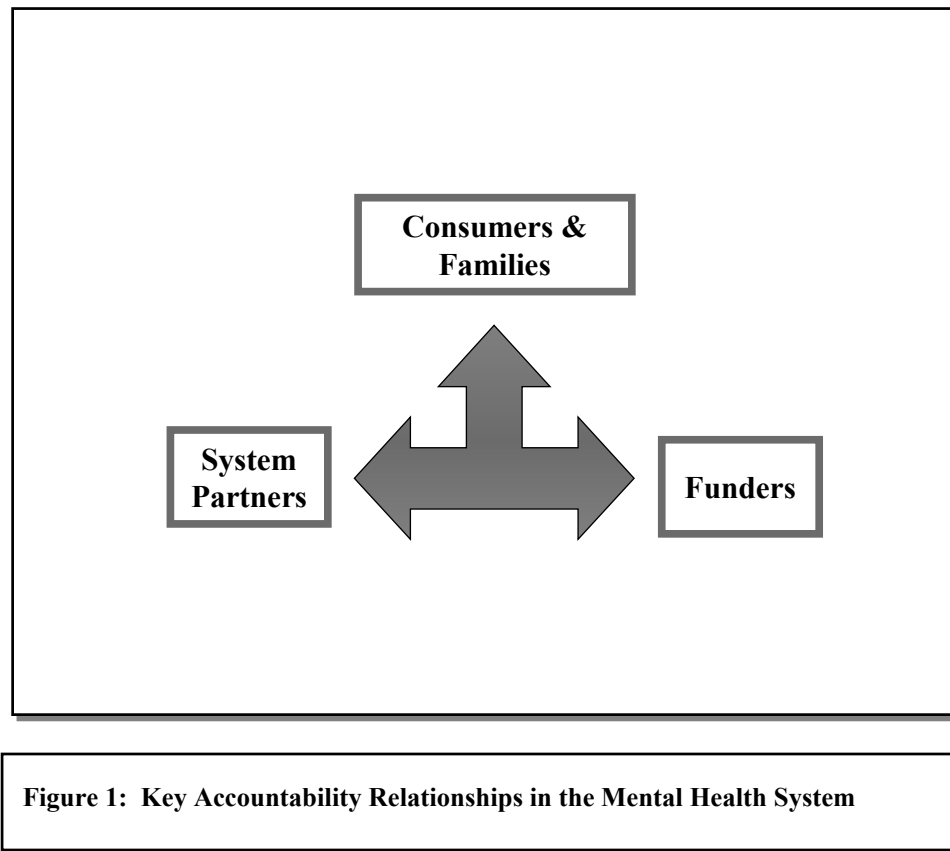
To whom are we accountable?

Accountability occurs within the context of relationships. Traditional views of accountability have emphasized hierarchical relationships within organizations (usually at the level of employer and employee), or relationships between agencies and their funders. These models are insufficient to deal with the complex relationships that will be required in the reformed mental health system. To be applicable to mental health, traditional notions of accountability must be broadened to include a wider array of stakeholders. More specifically, in order to provide seamless, wrap-around care that is consumer focused, the mental health system will need an accountability framework that builds on multiple accountability relationships. First and foremost among these are mental health consumers and their families. In order to become consumer-focussed, the mental health system must become accountable to those who will most directly be impacted by their services. Secondly, if local agencies are going to operate as interdependent parts of an integrated continuum of care, they must be accountable within networks to their network partners. Finally, local mental health systems must become accountable, as systems, not as isolated agencies, to their primary funders. The tripartite nature of our view of mental health accountability is depicted in **Figure 1**.

It reflects the three main target audiences for accountability reporting as:

- consumers;
- system partners, defined as networks of agencies composed of major service players (both mental health or other service providers) having well-defined leadership structures and formal partnership agreements, accept responsibility for providing comprehensive and integrated services to a defined target population;
- funders, usually the Ministry of Health and Long Term Care, but in some cases, multiple funding relationships may exist. In the proposed governance structure, the

Mental Health Trust would be delegated with this responsibility and accountability would be reported to funders through this structure. This would ensure appropriate consumer and family involvement as these groups would be represented on the Trust.



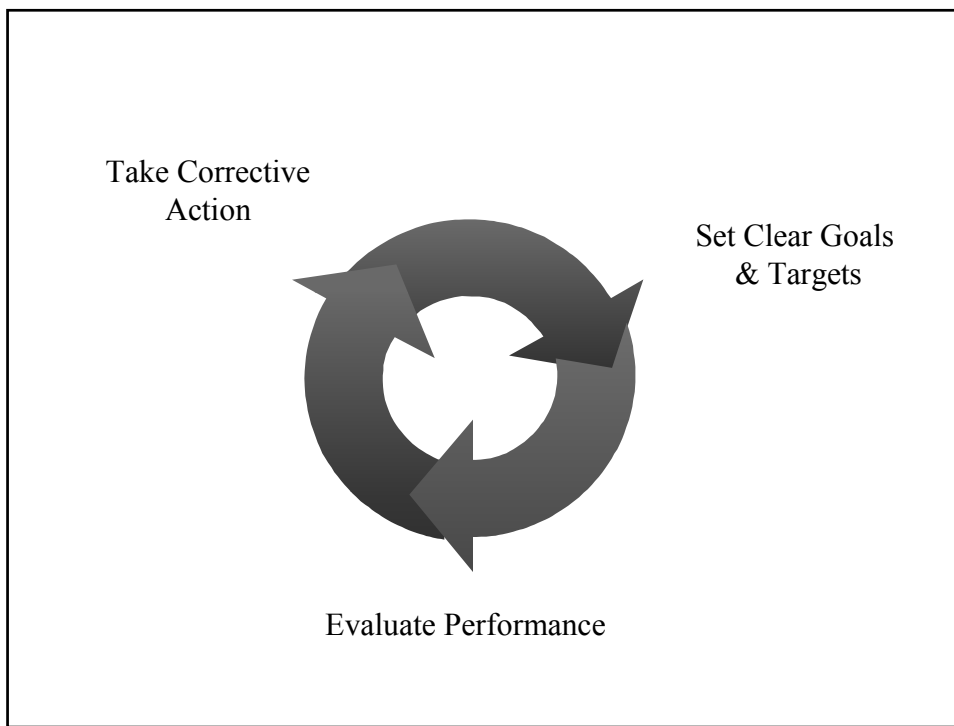
What process will be used to achieve accountability?

Figure 2 shows the key components of an accountability process as it is widely depicted throughout the literature. In order to be accountable, clear goals and targets are first required. In order to achieve system accountability across a continuum of care, this means that networks of agencies must have clearly defined responsibilities toward a specific service population and be able to specify the outcomes to be achieved. Then they must work together jointly, within shared care models, to achieve these ends. In the past, individual agencies were funded to provide certain services and they reported to Government separately concerning their activities and service volumes. They were seldom held accountable for their contribution to system integration. In the future, agencies must specify not only the volumes of services they provide, but the impact these have for consumers and their families in terms of an integrated continuum of care.

Once targets are known, performance can be assessed through routine performance monitoring, annual reporting of key indicators, periodic quality audits, and program evaluations. More complex questions may require research, ideally in cooperation with university-based researchers.

Finally, an accountability process requires a way to use performance data constructively, to improve service delivery and take corrective action. Therefore, a culture of self-assessment and continuous quality improvement must be fostered. Effective performance monitoring cannot occur if performance data are used punitively, or if financial incentives or disincentives are tied directly to the outcomes obtained. If financial disincentives are used to create winners and losers, data quality and integrity will suffer and agencies may feel pressure to show their results in the best light.

Figure 2: Essential Components of an Accountability Process



Active reporting of performance is another important feature of an effective accountability process. The results of the accountability process, particularly the corrective actions that are taken to improve service delivery, must be communicated with key stakeholders. In other words, agencies must answer to their consumers, family members, agency partners, and government funders (ideally through Ministry of Health delegated district governance

structures) for the outcomes they obtain. When outcomes are less than expected, explicit plans for corrective action must be identified and communicated as well.

Finally, performance monitoring is an ongoing, iterative process. Each time corrections to the system are made, they must be evaluated to ensure that the expected improvements occur. Therefore, a continuous quality improvement cycle is at the core of an effective accountability process.

Several of these key changes that will occur are summarized in **Table 1**.

Table 1: Examples of Accountability Now and in the Future

Current System	Future System
Accountability is hierarchical between the agency and a funder.	There will be multiple points of accountability to consumers, funders, and the system.
Agencies collect and report utilization data, but not in any common standardized way.	Agencies collect and report common standardized utilization and outcome data.
Formal accountability processes are seldom used.	Performance monitoring and accountability processes will become a central part of quality care and system performance.
Agencies are not held accountable for their contribution to system integration.	Agencies will be held accountable for their contribution to system integration.
Agencies report their activities separately to the Ministry.	Agencies will report individual and network activities to the District Mental Health Trust.*
No district structure that is accountable to the Ministry for system functioning.	The District Mental Health Trust* will report mental health system performance to the Ministry.
* The District Mental Health Trust is proposed in the Governance document as the duly designated authority for mental health system functioning in the Southeastern Ontario Mental Health planning district.	

Some have worried that district reporting structures may create a buffer between agencies and government funders that could be used to avoid being held accountable. However, clear service agreements between agencies and funders that specify the need to participate in local networks, the measures that will be used to evaluate performance in this respect, as well as the mechanisms by which data will be collected and shared, can largely mitigate this problem. Clear specification of funding and other sanctions that will be used when accountability requirements are not met are essential.

What are we accountable for?

To be accountable, there must be clearly defined goals and targets. The goals of mental health reform are specified in *Making it Happen*. These include the extent to which the system:

- is consumer-focussed,
- provides coordinated care,
- fosters consumer autonomy (i.e. in least restrictive treatment environments),
- is accessible (providing services at the right time to the right people)
- provides an equitable distribution of resources (so matches services to needs similarly across socio-demographic, cultural, and geographic sub-groupings),
- is safe,
- is effective (by relying on best practices for care), and
- is efficient.

Table 2 provides examples of key performance indicators related to each of these broad domains. These are not meant to be exhaustive, but illustrative of indicators that can be collected at the level of the consumer, the program, and the system. Indeed, it is expected that agencies will continue to be responsible for monitoring their own effectiveness and efficiency. This will require them to collect much more data than is presented in Table 2 to assess their own inner workings and the performance of their staff.

Developing and implementing standardized measurement systems that could be used to monitor performance must remain a priority for mental health reform. In order to remain consumer-focussed and insure that an appropriate range of measures are adopted, consumer and family members must be actively involved in this process. Following the spirit of *Making it Happen* indicators that relate directly to consumer experiences with the care process ought to carry more weight than those that are more transparent and relate to system functioning. This will ensure that agencies and networks can be responsive to changing consumer needs.

Table 2: Potential System-Level Performance Indicators

<i>Recommended Accountability Domains</i>	<i>Examples of Potential Indicators</i>
<i>Consumer focussed</i>	Consumer satisfaction ratings on all aspects of service Per-capita resources for consumer initiatives Consumers participation in governance, accountability, program planning and treatment
<i>Integrated & coordinated care</i>	Continuity of care Provider and service linkage activities Involuntary commitment rate Emergency presentations Consumers with adequate & stable housing Criminal justice contacts Educational and vocational opportunities Cases lost to follow-up or missed appointments
<i>Fosters autonomy & promotes least restrictive alternatives</i>	Involuntary Hospitalization Rate Frequency of Community Treatment Orders Frequency of police conveyances to emergency rooms Patterns of service flow across levels of care Community integration
<i>Equitable in matching services to needs</i>	Geographic variation in treated prevalence Socio-cultural variation in treated prevalence Ratio of relative needs to treatment coverage Adequate coverage to meet population needs
<i>Accessible</i>	Perceived barriers to care Hours of service operation Duration of untreated symptoms Duration of waiting times
<i>Safety</i>	Error and/or complication rate Unusual incident rate Staff skills and competencies Overwork and workplace stress
<i>Effective in achieving outcomes</i>	Reduction in symptoms Improvement in functioning Improvement in quality of life Reductions in family burden Improvement in social and economic well-being Increased community awareness and knowledge Reduced stigma Staff training and expertise in best practices
<i>Efficiency or value for money</i>	Cost per treated case Cost per episode of care Cost per outcome of care Recruitment and retention of trained staff Staff satisfaction
<i>Note: Measures adapted from McEwan and Goldner (2001) and Southeastern Ontario District Integrated Mental Health Services System Design Logic Model</i>	

System requirements for district accountability:

Several things are necessary in order to promote accountability and performance monitoring at the system level:

- **District-level performance monitoring and reporting**

District-level performance monitoring and reporting will promote better system-level functioning and service integration; faster uptake of performance data and implementation of best practices; greater responsiveness to local conditions and needs; and promote management flexibility at the district-level. For all of these reasons, district-level accountability and performance monitoring is considered to be fundamental to effective system functioning and promotion of best practices.

In order to promote better system functioning, district-level mandates, structures, reporting processes, and sanctions must be established by the Ministry of Health and Long Term Care and resources sufficient to carry out these functions must be organized. District-based mental health systems, and the agencies that comprise these systems, cannot be held accountable for responsibilities they are neither mandated, nor funded to fulfill.

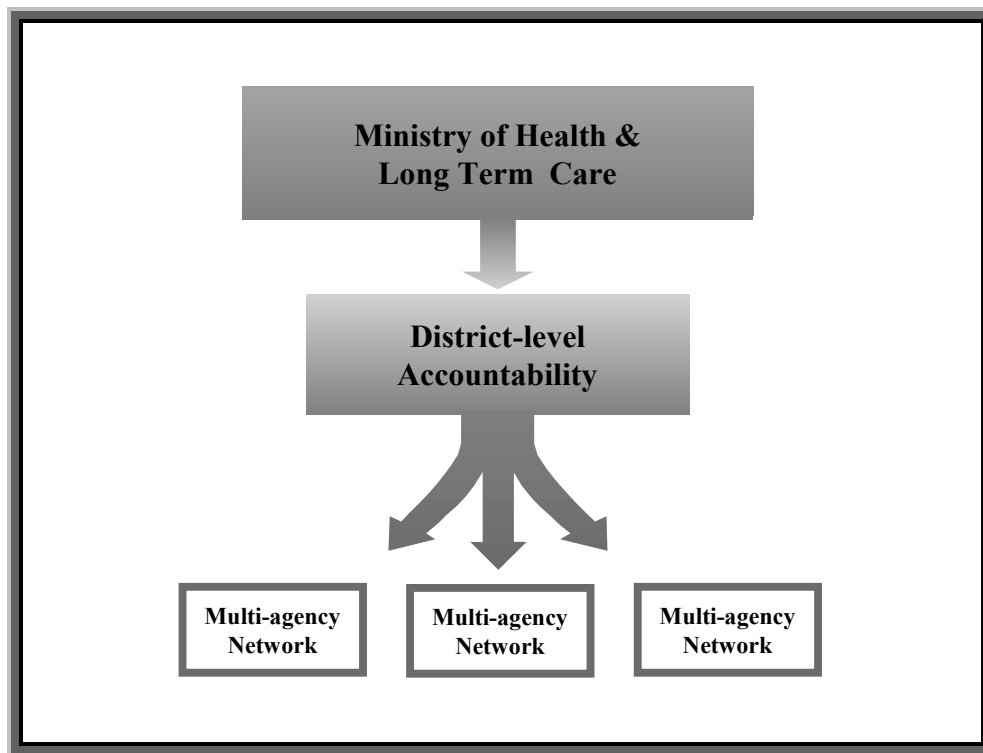
- **Multi-agency accountability:**

In a highly functional mental health system, services will be integrated and targeted to consumer needs. Priority populations identified in *Making it Happen* include persons with severe mental illness, forensic consumers, persons with concurrent substance abuse and mental disorders; seniors, children, and those dually diagnosed with developmental disabilities and mental disorders. In order to meet the complex needs of these groups, many agencies will have to work in concert. In turn, then, they must be held accountable for inter-agency coordination and programming.

The concept of multi-agency accountability for shared programming builds on network initiatives already underway in the Southeastern Ontario district (such as the Human Services Justice Coordination Project, the Geriatric Psychiatry Program, the Developmental Disabilities Program or the ARGUS database project) as well as the various integrative Champion Groups that have developed under the Mental Health Implementation Task Force.

The proposed decentralized, district-level accountability model is depicted in **Figure 3**.

Figure 3: Decentralized Accountability Model



- **Good quality linked data**

Good quality linked data will be a prerequisite for performance appraisal and program evaluation across networks of care. Efforts to create minimum datasets in mental health have been repeatedly stalled by differing treatment ideologies, a lack of structural supports such as qualified data entry personnel or computer technology, or overly-complex data collection methodologies that are too costly or infeasible to implement. A lack of equipment and technical support staff has been particularly problematic for under-funded community agencies. Therefore, the development and implementation of simple, easy-to-complete measures that address the indicators are necessary first steps for performance monitoring.

Data collection of this magnitude will have important implications for agency workloads. Much of the data will need to be collected at the level of the individual consumer, aggregated at the level of the program, then aggregated across programs in the district network. In order to link individual consumers across programs and protect their confidentiality, unique but anonymous identifiers (such as those used in the Comprehensive Assessment Projects) must be used.

- **Local research expertise**

Setting benchmarks and correctly interpreting outcomes is a complex task that may require considerable research expertise. Therefore, accountability processes are only strengthened if they routinely access methodological and statistical expertise of university-based researchers. Access to university-based researchers also improves local capacity to conduct mental health services research that is applicable to local conditions and responsive to local needs. We acknowledge that planning research is of mutual benefit to both university-based and community-based agencies—a benefit that will be fully realized only within the context of a strong partnership. A formal partnership with Queen’s University Academic Health Sciences Centre would facilitate regular access to relevant mental health research and evaluation expertise, and provide for arms-length appraisals of performance data and results.

- **Receptor capacity – uptake and use of results**

A key requirement for accountability is that results are used by participants to improve outcomes of care for consumers and system functioning. In the past, system-based research in mental health has been poorly funded relative to other areas. Consequently, research on best practices has been slow to develop, and slower to be incorporated into daily practice. A lack of internal technical experts knowledgeable about mental health that can function as knowledge brokers (evaluating the literature, synthesizing key findings and drawing implications for practice) is lacking. Yet this function is critical if results are to be used.

Recommendations:

In order to promote coordination of services at the district level and greater accountability for mental health system functioning the Research Committee of the Southeastern Ontario Mental Health Implementation Task Force recommends that:

- 1.0 The planning and evaluation research unit proposed in the Governance document be commissioned to develop a district-wide accountability process designed to:
 - create an operational plan (including an budget) for the collection of standardized, linked performance monitoring data;
 - harmonize data demands across different agencies;
 - develop and implement information brokerage models to synthesize and communicate the literature on best practices to key participants within the district;
 - actively communicate with accountability partners regarding the results and outcomes of local accountability processes; and
 - collaborate with other systems-based accountability units in multi-centred or provincial evaluation initiatives.

- 2.0 Wherever appropriate, infrastructure funding be provided to agencies to support the costs of standardized data collection, to support staff orientation and training, and to offset the costs of harmonizing data and computer requirements across agencies. Wherever possible, standardized data collection should build on existing systems and structures.
- 3.0 A formal relationship between Queen's University Academic Health Sciences Centre and the local planning and research evaluation unit be developed to supersede any direct relationships that may exist with individual Queen's researchers. This will better coordinate scarce expertise and build research capacity needed to:
- support appropriate analysis and interpretation of accountability data,
 - foster local mental health system research and the dissemination of results,
 - create local research capacity and promote external critical appraisal of system functioning.
- 4.0 Program-specific data dealing with service volumes, workload measurements, and clinical outcomes be standardized to support the collection and analysis of district-wide system indicators to assess performance, but that every effort be made to minimize data collection burden on front line staff by implementing a **minimum** dataset.
- 5.0 With strong consumer involvement, performance indicators be developed to monitor district-wide system functioning for outcomes such as:
- consumer focus,
 - consumer autonomy (and use of least restrictive alternatives),
 - integrated and coordinated care,
 - accessibility,
 - equity in matching services to needs,
 - safety,
 - effectiveness in achieving system outcomes, and
 - efficiency or value for money.

Reference material consulted to develop this report:

Alberta Health (1998). Achieving Accountability in Alberta's Health System. <http://www.health.gov.ab.ca/public/document/accnt98/index.htm>.

Alberta Health and Wellness (1999) Who is Accountable in Health: Roles and Responsibilities in Alberta's Health System. <http://www.health.gov.ab.ca>.

Arboleda-Flórez J (2001). The State of the Evidence. Stigmatization and Human Rights Violations. In, World Health Organization, Mental Health: A Call for Action by World Health Ministers. (p. 57-71) Geneva.

Auditor General of British Columbia (2001). A Review of Governance and Accountability in the Regionalization of Health Services. <http://www.oag.bc.ca/PUBS/1997-98/report-3/sec-1.htm>.

Champlain District Mental Health Implementation Task Force (2001). Foundations for Reform: A Mental Health System Design for the Champlain District. Draft report and presentation to the Research Committee December 2001.

Corporate Policy Branch (1997). Accountability Directive. Province of Ontario: Queen's Printer for Ontario.

Health Canada (2001). Best Practices in Mental Health Reform: Discussion Paper. http://www.hc-sc.gc.ca/hppb/mentalhealth/pubs/disc_paper/e_disc7.html.

Hirdes JP, Marhaba M, Smith TF, Clyburn L, Mitchell L, Lemick RA, Telegdi NC, Peres E, Prendergast P, Rabinowitz T, Yamauchi K. (2000/2001). Development of the Resident Assessment Instrument—Mental Health (RAI-MH). Hospital Quarterly, Winter, 44-51.

Macdonald JK and Shortt SED (1999). An Inventory and Analysis of Accountability Practices in the Canadian Health Care System. Queen's University: Queen's Health Policy.

Manitoba Health (1999). Achieving Accountability. <http://www.gov.mb.ca/health>

Marhaba, Mounir, Ontario Joint Policy and Program Planning Committee, The Resident Assessment Instrument, Presentation to the Research Committee, September 10, 2001.

McEwan K and Goldner EM (2001). Accountability and Performance Indicators for Mental Health Services and Supports. University of British Columbia: Mental Health Evaluation and Community Consultation Unit.

National Health Performance Committee of Australia (2001). National Health Performance Framework Report. Report to the Australian Health Minister's Conference. Queensland Health. [www/health.gov.au/publicat.htm](http://www.health.gov.au/publicat.htm).

New Brunswick Health and Community Services (2000). *Building on our Strengths: A Framework for Region Hospital Corporation Accountability*. (ISBN: 1-55236-661-8).

Ontario Ministry of Health and Long Term Care (1999). *Making it Happen: Implementation Plan for Mental Health Reform*. Queen's Printer for Ontario.

Ontario Ministry of Health and Long Term Care (1999). *Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports*. Queen's Printer for Ontario (ISBN 0-7778-8565-4).

Ontario Ministry of Health and Long Term Care (2001). *Proceedings of the Policy Forum on Mental Health System Integration*, October 17, 2001.

Southeastern Ontario District Health Council (1999). *Mental Health Services: A Foundation for System Planning*.

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Human Resources:

A Plan for a Reformed Mental Health System in Southeastern Ontario

**Prepared by the Human Resources Committee of the
Southeastern Ontario District Mental Health Implementation Task Force**

A PLAN FOR A REFORMED MENTAL HEALTH SYSTEM IN
SOUTHEASTERN ONTARIO FOR

Human Resources

Submitted To
The Southeastern Ontario Mental Health Implementation
Task Force

BY:
The Human Resources Committee

June 2002

Committee Membership

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Ms. Vicky Huehn	Vice Chairperson Seriously Mentally Ill Champion
Mr. Wayne Barnett	Forensic Champion
Mr. Gerry Gregory	Concurrent Champion
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Preface

This report represents the collection and discussion of information gained through a review of the literature and a forum with mental health educators and managers. Because of the submission date, the report was unable to fully appreciate or incorporate information from the Children and Youth Committee's forum or from the report and analysis of regional information obtained from the Comprehensive Community Assessment Project (CCAP). Further review of these resources is encouraged to determine a number of factors including present resource allocations.

In addition, there should be special attention paid to the report's inability to capture the reality of the aboriginal community.

The authorship of the paper belongs to the whole committee. The work related to each chapter was assigned to specific members of the committee as follows:

Chapter 4: Wayne Barnett, Terry Krupa

Chapter 5: Brenda Wattie

Chapter 6: Jane Howard

Chapter 7: Vicky Huehn

In the body of this report there are eleven main recommendations. In addressing these recommendations there needs to be sensitivity to the numerous recommendations that flowed naturally out of the eleven key points.



Introduction & Purpose

This report is submitted to the Mental Health Implementation Task Force on behalf of the Human Resources Committee.

This report outlines recommendations for human resources for Southeastern Ontario in a reformed mental health system. It incorporates the following basic components:

- achieve and maintain competency of providers;
- address the needs of children and youth in the reformed system,
- meet the education, training, and continuing professional development needs of providers; and
- recruit, retain and remunerate well-qualified providers.

Chapter 2

Human Resources Plan

This section of the report outlines recommendations for implementing a human resources plan for a reformed mental health system in Southeastern Ontario. The main goal is the development of a district approach to human resources including; core competencies, education and training, continuing professional development, and recruitment, retention, and remuneration of people employed in the mental health system and other related systems, thereby assisting the Task Force in the fulfillment of *Making It Happen*. It follows the Human Resource Committee's implementation strategies which are itemized separately.

The following recommendations are placed here in order of priority. They are repeated in the appropriate section of the report.

Recommendations

1) Remuneration - Recruit, Retain and Remunerate

There should be an immediate implementation of new funds to ensure parity in compensation across all transfer payment agencies funded by MOHLTC.

- To resolve inequities in compensation among mental health providers;
- To create a program for salary and benefit administration that ensures equity and external competitiveness for employees.

2) Children and Youth - Children and Youth

There should be a Ministry for Children and Youth with the power to oversee and co-ordinate all provincial services and programs for children and youth.

- To rectify the fragmentation and inequities of provincial systems serving children and youth.

3) Access to Clinical Resources - Achieve and Maintain Competency

There should be a variety of physician payment options including salary, alternate funding payment, fee for service, and adequate sessional monies

- To support provision of evidence-based mental health and psychiatric intervention at the primary, secondary and tertiary levels to all those across the lifespan in the region who require it.
- The Ministry of Health & Long-term Care and Ministry of Community and Social Services should provide more sessional money to mental health agencies to access the services of general practitioners and psychiatrists in community settings. These sessional fees are needed for travel to community settings and to obtain psychiatrists' and general practitioners' consultation on mental health services provided across the lifespan, including children and youth, adults, and the elderly. Their services are especially needed at the assessment and diagnosis stages.

4) Core Competencies - Achieve and Maintain Competency

The core competencies including the creation of a network of specialty population champions as recommended and outlined in the human resources committee report should be adopted for all providers in the district.

- The governing structure of the reformed mental health system in Southeastern Ontario should adopt standards of practice to promote a culture of leadership that develops leaders, supports leadership values, and encourages leaders to act as mentors to other staff.

5) Human Resources Network - Recruit, Retain and Remunerate

There should be an ongoing network composed of providers and employers in the district developed to address cooperation among mental health agencies on recruitment and retention of providers.

- It should be composed of providers, employers, families, and consumers in the district to address cooperation among agencies on recruitment and retention. This should be resourced by the Governance structure of the reformed mental health system of the Southeastern Ontario. Examples of work to be considered would include:

- undertake a recruitment campaign to raise the profile of careers in mental health and encourage more consumers to train as mental health providers,
- assess current retention strategies used in the district and share findings with agencies.
- develop consistent practices around job descriptions, qualifications, and compensation.

6) Recruitment - Recruit, Retain and Remunerate

Standards of practice should be adopted that promote a culture of leadership that develops leaders, supports leadership values, and encourages leaders to act as mentors to other staff.

- A leader need not hold a position that involves supervising people, but should act as a mentor to others and reflect an attitude that supervisors should treat staff in the way that providers are expected to treat clients.
- Consumers, family members and volunteers should be included as important participants in the care system.
- Consumers should be confidentially enumerated to give validity to all the positions occupied by users of the system.

7) Continuing Professional Development - Continuing Professional Development

A protocol for ongoing consultation in the district among providers, employers, and educators regarding coordination of basic education and training and continuing professional development should be set up.

- This would apply to all providers delivering mental health services across the lifespan, including children and youth, adults, and the elderly. This consultation would address:
 - promoting continuing education from basic training through every career stage,
 - seeking input from consumers and families,
 - seeking and sharing advice on assessing educational needs and designing appropriate educational programs,
 - developing consistent practices among agencies toward supporting and funding employees' educational activities.

8) Downsizing - Recruit, Retain and Remunerate

When downsizing of a mental health agency must occur, agencies should undertake employee transition planning that follows the better practices guideline

- Throughout the implementation of the reformed mental health system, it is important that qualified personnel presently in the system be retained.
- When downsizing of a mental health agency must occur, agencies should undertake employee transition planning that follows the better practices guidelines. Specifically, agencies should:
 - achieve staff reductions through attrition, retirement, relocating employees to other vacancies in the agency or to other agencies in the district, and accepting requests for reduced hours of work,
 - hold transition management workshops,
 - define new roles for staff and provide training to meet these roles, and
 - communicate information to staff through bulletins and meetings to clarify direction and solicit their involvement.

9) Training Programs - Continuing Professional Development

An evaluation of training programs should be undertaken and the findings used to inform education and training programs in the district.

- To evaluate and recommend specific educational programs and practices, including online programs and provider mentoring and networking. Initial areas of focus should include strengthening the mental health skills of primary care providers, multidisciplinary practice, dealing with the interpersonal demands of mental health practice, and providing care to specialty populations.

10) Pilot Program for Competency - Achieve and Maintain Competency

A pilot program should be implemented to recognize and reward the clinical competence of providers in this district.

- There should be a mechanism to pilot a program for recognizing and rewarding the clinical competence of providers delivering mental health services across the lifespan, including children and youth, adults, and the elderly. This mechanism would:
 - set provincial benchmarks for mental health competencies and establish performance indicators for assessing competencies,
 - assist agencies to develop programs to assess their performance and design agency learning plans,
 - promote an attitude of lifelong learning and encourage leadership in the area of clinical competence, and provide resources to recognize and reward clinical competence consistently across agencies and regions.

11) Pilot Initiative for Downsizing - Recruit, Retain and Remunerate

A pilot initiative should be undertaken to develop and implement local employee transition strategies that test reported better practices guidelines.

- There should be a pilot initiative based on better practice guidelines that is planned, operationalized and evaluated for its effectiveness in retaining qualified staff members throughout the system of care.
 - set standards for use in change processes affecting human resources
 - assist agencies in the transition process,
 - commit partners to working together as outlined in better practice standards.

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Considerations for Human Resources

Why do human resources require direct attention in the mental health system?

1) Recognizing the critical importance of human resource planning within the mental health system

The success of the reformed mental health system is highly dependent on all people involved in any part of the system of care to the clients, including consumers, family members and volunteers. In the system of care, the main focus is the person who is being served. This is not a technological problem that requires routine maintenance. Rather, the service system deals with people and all their concerns. This human factor is the determining issue for the importance of human resource planning. The ability to achieve recovery relies on the expertise of the people involved.

2) Protecting the public

This paper recognizes that within the mental health system there is the capacity for serious harm to individuals receiving services that are purported to be helpful. In fact, under the guise of a well developed and monitored system, people can be led to believe that their best interests are protected, when in fact there can be very few safeguards to ensure this. Even with the best interests and intentions in place we can, and should, expect that the system is fraught with the capacity to do harm and to be judged as doing harm. We need to plan our system accordingly.

3) Enabling the committed/invested provider

Individuals who enter the mental health system as providers do so, by and large, because of a strong desire to “help”. Providers frequently invest many years of their lives to study, and to prepare themselves to help in a manner that is consistent with the best knowledge and practice currently available. We need to develop a system that can enable them to bring value to the life of the vulnerable person. The best intentions of providers do become constrained within structured systems and these constraints need to become the focus of our efforts. We need to be concerned with ensuring a system that will allow the focus and scope of practice for each provider to be practiced in a manner that is consistent with this focus and meets the needs of the vulnerable person. We must avoid constructing a system that limits providers’ capacity to help. We must enable the provider to be all that they profess to be.

4) Creating a culture of growth, development and life long learning in the mental health system.

Recruitment and retention of skilled and dedicated human resources in mental health depends on creating a culture that acknowledges and values the work of providers. This culture should empower providers to develop to the full extent of their abilities and to continue to evolve in the context of an ever-changing mental health field. Growth and development might be monitored in highly technical accountability frameworks, but the energy and the inspiration for growth comes from the presence of people who are recognized as champions and role models and the mentoring that follows.

We need to be ever sensitive to how the system that we create can frustrate current and future providers and lead them to turn away from mental health as a highly desirable career. We need to be aware of the extent that a system that is seen as undesirable and frustrating by providers fuels the stigma and negative beliefs about mental illness that are rampant in our communities. We need to be aware that creating an enabling system for providers is mutually beneficial for providers, consumers and the public.

5) Ensuring the well being of the broader community

Healthy and safe communities are dependent on having ready access to a mix of caring and competent individuals who are dedicated to, and supported in, promoting mental health. Healthy communities are resourced and organized in a manner that will readily meet the needs of all members. Healthy communities also operate in a manner that allows all members to contribute, to give back, to the broader community. It is typical for individuals with mental illnesses to be systematically marginalized from access to the resources required to meet their needs and from making meaningful contributions to their communities.

6) Providing an employee compensation program which values and recognizes the mental health system's dependency on its "Human Capital"

Employee costs in health care are the largest costs of providing services. Hospitals and health care agencies continue to realize salary, wage and benefit costs which collectively represent as much as 85% of their total operating budget. To survive and thrive, they need to keep these costs in balance with their service mandates, targeted outputs and desired outcomes. To win "the war for talent" they must have competitive wages, salaries and benefits. Employees want to know that they are being compensated fairly and equitably. The public needs to be assured that their tax dollars are being used effectively, efficiently and economically to the betterment of the health and well being of their communities. Accordingly, it is incumbent on the mental health system to provide a salary and wage administration program, which reflects what is right and fair for the common good of the employee, employer and public at large.

7) Facilitating the free flow of mental health workers across and throughout the mental health system

Mental health reform has shaken the mental health work force with its emphasis on a shift from institution to community based care. It also challenges the system to shift from urban to rural centered care in search of a balanced provision of care closer to the individual's home. This relocation of work commands that the mental health care worker follow suit. Unfortunately, Ontario continues to experience an under supply of highly trained, experienced and skilled workers. Today, most of this critical mass of workers is located in close proximity to urban based, treatment, teaching and research centers. As new treatments and approaches to community care work their wonders, the need for bedded care diminishes and beds close. Mental health care workers become job threatened and shaken by an overall sense of impending displacement from their chosen vocation and/or community. The opportunity exists for the "community of mental health care employers" to behave as one and enter into agreements with the funder and various labour/professional groups. Through their collective effort, it is possible to ease the worker pain and facilitate their transition into and through a reforming mental health care system. This is particular true of Providence Care Continuing Care –Mental Health Services downsizing realities and builds upon the success gained when the hospitals in Kingston implemented a joint human resource downsizing initiative. The system needs to value its "Human Capital", embrace employee portability, and enable the free flow of its work force across and throughout the system.

Chapter 4

Core Competencies in the Mental Health system

Core competencies are at the heart of quality mental health services.

Recommendations

The governing body of the reformed mental health system in Southeastern Ontario should adopt the core competencies including the creation of a network of speciality population champions as recommended in the this chapter.

- The governing structure of the reformed mental health system in Southeastern Ontario should adopt standards of practice to promote a culture of leadership that develops leaders, supports leadership values, and encourages leaders to act as mentors to other staff.

A pilot program should be implemented to recognize and reward the clinical competence of providers in this district.

- There should be a mechanism to pilot a program for recognizing and rewarding the clinical competence of providers delivering mental health services across the lifespan, including children and youth, adults, and the elderly. This mechanism would:
 - set provincial benchmarks for mental health competencies and establish performance indicators for assessing competencies,
 - assist agencies to develop programs to assess their performance and design agency learning plans,
 - promote an attitude of lifelong learning and encourage leadership in the area of clinical competence, and provide resources to recognize and reward clinical competence consistently across agencies and regions.

CONSIDERING COMPETENCIES IN HUMAN RESOURCES PLANNING

A: Core Competencies

1) Definition of core competencies

Core competencies need to be addressed at two levels: the individual and the system as a whole.

At the level of the individual we include consumer, family, volunteer and professional providers. At this level, core competencies are those required knowledge, skills, experiences and attitudes of providers that are necessary to bring about desired outcomes in mental health practice.

At the level of the system we include agencies, organizations, training and education centers, centers for research and innovation and the complete range of governments. At this level, core competencies are those required structures and processes that enable the system to work as a collective on behalf of the individual.

2) Assumptions

This discussion of core competencies is guided by the following explicit assumptions.

- a) Core competencies must be understood beyond the level of the individual provider. A broad consideration of how people learn and apply this learning must be understood at the levels of the:
 - Individual (as a self-reflective practitioner);
 - Employer (who addresses education and training needs of service providers);
 - Community, (the needs of the broader community with respect to training/education of practitioners).
- b) Core competencies must be understood beyond activities with “individuals with mental health problems”.

Any discussion of competencies needs to be framed in an understanding of the range of help available to people experiencing mental health problems.

At its most fundamental level this is at the level of the community. The community provides the social structures that mediate an individual's well being and participation in society (for example, through employment, school, churches, family). These structures must have the capacity and mix of help required to meet the varied needs of community members,

including those with mental health problems. At the community level, we are forced to consider the social-determinants of health, those resources that indicate the general mental health of the community at large, including access to employment, education, health care, etc.

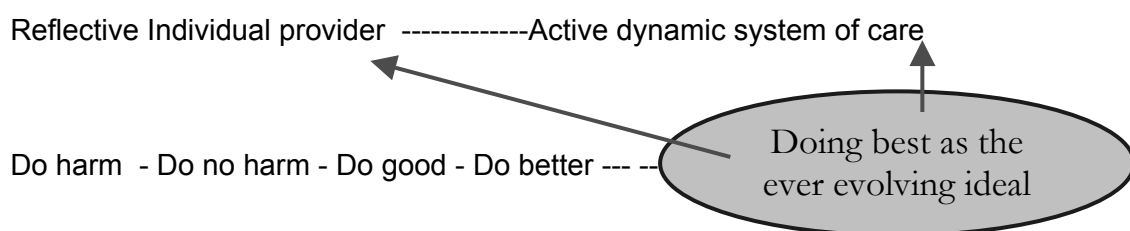
Beyond community structures, people require specialized services for mental health issues that are provided by skilled and competent providers. We need to ensure that we address competency issues at this broad level. This is more than a health mandate. It demands that services be conceptualized on an intersectorial level, encompassing a broad range of service systems (for example, COMSOC, housing, education, etc.)

- c) We assume that all individuals who are in need of mental health care are able to benefit when they receive competent mental health services. We must operate from the assumption that those with even the most severe forms of mental illness can experience improvements in their well being. Competencies must be applied in a manner that recognizes that individuals can experience health and disorder simultaneously. This means that we must operate from the assumption that people can develop their personal capacities and make meaningful contributions to their communities despite the persistence of mental illness.
- d) Competency is an unfortunate misnomer. It implies a static ideal. In reality, it is an attitude of lifelong learning where one expects to have advancements and innovation in the field. Today's best practices must become tomorrow's better practices. Through constant innovation, evaluation and research the field moves ahead to create a more responsive and effective system.

3) A system philosophy for core competencies

A system philosophy must recognize the ever evolving nature of mental health service delivery. The dynamic nature of practice in the mental health arena includes both the individual providers who actively engage in reflective practice, and a mental health system characterized by change and innovation. Far from a practice environment that aims to "do no harm", the system philosophy should be based on striving to do the best, with the understanding that the best is forever evolving. Figure 1 presents as a visual representation of this system philosophy:

Figure 1:
The transaction between provider and system evolving competencies



4) Individual level core competencies

Individual core competencies can be considered on at least two levels:

- a) those competencies that apply to all mental health providers, and are expected regardless of differences in title or credentials, job description, education and training or place of employment;
- b) those competencies that apply specifically to the individual's practice designation/title/credentials.

Those competencies that apply to everyone in mental health practice

These competencies reflect practice that:

- are respectful;
- prioritizes safety and well-being;
- ensures that the human and civil rights of service recipients are protected;
- attends to the individual as a member of a community;
- engenders a collaborative and person centered relationship with service recipients;
- are consistent with innovation in the field.

These are competencies performed by providers in a conscious and systematic manner.

These competencies include:

- Performing duties with integrity by reliably and consistently delivering on promises and honoring commitments;
- Maintaining transparency of practice and communicating to all stakeholders the nature, purpose and extent of practice;
- Refraining from any activities, including the abuse of alcohol, drugs, or other mood altering chemicals, where ones' personal conduct might diminish capabilities, denigrate professional status, or constitute a violation of law;
- Performing duties in a manner that is consistent with human ethics and informed consent and bringing suspected unethical behaviour to the attention of the colleague in question, the colleague's supervisor or professional body;
- Performing duties in a manner that demonstrates respect and dignity without regard for race, gender, disability, religion, sexual orientation or preference, or socioeconomic status;
- Adhering to generally accepted standards of practice and conduct;
- Recognizing one's personal scope of practice and practicing accordingly. This demands the avoidance of claiming or implying any personal capabilities or professional qualifications beyond those actually attained, recognizing that competence gained in one field of activity must not be used improperly to imply competency in another;
- Developing a network of contacts within the resources available locally and performing duties in a manner that demonstrates sharing and seeking of knowledge;
- Performing duties in a manner that is keenly sensitive to the potential for harm to service recipients, providers and the broader public and that upholds standards for the best interests of all;
- Performing duties in a manner that is in keeping with the particular knowledge, experience, abilities and personal suitability required for the specific service;
- Regularly evaluating one's personal strengths, limitations, biases or levels of effectiveness, always striving for self-improvement and seeking professional development and further education and training;
- Performing duties in a manner that does not make unsubstantiated claims about service and program efficacy;
- Providing services in a manner that is free of conflict of interest;

- Acting in a manner that supports the interest and efforts of family, friends, peers and community members to bring value to the life of the client with mental illness;
- Practicing in a manner that is consistent with the conditions that are necessary to develop the motivation for beneficial change.
- Maintaining good interdisciplinary team performance and function.

4) Additional Competencies that apply to regulated mental health workers

Regulated mental health workers are licensed by college or professional organizations and are governed by defined competencies. Regulated mental health workers must be members in good standing of their respective colleges to be able to claim the designated title and the associated competencies. Mental health providers governed by regulatory colleges or professional organizations include, but are not necessarily limited to:

- Psychiatry/Medicine
- Nursing
- Occupational therapy
- Social work
- Psychology
- Pharmacy

Core competencies for each of these mental health providers are available through colleges/regulatory bodies. Mechanisms for complaints or concerns related to an individual provider's level of competency are also available through these regulatory bodies.

5) Additional competencies that apply to unregulated mental health providers

Many mental health providers have received training in specific areas of mental health but are not regulated or controlled by a regulatory body. Their competencies may be supported by professional organizations. These mental health providers are identified in government documents. Their training typically occurs through community colleges (e.g. development services workers, behaviour technologists, addictions counselors). The professional associations of these mental health providers may provide details about the nature and scope of practice and may have mechanisms in place to standardize practice and provide public protection. For example, the International Association of Psychosocial Rehabilitation Services has standardized competencies and certification for psychiatric rehabilitation practitioners and has developed a certification examination.

6) Additional competencies that apply to mental health consumer providers

Increasingly peer support is being recognized as an integral aspect of the mental health system. Peer support recognizes the experience of consumers and the benefits of this experience to enable health and well-being in others. Hiring consumers to provide mental health services produces benefits for the recipients of services, for the consumer-providers themselves, and at the system-level. Consumer-providers role model to other consumers that recovery is possible. Their work in the mental health system improves their self-esteem. They provide possibilities for educating other staff and management. Two important benefits of hiring consumers, as providers are their advocacy against stigma and their potential to give consumer input. However, there can be barriers to involving consumers in service provision. Particular challenges include: the relationship of being both a consumer and a provider of mental health services and the role confusion arising during the transition from consumer to provider. Consumer-providers need to be clear about when each of their roles is applied and the boundaries between work and their personal relationships. Agencies need to clarify roles and responsibilities for all providers.

7) Additional competencies specific to specialty areas in mental health service delivery

Within the context of mental health reform implementation in Southeastern Ontario several distinct populations have been identified within the mental health service system. Providers who are working with these populations should possess specific competencies to be responsive to the needs of these distinct groups. The tables below provide an introduction to the competencies for several populations. They have been developed, in consultation with identified champions from each of these areas, to stimulate ongoing discussion.

A serious limitation of the discussion is our committee's inability to recognize early on the need to include an aboriginal champion on our committee. This resulted in a failure to include aboriginals as a distinct population within the mental health service system. The core competencies associated with aboriginal mental health are reported to be significantly different from those listed in the other nine distinct populations. There is a sizable population base of aboriginal people in this region. Therefore, the mental health system has an obligation to ensure that their human resource and competency needs are fully addressed.

DEFINITION	COMPETENCIES
<i>Moderate mental illness:</i> A person whose mental health problems, although not sufficiently serious, persistent or disabling enough to be considered to be a serious mental illness, are severe enough to hamper their functional abilities, their capacity to develop and maintain satisfying relationships with others and to require treatment.	• The primary modalities identified as best practices for this population are pharmacological treatment and/or psychotherapy. Such services require specific knowledge, experience and training. • Evidence indicates that a person with a moderate mental illness is likely to require individualized care from a specific provider and less likely to require the services of a comprehensive system of care. Consequently, providers must remain sensitive to their own limitations and to the need to refer when the care requirement falls outside their level of competency.

DEFINITION	COMPETENCIES
<i>Serious mental illness:</i> The critical elements to define serious mental illness are: significant disability that severely limits the ability to function; diagnosis of major mental disorder; duration of the disability and diagnosis is longstanding	• Evidence indicates that the individual with serious mental illness requires a comprehensive approach to care that includes treatment; recovery and rehabilitation; support, and; community development. Consequently, providers must demonstrate attitudes and abilities to encourage an integrated approach to care. • Evidence suggests that a person with serious mental illness is vulnerable to profound psychotic experiences. This requires that providers have specific knowledge, skills and training in this area.

DEFINITION	COMPETENCIES
Concurrent Disorders: This client is struggling with an addiction/substance abuse problem as well as a major mental disorder	Knowledge of substance use, its effects on human beings and the interplay with major mental illness (i.e. integrate knowledge of mental health and addictions field in approaches to care). Knowledge and implementation of evidence based prevention, treatment, rehabilitation, support and community development practices for concurrent disorder. Practice from a harm reduction perspective that reduces economic, social and physical harm arising from the use of substances concurrently with a major mental illness. An attitude towards practice that encourages an integrated approach to care with the mental health system.

DEFINITION	COMPETENCIES
Forensic/legal: The forensic client is a person who is being dealt with by the court or the Ontario Review Board under Part XX.1 of the Criminal Code of Canada; suffers from a major mental disorder and is in conflict with the law.	Understanding and implementation of the legally mandated requirements attached to working with the forensic client (i.e. knowledge and application of criminal law and court and/or Review Board dictums. Knowledge, concerning the application, generation and processing of risk, potential for societal harm and clinical needs information. An attitude towards practice which supports the shared responsibility model for common clients (i.e. the forensic client who is in need or in receipt of services from multiple jurisdictions within human and/ or justice service sectors) including creativity, flexibility, responsiveness and cooperation.

DEFINITION	COMPETENCIES
Dual diagnosis: A person with a dual diagnosis has a diagnosis of developmental disability as well as a diagnosis of mental illness and/or challenging behaviour.	Knowledge, skills and experience to distinguish the features of mental illness from those associated with the cognitive and adaptive behaviour challenges associated with developmental disability. Knowledge, skills and experience to address the interactions between the mental illness and developmental disability and to provide the support needed to enhance the client's coping and competence to carry out everyday living skills. Evidence indicates that the individual with a dual diagnosis requires a comprehensive approach to care that includes diagnosis, treatment and rehabilitation. Knowledge, skills and experience to understand and respond to the challenging behaviours that can be demonstrated by persons with dual diagnosis. In order to ensure proper care for the individual there must be a commitment to enhancing community capacity for treatment and support services.

DEFINITION	COMPETENCIES
Family: This includes parents, siblings and extended relatives of the person with mental illness. For many individuals with mental health problems, family may include a broad range of supportive people who are not relatives.	Evidence suggests that families experience significant day to day challenges and emotional distresses in response to supporting their relative with a mental illness. Providers require the knowledge, skills and training to understand and support families.

DEFINITION	COMPETENCIES
<i>The aging population:</i> Older persons, (over 65 years of age), whose primary problem is a major mental illness with or without a complex medical condition.	• Knowledge of the older years as a distinct phase of human development. • Knowledge of the interdependence of the physical, emotional, cognitive and social aspects of the older person and his/her mental health and general well being. • An attitude towards practice that encourages an integrated approach to care, across multiple systems including mental health, long-term care and chronic care.

DEFINITION	COMPETENCIES
<i>Children and youth:</i> Children and youth, for the purposes of this paper, are nineteen years of age or under, with mental health problems. Mental health problems affect a high number of children and comprise a wide gamut of disorders ranging from emotional and behavioural distress, depression, personality disorders, addiction and disorders of neurological origin and psychosis in a very small proportion of young people	• The complex nature of childhood mental health and its impact on lifelong development requires providers to have knowledge, experience and training specific to this population. • Knowledge of childhood and adolescence as distinct phases of human development • Effective treatment of children and youth demands successful work with parents and other significant adults. • Children are “dependent” and routinely fall under the care of adults (e.g. teachers, coaches, parents, community groups, daycare workers). There can be a tendency for caregivers to underestimate the nature of childhood mental health problems. They may fail to recognize that the nature of the presenting problems are outside their scope of care giving, calling for consultation or direct services from trained, professional experts. Consequently, providers must remain sensitive to their own limitations and to the need to refer when the care requirement falls outside their level of competency.

8) System level competencies

Systems level competencies refer to organized and systematic structures and processes that promote and support the expression of competency, throughout the system. Several components of system level competencies are described below.

9) Training built into the system

While individual providers of mental health services are responsible for ongoing self-reflection and the identification of personal learning needs, a competent system supports these efforts through systematic and organized opportunities for ongoing education and development. On a local/regional level, a competent system has structured mechanisms for the ongoing evaluation and response to education and development needs.

10) Recognition of the complexities of mental illness

A competent system is one that maintains a balanced perspective that honours the capacity of community structures and networks to promote the well-being and mental health of citizens. This balanced perspective also recognizes that, at times, the complexity of mental illness will require providers who have specialized levels of training, knowledge and experience.

11) A culturally sensitive system

The importance of cultural sensitivity in the delivery of mental health services has received considerable attention. A culturally sensitive system is one that understands the cultural makeup of the population to ensure that the needs of specific populations can be addressed.

12) A system that values its children and youth

A competent system recognizes that the years of childhood and youth represent the foundation for the individual's future health and well being in adulthood and the community's ongoing health and well being. Children with mental health disorders who are not effectively treated do not shed problems as they grow, but become vulnerable and less resilient as they grow towards adulthood, a path frequently resulting in criminality and/or adult mental ill-health. When this happens, the community is compromised in its ability to benefit from the strengths and potential contributions of these individuals. There is under-funding and lack of support from society for mental health services for young people. Unlike paediatric hospitals, there is no mandate for children's mental health services to be in existence, maintain quality control, develop expertise or serve a universal population. This presents a formidable challenge for human resource planning.

13) Leadership

Leadership is usually defined as the process of influencing the activities of individuals or groups in efforts toward goal achievement in a given situation (Kaluzny et al, 1982).

A leader is an individual who knows where h/she is going, determines what is to be accomplished, and persuades others to follow him/her in the accomplishment of that purpose (Stoner, 1982 : Rakich et al, 1993).

For the mental health system to be competent, it must be led by individuals educated, experienced and skilled in all facets of leadership. This requires the collaborative effort of the system and its leaders toward supporting and enabling life long learning, knowledge sharing and innovation. It also depends on its leaders to hone their abilities through the act of leading others. The system must provide for this opportunity through the: a) identification of potential leaders; b) delegation of leader responsibilities and accountabilities; c) provision of on the job training and mentoring; and d) application of on going, leader monitoring and evaluation. When done well, the ultimate result will be a "Human Service System" which is led by individuals with demonstrated technical, human and conceptual skills, using a situational leadership style to advance mental health reform and the well being of its communities.

14) Multiple perspectives on health and disorder

A competent system requires resources to cover the full range of perspectives on how to enable health and well-being. At the very least the system needs to ensure that there are adequate resources for each of the following:

Rehabilitation: The on-going process to address the long term and broad effects of illness, disorders or life events such as abuse. Rehabilitation assists the person and the family to return to as optimum a level of mental and physical health as possible.

Rehabilitation includes:

- Activities that are directed towards improving, restoring or maintaining a person's capacity for health;
- Relapse prevention and wellness promotion;
- Approaches focusing on improved functioning in living, learning and working environments;
- A specific focus on improving vocational and employment functioning.

Support: Approaches and services to assist the individual to sustain a good quality of life and to access social and health care services.

Support includes:

- Service coordination;
- Peer supports and self-help initiatives;
- Housing and income related services;
- Social supports such as drop-ins, recreational programs, volunteer and educational programs.

Treatment: Those interventions directed toward assessing, alleviating, reducing or managing the symptoms of an illness or disorder, or symptoms resulting from trauma of abuse.

Treatment includes:

- Identification and assessment of signs and symptoms;
- Bio-psycho-social investigations;
- Diagnostic evaluations;
- Client-centred consultation;
- Development of working alliances among providers;
- Counseling and psychotherapy;
- Medication management;
- Hospitalization;
- Specific medical and psychiatric care.

The above definitions have been developed from the Making it Happen (1999; 2001) documents. A fourth perspective has been added, community development, to ensure that the system is directly addressing the capacity of the community to promote mental health and inclusion.

Community development: Those interventions directed to evaluating, and enhancing the community capacity to understand, include and support individuals with mental illness as assets and contributors to the community.

Community development includes:

- Evaluating the capacities of communities;
- Building relationships with community;
- Community organization;

- Building community coalitions;
- Advocacy and lobbying;
- Building community economic activity;
- Supporting community activities.

15) A model for supervision

A competent system has a well developed framework for the ongoing supervision of all providers. While this may appear to be particularly relevant for new providers in the mental health system, supervision is an integral aspect of recognizing and addressing the practice needs of even very experienced providers. Supervision can be developed as the mechanism for ensuring self-reflection and evidence based practices supported by the identification of education and training needs.

16) Champions

A competent system can benefit from a network of subspecialty champions that attract human resources, inspire innovative practice, share knowledge and co-create innovation, operate within a global community, and serve as role models and mentors by practicing their specialty. While champions can emerge naturally, the competency of a system can be enhanced by focusing efforts towards the development of and connecting with champions in key areas of service delivery.

17) Technology and Information Systems

The competency of a system is influenced by its capacity to enable the free access to and the timely sharing of knowledge.

18) Accountability framework

A competent system has an explicit accountability framework which delegates authority and holds people accountable for the input and outcome of their efforts. This framework includes evaluation and monitoring mechanisms to ensure that competency prevails at all levels. The accountability framework should maximize innovation and evidence based practice.

19) A commitment to education and training of future providers

A competent mental health system systematically builds for the future by investing resources in the education and training of student providers. In addition to providing opportunities for exposure to mental health practice, the system must commit to promoting an atmosphere of respect and hopefulness within a framework of innovation and inquiry. This creates the climate for learning that is likely to encourage students to pursue, and excel at, careers in the mental health arena.

Chapter 5

Children and youth in the mental health system

A Province that values its children and youth enhances the health and well-being of all its citizens.

Recommendation

There should be a Ministry for Children and Youth with the power to oversee and co-ordinate all provincial services and programs for children and youth.

- To rectify the fragmentation and inequities of provincial systems serving children and youth.

Mental health services for children and youth require special consideration in the Human Resources (HR), field, for the structures, jurisdictions and staffing of these services differ from those of adults. A major difference from adult services is that work with a young person in trouble also requires assessment and work with family members, usually parents. Further, it is important to make links with workers in other services, such as schools, child welfare, correctional services and Children's Aid Societies (CAS), who undertake child protection. A thriving Children's Mental Health Centre can also provide support and opportunities to establish preventive and early intervention services in the area. Children and youth with mental health problems comprise a wide range of disorders, from emotional and behavioural disorders, addiction, a variety of disorders of neurological origin to a small number of cases of psychosis. Generally, mental illness is not recognised until adulthood, but studies show that mental and emotional troubles in childhood should be taken very seriously, and that psychiatric disorders can arise and persist from the earliest years and that they develop further into adulthood. (Beitchman 1992).

In 1977 the Government of Ontario took children's mental health services out of the health jurisdiction in order to gain federal dollars by making them a social service. Some mental health services for children and youth still exist in hospitals, but they can serve only a small number of patients and families. In our Southeast District we have four Children's Mental Health Centres, each with satellite offices, and one hospital, situated in Kingston, provides mental health services for children and youth. Unlike the CAS agencies, which are also in the social service jurisdiction, the Province has not given the Centres a legislated mandate to be in existence, to maintain quality control measures, or to serve a universal population. This difference has H R implications. Child and youth mental health services in hospitals are covered by the health mandate. It should be noted that current federal transfer funding does not give the Province any motivation to place a service in any specific jurisdiction.

The Ontario Health Study of Offord, 1989, showed that almost 1 in 5 children and youth had at least one diagnosable disorder and two-thirds of this group had two or more psychiatric disorders. The study also showed that only 1 in 6 of these children received any type of therapeutic intervention, which included such non-clinical interventions as talks with guidance teachers and clergymen. It is important to note that children with disorders who are not effectively treated do not shed problems as they grow, but become more vulnerable and less resilient as they approach adulthood, a pathway which can result in adult mental ill-health and/or criminality. (Wattie, 1999). If government and society at large understood this connection and considered the enormous costs of inpatient and community care, addiction services and incarcerations in prisons, the mental health of children and youth would become an urgent matter of the highest priority.

In relation to core competencies, mental health work with children and youth calls for well trained staff with experience and expertise in a complex and difficult field. Unfortunately, many people see work with children as a simple, pleasant job and fail to perceive the demanding expertise required. It is critical to have competence to diagnose the presenting problem, to have competence to develop an effective family treatment plan and competence to supervise therapy or casework with young persons and their families, as needed. In turn, this calls for the consultation or presence on staff of professional experts such as child psychiatrists, child psychologists, clinically trained social workers, specialist nurses, and occupational therapists. HR data on the Children's Mental Health Centres are inadequate, (see below), but it appears that child and youth workers and behavioural technologists trained in community colleges form the major part of the staff and we would expect that they would work as a team with any clinicians who may be available. Given the complexity and breadth of this demanding field, it is also critical to provide good opportunities for professional staff development, for example by encouraging staff to attend the annual Hincks-Dellcrest Conference in Toronto.

Given the lack of awareness and support in society for mental health services for young people and the scarcity of specialized clinicians such as child

psychiatrists, this field presents a formidable challenge for H R planning. The lack of a legislated mandate for the Children's Mental Health Centres allows varying quality and approaches, resulting in important degrees of inequity in the quality of work done across the province. Thus, in a city like Toronto there are excellent services while in other areas weak local boards are content to have less staff expertise and less likelihood of clinical diagnosis. When quality of work suffers, families turn to private services or wait in long lists at the few hospitals offering mental health services for children and youth. CAS agencies also have recourse to private practitioners. There is now a successful Telepsychiatry program of the Division of Child Psychiatry of the University of Toronto. This is an excellent and welcome addition to provincial services but unfortunately it is restricted to specific populations, northern, distant locations and aboriginal communities.

What needs to be done

Policies and programs for children and youth are found in different structures of the bureaucracy, each having its own funding and its own degree of priority. Perhaps the most important jurisdictional split is that which leaves the mental health of children outside the mandate of health, split from the mental health of their parents and without a requirement for quality control and standards, such as services for adult mental health and child protection now have.

In Southeast Ontario the HR data gathering process used a tool designed for adult psychiatric hospitals, which resulted in a lack of staff data on the Children's Mental Health Centres. We have full data from the child and youth program in the hospital but there is no basis of comparison. The provincial government needs to remedy this lack of information, which may be province-wide, by commissioning a review of the services and HR patterns in Children's Mental Health Centres.

The Ontario Health Study of Offord, 1989, was an outstanding study, but data gathered in the early 1980s can not be expected to give us the information we need to-day on young people and on the required service programs. We need a new epidemiology of child and youth mental health, including service data from both social service and health jurisdictions, substance abuse services in both jurisdictions and data from aboriginal populations. Such work as diagnostic epidemiology and service surveys have been going ahead in the U.S. and are supported by the National Institute for Mental Health, which has no opposite number in Canada. From one such group of U.S. researchers we have a comment, which calls for a broader approach to the human resources, required in the mental health of children and youth:

"These data also suggest that greater attention needs to be paid to the many professionals, especially social workers, psychologists, teachers, who play critical roles in the identification and treatment of children with serious emotional disturbances. Schools present an important opportunity for the early

detection of psychiatric disorders and the mobilization of resources for the support of youths with serious emotional and behavioural problems.” (Leaf, 1996.)

On this note, it is clear that the HR needs to support children and youth with mental health problems reach out well beyond existing health and social service jurisdictions, to encompass other programs and services in the provincial structure. Currently, although the government maintains Integrated Services for Children at the ADM level in the Ministry for Family and Children’s Services, the reality is an uneven, fragmented and uncoordinated children’s service system. When those services fail children and youth, many arrive at the protection system, the Young Offender’s system, and ultimately the streets.

It is for this reason that child advocates in Ontario have long requested a single central agency to plan, co-ordinate and monitor programs for children and youth at the ministerial level, preferably that of a senior Minister for Children. Such a ministry should plan, co-ordinate and monitor programs for children and youth across the provincial systems. Incorporating education into planning for mental health is particularly urgent, given the staff cuts of school social workers, guidance teachers and psychologists in recent years. This ministerial office should not rely on advice and policy from the civil service alone, but should also maintain a knowledgeable advisory group with its own independent chair. Such a group is necessary to assist in the demanding task of assessing the current patch-work of services and working towards a new provincial organisation which will build effective linkages and improve the co-ordination and quality of services across the province.

Chapter 6

Continuing Professional Development in the Mental Health System

Continuing competence is founded on individual and organizational commitment to lifelong learning.

Recommendation

There should be a variety of physician payment options including salary, alternate funding payment, fee for service, and adequate sessional monies

- To support provision of evidence-based mental health and psychiatric intervention at the primary, secondary and tertiary levels to all those across the lifespan in the region who require it.
- The Ministry of Health & Long-term Care and Ministry of Community and Social Services should provide more sessional money to mental health agencies to access the services of general practitioners and psychiatrists in community settings. These sessional fees are needed for travel to community settings and to obtain psychiatrists' and general practitioners' consultation on mental health services provided across the lifespan, including children and youth, adults, and the elderly. Their services are especially needed at the assessment and diagnosis stages.

Recommendation

A protocol for ongoing consultation in the district among providers, employers, and educators regarding coordination of basic education and training and continuing professional development should be set up

- This would apply to all providers delivering mental health services across the lifespan, including children and youth, adults, and the elderly. This consultation would address:
 - promoting continuing education from basic training through every career stage,
 - seeking input from consumers and families,
 - seeking and sharing advice on assessing educational needs and designing appropriate educational programs,
 - developing consistent practices among agencies toward supporting and funding employees' educational activities, and

Recommendation

An evaluation of training programs should be undertaken and the findings used to inform education and training programs in the district.

- Evaluating and recommending specific educational programs and practices, including online programs and provider mentoring and networking. Initial areas of focus should include strengthening the mental health skills of primary care providers, multidisciplinary practice, dealing with the interpersonal demands of mental health practice, and providing care to specialty populations.

The consequences of "keeping up" or "not keeping up" are arguably greater in health care than in any other area of endeavour. In mental health care poor outcomes are not as clearly understood by the public to be linked to poor intervention; it is easier to see the connection between surgical error and resultant disfigurement than to see the relationship between worsening depression and inadequate approaches to treatment.

Along with advancing knowledge in the health sciences there is a growing need to understand how knowledge is best developed, shared and incorporated into practice. This means "learning how to learn" throughout delivery systems. Many of the health care professional regulatory bodies (e.g. physicians, specialists including psychiatrists, occupational therapists, social workers) have mandatory educational programs linked to continuing certification. There are many managers and providers who do not have such

affiliations and access to the associated educational resources. The current provincial processes of Health Care Restructuring, Primary Care and Mental Health Reform create the opportunity for regional approaches to continuing education that complement, augment and reinforce existing learning possibilities.

We have the opportunity and the imperative to build a system in which knowledge is continually generated, tested and shared so that early identification, diagnosis and effective treatment becomes standard. The expanding literature on learning provides some of the principles upon which such a system could be based.

Traditional formal approaches to continuing education alone may have limited learning value. For example, follow-up studies show little or no change occurs in physician behaviour or patient outcome after attendance at traditional courses or conferences (Davis et al, 1999). In contrast, there is evidence physicians are most likely to change clinical approach when educational events allow participants to compare their practice methods with evidence-based best practice guidelines. This involves providing tools for clinicians to carry out audits of their own practices, e.g. Treatment approaches to specific illnesses, to see how they compare to currently established best practices (Abbey, 2000). Adult learning is strongly affected by context, particularly usefulness for immediate application to duties and responsibilities (Merriam & Caffarella, 1999). Continuing professional development requires participants "to be good adaptive learners, so that they can perform effectively when situations are unpredictable and task demands change" (Resnick, 1987). Practitioners, then, learn best when "learning" relates most closely to "doing".

Successful organizations should themselves learn (Senge, 1990). A learning organization is responsive to the larger context or environment, promotes discussion, team learning and collaboration among employees, empowers employees towards a "collective vision", develops systems to monitor and share learning, and creates ongoing learning opportunities for workers (Watkins & Marsick, 1993). Individuals spend significant portions of their time in the workplace learning new tasks and solving new problems. Their success in meeting these challenges is partly within the control of the individual but also greatly influenced by the organizational climate (Knapper, with others, 1995, 1997, 2000, 2001).

Promising new concepts of continuing professional development are emerging. These emphasize workplace learning and collaborative approaches. In "communities of practice", members share knowledge and provide mentorship. The members of such groups may be within or across organizations. They may be widely dispersed in location and take advantage of technologies to share information, creating "virtual communities" (Wenger, 1998). The "practitioner-researcher" is encouraged in his or her workplace to incorporate established theory into practice, and to question and evaluate approaches with a view to further development and improvement (Jarvis, 1999). Jarvis calls for

partnerships between higher education and the professional workplace that could result in a synergistic approach in the generation of knowledge and its application in practice.

The Southeastern region is an ideal area in which to develop a unique regional approach to individual, organizational and system learning. There is a richness of educational endeavour and interest across agencies and institutions. The university and two community colleges are recognized providers of high quality health care education. Further, Queens University is also a well-recognized resource for providing assistance in educational systems development. Of particular relevance currently is the Education, Work and Learning group, consisting of members from multiple disciplines and faculties. This group is pursuing various projects aimed at enhancing the understanding of education, work and learning in the workplace, including health care settings.



Recruitment, Retention and Remuneration in the Mental System

Leadership must mentor

The operation envisioned for the mental health system is identified by a comprehensive service system that is integrated and linked. The principles include a coordinated client-centred focus that provides choice.

The success of the reformed mental health system is highly dependent on all people involved in any part of the system of care to the clients, including consumers, family members and volunteers.

To provide this kind of client focussed service, the system must focus on its human resources with a similar kind of zeal. The system will only be as good as the people who work in it. The employees of the system require support and attention to maximize their ability to be responsive to the needs of their clients.

The leaders of the service who are responsible for the system accountability and outcome measurements, need to reflect to their employees the same kind of attitude that the service providers are expected to use with their clients. They need to have core competencies to properly assist and support their employees.

There are three essential areas that need to be included within the consideration of human services component of the reformed mental health system; recruitment, retention, remuneration.

These three topics are not exclusive of each other and require considerable attention to improve the system and ensure that the properly qualified workers are available. The principles of recruitment must continue on during the ongoing work of retention and proper remuneration must be available throughout the system.

1) Recruitment

Mental health agencies have difficulty recruiting well-qualified personnel.

Recommendation:

There should be an ongoing network composed of providers and employers in the district developed to address cooperation among mental health agencies on recruitment and retention of providers in the district.

- It should be composed of providers, employers, families, and consumers in the district to address cooperation among agencies on recruitment and retention. This should be resourced by the Governance structure of the reformed mental health system of the Southeastern Ontario. Examples of work to be considered would include:
- Undertake a recruitment campaign to raise the profile of careers in mental health and encourage more consumers to train as mental health providers,
- Assess current retention strategies used in the district and share findings with agencies,
- Develop consistent practices around job descriptions, qualifications, and compensation.

In the literature, managers link recruitment problems of qualified staff members to being in less popular locations, competition with other agencies, and being unable to offer higher salaries. They are frequently unable to recruit on a competency-basis because most applicants lack sufficient experience (Holmshaw et al., 1999). Competency refers to the core competencies as explained earlier in this paper and defined in the glossary. Proposed solutions include additional funding for more positions and higher salaries, as well as increasing cooperation and decreasing competition between agencies (Holmshaw et al., 1999; Scheffler, Ivey, & Garrett, 1998). A study of rural mental health professionals, suggests that managers should emphasize the scope, variety, challenge, and autonomy of work when recruiting (Wolfenden, Blanchard, & Probst, 1996).

These findings are similar to the discussions that took place at a forum on recruitment, retention, and remuneration with mental health providers and others who are concerned about the difficulties in recruiting qualified personnel.

In this district, participants in the discussions recommended marketing the image and the value of mental health to the general public and to students of health care such as nursing, occupational therapy and behavioural science technology, to build the number of people interested in mental health careers. They also recommended that agencies market the benefits of their work settings to current health providers to increase the pool of mental health employees. Managers need to look at job sharing and flexibility to attract employees and to focus on recruiting students who come to their agency for training placements.

There are several essential areas of consideration in the question of recruitment. An issue requiring immediate attention is the attitude taken by those responsible for attracting people to these job positions. The leader should give the same attitude of respect and consideration expected by the mental health practitioner towards their client to employees.

Quality of life in all situations, both at work and outside of work, should be a consideration for the leaders of the services while designing recruitment incentives. It is important to recognize that the factors both inside and outside the workplace affect the abilities of the employee. There must be conscious efforts to make provisions to address the concerns of employees, which will enable them to maximize their effectiveness with their clients.

To have the necessary staff members in the future, there must be emphasis placed on the current educational system. At a meeting with educators and health service providers, the importance of students was noted. Not only do they receive invaluable hands on learning experience, but also the providers have the opportunity to have potential future employees receive training and experience.

The field of mental health service provision continues to be unknown to some of the public. This lack of information, or perhaps misunderstanding, does not allow potential workers to be aware of exciting career opportunities. To correct this issue, consideration should be given to a marketing technique that would assist in the general public's understanding of the mental health system. This advocacy would lead to an increased acceptance of the system, its needs, and it would be have more consideration as a meaningful career pursuit.

Mental health educators and managers at the discussion forum emphasized that the key to retention is recruitment. Expectations at hiring set the stage for staying with the agency. Describing positive and realistic employment opportunities is crucial. Community mental health agencies in this district do not have high turnover. Investigation into their retention practices would be useful. Participants of the forum were very interested in meeting again to establish an ongoing working group to address issues related to human resources.

2) Retention

Fulfillment, emotional strain, and salary interact to influence mental health providers' decisions to stay or leave.

Retention begins with recruitment. The issue is to maintain the level of interest and commitment to the service that is expressed by qualified candidates during their recruitment process. It is necessary to listen to the employees and respond to their needs for growth, motivation and interest. By encouraging and supporting them, they will be motivated to provide quality services.

The recommendation of researchers is that managers show a more balanced concern between salary and benefit levels and workplace issues, including training in the management of emotional issues and potential for personal and professional development (Blankertz & Robinson, 1997).

The key to retention is assisting staff to maintain a sense of fulfillment.

Recommendation

Standards of practice should be adopted that promote a culture of leadership that develops leaders, supports leadership values, and encourages leaders to act as mentors to other staff.

- A leader need not hold a position that involves supervising people, but should act as a mentor to others and reflect an attitude that supervisors should treat staff in the way that providers are expected to treat clients.
- Consumers, family members and volunteers should be included as important participants in the care system.
- Consumers should be confidentially enumerated to give validity to all the positions occupied by users of the system.

The fulfillment of helping people attracts providers and motivates them to stay in the field (Blankertz & Robinson, 1997; Kipping & Hickey, 1996). Professional fulfillment is reinforced by involvement in organizational decision-making, opportunities for personal development, and praise from supervisors (Martin & Schinke, 1998; Thomsen, Soares, Nolan, Dallender, & Arnetz, 1999).

Leaders of the system need to acknowledge the reasons for people's interest and focus their energies on ensuring that employees know that they are valued. People's commitment to helping others and making a difference in clients' lives should be a core part of the system's philosophy.

Working with people with mental illness, however, can exert an emotion strain and if unmanaged can lead to burnout. Staff turnover among mental health providers is linked to higher emotional strain, lack of training, less fulfilling or demanding work,

and a perception of low potential for career development (Ben-Dror, 1994; Blankertz & Robinson, 1997). A training program reduced burnout among occupational social workers in Israel by increasing providers' competence with mental health issues in the clinical setting and by encouraging discussion of emotional issues (Rabin et al., 2000).

Retaining mental health providers requires leaders to acknowledge the primary reason providers that enter and remain in the field – the opportunity for fulfilling work by helping people with mental health problems. Leaders need to help staff deal with the interpersonal demands of their work to reduce emotional strain. They need to provide training in establishing effective relationships with clients. Also, they should use more experienced workers to mentor coping skills to newer providers and support interdisciplinary interaction among providers. Leaders also need to acknowledge and reinforce providers' efforts and successes with clients, through praise and recognition, and create opportunities for career progress (Bhatara, Fuller, O'Connor-Davis, & Misra, 1996; Blankertz & Robinson, 1997; Wolfenden et al., 1996). One study suggested that funds directed at training and career development, rather than simply increasing salaries, would be more effective at retaining employees and would improve provider practice (Blankertz & Robinson, 1997).

Keep the current qualified employees

Recommendation: Downsizing

Recommendation

When downsizing of a mental health agency must occur, agencies should undertake employee transition planning that follows the better practices guideline

- Throughout the implementation of the reformed mental health system, it is important that qualified personnel presently in the system be retained.
- When downsizing of a mental health agency must occur, agencies should undertake employee transition planning that follows the best practices guidelines. Specifically, agencies should:
 - achieve staff reductions through attrition, retirement, relocating employees to other vacancies in the agency or to other agencies in the district, and accepting requests for reduced hours of work,
 - hold transition management workshops
 - define new roles for staff and provide training to meet these roles, and
 - Communicate information to staff through bulletins and meetings to clarify direction and solicit their involvement.

The mental health system needs to retain qualified employees and should seek to maintain their active involvement. Retraining and redirection to other positions in the system should be undertaken. People need to feel valued and included. The change process involved with the need for reorganization must demonstrate respect and dignity for the worth of all of the human resources.

Downsizing of staff in certain settings should be completed through attrition, retirement, relocation and shared job positions. Retraining should be offered and provider partners in the district should be committed to work together to retain qualified employees within the field of mental health care.

Downsizing experiences indicate that successful retention of employees includes their involvement.

Recommendation

A pilot initiative should be undertaken to develop and implement local employee transition strategies that test reported better practices guidelines.

Studies have indicated that downsizing of hospitals, had the best outcomes when staff were involved in the process. A study of mental health professionals who had left positions at a psychiatric hospital found that the decision to leave occurred over a long period of time, suggesting an opportunity for leaders to work with vulnerable employees to resolve problems and prevent their leaving (Hiscott & Connop, 1996).

In the first three years of the downsizing of a provincial psychiatric hospital in British Columbia resulted in the elimination of 246.5 staff positions. This was achieved through attrition and retirement, relocating employees in downsized positions to other hospital vacancies, and accepting requests for reduced hours of work and for the creation of regular part-time positions. Labour adjustment strategies included placement of employees in positions in the community and employee-driven lateral transfers to other government ministries and agencies (Macfarlane et al., 1997).

The first requirement for managing the transition process is to have a clear vision of where the organization is going and what it will look like. Employees are more likely to embrace change if they can see the end goal and feel respected for their involvement. Frequent and repeated communication with employees about the vision and the changes required, using a variety of strategies, is needed throughout the transition process.

Employees should be allowed to and encouraged to discuss their anxieties and ambivalence toward the organizational change. The leadership system needs to define new roles for staff and provide training for staff to meet these new roles.

In British Columbia's experience of downsizing their psychiatric hospital, employees were encouraged to attend transition management workshops to explore their reactions to the downsizing process. Information sessions, bulletins

and newsletters, and ward meetings provided information to staff, clarified direction, discussed their concerns, and solicited their involvement (Macfarlane et al., 1997). People need to feel included and have power in situations that involve them. By encouraging meaningful participation, people will feel a part of the change rather than a victim of its action.

A commitment to re-invest funds into community mental health services helps to gain the commitment of hospital and community staff (Macfarlane et al., 1997; Swidler & Tauriello, 1995). The initial experience in the downsizing of the provincial psychiatric hospital in B.C. found that it was imperative that the community be involved early in downsizing planning. Identifying which patients should be discharged required community input. Joint involvement of the community and the hospital lead to a positive and productive relationship between community and hospital staff (Macfarlane et al., 1997).

Kingston has an experience of health care providers working together to design a program to facilitate change while respecting the various partners and current qualified employees. Providence Continuing Care Centre, Kingston General Hospital and Hotel Dieu Hospital implemented such an agreement a number of years ago, which was tagged as the made-in-Kingston solution. In 1999 community and hospital mental health providers gathered to come up with a joint plan to respond to ministry directives concerning the provision of mental health services. Kingston must have the commitment to do such work again, respecting each provider and the qualified staff members presently in the system. Employees who wish to continue to be a part of the new system are to be encouraged to be a part of the change process, participate in retraining and adjust to the requirements of the job. Present staff members whose positions may become redundant must indicate that they are willing to fulfill the job descriptions by having the required core competencies and participating in provided retraining to learn the required skills.

In a reformed mental health system, it is key to keep all participants in the process informed and included as much as possible in potential changes.

Expectations set at hiring, set the stage for staying with the agency. Describing positive and realistic employment opportunities is crucial. Community mental health agencies in this district do not have high turnover. Investigation into their retention practices would be useful. Participants at the human resource forum also felt that a lack of full-time positions makes retaining staff difficult.

Retention of employees is an on-going process. It requires constant attention to the needs of the employees that relate to their ability to work with clients. There must be an emphasis on providers' opportunity for growth and the full use of their ability. Feedback must be given that expresses appreciation for their efforts and the positive impact that is felt by the system because of their efforts.

Consumer and Family member roles

There has been much discussion regarding people who have had a mental illness bringing their expertise to the successful operation of a system of care. Family members and volunteers also bring a valuable perspective through experience that cannot be replicated through education alone.

Consumers have the potential to be part of the system given they have the necessary experience and education.

The most well known is the peer support model for consumer employment in the mental health system that is provided through Consumer Survivor Development Initiatives. There are many other roles that are filled by consumers. Having more consumers involved in the system supports the recovery philosophy and will help to decrease stigma among everyone in the community. As with the core competencies, the system should be a role model to the rest of the society.

It is critical that stigma be addressed with all parts of society. According to a very recent publication, perceived social support and psychosocial functioning are significantly related to the extent to which ACTT clients are able to fulfill the tasks of daily living (Prince & Prince, 2002). All members of a community must be encouraged not to stigmatize – certainly the mental health care system can model that philosophy and be active in its hiring of qualified consumers.

All staff members must be evaluated on their own core competencies, education and experience for a job, without having to be concerned that any personal information would affect the hiring. Being an identified consumer of the system should not lead to fear of stigmatization. We need to acknowledge and appreciate the many different roles filled by consumers. This district should welcome the opportunity to confidentially enumerate the consumers working throughout the system of care.

The many different roles taken by consumers need to be acknowledged, celebrated and encouraged.

3) Remuneration

Inconsistent compensation practices are a concern

Recommendation

There should be an immediate implementation of new funds to ensure parity in compensation across all transfer payment agencies funded by MOHLTC.

- To resolve inequities in compensation among mental health providers;
- To create a program for salary and benefit administration that ensures equity and external competitiveness for employees.

A major stumbling block to a common human resource plan are the variations of funding which led to inequities of compensation among the providers. This is not only highlighted among institutional versus community partners, but among the community mental health programs. Such inequities lead to practitioners moving between providers to access the most beneficial compensation system.

Mental health educators and providers who attended the forum on recruitment, retention, and remuneration said that the biggest obstacle related to remuneration is the lack of equitable pay for practitioners who have similar job descriptions. There is considerable variation in pay and benefits for providers among agencies, between community and hospital settings, and between union and non-union workplaces. They recommended that job functions, salaries, and qualifications become consistent among mental health agencies in this district to reduce competition for employees. Participants felt that a lack of full-time positions makes retaining staff difficult.

Compensation equity objectives, however, need to be supported by budget increases. The experience of non-profit agencies that were required to adopt pay equity but received no budget increases was that it led to a loss of positions in their organizations. Additional legislation such as pay equity has put additional burdens of payment without additional resources. This has led to job layoffs or temporary closings of programs. Compensation in the private sector often lures away professionals from the public sector. Not only are the interests and commitment of these practitioners lost but also members of the target population are unable to access the skills of these professionals.

Remuneration is a critical element of both recruitment and retention. Without appropriate compensation, it is hard to recruit and retain people. Without fair and equitable compensation, it is difficult for various agencies to work together on a human resources strategy.

Documentation indicates under funding is widespread in the sector

Documentation indicates under funding is widespread in the community sector. The provincial government acknowledged it formally in the early 1990's and gave funds to the Federation of Community Mental Health and Addictions Programs to commission the Hay Report. This report was a compensation study to examine staff remuneration. The report was based on the principle of equal pay for work of equal value and established a framework of job descriptions and classification with salary and benefit guidelines.

One of the conclusions of the study's authors was that there was a significant cash compensation disparity in existence when Community Mental Health and Addiction pay practices were compared to the external marketplace. It was recommended that the selected public sector comparator group be the benchmark to use to assess the competitiveness agencies' compensation forms. The following recommendation was forwarded to the Ministry of Health "That the appropriate parties undertake the planning implementation of the steps necessary to move salary range maximums for Community Mental Health Addiction jobs to the average of the selected public sector job, as identified in this report... We would further recommend that this new compensation standard be achieved as soon as possible."

This report is dated 1990. Twelve years later, the same issues are present.

In 2001, the Champlain District Mental Health Implementation Task Force received a motion that new funds be made available to ensure parity in compensation among all community mental health workers.

The compensation data of the CCAP suggests that remuneration equity continues to be an issue.

The necessary funding to fully and fairly compensate all providers in the mental health system needs to be implemented to fully enable district initiatives. To facilitate full coordination and district cooperation, providers need to be on a basis of equal work for equal pay.

Physician Remuneration

Access to Clinical Resources

Recommendation

There should be a variety of physician payment options including salary, alternate funding payment, fee for service, and adequate sessional monies

- To support provision of evidence-based mental health and psychiatric intervention at the primary, secondary and tertiary levels to all those in the region who require it.

- The Ministry of Health & Long-term Care and Ministry of Community and Social Services should provide more sessional money to mental health agencies to access the services of general practitioners and psychiatrists in community settings. These sessional fees are needed for travel to community settings and to obtain psychiatrists' and general practitioners' consultation on mental health services provided across the lifespan, including children and youth, adults, and the elderly. Their services are especially needed at the assessment and diagnosis stages.

Physician payment practices must be revised to provide adequate remuneration for **evidence-based practice** for individuals with the full range of mental illness. While fee-for-service payment may be adequate for individual or group-based interventions for some people in the mild to moderately ill range, it does not cover all aspects of collaborative multidisciplinary approaches, which are most effective for many moderately ill individuals, and most who are severely ill. Examples of such models include consultation to community agencies, "shared-care" collaboration between psychiatrists and family physicians, and participation in assertive community treatment and case management teams.

Models of payment must be varied and flexible, and include salary, alternative funding payment, fee-for service, and sessional options. Allocations of alternative funding positions to the academic setting must be made in such a way that there is assurance of adequate provision of secondary and tertiary level psychiatric intervention to residents of the region who require it in addition to fulfillment of teaching and research obligations to the university. A variety of payment possibilities that will cover all aspects of direct and indirect evidence-based care are seen as a key element in encouraging greater physician participation in an integrated reformed mental health system.

4) Summary

The Human Resources Retreat day allowed for almost 30 participants from the district to discuss the issues facing the mental health system in regard to human resources. There was a recommendation that this group be brought together again and continue to work to improve co-ordination and the quality of our human resources on a district level.

We need to acknowledge the strength of our workers and support them in their own development so that they maintain their high degree of commitment to their jobs, and thus provide the highest possible service to the clients in the system. The system must not discourage or frustrate but rather encourage and empower. We need to allow growth and portability of staff members through the system. Qualified staff members should be encouraged to stay within the system and provided with professional development opportunities.

Fair remuneration throughout the system will allow a district-wide approach to adequate staff recruitment and retention.

Most critically, we must treat our staff members in the manner in which we expect them to support the clients. There must be the recognition that we are a team of people, each with our own strengths, maximizing the opportunities available.

Chapter 8

References

- Abbey, S. (2000). Best practice courses: Maximizing value for your CPD dollar. *C.P.D. Dialogue*, 1(2), 1.
- Beitchman, et.al, Child Psychiatry and Early Intervention: IV, Canadian Journal of Psychiatry, Vol. 37.4. 1992.
- Ben-Dror, R. (1994). Employee turnover in community mental health organization: A developmental stages study. *Community Mental Health Journal*, 30(3), 243-257.
- Bhatara, V. S., Fuller, W. C., O'Connor-Davis, L., & Misra, L. K. (1996). Improving job satisfaction of rural South Dakota mental health providers through education: A pilot study. *South Dakota Journal of Medicine*, 49(3), 93-96.
- Blankertz, L. E., & Robinson, S. E. (1997). Turnover intentions of community mental health workers in psychosocial rehabilitation services. *Community Mental Health Journal*, 33(6), 517-529.
- Davis, D., O'Brien, M. A. T., Freemantle, N., Mazmanian, P., & Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behaviour or health care outcomes? *Journal of American Medical Association* 282(9), 867-874.
- Delva, M. D., Knapper, C. K., Kirby, J. R., & Birtwhistle, R. V. (2001). *Approaches to learning in professional practice: Implications for continuing and undergraduate medical education*. Toronto, ON: Paper presented at the meeting of the Association of Canadian Medical Colleges.

- Hiscott, R. D., & Connop, P. J. (1996). Why hospital mental health staff terminate employment. *Perspectives in Psychiatric Care*, 32(1), 7-11.
- Holmshaw, J., Parkman, S., & Duggan, M. (1999). Fitness to practise in community mental health. *Nursing Times*, 95(34), 52-53.
- Jarvis, P. (1999). *The practitioner-researcher: Developing theory from practice*. San Francisco: Jossey-Bass.
- Kaluzny, A.; Warner, M. & Selman (1982). *Management of Health Services*. Englewood Cliffs:Prentice Hall, Inc. pg. 256.
- Katich, J.; Longest, B. & Darr, K. (1993). *Managing Health Services Organizations* (3rd Ed.). Baltimore:Health Professions Press, Inc. pgs. 526-27.
- Kipping, C., & Hickey, G. (1996). Mental health: Hand-picked recruits. *Nursing Times*, 92(34), 51-56.
- Kirby, J. R., Knapper, C. K., & Carty, A. E. (1997). *Approaches to learning at work: A report to the Bank of Montreal*. Kingston, ON: Queen's University, Faculty of Education.
- Knapper, C. K. (1995). Approaches to study and lifelong learning: Some Canadian initiatives. In G. Gibbs (Ed.), *Improving student learning through assessment and evaluation*. Oxford: Oxford Centre for Staff Development.
- Knapper, C. K., & Cropley, A. J. (2000). *Lifelong learning in higher education*. London: Kogan Page.
- Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., Narrow, W. E., Vaden-Kiernan, M., & Regier, D. A. (1996). Mental health service use in the community and schools: Results from the four-community MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(7), 889-897.
- Macfarlane, D., Fortin, P., Fox, J., Gundry, S., Oshry, J., & Warren, E. (1997). Clinical and human resource planning for the downsizing of psychiatric hospitals: The British Columbia experience. *Psychiatric Quarterly*, 68(1), 25-42.
- Martin, U., & Schinke, S. P. (1998). Organizational and individual factors influencing job satisfaction and burnout of mental health workers. *Social Work in Health Care*, 28(2), 51-62.
- Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood: A comprehensive guide*. San Francisco: Jossey-Bass.

- Offord, D.R. Ontario Child Health Study: Children at Risk. Ministry of Community and Social Services of Ontario, 1989
- Ontario Federation of Community Mental Health and Addiction Programs. (1990) *Compensation Results*. Hay Management Consultants.
- Ontario Ministry of Health. (2001). *Operational Framework for the Delivery of Mental Health Services and Supports*.
- Ontario Ministry of Health. (1999). *Implementation Plan for Mental Health Reform*.
- Prince, P. N., & Prince, C. R. Perceived Stigma and Community Integration Among Clients of Assertive Community Treatment. *Psychiatric Rehabilitation Journal* 25. (4), 323-331. 2002.
- Rabin, S., Saffer, M., Weisberg, E., Kornitzer-Enav, T., Peled, I., & Ribak, J. (2000). A multifaceted mental health training program in reducing burnout among occupational social workers. *Israel Journal of Psychiatry & Related Sciences*, 37(1), 12-19.
- Rakich, J.S., Longest, B. B., & Darr, K. (1993). *Managing Health Services Organizations*, 3rd Ed. Baltimore: Health Professions Press Inc., p. 279.
- Resnick, L. (1987). Learning in school and out. *Educational Researcher*, 16(9), 13-20.
- Scheffler, R. M., Ivey, S. L., & Garrett, A. B. (1998). Changing supply and earning patterns of the mental health workforce. *Administration & Policy in Mental Health*, 26(2), 85-99.
- Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday.
- Stoner, J. (1982). *Management* (2nd Ed.). Englewood Cliffs: Prentice-Hall, Inc. pg. 17.
- Swidler, R. N., & Tauriello, J. V. (1995). New York State Community Mental Health Reinvestment Act. *Psychiatric Services*, 46(5), 496-500.
- Thomsen, S., Soares, J., Nolan, P., Dallender, J., & Arnetz, B. (1999). Feelings of professional fulfillment and exhaustion in mental health personnel: The importance of organizational and individual factors. *Psychotherapy & Psychosomatics*, 68(3), 157-164.
- Watkins, K. E., & Marsick, V. J. (1993). *Sculpting the learning organization*. San Francisco: Jossey-Bass.
- Wattie, Brenda. (1999) *Our Concern is for Children*.

Wenger, E. (1998). *Communities of practice: Learning, meaning and identity*. London: Cambridge University Press.

Wolfenden, K., Blanchard, P., & Probst, S. (1996). Recruitment and retention: Perceptions of rural mental health workers. *Australian Journal of Rural Health*, 4(2), 89-95.

Glossary

Consumer

Is someone who has experienced or is experiencing mental health problems (Human Resources Committee, Mental Health Implementation Task force, Southeastern Ontario, 2002).

Consumer Provider

Is a provider who is or has been a consumer of mental health services and has the core competencies to provide services. (Human Resources Committee, Mental Health Implementation Task force, Southeastern Ontario, 2002).

Core Competencies - Individual

Are the required knowledge, skills, experiences and attitudes of providers that are necessary to bring about desired outcomes in mental health practice. This level applies to consumer, volunteer and professional providers (Human Resources Committee, Mental Health Implementation Task force, Southeastern Ontario, 2002).

Core Competencies - System

Are the required structures and processes that enable the system to work as a collective on behalf of the individual. This level applies to agencies, organizations, training and education centres, centres for research and innovation and the complete range of governments (Human Resources Committee, Mental Health Implementation Task force, Southeastern Ontario, 2002).

Designated Title

Are titles, given under provincial law, to professional providers, which only those duly registered with the profession may use. (Human Resources Committee, Mental Health Implementation Task Force, Southeastern Ontario, 2002).

Evidenced-based Practices

Are health care practices that have been formally evaluated and proven to have benefited the individual in need and the health care system. (Human Resources Committee, Mental Health Implementation Task Force, Southeastern Ontario, 2002).

Multidisciplinary/Interdisciplinary Team

Is a group of mental health providers with specialized expertise and a common commitment to meet the consumer's needs, one that supercedes the boundaries of their own disciplines. Every member of the team recognizes the value of his/her own particular level of expertise, in either a professional or personal capacity, for meeting at least one of the consumer's needs with the awareness that each discipline relates with other disciplines in the delivery of the overall plan of care to the consumer. (Rakich et al., 1993)

Performance Indicator

Is a benchmark to measure whether a task or behavior has been adequately completed within standard. ("Workplace Planning Education and Training", Workforce Action Team, 2001).

Quality Assurance Program

Is a program that ensures that the quality of care rendered by providers continuously meets acceptable standards and that consumer safety and well being take highest priority at all times. (Williams et al., 1982).

Scope of Practice

Outlines the specific tasks and health care services that a provider may perform, as regulated by provincial law, colleges and professional associations, Each profession has its own scope of practice. (Human Resources Committee, Mental Health Implementation Task Force, Southeastern Ontario, 2002).

Special Populations

Moderately Mentally Ill

Are individuals whose mental health problems, although not sufficiently serious, persistent or disabling enough to be considered to be a serious mental illness, are severe enough to hamper their functional ability (their capacity to develop and maintain satisfying relationship with others) and to require treatment.

Seriously Mentally Ill

Are individuals, with a significant disability that severely limits their ability to function, who suffer from a major mental disorder, with the duration of both conditions being longstanding

Concurrent Disordered

Are individual struggling with an addiction/substance abuse problem and a major mental disorder.

Forensic/Legal Client

Are individuals who: are being dealt with by the court or the Ontario Review Board (under Part XX.1 of the Criminal Code of Canada); struggling with a major mental disorder; and are in conflict with the law.

Dually diagnosed

Are individuals diagnosed with a developmental disability and a major mental illness and/or challenging behaviour.

Family

Includes parent, siblings, extended relatives, and, at times, a broad range of supportive people who are not relatives of the person with mental illness

The Aging Population

Refers to older persons (over 65 years of age) whose primary problem is a major mental illness, with or without a complex medical condition.

Children and Youth

Refers to younger persons (19 years of age or under) with mental health problems/disorders ranging from emotional and behavioural distress, depression, personality disorders, addiction and disorders of neurological origin, and, in a very small proportion of young people, psychosis.

Specialty Champion

Are individuals who specialize in the care of a specific, special population and have demonstrated an ability to: attract others to their subspecialty;

inspire innovative practice; share knowledge and co-create innovation; operate within a global community and serve as role models and mentors while practicing their specialty with passion and excellence.

Standards of Practice

Represents the general competencies that providers must use to ensure that they provide appropriate care in the variety of situations that they meet in their practice (COTA, Standards of Practice, 1996).

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Remuneration

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME

1. The Ministry of Health & Long Term Care to fund the governing body of the reformed mental health system in Southeastern Ontario to implement a process to resolve inequities in compensation among mental health providers and to create a program for salary and benefit administration that ensure equity and external competitiveness for employees.	SHORT TERM	6 months	Ministry of Health & Long Term Care	Employers Providers	The will and commitment to move quickly to make recommendations for pay equity. Need funds to contract out for study. The Ministry may lack the funds to achieve pay equity.	Study reports available. The governing structure of the reformed mental health system in Southeastern Ontario implements pay equity recommendations.	Pay equity achieved. Agencies able to fill positions with qualified providers. Less Staff turnover. Full district collaboration on human resource issues can be undertaken.
	MEDUIM TERM	Year 1					
	Design and implement policy						

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources – Children and Youth

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME

2. In the area of child and youth, mental health there is in Ontario a jurisdictional split between health and social services that has resulted in serious inequalities of staffing and quality control. There are also splits between both of these jurisdictions and other important systems serving children and youth, such as education and corrections. It is recommended that a senior secretariat at the ministerial level should undertake a review of the various levels and types of mental health services for children and youth in Ontario.	SHORT TERM Identify ministry representatives	6 months	A 'Minister for Children' or other senior politician.	Child Advocacy Groups	Require collaboration from Various provincial offices Political will	Criteria to be developed by an Advisory Committee Would require a strategy to cover all children's services	Advisory recommendations to the various Ministers and their staff to implement changes.
	MEDIUM TERM Senior secretariat at the ministerial level should undertake a review of the various levels and types of services for children and youth in Ontario.	Year 1		Provincial Service Associations Providers Families			

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources - Access to Clinical Resources

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME
3. The Ministry of Health and Long-Term Care to provide a variety of physician payment options including salary, alternate funding payment, fee for service, and adequate sessional monies to support provision of evidence-based mental health and psychiatric intervention at the primary, secondary and tertiary levels to all those in the region who require it.	SHORT TERM Increase funding for sessional monies.	6 months	Employers	Employers Providers	Ministry of Health & Long Term Care may be unable to invest funds. Need additional funds for services.	Observe mental health agencies accessing general physicians and psychiatrists more often.	Increased support and availability of psychiatrists to mental health agencies. Better quality of care.

**Final
RESOURCES**

IMPLEMENTATION STRATEGY - HUMAN

Key Area of Focus: Human Resources – Core Competencies

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME

4.The governing body of the reformed mental health system in Southeastern Ontario should adopt the core competencies for mental health providers as recommended and outlined in the human resources committee report.	SHORT TERM Establish core competency standards	6 months	The governing body of reformed mental health system in Southeastern Ontario	Employers Providers	A culture shift among mental health agencies is key to using the standards. There may be resistance from those used to a traditional approach. People are afraid of change.	Every agency uses the competency standard in their policies.	Better quality Of Care. Providers Have higher levels of competency.

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources – Human Resources Network

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME

5.The governing body of the reformed mental health system in Southeastern Ontario to develop an ongoing network composed of providers and employers in the district to address cooperation among mental health agencies on recruitment and retention of providers in the district.	SHORT TERM Coordinate recruitment strategies. Undertake recruitment campaign. Assess retention strategies and share findings. Develop consistent hiring practices.	Year 1	The governing body of reformed mental health system in Southeastern Ontario's regional research and evaluation unit.	Employers Providers Consumers Families	Mental health providers may be hesitant to collaborate on 3 RRR's. Need funds for recruitment campaign. Unions may not support objective.	Agencies have consistent RRR practices. Recruitment campaign reaches general public, health care students and providers.	Less staff turnover. Less conflict among agencies due to competition for staff. More Applications per position.
		Year 1					
		Year 1					
		Year 2					

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME
6. The governing body of the reformed mental health system in Southeastern Ontario to adopt standards of practice to promote a culture of leadership that develops leaders, supports leadership values, and encourages leaders to act as mentors to other staff.	SHORT TERM Coordinate recruitment strategies. Undertake recruitment campaign. Assess retention strategies and share findings. Develop consistent hiring practices.	Year 2	The governing body of reformed mental health system in Southeastern Ontario.	Employers Providers Educators	Task of setting standards is complex	Agencies have policies requiring leadership behaviour.	Increased providers satisfaction and morale. Less staff turnover.

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources – Continuing Professional Development

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME
7. The governing body of the reformed mental health system in Southeastern Ontario to develop a protocol for ongoing consultation in the district among providers, employers, and educators regarding coordination of basic education and training and continuing professional development.	SHORT TERM Promote continuing education attitude. Seek input from consumers & families. Agencies share advice on education practices. Develop consistent practices for supporting activities.	Year 1	The governing body of the reformed mental health system in Southeastern Ontario regional research and evaluation unit.	Employers Providers Educators Consumer Family	Involving Providers is key to acceptance of committee suggestions. Agency decision-making process may make implementation of committee suggestions difficult. Mental health Agencies need to reorganize budgets to make available funds for educational activities. Need funding for evaluation studies.	Observe similarities in education programs and collaboration among agencies. Consistent Policies are established. Increase in the number of training programs and training activities.	Better quality of care. Less staff turnover. Increased provider satisfaction. Fewer staff sick days. Decreased number of unusual or violent incidents. Fewer providers have difficulty meeting continuing professional development requirements.
		Year 1					
		Year 1					
		Year 1					
	MEDIUM TERM Evaluate education programs.	Year 3					

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources - Downsizing

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME

8. When downsizing of a mental health agency must occur, agencies should undertake employee transition planning that follows the better practices guideline.	SHORT TERM Follow guidelines to achieve staff reductions. Hold transition management workshops. Define new roles for staff and provide training. Communicate information to staff.	6 months		Providers Consumers Families	People are afraid of change. Unions may not support process. An attitude of inclusion is important for facilitating process.	Observe smooth transition of employees to new positions. Agencies communicate and involve staff and the affected agencies.	Providers, consumers, families are satisfied. Providers are appropriately skilled for their new positions.
		Year 1					
		Year 1					
		Year 1					

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources – Training Programs

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME
9. The governing body of the reformed mental health system in Southeastern Ontario should undertake an evaluation of training programs and use the findings to inform education and training programs in the district.	SHORT TERM Conduct evaluation studies	6 months	The governing body of the reformed mental health system of Southeastern Ontario	Researchers Employers Educators	Need funds to support an evaluation of education and training. A study of education And training is already Funded and moving Forward at Queen's University.	Study reports available. The governing body would share the findings with agencies, educators in the district, including the education and training consultation group. Meetings between mental health agencies, educators and the researchers are held to facilitate information.	Agencies and educators will have good information to inform their educational practices.
	MEDIUM TERM Share findings with agencies and educators	Year 2					

Final

IMPLEMENTATION STRATEGY - HUMAN RESOURCES

Key Area of Focus: Human Resources – Pilot Program for Competency

OVERALL RECOMMENDATION/ISSUE	RECOMMENDED ACTIONS/ STRATEGIES	TIMEFRAME TO IMPLEMENT MAJOR MILESSTONES	ACTION LEAD	STAKEHOLDER PARTICIPANTS	CRITICAL ENABLERS/RISK S	MONITORING PROCESS/ EVALUATION CRITERIA	EXPECTED OUTCOME
10. Ministry of Health & Long Term Care to fund the governing structure of the reformed mental health system in Southeastern Ontario to pilot a program for recognizing and rewarding the clinical competence of providers in this district.	SHORT TERM Set benchmarks & establish performance indicators.	Year 1	The governing body of the reformed mental health system in Southeastern Ontario	Employers Providers Educators Consumers Families	Initial tasks of setting benchmarks and performance indicators are complex. Needs additional funds for recognizing and rewarding clinical competence. Unions may not support this objective .	Benchmarks and performance indicators shared with mental health agencies in the district. Mental health agencies have learning plans. Agencies have policies that encourage and support clinical competence.	Better quality of care. Increased provider satisfaction. Less staff turnover. Providers have higher levels of competency.
	MEDIUM TERM Assist agencies' assessment of learning & learning plans.	Year 2					
	Promote attitude of competency.	Year 2					
	Provide resources for competency.	Year 2					



Technical and Background Report to the Integration Committee of the Southeastern Ontario Mental Health Implementation Task Force

**Prepared by the Integration Committee of the
Southeastern Ontario District Mental Health Implementation Task Force**

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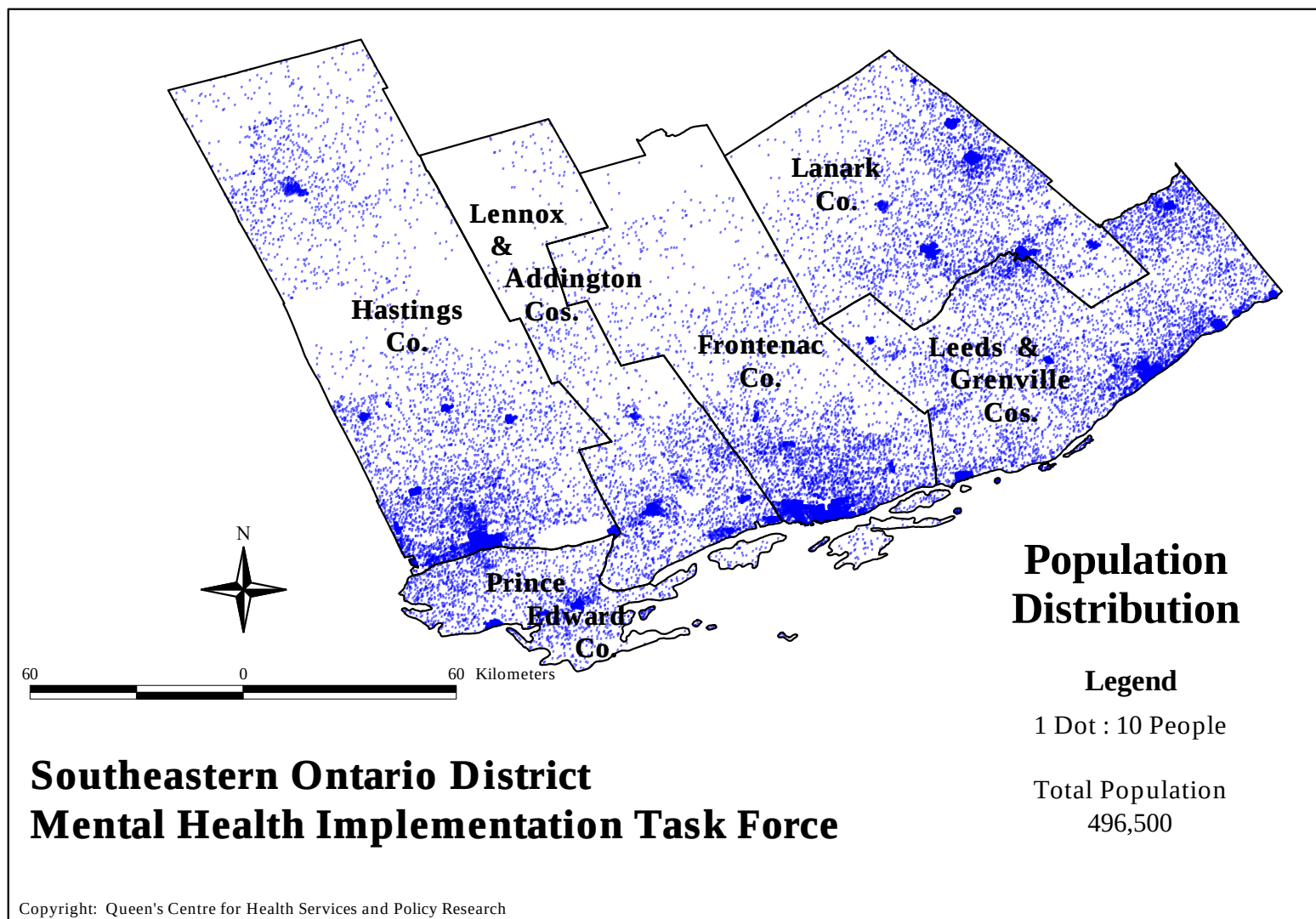
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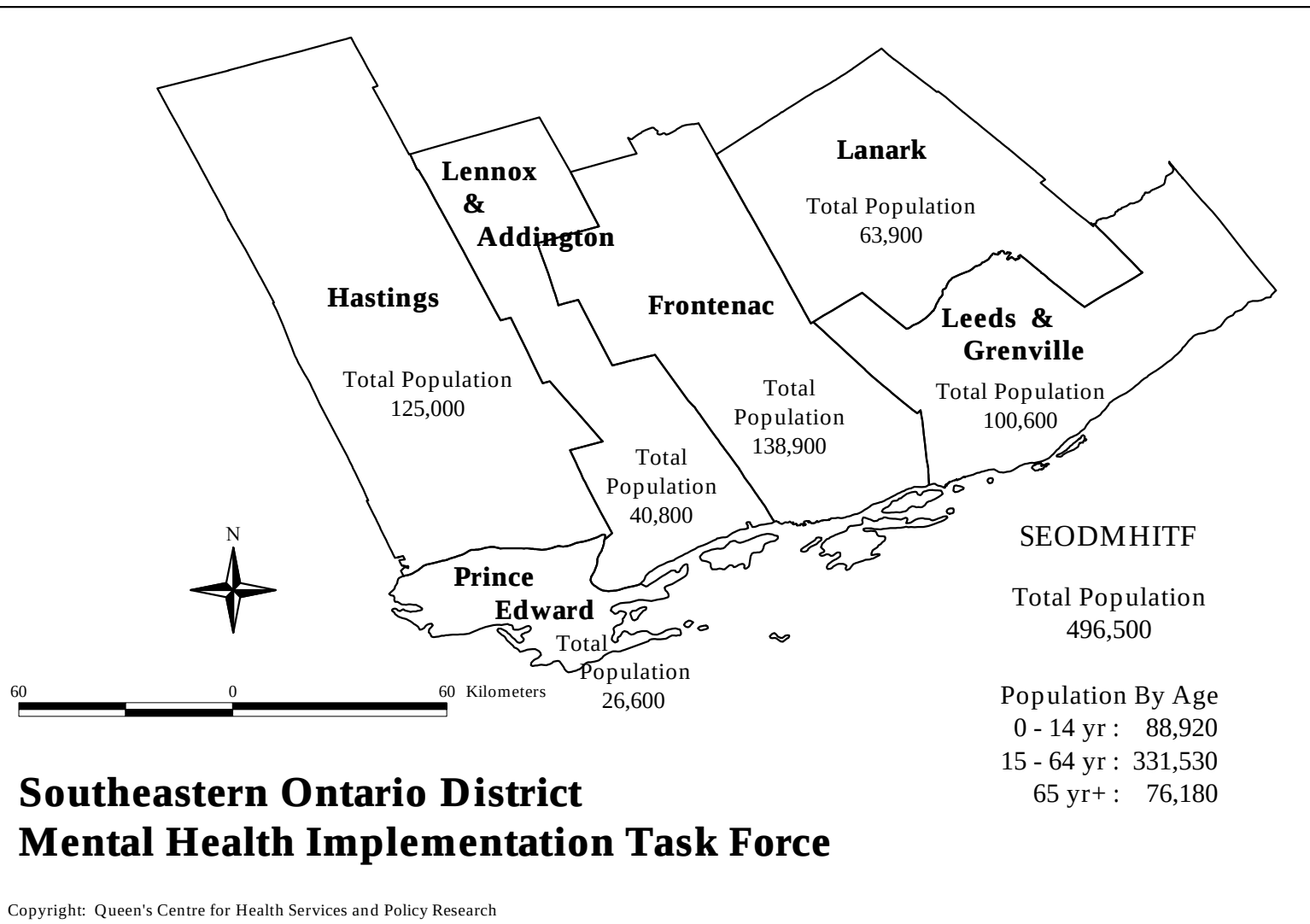
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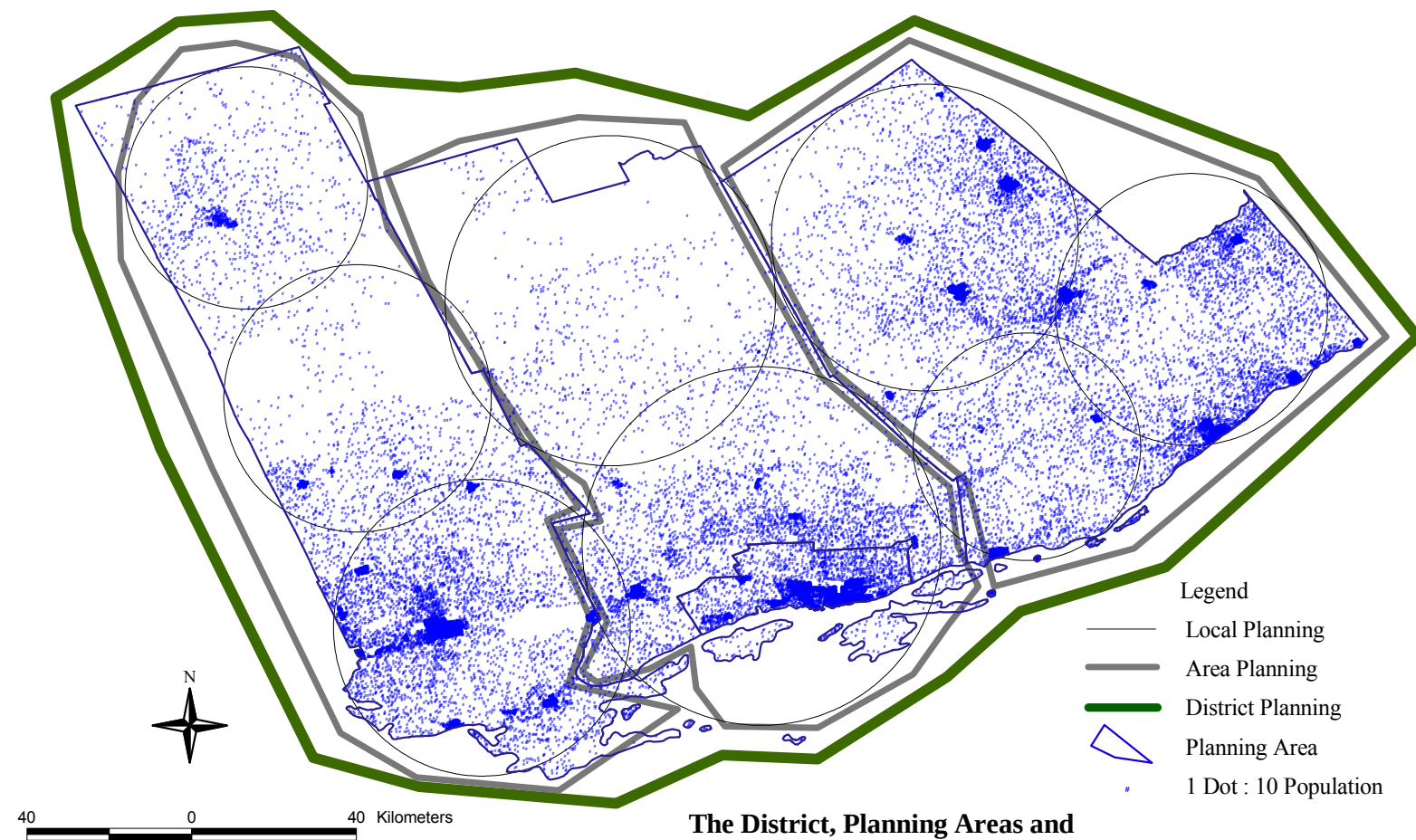
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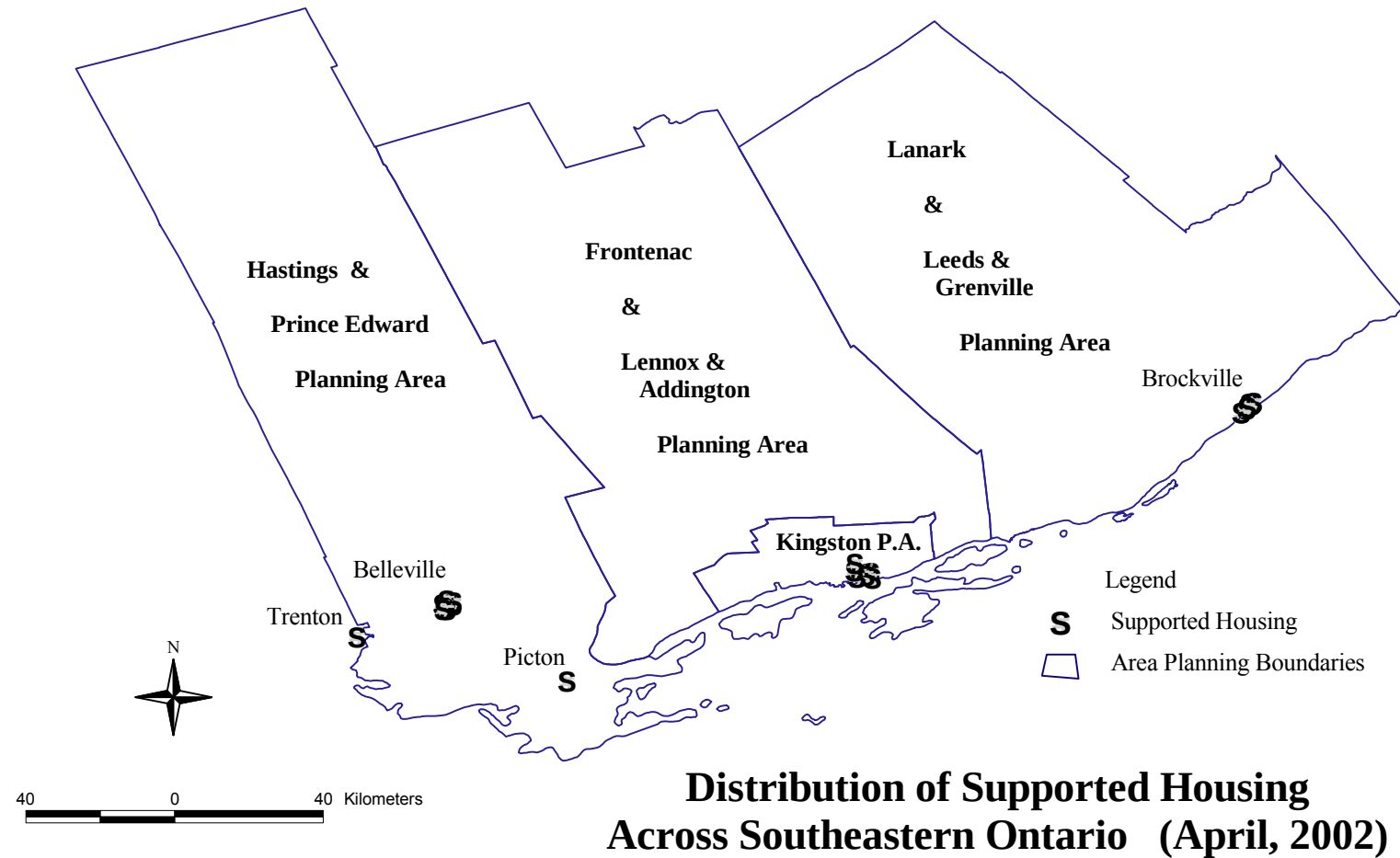
Mental Health Implementation Task Force Southeastern Ontario



**The District, Planning Areas and
Sub-Planning Areas within the Six Counties**

Mental Health Implementation Task Force

Southeastern Ontario



Chapter

1



Introduction and Executive Summary

This Technical and Background Report to the Integration Committee of the Southeastern Ontario Mental Health Implementation Task Force summarizes the combined efforts of the Integration Committee and its working groups. The report proposes a strategy for reform of the mental health system and services in the Southeastern Ontario district.

The Integration Committee, created by the Southeastern Ontario Mental Health Implementation Task Force, was charged with the responsibility to make recommendations on the development and implementation of “a consumer-centered, integrated, accessible, coordinated best practice continuum of services and supports across the age span and three levels of care” for all persons with a mental health need at any stage of life.

Three working groups were struck to advise the Integration Committee on issues related to First Line, Intensive and Specialized levels of need and service. The Integration Committee and the Working Groups worked within the framework of “Logic Models” which identified, expressed and articulated the essential components, process objectives, outcomes and strategic goals necessary to realize the reform vision embodied in *Making It Happen*. The logic models are included as Appendix B in Section II of this report.

The Integration Committee and Working Groups took ownership of their responsibilities and produced analysis, advice and recommendations that truly reflected their informed, detailed and thoughtful deliberations. Their opening objective was to produce fully articulated individual reports and recommendations for the Task Force.

This report is designed to provide a compilation of the work achieved by the Working Groups and the integration committee to September 2002. It stands as a technical and background paper to support the Integration Committee’s formal Report. The report is produced in two sections:

Section I was prepared by and for the Integration Committee, and informed by the deliberations of the Working Groups with input from many other sources including population-specific Champion Groups.

Section II provides background material, including some selected best practice literature reviews, the logic models used to guide the Working Groups and Committees, the reports of the Working Groups, a compendium of working group recommendations compiled by the Task Force Secretariat and a demographic profile of the Southeastern Ontario District.

1.1 A Focus on the Consumer and the Family

The Southeastern Ontario District Mental Health Implementation Task Force (SEODMHITF) is committed to the significant involvement of consumers and family members. This report begins with their perspectives (Chapter 2). The perspectives were written by a consumer and a family member and are included with no significant editorial change.

The consumer perspective reaffirms and supports the adoption of a recovery philosophy by the SEODMHITF. It focuses on the need to reduce stigma, the importance of employment and the benefits of peer support in promoting the self-esteem of the consumer. It stresses the difficulties faced by the consumer seeking help from the current system and the need for advocacy by the consumer with the support of others.

The family perspective includes a compelling description of the impact on families who are supporting a member with mental health issues. It too stresses the need for stigma reduction and community education. It encourages professionals to engage family members in the care and planning for the mental health needs of their loved ones, and argues that their insights, knowledge and ongoing support to the consumer can contribute to better outcomes for them.

1.2 A Reform as an Evolutionary Process

Those who ignore the mistakes of their history are bound to repeat them. Chapter Three provides a brief review of the history of mental health services

movement of the 1950s and the subsequent struggles to develop effective, community-based, systems during the last half of the 20th-Century.

The chapter outlines the policy directions established in the early 1980s towards “a balanced and comprehensive mental health care system” and “a separation of treatment and accommodation.” It notes the objectives estab-

lished in the late 1980s to provide supports that extend beyond clinical treatment to include living and functioning in the community and the coordination of services to establish a continuum of care.

The chapter then describes the framework, development work and strategic planning initiatives of the early 1990s, the interventions of the Health Services Restructuring Commission in the mid-1990s and the significant background work in the late 1990s that led to the creation of the Mental Health Implementation Task Forces. Armed with a range of background materials, framework guidelines and policy directions, the task forces set out to design, and soon will complete, specific mental health reform plans for their designated geographical districts.

It is this context that defines the work of the Integration Committee and its Working Groups.

1.3 Careful Planning and Best Practices

The work of the Integration Committee and the Working Groups was to be guided by two major perspectives: the Logic Models that set their objectives, and Best Practices that conditioned their recommendations. A complete set of logic models is included in Section II, Appendix B of this report and a number of Best Practices literature reviews are included as Section II, Appendix A. A comprehensive inventory of recommendations made by the committee and working groups is included in Section II, Appendix D.

Chapter Four of this report correlates and integrates the logic models and best practices with the discussions and recommendations of the First Line, Intensive, and Specialized Services Working Groups.

The three working groups share a single set of *long-term* objectives which express the *Making It Happen* vision. They are:

1. An improvement in the quality of life for consumers, families and significant others across the age span;
2. An improvement in the economic, physical, and social well-being of people living with a serious mental illness and other mental health problems;
3. An increased number of consumers benefiting from increased access to mental health services, supports and interventions;
4. An improvement in accessibility, treatment effectiveness and system efficiency by providing a seamless continuum of high-quality and consumer-centered care;

5. An improvement in clinical outcomes through the provision of crisis, early intervention, intensive treatment and specialized services; and,
6. An improvement in the systems' ability to respond to consumer needs.

Each Working Group made recommendations that are specific to their particular focus and the chapter outlines a number of defined services (different types of information and referral, crisis intervention, community treatment, and specialized services *etc.*), the objectives in establishing and promoting them and the best practices implications related to them.

The provisional reports included in Section II, Appendix C, illustrate the wide ranging discussions and background to the recommendations of the Working Groups. A common theme that emerged from all of the groups, which will go on to condition the systems design and implementation plan, is that, wherever possible services should be available to the consumer as close to home as possible. This is conditioned by a recognition that highly specialized and relatively rare resources will have to be more centralized and consequently more remote from the consumer's home.

1.4 A Consumer-Centered Reform Plan

The extraordinary workload, together with the convergence of report deadlines mentioned in the introduction of this chapter, left little time for the Working Groups to turn their attention to the detailed analysis and planning required to produce a comprehensive systems design and implementation plan for the district.

The provisional reports of the working groups, together with the collection and analysis of some limited data and material from preliminary reports of other Task Force committees, and suggestions from the authors, provided the basis for the tentative reform plan described in Chapter Five of this report. This material should be helpful to the development of a comprehensive plan by the Task Force.

Advice to the Integration Committee calls for the development of a systems structure built around the three-tiered levels of service (First Line, Intensive and Specialized) and based on the traditional planning areas across the district (Hastings and Prince Edward Counties, Frontenac, Lennox and Addington Counties and Lanark, Leeds and Grenville Counties).

The framework provided suggests that:

1. The Ministry of Health and Long-Term Care, at the corporate level, be the lead ministry for all mental health services across the age span and continuum of need with primary responsibility for legislation, policy and funding;

2. The Ministry of Health and Long-Term Care Regional and local offices be the primary interface organizations with the service delivery system at the operational level;
3. Local (municipal) governments are service hosts and providers and should be seen as partners in the system;
4. The Southeastern Ontario Mental Health Trust be created to implement, monitor, and evaluate the system;
5. Area-focused Mental Health Councils be created as time-limited advisory planning bodies to assist the Trust in implementing the system;
6. Multi-Service Agencies be created for communities that do not have a strong local service delivery system;
7. Public Health Units, Community Health Centres and Family Health Networks be affiliated to ensure that these organizations are integrated into the Mental Health system for the mental health-related responsibilities they have;
8. Centres of Excellence be created as primary providers of specialized services, advice and training; and,
9. Hospital Networks be developed to provide support to community hospitals by Schedule 1 facilities.

These nine suggestions emerge from a wide range of materials and sources including the Task Force Secretariat, various independent consultants, the Task Force Committees and published and grey literature. Taken as a whole they provide guidance for the development of a comprehensive plan for the district.



Consumer and Family Perspectives on Mental Health Reform

2.1 The Consumer Perspective

► **Living with a mental illness is difficult at the best of times.**

Not only do we have to deal with the symptoms of the illness and the effects of treatment, but with the impact that it has on our lives; our ability to live in a nice home, have an adequate income, work and engage in meaningful activity, maintain friendships and have positive relationships with family members. The illness itself is only one part of what needs to be addressed in order for us to recover and live a satisfying life.

► **Recovery is possible with the right kind of support and encouragement.**

Recovery is the ongoing process of learning to cope with and lessen the impact that the illness has on our lives. This process is different for each individual and is based on personal preferences and choices.

Through a comprehensive review of recovery literature, Ruth Ralph has identified a number of internal and external factors that help people recover. Consumers become aware of the impact that the illness has on them, recognize the need to change and begin to do something about it. They learn to manage their own health and cope with the difficulties and barriers that they face.

In order to do this, consumers need encouragement and support from friends, family and professionals who give us hope and believe that we can recover our illness. Consumers need to become empowered, that is to learn the skills we need to take control of and responsibility for our own lives.

We all have hopes and dreams, gift and abilities that need to be recognized and fostered. Recovery is not just a philosophy, but also a possibility for all of us with the right kind of support and encouragement.

► The Southeastern Ontario Implementation Task Force has adopted a recovery philosophy.

It is not enough to just say that our programs and services are recovery oriented. As Jacobson and Curtis have stated, there needs to be a “fundamental shift towards sharing both power and responsibility.” Contacts with service providers need to focus on building up the person’s ability to manage their own lives. There is a shift from “doing for” consumers to “working with,” helping them grow and change based on their choices and dreams.

Some of the strategies that make a mental health system recovery oriented as identified by Jacobson and Curtis include; education, consumer involvement, support for consumer operated services, emphasis on relapse prevention and management and stigma reduction initiatives. Ralph states that “the most important recommendation is that consumers, researcher and policy makers work together and learn from each other.”

► Stigma is a mental health issue that needs to be addressed.

One of the biggest problems that people face is stigma, which exists even within our health care system. Those with a mental illness should be treated no differently than those with other kinds of health problems. Stigma prevents people from receiving the help that they need and from feeling accepted in our communities. It is an issue that the reformed system needs to address and work to eliminate.

Many consumers are forced to live in substandard conditions, which has a direct impact on their mental health. The reformed system needs to help consumers find decent, safe affordable places to live in. It is important that more subsidized housing be made available for consumers, that boarding homes be regulated and brought up to reasonable standards and that support be provided to help people locate, secure and retain their housing.

► Employment has a positive impact on emotional well-being.

The Comprehensive Assessment Projects done at the former Kingston and Brockville Psychiatric hospitals show that about 90% of patients have had permanent jobs in the past, almost all being full time. The current estimated unemployment rate of consumers with a serious mental illness is between 75 and

89%. This high level of unemployment does not reflect the ability or desire that many consumers have to work.

Successful supported employment programs and consumer run business have demonstrated that consumers, even those who are seriously ill, are very capable of being successfully employed. Working has a positive impact on their well-being. We need to build on these successes and provide supports that are available to all consumers who express a desire to work to help them reach their full potential.

One of the problems that occur in our system is that service providers may only see consumers when they are acutely ill which can lead to misperceptions about what consumers are capable of doing. One way of overcoming this is to employ consumers within mental health agencies. This will help educate staff about the true abilities of consumers and reduce some of the stigma that still surrounds those with a mental illness.

When a consumer interacts with a peer who is successfully employed or working in a mental health agency, they are often inspired by seeing what is possible. This can help to instill hope, which is one of the key factors leading to recovery.

► Peer support helps to increase self-esteem and leads to greater self-reliance.

Consumers know the value of peer support and the benefit of having someone to talk to who truly understands what they are going through. Many consumers say that the support they receive from their peers is as helpful as what they receive from professional services.

Currently, peer support is being provided through Consumer Initiatives, self-help groups and by peer specialists on Assertive Community Treatment Teams. While this is a good start, a reformed system needs to build on the importance and success of these approaches and make peer support available to all consumers in a way that is fully integrated with all other supports and services.

Research on Consumer Initiatives shows that participation in these programs leads to increased self-esteem, better coping skill, and to greater self-reliance. As well consumers experience a decrease in symptoms, become less reliant on mental health services and are hospitalized for fewer days.

Consumer Initiatives and self-help groups have always been recovery oriented and promote self-reliance and empowerment. It has only been in recent years that the formal mental health system has recognized how effective this approach is and the principles are beginning to be incorporated in the delivery of services across the system.

► In our current system, it is hard for consumers to get the help that they need when they need it.

People do not know who to call for information or what to do when they first begin to have a mental health problem. Services generally are not tailored to individual needs and consumers have little choice about where and from whom they receive services. Little attention is paid to preventing relapse and many people are forced to wait until they are very ill before they can get the services that they need. Consumers end up in emergency rooms because they do not know what else to do.

Making It Happen identifies the importance of tailoring services to consumer needs, improving consumer choice, making access more streamlined, and having services coordinated and linked to make it easy for people to move throughout the system as required. People with a mental illness, like people with any illness, deserve to have easy access to high quality care that meets their personal needs and preferences.

► Children and youth have special needs that must be addressed.

Our current system of mental health services for children and youth is very fragmented, with services provided and funded by two ministries. Often the mental health needs of children and youth are not met. It may be that a child has an ill parent or sibling which causes them distress as they try to cope, or the child may be experiencing distressing symptoms and does not understand what is happening to them. The needs of children and what works best to help them when they are ill are different for children than for adults. The reformed system needs to find ways to ensure that children and youth at risk are identified early and treated as soon as possible to prevent them from becoming chronically ill adults.

► Advocacy is essential for recovery.

For consumers, advocacy is an essential service. When we are ill, it can be very difficult to speak up if we are experiencing a problem with the care we receive or are having difficulty accessing services. We need to have advocates who can support us to voice our own concerns or speak on our behalf when we cannot do this for ourselves. By supporting people to speak up for themselves, we are helping them to take control of their own lives, which is essential for recovery. Consumer advocacy programs need to be adequately resourced and available to all consumers of mental health services, including inpatient and community programs.

► A consumer centred mental health system involves consumers as active and valued participants in planning, evaluation and governance.

Making It Happen makes many recommendations that support the shift towards a recovery philosophy in Southeastern Ontario including having consumers involved as “active and valued participants in the planning, evaluation and governance of mental health services.” At a program or agency level, this can be achieved through having consumers actively involved in consumer/patient councils, as committee and board members, and as members of the staff. Consumers have a wealth of knowledge about effective coping skills, what treatment and approaches work well and how existing programs and agencies can be modified to promote recovery. By working together as partners, we can “Make It Happen.”

2.2 The Family Perspective

Family members who have to deal with a loved one’s serious mental illness react in predictable ways to its onset and progression. There is likely to be a period of denial and the hope that the situation is not what it appears to be. Families are devastated. Feelings of bewilderment, shame, guilt, fear, resentment and powerlessness are common. There is a tendency to isolate and to hide the problem from friends and neighbours. Family members face a terrible dilemma. The loved one is still there but in important ways is not the same person they have known and loved. Families must deal with a double-edged sword: positive behaviours they have depended on from their relative (stability, intimacy, reliability, *etc.*) are no longer there; negative behaviours they have never seen the loved one exhibit previously (aggressiveness, irritability, suicidal ideation, apathy, wide mood swings, self absorption, delusions, hallucinations, psychotic episodes, *etc.*) are now common. The period of denial by the family is often followed, over time, by anger, guilt, depression, and eventually by acceptance of, and a desire to cope with, the new living situation.

Family member’s reactions to the illness vary. There are a number of distinct relative groups who share the basic situation of dealing with serious mental illness but who have different perspectives, levels of involvement, needs and concerns:

1. Primary caretakers (parents and spouses) in many cases must deal with a myriad of problems facing their loved one: compliance with medications, nutrition and self care, relapse prevention, safety concerns for the relative and others, dealing with police, economic survival, housing, abuse of drugs/alcohol, *etc.*;
2. Spouses have the additional burden of having to cope with the loss of a confidant, loss of sexual intimacy, loss of the partner who shared the

burdens of child rearing and other family responsibilities and must also deal with the family's shattered dreams and plans for the future;

3. Siblings and children must deal with wildly disproportionate attention being given to the sibling or parent who is ill, may witness terrifying and bizarre behaviour, may have more chores and work to do, are forced to grow up quickly, must often deal with the fear of harm from the ill relative, face the fear of becoming ill themselves or passing the illness to their children, *etc.*

All family members must face these problems while dealing with stigma and the lack of knowledge about serious mental illnesses in our society. These problems affect a large number of Canadians: "Although definitions vary, it has been estimated that 2-3% of Canadians (over 700,000 people) have a serious or persistent mental illness that causes significant suffering and results in socio-economic disability" (*A Framework For Mental Health System Accountability in Southeastern Ontario*, Prepared For The Consideration of The Southeastern Ontario Mental Health Implementation Task Force).

The issues important to family members of persons suffering from serious mental illnesses are:

1. Insensitivity of mental health professionals to the emotional distress experienced by family members.
2. Difficulty understanding medical jargon: "It is almost impossible to make an informed decision if we cannot interpret the language."
3. Difficulties accessing help: "Accessing entry into the system has been very difficult and confusing as we, as family, are often overwhelmed by the demands of the illness and face either closed doors or are shuffled from one organization to another in our attempts to access the type of support we need at that stage of the illness."
4. Lack of family involvement in treatment: "Families must be permitted and encouraged to become more (involved) with their loved one's progress or lack of it during hospitalization."
5. Family education regarding the illness is lacking but is essential if families are to cope with the problem.
6. Economic concerns: "Mental illness creates poverty forcing many to live a hand-to-mouth existence in destitution and homelessness as they are unable to avail themselves of employment appropriate to their education."

► **What Families Need From a Reformed Mental Health System:**

Simply this: education, stigma reduction/destruction and input into and support from the mental health system for family members.

The need for better education about serious mental illnesses is paramount for families learning to deal with a relative's illness. Our specialized working group has already discussed a number of strategies to better inform the general public about the nature, course and outcomes of mental illness and these are relevant to family education as well: That mental health programs be included as core programs in health units in Southeastern Ontario, and funded appropriately. The concept of a district 'public educator' position is seen as an important component of this initiative.

It will be important to use creative and innovative programs and to capitalize on those already in existence. For families, programs such as the National Alliance for the Mentally Ill (NAMI) Family-to-Family Education Program sponsored in Kingston by the two local family resource centres (Providence Continuing Care Centre-Mental Health Services and Frontenac Community Mental Health Services) are very useful.

It will be important to work with educators to include a mental health component in school curricula, especially in elementary grades. Informed family members armed with knowledge of the illness and prepared to share their own experience with others are often very effective as "guest speakers" in schools at all grade levels.

► **Stigma Reduction:**

Families often suffer the additional burden of living in shame and isolation and efforts must be made to break down the barriers keeping people from sharing their experience, strength and hope with each other to better deal with the ongoing effects these illnesses have on their lives. The number one problem here is the stigma that attaches to persons suffering from serious mental illnesses and the family members who stand by them. Suffering from a mental illness should not engender disrespect, fear, loathing and discrimination from one's fellows – yet this is the experience of many, if not most, of our mentally ill relatives and their family members. Societal attitudes can be changed, as the success of groups such as Mothers Against Drunk Driving has demonstrated. To affect this kind of alteration in the public perception of mental illnesses and those who suffer from them will be a massive undertaking involving:

1. Education at many levels – including endorsement of anti-stigmatization efforts by social and community leaders, entertainment figures and sports stars – must be encouraged.

2. Negative images in the entertainment and news media which fuel public fears and may overtly contradict positive educational efforts must be fought against and discouraged.

As families gain education and experience in dealing with these problems they can become advocates and leaders in this fight.

► **Input/Support:**

Family members have identified a number of ways health care professionals and others involved in the care of seriously mentally ill individuals can help families deal with the effects of these illnesses in their lives. These include:

1. Simplified consumer/family access to the range of services and supports within the local mental health system.
2. Increased community supports and periodic respite for family caregivers.
3. Collaboration with family members in treatment planning.
4. Informing families of changes in treatment strategies or medications.
5. Establishing open channels for family complaints or grievances.
6. Offering advice and assistance during crises.

► **How Families Can Help Mental Health Professionals:**

Family members are a huge potential source of help for health care professionals dealing with individuals suffering from severe mental illness. There are a number of ways family members/caregivers can be of assistance or give input:

1. Family members can give key insights on the history of their relative's illness; severity of initial episodes, reaction to hospitalization, effect of the illness over time on personality, drug or alcohol abuse, etc.
2. Family members know the individual's strengths, weaknesses, likes and dislikes, talents, hopes and dreams.
3. Family members may have important information about their relative's past response to particular medications, compliance, side effects, etc.

4. Family members are quite often able to predict relapse several weeks before hospitalization becomes necessary based on their intimate knowledge of the individual's idiosyncratic behaviours, compliance with treatment, etc.
5. Family members are a good source of information on an individual's day to-day functioning and an early warning system for problems.

References:

1. Eppel, MacKay, Pedersen, Szathmary *et al.* (1999) *Partners In Healing: Perspectives on the Experience of Psychiatry*. McMaster University Press
2. Jacobson, N. and Curtis, L. (2000) *Recovery as a policy in mental health services: Strategies emerging from the States*. Psychiatric Rehabilitation Journal, 23(4).
3. Ontario, Ministry of Health and Long-Term Care (1999) *Making It Happen: Operational Framework*.
4. Ontario Ministry of Health and Long-Term Care (2001) *Making It Work: Policy framework for employment supports for people with a serious mental illness*
5. Ralph, Ruth (2000) *A Synthesis of a Sample of Recovery Literature*, (Prepared for National Technical Assistance Centre for State Mental Health Planning)



A History of Mental Health Reform in Ontario

“... progress in understanding mental illness is uneven, complex, unpredictable, and serendipitous.” (Andreasen, 2001)

The history of mental health reform is simultaneously the story of competing ideas concerning the nature(s) of mental illness, the optimal response(s) to the mentally disordered, the cause(s) of mental illness, and the preferred treatment(s) of people with mental disabilities. All of these ideas are present at all times moving into and out of prominence as our understanding of mental illness, of the role of the mind and of the brain, evolves and develops. Most contemporary mental health professionals endorse biopsychosocial explanations – with emphasis on the neurological role of the brain – while many forms of treatment rely on psychological and sociological factors in recognition that “the artificial separation of biological from psychological and social factors has been a formidable obstacle to understanding of mental and behavioural disorders” (WHO, 2001). The history of mental illness and mental health reform is also characterized by “an enormous diversity of ways in which the history of ideas, institutions and practices [have] been represented by and for each generation” (Coppock and Hopton, 2000) making it particularly hard to disentangle the history of mental illness and mental health reform from the larger social, political, economic, cultural and intellectual context in which these various stories play out. In western society, the modern history of mental illness, care of mentally ill persons and the role of the people who have cared for them is simultaneously the history of eugenics, of the professionalization of psychiatry, of class conflict, and of concern for the future of racial stock (Coppock and Hopton, 2000). No brief account of mental health reform can do justice to the full measure of this “historical maze” but we can illuminate a few essential moments in Ontario’s path toward more humane treatment of the mentally disordered.

3.1 The Nature(s) of Mental Illness

In 1839, when a special section of Toronto's York Jail was delegated to the asylum of mentally disordered persons, the dominant understanding of mental illness was "marked by a traditional mingling of magical, religious and scientific concepts [in which] cases of mental disorder might be attributed to divine retribution, diabolical possession, witchcraft, astrological influences, humoral imbalances, or to any combination of these forces" (MacDonald, 1981). The patients held there experienced a range of symptoms, imperfectly understood, including terrifying intrusions from outside forces, confused and irrational ideas, anxieties and fears. Some heard voices, others were depressed or guilt-ridden, still others were withdrawn and uncommunicative. "Superstition, moral condemnation, ignorance and apathy were the attitudes that dominated the treatment of mental disorders" and these values were reflected in the administration of institutions for mentally disordered persons (Coppock and Hopton). Mental illness was frightening and incurable. The best that could be done for the mentally ill – and for the community too – was asylum in both senses of the term: protection *of* the community from the feared predations of mentally disordered persons and protection *of* the mentally disordered from an aroused and anxious community. Mental illness was explained by a range of considerations drawing from a menu of perspectives including witchcraft and racism; but treatment consisted mostly of confinement, there being at this time little recognition that a person could experience 'recovery' in any meaningful or enduring sense.

3.2 The Cause(s) of Mental Illness

There were countertendencies, however, and chief among these was the re-emergence of medicine as an empirical and scientific discipline and the birth of biomedical understandings of disease. Concurrent with these developments – beginning around 1800 – was an emphasis on the fundamental dignity of all persons which provoked people interested in the well being of the mentally disordered to advocate for improving the conditions of their lives. The first generation of psychiatrists – according to Andreasen's account in *Brave New Brain* – were medical specialists intrigued by the challenge of caring for the mentally ill. The names of Benjamin Rush, Philippe Pinel and Vincenzo Chiarugi are associated with this period of hospital and asylum development.

A particular challenge for the first generation of specialists devoted to the care of the mentally ill was that of organizing the conditions and syndromes experienced by the mentally ill into a scheme through which their conditions could be understood, compared and possibly treated. In 1844 pioneering psychiatrist Amariah Brigham wrote that "Insanity is often but an effect of a slight injury or disease of a part of the brain,"

and in many cases only a few of the faculties of the mind are disordered. From this we infer that the brain is not a single organ, but congeries of organs ... thus each mental faculty has an especial organ, and therefore certain faculties may be disordered by a disease of the brain, while others are not affected” (Andreasen, 2001).

With his colleagues Brigham categorized mental health conditions according to a typology of three: melancholia, mania, and delirium. With time it became possible – using the new technologies of microscopes, and stains for various kinds of cells – to more clearly identify specific conditions in certain patients: mentally ill persons infected with a bacterium associated with syphilis. In its tertiary stage of development the *Treponema pallidum* spirochete produces symptoms such as paranoia, grandiosity and mental confusion which, in 1900, accounted for as many as 25% of patients in mental hospitals. “The delineation of this specific mental illness,” observes a recent review of the history of mental illness, “is psychiatry’s biggest success so far” (Andreasen, 2001).

By the middle of the 19th-Century “the mad” were clearly identified as a distinctive population for which special accommodations were appropriate. In 1846 the first purpose-built institution opened in Toronto around the same time as the Hôpital Louis H. Lafontaine in Montreal and then another facility in 1857 in Kingston. These “museums of madness” contained all manner of social outcasts: the quality of treatment was uneven and erratic, giving rise to “Chubb lock psychiatry” (Coppock and Hopton, 2000). This was an era influenced by the ideas of Francis Galton and the eugenics movement which linked together the mad, the bad and the degenerate. The prevailing belief among eugenicists was that mentally deficient people – invariably of lower class origin – were also sexually more permissive and that curbing their reproductive success through segregation and sterilization was a matter of urgency, critical to the preservation of the national (*i.e.*, racial) stock (Wolfensberger, 1975). “Assumptions about genetic and racial inferiority [were],” Coppock and Hopton observe, “deeply embedded in Western psychiatric theory.”

3.3 The Optimal Response(s) of Mental Illness

The rise of the institution – or asylum – as a purpose-built residence and treatment facility for the mentally disordered must be understood as a central theme in the story of mental illness and mental health reform. In 1800 a handful of mentally ill persons were confined in a variety of *ad hoc* establishments and arrangements. Scarcely one hundred years later the numbers had swollen, and conditions worsened, to the point where the Government of Ontario passed the *Act Relating to Lunatic Asylums and the Custody of the Insane* (1913), by which time the population of Ontario’s institutions had reached 6,900 persons.

This phase in the history of our understanding of mental illness and the most appropriate response to it is, as Coppock and Hopton observe, variously and contentiously represented. It is either:

1. “a ‘march of progress’ from the gloomy days of indifference, neglect and brutality toward a more enlightened ‘moral’ approach characterized by the application of science, humanitarianism and benevolence, (e.g., Andreasen’s *Brave New Brain*);
2. an exercise in social control motivated by the emergence of the modern state in capitalist societies and/or medical imperialism; (e.g., Michel Foucault’s *Madness and Civilization: A History of Insanity in the Age of Reason*) or
3. a complex dynamic involving elements of both of these positions (though more accidental than conspiratorial) producing unintentionally repressive consequences” (Coppock and Hopton, p. 16-17).

As represented by, for example, Nancy Andreasen – current editor-in-chief of the *American Journal of Psychiatry* – the ‘march of progress’ view traces a path from an age when the mentally disordered were left to roam, uncared for or exploited and maltreated in a disparate range of settings that predated the ‘curative’ institutions of the 18th and 19th Centuries. The sheer force of human misery, coupled to the desire of the early psychiatrists to understand the nature of mental illness as a condition, compelled experimentation with more humane forms of treatment and eventually a series of legislative reforms such as England’s 1845 *Lunacy Act* which established a system of public asylums. These were understood as technical responses to psychiatric conditions which environments provided the best possible conditions under the circumstances as they were then known. The asylum system did not, however, live up to expectations and as numbers swelled conditions grew steadily worse. The new non-restraint “humane” approach captured in the term “moral therapy” proved no more effective than bleeding, purging, blistering or vomiting (Coppock and Hopton, 2000).

In 1898, Dr. C. K. Clarke (considered to be the father of Canadian psychiatry) learned of a voluntary association in England called the “After Care Society” which – he thought – might assist in the management and care of discharged patients who were ill-fitted to endure life in the community (CMHA, 2002) and in 1912 Ontario saw the establishment of a Provincial Association for the Care of the Feeble-Minded and a Social Service Clinic at the Toronto General Hospital. Clarke and those around him advocated building of more comfortable institutions providing better food and care; hiring more staff and doctors competent in the care of the mentally ill; addressing the causes of mental illness; and discovering effective treatments and ways to prevent reoccurrence. Dr. Clarke’s efforts led in 1909 to the opening of the first psychiatric outpatient

clinic in Toronto and eventually to the founding of the Toronto Psychiatric Hospital (The Clarke Institute of Psychiatry's predecessor) in 1924 (A Brief History of the Clarke, 2002).

The numbers of the mentally ill were swollen with the experience of mental breakdown of Canadian soldiers in the trenches of France and Belgium. Initially understood as a consequence of prolonged exposure to concussion from exploding shells, this new generation of mentally ill men was later understood to be the products of functional disorders associated with severe stress – and after 1918 many of these persons were placed in provincial mental hospitals which were, by and large, ill-equipped to meet their needs (CMHA, 2002). Toward the end of the 1920s, outpatient clinics and new treatments began to appear and by the end of the 1950s new classes of drugs became available.

By 1959 there were 12 mental hospitals across Ontario and similar institutions springing up elsewhere in Canada. These hospitals essentially constituted the mental health system across the country as even ambulatory services were provided from these hospitals. This was the high-water mark of institutionalization and the beginning of the demise of the institutional model for the treatment of the mentally disordered. During the 1960s Ontario and Quebec developed new treatment regimes employing major, potent and effective medications. These regimes permitted ambulatory treatment and, concurrently, provincial governments began limiting the number of inpatient beds. Simultaneously with these changes there emerged concerns around the protection of minority – including mental health consumers – rights in an economic atmosphere which was, to a limited degree, permissive of organizational change. These changes in social attitudes were complemented and reinforced by the rise in influence of the Canadian Mental Health Association (CMHA) which advocated for better treatment for the mentally ill coupled to changes in how mental health services were delivered. Between 1961 and 1976, 34,000 mentally ill persons were released while the total bed capacity across the country's 14 mental hospitals was reduced to 4,662 (Guest, 1980).

More For The Mind: A Study of Psychiatric Services in Canada, also known as the "Tyhurst Report," was published by the Canadian Mental Health Association in 1963. Its key recommendation was that mental illness should be dealt with in the same organizational, administrative, and professional framework as physical illness. Writing in *More For The Mind*, Dr. John Griffin argued that "mental health transcends concern with sickness and health."

It relates to the whole spectrum of organized social living. It has to do not only with spotting and treating children with mental health problems in the school, but with the whole fabric of the school itself. It has to do not only with the neurotic and character disorders of adults in the community, but with their marital, occupational and social needs. Thus

the mental health problem of the community, while having an important psychiatric aspect, will not be resolved successfully by psychiatric planning alone. It will involve careful joint study and planning with many professional disciplines, including among others, psychology, education, social work, theology and the law (CAMH, 2002).

3.4 The Preferred Treatment(s) of the Mentally Ill

The application of neurology and scientific approaches to brain functions in the 1930s fed into the growing realization of a biological basis for mental illnesses, a view given greater credence since the 1950s by the discoveries of psychotropic drugs and their potential for stabilizing and controlling psychiatric symptoms, and by the growing appreciation that overcrowding was not going to abate irrespective of continued construction. By 1957, for example, Canada was home to 77 mental hospitals with a bed utilization ranging between 110% in New Brunswick to 156% in Saskatchewan (Mental Health Statistics, 1960). The new classes of drugs enabled more people to be treated in the community rather than warehoused in what were now beginning to be understood as regressive throwbacks. Between 1961 and 1976, 34,000 mental patients were discharged and by 1984 Canada's population of mental hospitals had decreased from 77 to 14 and a total bed capacity of 4,662 (Statistics Canada, 1985).

Ontario's transition from mental hospitals to community-based services, however, has not happened easily or smoothly because the social contexts that invariably affect the mentally ill – including homelessness, criminalization, imprisonment, victimization, poverty, unemployment and stigma – are implicated in the success of deinstitutionalization and this latter process was hastily implemented and poorly conceptualized. But as the process of de-institutionalization accelerated in the 1980s so, too, did understanding of the roles and capacities of mental health service consumers. The 1980s saw the development of a range of programs as funding was made available largely through District Health Council (DHC)-led processes to a total of 355 programs across the province, most of which were treatment or clinical in nature.

Another important development occurred with the enactment of the Canadian Charter of Rights and Freedoms in 1982. Although health care, including mental health care, is delegated to the provinces, the Charter of Rights and Freedoms provides that it must be delivered in accordance with the rights and freedoms enjoyed by all Canadians. This means that, as per Section 9, no person can be detained or imprisoned arbitrarily. Section 10 stipulates that at the moment of detention every person has a right to legal counsel and to *habeas corpus* and Section 15 outlaws discrimination on the basis of race, ethnic origin, nationality, colour, religion, sex, age or physical or mental disability (Charter of Rights and Freedoms, 1982). This new legal regime demanded that the provinces clearly and specifically define “mental disorder” as well as estab-

lish parameters for commitment in order to determine under what conditions a person could be committed and for how long. Most provinces have since adopted a definition of ‘mental disorder’ along the following lines: *a substantial disorder of thinking, affective tone, perceptions, orientation, or memory so that it produces a major disruption of judgement, behaviour, capacity to recognize reality, or capacity to face ordinary demands of life* (Fish, 2000).

3.5 The Emergence of Recovery Philosophies in Mental Health Care

The past fifty years has seen an evolution in our model of care for people with mental health problems. The institutionalization model – warehousing the mentally ill and treating them on the basis of long-term confinement (Wolfensberger, 1975) – has given way to a model of community-based recovery from mental illness. Recovery-oriented philosophies are premised on the belief that people with mental illnesses need to be supported thus to maximize their participation in society (Ralph, 2000) – in real environments such as work, housing and social settings – “in ways that minimize any distinction between people with and without mental illness.” Recovery models stress that experiences in real environments enable persons to attain “a sense of their personhood outside of their illness” and an opportunity thereby to participate in their own treatment, rehabilitation and support. While there are a number of recovery models, they share a belief that a paradigm shift is necessary in order to move from a maintenance model – which presumes perpetual dependence – to the expectation that people with a mental illness can take control of their illness, contribute in meaningful ways and live enjoyable lives.

Where a “maintenance” model requires only basic services to attain and sustain symptom stability, recovery philosophies – and the models that flow therefrom – call forth a much more complex and sophisticated range of services and service delivery modalities in order that people with severe and persistent mental illnesses may live rich and fulfilling lives in their communities with the assistance of the full spectrum of pharmacological, cognitive therapeutic, educational, rehabilitational, psychosocial, community and employment supports. It is this vision that *Making It Happen* seeks to realize and the model that the Southeastern Ontario Mental Health Implementation Task force has adopted as its gold standard.

The current phase of reform goes under the heading of “community-based treatment” or decarceration and envisions that as many as possible mentally ill people will be returned to the community with adequate supports and services to enable them to live fully realized and meaningful lives. It envisions the creation of a range of support services which amount to, in effect, mobile hospitals such that teams of persons with expertise in the treatment and rehabilitation of mentally disordered persons come to the community and deliver whatever treatment is needed – as much as possible – in the community itself. The

reform strategy also envisions the cultivation of “mentally healthy communities” with the intention of reducing through public education the social barriers of stigma and discrimination which are every bit as punitive as were the old institutions.

These reforms follow in the wake of significant scientific advances in the understanding of how mental illness functions, how it affects people and how it might best be managed, treated and in some cases even mitigated. There has been a profusion of new technologies in recent decades: neuroimaging, CT scanning, and genetic mapping each of which shed light on the nature of the brain’s complex activity, and the site of specific conditions associated with identified syndromes. Our understanding of how the brain ‘works’ has improved with advances in theory and observation and today the majority of treatment professionals adhere to a biological view of the brain – i.e. the brain as a network of billions of neurons; the biological model of the brain. The biological model of the brain has expanded the range of treatment options and redefined our conception of mental illness and mental health. These new understandings have been taken up and embodied in government policies in a slow but steady renovation of Ontario’s mental health strategy.

In 1983 Ontario’s Ministry of Health released a discussion paper called “Towards a Blueprint for Change: A Mental Health Policy and Program Perspective” (also known as the Heseltine Report). Heseltine recommended “a balanced and comprehensive mental health care system” and “a separation of treatment and accommodation” (*Making It Happen: Implementation Plan*, 1999). In 1988, following a series of consultations across the province, Robert Graham released his “Building Community Support for People: A Plan for Mental Health in Ontario.” Graham offered a long-range plan for an organized, comprehensive, community focused mental health system and identified people with a serious mental illness or disability – defined according to dimensions of diagnosis, disability and duration – as the priority for mental health services. He further argued that supports need to extend beyond the clinical treatment to include living and functioning in the community and that all services should be coordinated to establish a continuum of care. The Graham report established province-wide principles and objectives to guide planning and encouraged consumers and their families to be involved in mental health care reform.

“Putting People First: The Reform of Mental Health Services in Ontario” (1993) outlined a framework for reform and expressed in its statement of values that a reformed mental health system ought to reach out to people who have traditionally had trouble achieving access to the supports and services necessary for them to experience meaningful and productive recovery from mental illness. The plan set out a ten-year strategy based on common values and vision and included specific plans, targets and timetables for shifting resources from the Provincial Psychiatric Hospitals to communities, including optimum bed

ratios, hospitalization rates and key service ratios. A bed closure moratorium was put in place while DHCs planned regional mental health systems designed to connect psychiatric hospitals with community mental health services. In October 1996, the Health Services Restructuring Commission (HSRC) called for the establishment of regional Mental Health Agencies (later renamed Mental Health Implementation Task Forces) and for devolved decision-making organizations dedicated to “expediting provincial divestment of PPHs and ensuring reinvestment in the mental health sector in the community/district/region concerned” (HSRC, 2000).

Human rights concerns have moved into the forefront of treatment of people with mental disorders. In June 1998, M.P.P. Dan Newman – then Parliamentary Assistant to the Minister of Health – released “2000 and Beyond: Strengthening Ontario’s Mental Health System” in which he called for a reform of the mental health system focused on the quality of life of individuals with serious mental illness, a holistic approach to mental health that addresses the broader determinants of health and the creation of an integrated and comprehensive system of mental health services to “provide a continuum of care for those who need it from prevention to community and in-hospital treatment (Newman, 1998). Newman also stressed the need for integration of mental with other types of health care toward the creation of a continuum of care.

In 1999 the Government of Ontario released the fully realized vision of mental health reform grounded in the conclusions of all previous studies and the best scientific evidence available on ‘what works best’ in mental health care delivery. Their findings were articulated in three policy directives which – taken as a whole – situate, for the first time, the consumer of mental health services at the centre of the mental health system:

1. *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports;*
2. *Making It Happen: Implementation Plan for Mental Health Reform; and,*
3. *Making It Work: Policy Framework for Employment Supports for People with Serious Mental Illness.*

The *Making It Happen* directives are based on commissioned reviews of the scientific literature relating to mental health care by Toronto’s Clarke Institute of Psychiatry, under the direction of Paula Goering, and one by the Mental Health Evaluation and Community Consultation Unit of the Department of Psychiatry at the University of British Columbia. They are:

1. Paula Goering, *et al.*, *Best Practices in Mental Health Reform: A Situational Analysis* (Ottawa: Health Canada, 1997);

2. Paula Goering, *et al.*, *Best Practices in Mental Health Reform: Discussion Paper* (Ottawa: Health Canada, 1997);
3. Paula Goering, *et al.*, *Review of Best Practices in Mental Health Reform* (Ottawa: Health Canada, 1998); and,
4. Kimberley McEwan and Elliot Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit* (Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, January 2001).

Currently, there are nine Mental Health Implementation Task Forces operating across Ontario. The principles guiding their recommendations, based on those embodied in the *Making It Happen* triad of policy directives, are seven;

1. the consumer is at the centre of the mental health system;
2. services will be tailored to consumer needs with a view to increased quality of life;
3. consumer choice and access to services will be improved;
4. services will be linked and coordinated so that consumers will move easily from one part of the system to another;
5. services will be based on best practices;
6. mental health funding will continue to be protected; and
7. there will continue to be investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.

The consumer-centred system in which services are experienced should be integrated and seamless. The full realization of this vision will require the deployment of information systems to facilitate and determine the need for mental health services in local communities – as well as to ensure effective accountability of the different delivery agencies. Also required is a new vision that shifts the focus from treatment services to prevention, to management of their determinants and to the promotion of mental health in the population. The success of this vision, of course, is contingent on buy-in by all three levels of governance but crucially upon public acceptance and participation.

3.6 The Provincial Forensic System; Strategic Directions and the distribution of Mental Health Forensic Beds in Ontario

Mental health forensics is the “study, assessment, treatment, rehabilitation, and management of mental disorder in relation to violent or aggressive behaviour” (SCMHAE, 2002). These are people with a mental illness who have come into conflict with the law and in some cases represent a threat to public safety. Yet it is incumbent on government and policy makers to extend to these people the same set of supports and treatment opportunities that are to be available to every other citizen of Ontario with a mental health problem. The two key policy documents designed to guide mental health planning for Forensic Services are:

1. “The Provincial Forensic System: Strategic Directions” (Ministry of Health: Institutional Health and Community Services, Mental Health Programs and Services, April 1997) and,
2. “The Distribution of Mental Health Forensic Beds in Ontario” (Mental Health Unit, Institutional Health and Community Services, October 1998).

What is to be done with persons who have a mental illness and who come into conflict with the law? Operational pressures on Ontario’s forensic system regularly reach crisis proportions in the absence of agreement on what the system needs to look like and the principles that ought to drive it. The challenge facing policy makers and mental health treatment professionals is striking the right balance between protecting public and treatment staff, containing costs associated with long-term forensic incarceration, integrating those offenders who *can* be integrated (a risk-management exercise) and delivering the full spectrum of treatment modalities to those who can be treated. The art of balancing public safety with rehabilitation is not a medical or scientific consideration so much as a public policy one.

The bottom line is that, according to risk level and clinical need criteria, forensic patients are to be – at the earliest opportunity – integrated into broader mental health programs across Ontario.

The MOHLTC’s vision developed to guide this strategy incorporates the following six elements:

1. That offenders with mental disorders not be stigmatized or discriminated against but integrated into the broader mental health system, consistent with level of risk and psychiatric need;
2. That the lives of mentally disordered offenders can and will improve;

3. That government has a duty to protect the public from dangerous persons – and that mentally disordered offenders also have a voice in how they choose to live, learn, work and relax;
4. That the same consumer-focused, comprehensive, coordinated, accountable and accessible mental health service delivery system available to everyone else also be available to offenders with mental illnesses;
5. That public education, community acceptance, promotion of tolerance and crime prevention initiatives be strengthened to facilitate successful community reintegration; and
6. That the MOHLTC cooperate with partners in justice, social services and other relevant ministries to develop strategies for reducing crime, implementing appropriate alternatives to prosecution in the criminal justice system, divert from incarceration, protect public welfare and “provide for the welfare and well-being of individual mentally disordered clients.”

The future of forensic bed capacity, and the geographic distribution of forensic beds across Ontario, is conditioned by three major assumptions:

1. That the province’s forensic strategy will be substantially implemented;
2. That mental health reform – specifically enhancing the capacity of community support infrastructure – will proceed; and,
3. That the justice systems will collaborate with the MOHLTC’s efforts to “match intensity of service to the degree of patient need” (Distribution of Mental Health Forensic Beds, 1998, p. 2).

The major recommendations are:

1. To increase the ratio for dedicated regional secure beds from the current 2.68 per 100,000 to 3.1 per 100,000 of total population (3.8 per 100,000 adult population) increasing from 306 to 450 by the year 2003;
2. That the geographic distribution of forensic beds break out thus: North West – 2; Toronto-Peel – 72; Central East – 9; Central West – 52; and South West – 9, for a total of 144 new dedicated regional forensic beds;
3. The more equitable distribution of forensic bed capacity occur on a phased-basis in which some of the existing secure beds in Eastern Ontario and Muskoka-Simcoe will be converted to open protected beds; and

That there will be one site within Ontario to provide the high security service for a maximum of 140 beds with the expectation that this number will include long-term patients, without community access, and maximum secure clients.

References to Chapter 3: History of Mental Health Reform in Ontario

A Brief History of the Clarke, 2002, Online at
http://www2.camh.net/clarkepages/about_the_clarke/brief_history.html

Andreasen, Nancy C., *Brave New Brain* (Oxford University Press, 2001)

Canadian Mental Health Association (Online History) at
http://www.cmhapeel.ca/detail_history.htm as of August 7, 2002.

Charter of Rights and Freedoms, 1982, online at
<http://laws.justice.gc.ca/en/charter/>

Continuing to Meet The Challenge, Facilitating Recovery: Integration Framework for Mental Health Services for Adults with Severe and Persistent Mental Illness, (The Coalition of Ontario Psychiatrists, Ontario Medical Association – Section on Psychiatry and Ontario Psychiatric Association, June 2001).

Coppock, Vicki and John Hopton, *Critical Perspectives on Mental Health* (London: Routledge, 2000)

Dominion Bureau of Statistics (1962): *Mental Health Statistics, 1960*. (Ottawa: Queen's Printer)

Guest, Dennis, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980).

Fish, A., "Brian's Law: Amendments to Ontario's Mental Health Act," *Dialogue, Newsletter of the Ontario Psychiatric Association*, December 2000, pp. 10-11.

Foucault, Michel, *Madness and Civilization: A History of Insanity in the Age of Reason* Translated by Richard Howard. (New York: Pantheon, 1965).

Jones, Kathleen, *Asylums and After* (London: Athlone Press, 1993)

MacDonald, Michael, *Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth-Century England* (Cambridge University Press, 1981)

Ralph, Ruth (2000) "A Synthesis of a Sample of Recovery Literature," (Prepared for National Technical Assistance Centre for Statement Health Planning).

SCMHAE, Simcoe County Mental Health and Addiction Education: Mental Health Process in Ontario, online at <http://www.mhcva.on.ca/MHP/mhpfor1.htm>
Statistics Canada, *Mental Health Statistics, 1983-84* (Ottawa Statistics Canada, 1985)

Wolfenberger, Wolf, *The Origin and Nature of Our Institutional Models* (Syracuse: Human Policy Press, 1975).

World Health Report 2001; *Mental Health; New Understanding, New Hope* (Oxford University Press, 2001).

Chapter

4



Best Practice Characteristics of the Reformed Mental Health System

Best Practices in Mental Health care are generally ‘what works best’ defined in terms of improving and maintaining the quality of life of a person with a mental disorder according to indicators derived from the determinants of population health. Usually this evidence is derived from randomized control studies, but that’s not always possible, ethical or easy. There is general agreement, however, that the provision of a variety of supports, modalities, programs and approaches is capable of improving the life of people with mental disorders and that – subject to the usual limitations of resource – all such efforts should be made toward that end. Where ‘best practices’ are not available in robust and reliable form, experts – on the basis of ‘best evidence’ – publish ‘consensus statements’ which stand in for best practices until these can be identified. The Working Groups heard presentations from researchers and practitioners on the cutting edge of mental illness. They surveyed the state of the art in the scientific literature and they, in many cases, drew from their own front line experience as mental health care delivery persons.

Several caveats are worth noting about the best practices research literature in mental health. First, terminology is not used in a consistent fashion across studies, making comparison difficult. Second, it is not unusual to find conflicting evidence on key issues. Third, the literature changes rapidly, rendering reviews from as little as half a dozen years ago out of date. Fourth, the effectiveness of approaches to service organization may be specific to the circumstances of the jurisdiction in which the interventions were evaluated. Fifth, some issues, specifically impact on clinical outcomes of various treatment modalities, are notable by their absence. Finally, for many aspects of service delivery there is simply no best practices literature available. The existing mental health research literature contains information on best practices for some, but not all, components of mental health care. Here, as in other places, reliable information is scant.

This chapter integrates best practices in mental health care with objectives supplied by the Logic Models of the First Line, Intensive and Specialized Working Groups. A logic model is a graphic representation of the linkages between program activities and the changes these activities will – or are expected to – produce.

Each of the three Working Groups advisory to the Integration Committee drafted Logic Models which were to guide their deliberations and focus their efforts through the elaboration of three principles:

1. **A Grounding Question:** “What type of system do we want in place for ourselves and our families?”
2. **A Mission Statement:** “The development of an integrated, accessible, coordinated Best Practice continuum of services and supports across three levels of service (i.e., First Line, Intensive and Specialized) taking into account policy, legislation, and the needs of varying populations of people in both urban and rural settings across the lifespan of the consumer while ensuring a balance between people with a serious mental illness and others with mental health problems” and,
3. **Consumer-centred guiding principles:** Integrated, accessible, accountable, affordable, coordinated, responsive (timely), understanding and knowledgeable.

The Logic models then broke into components the various elements associated with each level of service (in bolded headings below) for which each logic model specified process- and short-term objectives. The Logic Models were organized along a two dimensional matrix according to, on the horizontal axis, the various subcomponents inherent in the delivery of First Line, Intensive or Specialized Services and, along the vertical axis, in terms of Main Components, Process Objectives, Outcomes and Strategic Goals. (The logic models appear in Appendix B of Section II of this background and technical report.)

The three working groups shared a single set of Long-term objectives which express the *Making It Happen* vision. They are:

1. An improvement in the quality of life for consumers, families and significant others across the age span.
2. An improvement in the economical, physical, and social well-being of people living with a serious mental illness and other mental health problems.
3. An increased number of consumers benefiting from increased access to mental health services, supports and interventions.

4. An improvement in the accessibility, treatment effectiveness and system efficiency by providing a seamless continuum of high-quality and consumer-centered care.
5. An improvement in clinical outcomes through the provision of crisis, early intervention, intensive treatment and specialized services.
6. An improvement in the systems' ability to respond to consumer needs.

4.1) The First Line Services Logic Model

4.1.1) Information and Referral Services: The full realization of the *Making It Happen* vision comprehends a multi-faceted information strategy incorporating a spectrum of public interventions ranging from school-based anti-stigmatization educational programs to prominently displayed mental health information telephone lines, internet web-sites and easily accessible information packages of various kinds. Anti-stigmatization, in particular, is necessary to cultivate and nurture a community environment that is welcoming and accommodating of people with mental illness (2,3). The Working Groups agreed upon the centrality of public and professional education toward de-stigmatization. These issues are dealt with in detail by the reports of other committees.

Logic Model Process Objectives	■ To establish a district-wide and accessible community information system which would include, but not be limited to, a mental health information line, web site and referral agents. ■ To provide accessible information to the community about mental health promotion, mental illness and the range of services available in Southeastern Ontario.
Logic Model Short-Term Objectives	■ To decrease the number of entry points to mental health services. ■ To reduce mental health-related visits to area hospital emergency rooms. ■ To increase the community's awareness of mental health, mental illness, and the range of services available in Southeastern Ontario.

► What the Best Practices Literature Endorses

Persons with a mental illness or their surrogates must be able to access the appropriate care provider or mental health service in a timely manner, and

their relevant clinical information must be readily available to the services to which they are referred. Since there exist multiple First Line entry points to the mental health system, it is difficult to stipulate one set of best practices. However, three points arise from the best practices literature:

1. It is possible to provide concise but effective educational packages for all regional front line providers to standardize and enhance the accuracy of initial clinical assessments (4).
2. Triage instruments have been shown in emergency departments (5) and in mental health centers (6) to direct patients to the appropriate sources of care. Such instruments, however, may not be suited to prioritizing patients for service receipt (7).
3. Clear procedures on release of patient information, consistent with existing legislation, are necessary to protect patients but also to involve appropriately family and additional providers in the patient's care (8)

4.1.2) Crisis Services*: A significant number of consumers make their first contact with the mental health system a time of personal crisis. To meet such needs, crisis response systems (CRSs) encompass a range of services integrated across various providers including mental health personnel, family practitioners and the police.

Logic Model Process Objectives	■ To provide a coordinated and accessible district wide 24/7 day crisis response service. ■ To screen consumers for immediate needs, including a risk assessment. ■ To determine suitable services for each inquiry or contact and follow up as needed.
Logic Model Short-Term Objectives	■ To have a comprehensive, coordinated and minimally intrusive service that: Alleviates acute distress in the lives of consumers. Increases consumers' and families' ability to cope with the issues and with the active crisis. Reduces mental health related visits to area hospital emergency rooms.

*E.g. 911, Telephone, Mobile, Quick Next Day Response and Community-based mental health safe beds

► What the Best Practices Literature Endorses

The goals of crisis services are to assist the consumer to remain in the community and to develop strong community-based supports suited to early intervention (9). The ideal mental health system has a balance of these services, geographically distributed to optimize rural/urban coverage. The evidence base for the following programs is limited. Descriptive studies suggest, however, that crisis housing, diversion programs and crisis centres all work for many, but not all, people in a crisis (1).

Common components of a Crisis Response System germane to First Line Services are:

<i>24/7 Universal Telephone Access:</i>	Crisis response telephone and warm lines – which divert people from inpatient hospitalization using minimally intrusive options – are endorsed in the best practices literature. Telephone crisis lines are a particularly effective instrument for connecting the consumer – or the consumer's family – to the mental health care delivery system. A primary role for telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services as indicated.
<i>Walk-in Crisis Services:</i>	Walk-in services provide face-to-face assessment and intervention, typically including screening and assessment, stabilization, perhaps treatment and linking to relevant services. Hospital emergency rooms are often used for this service, though many do not have the relevant specialists or well-defined crisis management procedures in place.
<i>Mobile Crisis Outreach:</i>	Mobile crisis services can intervene quickly day or night wherever needed and are particularly useful for linking previously unknown consumers e.g. through the police – to the existing system of help and support. The teams may operate out of community locations, crisis centres, multi-purpose community mental health centres or hospitals (10).

<i>Crisis Residential Services:</i>	Residential crisis services provide the person-in-crisis with support in a calm, protected and supervised non-hospital environment in those circumstances when crisis resolution may require separation from the consumer's home environment. During this respite, the person can re-stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings may be used as an alternative to hospitalization, including family-based crisis homes, crisis apartments, or group homes (11). A combination of crisis residence and day hospital was recently reported as effective and less expensive than in-hospital treatment (12,13).
<i>Psychiatric Emergency/Medical Crisis Services</i>	Some hospitals have developed special programs of multi-disciplinary teams who assess and provide immediate support and some have added 24 hour holding beds to permit more extended evaluation with the objective of referring more individuals to ambulatory services (14), urgent day clinics, day hospitals or community support programs. The preferred model – endorsed in the research literature – is for hospital services to be integrated with CRS so that unnecessary admissions can be avoided, so that necessary admissions can proceed as quickly as possible, so that length of stay is minimized, discharge planning begins at admission and individuals are linked to support services upon discharge.

4.1.3) Mental Health Services and Primary Care: Many consumers make first contact with mental health services, not through CRS, but via a family physician. Often this will be the sole source or diagnosis and treatment, and will suffice for uncomplicated minor or self-limiting conditions. Family physicians deal with a variety of mental illnesses including anxiety and depression, grief, situational reactions, or alcoholism. In collaboration with psychiatrists they may participate in shared care for the severely mentally ill. They provide counseling and various types of short-term psychotherapy, prescribe medications, refer patients to psychiatrists and social agencies, screen for early signs of illness, and educate patients about services available in the mental health system.

Logic Model Process Objectives	■ To provide a range of accessible and affordable mental health counseling interventions for consumers and families regardless of the level of severity of their mental health issues. ■ To reduce mental health related visits to area hospital emergency rooms.
Logic Model Short-Term Objectives	■ To increase or maintain the functioning of consumers and families within the environment of their choice. ■ To increase consumers' and families' readiness and capacity to make positive changes and achieve their desired treatment goals.

If, as the consensus on mental health information agrees, the most important component in terms of First Line services is the role of family doctors and general practitioners, then it is worth considering the ratio of active family physicians to population across Southeastern Ontario as of December 2000.

Table 1: Ratio of County Population to Family Physician

County	Family Physicians	Pop : active FP
Frontenac	187	746 : 1
Lanark	67	941 : 1
Leeds & Grenville	70	1430 : 1
Lennox & Addington	38	1071 : 1
Prince Edward	24	1098 : 1
Source: Ontario Physician Resource Data Centre (December 2000)		

It is clear, on the basis of this information, that services of family physicians – arguably the premier front line care providers in terms of their capacity to refer people to more specialized care – are stretched thin across Prince Edward County, Lennox and Addington and Leeds and Grenville whereas Frontenac and Lanark are comparably well served.

► What the Best Practices Literature Endorses

There is evidence that from two American studies that psychiatric conditions are frequently poorly managed by non-specialists (15,16). Access to psychiatrists for collaborative care or chart reviews may enhance competency, as may targeted continuing education programs. Preliminary and descriptive studies suggest that integrating mental health professionals into primary care settings can (1,17,18):

1. enhance continuity of care;
2. increase accessibility to mental health services;
3. lead to more efficient use of mental health services;
4. provide new opportunities for continuing education for physicians; and,
5. improve communication between mental health services and family practitioners.

Close integration may be more feasible in environments where family physicians are not paid by fee-for-service, such as Community Health Centres (salaried), Health Services Organizations (patient capitation payment), or Reformed Primary Care (capitation plus targeted incentives). Not only do physicians potentially have more time for patient encounters and continuing medical education programs under alternative funding arrangements, but also there are frequently associated programs available from which to fund additional mental health professionals as part of the primary care team.

4.1.4) Hospital Emergency Services

Logic Model Process Objectives	To establish an accessible and coordinated Schedule 1, 24/7 district-wide system which will include: ■ Hospital-based holding beds; ■ Medical and non-medical detoxification; ■ 24/7 mental health workers in all Schedule 1 emergency departments with access to a psychiatrist; ■ Non-Schedule 1 hospitals will have access to 24/7 mental health workers at district Schedule 1 hospitals; ■ A shared capacity consumer information system; and ■ A coordinated protocol with community crisis service
Logic Model Short-Term Objectives	■ To increase the capacity of the health care system to address and respond to immediate and presenting mental health needs. ■ To improve the level of emergency response to consumer needs as appropriate.

■ What the Best Practices Literature Endorses

Schedule 1 hospital and emergency services – while necessary – should be a last resort. The best practices literature endorses home treatment and day hospitals and keeping inpatient hospital admission as short as appropriate under the circumstances. Some hospitals have developed special programs of multi-disciplinary teams who assess and provide immediate support and some have added 24-hour holding beds to permit more extended evaluation with the objective of referring more individuals to ambulatory services (9), urgent day clinics, day hospitals or community support programs.

The preferred model is for hospital services to be integrated with CRS so that unnecessary admissions can be avoided, so that necessary admissions can proceed as quickly as possible, length of stay is minimized, discharge planning begins at admission and individuals are linked to support services upon discharge. A combination of crisis residence and day hospital was recently reported as effective and less expensive than in-hospital treatment (10,11). Home care crisis treatment may also be effective on its own (12,13) and more cost effective than hospitalization (14).

4.1.5) Outreach: A district-wide highly-visible community information system, which (a) makes the existing system of care visible to greater numbers of people and (b) begins the process of directing people to the service most accessible to them is a priority from the perspective of first line services. Getting the message will go some distance toward addressing existing need, but more importantly to capturing unmet psychiatric need – people with mental health problems and their families who are suffering in isolation or because of lack of knowledge of existing services. It is imperative that information systems be networked together in such a way that people who need mental health care need not be shuffled from agency to agency – but that every agency is plugged into and connected so that the consumer of mental health services experiences a seamless continuum from first encounter to final discharge.

Logic Model Process Objectives

- To develop a range of outreach related activities.
- To engage consumers who are at risk or who are experiencing problems.
- To provide accessible services in an environment based on the needs of the consumer directly or through telepsychiatry.

**Logic Model
Short-Term
Objectives**

- To decrease episodes and crisis situations.
- To improve the level of emergency response to consumer needs as appropriate.
- To increase the community's awareness of mental health related issues.
- To increase the number of potential consumers who make inquiries into the mental health system.

► What the Best Practices Literature Endorses

In general, diversity of outreach forms is preferred – more outreach is better than less. Perhaps most pressing is stigma reduction, certainly most pressing from the perspective of consumers, which can be effectively reduced through programs targeted at children in the public school system. There is broad consensus that early intervention – as close as possible to first onset – greatly improves the chances of speedy and complete recovery. Catching problems early, before they take hold and begin undermining mental health, is not only possible but – given the cost and prevalence of mental health problems – imperative.

4.1.6) Primary Care Services: The challenge facing the provision of quality primary services is to ensure the following criteria are met:

Accessible: Care must be accessible on an as-needed basis. This means that consumers or their representatives must be aware of where to turn, and that the time taken to provide the services they require must be matched to the urgency of their need. Additionally, neither distance nor economic barriers should compromise access to the required service. Shared service models of care need to be thoroughly investigated and, where appropriate, innovated upon. General health staff – e.g. particularly GPs – must be, at a minimum, able to detect evidence that a person in their care may require more thorough and expert attention. Currently many GPs find it difficult to deal with persons with a mental illness, while the fee-for-service pay structure actually discourages GPs from spending the necessary time with a client.

Appropriate: The care required should match the consumer's need. It should follow the principle of least intrusion, but equally should not substitute less intensive care than best practices have demonstrated to be optimal. In this context the term “optimal” captures both desired clinical outcomes and reasonable cost.

Integrated: The provision of First Line care occurs at the inter-face of the community and the mental health system. The individual's health information

must travel with the consumer as he or she enters the system and must, complete and up-to-date, accompany the consumer on return to the community. This requires communication amongst all care providers, pharmacists and mental health agencies.

To what degree are these three characteristics evident in current services and to what extent can they be incorporated into future First Line Services? At this time this question is impossible to address. It ought, for that reason, to be among the first priorities of the proposed research and evaluation unit, which is articulated in the governance report. Massaging the current system of first line services into a system which (a) realizes the values and ideals embodied in *Making It Happen* and (b) meets the lived needs of people with mental health problems across Southeastern Ontario requires a great deal more – and more detailed – information than either the health or mental health care systems are currently configured to supply. This is especially true of First Line services because – by definition – these are the first point of contact for most people who require the expertise of mental health care service providers.

Logic Model Process Objectives	■ To develop a system of multi-disciplinary, integrated primary care services which will provide a range of assessment, treatment, counseling, stabilization, and coordination services (e.g., brief intervention, referral, and consultation) to consumers with mental health problems.
Logic Model Short-Term Objectives	■ To reduce the frequency and severity of future episodes. ■ To reduce mental health related visits to area hospital emergency rooms.

► What the Best Practices Literature Endorses

Enhancing the continuity of care can be achieved by integrating mental health professionals into primary care settings. This leads to the more efficient use of mental health services and provides upgrading and educational opportunities for physicians (preferred) – it also improves communication between mental health services and family practitioners (1).

4.2 The Intensive Services Logic Model

4.2.1) Intensive Services at Schedule 1 Facilities

Logic Model Process Objectives	■ To provide a range of hospital-based acute care services including: Emergency and Crisis Response Services Short-Term Inpatient Assessment/Holding Beds Assessment, Stabilization, and Short-Term Inpatient Treatment Discharge Planning Day Hospital Therapeutic Educational day treatment programs Outpatient Services First episode clinics Consultation, Education, Coordination, and Integration.
Logic Model Short-Term Objectives	■ To reduce consumers' level of distress and symptoms. ■ To increase consumers' ability to return to a community setting. ■ To reduce consumers' risk to themselves and/or others. ■ To improve the links into the consumers' next stage of treatment.

► What the Best Practices Literature Endorses

It has long been understood that early intervention and treatment can lessen the impact of psychiatric emergencies and reduce the severity of psychotic symptoms. “Several promising, large-scale studies suggest early intervention in schizophrenia may forestall the worst long-term outcomes ...” (40). There is no precise way to predict which persons will benefit most from early intervention and treatment, but little doubt that all efforts should be undertaken to minimize the severity of a psychiatric emergency. Another study, however, found that “the favorable effects of the early and intensive treatment disappeared rapidly” in the absence of follow-up, compliance with medication, stress management and case management (41).

Keeping length of stay as short as possible is appropriate most of the time for most persons with a mental illness (1). But that consumers benefit from early diagnosis, treatment and follow-up is beyond dispute – and Schedule 1 facilities are preferentially resourced to provide first episode treatment, linkage to follow-up services and pre-discharge planning. There is also ample evidence that edu-

cating a person who has experienced a first episode psychiatric emergency – their family and support network – can lessen the severity and social/personal consequences of subsequent psychiatric events.

4.2.2) Intensive Case Management:* For consumers who are not in crisis, but require intervention beyond the capacity of primary care providers alone, more specialized care in the form of Case Management (CM) may be appropriate. While at present most primary care physicians and other First Line providers have little role in the more sophisticated forms of case management, their roles will increase as a consequence of the shift in care provision from an institutional to a community focus. This is particularly likely in the context of current Primary Care Reform. As well, given the apparent shortage of psychiatrists, especially in fields such as psychogeriatrics, family physicians may be asked to play a larger role in mental health services. Given their community-base, familiarity with the critical importance of continuity of care, and a practice approach that stresses the need not only to treat the “whole person” but also to involve family as appropriate, family physicians may make an important contribution to case management.

Logic Model Process Objectives	■ To provide linking, advocacy, monitoring and service coordination to consumers and families. ■ To provide on going assessment, counseling, and support to consumers and families before, during, and after the completion of their treatment plan ■ To reassess consumers’ circumstances and continue case management as needed.
Logic Model Short-Term Objectives	■ To improve consumers’ access to appropriate services and supports taking into account consumer choice. ■ To increase consumers’ ability to manage their mental health and to function in their daily lives. ■ To increase consumers’ ability and capacity to make positive change, achieve desired treatment goals, and live as independently as possible in the community.
*Additional terminology under this heading includes Case Management and Intensive Clinical Case Management	

What the Best Practices Literature Endorses

Case management lacks a specific definition, but generally signifies a multifaceted, multi-disciplined approach designed to help consumers function at the highest level possible with the least possible restrictions. It is based on close, long-term relationships with the consumer and offers services such as assessment, planning, monitoring, referral and advocacy. Five models are on offer, only four of which rise to the level considered for best practices.

1. Not endorsed. *The Expanded Broker Model* of CM uses a case manager to broker services for the client. Its outcomes are sufficiently poor to exclude it from a list of best practices (19).
2. *The Rehabilitation Model* focuses on improving client living skills through identification of deficits, while the Personal Strengths Model centers on making best use of the clients own resources.
3. *The Full Support Model* or Assertive Community Treatment (ACT) provides clinical and social support through a multi-disciplinary team around the clock; it is the most widely replicated and studied form of CM. A recent review has labeled it the best practice approach (19).
4. Closely related, *Intensive Case Management* is geared to high-need individuals and is intended to assist them in remaining out of hospital. It involves frequent contact, proactive outreach, small case-loads, 24-hour availability, and a community-based practice venue.

The multiplicity of meanings to the generic term case management makes comparison of evaluation studies difficult. However, this review will focus on the two most common usages found in the literature.

Model I:

Assertive Community Treatment (ACT)

The major findings reported in the scientific literature concerning ACT include the following:

- Reduced hospitalization for patients in ACT (20,21), though contrary findings have also been reported (22,23);
- Costs for patients receiving ACT have been reported as less than alternative approaches (21,24) but such evidence is weak and may vary with the study setting.
- The impact of ACT on client clinical status is insufficiently studied.
- Client and family satisfaction and client social functioning appear superior with ACT exposure (22,25);

Model I: Assertive Community Treatment (ACT) (continued)	■ ACT programs are effective in maintaining clients in treatment (25,26) ■ Rural locations may impose barriers to the effective implementation of ACT programs (23,27). ■ On the whole, ACT programs promote client retention, enhanced social functioning and – possibly – reduced hospitalization.
Model II: Community Care*	■ Managed community care programs lead to improved client retention and improved social functioning (28-30). ■ Opinion on clinical improvement (28,31) and impact on hospitalization (28,32) lacks consensus. ■ Costs have been found to be both greater (29), and less (31), than conventional care models. *Terminology may also include Intensive Community Care, Community Mental Health Teams, and Intensive Psychiatric Community Care.

The major advantage of the above programs – on the basis of the best practices literature – appears to be in the area of treatment continuity and social functioning. The key findings are that:

1. Intensive Case Management (ICM) retains consumers in programs more effectively than standard approaches (33,34).
2. Social functioning, in some studies including consumer/family satisfaction and quality of life, is improved (33-37).
3. Opinion is divided on whether clinical improvement is (36,37) or is not (34,38) associated with ICM.
4. Some studies have shown reduced hospitalization rates (34,38).
5. Costs are higher than conventional approaches (33,35).

The above points are consistent with the conclusions of the most recent systematic review of case management studies (39).

In sum, various case management approaches appear suited to promoting continuity of client contact and enhanced social functioning and satisfaction. Such tactics may reduce hospital use, but cost impacts are variable. Clinical outcomes do not appear to improve. Community-based primary providers will increasingly be seen as appropriate members of multi-disciplinary case management teams.

4.2.3) Intensive Community Treatment and Support: The clinical and social benefits of employment and training have been recognized for well over a century; without such support, reintegration into the life of the community is compromised.

Logic Model Process Objectives	■ To provide a range of treatment, rehabilitation, and support services to consumers in the least disruptive manner in the community: ■ consumer and group therapies ■ psycho-social rehabilitation and skill development programs (e.g., vocational and educational services) ■ bridging to crisis services ■ To provide follow-up and aftercare services.
Logic Model Short-Term Objectives	■ To improve consumers' access to appropriate services and supports taking into account consumer choice. ■ To increase consumers' ability to manage their mental health and to function in their daily lives. ■ To increase consumers' ability and capacity to make positive change, achieve desired treatment goals, and live as independently as possible in the community.

► What the Best Practices Literature Endorses

There is good evidence to endorse a range of vocational and educational services and for shifting resources toward supported employment models (see Appendix A). Intensive Services ought to include career counseling to assess consumer preferences and capacities, and placement services to begin the reintegration process. Sheltered work environments have a long history in mental health services, but supported employment represents a more recent approach in the rehabilitation field. Clients work as regular and remunerated employees with flexible, ongoing support (1). This represents an effective compromise between sheltered employment and fully competitive employment, and is suited to the needs of even those with serious psychiatric illness. The approach includes provision of continuous, time-unlimited individual support and attention to client preferences. Support education and social/recreational programs are promising but in need of further evaluation.

4.2.4) Court Diversion: A prison – because of the extraordinary stress and fear for personal safety, coupled to the boredom of daily routine – is about the worst place for any person with a mental illness. Yet prisons here and in the United States (and the UK) have become dumping grounds for the mentally ill through a lack of alternatives to incarceration (43). Not only are many people with mental illness incarcerated, there is ample evidence to show that people with a moderate mental illness may find their symptoms and conditions worsen under conditions of incarceration. (See the Forensics Champion Report.)

Logic Model Process Objectives	■ To divert consumers from the criminal justice system who have a mental disorder and who have been charged with a minor offence(s).
Logic Model Short-Term Objectives	■ To reduce the criminalization of consumers with mental illness. ■ To improve the linkages between the mental health and criminal justice systems.

4.3) The Specialized Services Logic Model

Logic Model Process Objectives	■ To provide advocacy to consumers and families. ■ To provide continuous and comprehensive treatment, rehabilitation, and support services to those people with serious mental illness who have multiple and complex needs that are more difficult to treat and are not manageable at another level. ■ To refer consumers to outside services where appropriate.
Logic Model Short-Term Objectives	■ To deliver 75% or more of the services outside program offices with an emphasis on outreach, relationship building, individualization of services, and consumer choice. ■ To avert hospitalization whenever appropriate. ■ To increase consumers' ability to remain in an integrated setting in the local community. ■ To increase consumers' access to specialized services where necessary.

4.3.1) Assertive Community Treatment Teams (ACTT): The major advantage of Assertive Community Treatment programs – see above at 4.2.2 – is in the area of treatment continuity and social functioning. The key findings are that:

1. Intensive Case Management (ICM) models retain consumers in programs more effectively than standard approaches (33,34).
2. Social functioning, in some studies including consumer/family satisfaction and quality of life, is improved (33-37).
3. Opinion is divided on whether clinical improvement is (36,37) or is not (34,38) associated with ICM.
4. Some studies have shown reduced hospitalization rates (34,38).
5. Costs are higher than conventional approaches (33,35).

The above points are consistent with the conclusions of the most recent systematic review of case management studies (39). In sum, various case management approaches appear suited to promoting continuity of client contact and enhanced social functioning and satisfaction. Such tactics may reduce hospital use, but cost impacts are variable. Clinical outcomes do not appear to improve. Community-based primary providers will increasingly be seen as appropriate members of multi-disciplinary case management teams.

4.3.2) Specialized Population Outpatient and Mobile Inreach and Outreach Teams:

Logic Model Process Objectives	■ To provide advocacy to consumers and families. ■ To provide clinical consultation, assessment, and treatment planning (using a balance of direct, indirect, and shared care service) to those who serve consumers with mental health needs including First Line service providers, Intensive service providers, and families. ■ To provide education to service providers in mental health and other related fields. ■ To engage in coordination and collaboration for the specialty populations within the mental health system and other relevant systems. ■ To engage in joint planning and development with First Line and Intensive Services for the specialty populations. ■ To ensure that crisis intervention and case management services are available to consumers and families. ■ To engage in and support ongoing program and system evaluation.
Logic Model Short-Term Objectives at the Consumer Level:	■ To avert hospitalization whenever appropriate. ■ To increase consumers' ability to remain in an integrated setting in the local community. ■ To increase consumers' access to specialized services where necessary.
Logic Model Short-Term Objectives at the System Level:	■ To expand the capacity of relevant services.

► What the Best Practices Literature Endorses

Best practices show that improved social functioning is associated with discharge of long-stay patients, that individuals and families prefer community care to hospitalization and that clinical and social outcomes are as good for discharged individuals receiving community care as for matched counterparts remaining in hospital (1). It has been widely demonstrated that day hospitals are less costly with comparable outcomes, that they are able to offer more intensive treatment in a less restrictive environment, that shorter lengths of stay achieves outcomes similar to longer stay admissions, and that home-based treatment is effective for many patients.

4.3.3) Residential Treatment: The imperatives here are (first) to prevent people with a mental illness from falling into homelessness which would exacerbate the course of their illness and (second) to smooth the transition between first line intervention and intensive or specialized care so that the consumer experiences no break or interruption in care delivery. A recurrent problem is that consumers lose their housing when they require short-term inpatient stabilization – so that upon discharge they may have to restart their residential experience.

Logic Model Process Objectives	■ To provide 24 hour consumer responsive, highly structured, and staffed residential treatment to consumers who would otherwise be placed in hospitals.
Logic Model Short-Term Objectives	■ To improve the transition to independent housing for the more complex and disabled consumers.

► What the Best Practices Literature Endorses

Arranging appropriate housing is a key function of mental health services when a consumer presents in crisis or when consumers who are suffering from mental illness in the community find it necessary to move their residence but are not actively followed by an ACT team. This role will increase as more primary providers participate in case management programs. Not only may housing have direct therapeutic implications, but also stability of living arrangements is essential in ensuring continuity with patients.

A distinction is made between two broad categories: custodial models - which tend to be larger facilities with little programming - and alternative housing

models, which generally are rather small and focused on rehabilitation and community support services. The goal of all these programs is to attain a high enough level of functioning to move into independent living from residential services.

The supported housing options endorsed by the best practices literature share the following features:

1. Housing is generic and widely dispersed in the community;
2. The provision of flexible individualized supports varies by intensity and time;
3. Consumers have more, rather than fewer, housing choices;
4. Consumers get assistance in locating and maintaining housing;
5. There are no restrictions on tenure in residence;
6. Case management services follow the consumer, irrespective of housing re-location or hospitalization.

Evidence from the literature shows that alternative living arrangements, when combined with ACT, can successfully substitute for long-term inpatient care, often at lower cost for equal or better outcomes (13,30).

Assertive Community Treatment provides the current best practices model for residential treatment. It is a 24/7 model which relies on an interdisciplinary team approach. Intensive Case Management – working in an integrated manner with other support services – can build partnerships and alliances between supported housing organizations in such a way that gaps between treatment modalities can be minimized.

4.3.4) Specialized Inpatient Services

Logic Model Process Objectives	■ To provide people with serious, complex, and/or rare mental disorders whose service requirements cannot be met in First Line or Intensive levels of services with centralized diagnostic and therapeutic health care (e.g., detailed assessment and treatment, medication management, and behavioural approaches) by specialized professionals.
Logic Model Short-Term Objectives	■ To improve the transition to independent housing for the more complex and disabled consumers.

► What the Best Practices Literature Endorses

Well designed follow-up studies show that:

1. Discharge of long-stay patients is associated with improved social functioning over time;
2. Individuals and families prefer community care to hospitalization; and
3. Clinical and social outcomes are at least as good for discharged patients receiving community care as for matched counterparts remaining in hospital.

Numerous controlled trials show that:

1. Hospitalization is less costly than inpatient care with comparable outcomes;
2. Day hospitalization offers more intensive treatment in a less restrictive and more home-like environment;
3. Shorter length of stay is generally not associated with increased readmission and achieves similar outcomes to longer stay admissions; and
4. Home-based treatment is an effective alternative to admission for many patients.

Preliminary descriptive studies show that:

1. Integrating mental health professionals in primary care settings can enhance continuity of care; increase accessibility to mental health services; lead to more efficient use of mental health services; provide new opportunities for continuing education for physicians; and improves communication between mental health services and family practitioners.

► Key Elements of Best Practice

1. Long-stay patients in Provincial Psychiatric Hospitals are moved into the community with carefully planned transitions to alternative care models.
2. Inpatient stays are kept as short as possible without harmful effects on patient outcomes.
3. Partial hospitalization programs are available as an alternative for inpatient admission. Day treatment is an option for those with non-psychotic diagnosis.
4. Home treatment programs (that are either assertive community treatment teams or adjuncts to intensive case management) are available as an alternative for inpatient admission.
5. New service delivery models that link family physicians with mental

health specialists are in place (43).

■ Summary

This review has focused best practices as they apply, not to the clinical management of patients, but to the management of components of the mental health system. It applies equally to all consumers across the life cycle. The key best practices are:

1. Successful intervention begins with the ability of the mental health system to ensure uniform and expeditious triage at multiple points of entry.
2. It is desirable to deploy the least intrusive approach to treatment necessary to achieve the best consumer outcome. Generally this means treatment in a community setting, which often can be achieved through a Crisis Response System and the use of Assertive Community Treatment.
3. While traditionally the role of First Line providers has been limited in case management approaches, participation is likely to increase substantially with the accelerated shift away from institutional care for the mentally ill and with the evolution of Primary Care Reform.
4. First Line providers are found in emergency departments, family physician offices and elsewhere. Shared clinical information and collaboration in treatment is essential amongst all levels of provider.
5. Successful re-integration of consumers into the community requires support to achieve appropriate housing, training, and employment.

4.4) Consumer Self-Help and Consumer Initiatives

Appendix A of Section II summarizes the current scientific literature on Consumer and Self Help Initiatives. The principle conclusions are that while there is variability in the quality of studies conducted to evaluate self-help and consumer initiatives, there is consistency in findings (43). Compared with professionally led groups, self-help groups emphasize experiential knowledge and social support, and tend to be more spontaneous, unstructured and unconstrained by time.

► Participation of consumers in self-help programs is associated with:

1. reduced hospitalization;
2. reduced other service use;
3. increased knowledge, information and coping skills;
4. increased self-esteem, confidence, sense of well-being and of being in control; and,
5. stronger social networks and support.

► Key Elements of Best Practice

There are growing numbers of funded organizations that utilize non-service models to engage in:

1. mutual support;
2. advocacy;
3. cultural activities;
4. knowledge development and skills training;
5. public education;
6. educating professionals; and,
7. economic development.

Evaluation of the effectiveness of these initiatives that uses appropriate, alternative methods is supported. The general public and mental health professionals should be educated about the value of self-help. Steps need to be taken to attract and train strong leaders for self-help groups.

4.5) Family Self-Help

Appendix A of Section II summarizes the current scientific literature on Family Self Help Initiatives. Existing research is, at this stage, limited in quantity and quality, with single group, cross-sectional study designs frequently used (43).

► Study findings associate participation in support groups with:

1. increased levels of information among participants;
2. improved coping skills;
3. reduced caregiver burden;
4. improved identity as caregiver;
5. improved relationship with and ability to support ill relative; and,
6. improved emotional support.

▀ **Key Elements of Best Practice**

1. Funding should be provided to family self help groups (as individual or joint consumer-family initiatives) and funds ought to be used in planning and evaluation of care delivery.
2. Evaluation of the effectiveness of groups that use appropriate, alternative methods is encouraged and endorsed.

References to Chapter 4: Best Practices in Mental Health Care

1. Health Systems Research Unit, Clarke Institute of Psychiatry. *Review of Best Practices in Mental Health Reform* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, 1997), XX.
2. National Health Service. *Modern standards and service models, mental health*. London: 1999.
3. World Health Organization. The world health report 2001, *Mental Health: New Understanding, New Hope*. Geneva: 2001.
4. Obrien L. Fitzgerald M. Barber H. Henry J. Evaluating the effect of assessment education with community psychiatric nurses using a file audit tool. *International Journal of Psychiatric Nursing Research*. 5:516-525, 1999.
5. Smart D. Pollard C. Walpole B. Mental health triage in emergency medicine. *Australian and New Zealand Journal of Psychiatry*. 33:57-66, 1999.
6. Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle 98195, USA. Field test of a tool for level-of-care decisions in community mental health systems. *Psychiatric Services*. 49:91-97, 1998.
7. Phelan M. Seller J. Leese M. The routine assessment of severity amongst people with mental illness. *Social Psychiatry and Psychiatric Epidemiology*. 36:200-206, 2001.
8. Bogart T. Solomon P. Procedures to share treatment information among mental health providers, consumers, and families. *Psychiatric Services*. 50:1321-1325, 1999.
9. Goering P, Durbin J. *A Background Paper for Mental Health Reform in Ontario*. (Toronto: Ontario Ministry of Health. 1994).
10. Reding GR. Raphelson M. Around-the-clock mobile psychiatric crisis intervention. *Community Mental Health Journal*. 31:179-190, 1995.
11. Bond GR. Witheridge TE. Wasmer D. Dincin J. MacRae SA. Mayes J. Ward RS. A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hospital and Community Psychiatry*. 40:177-183, 1989.
12. Sledge WH. Tebes J. Rakfeldt J. Davidson L. Lyons L. Druss B. Day hospital/crisis respite care versus inpatient care, Part 1: Clinical outcomes. *American Journal of Psychiatry*. 153:1065-1073, 1996.

13. Sledge WH. Tebes J. Wolff N. Helminiak TW. Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *American Journal of Psychiatry*. 153:1074-1083, 1996.
14. Gillig PM, Hillard JR. Bell J. Combs HE. Martin C. Deddens JA. The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*. 146:369-372, 1989.
15. Anfinson TJ. Bona JR. A health services perspective on delivery of psychiatric services in primary care including internal medicine. *Medical Clinics of North America*. 85:597-616, 2001.
16. Wang PS. Berglund P. Kessler RC. Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine*. 15:284-292, 2000.
17. Von Korff M. Katon W. Bush T. Lin EH. Simon GE. Saunders K. Lundman E. Walker E. Unutzer J. Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosomatic Medicine*. 60:143-149, 1998.
18. Hemmings A. Counselling in primary care: a randomised controlled trial. *Patient Education and Counselling*. 32:219-230, 1997.
19. Bedell JR. Cohen NL. Sullivan A. Case management: the current best practices and the next generation of innovation. *Community Mental Health Journal*. 36:179-194, 2000.
20. Salkever D. Domino ME. Burns BJ. Santos AB. Deci PA. Dias J. Wagner HR. Faldowski RA. Paolone J. Assertive community treatment for people with severe mental illness: the effect on hospital use and costs. *Health Services Research*. 34:577-601, 1996.
21. Essock SM. Frisman LK. Kontos NJ. Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry*. 68:179-190, 1998.
22. Fekete DM. Bond GR. McDonel EC. Salyers M. Chen A. Miller L. Rural assertive community treatment: a field experiment. *Psychiatric Rehabilitation Journal*. 21:371-179, 1998.
23. Clarke GN. Herinckx HA. Kinney RF. Paulson RI. Cutler DL. Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*. 2:155-164, 2000.

24. Taube CA. Morlock L. Burns BJ. Santos AB. New directions in research on assertive community treatment. *Hospital and Community Psychiatry*. 41:642-647, 1990.
25. Lafave HG. de Souza HR. Gerber GJ. Assertive community treatment of severe mental illness: a Canadian experience. *Psychiatric Services*. 47:757-759, 1996.
26. Herinckx HA. Kinney RF. Clarke GN. Paulson RI. Assertive community treatment versus usual care in engaging and retaining clients with severe mental illness. *Psychiatric Services*. 48:1297-1306, 1997.
27. McDonel EC. Bond GR. Salyers M. Fekete D. Chen A. McGrew JH. Miller L. Implementing assertive community treatment programs in rural settings. *Administration and Policy in Mental Health*. 25:153-173, 1997.
28. Tyrer P. Simmonds S. Joseph P. Marriott S. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database of Systematic Reviews*. 1, 2002.
29. Thornicroft G. Wykes T. Holloway F. Johnson S. Szumukler G. From efficacy to effectiveness in community mental health services. PRISM Psychosis Study 10. *British Journal of Psychiatry*. 173:423-237, 1998.
30. Sellwood W. Thomas CS. Tarrier N. Jones S. Clewes J. James A. Welford M. Palmer J. McCarthy E. A randomised controlled trial of home-based rehabilitation versus outpatient-based rehabilitation for patients suffering from chronic schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*. 34:250-253, 1999.
31. Rosenheck RA. Neale MS. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*. 55:459-466, 1998.
32. Tyrer P. Evans K. Gandhi N. Lamont A. Harrison-Read P. Johnson T. Randomised controlled trial of two models of care for discharged psychiatric patients. *British Medical Journal*. 316:106-109, 1998.
33. Johnston S. Salkeld G. Sanderson K. Issakidis C. Teesson M. Buhrich N. Intensive case management: a cost-effectiveness analysis. *Australian and New Zealand Journal of Psychiatry*. 32:551-559, 1998.
34. Holloway F. Carson J. Intensive case management for the severely mentally ill. Controlled trial. *British Journal of Psychiatry*. 172: 19-22, 1998.

35. Issakidis C. Sanderson K. Teesson M. Johnston S. Buhrich N. Intensive care management in Australia: a randomized controlled trial. *Acta Psychiatrica Scandinavica*. 99:360-367, 1999.
36. Chan S. Mackenzie A. Jacobs P. Cost-effectiveness analysis of case management versus a routine community care organization for patients with chronic schizophrenia. *Archives of Psychiatric Nursing*. 14:98-104, 2000.
37. Chan S. MacKenzie A. Ng DT. Leung JK. An evaluation of the implementation of case management in the community psychiatric nursing service. *Journal of Advanced Nursing*. 31:144-156, 2000.
38. Wykes T. Leese M. Taylor R. Phelan M. Effects of community services on disability and symptoms. PRISM Psychosis Study 4. *British Journal of Psychiatry*. 173:385-390, 1998.
39. Marshall M. Gray A. Lockwood A. Green R. Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. 1: 2002.
40. National Alliance For the Mentally Ill
<http://www.nami.org/update/970424140103.html> as of 21 April 2002.
41. Linszen D, Lenoir M, de Haan L, Dingemans P, Gersons B, Early intervention, untreated psychosis and the course of early schizophrenia. (1998). *British Journal of Psychiatry* 172 (Suppl 33): pp. 84-89 reference at <http://www.psychlaws.org/MedicalResources/Delay6.htm>.
42. Torrey, E.F. (1995). Editorial: Jails and Prisons - America's New Mental Hospitals. *American Journal of Public Health*, 85(12), p. 1612.

Table of Specialized Services discussed in recent best practices and related literature review *

Patient	Clarke (1)	Cochrane (2)	Cochrane (3)	Cochrane (4)
Seriously M.I.	X	X	X	X
Dual Diagnosis		X		
Concurrent		X		
A. Brain Injury		X		
Child/Adoles.				
Geriatrics				
Forensics				

1. Health Systems Research Unit, Clarke Institute of Psychiatry. *Review of Best Practices in Mental Health Reform* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, 1997).*
2. Cochrane J *et al.*, Tertiary mental health services: II. Subpopulations and best practices for service delivery. *Can J Psych* 2000 45: 185-90.
3. Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. Issue 1, 2002.
4. Marshall M, Gray A, Lockwood A, Green R. Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. Issue 1, 2002.

***Note:** Source 1 above is the best practices document relied upon and supplied to the Task Force by the Ontario Ministry of Health and Long-term Care. It covers literature up to approximately 1996. Sources 2 to 4 were the only general peer-reviewed documents on best practices identified during an extensive OVID search of the Medline and Evidence Based Medicine databases, 1996 to 2002.

¹E.g. 911, Telephone, Mobile, Quick Next Day Response and Community-based mental health safe beds.

²Additional terminology under this heading includes Case Management, and Intensive Clinical Case Management.

³Terminology may also include Intensive Community Care, Community Mental Health Teams, and Intensive Psychiatric Community Care.

Chapter

5



A Consumer-Centred Implementation Plan for Southeastern Ontario's Reformed Mental Health System

The purpose of this chapter is to present an overview of the district and an operational vision of a reformed system of Mental Health Services. The vision incorporates, as much as possible, that of a system that has emerged from the many recommendations and directions produced by the Task Force, its Committees, its Working Groups and its Champions who themselves worked with the policy directions for a reformed Mental Health System enunciated by the Ministry of Health and Long Term Care in *Making It Happen*.

5.1.1) Context: The Southeastern Ontario District

The Southeastern Ontario Planning district is comprised of Prince Edward, Hastings, Lennox and Addington, Frontenac, Leeds and Grenville, and Lanark. The area covers approximately 20,000 square kilometers. The district boundaries (are co-terminus with the planning boundaries of the current Southeastern Ontario District Health Council which has emerged from the three former DHCs whose planning areas covered (1) Hastings and Prince Edward (2) Frontenac, Lennox and Addington and (3) Leeds-Grenville and Lanark. Each of the former DHCs had slightly different ways of sub-dividing their districts for planning purposes.

The differences in how the planning areas were defined speak to the different ways that communities in the Southeastern Ontario district have seen and organized themselves historically. The population of the district is heavily concentrated along the Hwy. 401 corridor and south to Lake Ontario. The proportion of the population that is seniors is slightly higher than the provincial average and there is a higher percentage of seniors who live alone.

Unemployment rates across all age groups in the district (8.4% - 1996 census) tend to be lower than provincial average unemployment rates (9.1%). However, the unemployment rate was higher in the district's villages and towns and in the City of Brockville.

The incidence of low income in the district (12.1% of individuals in private households) is lower than the provincial average (17.1%). Low income people, however, are congregated in the urban areas of the district where low income rates are similar to those of the province.

For a more detailed overview of the demographics of the district see: "Demographics of the Five County Region" – Kingston, District Health Council (Appendix E of Section II).

Prior to the Health Services Restructuring Commission, the district hosted two major Provincial Psychiatric Facilities. The Commission directed the closure of Brockville Psychiatric Hospital and the transfer of community services to the Schedule One Hospital in Brockville (Brockville General). The Commission also directed a substantial reduction in the size of Kingston Psychiatric Hospital and the divestment of its governance and management to the Providence Continuing Care Centre.

The district hosts eleven Federal Penitentiaries with an offender population of about 3000 at any given time and a total of about 4500 over the course of a year and two large provincial Correctional Facilities. A large provincial "super jail" is to be built in Brockville over the next few years.

Prior to the restructuring of Developmental Services, the district also hosted four large provincially operated facilities for the Developmentally Disabled. These facilities have been largely downsized or closed and their services are now provided by community-based Associations for Community Living (9 in the Southeast District) and other service provider agencies. Rideau Regional Centre is the last remaining provincially operated facility for the Developmentally Disabled in the district and is in the process of being closed.

The district has a history of providing residential care to an unusually large proportion of seniors. This history of hosting institutions for people with special needs in institutions has led to unique challenges for the district to reform its systems and to restructure its programs and services to be delivered largely in the community.

The district also hosts an Academic Health Sciences Centre (Queen's) and its affiliated teaching hospitals which provide a large portion of the specialized physical and mental health needs of the district population.

5.1.2) Population change in the SEO District.

The Mental Health system in the Southeastern Ontario district serves a current population of 496,500 which is expected to grow to 525,500 in the next ten years. The composition of that population within the age groupings will also change, showing a decline in the population of children by 10,270 and an increase in the population of Seniors by 10,040. For planning purposes it is important to anticipate population change when determining where, how much and what services will be provided.

The projected population changes over the next ten years will not be equally distributed across the district or among age groups. The total population will increase by 5.9% or at about one half the projected provincial population growth (11%) over the same time period. The number of seniors will increase by 13% while the number of children will decrease by 12%.

Table 5.1: SEODMHITF - Population Change Summary

	2001	2006	2011	Change	% Chg.
Ontario	11,861,000	12,536, 000	13,198, 000	1,337, 000	11%
District	496,500	511,600	525,500	28,500	5.90%
Hastings	125,000	129,900	133,900	8,900	7%
Prince Edward	26,600	27,700	28,500	1,900	7%
Lennox & Addington	40,800	41,600	42,500	1,700	4%
Frontenac	138,900	141,200	142,900	4,000	2.80%
Leeds & Grenville	100,600	103,600	106,300	5,700	5.60%
Lanark	63,900	67,600	71,400	7,500	11.70%
By Age					
0-14	88,920	82,450	78,650	-10,270	-12%
15-64	331,530	348,760	360,670	29,140	9.60%
65+	76,180	80,200	86,220	10,040	13%

Source: "Ontario Population Projections" – Ont. Ministry of Finance, July 2000

5.1.3) The Prevalence of Mental Illness Among this Population

There are a variety of estimates of the prevalence of mental illness and its various components that can be applied to the base population of the district. The Working Groups reviewed a number of reports and proposals that included “prevalence” estimates for particular population groups.

It should be noted that all such estimates come with strong warnings that estimating prevalence is not an exact science and that figures, produced mainly from sampling data with wide variability, should be used with caution. Prevalence data is often not well defined – it may reflect during a lifetime, during a particular year, or at any given time. Different published estimates, used for different purposes, apply to different groups (for example: the estimate that 2.5% of the population is seriously mentally ill is applied variously to the total population, the total population over 19 yrs old, or the total population aged 15-64 while 2.55 to 5% is applied to children and adolescents.)

Nevertheless, there are prevalence rate applications used by working groups and champions committees in their deliberations and these will be useful in estimating the potential mental health service needs in the district.

Table 5.2: Prevalence Estimates – Southeastern Ontario

Category	2001	2011
All mental illness @ 18.6 %	92,349	97,743
Seriously Mentally Ill @ 2.5 %	12,414	13,137
Concurrent Disorders @ 50% Of SMI	6,208	6,568
Developmental Disability @ 1 %	4,965	5,360
Dual Diagnosis @ 40% of Dev. Dis.	1,986	2,140
Children and Adolescents @ 18.1%	16,094	14,235
Children SMI @ 5.4 %(To age 15)	4,801	4,247
Seniors @ 15%	11,427	12,933
Seniors Requiring Direct Care @ 2%	1,524	1,724

Source: “Ontario Population Projections” – Ont. Ministry of Finance, July 2000

5.1.4) The Use of Mental Health Services

Not all people who have mental health problems have access to mental health services and not all people elect to use mental health services that may be available to them. The Ministry reports some global utilization data on some elements of mental health services but, for measurement and comparison purposes, such data offers little but the number of consumers in some programs and services.

Table 4 below provides a glimpse at utilization of services in the Southeastern Ontario District for some indicators that are available. Even these are somewhat questionable because they rely on the accurate use of ICD9 codes (International Classification of Diseases, 9th Edition). The ICD9 codes, used for encounter billings by physicians, are subject to variable interpretation.

Nevertheless, this table does provide some interesting observations on the use of some services in the district. For example there are relatively fewer people receiving Ontario Disability Support Benefits (ODSP) in Lanark/Leeds and Grenville (1/104) than in Hastings Prince Edward (1/80) or in Frontenac Lennox and Addington (1/73).

Table 5.3: Selected Indicators of Program/Service Utilization

	Hast/PE.	F/L&A	L&G	SEO D
ODSP Recipients	1,910	2,465	1,570	5,945
Hosp. Discharges-99/00	700	850	210	1,760
PPH Discharges - Home County	75	345	430	850
GP Units of Service (MH) - 99/00	34,620	93,603	56,210	184,433
Psychiatrist Units of Service-99/00	25,115	73,998	52,454	151,567
GP + Psych Units of Service	59,735	167,601	108,674	336,010
Population 2001	152,300	179,700	164,500	496,500

Source: MOHLTC Summary Data

5.2) An Overview of Available Programs and Services

In 2001, there were 20 identified organizations offering a wide range of programs funded by the MOHLTC to provide mental health services in the district.

In addition, the Ministry of Community and Social Services funds 5 Children's Mental Health Centres, 6 Children's Aid Societies, Juvenile Corrections, residential and support services to the developmentally handicapped (dual diagnosis) and the Ontario disability Support Program for those who cannot work.

It is difficult to quantify the number of programs and services provided by other ministries (e.g. Housing, Colleges and Universities) and municipalities (Public Health, Transportation, Housing and Social Services) because their programs tend to have a wide client base that includes people with mental health needs. Similarly, there are also many community based agencies (Churches, Advocacy groups, Counseling groups) and individuals (Private Practice Psychologists and Social Workers) who claim to offer mental health related services.

The Integration Committee was presented with an overview of MOHLTC funded, or partially funded, services and programs in the Southeastern district. The presentation included some information on program sponsors, specific services, funding levels and staffing. It provided a very useful overview of services available in the district at the time of the presentation.

In each of the three planning areas of the district there is a comprehensive range of programs and services to meet the first line, intensive, and specialized needs of consumers. However, questions remain as to the appropriate accessibility of services within the consumer's immediate community. Many of the programs are district-wide, while others are area wide. There are few agencies providing an integrated comprehensive range of services at the local community level and this creates difficulties for the consumer in accessing crisis response, ongoing treatment, transportation, housing, employment and other support services.

A detailed inventory of programs and services in the district is provided in Tables 10, 11 and 12 at the end of this chapter.

5.2.1) Funding

The MOHLTC provides extensive data on mental health expenditures by county and the extracted data for the Southeastern district planning areas provide some interesting comparisons on expenditure patterns as they existed at the end of the 2000/2001 fiscal year.

As host to two Provincial Psychiatric Hospitals in transition, the district expenditure patterns are in a process of dynamic change that will eventually see significant transfers of funding from the Provincial Psychiatric Hospitals to community hospitals and community based services.

Comparisons between the district patterns and the Provincial patterns, which

show substantially higher per capita spending in the Southeastern district, must be cautious, given the large PPH capacity and also given that the district hosts an Academic Health Science Centre with significant tertiary and quaternary service capacity.

A comparison of spending among the planning areas within the district also reflects the PPH locations and the location of the three Schedule 1 Hospitals in the areas.

Table 5.4: Mental Health Spending in the Southeastern Ontario District 2000/2001

	H-PE	F-L&A	L/L&G	Total	Ont.
Population	152,300	179,700	164,500	496,500	11.5m
Total MH spending	26,476,255	85,257,108	90,192,054	214,134,457	
MH spending Per Capita	173.78	474.41	548.27	431.28	231.53
MH spending less PPH spending	26,476,255	37,612,501	30,202,872	135,471,362	
Per Capita	173.78	209.30	183.60	272.85	174.82
Community based Services	3,753,881	5,885,389	39,641,163	13,675,433	
Per Capita	24.64	32.75	24.10	27.54	28.57
Other MH Services	26,713,324	37,131,502	26,239,109	90,083,985	
Per Capita	175.40	206.63	159.51	181.43	145.68

5.2.2) Service Gaps

The Working and Champion Groups within the Integration Committee identified a number of gaps in services within the district and have made several recommendations for expanded and enhanced services including:

- Training and recruitment of Psychiatrists;
- Expanded cooperation with and engagement of General and Family Practice physicians;
- Expanded inventory of holding/safe beds;
- Expanded 24/7 crisis services;
- Expanded mobile crisis services;
- Expanded capacity for residential treatment; and,
- Expanded information and referral services.

A detailed analysis of service needs and services available will be provided in the forthcoming reports on the Community Comprehensive Assessment project.

5.2.3) Preliminary Observations from the Community Comprehensive Assessment Project (C-CAP)

The C-CAP was to assess the extent to which community mental health services match current clients' needs. The specific group of clients who formed the basis of the study were current users of community-based mental health treatment programs in the district. Programs addressing the needs of specialty populations, such as geriatrics, forensic, concurrent disorder or dual diagnosis were excluded as were agencies and services outside the formal mental health system. (Matching Community Health Services to Needs" – SEOMHITF – April 2002)

Some preliminary observations have been made available and are used cautiously here, pending the finalization and approval of the research reports. The project provides significant information about the relationship between need for care and care received by the client group specified for the research:

Total Group

- 45% of the client group were under serviced
- 26% received services matching their needs
- 29% were over serviced

16-24 age group

- 49% were under serviced
- 28% received services matching their needs
- 24% were over service

25-64 age group

- 46% were under serviced
- 25% received services matching their needs
- 29% were over serviced

65+ age group

- 24% were under serviced
- 26% received services matching their needs
- 49% were over serviced

This preliminary data gives a clear indication that, along with an expansion of services required in the Southeastern Ontario district, there is a need for a review of priorities and some rationalization of services within the district.

5.2.4) Characteristics of the Current System's Functioning

Beyond the development of a comprehensive inventory of services required as the starting point for planning a reformed Mental Health System is the broader subject of system relationships and system-wide instruments of planning and integration. Some characteristics of the existing system that emerge from observations, anecdotal evidence, and report commentaries which are counterproductive to the development of a system with the objective of streamlined access include:

1. **Fragmented Services:** There are too few service agreements among agencies – nor is there active commitment to create information linkages or protocols to support shared clients. There are no common intake, assessment or discharge protocols among the multiple case management agencies.
2. **Lack of Public Awareness/Information:** Agencies do not co-ordinate services to ensure minimal duplication – and there is limited public knowledge about the range of services available.
3. **Limited Access to Existing Services:** Lack of coordination gives rise to long waiting lists between case management services as client flow is not actively managed.
4. **Inconsistencies Among Agencies:** Communication between agencies is limited, consistent understandings for the variety of protocols and practices are rare – and therefore there is inconsistency regarding philosophies, policies and procedures between the various agencies.
5. **Lack of Planning Information:** Organizations gather information independently of each other, giving rise to a lack of common or reliable information for planning and coordination. There is a lack of standardized terminology across services. Past efforts to so standardize have failed and the fragmentation in the “consumer voice” is reflected in the fragmentation along agency lines.
6. **Urban/Rural Issues:** Distance and lack of transportation limits access to services sited in major centers. Satellite Office arrangements are not always responsive to local community need.
7. **Case Coordination:** Agency activities are not coordinated around needs and requirements of the consumer and joint planning is absent.

Discussions and reports from the Integration Committee, its Working Groups and Champion Groups suggest that, to one extent or another, these characteristics do apply to the current system of mental health services in the SEO district.

Responsibility for the mental health system in Ontario is distributed widely among various organizations and organizational levels within the Provincial government, the Municipal governments and many local agencies funded by governments and their communities.

The Ontario government is in the process divesting its direct services to funded community agencies, decentralizing its internal administrative operations to provide more community access, and refocusing its attention to legislation, funding and policy.

Ontario Municipalities have been assigned increasing responsibility for many of the community and personal services required by mental health consumers (short and longer term income support, housing, transportation, recreation) and direct mental health service delivery is increasingly the responsibility of community agencies.

The challenge for the Integration Committee and the Task Force is to propose a design vision that can correct the dysfunctional characteristics of the current system, build on its strengths, and prepare to accept an ever expanding role in service delivery as the reform of the Provincial Psychiatric Hospitals progresses.

5.3) Characteristics of a Reformed System

Making it Happen suggests that service systems should be designed to be flexible enough to respond to all those with service needs. The vision is, therefore, a planning framework around which need can be measured and services established. Consumers cannot be limited to accessing services within their own planning district and there needs to be access to services throughout the district. Consumers will also access different levels of services as their needs change. The recovery process is not linear and consumers, from time to time, will need more or less service of more or less intensity.

The vision relies heavily on the development of an appropriate balance of services throughout the district either in the community, through mobile outreach services or, in some cases, centralized inpatient and mobile services.



5.3.1) The Vision

A major objective of mental health reform endorsed by all of the working groups is a system that ensures that services are delivered as close to the home of the consumer as possible. Included in that objective is the concept of streamlined and equitable access to services. Given, however, that it is not possible to provide every service in every community, it is necessary to design a service delivery system that locates services “where numbers warrant” meaning that some services will be delivered in most if not all communities, others on a defined area basis and still others on a district-wide basis.

The illustration above envisions a mental health system predicated on the assumption that communities within which people live are basically healthy communities in which there is adequate access to education, employment, food, shelter and transportation as well as a supportive social, recreational and spiritual infrastructure. These are the essentials to the promotion of good mental health and the prevention of mental health deterioration.

Many communities have, or can develop the capacity to support their members with mental health service needs and virtually all communities can provide for

first line Services. As the service needs of individuals become progressively more complex and unique — requiring intensive, specialized and/or residential accommodation — building an effective and affordable system requires the provision of services on a progressively broader geographic base.

A “mentally healthy” Southeastern Ontario district, the broadest level of Community for planning purposes, will have a full range of services readily accessible to its citizens. The various levels of services provided at each definable community within the district will depend on levels of need and the resources available. The “vision” suggests that people with mental health service needs should be able to access progressively more complex and progressively less complex services according to their changing level.

Essential to the achievement of Mental Health Reform is a system organized to accommodate the unique needs of the district, to build upon its unique resources, and to produce a system in which:

1. There is a comprehensive continuum of services that ensures clients receive the services they need when and where they need them;
2. There is Streamlined Access to the mental health system through fewer entry points and centralized information and referral mechanisms;
3. Clients with multiple service needs are treated within shared service models of care;
4. There is enhanced capacity based on reinvestments reflecting best practices and meeting systems needs;
5. Clear system service responsibility and accountability achieved is based on consumer need; and,
6. Decentralized regional structures responsive to local and regional needs.

It was the task of the Integration Committee to build upon the work of its companion task force committees (Research, Human Resources, Community) its working groups and its champion representatives to produce a vision of governance for a mental health system that incorporates these objectives.

The vision must make provision for the organization, governance, accountability and delivery of the full range of core services defined by best practices, and the range of services must include at least:

1. Case Management/Assertive Community Treatment;
2. Crisis Response Systems/Emergency Psychiatric Services;
3. Housing/Community Support, Transportation, Recreation;
4. Inpatient/Outpatient Care;
5. Consumer Self Help and Consumer Initiatives;
6. Family Self Help; and,
7. Vocational and Educational Services.

The vision must be built on a framework that incorporates all levels of need (for First Line, Intensive, and Specialized services) while recognizing that consumers may move, over time, from one level of need level to another as they engage in the recovery process.

The vision must take into account the geography and the distribution the people within its boundaries in order to ensure that services are provided to people as close to their own homes as possible. At the same time, the vision must recognize that service levels are progressively more complex and progressively more expensive and that they cannot all be provided in every community within the district.

The vision must take into account the existing programs and services provided by organizations within the district and it must have the built-in capacity to effect change where necessary to ensure that there is streamlined access to and from an integrated and coordinated service system that promotes recovery for the consumer. It must be able to ensure that resources are directed to achieve the best possible outcomes for consumers.

The vision must be designed to ensure that each component of the system within the district relates easily one to another and that the system itself relates easily to the outside world; to the MOHLTC which is its primary sponsor, to other ministries of the provincial government which provide mental health related services, to other governments (municipalities) which host and support the system, to the communities at large and particularly to the consumers and survivors for whom it exists.

The system must have clearly identified leadership and direction to ensure that reform is implemented and it also must have the infrastructure support necessary to ensure that reform is sustained. These features are built into the governance and accountability proposals made to the Task Force

5.3.2) Organizational Components of a Reformed System

We have noted that the traditional planning areas within the district are:

1. Hastings, Prince Edward
2. Frontenac, Lennox and Addington
3. Lanark, Leeds and Grenville

Planning on the basis of these county groupings, which have roughly equal populations, supports the traditional and historical geographic relationships

and provides the definition for the core sub-groupings for the district around which services can be planned.

It is also important to note, however, that people living within these planning areas see their own counties as unique and distinct from neighboring counties and that detailed implementation planning will have to acknowledge that uniqueness in determining different community expectations and capacities to meet service needs.

It is envisioned that some, if not all, First Line Services will be delivered at the county, town or city level; some, but not all, Intensive services will be delivered at the area level and some, but not all, specialized services will be delivered at the district Level.

The outer ring suggests that a healthy community promotes mental health and prevents mental illness is a desirable state for all communities within the district.

The first interior ring suggests a local community service and support system that responds quickly to the needs of its citizens with mental health needs delivering the first line of service. The community could be a city, town, village, or rural area with a relatively small population base. (The Canadian Mental Health Association, for example, establishes chapters in communities with a population base as few as 3,000 people).

The next interior ring is a larger geographic area, perhaps a county or combination of counties, where organizations can be developed to provide more intensive services to those with more difficult mental health needs.

The inner core provides for highly specialized services that can only be delivered on a district-wide basis.

5.3.3) District Organization

In order to meet the criteria for a reformed system described above, the Integration Committee proposes the development of a systems organizational structure, built around the three tiered levels of service provided, as appropriate at the district, Area, and local community levels based on the traditional planning areas in the district. The implementation plan requires the integration of existing structures and components with new mechanisms of governance, planning, and service delivery. Essential components of the system to be developed will include:

1. The MOHLTC at the corporate level as the lead Ministry for all mental health services across the age span. Primary responsibility is for legislation, policy and funding;
2. The MOHLTC Regional and local offices as the primary interface organization with the service delivery system at the operational level;

3. Local Governments as service hosts and service providers;
4. The Southeastern Ontario district Mental Health Trust;
5. Area focussed Mental Health Planning Councils (Time Limited);
6. Multi Service Agencies;
7. Affiliations with Public Health Units, Community Health Centres and Family Health Networks;
8. Centres of Excellence; and,
9. Hospital Networks.

5.3.4) The Ministry of Health and Long-Term Care

The SEOMHITF has recognized that in order to develop an integrated system at the district, Area and Local levels, there must be some integration of the government approaches to its management of its own responsibilities and the structures through which it deals with communities and community agencies.

The Integration Committee has thus made recommendations that speak to coordinated inter-ministerial policy development and the designation of the Ministry of Health and Long Term Care as the lead Ministry for all mental health services across the age span and the spectrum of needs and services. The MOHLTC would be responsible for ensuring a coordinated and integrated approach to Mental Health related policy, program design, systems development and management.

Implicit in this responsibility is clear definition and appropriate delegation of responsibility and authority to the Regional offices of the MOHLTC and those of other Ministries with programs that directly impact on the district Mental Health system. There is also a need to address regional boundary discrepancies between provincial organizations.

Local governments have a significant impact on the functioning of the Mental Health system. Municipal by-laws, regulations and funding control the location and quality of housing, transportation, and recreational and income and employment supports for mental health consumers. It is essential that local governments be considered partners in the mental health service delivery system and that their roles be recognized in the reformed system.

5.3.5) The Southeastern Ontario District Mental Health Trust

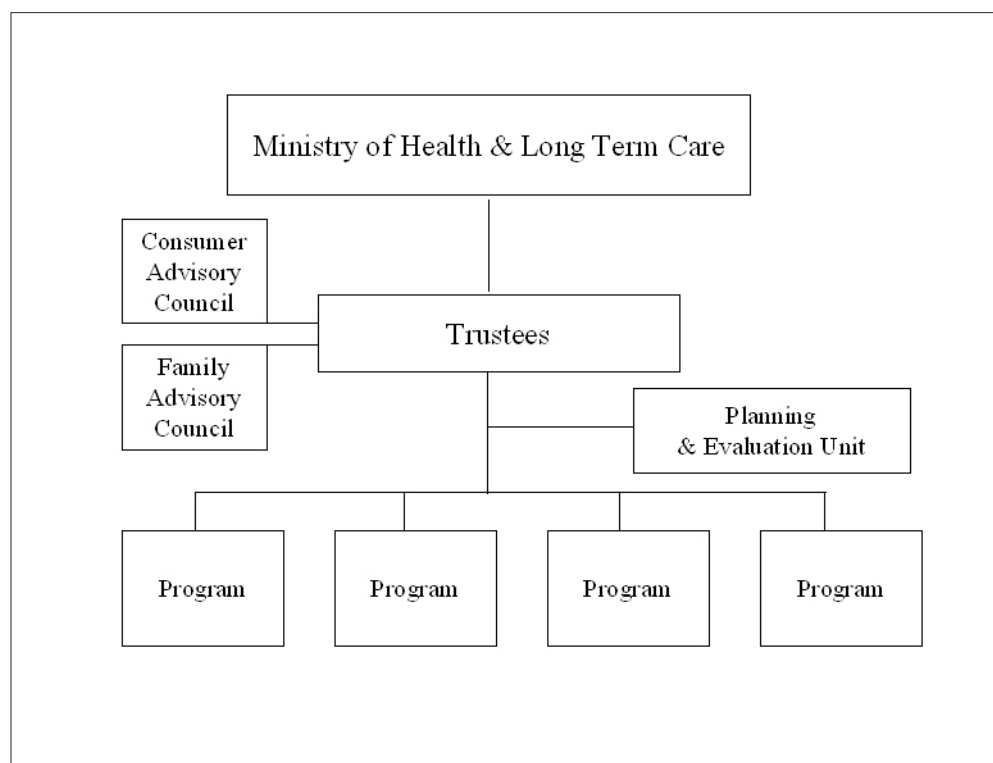
As a key feature in the development of a Southeastern Ontario mental health reform implementation strategy, the SEOMHITF is recommending the creation of The Southeastern Ontario District Mental Health Trust. The Trust will be the organizational vehicle responsible for the detailed design and implementation of a reformed system.

The Trust will be responsible to the Ministry of Health and Long Term Care for all aspects of mental health system functioning in the Southeastern Ontario mental health district including:

1. implementing mental health reform and system functioning in the Southeastern Ontario district;
2. advancing inter-agency cooperation and service integration by creating district-wide programs and service networks based on formal inter-agency partnerships and service agreements mandated to meet the needs and be held accountable for clearly defined population groups;
3. advancing community mental health by developing district-wide mental health promotion, prevention, and advocacy – initiatives built on partnerships between consumers, family members, and mental health professionals;
4. setting strategic directions for system functioning;
5. maintaining accountability for all aspects of system-functioning and service delivery within the district;
6. conducting strategic, system-level planning;
7. advising the Government through the Ministry of Health and Long Term Care regarding all aspects of system functioning ranging from strategic planning to funding to service delivery in the district, including how new and existing funds may be reallocated to support system functioning activities;
8. promoting greater visibility of needs of those with a mental disorder
9. coordinate opportunities for training and clinical across district-level service networks and programs
10. foster excellence in service delivery by identifying and setting clinical standards and ensuring that mechanisms are in place to meet and monitor these;
11. participating in regional and provincial initiatives;
12. fostering a culture of cooperation and excellence through participation in research, education, and inter-agency initiatives, and,
13. creating relevant advisory mechanisms to support smooth system functioning or decision-making.

5.3.6) The Organization of the Trust

The organization of the proposed governance vision is displayed in the following organization chart.



It should be noted that the organization is essentially a modified district board of governors mandated to recommend and implement plans related to all aspects of mental health service delivery in the district. The Trust will become a stand-alone mental health systems planning and monitoring agency equipped with staff infrastructure, supports for research, planning and evaluation. The Trust will have no direct service delivery program, budget allocation or financial management responsibilities, but it will have a strong mandate to advise government decision makers on all plans and proposals put forward by the service delivery sector. To support the planning role staff should be provided to the agency to liaise with governments and local delivery agencies, support restructuring of existing services, lead the development of new services and effect the agreements necessary to implement the reformed system

5.3.7) Planning, Research and Evaluation

Included in the governance proposal to create a Southeastern Ontario District Mental Health Trust is provision for a Planning, Research and Evaluation Unit proposed in “A Framework for Mental Health System Accountability in Southeastern Ontario”, mandated to:

1. implement district level accountability processes;

2. oversee the implementation and collection of standardized, linked performance monitoring data;
3. harmonize data demands across different agencies;
4. plan and conduct evaluation research;
5. analyze and interpret performance monitoring and evaluation data;
6. develop and implement information brokerage models to synthesize and communicate the literature on best practices to key participants within the district;
7. actively communicate with accountability partners regarding the results and outcomes of local accountability processes; and,
8. collaborate with other systems-based accountability units in multi-centered or provincial evaluation initiatives.

The need for infrastructure research capacity is compelling. There is a dearth of current and reliable information across the mental health service delivery system in Ontario. Existing data collection processes record programs, services, and utilization but are limited in terms of measuring consumer need. They lack standardization, are of dubious reliability and validity and are inadequate for assessing quality of care (Marhaba, 2002). What information exists is scattered and fragmented, unreliable and often outdated. Similar programs may go under completely different names, hours of access may be limited, actual services may be limited to specific days, or even hours of the week. The full realization of the *Making It Happen* vision for reformed mental health care service delivery requires the development of a comprehensive data and evaluation infrastructure both to understand how the consumer's needs are or are not being met and to plan for the improvement of the mental health care system (Ziglin, 1995).

Some initiatives have been undertaken to address the issue of data development. The "Community Mental Health Monitoring Tool" proposed by the Eastern Regional Office of the MOHLTC shows promise.

One of the main challenges of the research and evaluation unit, proposed as a part of the "Trust" will be to work with the SEO District Health Council and the Health Information Partnership to develop and implement a district-wide mental health data and information capacity. The document resource inventory collected by the Task Force contains data and service specific and localized information. There is, however, very limited district-wide comparable data and information that has been collected and displayed for a district, area or community level.

In order for the Trust to create and implement a district-wide system it will be necessary to create mechanisms that focus on planning for the three identified planning areas within the district centered in Belleville, Kingston, and Brockville. It is suggested that the Trust create short-term, time-limited planning groups for each area. These planning groups would be composed of consumers

and providers within the area, supported by staff of the Trust, with a mandate to develop and implement specific area plans. Once the reform plans are in place, the Councils would be disbanded leaving to the Trust the ongoing responsibilities for the continued planning and monitoring of the system.

5.3.8) Multi-Service Agencies

One of the weaknesses of the current system is the number of small, unaffiliated programs operating in local communities throughout the district. This leads not only to problems of consumer access, but also to issues of financial viability, economies of scale, and systems efficiency. The Trust will need to effect some restructuring of services at the local community level to ensure that there are strong multi-service agencies in selected communities within the district and to create them where they do not exist. There are already some examples of such agencies within the district.

A compelling example of service systems built around strong local multi-service agencies is the Developmental Service System in the district which serves a client base much smaller than the client base of the Mental Health system. Viable “Associations for Community Living” (or their equivalents) are located in Belleville, Picton, Kingston, Napanee, Belleville, Carleton Place and Sharbot Lake.

Such Local Associations have planning, advocacy, and service delivery responsibilities for their communities and they tend to be governed by consumers, their families, and other interested people in the local community. Among other responsibilities, they become the primary care givers for people discharged from the Provincial facilities for the developmentally disabled. They do not necessarily have a “monopoly” on services but co-exist with a variety of other service providers in their communities. They do, however, provide networks of services around which systems can be built.

As a part of the implementation strategy it will be necessary for the Trust to support the development of affiliation arrangements with the District Health Councils, the Health Information Partnerships, Public Health Units, Community Health Centres, and Family Health Networks all of which have broad responsibilities within the over Health system and all of which are or have the potential to make significant contributions to the reformed Mental Health system.

The creation of the Trust does not, in any way, pre-empt the primary roles and functions of any of these organizations but rather the Trust has the potential to engage these organizations in support of the Mental Health System.

5.3.9) Centres of Excellence

The district hosts an Academic Health Science Centre which includes a Faculty of Medicine and affiliated teaching hospitals through which can be built the range of intensive and specialized services that can and should be delivered at a district-wide level. A “Centre of Excellence” implies the existence of a critical mass of professionals engaged in Research, Education, and Teaching. In addition to providing direct speciality services, they have the potential to enrich and enhance the skill levels of other professionals in the broader system, creating less dependency on district-wide services.

Working and Champion Groups have recommended that a number of these Centres be developed (Seniors, Dual Diagnosis, Forensics, Children and Adolescents). The Trust will have the responsibility to advocate for the resources required to create the Centres and to help define their roles, functions and responsibilities within the district-wide system.

Through its working groups the Integration Committee has recommended that stronger affiliation and service agreements between and among Schedule 1 hospitals and local community hospitals be established. Such agreements would be designed to ensure that local hospitals are able to serve and support consumers in their own communities to the greatest extent possible. Three such networks are envisioned, some of which are at least partially in place. The configuration for each network would be:

1. Belleville (Picton and Bancroft)
2. Kingston (Napanee)
3. Brockville (Almonte, Arnprior, Carleton Place)

The Trust can take a lead role in ensuring that sufficient agreements are in place to reach this objective, advocating where necessary for enhanced funding and services at the local level.

References to Chapter 5: A Consumer-Centered Implementation Plan

- Bedell JR. Cohen NL. Sullivan A. Case management: the current best practices and the next generation of innovation. *Community Mental Health Journal*. 36:179-194, 2000.
- Bogart T. Solomon P. Procedures to share treatment information among mental health providers, consumers, and families. *Psychiatric Services*. 50:1321-1325, 1999.
- Chan S. Mackenzie A. Jacobs P. Cost-effectiveness analysis of case management versus a routine community care organization for patients with chronic schizophrenia. *Archives of Psychiatric Nursing*. 14:98-104, 2000.
- Clarke GN. Herinckx HA. Kinney RF. Paulson RI. Cutler DL. Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*. 2:155-164, 2000.
- Cochrane J, Goering P, Durbin J, Butterill D, Dumas J, Wasylenki D. Tertiary mental health services: II. Subpopulations and best practices for service delivery. *Canadian Journal of Psychiatry* 2000; 45: 185-190.
- Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental illness. *Cochrane Database of Systematic Reviews*. Issue 1, 2002.
- Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle 98195, USA. Field test of a tool for level-of-care decisions in community mental health systems. *Psychiatric Services*. 49:91-97,1998.
- Essock SM. Frisman LK. Kontos NJ. Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry*. 68:179-190, 1998.
- Fekete DM. Bond GR. McDonel EC. Salyers M. Chen A. Miller L. Rural assertive community treatment: a field experiment. *Psychiatric Rehabilitation Journal*. 21:371-179, 1998.
- Fenton WS. Mosher LR. Herrell JM. Blyler CR. Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. *American Journal of Psychiatry*. 155:516-522, 1998.
- Gillig PM, Hillard JR. Bell J. Combs HE. Martin C. Deddens JA. The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*. 146:369-372, 1989.

Health Systems Research Unit, Clarke Institute of Psychiatry. *Review of Best Practices in Mental Health Reform* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, 1997), XX.

Herinckx HA. Kinney RF. Clarke GN. Paulson RI. Assertive community treatment versus usual care in engaging and retaining clients with severe mental illness. *Psychiatric Services*. 48:1297-1306, 1997.

Holloway F. Carson J. Intensive case management for the severely mentally ill. Controlled trial. *British Journal of Psychiatry*. 172: 19-22, 1998.

Issakidis C. Sanderson K. Teesson M. Johnston S. Buhrich N. Intensive care management in Australia: a randomized controlled trial. *Acta Psychiatrica Scandinavica*. 99:360-367, 1999.

Johnston S. Salkeld G. Sanderson K. Issakidis C. Teesson M. Buhrich N. Intensive case management: a cost-effectiveness analysis. *Australian and New Zealand Journal of Psychiatry*. 32:551-559, 1998.

Joy CD. Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*. 1:2002.

Knapp M. Marks I. Wolstenholme J. Beecham J. Astin J. Audini B. Connelly J. Watts V. Home-based versus hospital-based care for serious mental illness. Controlled cost-effectiveness study over four years. *British Journal of Psychiatry*. 172, 506-512, 1998.

Lafave HG. de Souza HR. Gerber GJ. Assertive community treatment of severe mental illness: a Canadian experience. *Psychiatric Services*. 47:757-759, 1996.

Marshall M. Gray A. Lockwood A. Green R. Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. 1: 2002.

McDonel EC. Bond GR. Salyers M. Fekete D. Chen A. McGrew JH. Miller L. Implementing assertive community treatment programs in rural settings. *Administration and Policy in Mental Health*. 25:153-173, 1997.

Morse GA, Calsyn RJ, Klinkenberg WD, Trusty ML, Gerber F, Smith R, Tempelhoff B, Ahmad L. An experimental comparison of three types of case management for homeless mentally ill persons. *Psychiatric Services* 1997; 48: 497-503.

O'Brien L. Fitzgerald M. Barber H. Henry J. Evaluating the effect of assessment education with community psychiatric nurses using a file audit tool. *International Journal of Psychiatric Nursing Research*. 5:516-525, 1999.

Phelan M. Seller J. Leese M. The routine assessment of severity amongst people with mental illness. *Social Psychiatry and Psychiatric Epidemiology*. 36:200-206, 2001.

Rosenheck RA. Neale MS. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*. 55:459-466, 1998.

Ruggeri M. Leese M. Thornicroft G. Bisoffi G. Tansella M. Definition and prevalence of severe and persistent mental illness. *British Journal of Psychiatry* 177:149-155, 2000.

Salkever D. Domino ME. Burns BJ. Santos AB. Deci PA. Dias J. Wagner HR. Faldowski RA. Paolone J. Assertive community treatment for people with severe mental illness: the effect on hospital use and costs. *Health Services Research*. 34:577-601, 1996.

Sellwood W. Thomas CS. Tarrier N. Jones S. Clewes J. James A. Welford M. Palmer J. McCarthy E. A randomised controlled trial of home-based rehabilitation versus outpatient-based rehabilitation for patients suffering from chronic schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*. 34:250-253, 1999.

Sledge WH. Tebes J. Rakfeldt J. Davidson L. Lyons L. Druss B. Day hospital/crisis respite care versus inpatient care, Part 1: Clinical outcomes. *American Journal of Psychiatry*. 153:1065-1073, 1996.

Smart D. Pollard C. Walpole B. Mental health triage in emergency medicine. *Australian and New Zealand Journal of Psychiatry*. 33:57-66, 1999.

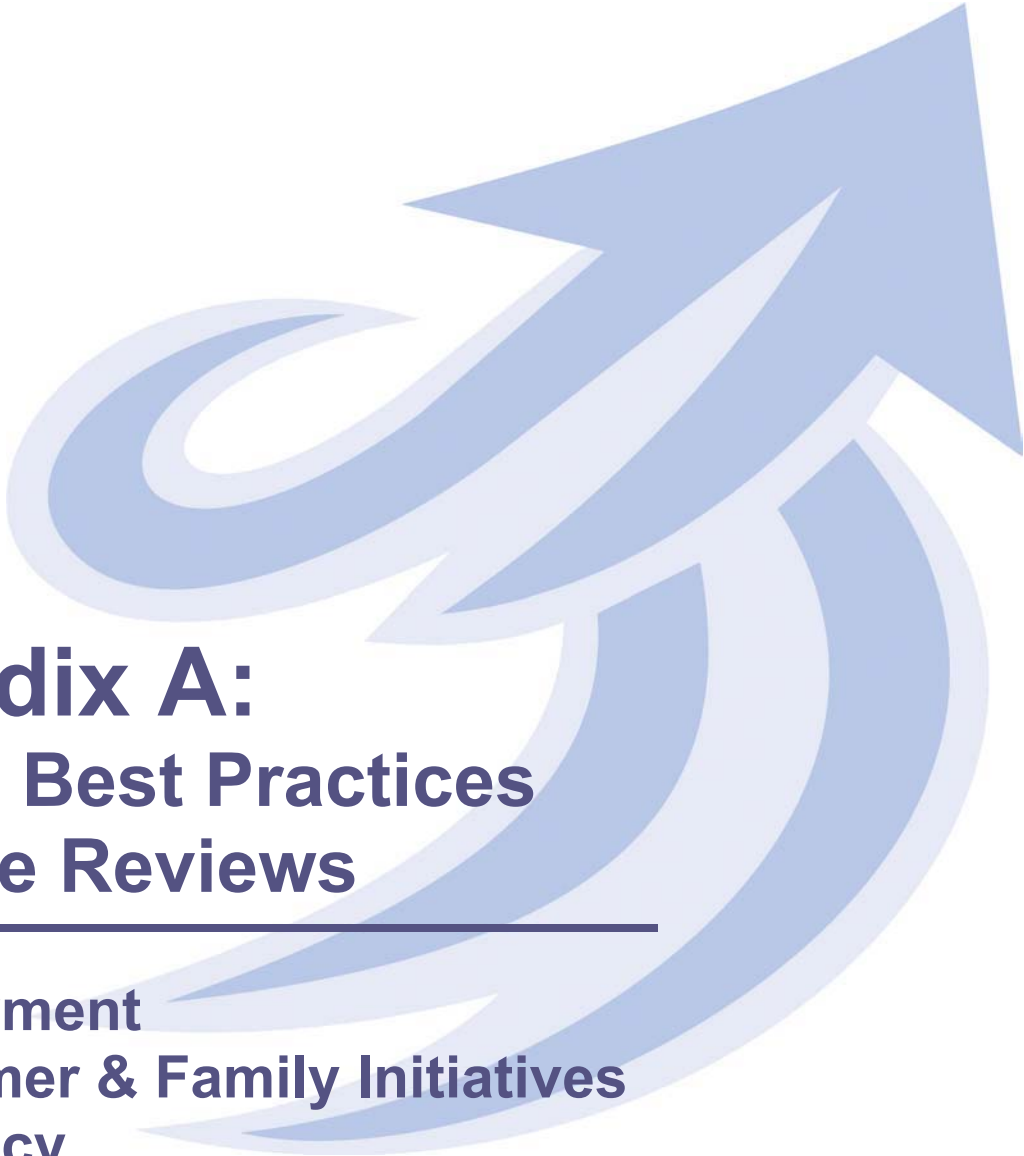
Taube CA. Morlock L. Burns BJ. Santos AB. New directions in research on assertive community treatment. *Hospital and Community Psychiatry*. 41:642-647, 1990.

Thornicroft G. Wykes T. Holloway F. Johnson S. Szmukler G. From efficacy to effectiveness in community mental health services. PRiSM Psychosis Study 10. *British Journal of Psychiatry*. 173:423-237, 1998.

Tyrer P. Simmonds S. Joseph P. Marriott S. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database of Systematic Reviews*. 1, 2002.

Wasylenki D, Goering P, Cochrane J, Durbin J, Rogers J, Prendergast P. Tertiary mental health services: I. Key concepts *Canadian Journal of Psychiatry* 2000; 45: 179- 184.

Wykes T. Leese M. Taylor R. Phelan M. Effects of community services on disability and symptoms. PRiSM Psychosis Study 4. *British Journal of Psychiatry*. 173:385-390, 1998.



Appendix A:

Selected Best Practices

Literature Reviews

Employment
Consumer & Family Initiatives
Advocacy
Housing
Streamlined Access

Appendix A1

Employment Supports for People with Serious Mental Illness

The Scope of the Issue and its Consequences

Employment is a major issue affecting the health and well-being of persons with severe and persistent mental illness and is consistently cited by consumers as a most pressing need (Kirsh, *et al.*, 2000, Mueser, *et al.*, 1997). People with mental illnesses have trouble finding jobs when left to their own initiative (Jones, *et al.*, 2001) and their unemployment rate is variously estimated to range from 75-90%. They also have difficulty maintaining jobs (Dorio, *et al.*, 2002, Becker, *et al.*, 1998) and unhappy terminations tend to be a recurring experience. In one American study, people terminated jobs for a number of reasons; not wanting to work; substance abuse problems; physical health problems; obtaining a better job; poor attendance but also – in a large number of cases – as a consequence of problems arising on the job itself (Becker, *et al.*, 1998). Yet research shows that people with mental illnesses *can* work and that their higher than average rate of unemployment cannot be explained by either lack of desire or ability to work (Gates, *et al.*, 2001).

Advocates for the integration of work with mental health programs emphasize the therapeutic value of employment as well as the disabling effects of unemployment (Mank, *et al.*, 2000). Work is now widely “believed to have positive effects on a range of different areas, such as finances, self-esteem, satisfaction with life, mental health service utilization, and symptomatology” (Mueser, *et al.*, 1997). Competitive employment is a primary goal for many people with severe mental illness (Drake, *et al.*, 1999) and research evidence suggests that their preference is for regular jobs supervised by regular employers for regular wages in integrated settings (rather than sheltered or prevocational jobs in sheltered settings). A growing body of opinion is converging around the desirability of supported employment for (a) displacing symptoms, (b) providing structure and meaning, (c) creating opportunities for socialization, and (d) generating personal income (Fuller, *et al.*, 2000).

What Are its Causes and Determinants?

Explanations vary and even conflict (Kirsh, *et al.*, 2000). Mental health professionals have until quite recently discouraged patients from seeking competitive employment because of the presumed link between job-related stress and symptom exacerbation, but although current research no longer supports this view the links between stress and symptom exacerbation are still not well understood (Drake, *et al.*, 1999, Kirsh, *et al.*, 2000). Where some studies find associations between diagnosis and poor vocational outcomes, others find none and the conclusion of one recent study is that “the predictive

value of all of the clinical indicators examined to date are, at best, questionable” (Kirsh, *et al.*, 2000). Some findings suggest that about one in three mental health consumers lack the initiative or interest to enroll in employment programs – and that their stated disinterest reflects a genuine hesitancy to seek competitive work (Mank, *et al.*, 2000). Then there is the issue of stigmatization by co-workers, fear of the mentally ill and a lack of compassion and willingness to engage in the workplace with another employee who is different.

Another line of thinking holds that some individuals are reluctant to work because they lack self-confidence or experience. Unless they express a desire to work, there may be no positive incentive for life improvement in most mental health programs (Mank, *et al.*, 2000). Dependence on public financial assistance is generally instituted early in the course of illness and maintained for long periods of time. It may be difficult for some persons with mental illness to, in the context of their jobs, balance the imperatives of managing work, their illness, their physical well-being (i.e. substance abuse issues if any) and their interpersonal relationships with co-workers (Becker, *et al.*, 1998).

There is also evidence to suggest that women with mental illness experience employment quite differently from men, and that these differences may reflect but also go beyond the disparities that women encounter more generically in the workplace. Women with a mental illness are highly likely (up to sixteen times more likely) to be harassed, sexually assaulted or coerced (Goodman, *et al.*, 2001). On the other hand there is evidence that men have problems – particularly with hygiene and sexual aggressiveness – that women may not. Although there does not yet exist research into its significance, it is clear from a study of existing data bases that women with mental illness typically work in jobs traditionally stereotyped by gender (i.e. food service, clerical) which jobs provide fewer opportunities for advancement, lower pay and limited variety compared to the jobs typically held by men. On the basis of the currently available evidence, however, there is cause for concern that while women with mental illness were more likely to be living independently in the community, they were less likely to be working than men and earning less when they did, which mirrors the situation for men and women who are not mentally ill. Olson and her collaborators found that women with disabilities typically earn about 56% of the earnings of men and are significantly less likely to have full time employment (Olson, *et al.*, 2000).

What is clear is that there has grown up a culture of low-expectations alongside a complementary culture of stigmatization and consequent denial of opportunities (Kirsh, *et al.*, 2000) the consequence of which has been to deny persons with mental illness a chance to optimize their life chances and advance the course of their recovery through work. Work provides a number of payoffs relevant to recovery from mental illness: it supplies another avenue of integration into mainstream society; it gives persons with mental illness a chance to interact with people on the job; it puts money in their pocket; it provides a stabilized routine around which they can organize their lives; and it gives them an opportunity to see a life beyond recovery from mental illness.

Best Practice Solutions

The objective of integration of mental health consumers into regular employment is to as much as possible normalize the lives of persons with mental illness by making them as much as possible a part of the larger community, including communities of work and social relationships (in and outside of work). Until quite recently the sheltered work environment was thought to be (a) the best option for the patient to protect them from the harshness of life in a community hostile toward and fearful of the mentally ill, and (b) the best the patient was in any event capable of doing. Contemporary thinking stands this view on its head: today the objective is to get the consumer into paid and competitive employment as quickly as possible – bypassing, in many cases, prevocational training where too many consumers seem to stall (Meisler, *et al.*, 1998).

Supported Employment (SE) is the current gold standard in the best practices literature (National Mental Health Association, 2002). Its debut in the 1980s represented a paradigm shift in thinking about vocational services and their relationship to empirical outcomes (Drake, *et al.*, 1999). The goal of SE is to (a) increase the number of people in competitive employment and (b) improve their ability to keep jobs once acquired. The United States Rehabilitation Act defines SE as “competitive work in integrated work settings,”

consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the individuals, for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability (Bond, *et al.*, 2001).

Unpacking this definition somewhat yields the following clarifications:

1. *Competitive work* is work that is paid consistent with wages paid to non-disabled workers with similar job functions in which full or part-time schedules can be determined on an individual basis.
2. *Integration* refers to work settings in which disabled and non-disabled workers are in frequent contact or in which disabled workers are in contact with the public.
3. *Qualified Workers* – in the SE scheme – are those with a history of intermittent or interrupted employment, or who have been unable to gain and maintain employment without support or who, because of their disability, need ongoing time-unlimited support.
4. *Ongoing Support* – includes individualized supports such as job site training, family support or any service necessary (at least twice a month) throughout the term of employment.

SE services can generally be grouped into two classes: (a) interventions integrated at the system level or agency level (*across programs*) in which staff from a vocational program

meet regularly with staff from mental health programs to discuss client needs and service plans, or (b) interventions at the program or staff level (*within programs*) in which vocational programs are routinely available along with mental health services (Mank, *et al.*, 2000). Boston University's "Choose-Get-Keep" program is an example of a specialized vocational program in which vocational and case management programs routinely collaborate, though there are a number of other models available for consideration. There is, at this time, no clear evidence which of the two classes produces the best outcomes (Mank, *et al.*, 2000).

The United States National Mental Health Association has recently reviewed five currently operating models of Supported Employment:¹

The Job-Coach Model employs a job coach to assist a person in finding a job and to provide vocational support on and off the job site. Most support is provided in the community rather than in a treatment or mental health centre. The job coach may work with the consumer, employer as well as co-workers and family members to facilitate a successful work experience.

The Choose-Get-Keep-Leave Model is a skills-oriented approach named for the sequence in which persons with a mental illness are provided employment support. An employment specialist helps the individual *choose* a job that is compatible with his or her needs and interests, experiences and personal values. Then they work together to *get* the job that meets those desires by developing an appropriate resume and preparing the individual for interviews. Ongoing support is designed to assist the individual to *keep* the job once attained until the individual decides it time to *leave* the job in order to move onto another experience facilitative of growth and future employment success.

The Assertive Community Treatment Model is based on interdisciplinary teams providing case management, psychiatric medications and services including an employment specialist to work with individuals on their employment needs. While ACT has been shown to be effective at decreasing hospitalizations and increasing housing stability, findings are inconsistent regarding their effectiveness on social adjustment and work.

The Individual Placement and Support Model emphasizes integration of vocational and clinical services in multidisciplinary teams combining the ACT with Choose-Get-Keep-Leave concepts of client choice. The IPS model is taken up in more detail below.

The Menu Approach combines elements of various approaches under a philosophical framework based on four principles:

1. Work offers many benefits other than a means to 'pay the bills.' It provides a sense of purpose, social interaction and an opportunity to

¹The full review can be downloaded at www.nmha.org/pbedu/adult/supported_employment.pdf

contribute to the community (the last value rates highly in studies of consumer preferences);

2. Virtually all persons with mental illness can participate in and benefit from meaningful paid work.
3. Consumers should be able to choose from a ‘menu’ of employment options; and
4. Experience in different kinds of paid work is an important part of developing long-term employment in competitive settings.

“Natural supports” – a source of extended service for supported employment – is defined as “a strategy to eliminate the discrimination and separation produced by the presence of job coaches providing direct training, coaching, and support to workers with disabilities” (Banks, *et al.*, 2001). The idea behind natural supports is that persons with mental illness in an SE job have access to any assistance, relationships or interactions that permit that person to secure or maintain a job while corresponding to the typical (i.e. natural) work routines and social interactions of other employees. The emphasis is on integration into workplace culture which does not accentuate limitations of individuals. The objective is to, as much as possible, make the work experience for people with mental illness *typical* on the grounds that the more typical a work experience is the more likely the worker’s wages will rise and integration will progress. Higher wages tend to correspond with higher levels of social interaction. The challenge for SE programs – in this regard – is finding the right way to disclose a mental illness to an employer in order to gain the employer’s cooperation with the fluctuating course of a psychiatric disability. Symptoms of mental illness typically modulate between periods of remission and reoccurrence – which may interfere with workplace performance and relationships with co-workers. Accommodations may include (a) part-time scheduling, (b) flexible hours, (c) limiting distraction, (d) additional positive feedback, (e) more frequent breaks, (f) time off for scheduled clinical service, and (g) education of co-workers and supervisors. The important finding from this stream of research, however, is that “higher levels of social integration correspond with higher wages” (Banks, *et al.*, 2001).

The individualized placement and support (IPS) model is the most standardized and carefully studied Supported Employment model. Where traditional vocational approaches rely on extensive pre-employment testing, counseling, training and work adjustment trials to prepare individuals for employment, this SE model emphasizes rapid placement in competitive jobs “with training and supports provided as needed after the individual is on the job” (Drake, *et al.*, 1999). In a study published in the *Archives of General Psychiatry*, the IPS model performed better than a competing model – enhanced vocational rehabilitation (EVR) – by a margin of 2:1, though the authors note that their study is limited by the fact that participants generally had good employment histories and few came from minority backgrounds (Drake, *et al.*, 1999). The EVR model – which was used as a control group for comparison – seems to fail at the step of transitioning people from sheltered work to competitive jobs. By contrast, the IPS model evaluated in Washington D.C. produced good outcomes in both vocational and non-vocational realms

when clients were able to access high quality intensive case management services integrated with substance abuse services and housing supports.

The IPS model demonstrates one other virtue worth noting: too often separate and parallel agencies have difficulty cooperating to individualize services. The inclusion of employment specialists on mental health teams in the IPS model overcomes these communication and coordination difficulties (Drake, *et al.*, 1999). Complementary to the individualized placement and support model is the preparation of co-workers and mentors, supporters and trainers. Research has shown that “training provided to co-workers by supported employment personnel (job coaches) was related to increased employment outcomes for employees with more severe disabilities and behavioural issues” (McFarlane, *et al.*, 2000). Another finding arising from the recent literature concerns shifting the focus from the individual to the environment in understanding the process and outcomes of work integration in mental health, (Kirsh, *et al.*, 2000) though this avenue of research requires replication with larger data sets.

Six principles encapsulate the Individual Placement and Support Model:

1. Competitive employment as the goal;
2. Rapid job search;
3. Integration of rehabilitation and mental health;
4. Attention to consumer preferences;
5. Continuous and comprehensive assessment; and
6. Time un-limited support.

An impediment to SE models of the kind endorsed by the best practices literature arises from the unequal distribution of required expertise and talent to actually implement the programs which work best (Meisler, *et al.*, 1998). Providing agencies may have to craft hybrids out of a need to compromise between the requirements of different programs – thus undermining *fidelity* (i.e. accurate representation of critical program components) to any one model – in order to get a program off the ground (Becker, *et al.*, 2001). Another impediment is the resistance that arises from the philosophical orientation or organizational culture of a long-standing vocational rehabilitation program to collaborate toward the goal of SE with mental health care providers or buy into their vision. The more complex and demanding the program, it appears from experience to date, the more obstacles are encountered in effective implementation.

The clubhouse model represents a facility-based intervention designed to offer persons with serious mental illness membership in a mutually supportive community – organized around a “work-ordered” day – in which members work side-by-side with staff Monday through Friday on voluntary labour essential to the running of the clubhouse (Macias, *et al.*, 2001). Clubhouses certified by the International Centre for Clubhouse Development (ICCD) provide comprehensive case management by trained staff as well as an array of

services (including supported education and housing, help with entitlements and transportation, counseling and medication management). They also provide SE services, specifically rapid job searches, job development, on-site job training and follow-along job support. The clubhouse model is intended to be a lifetime source of support and companionship. There are a couple of clubhouse models on offer,

The designation of SE as best practices emerges from the converged findings of eight randomized controlled trials and three quasi-experimental studies. SE's effectiveness appears, according to a systematic review of supported employment published in *Psychiatric Services*, to be generalizable across a broad range of client groups, characteristics and community settings (Bond, *et al.*, 2001).

Components predictive of a successful SE program include:

1. The agency providing SE services is committed to competitive employment as an attainable goal for its clients with severe mental illness, devoting its resources for rehabilitation services to this endeavor rather than to day treatment or sheltered work. This component is common to successful programs as demonstrated in numerous studies.
2. Strong evidence suggests that the most successful SE programs employ a rapid job search approach to help clients obtain jobs directly, rather than providing lengthy pre-employment assessment, training and counseling.
3. Strong evidence supports the conclusion that staff and clients find individualized job placements according to client preferences, strengths and work experiences.
4. Equally strong is the evidence for follow-along supports, maintained indefinitely.
5. Close integration of SE programs with mental health treatment teams is strongly supported by theory and evidence, however rarely implemented in practice.

Though strong, the evidence for SE is limited by its focus – thus far – on predominately majority white populations in the United States. Comparable studies of minority populations have employed smaller sample sizes and await replication and confirmation. It is known, albeit anecdotally, that language and ethnicity pose some barriers but these are secondary to the reluctance of service providers to embrace SE in preference over rehabilitation services (Bond, *et al.*, 2001). Two recent meta-analyses of the literature conclude that SE is a more effective way of helping people with serious mental illness find competitive employment than is prevocational training (Bond, *et al.*, 2001, Crowther, *et al.*, 2001). Claims for the superiority of accelerated entry into competitive employment include:

1. Employment actually helps to reduce psychiatric symptoms (this evidence is not robust);

2. Clients confirm that SE builds confidence and bolsters coping mechanisms; and
3. Although not yet a robust conclusion, vocational success has been associated with symptomatic improvement (Bond, *et al.*, 1995).

In its assessment of Supported Employment Programs across the United States, the National Mental Health Association (NMHA) – in collaboration with the National Association of State Mental Health Program Directors (NASMHPD), the Centre for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) – identified six critical goals for SE programs. They are:

1. Pay is at least minimum wage but preferably at the prevailing wage rate;
2. People with and without disabilities work together in an integrated setting;
3. Support is ongoing and provided as needed;
4. Services are individualized;
5. Job selection is based on a person's preferences and skills; and
6. Competitive employment is the goal.

Additionally, the NMHA has identified ten elements considered key to the success of all community-based programs, including SE services:

1. *Recovery Philosophy* – SE programs need to recognize that people with mental illness can and do recover and that employment can play a key role in the recovery process;
2. *State-of-the-Art* – SE programs must provide high quality services incorporating the latest advances in treatment and services that are evidence-based and/or at the cutting edge of the field;
3. *Voluntary* – Participants must be given the choice to participate in the program as well as a wide range of options for service;
4. *Empowering* – An environment needs to be created that encourages individual choice and self-determination and services must be individualized to meet the needs of participants;
5. *Holistic Philosophical Orientation* – SE programs must strive to maximize a person's strengths and abilities as well as manage symptoms of mental illness;
6. *Embrace True Community Integration* – SE programs must provide treatment and services in the community so people can learn life skills in the environment in which those skills will be used;

7. *Community Supported* – SE programs need to collaborate with other service providers and secure the financial and other support of a cross section of stakeholders;
8. *Effective Administration* – A system of accountability, responsibility and fiscal success must be established and secured;
9. *Cultural Competence* – SE programs will have to serve diverse populations reflecting the composition of the local community and take steps toward addressing this need; and finally,
10. *Measurable Program Outcomes* – Ongoing and continuous program and service evaluation must be incorporated to ensure the effectiveness of service delivery in meeting the goals of consumer satisfaction.

Appendix A2

Consumer & Family Initiatives

The Scope of the Issue and its Consequences

Only recently has our understanding of mental illness emerged from the understanding that the mentally ill were essentially condemned to lifetime marginalization. Within such an understanding – lacking all prospect of improvement for their son, daughter or sibling – there was little for families to do and indeed many families lived in ignorance of mental illness and with anxiety for the well-being of their mentally ill family member. Families risked stigmatization if they revealed to a hostile and uncaring community that presence of a mentally ill person. For decades families and particularly parents were blamed for the mental illness of family members, and stigmatized by mental health professionals as the aetiological agents of illness (Sommer, 1990, Lefley, 1998)). Families were disparaged as cold and rejecting – which dismissal afforded little scope for collaboration with or learning from professional caregivers. In extreme instances, murder-suicides resulted – and still do -- when parents could no longer cope with their mentally ill offspring or imagine a future for them once their family caregivers were deceased.

Over the course of the 1980s a shift in thinking took hold concerning the potential capacities of consumers and the role(s) they could play in organizing, delivering and using community support. The recent trend toward a lessening of stigma – coincident with the rise of a biological understanding of mental illness – has made parents and siblings more willing to take an active interest in the treatment offered their family members (Sommer, 1990). Ontario's 1988 *Graham Report* identified self-help and family support as priority functions in a reformed mental health system, and in 1991 \$3.5 million dollars was made available for the Consumer/Survivor Development Initiative (CSDI) which funded a large number of organizations for consumers and survivors as well as a central support and monitoring team. Governments have begun to provide resources directly to consumer organizations to enhance their capacity for advocacy, economic development and self help, independent of professional mental health staff or agencies. The new thinking is that formal services are only one modality for helping consumers and that other, non-service, alternatives – such as self help groups and mutual aid – are also valid and worthy of support (Goering, *et al.*, 1997).

Today's best wisdom is that consumers have historically had insufficient impact on the design and delivery of mental health supports and services and the effort is on to include their participation and input in many more areas of mental health care service design, delivery and evaluation (Hess, *et al.*, 2001). Indeed evidence from the psychosocial realm asserts that family members need not fall into a spiral of hopelessness and despair but – with appropriate training and support – can learn and practice the social skills conducive to living with, and supporting the recovery of, a mentally ill family member (Penn, *et al.*, 1996).

A consequence of the new activism of family members and consumers themselves is that mental health professionals may sometimes find themselves caught between the twin imperatives of protecting the privacy of the therapeutic relationship with the mental health consumer and wanting to help and give support to family members who may be struggling to understand the changes in their loved ones. Various movements and self-help groups have emerged in response to the different experiences, needs and perceptions of mental illness and recovery and the differences are ideologically complex, energizing the strongly-held values of the various stakeholders. Accordingly, what is to be done for the mentally ill by their family members is interwoven with value systems of individualism, agency, internal locus of control and attitude toward dependency. And these value systems, of course, are mediated by the cultural milieu in which they reside.

Thus, planning around consumer and family initiatives, indeed our whole way of thinking about such things, must comprehend the differing interpretations of mental illness – and appropriate treatment modalities of mental illness – brought to the table by the various stakeholders (Lefley, 1998).

Then there is the vexaciously difficult contest between what the family may regard as relevant and necessary treatment versus what the consumer him or herself deems appropriate. The very existence of a phenomenon known as mental illness is itself contested, and the range of relevant treatments is also thereby disputed. When a family member with a mental illness – so defined according to one body of scientific opinion by one set of specialists – collides with an equally determined faction that calls into question the fundamental assumptions regarding the nature or existence of mental illness, the tension can make for complicated relationships. This complexity is exacerbated by the (some would say) long-overdue rise of a “rights discourse” in western liberal democracies which, as it plays out in the mental health domain, implies that old-fashioned coercion of mentally ill people is no longer tolerated. But even this is contested, as people in the anti-psychiatry movement contend.²

What Are its Causes and Determinants?

The absence of hope for mentally ill persons and the marginalization of family members from any treatment regime created a legacy of passivity and hopelessness which has only begun to be redressed in the last twenty-thirty years. Most fundamental in this change has been the advent of community-based treatment modalities with all that these implied for the family members, who often acted as the shock-absorber when, unprepared to accommodate them, the mentally ill were discharged into the community or back into the care of their families. Families of mentally ill persons have for many years been providing unsupported services to family members motivated from a sense of love and obligation. Until recently there has been little professional acknowledgement, training or support for family members who must, nevertheless, work constantly at preventing or minimizing exposure to stressors; assisting with tasks of daily living; protecting and fostering interpersonal relationships; seeking out community supports; advocating on behalf of mentally ill relatives; providing financial assistance and emotional support;

²See the website <http://www.antipsychiatry.org/>

providing crisis support and enhancing the self-esteem of family members with mental illnesses. In consequence family members have subjected themselves to mental and physical exhaustion; various kinds of deprivation and loss; and changes in their home environments as the illness ran its variable and disruptive course through everyone's lives.

How the idea of mental illness itself is conceptualized or understood influences the range of appropriate treatments and the relevant role of families. Conceptualizing mental illness as deviance – rather than disease – spurred an ideology that “accelerated the often premature closing of [psychiatric] hospitals, typically before adequate community services had been developed” (Lefley, 1998). The contemporary view is that mental illnesses “are a highly diverse group of brain disorders, “biological disorders, behaviourally expressed, [which] require comprehensive treatment, protection for the subject and social acceptance of an innate biologically determined differentness without stigmatization” (Lefley, 1998). Proponents of this view hold that the conditions associated with mental illness are therefore best served by psychotropic medications, supportive therapies, rehabilitative modalities and appropriate survival mechanisms with a heavy emphasis on non-discrimination.

Thus, people who hold mental illness to be a social construction are generally radical consumers – self-identified survivors – and a small number of anti-establishment psychiatrists. People who hold to a psychogenic view (family dysfunction and/or conditioned behaviour as the source of mental illness) also tend to acknowledge biological determinants and heritability of major Axis I diagnoses such as the schizophrenia or unipolar/bipolar disorders. Finally, those individuals and groups who hold to a biologically based view of mental illness– in which psychosocial aspects follow from rather than precede – are currently in the ascendant among mental health professionals.

The take-home message here is that how one understands the origin and nature of mental illness influences one's understanding of (a) how best to treat mental illness, (b) the range of suitable, relevant and appropriate roles for family members in that treatment regime, and (c) what socio-economic, political and legal changes are required.

The rise of a biological understanding of mental illness has enlarged the limits of the possible for family members of persons with a mental illness and spawned organized lobby and advocacy groups – such as the US-based National Alliance for the Mentally Ill (NAMI) – which has changed how mental illness is lived and experienced by family members.³ Family members have begun to more assertively express their needs and articulate more precisely the kinds of supports most relevant to them. In a study – The Family Initiatives Project – done in Western Ontario, the following supports were identified as most urgent:

1. Information and education on the nature and course of mental illness;

³<http://www.nami.org/>

2. Case management and support coordination;
3. Respite from their mentally ill family member;
4. Housing for mentally ill relatives;
5. Affordable counseling services for family members supporting a mentally ill person; and
6. More resources for family self-help groups.⁴

Best Practice Solutions

The evidence-based literature concerning consumer and family initiatives is comparatively scant – this being a relatively new area of research in mental health service delivery – and limited both in quality and quantity (Goering, *et al.*, 1997). Still, indicators point to directions for identifying promising practices and the overall climate of decentralization and downsizing suggests that the longer-term trend is for more emphasis on community-based supports and resources, particularly for the psychosocial development and recovery of persons with serious and persistent mental illness.

Self-help Groups (SHGs) – which took their impetus from the rise of Alcoholics Anonymous and its family member group Al-Anon – are understood to be a “profound new influence” on the future delivery of mental health services; the “third revolution” in mental health treatment (Sommer, 1990). SHGs are consumer-initiated responses to inadequacies of established treatment, adaptation and rehabilitation. SHGs claim to overcome the passivity of those involved, to enhance and build self-esteem, confidence and personal responsibility. When mobilized into larger collectives they can also be political forces. Expert opinion endorses increased funding for such initiatives coupled to thorough evaluations of outcomes, the sooner to identify “best practices” in this realm.

SHGs can be defined according to what they provide group members:

1. Help and support in dealing with their problems;
2. An origin and sanction for existence resting with the group members rather than with an external agency;
3. The primary resource of members relying on their own organizational skills;
4. A collective of people who share a common core of life experiences and problems; and

⁴Final Report and Executive Summary of the Family Initiatives Project of Brant, Dufferin, Haldiman-Norfolk, Waterloo Region and Wellington Counties, (March 1998) online at <http://www.bfree.on.ca/comdir/medical/eclipse/faminit.htm>.

5. A chance for lay persons to control their own organization (Sommer, 1990).

A recurring motif in the current literature concerns empowerment through involvement and participation. Empowerment, as it applies to recovery from mental illness, requires some ‘conceptual unpacking’ because it is used in different ways and various nuances are highlighted in different usages. Common themes include:

1. notions of power and personal control or influence over external conditions, such as resource allocation for treatment and support;
2. “an interactive process through which people experience personal and social change, enabling them to take action to achieve influence over the organizations and institutions which affect their lives and the communities in which they live” (Wilson, 1996); and
3. a process often triggered by an external occurrence (e.g., personal crisis) which interacts with the person’s frustration and anger and sets in motion the mobilization of internal resources toward recovery.

Empowerment involves progression through four stages of development comparable to the stages of life (i.e. infancy, childhood, adolescence and maturity) during which mental health consumers develop skills, self-confidence, self-esteem and maturity through continued long-term involvement with advocacy organizations and efforts. Empowerment, according to this formulation, is affected by (a) increasing knowledge and skills, (b) increasing effects on both positive and negative consequences and, (c) increasing environmental opportunities (Hess, *et al.*, 2001).

In the *Canadian Journal of Community Mental Health*, Stephanie Wilson delineates three levels of empowerment: the personal, the the small group and the community (Wilson, 1996). She claims that the recovery model plays an important role in personal empowerment, that the small group also facilitates empowerment through joint-problem solving and that at the community level empowerment relates to the allocation of resources beneficial to the group. Empowerment at one level, she cautions, does not translate automatically into empowerment at another. The idea behind empowerment initiatives is to energize or re-energize (as the case may be) the decision-making, autonomy-enabling capacities of persons with a mental illness which illness may have stripped them of this ability through prolonged hospitalization and dependence on others.

One avenue through which consumers – and family members too – can exert control and feel their influence is through participation and involvement with mental health service delivery professionals and researchers. There is evidence that participation in community activities is associated with a virtuous circle of increased levels of confidence and personal control which facilitated further involvement which in turn enhanced self-esteem, confidence and well-being (Wilson, 1996). Participation was found to contribute to empowerment through increased opportunities for social interaction, through the development of social roles, through the cultivation of confidence, self-esteem and

improved well-being arising from the awareness that all of these things made the community a better place to live (Wilson, 1996). Self-help groups are shown to be effective at reducing social isolation and enabling individuals to appreciate that they are not alone in their experiences of mental illness. Solving individual problems, as part of a problem-solving collective, nurtures feelings of efficacy and cultivates personal empowerment. Such involvement would, at the very least, respond to the demand “Nothing about us without us.”

Within the formal mental health system, there has recently been an increase in the participation of consumers and consumer advocates on hospital boards and committees, resident councils and other bodies through which consumers can influence decisions that affect them. Involvement by consumers can occur at three levels, corresponding to the levels of empowerment themselves; individual, small group (or service agency delivery) level and the community (local, district-wide or national) level.

The take home message is that participation by mental health consumers tends to increase opportunities for social interaction and for the development of social roles – that this leads to an increase in the confidence of such individuals and that belongingness and participation create a virtuous circle of consumer empowerment (Wilson, 1996, Hess, *et al.*, 2001).

A most hopeful development is the evidence emerging from studies of psychosocial treatment, education and rehabilitation, which is now an established area of evidence-based treatment (Dixon, *et al.*, 2001) endorsed by numerous service providers.⁵ Psychosocial rehabilitation is a process offering individuals who are impaired, disabled or handicapped by a mental disorder the opportunity to reach their optimal level of independent functioning in the community. It involves both improving the individual’s competencies and introducing environmental changes. It is a comprehensive process rather than a technique. Psychosocial rehabilitation is intended to enable individuals to acquire or regain the practical skills needed to live and socialize in their communities, including assistance in developing social skills, interests and leisure activities, all of which are conducive to imparting a sense of participation and personal worth (WHO, 2001). The over-arching principle driving this treatment modality is that persons with a mental illness can – once they come to understand the nature of their condition – learn to function in such a way as to minimize the worst effects of their illness. The same principles can be taught to family members so that the negative and regressive dynamics associated with living with a mentally ill family member can be avoided or moderated.

The key components of psychosocial treatment (Weiden, *et al.*, 1999) are:

1. *Patient and Family Education* – people in the patient’s life need to know as much as possible about the nature of mental illness, the course and methods of treatment, in order to be able to develop the skills needed to avoid relapse and

⁵See the website for the Family Psychoeducation Program of the Transcultural Mental Health Care Centre in New South Wales, Australia, at <http://www.tnhc.nsw.gov.au/projects/psychoeducation.htm>.

- progress toward recovery. Family education is not a one-time event, but an ongoing process relevant to every phase of the illness and recovery.
2. *Collaborative Decision Making* – joint decision making and goal setting is now recommended at every stage of treatment and is most effective if inclusive of all family members. As persons with a mental disorder recover they may begin to take more control over the management of their condition.
 3. *Medication and Symptom Monitoring* – identifying early signs of relapse and assisting in the management of medication and dosage can lengthen the time between psychotic episodes and give family members a window into the effectiveness, including side-effects, of medication.
 4. *Assistance with Obtaining Services and Supports* – people with a mental disorder often have trouble (on their own) obtaining services or applying for programs like disability allowances. Such assistance is important for stabilization of lifestyle for people who are severely ill.
 5. *Arrange for Supervision of Financial Resources* – some people with a mental disorder may need help managing their money, particularly so if the illness is severe and unstable. Family members may be well placed to assist with this.
 6. *Training and Assistance with Activities of Daily Living* – independence requires a basic skill set which some people with mental illness may need to learn or relearn. Such basic things as preparing food, shopping, personal hygiene and how to engage in social or leisure activities may be communicated through efforts of coordinated volunteers organized by family self-help groups.
 7. *Supportive Therapy* – while psychotherapy (by itself) is not particularly helpful in some cases (e.g., schizophrenia) the provision of emotional support and reassurance, the promotion of healthy behaviour, the effort to help the mentally ill make the most of their capabilities all contribute to the progress of recovery. These can be realized through group therapy, particularly after an acute episode and during the maintenance phase.
 8. *Peer Support/Self-Help Groups* –peer-run, mutual support, recovery-oriented groups can play a very important role in the recovery process for many people with a psychiatric disorder (Toprac, *et al.*, 2000). They can be excellent forums for sharing, for friendship, for discussion and peer advice and (when appropriate) for in-depth learning from mental health professionals.

A promising recent avenue of support for family members is psychoeducation which involves teaching persons with a mental illness and their family members about the nature and course of mental illness. Unlike patients with other illnesses (e.g. diabetes) who have long been encouraged to learn about – the better to manage – their illness, psychiatry has not traditionally educated persons with mental illnesses. The new

emphasis on psychoeducation, or consumer education, is credited in part (among other forces) to the rise of the consumer advocacy and family education movements and, in the US, the Joint Commission on Accreditation of Healthcare Organizations (Bisbee, 2000).

Patient and family education can be provided by a number of different professionals and paraprofessionals in the care and service delivery chain. Psychiatrists can educate in the context of every encounter they have with a patient; pharmacists can provide medication education when prescriptions are filled and during discharge counseling; nurses educate as part of their routine practice; therapists educate in the context of working with clients; and case managers educate their clients as part of their role as advocate, broker and manager of the client's disorder and service needs. While it may be harder to educate children, adults may be more receptive to learning about causes, course, prognosis and recovery. Educating on the balance of rights and responsibilities has come to be seen as relevant and important for persons with mental illness, as is communicating the message that while – from a biological perspective – mental illness may not be *curable* it can be managed and even successfully controlled with the right combination of state-of-the-art therapy, medication, coping skills and learning styles. What is paramount is that education occur when readiness to learn is most developed (location can vary depending on the routines of the family and needs of the consumer).

Some content areas for psychiatric education – relevant to both consumers and their families – are:

1. Patient rights and responsibilities;
2. What mental illness is thought to be;
3. What medications do and what side-effects to expect;
4. Techniques in self-observation and illness monitoring;
5. Techniques in relapse prevention;
6. Adopting and living a recovery lifestyle;
7. Techniques for stress management;
8. Techniques for coping with symptoms;
9. Strategies for managing family interactions;
10. Techniques and strategies for communicating with family members; and
11. Techniques and strategies for living in the community (Bisbee, 2000).

The best practices literature in this domain yields fifteen principles for clinicians to employ in working with families, to lighten their suffering, support their efforts toward recovery and realize the best possible outcomes for the patient (Dixon, *et al.*, 2001). They are:

1. Coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship.
2. Pay attention to both the social and clinical needs of the consumer.
3. Provide optimum medication management.
4. Listen to families' concerns and involve them as equal partners in the planning and delivery of treatment.
5. Explore family members' expectations of the treatment program and expectations for the consumer.
6. Assess the strengths and limitations of the family's ability to support the consumer.
7. Help resolve family conflict by responding sensitively to emotional distress.
8. Address feelings of loss.
9. Provide an explicit crisis plan and professional response.
10. Help improve communication among family members.
11. Provide training for the family in structured problem-solving techniques.
12. Encourage family members to expand their social support networks – for example, to participate in family support organizations such as the National Alliance for the Mentally Ill.
13. Be flexible in meeting the needs of the family.
14. Provide the family with easy access to another professional in the event that the current work with the family ceases.

Appendix A3

Advocacy

The Scope of the Issue and its Consequences

Advocacy by and for the mentally ill is an area of intense contention, dispute and controversy with important consequences for the well-being of consumers and their families, as well as for the self-understanding of professionals in the mental health service delivery system. Since it is a comparatively new development in the realm of mental health care, it is hard to evaluate according to the criteria of evidence-based best practices. The problem is that consumer's needs for various types of treatments and services differs significantly over the course of the illness and according to the prevailing philosophical outlook of the treatment providers. Within the client movement there exists a range of opinion as to whether clients should work and campaign separately or in collaboration with service providers (Kumar, 2000). As a consequence, the advocacy movement is factionalized and divided within consumer groups, within family groups and between consumer and family groups – to say nothing of those persons and groups who advocate for the non-existence of mental illness altogether or of the differing treatment preferences of the many professionals and paraprofessionals who actually deliver treatment at the front line.

A central axis of contention between factions turns on the differing perspectives of consumers – or clients or survivors – and their families over the appropriate treatment modality for people at various stages of mental illness. “The degree of support for evidence-based practices by consumer advocates depends largely on the degree of disability of the persons for whom they are advocating (Frese, *et al.*, 2001) so that advocates for the most seriously mentally ill are more likely to be supportive of evidence-based practices compared to advocates for consumers who are further along the road to recovery – who are more likely to advocate for the recovery model and philosophy (which is less susceptible to the same kind of evidence-based quantifiable evaluation). The rise of advocacy groups among both consumers and their families has undoubtedly empowered and enlarged the advocacy capacity of key stakeholders, but it has also complicated delivery of care and energized complex disputes within an already ideologically-charged terrain. According to Robert Sommers in *Psychiatric Quarterly*, it is “difficult to find major issues in the mental health field on which the views of family and client organizations are in agreement” (Sommers, 1990).⁶

Where the recovery model emphasizes that responsibility for and control over the recovery process must be given in large part to the person who has the condition, the evidence based approach emphasizes external scientific reality. Where the recovery

⁶Organized family advocacy for the mentally *retarded* has a decades-long history and has been visible and politically effective. Family advocacy for the mentally ill, however, is a comparatively recent phenomenon and – from all appearances – is here to stay.

model stresses the importance of the phenomenological and subjective experience of the mentally ill person, the evidence-based approach suggests that – in some instances – the recovery model’s focus on hope, healing, empowerment, social connectedness and human rights may actually impair recovery, measured in more concrete or scientific terms. Thus there are many circumstances where the two models may conflict. Treatment decisions cannot be made entirely on scientific grounds, in any event, but must always involve both medical facts and choices based on values (Frese, *et al.*, 2001).

An axis of contention turns on the question of what is mental illness itself and, for that matter, what is mental health? Health and Welfare Canada’s 1988 declaration claimed that “mental health and well-being are determined by the interactions between the individual, the community of which he or she is a part, and the environment in which he or she lives, i.e., social, economic and cultural environments” (Wilson, 1996). In this conceptualization “it is quite possible for an individual with a medically diagnosable mental illness to have good mental health under conditions that support harmonious interactions between the individual, the community, and the environment” (Wilson, 1996). People with a serious and persistent mental illness find it difficult to overcome the stigma associated with their condition, probably the most significant obstacle to their efforts to advocate on their own behalf. Before the rise of neurobiological science, persons struck with a serious mental illness had essentially two unappealing options: withdraw from the world and isolate themselves in specially-delegated facilities or take their chances in an unforgiving and hostile community.

For those who subscribe to neurological or biological explanations, mental illness is a condition not unlike physical illness which can be to some extent redressed through medical and pharmacological avenues coupled to – where efficacious – various forms of cognitive or behavioural therapy. Others, however, subscribe to a view of mental illness as a product of various kinds of social labeling the intensity and definition of which changes from era to era and location to location (Lefley, 1998). Critics of the bio-medical approach argue that insufficient attention has been directed to the quality of life impacts of serious mental illness, such as stigma, social isolation and poverty. Certainly the quality of life of people with mental disorders undermines their recovery, but in which direction the arrows of causation run is both uncertain and controversial.

From a provider perspective, it is uncertain whether families should be seen as collaborators in treatment, as a focus for treatment in family therapy, or as a third party who ought best be kept out of the relationship between therapist and client in order to maintain confidentiality (Sommers, 1990). Family groups sometimes find themselves in an adversarial relationship with self-help groups on such important issues as criteria for involuntary hospitalization, commitment laws and drug or electroshock treatment (Sommers, 1990). Some client advocacy groups oppose the professionalization of power while family groups may support it – similarly clients often seek to abolish involuntary commitment, enforced drugging and electro-convulsive therapy while groups advocating for families may endorse and even favour strengthening these provisions (Sommers, 1990).

Yet another source of contention between families and consumers arises over the distribution of mental health treatment resources and whose preferences ought to determine what resources are applied to which areas of concern. Some consumers (and their families) argue for the kinds of supports and resources that address the psychosocial contexts of their lives – noting that the lived experience of people with severe and persistent mental illness contributes to the exacerbation of their conditions through homelessness, poverty, stigmatization, lack of social and recreational opportunities and community acceptance (Wilson, 1996). A reformed and renovated mental health service delivery system, dedicated to delivering state of the art care to mental health consumers and the people who love them, must then accommodate itself to this reality and learn ways to collaborate toward the best interests of the mentally ill.

What Are its Causes and Determinants?

People using mental health services have for too long been viewed as passive recipients, unable to articulate their own needs and wishes and subject to forms of care decided on by others. As passive takers of the services of other people, they have not been understood to be ‘agents’ in any meaningful sense themselves – i.e. people with real and practical ideas about how to live their lives from the inside according to their own revisable values and aspirations.⁷ Too many consumers – and family members too – are lacking the skills to express their views and opinions in a clear and positive manner (Hess, *et al.*, 2001). Family members often have neither training nor experience to permit them to actively influence political processes toward the improvement of conditions for the mentally ill (Hess, *et al.*, 2001). Another kind of difficulty – a barrier for some people – is the matter of choosing which level of government to focus upon, how much time to devote to advocacy and which issues to highlight.

Since the late 1960s and early ‘70s, however, mental health consumers have begun to articulate their own visions of what services they need and want – and among the most powerful themes to emerge from this trend have been the following:

1. The right to self-determination;
2. The right to information about medication and other forms of treatment;
3. The right to services which actively facilitate community involvement and participation;
4. The right to live in a stigma-free environment;
5. The removal of barriers to integration, employment and harassment;
6. The right to have access to alternative forms of treatment and therapy;
7. Better legal protection of existing rights; and
8. An end to long-term institutionalization (WHO, 2001).

⁷This formulation derives from Will Kymlicka’s *Liberalism, Community and Culture* (Oxford University Press, 1989).

Partisans for the recovery model argue that traditional medical or evidence-based approaches cultivate paternalism, prolonged illness, weakness and limitations rather than potential for growth and progress. The evidence-based model, on this account, stamps out hope by implying that biology is destiny and by emphasizing an external locus of control. Physicians are viewed as powerful and oppressive figures acting out of misguided beneficence but nevertheless nurturing a culture of helplessness and dependence (Frese, *et al.*, 2001). Extreme critics of the medical model dispute the very existence of mental illness as a biopsychosocial condition although more moderate critics accept the existence of the illness and acknowledge the limitations thereby created. The challenge, seen from the perspective of trying to reconcile the medical with the recovery model, resides in shifting the locus of control from the treatment provider to the consumer as the latter gradually attains the capacity to make reasoned and appropriate decisions on the course of treatment for themselves. Still, it is hard to dispute that – as a practical matter – one must attain a certain degree of autonomous capacity in order to be in a position to benefit from the capacity for recovery.

There are two emergent approaches to the treatment of mentally ill persons: the ‘scientific, objective, evidence-based’ approach emphasizes external scientific reality whereas the ‘recovery’ model stresses the importance of the phenomenological or subjective experiences and autonomous rights of persons in recovery. The two models will, on occasion, conflict because when consumers make choices about treatment they will sometimes choose treatments that are not evidence-based and for this reason treatment decisions cannot be made entirely on factual, scientific grounds, but must involve medical facts *plus* value-based choices. Science can identify alternative approaches and the probability of specific outcomes – efficacy, adverse effects, *etc.* – but the decision of which combination of anticipated and adverse effects is preferable is inherently a value judgment (Frese, 2001).

Best Practice Solutions

Strong input from consumers is required to ascertain what services and programs are most useful and appropriate, what alternatives need to be considered and what processes need improvement (Hess, *et al.*, 2001) but the notion of best practices – as usually employed – is harder to apply in this context. While it ought to be obvious that everything should be done to advance the well-being and recovery of persons with mental illness and their families, it is not obvious all stakeholders are going to share a common vision on how best to achieve well-being or recovery or even what that term means for different parties. The issue is further complicated by the division within and between the various factions on the consumer side: e.g., those who call themselves consumers (including family members who see themselves as indirect consumers of mental health services) and those who view themselves as formerly victims – eventually ‘survivors’ – of the psychiatric-pharmaceutical complex (Wilson, 1996).

Family psychoeducation – the practice of educating family members about the nature and experience of mental illness – is widely and favourably reviewed in the best practices literature (Fowler, 1992, Dixon, *et al.*, 2001, Penn, *et al.*, 1996). Consumer advocacy

organizations benefit from the opportunity to engage with and learn from each other – in other words to *network* – toward the objective of mutual education and confidence building. Learning advocacy takes time and it takes time to learn the bundle of skills associated with effective advocacy: running meetings, leading groups, communicating with decision-makers, and getting the message out to the media (Hess, *et al.*, 2001). There is evidence, too, that vigorously engaged advocates who are also consumers reap the benefits of their activity in a felt sense of accomplishment and meaning through their interaction with other people. The identification of shared goals seems to erase distinctions between consumers and family members as they collaborate and socialize. Grassroots advocacy, done properly, increases self-confidence and self-esteem as well as the capacity to make autonomous choices (Hess, *et al.*, 2001).

At the end of the day, however, we still need to know more about the impact of consumer involvement activities on the mental health system in relation to cost effectiveness and efficiency. We need also to learn more about how consumer involvement benefits the personal sense of health and well-being of persons with a mental illness and role of empowerment in easing symptoms and improving integration into the community. Preliminary findings are encouraging, more research in this area would lead to better understanding and, ultimately, better prospect for recovery (Wilson, 1996).

The US-based National Alliance for the Mentally Ill – perhaps the organization with the longest history and record of advocating for the mentally ill – has identified eight priorities toward the realization of consumer and family advocacy (Frese, *et al.*, 2001). They are:

1. Participation by consumers and their family members in planning of mental illness services;
2. Equitable health care insurance coverage (called parity in the US);
3. Access to newer medications;
4. Assertive community treatment ;
5. Work incentives for persons with severe and persistent mental illness;
6. Reduction in life-threatening and harmful actions and restraints;
7. Reduction in the criminalization of persons with mental illness; and
8. Access to permanent, safe and affordable housing with appropriate community supports.

References to Employment, Consumer & Advocacy

1. Amenson, Christopher, *et al.*, "Rehab rounds: dissemination of educational classes for families of adults with schizophrenia," *Psychiatric Services*, 52 (May 2001), pp. 589-92.
2. Banks, Becky, *et al.*, "Workplace supports, job performance, and integration outcomes for people with psychiatric disabilities," *Psychiatric Rehabilitation Journal*, 24:4 (Spring 2001), pp. 389-96.
3. Becker, Deborah, *et al.*, "Job terminations among persons with severe mental illness participating in supported employment," *Community Mental Health Journal*, 34:1 (February 1998), pp. 71-82.
4. Becker, Deborah, *et al.*, "Converting day treatment centres to supported employment programs in Rhode Island," *Psychiatric Services*, 52 (March 2001), pp. 351-57.
5. Becker, Deborah, *et al.*, "Fidelity of supported employment programs and employment outcomes," *Psychiatric Services*, 52 (June 2001), pp. 834-36.
6. Bisbee, Cynthia Carson, "Psychiatric Patient Education," *Psychiatric Times*, 17:4 (April 2000) on line at <www.psychiatrictimes.com/p000476.html>
7. Bond, Gary, *et al.*, "Accelerating entry into supported employment for persons with severe psychiatric disabilities," *Rehabilitation Psychology*, 40:2 (1995), pp. 75-93.
8. Bond, Gary, *et al.*, "Implementing supported employment as evidence-based practice," *Psychiatric Services*, 52 (March 2001), pp. 313-22.
9. Boydell, Katherine, *et al.*, "What makes a house a home? An evaluation of a supported housing project for individuals with long-term psychiatric backgrounds," *Canadian Journal of Community Mental Health*, 10:1 (Spring 1992), pp. 109-23.
10. Caras, Sylvia, "Personal accounts: the downside of the family-organized mental illness advocacy movement," *Psychiatric Services*, 49 (June 1998), pp. 763-64.
11. Cimera, Robert, "Are individuals with severe mental retardation and multiple disabilities cost-efficient to serve via supported employment programs?" *Mental Retardation*, 36:4 (August 1998), pp. 280-92.
12. Cohen, Carl, *et al.*, "Homeless mentally ill or mentally ill homeless?" *American Journal of Psychiatry*, 149:6 (June 1992), pp. 816-824.
13. Corrigan, Patrick, *et al.*, "The construct validity of empowerment among consumers of mental health services," *Schizophrenia Research*, 38 (1999), pp. 77-84.
14. Crowther, Ruth, *et al.*, "Helping people with severe mental illness to obtain work; systematic review," *British Medical Journal*, 322 (2001), pp. 204-8.
15. Dixon, Lisa, *et al.*, "Update on family psychoeducation for schizophrenia," *Schizophrenia Bulletin*, 26:1 (2000), pp. 5-20.
16. Dixon, Lisa, *et al.*, "Evidence-based practices for services to families of people with psychiatric disabilities," *Psychiatric Services*, 52 (July 2001), pp. 903-910.
17. Dorio, JoAnn, *et al.*, "Differences in job retention in a supported employment program Chinook Clubhouse," *Psychiatric Rehabilitation Journal*, 25:3 (Winter 2002), pp. 289-98.

Background and Technical Report: Section II, Appendices

18. Drake, Robert, *et al.*, "A randomized clinical trial of supported employment for inner-city patients with severe mental disorders," *Archives of General Psychiatry*, 56 (July 1999), pp. 627-33.
19. Drake, Robert, *et al.*, "Research on the individual placement and support model of supported employment," *Psychiatric Quarterly*, 70:4 (Winter 1999), pp. 289-301.
20. Fowler, L., "Family psychoeducation: chronically psychiatrically ill Caribbean patients," *Journal of Psychosocial Nursing & Mental Health Services*, 30:3 (March 1992), pp. 27-32.
21. Fox, Lindy, "A consumer perspective on the family agenda," *American Journal of Orthopsychiatry*, 67:2 (April 1997), pp. 249-53.
22. Frese III, Frederick, "Advocacy, recovery, and the challenges of consumerism for schizophrenia," *The Psychiatric Clinics of North America*, 21:1 (March 1988), pp. 233-47.
23. Frese III, Frederick, *et al.*, "Integrating evidence based practices and the recovery model," *Psychiatric Services*, 52 (November 2001), pp. 1462-68.
24. Fuller, Thomas, *et al.*, "Rehab rounds: a hybrid supported employment program for persons with schizophrenia in Japan," *Psychiatric Services*, 51 (July 2000), pp. 864-66.
25. Gates, Lauren, *et al.*, "Have I got a worker for you: creating employment opportunities for people with psychiatric disability," *Administration and Policy in Mental Health*, 28:4 (March 2001), pp. 319-325.
26. Goering, Paula, *et al.*, "Best Practices in Mental Health Reform: Situational Analysis" (Ottawa: Minister of Public Works and Government Services, Canada, 1997).
27. Goodman, Lisa, *et al.*, "Recent victimization in women and men with severe mental illness: prevalence and correlates," *Journal of Traumatic Stress*, 14:4 (October 2001), pp. 615-32.
28. Herman, S.E., *et al.*, "Parents' perspectives on quality in family support programs," *Journal of Mental Health Administration*, 23:2 (Spring 1996), pp. 156-69.
29. Hess, Robert, *et al.*, "Empowerment effects of teaching leadership skills to adults with severe mental illness and their families," *Psychiatric Rehabilitation Journal*, 24:3 (Winter 2001), pp. 257-65.
30. Hogan, Michael, *et al.*, "Normal housing: a key element of a supported housing approach for people with psychiatric disabilities," *Community Mental Health Journal*, 28:3 (June 1992), pp. 215-25.
31. Jones, Curtis, *et al.*, "Predicting work outcomes and service use in supported employment services for persons with psychiatric disabilities," *Psychiatric Rehabilitation Journal*, 25:1 (Summer 2001), pp. 53-59.
32. Kirsh, Bonnie, "Factors associated with employment for mental health consumers," *Psychiatric Rehabilitation Journal*, 24:1 (Summer 2000), pp. 13-21.
33. Kumar, Shailesh, "Client empowerment in psychiatry and the professional abuse of clients: where do we stand?" *International Journal of Psychiatry*, 30:1 (2000), pp. 61-70.
34. Latimer, Eric, "Economic Aspects of supported employment for persons with severe mental illness," *Canadian Journal of Psychiatry*, 46 (August 2001), pp. 496-504.
35. Lefley, Harriet, "Families, culture, and mental illness: constructing new realities," *Psychiatry*, 61 (Winter 1998), pp. 335-53.

Background and Technical Report: Section II, Appendices

36. Lehman, Anthony, *et al.*, "Improving employment outcomes for persons with severe mental illness," *Archives of General Psychiatry*, 59 (February 2002), pp. 165-72.
37. Levy, Clifford, "For mentally ill, death and misery," Series on New York City, *The New York Times Online*, April 28, 2002.
38. Macias, Cathaleene, *et al.*, "Work interest as a predictor of competitive employment: policy implications for psychiatric rehabilitation," *Administration and Policy in Mental Health*, 28:4 (March 2001), pp. 279-97.
39. Mank, David, *et al.*, "Direct support in supported employment and its relation to job typicalness, coworker involvement, and employment outcomes," *Mental Retardation*, 38:6 (December 2000), pp. 506-516.
40. McFarlane, William, *et al.*, "Fact: integrating family psychosocial and assertive community treatment," *Administration and Policy in Mental Health*, 25:2 (November 1997), pp. 191-98.
41. McFarlane, William, *et al.*, "Employment outcomes in family-aided assertive community treatment," *American Journal of Orthopsychiatry*, 70:2 (April 2000), pp. 203-13.
42. Meisler, Neil, *et al.*, "Rehab rounds: replicating effective supported employment models for adults with psychiatric disabilities," *Psychiatric Services*, 49 (November 1998), pp. 1419-1421.
43. Mueser, Kim, *et al.*, "Work and nonvocational domains of functioning in persons with severe mental illness: a longitudinal analysis," *The Journal of Nervous and Mental Disease*, 185:7 (July 1997), pp. 419-26.
44. National Mental Health Association, *et al.*, "Supported Employment for Persons with Psychiatric Disabilities: A Review of Effective Services (online at www.nmha.org/pbedu/adult/supported_employment.pdf)"
45. Newman, Sandra, "Housing attributes and serious mental illness: implications for research and practice," *Psychiatric Services*, 52 (October 2001), pp. 1309-1317.
46. Olsen, Deborah, *et al.*, "Gender differences in Supported Employment," *Mental Retardation*, 38:2 (April 2000), pp. 89-96.
47. Parkinson, Shannon, *et al.*, "From housing to homes: A review of the literature on housing approaches for psychiatric consumers/survivors," *Canadian Journal of Community Mental Health*, 18:1 (Spring 1999), pp. 145-62.
48. Penn, D.L., *et al.*, "Research update on the psychosocial treatment of schizophrenia," *American Journal of Psychiatry*, 153:5 (May 1996), pp. 607-17,
49. Powell, Thomas J., "Predictors of psychosocial outcomes for patients with mood disorders: the effects of self-help group participation," *Psychiatric Rehabilitation Journal*, 25:1 (Summer 2001), pp. 3-33.
50. Resnick, Sandra, *et al.*, "The Indiana Job Satisfaction Scale: job satisfaction in vocational rehabilitation for people with severe mental illness," *Psychiatric Rehabilitation Journal*, 25:1 (Summer 2001), pp. 12-19.
51. Seilheimer, Thomas, *et al.*, "Self-efficacy and consumer satisfaction with housing," *Community Mental Health Journal*, 32:6 (December 1996), pp. 549-59.
52. Solomon, Phyllis, *et al.*, "The state of knowledge of the effectiveness of consumer provided services," *Psychiatric Rehabilitation Journal*, 25:1 (Summer 2001), pp. 20-27.

53. Sommer, Robert, "Family advocacy and the mental health system: the recent rise of the Alliance for the Mentally Ill," *Psychiatric Quarterly*, 61:3 (Fall 1990), pp. 205-21.
54. Toprac, Marcia, *et al.*, "The Texas Medication Algorithm Project Patient and Family Education Program: A Consumer-guided initiative," *Journal of Clinical Psychiatry*, 61:7 (July 2000), pp. 477-483.
55. Trainor, John, *et al.*, "Housing for people with mental illness: a comparison of models and an examination of the growth of alternative housing in Canada," *Canadian Journal of Psychiatry*, 38 (September 1993), pp. 494-500.
56. Weiden, Peter, *et al.*, "Expert Consensus Treatment Guidelines for Schizophrenia: A Guide for Patients and Families," *Journal of Clinical Psychiatry*, 60 (1999), pp. 73-80 available at <<http://www.psychguides.com/scgl.pdf>>
57. Wilson, Stephanie, "Consumer empowerment in the mental health field," *Canadian Journal of Community Mental Health*, 15:2 (Fall 1996), pp. 69-83.

Appendix A4

Housing for Persons with Mental Illness

The Scope of the Issue and its Consequences

Residential accommodation and associated programs for people with mental health needs is an evolving, complex and sometimes controversial issue for those attempting to reform mental health systems. *Making It Happen* lists expanded housing alternatives and options as a major policy initiative in the reform process. (Ontario MOHLTC (2001))

The issues related to the design of accommodation and related programs for people with mental health challenges have become more complex as the issue of homelessness in the general population has become a more pressing concern.

A very high proportion of the seriously mentally ill require housing supports (Ontario, 1996) and there is a high prevalence of mental illness found among the homeless population. Many of the homeless do not seek treatment or use other critical supports, and they are hard to engage in services (Health Canada 2001) Characteristics of homeless people that affect service provision include distrust, lack of social supports, and extreme poverty. (Fischer *et al.*, 1996) Homelessness with the associated loss of income or employment is a condition from which it is difficult to recover. (CMHA 1997)

There are methodological difficulties in determining the prevalence of mental illness among the homeless but estimates run as high as 47-50% of homeless people having any type of mental health problem. The National Research Center on Homelessness and Mental Illness estimates that 20-25% of the single adult homeless population suffers from some form of severe and persistent mental illness (NCH, 1999). Prevalence rates vary in different sub-groups and from place to place. There are higher prevalence rates in lower socio-economic groups. (Fischer *et al.*, 1996))

There is a significant lack of affordable housing in Ontario and consumers are confronted with inadequate housing and long waiting lists.) The problem in Ontario has been exaggerated by the loosening of rent controls making housing less affordable to low income people, cutbacks in spending on specialized housing, and the fact that there is no single Ministry responsible for housing. (CMHA, 1997; Forum, 2001)

The case for housing as an essential component of community support has been made and the case for a current crisis in housing has also been made. In addition, there is an insufficient range of models of housing available to the consumer. (CAMH, Spring 2002)

Housing and Support for People with Mental Illness

Although homelessness is a significant problem for people with mental health needs, the main focus of this chapter is on housing programs and services and more specifically on the short and long term accommodation needs of this population. In Ontario, using the MOHLTC guideline prevalence rate of 2.5 % for the seriously mentally ill, there are 275,000 potential consumers who need housing supports in this category alone. It is widely accepted that one-third of individuals with serious mental illness will require housing supports at some time. (Ontario, MOHLTC, 1996) which translates into a need to provide such supports to 90,000 people. The combined total of beds funded by the province as at Sept 30, 2001 totaled 11,688. Not all of these beds are dedicated to SMI consumers. (Ontario, MOHLTC, Nov. 2001) At the same time, it must be recognized that significant numbers of people manage some type of mental health problem but the majority will not want or need specialized housing (CAMH 2002)

In the Southeastern Ontario District, with an estimated SMI population of 12,500, there are 90 landlords and 20 community agencies providing variable levels of accommodation and support to mental health consumers (SEODHC, Sept. 2001)

The Provincial Forum of Mental Health Implementation Task Forces expressed concerns about lack of affordable housing options in Ontario. They suggested that a continuum of housing options, based on best practices should be made available to consumers, recognizing consumer preference as the driving catalyst. They also suggested that annualized dollars be attached to individuals rather than programs (a major change in funding policy for Ontario), housing should be based on consumer need and housing should be de-linked from service provision. The Continuum should include: Family homes with supports, Home share arrangements, Co-operative settings, Multi-unit apartments, Homes with shared living spaces and Private ownership.

The Forum suggested that, in addition to providing a wide range of supported living environments, including group and individual settings, supports to families should be provided, and that housing placements reviewed to ensure that consumer needs are met. (Provincial Forum, 2001)

What are its Causes and Determinants?

“There is little that is more basic to the practice of community psychiatry than understanding and dealing with the issues related to where patients live”
(Lehman and Newman, 1996).

The past fifty years has seen an evolution in our model of care for people with mental health problems. The institutionalization model – warehousing the mentally ill and treating them on the basis of long-term confinement (Wolfensberger, 1975) – is evolving into a model of community-based accommodation and support system. A recovery-oriented philosophy is emerging, premised on the belief that people with mental illnesses need to be supported thus to maximize their participation in society (Ralph, 2000) – in

real environments such as work, housing and social settings – “in ways that minimize any distinction between people with and without mental illness.” In the recovery model, experiences in real environments enable the person to attain “a sense of their personhood outside of their illness” and an opportunity thereby to participate in their own treatment, rehabilitation and support. (Mazza and Sabo, 2001)

During that time we have seen a paradigm shift from: large numbers in mental hospitals to large numbers living in community and then the shift from the provision of structured housing programs to the concept of supporting individuals who live in ordinary housing arrangements. Initially the program approach to discharge planning involved a “linear Continuum” – graduated continuum of residential treatment programs in the community through which a person progresses towards higher functioning and less restrictive settings. Eight basic types of programs have been identified transitional halfway houses; long-term group residences; cooperative apartments; intensive care community residences; total rural environments; foster care; board and care homes; and nursing homes. Theoretically, people were to “graduate” from one program to the next however people rarely moved through this continuum – they tended to stay in one program for a long time. The next paradigm was a shift to “supported Housing” – “A conceptual and real shift away from the exclusive reliance on residential treatment settings as the sole model of delivery and a new emphasis on the development of normal housing options as a person’s own home.”(Lehman and Newman, 1996)

Developments in Ontario

Ontario has seen the same basic trend towards deinstitutionalization and two basic housing traditions have evolved that continues to shape and influence the field. The “Custodial models” approach began in the 1930’s with the “Approved Homes Program”. Through this program residents from large institutions were placed by the institution in homes that were approved for such community placements. The residents remained on the rolls of the psychiatric hospitals, and the hospitals remained responsible for them.

The development of the “Homes for Special Care Program” began in the mid 1960’s varied from the custodial model in that residents were actually discharged from the provincial psychiatric hospital and placed in community alternatives. The program sought to provide safe and secure housing for individuals discharged from Psychiatric Hospitals through three levels of care: residential, intermediate, and nursing using a combination of models from large boarding homes to small, family oriented foster care settings. (CAMH 2002)

The second tradition in Ontario - Alternative Housing – began in mid 1970’s where newer approaches to residential accommodation developed units that tend to be smaller and to focus on skills training and community integration. They are typically operated by non-profit agencies with a rehabilitation framework and encourage residents to be involved in decision making.(CAMH, 2002)

In 1996, the MOHLTC conducted a review of the Homes for Special Care Program,

noting that, at that time, the program served 1659 people with mental illness or developmental handicaps in 166 homes across the province. The homes ranged in size from 2 to 49 beds with an average capacity of 10 residents per home. Most homes had congregate living arrangements with 2-4 residents sharing a bedroom. Operators, for the most part, are private individuals and companies funded on the basis of per diem rates established by the Ministry.

The review concluded that changes to the HSC program were needed for five basic reasons:

1. Advances in clinical knowledge have rendered the custodial aspects of the program outdated. People who, in the past, were assumed to require custodial care are now being placed in settings where they live much more independently with the help of case managers.
2. Consumer preference studies were suggesting that, while professionals favoured transitional, highly staffed programs for the majority of consumers, consumers themselves sought normal housing with flexible supports. Most consumers preferred to live with one other person rather than live alone or in a large group.
3. Health system fiscal realities required that resources needed for care must be well focused and targeted.
4. The legislative structure of the program is inflexible and outdated.
5. The current status and future of the program was unclear.

The review went on to recommend a series of options for the Internal Structure and funding of the HSC Program all of which were directed at creating more flexibility for operating the program within the basic historical structure of the program itself. Recommendations included supporting smaller dwelling units, more privacy in bedrooms, and facilities, which encourage and support independence and skill development. Funding would be flexible and variable depending on the nature of the accommodation and the programs in the home. Residents would receive disability benefits and their costs of care would no longer be a charge against any estate that might be held for them by the Public Trustee.

In September 2000, the MOHLTC and the Ministry of Community and Social Services (now the Ministry of Community, Family and Children's Services) launched another consultation process towards creating the "Homes For Persons With Special Needs Program" which would incorporate the MOHLTC funded Homes For Special Care, Approved Homes, Habitat, and the Domiciliary Hostel Program shared between MCSS and the Municipalities. (Homes For Persons With Special Needs – Consultation Backgrounder). The initiative came about in recognition of the need to develop a comprehensive, integrated policy for provincially funded residential care programs and is a significant part of the Mental Health Reform process. The discussion takes place in the midst of significant further downsizing of the Provincial Psychiatric Hospitals recommended by the Health Services

Restructuring Commission. The consultation paper is in the form of a policy paper in that it specifies what the Ministry intends to do

The consultation backgrounder suggests that the new program will:

1. ensure that residents will receive consistent, high quality care in facilities funded through this program;
2. ensure an appropriate quality of life for residents through clearly defined standards, monitoring mechanisms and remedial measures;
3. ensure residents' overall health care needs are met by effectively linking them to required treatment and community based services; and
4. incorporate findings of research and best practices from other jurisdictions

In its own discussion on housing for mental health consumers, the Centre For Addiction and Mental Health (CAMH 2002) discusses the current Homes For Special Care program and raises serious concerns about its design and functioning. The program design produces "Transinstitutionalization" - the inappropriate application of institutional thinking outside of institutions. HSC legislation discourages rehabilitation and creates substantial obstacles for operators who want to move in this direction. The essentially institutionalized model of HSC has had other negative consequences as well – it has made large living units sizes seem acceptable and has legitimated crowded conditions and lack of privacy. The basic custodial model of HSC has been replicated in the development of newer programs including Domiciliary hostels and Habitat Services.

CAMH makes references to the directions suggested in the *Homes For Persons With Special Needs: Consultation Backgrounder* and argues that "This document calls for administrative restructuring, but in its conceptualization posits a homogeneous group of consumers who have reached their maximum level of functioning and a program that remains custodial. The usefulness of the paper is limited by the fact that this characterization is at odds with three things: best practice evidence in housing, clinical evidence regarding the course of serious mental illness, and actual assessments of the consumers involved"

CAMH makes a distinction between "Supportive alternative housing" which typically takes the form of cooperatives and group homes and where the support provided is tied to the facility and the people living there are seen as program clients, and "Supported alternative housing" which de-links the housing and support functions and argues that alternative models are enabling in that they attempt to enhance consumer skills and are monitored by funders to support this approach. Concerns are raised that there has not been a clear articulation of eligibility in terms of the degree of disability or support needs. They suggest that new strategies will be needed to:

1. make maximum use of rehabilitation oriented, non-custodial models of support including programs for consumers with very high needs;

2. ensure that support levels match consumer needs;
3. secure adequate levels of funding;
4. be fully integrated with other mental health community services, and,
5. target resources to those most in need.

Supported Housing, as distinct from supportive housing, provides for consumer choice, permanency, a normalized environment and ongoing supports. (Boydell and Everett, 1992; Hogan and Carling, 1992) “The more traditional supportive housing models, on the other hand, stress were based on the linear continuum described by Ridgeway and Zippel, (1990)

Ontario has adopted a recovery philosophy to guide the development of its mental health reform initiative, access to housing is an characteristic of a recovery-oriented system and shelter is an essential service in a recovery oriented system (Anthony, 2000) Supported Housing, rather than Supportive housing is more appropriate to the recovery model.

Best Practice Solutions

A considerable volume of literature speaks to best practices, better practices, and experimental projects in providing housing and supports to mental health consumers.

Mazza and Sabo, in a paper prepared for the Coalition of Ontario Psychiatrists (2001) argue that Supportive Housing is a critical component of effective community support and that “Group Homes” and “Board and Care Homes” are not the answer because they constitute “community institutionalization”. The environment itself, they say, is a tool for rehabilitation and that people exposed to typical community living must face typical community challenges.

A Health Canada discussion paper suggest that attention to the housing needs of the mental health consumer is a key element of a reformed system of care and that there needs to be a variety of alternatives available, ranging from supervised community residences with emphasis on supported housing for consumers. (Health Canada 2000)

The Canadian Mental Health Association argues that best practices include “a range of different housing alternatives, along with a shift in resources and emphasis on supported housing using generic housing widely dispersed in the community, with flexible individualized supports.

Fischer *et al.*, (1996) focusing on mental health services for people who are homeless argue that supported housing, with varying degrees of supervision to meet the varied needs of disabled persons is essential to a well developed mental health service system and basic to preventing homelessness. Consumer preference is critical – if consumers don’t like the arrangement that they are in, they may leave those arrangements and in the

process become homeless. Successful programs serving the people who are homeless often have several characteristics: they apply a public health perspective to the development of services; they focus on housing as a primary goal; and they emphasize the development of linkages so as to achieve continuity of care.

Kloss *et al.*, (2002) examine the potential value of working with landlords and property managers to promote success in supported housing for people with psychiatric and/or addiction disabilities suggesting that relationships with landlords can promote tenants' housing stability, rehabilitation, social integration, and success in community living. (It is interesting to note that less than half of the landlords providing housing to consumers in Southeastern Ontario who responded to the DHC survey, reported that they had been contacted by mental health support staff). (SEODHC, 2001)

The Centre for Addiction and Mental Health (CAMH) outline their view of best practices as they relate to housing for mental health consumers. They note importance of case management to the success of supported housing approaches and suggest : the use of generic housing dispersed widely in the community; the provision of flexible individualized supports which vary in type and intensity; emphasis on consumer choice; the provision of assistance in locating and maintaining housing; no restrictive policies on the length of time a client can remain in the residence; the provision of case management services that are not tied to particular residential settings but are available regardless of whether the client moves or is hospitalized.

The endorsement of supported housing is balanced in *Best Practices* by the recognition that a range of options is needed. People with severe and persistent mental illness vary considerably in their needs and preferences and no single housing model can be expected to successfully accommodate everyone (CAMH 2002). Ensuring appropriate housing is an important function of mental health services when a consumer is to be cared for in the community or is discharged from an inpatient facility. Not only may housing have direct therapeutic implications, but also stability of living arrangements is essential in ensuring continuity with patients. A distinction is made between two broad categories: custodial models - which tend to be larger facilities with little programming - and alternative housing models, which generally are rather small and focused on rehabilitation and community support services. The goal of all these programs is to attain a high enough level of functioning to move into independent living from residential services. The supported housing options endorsed by the best practices literature share the following features:

1. Housing is generic and widely dispersed in the community;
2. The provision of flexible individualized supports varies by intensity and time;
3. Consumers have more, rather than fewer, housing choices;
4. Consumers get assistance in locating and maintaining housing;

5. There are no restrictions on tenure in residence;
6. Case management services follow the consumer, irrespective of housing relocation or hospitalization.

The implementation of an evidence based, best practices oriented housing plan for the Southeastern Ontario District will require an extensive evaluation of the housing programs currently available in the region, re-engineering those programs that do not meet the best practice guidelines, training professionals and allied personnel who work with consumers on their housing issues and plans, and ensuring that there is an adequate supply of appropriate housing and supports to meet the needs of the consumer population in the region.

References to Housing for Persons with Mental Illness

1. Anthony, WA: *A Recovery-Oriented Service System: Setting Some System Level Standards* Psychiatric Rehabilitation Journal, Vol.24, No. 2 (Fall 2000) pp 159-168
2. Boydell, K M and Everett, B: *What makes a house a home? An evaluation of a Supported Housing project for individuals with long-term psychiatric backgrounds* Canadian Journal of Community Mental Health, Vol 10 No. 1, Spring 1992
3. Canadian Mental Health Association (CMHA) *Mental health and Homelessness: A CMHA Ontario position paper* (1997)
4. Canadian Mental Health Association (CMHA) *Submission to The Commission On The Future Of Health Care In Canada* (Undated)
5. Centre For Addiction and Mental Health; *Housing Discussion Paper* (Spring 2002)
6. Fischer, P.J.; Colson, P; Susser, E; *Homelessness and Mental Health Services*” in Breakey, WR. *Integrated Mental Health Services- Modern Community Psychiatry* New York, Oxford University Press, (1996) 300-309
7. Health Canada *Best Practices in Mental Health Reform: Discussion Paper* (June 2000)
8. Health Canada: *Accountability and Performance Indicators for Mental Health Services and Supports* (2001)
9. Hogan, MF and Carling, PJ *Normal Housing: A Key Element of a Supported Housing Approach for people with Psychiatric Difficulties* Community Mental Health Journal, Vol.28, No 3, June 1992
10. Kloos, B.; Zimmerman, SO; Scrimenti, K; Crusto, C: *Landlords as Partners for Promoting Success in Supported Housing: “It takes more than a Lease and a Key”* Psychiatric Rehabilitation Journal, Vol.25 No. 3 (Winter 2002)
11. Lehman, A.F.; Newman, S.J. *Housing in Breakey, WR. Integrated Mental Health Services- Modern Community Psychiatry* New York, Oxford University Press, (1996) 300-309
12. Mazza, G; Sabo, R *Continuing the Challenge– Facilitating Recovery: An integration Framework of Mental Health Services for Adults with Severe and Persistent Mental Illness* Coalition of Ontario Psychiatrists (Sept. 2001)
13. National Resource Center on Homelessness and Mental Illness (NCH) *Mental Illness and Homelessness* April 1999
14. Nelson, G; Hall G.B.; Walsh-Bowers, R: *The relationship between housing characteristics, Emotional Well Being and the Personal Empowerment of Psychiatric Consumer/Survivors*” Community Mental Health Journal, Vol.34, No. 1 (February 1998)
15. Ontario MOHLTC *Overview of Ontario’s Mental Health Service System (Reference Material Only)* (Nov.2001)
16. Provincial Forum of Mental Health Implementation Task Forces: *Provincial Themes For Mental Health Reform in Ontario* (Nov. 2001)
17. Ridgeway, O and Zippel, A.M. (1990) *The paradigm shift in residential services: From the linear continuum to support housing approaches* Psychosocial Rehabilitation Journal 13:11-31 {Cited in Lehman (1996)}

18. Southeastern Ontario District Health Council (SEODHC) *Mental Health Housing in Southeastern Ontario* (September 2001)

Appendix A5

Streamlined Access

The Scope of the Problem and its Consequences

People in Ontario are confronted with major challenges when they seek to receive mental health services from a system that is fragmented, uncoordinated and confusing.

This is the system that presents access challenges across the Province and to the 90,000 people in Southeastern Ontario who have some form of mental illness and the 12,500 of them who are considered to have serious mental illnesses (Offord *et al.*, 1996).

“We have 355 stand-alone mental health programs and 62 hospitals of various types offering mental health care across this province. We know from listening to consumers and families that this array of services is not easy to access, is often confusing in terms of finding out where to go for particular types of support and services, and places the burden of navigation on consumers and their families at times when they are unable to act as their own care managers. Furthermore, consumers and families indicate there is insufficient focus on those supports like housing, employment, vocational supports, and social skills development that will help people be active in their communities of choice” (Provincial Forum, Nov 2001).

There is a wide range of mental health programs and services provided directly through the Ministry of Health and Long Term Care delivered by an array of provider organizations that include: provincial psychiatric hospitals and their devolved successor organizations; specialized psychiatric residential facilities; Schedule 1 Acute Care Hospitals; other community acute care hospitals; Community Care Access Centres; community mental health programs; and primary Care physicians

And these are just the direct mental health services provided within the traditionally defined parameters of the provincially funded “mental health system”. The mental health reform objectives in Ontario include the development of a “Recovery Philosophy” within the system. A system based on the recovery philosophy includes not only treatment, crisis intervention, and case management, but also Rehabilitation, enrichment, rights protection (advocacy), basic support services (shelter, meals, health care), self-help and wellness/prevention. (Provincial Forum 2001; Anthony, 2000; CMA 2001, Wanke *et al.*, 1995)

When the broad range of services required to meet the total needs of the mental health consumer are factored in, the range of providers expands substantially to include ministries of the Ontario Government other than the MOHLTC – Community, Family and Children’s Services, Education, Municipal Affairs and Housing, Public safety and Security, Attorney General, Citizenship, Culture, and Transportation - each of which sponsors and/or provides programs and services essential to the mental health consumer. Beyond the provincial government, there are other provider organizations and individuals including municipalities, private practitioners, and independent businesses (landlords, transportation companies etc.)

Although many of these programs and services are available to all citizens, people with mental health issues often need help to access them. Access is hampered by lack of knowledge as to where to get the required services. (Newman, 1998)

“Streamlined Access” to services, in a reformed mental health system, is a high priority in Ontario, in other jurisdictions in Canada, and around the world. It is an objective that is closely tied to mental health systems restructuring at all levels of government and at the community level.

Causes and Determinants

Historically, at least in North America, the major providers of service to the seriously mentally ill were a small number of provincial/state psychiatric hospitals, almost always owned and operated by government. The advent of psychotropic medications in the 1950’s, which allowed the person with mental health needs to live in the community, led to a significant reduction in psychiatric hospital institutional beds in Canada and across North America. A new vision of “Community Psychiatry” and alternative supports in the community emerged to support those people who were receiving less and less services from the traditional sources (Durbin *et al.*, 2001, CMHA, 2001).

The first phase of mental health reform in Ontario - the downsizing and closures of Provincial Psychiatric Hospitals and the expansion of mental health services in local communities provided by local community organizations has occurred over the past 20-25 years without much attention to coordination and integration. “For many former hospital residents, the new system meant either abandonment, demonstrated by the increasing number of homeless mentally ill people; ‘trans-institutionalization; living in grim institution-like conditions such as those found in the large psychiatric boarding homes, or a return to family who suddenly had to cope with an enormous burden of care but very little support” (CMHA 2001).

A major obstacle to successful reform was “the exclusive focus upon changing services and reallocating dollars rather than addressing the perceived needs of consumers” (Anthony, *et al.*, 1998).

Services emerged in a haphazard way, focused on meeting one or more of the specific needs of the consumer without much consideration of the spectrum of needs of the individual with mental health challenges. (Task Force Forum Nov. 2001) The problem is that the multiplicity of services and the increased fragmentation of delivery systems have made it more difficult for consumers and their families to negotiate, access and coordinate necessary services (Mechanic, 1991)

What is “Streamlined Access”?

“Streamlined access” is a quality of the system which makes it possible for a consumer with mental health needs to easily access the services required to meet those needs and to receive “the right services at the right time in the right place” (Anthony, 2000: NHS;) At a minimum it is a characteristic of an integrated system that ensures that centralized information and referral functions are available so that the consumer knows where to go for services and that common assessment tools/protocols are used so that agencies can share information and the

consumer can avoid the burden of multiple assessments and reassessments.(Provincial Forum 2001, OSABU 1999)

Streamlining Systems

The goal of achieving streamlined access depends to a great extent on how the service delivery system is structured, organized and delivered. *Making It Happen* suggests a number of ways of achieving streamlined access that through a system that is built on a variety of streamlining strategies that include: the development of formalized service agreements among agencies; the designation of lead agencies or hospitals to accept specific components of service (e.g. specialized services) and to provide coordination and direction to service programs; the creation of networks of agencies; and the amalgamation of some existing agencies to produce stronger and better integrated programs.

While there are several promising examples of innovative approaches to service integration in Ontario (Durbin *et al.*, 2001) there is not yet a fully integrated and coordinated system of Mental Health care in any of the nine regions.

“Early in its mandate the HRSC also called for the establishment of regional mental health authorities to manage mental the health portion of the health care system -- a pilot authority was planned for NW Ont. but subsequently cancelled. The Minister did agree however with the concept of divesting the provincial psychiatric hospitals.” (Provincial Forum)

It is important to understand the concept of “Regional Authorities” as it is currently used in the health care system.

“Regional Health Authorities are autonomous health care organizations with responsibility for health administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions” (HEALnet, 2002).

By this definition a Regional Health Authority created by the Province would be divested the authority and the resources to fund and manage the health service system in a given geographic area. Such an authority would have the mandate to establish service plans and objectives and develop and negotiate the regional budget with the Province. The regional authority would negotiate budgets with the service delivery agencies, reallocate funds, monitor and evaluate program and service performance, exercise sanctions, implement restructuring.

On the other hand, nothing in this definition precludes the creation of a service sector (e.g. Mental Health) authority for particular parts of the system. It is interesting to note that those provinces that have created Regional Health Authorities (All except Ontario) have generally excluded Mental Health responsibility from that delegated to the RHAs.

Best Practices Solutions

Making It Happen identifies streamlined access to mental health services and supports as one of the six key goals of a reformed mental health system. Improving access will ensure that there is clear responsibility to:

1. Make information available;
2. Facilitate access to a comprehensive continuum of services responsive to the client's needs;
3. Coordinate the availability and selection of possible services; and
4. Enhance client choice and access to services.

Streamlined access and integrated systems are only two of the components of the provision of effective services. Poor coordination is sometimes blamed for failures actually due to insufficient resources or inappropriate services. (Anthony, 2000, NHS) A streamlined system must have some built in strategies to improve access and responsiveness to the consumer.

Clinical integration is integral to improved client outcomes and adequate resources are needed to support system integration. An integrated system of care changes the relationship among the components of the system and involves the loss of a certain degree of power and autonomy for each player. It will be particularly challenging to seek mechanisms and levers to bring hospitals into the integrated system as full participants. Systems integration requires a close examination of the legal and other implications. Issues in particular arise around sharing of client information, instituting shared resources, accountability for system performance and clients in the system.

Persons with a mental illness or their surrogates must be able to access the appropriate care provider or mental health service in a timely manner, and their relevant clinical information must be readily available to the services to which they are referred. Since there exist multiple entry points to the mental health system, it is difficult to stipulate one set of best practices. However, three points arise from the best practices literature:

1. It is possible to provide concise but effective educational packages for all regional front line providers to standardize and enhance the accuracy of initial clinical assessments (Obrien *et al.*, 1999)
2. Triage instruments have been shown to be effective in emergency departments (Pollard *et al.*, 1999) and in mental health centers to direct patients to the appropriate sources of care. Such instruments, however, may not be suited to prioritizing patients for service receipt (Phelan *et al.*, 2001).
3. Clear procedures on release of patient information, consistent with existing legislation, are necessary to protect patients but also to involve appropriately family and additional providers in the patient's care (Bogart *et al.*, 2001).

Achieving the streamlined access objectives requires restructuring of the system and how it operates, not only in terms of how it is organized and how individual agencies are mandated to provide what services to whom, but in terms of the cultural underpinnings that drive its current approach to delivering services. The “Guide to developing Recommendations for streamlining access to mental health services produced by the MOHLTC suggest a number of mechanisms that, if utilized, could lead to significant change in how agencies work and how the people working in them provide their services.

1. The development of a formalized collaborative process among a group or network of agencies/hospitals through which access is coordinated;
2. Service agreements among participating organizations that outline specific accountabilities required to formalize collaborative arrangements;
3. The establishment of lead agencies mandated to coordinate access to one or more key functions within the mental health system for either an identified geographical area or population. Service Agreements among the lead organizations and the other organization(s) will be required; and,
4. Amalgamating agencies to reduce the number of agencies providing similar or complementary services and to concentrate critical resources on service delivery.

Introducing the concepts of “Lead Agencies” and “amalgamation of agencies” leads directly to the concepts of governance and integration. How can the reformed system and its component parts be organized and managed to produce the key features of a system with streamlined access to mental health services suggested in the Guideline?

(Durbin *et al.*, (2001) undertook a comprehensive review of strategies available for mental health system integration. The review: examines strategies to develop a more integrated mental health service system, evaluates the effectiveness of these strategies, provides a literature review and develops a systems integration logic model. The authors suggest that there are three requirements for an integrated system – a) availability of full, coordinated continuum of services b) responsibility for a defined population c) clinical and fiscal accountability for the outcomes and health status of the population served.

“Governance models vary in their operation across the key dimensions of:

1. accountability;
2. system administration, monitoring and evaluation; and,
3. system development and change.

They can be represented on a continuum from lower to higher degrees of integration and from informal to formal arrangements. The models most appropriate for achieving the goals of system integration must be at the higher end of the continuum to have enough leverage

and scope to influence system development. Feasibility of implementation is also a concern. Three models, each with different strengths and limitations, meet these broad criteria: the Umbrella Group; the Regional Authority; and the Consolidated organization. The regional authority model is the most compelling, although hybrid models can be used.”

Two models specifically rejected are the “Parallel Alignment” in which each agency remains accountable to its own board and there are no formal ongoing relationships, and the “Collaborative Alignment” in which each agency remains accountable to its own board, there is no centralized entity with a systems mandate, but agencies voluntarily agree to improve service coordination by realigning some aspects of their service function or contributing to a joint service initiative. This is achieved through formal inter-agency agreements and memoranda of understanding.

The Umbrella Agreement

Agencies remain accountable to their own boards but sign formal partnership agreements and memoranda of understanding to create an overarching entity with a system mandate. Accountability of this entity is to the participating agencies that retain control of their own resources. Implementation of service integration is dependent on agreement from all participating agencies.

Authority

Agencies remain accountable to their own boards but contract with an entity (new or existing) that has a system mandate, is accountable to the funder and controls a pooled funding envelope. While the entity may provide some services, it primarily serves as a purchaser of service and uses service contracts to implement service integration.

Consolidated Alignment

Most agencies in the system are consolidated within a new organization that has a system mandate, is accountable to the funder and controls a pooled funding envelope. This new merged organization, as the primary provider of service to the system, is positioned to implement service integration.

Selection of Models

Models of integration may vary with respect to system mandate, agency accountability, and governance and should be designed on the basis of an environmental scan of the district. for which it is planned. Among the factors that condition the selection of the structural design for a given geographic region or area are the specific characteristics of the existing service system, its geographic and demographic characteristics, its client characteristics, the readiness of the community for change and the traditional challenges that confront that particular region.

Upon review of these characteristics, The Southeastern Ontario District has elected to recommend a variation of the “Umbrella Agreement” described above. (SEOMHIT, 2002)

The Southeastern Ontario Mental Health Trust

The Trust will be responsible to the Ministry of Health and Long Term Care for all aspects of mental health system functioning in the Southeastern Ontario mental health district including:

1. implementing mental health reform and system functioning in the Southeastern Ontario district;
2. advancing inter-agency cooperation and service integration by creating district-wide programs and service networks based on formal inter-agency partnerships and service agreements, mandated to meet the needs and be held accountable for clearly defined population groups;
3. advancing community mental health by developing district-wide mental health promotion, prevention, and advocacy initiatives built on partnerships between consumers, family members, and mental health professionals;
4. setting strategic directions for system functioning;
5. maintaining accountability for all aspects of system-functioning and service delivery within the district;
6. conducting strategic, system-level planning;
7. advising the Government, through the Ministry of Health and Long Term Care regarding all aspects of system functioning ranging from strategic planning to funding to service delivery in the District, including how new and existing funds may be reallocated to support system functioning activities;
8. promoting greater visibility of needs of those with a mental disorder;
9. coordinate opportunities for training and clinical across district-level service networks and programs;
10. foster excellence in service delivery by identifying and setting clinical standards and ensuring that mechanisms are in place to meet and monitor these;
11. participating in regional and provincial initiatives;
12. fostering a culture of cooperation and excellence through participation in research, education, and inter-agency initiatives; and,

13. creating relevant advisory mechanisms to support smooth system functioning or decision-making.

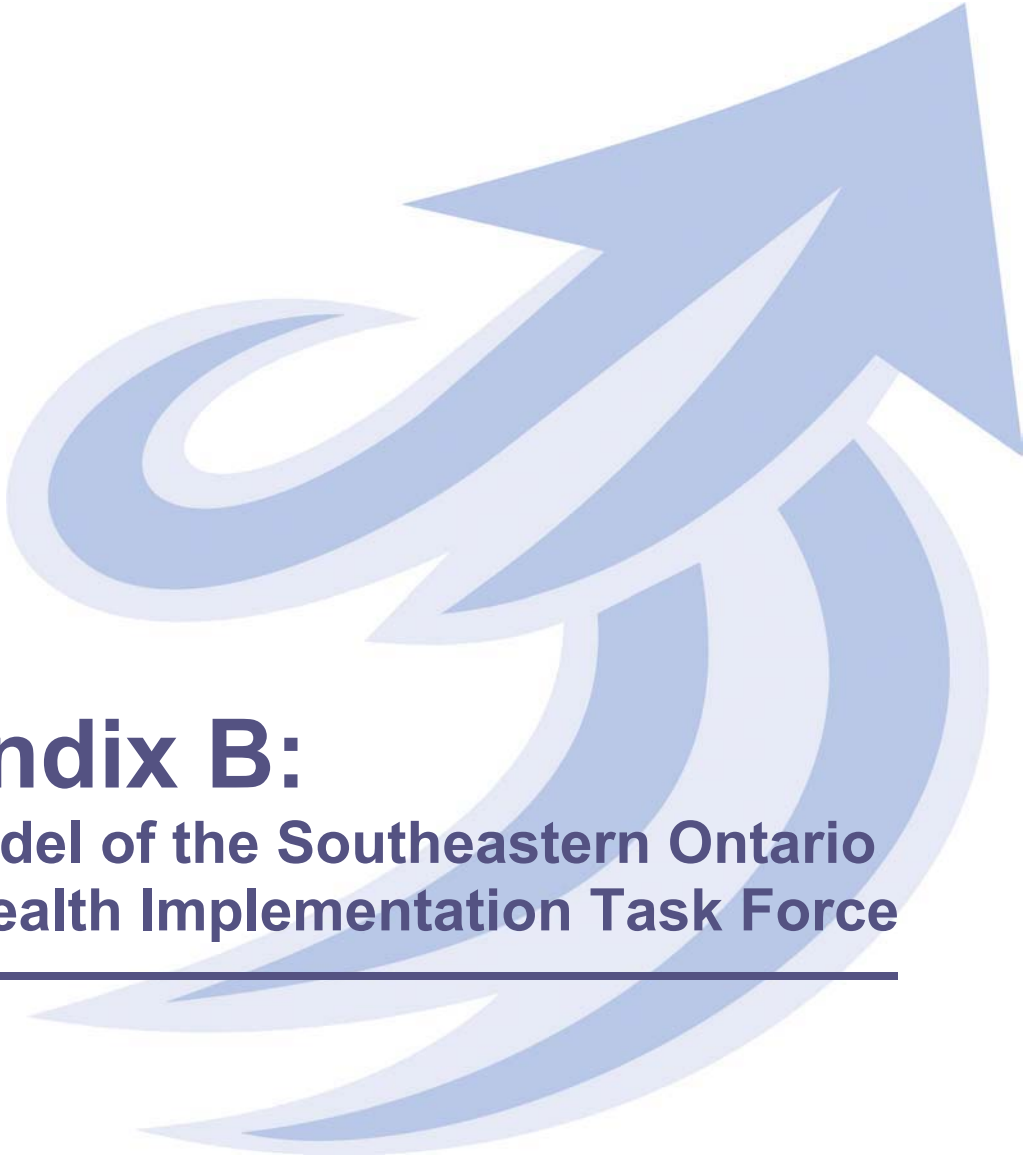
Included in the governance proposal to create a Southeastern Ontario District Mental Health Trust is provision for a Planning, Research and Evaluation Unit proposed in “A Framework for Mental Health System Accountability in Southeastern Ontario”, mandated to:

1. implement district level accountability processes;
2. oversee the implementation and collection of standardized, linked performance monitoring data;
3. harmonize data demands across different agencies;
4. plan and conduct evaluation research;
5. analyze and interpret performance monitoring and evaluation data;
6. develop and implement information brokerage models to synthesize and communicate the literature on best practices to key participants within the district;
7. actively communicate with accountability partners regarding the results and outcomes of local accountability processes; and,
8. collaborate with other systems-based accountability units in multi-centered or provincial evaluation initiatives.

There is a dearth of current and reliable information across the mental health service delivery system in Ontario. Existing data collection processes have little relevance to consumer needs, lack standardization, are of dubious reliability and validity and are inadequate for assessing quality of care (Marhaba, 2002). What information exists is scattered and fragmented, unreliable and often outdated. Similar programs may go under completely different names, hours of access may be limited, actual services may be limited to specific days, or even hours of the week. The full realization of the *Making It Happen* vision for reformed mental health care service delivery is not achievable in the absence of a thoroughly renovated data and evaluation infrastructure both to understand how the consumer's needs are or are not being met and to plan for the improvement of the mental health care system (Ziglin, 1995). One of the main challenges of the research and evaluation unit will be to work with the SEO District Health Council and the Health Information Partnership to develop and implement a district-wide mental health data and information capacity.

References to Streamlined Access

1. Anthony, WA: *A Recovery-Oriented Service System: Setting Some System Level Standards* Psychiatric Rehabilitation Journal, Vol.24, No. 2 (Fall 2000) pp 159-168
2. Bogart T. Solomon P. Procedures to share treatment information among mental health providers, consumers, and families. *Psychiatric Services*. 50:1321-1325, 1999.
3. Canadian Mental Health Association (CMHA) *Submission to The Commission On The Future Of Health Care In Canada* (Undated)
4. Durbin, J. Rogers, J. Macfarlane, D. Baranek, P. Goering, P. *Strategies For Mental Health System Integration: A Review – Final Report* Health Systems Research and Consulting Unit, Centre For Addiction and Mental Health, (August 2001)
5. Everett, B, Lurie, S, Higgins C. *The Whole Picture: A provincial framework for redesigning the Ontario Mental Health System – A discussion Paper* Canadian Mental Health Association, Ontario Division and The Ontario Federation of Community Mental Health and Addiction Programs (Undated)
6. HEALNet: *What is Regionalization?* (2002) <http://www.regionalization.org/Regionalization.html>
7. Health Canada *Best Practices in Mental Health Reform: Discussion Paper* (June 2000)
8. National Health Service, Britain (NHS) *Effective Care Co-Ordination in Mental Health Services, Modernising the Care Program Approach* (Undated)
9. Newman, D. *2000 and beyond: Strengthening Ontario's Mental Health System*, Ontario, MOHLTC (June 1998)
10. O'Brien L. Fitzgerald M. Barber H. Henry J. Evaluating the effect of assessment education with community psychiatric nurses using a file audit tool. *International Journal of Psychiatric Nursing Research*. 5:516-525, 1999.
11. Ontario Substance Abuse Bureau *Setting the Course – A framework For Integrating Addiction Treatment Services in Ontario* (1999)
12. Ontario, MOHLTC *Guide to Developing Recommendations For Streamlining Access to Mental Health Services and Supports* (2000)
13. Phelan M. Seller J. Leese M. The routine assessment of severity amongst people with mental illness. *Social Psychiatry & Psychiatric Epidemiology*. 36:200-206, 2001.
14. Provincial Forum of Mental Health Implementation Task Forces: *Provincial Themes For Mental Health Reform in Ontario* (Nov. 2001)
15. Smart D. Pollard C. Walpole B. Mental health triage in emergency medicine. *Australian & New Zealand Journal of Psychiatry*. 33:57-66, 1999.
16. Southeastern Ontario Mental Health Implementation Task Force A Framework for District Level Governance For Mental Health System Delivery (2002)
17. Wanke, MI, Saunders, LD, Pong, RW. Church, WJB: *Building a Stronger Foundation: A Framework for Planning and Evaluating Community-Based Health Services in Canada* Health Canada, 1993

A large, stylized blue arrow graphic that curves upwards and to the right, with a lighter blue shadow or outline following its path. It is positioned in the upper right quadrant of the page.

Appendix B:

Logic Model of the Southeastern Ontario Mental Health Implementation Task Force

Southeastern Ontario District Reformed Mental Health System

Grounding Question

What type of system do we want in place for ourselves and our families?

Mission Statement

The development of an integrated, accessible, coordinated Best Practice continuum of services and supports across three levels of service (i.e., first line, intensive, specialized) taking into account policy, legislation, and the needs of varying populations of people in both urban and rural settings across the lifespan of the consumer while ensuring a balance between people with a serious mental illness and others with mental health problems.

Guiding Principles

Consumer Centered

Balance ————— Collaboration

Integrated – Accessible – Accountable – Affordable – Coordinated – Responsive (timely) – Understanding/knowledge

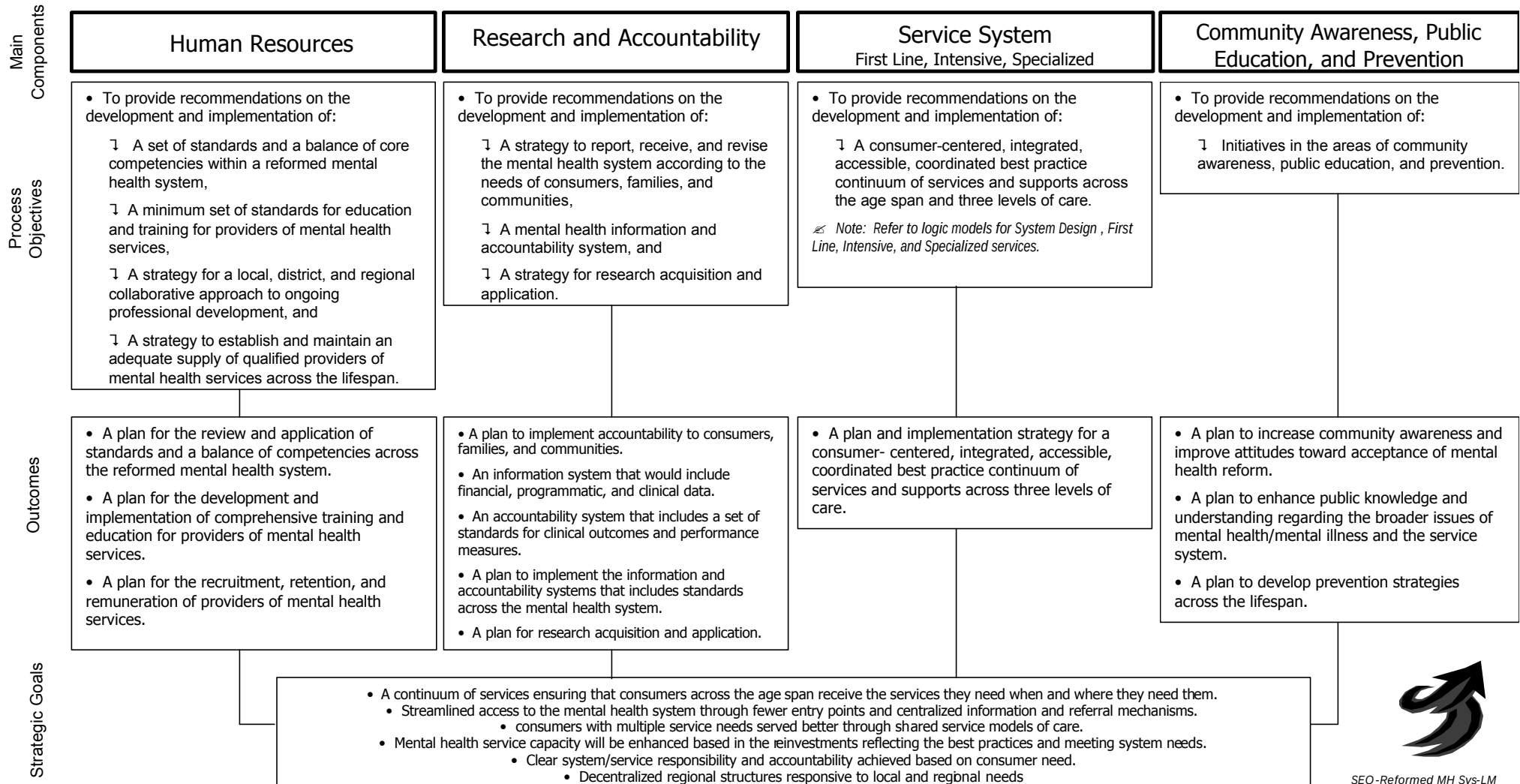
Originally Prepared on: July 20, 2001

This reformed mental health system design was developed by the Southeastern Ontario District Mental Health Implementation Task Force. The Task Force acknowledges the valuable contribution made by Chris Sullivan, member of the SEO-MHITF Integration Committee and a Senior Program Consultant with the Centre for Addiction and Mental Health, for facilitating the development of this reformed mental health system design.



SEO -Reformed MH Sys-LM
Ver 8; December 18, 2001

Southeastern Ontario District Reformed Mental Health System



Southeastern Ontario District Integrated Mental Health Services System Design

Originally prepared: September 2001

Prepared by: The Southeastern Ontario District Mental Health Implementation Task Force

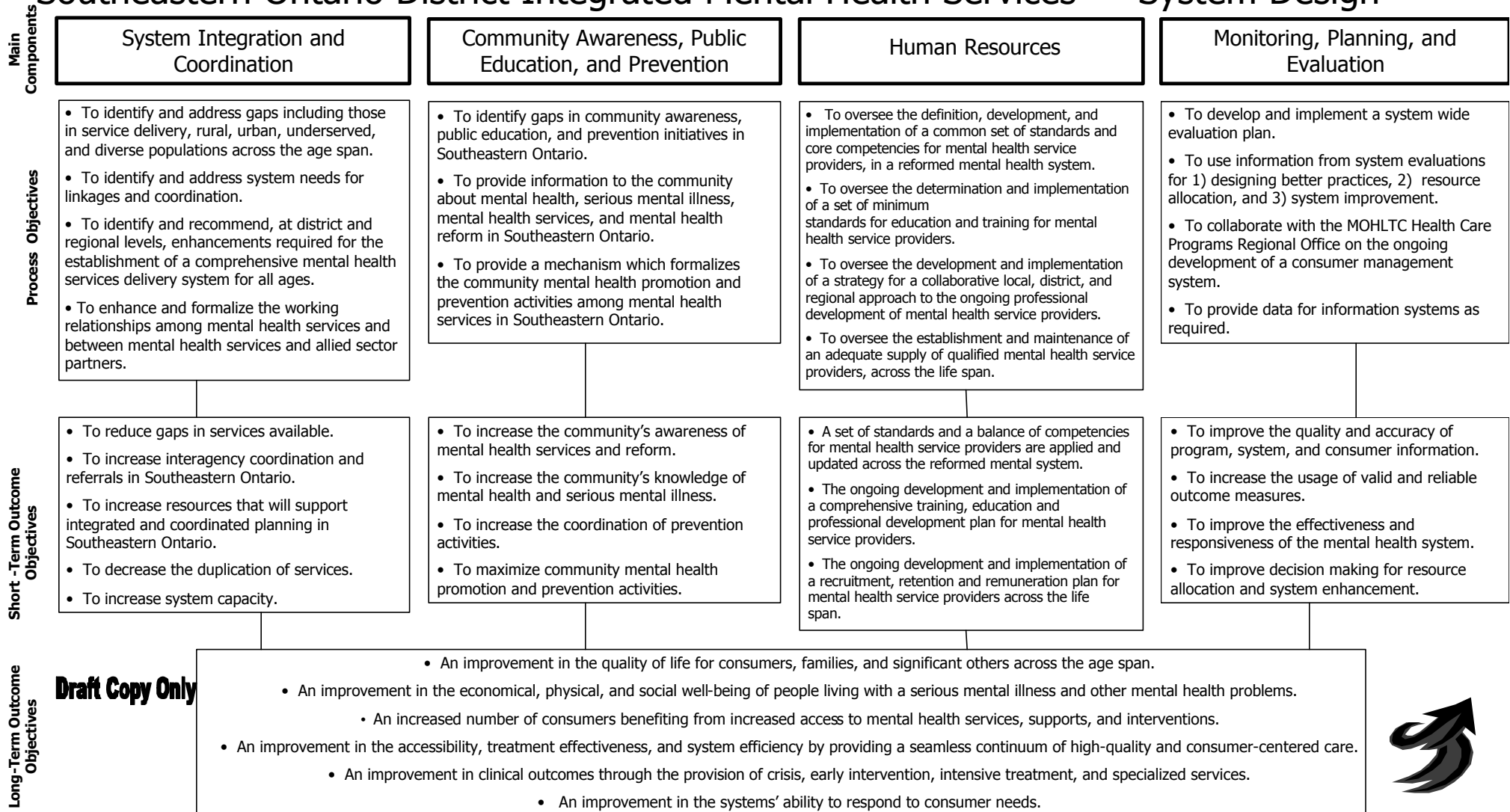
Levels of Service definitions as per *Making it Happen*, pages 11-12:

- **First Line Services:** Refers to prevention, assessment, and treatment provided by frontline health care providers including general practitioners, mental health services, social services and hospital primary care clinics.
- **Intensive Services:** Refers to mental health assessment, treatment and support services which are provided in community or hospital settings and are focused on people with serious mental illness.
- **Specialized Services:** Refers to highly specialized mental health programs provided in community or hospital settings and which focus on serving people with serious mental illness who have complex, rare, and unstable mental disorders. Long term care is not synonymous with specialized care. Treatment, rehabilitation, and support services are integrated within each program/service type and provided through a multi-disciplinary team approach.



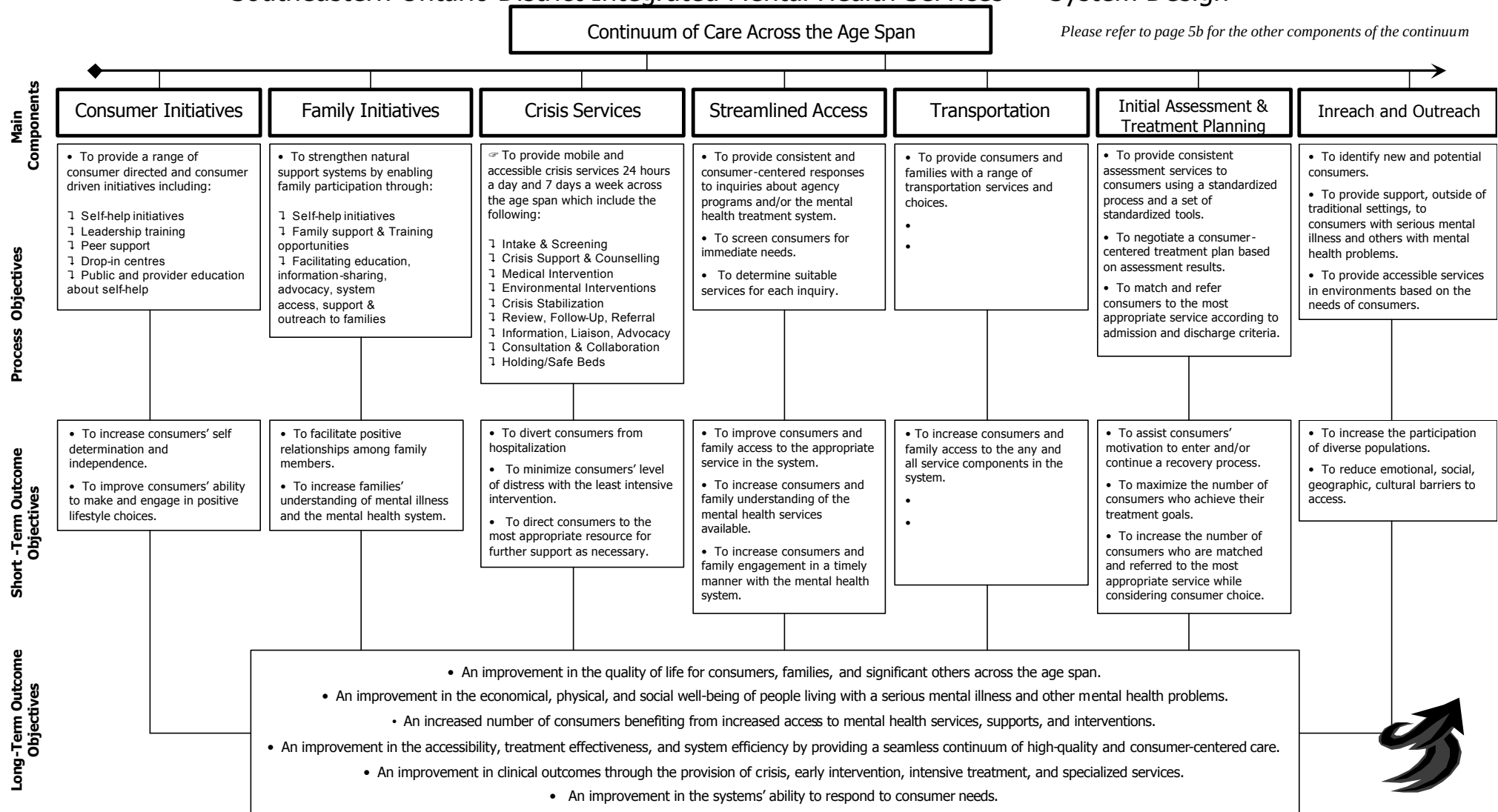
SEO-Mental Health Sys. Design,
Ver 12; December 18, 2001

Southeastern Ontario District Integrated Mental Health Services -- System Design



Southeastern Ontario District Integrated Mental Health Services -- System Design

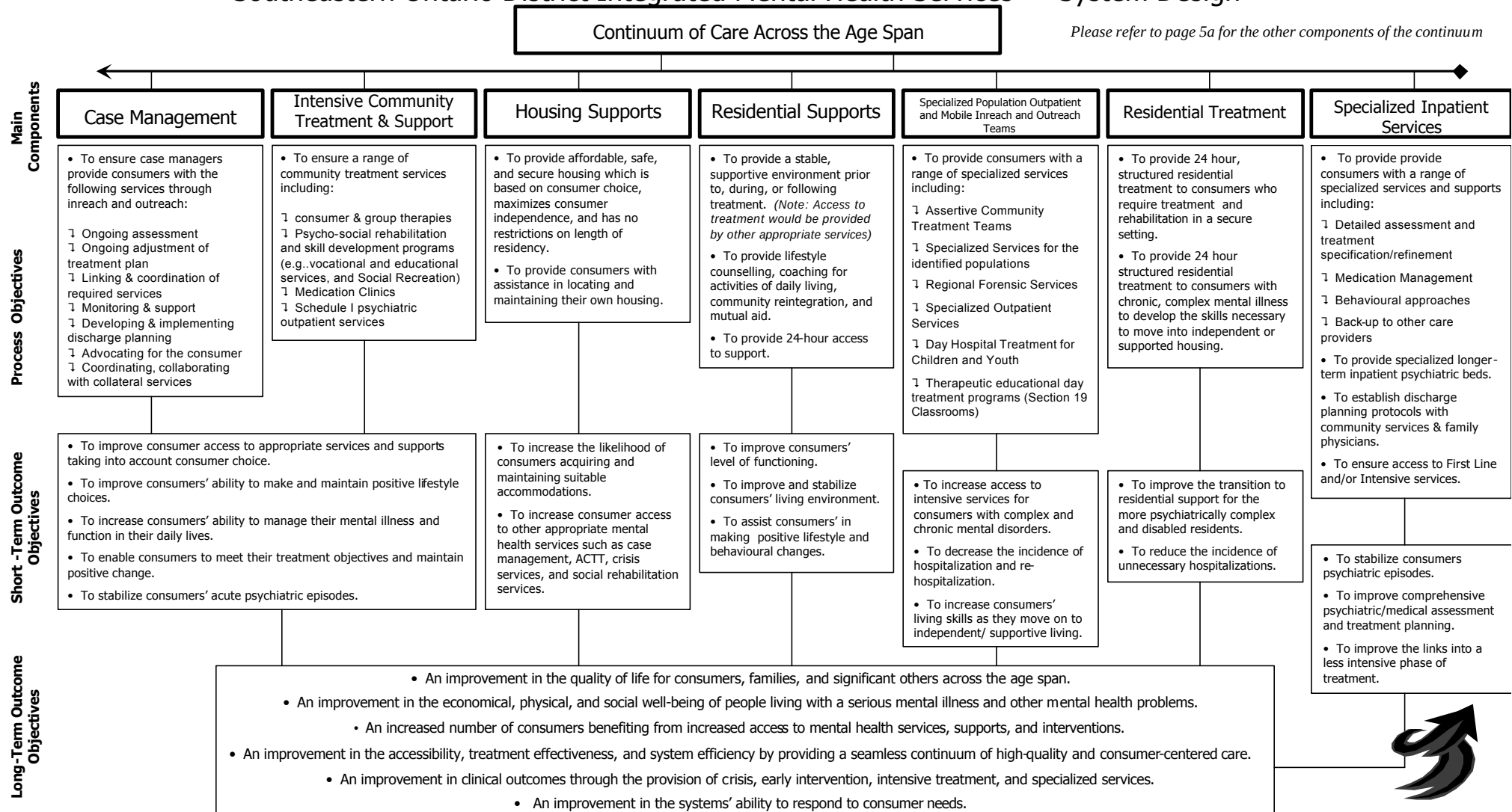
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SEO-Mental Health Sys. Design,
Ver 12; December 18, 2001

Southeastern Ontario District Integrated Mental Health Services -- System Design

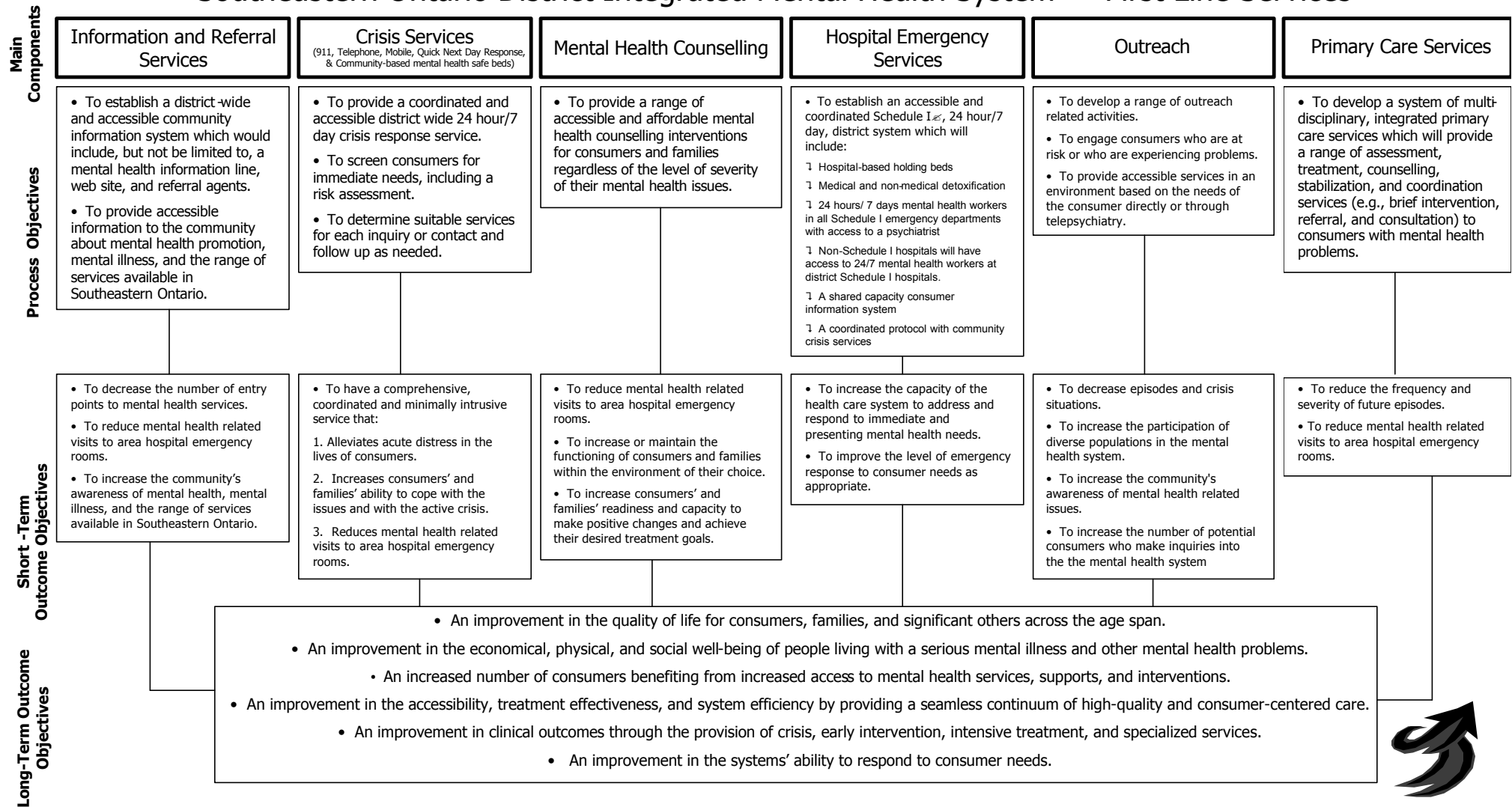
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SEO-Mental Health Sys. Design,
Ver 12; December 18, 2001

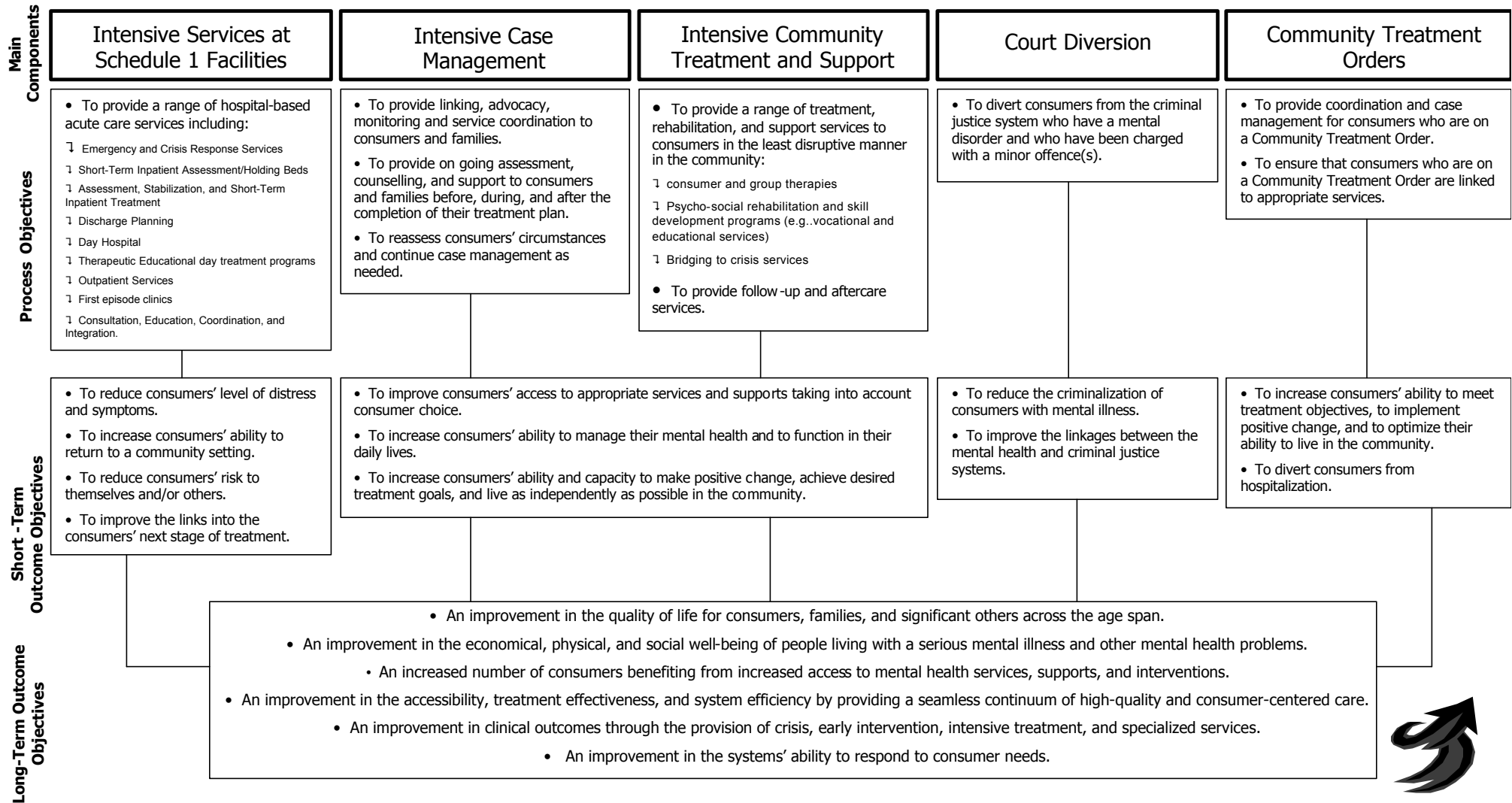
Southeastern Ontario District Integrated Mental Health System -- First Line Services

Page 6



Southeastern Ontario District Integrated Mental Health System -- Intensive Services

Page 7



SEO - Intensive Services Ver 8;
December 18, 2001

Southeastern Ontario District Integrated Mental Health System -- Specialized Services

Page 8

Specialized services are in place to provide care for the following specialty populations: Acquired Brain Injury, Child & Adolescent, Concurrent Disorders, Dual Diagnosis, Forensic, Geriatric Psychiatry, and Serious Mentally Ill {Adult}

Main Components

Assertive Community Treatment Teams (ACTT)

- To provide advocacy to consumers and families.
- To provide continuous and comprehensive treatment, rehabilitation, and support services to those people with serious mental illness who have multiple and complex needs that are more difficult to treat and are not manageable at another level.
- To refer consumers to outside services where appropriate.

Specialized Population Outpatient and Mobile Inreach and Outreach Teams

- To provide advocacy to consumers and families.
- To provide clinical consultation, assessment, and treatment planning (using a balance of direct, indirect, and shared care service) to those who serve consumers with mental health needs including First Line service providers, Intensive service providers, and families.
- To provide education to service providers in mental health and other related fields.
- To engage in coordination and collaboration for the specialty populations within the mental health system and other relevant systems.
- To engage in joint planning and development with First Line and Intensive Services for the specialty populations.
- To ensure that crisis intervention and case management services are available to consumers and families.
- To engage in and support ongoing program and system evaluation.

Residential Treatment

- To provide 24 hour consumer responsive, highly structured, and staffed residential treatment to consumers who would otherwise be placed in hospitals.

Specialized Inpatient Services

- To provide people with serious, complex, and/or rare mental disorders whose service requirements cannot be met in First Line or Intensive levels of services with centralized diagnostic and therapeutic health care (e.g., detailed assessment and treatment, medication management, and behavioural approaches) by specialized professionals.

Process Objectives

Short -Term Outcome Objectives

Long-Term Outcome Objectives

- To deliver 75% or more of the services outside program offices with an emphasis on outreach, relationship building, individualization of services, and consumer choice.
- To avert hospitalization whenever appropriate.
- To increase consumers' ability to remain in an integrated setting in the local community.
- To increase consumers' access to specialized services where necessary

- At the consumer level:
 - ↳ To avert hospitalization whenever appropriate.
 - ↳ To increase consumers' ability to remain in an integrated setting in the local community.
 - ↳ To increase consumers' access to specialized services where necessary.
- At the system level:
 - ↳ To expand the capacity of relevant services.

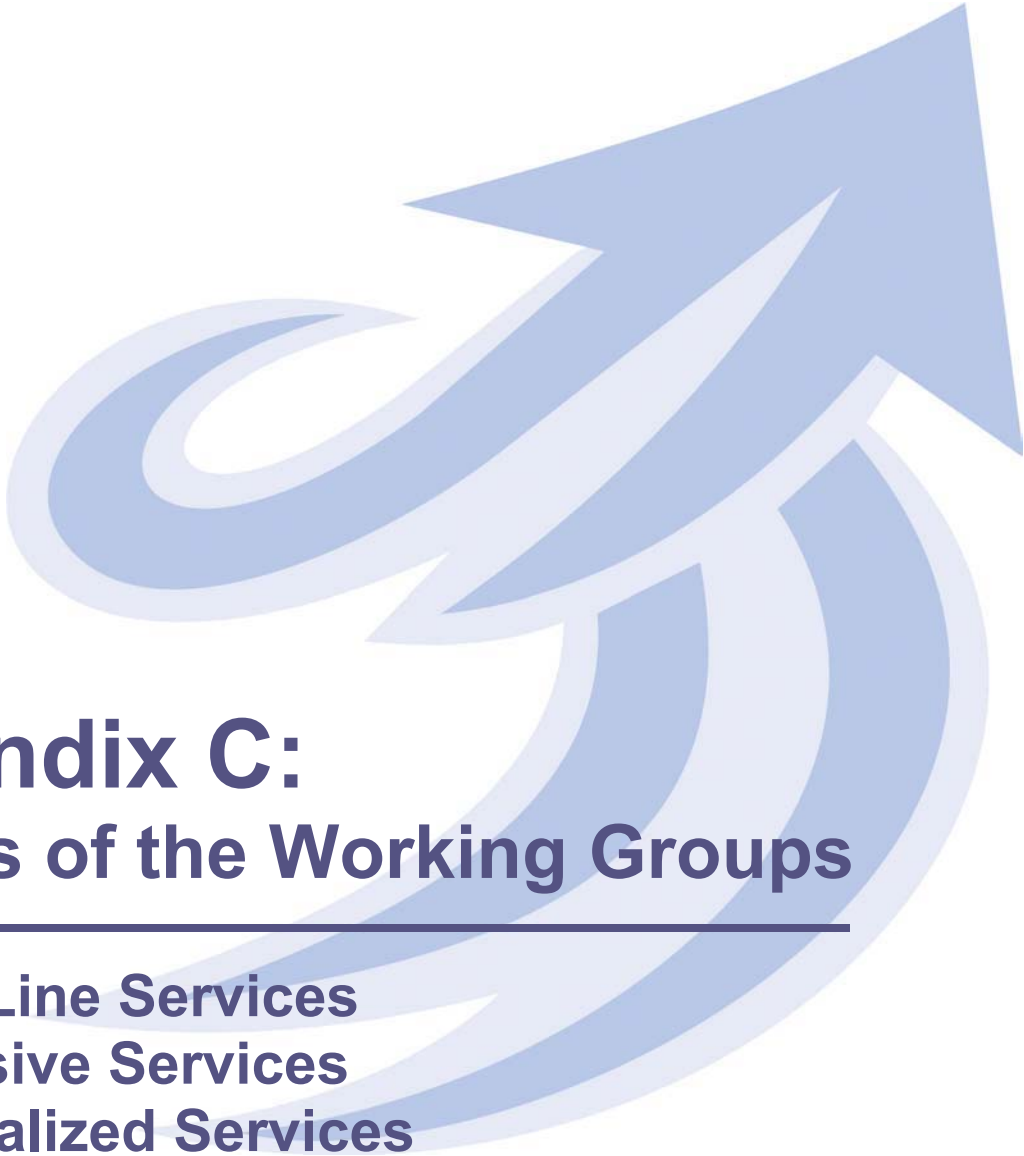
- To improve the transition to independent housing for the more complex and disabled consumers.

- To improve specialized diagnostic assessments.
- Improved treatment and stabilization.
- To reduce symptoms and improve personal well being.
- To increase consumers' ability to return to and reintegrated within a community setting.

- An improvement in the quality of life for consumers, families, and significant others across the age span.
- An improvement in the economical, physical, and social well-being of people living with a serious mental illness and other mental health problems.
 - An increased number of consumers benefiting from increased access to mental health services, supports, and interventions.
- An improvement in the accessibility, treatment effectiveness, and system efficiency by providing a seamless continuum of high-quality and consumer-centered care.
 - An improvement in clinical outcomes through the provision of crisis, early intervention, intensive treatment, and specialized services.
 - An improvement in the systems' ability to respond to consumer needs.



SEO - Specialized Services Ver 6;
December 18, 2001



Appendix C:

Reports of the Working Groups

First Line Services
Intensive Services
Specialized Services

Members of the First Line Working Group

The following members of the First Line Working Group respectfully submit this report to the Southeastern Ontario Mental Health Implementation Task Force:

Ms. Belia Brandow (Chair) (Seriously Mentally Ill Champion)

Ms. Colleen Small (Vice-Chair) (Dual Diagnosis Champion)

Ms. Joanne Maltby (Children & Youth Champion)

Dr. Kola Oyewumi (Concurrent Champion)

Ms. Lori-Ann Leggett (Consumer Champion)

Mr. Bill Reinhart (Family Champion)

Mr. Wolf Tausendfreund (Forensic Champion)

Ms. Hersh Sehdev (General Public Champion)

Ms. Betty Ann McGrath (Seniors Champion)

Mrs. Sandra Lawn (*Ex-Officio*)

Ms. Jane Banbury (*Ex-Officio*)

Mr. Dennis Timbrell (*Ex-Officio*)

Ms. Shauna Kingstone (Resource)

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Chapter 2 – Overview of Core Services

Chapter 3 – Overview of Best Practices

Chapter 4 – Recommendations for Implementation

Chapter 5 – References

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Summary of Recommendations

The recommendations of the First Line Working Group emerge from, and are built around, a framework developed for the purpose of guiding the work and recommendations of the group. The First Line Working Group's recommendations are broken out under two headings:

- (1) "Systemic Recommendations" which must be implemented for the realization and implementation of
- (2) "Specific First Line Recommendations" which embody the *Making It Happen* vision for a restructured mental health care delivery system across Southeastern Ontario.

The recommendations are summarized below and expanded upon in Chapter 4 of this report.

Systemic Recommendations:

The First Line Working Group recommends to the Integration Committee of the Southeastern Ontario District Mental Health Implementation Task Force:

1. That all recommendations forwarded to the Task Force be congruent with the prevention and recovery philosophy that puts the individual and family at the centre of the mental health system and which focuses on the development of healthy and accepting communities;
2. That mental health reform and primary care reform be developed to complement each other through a linked and co-ordinated system design and development;
3. That a mental health policy be developed for Ontario that takes into account the needs of varying populations in both urban and rural settings -- across the life-span of the consumer regardless of the severity of illness -- while ensuring a balance between people with a serious mental illness and others with mental health needs;
4. That incorporation of quality assurance, program evaluation, and accountability measures in every component of mental health care delivery is essential;
5. That an accessible universal community information system (not exclusively electronically based) be developed, updated regularly,

linked to the full range of available services and co-ordinated with other services in the district, region and province as appropriate;

6. That key elements of the community information system include, but not be limited to, a mental health information telephone line, web site and promotional materials designed to provide accessible information to the community about mental health promotion, mental illness prevention, early identification and intervention and the range of services available for all citizens in the Southeastern Ontario District;

7. That there be a long-term commitment to enhance and to adequately fund First Line services and protect CCAP-defined level 1 and level 2 funding for the mental health system across Ontario; and

8. That an expanded range of accessible, publicly funded mental health counseling interventions for consumers and families be provided irrespective of severity of mental health issues.

9. That in the realization of recommendations 7 and 8 above, current organizational mandates will need to be expanded.

10. That the Government of Ontario amend relevant legislation to facilitate appropriate information sharing and fund accordingly and that standardized assessment tools and data collection tools be established to ensure sharing of information between service providers based on client consent.

First Line Recommendations:

It is understood, through the development of the service system blueprint, that certain services consistent with First Line were developed elsewhere by other committees, specifically primary prevention, public education, stigma reduction, advocacy and consumer and family initiatives. These are, therefore, not fully developed in this report.

1) That there be an immediate enhancement and long-term commitment to adequately fund First Line services and protect CCAP-defined level 1 and level 2 funding for the mental health system across Ontario;

2) That **minimum** key components of a mental health system for First Line services must include prevention, community development, primary care services, information and referral services, comprehensive crisis services (including but not necessarily limited to warm lines, telephone crisis lines, mobile crisis teams, trauma response capacity, holding and safe beds), advocacy, hospital emergency services and outreach, non-medical detox, shared care between psychiatrists and primary care providers, recreation and leisure services, community

based counseling, broad community mental health promotion, education, vocational and employment supports;

3) That appropriately trained (e.g. in mental illness/mental health issues, suicide and crisis intervention, sensitivity to culture, religion, sexual orientation, etc.) triage personnel within the system be available and be recipients of ongoing professional cross-education and development;

4) That a network of coordinated and accessible 24/7 crisis response services be established within the district to screen consumers for immediate needs, including a risk assessment, determine and refer to suitable services and follow up of the referral as needed;

5) That there be a comprehensive range of client-centred services, relevant to local community needs, be available to ensure that they are based on client need and provided in the least intrusive manner and as close to home as possible;

- * that a range of community-based and accessible outreach activities be developed including education and consultation in schools, municipal governments, community agencies, social housing units;
- * that outreach services be accessible in every community to enhance availability and accessibility of specialized services through the use of e.g. telepsychiatry, traveling clinics to provide consultation and assessment;
- * that the sentinel role of primary care practitioners be recognized and that funding be available for non-billable activities required for comprehensive treatment of mental health clients as well as for system development, integration and reform;
- * that the role of primary care practitioners be highlighted in the prevention and treatment of mental health issues and that adequate training and support be provided;
- * that funding be made available for shared care between trained psychiatrist and primary care practitioners for consultations and for ongoing treatment
- * that a system of multi-disciplinary integrated primary care services which provides a range of assessment, treatment, counseling, stabilization and coordination services (e.g. early brief intervention, referral and consultation) be developed for consumers with mental health problems; and
- * that a network of coordinated and accessible 24/7 hospital emergency services, linked with Schedule 1 facilities, be developed in

such a manner that all hospital facilities will be able to draw upon Schedule 1 emergency mental health resources to ensure an appropriate first response.

Chapter 1: Introduction and Purpose

This report is submitted to the Integration Committee of the Southeastern Ontario Mental Health Implementation Task Force (SEOMHITF) on behalf of the First Line Working Group.

Purpose and Mandate:

The First Line Working Group was created to formulate recommendations for the Integration Committee regarding an implementation plan concerning First Line Services required for integrated, accessible and comprehensive reformed mental health service delivery system which must deliver services and supports across many dimensions (age, urban, rural), and across all populations, **irrespective of severity of illness**, as guided by the needs and perspectives of consumers and family members across Southeastern Ontario.

Goals of the First Line Working Group:

The Workplan of the First Line Working Group identified four goals:

- 1) defining the First Line service system and its components (articulated below);
- 2) identifying present system gaps, duplications, barriers, strengths and needs (developed in Chapter 2 below);
- 3) making recommendations in order of priority regarding an implementation plan for achieving the First Line service system (the task of Chapter 3); and
- 4) developing an interim/final report to be presented to the Integration Committee.

Defining First Line Services

According to *Making it Happen*, First Line refers to “prevention, assessment and treatment provided by front line health care providers including general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics (*Making It Happen: Operational Framework*, p. 17). The priority population for First Line Services is identified in *Making It Happen* as “people with serious mental illness” and First Line emergency crisis services “must be accessible to all people with symptoms of mental illness” (*Making It Happen: Operational Framework*, p. 17). First Line Services are the crucial connector between the mental health system as a whole and the consumer and the consumer's family. Since First Line Services are the first point of contact for most consumers, getting the balance right

and ensuring all First Line Care providers achieve a level of competence and awareness appropriate to their clinical role will ensure that many more people with mental health disorders receive the treatment they require in an early and comprehensive manner. Upon assessment at the First Line level, people will be directed to the service(s) which best meet their needs, i.e. brief crisis intervention, intensive and/or specialized services or generic supports in the broader social service/health care systems” (*Making It Happen: Operational Framework*, p. 13).

First Line Services include but are not restricted to information and referral; crisis telephone lines; mobile crisis teams; Schedule 1 hospital emergency services; holding/safe beds; primary care physicians; mental health counseling; community health centres, and health service organizations (refer to logic model included in this chapter).

Defining First Line Terminology

The First Line Working Group embraces the issue of mental health in its broadest scope based on social determinants of health. The following definitions are being provided to fully comprehend the logic model and the recommendations of the First Line Working Group. Our hope is that this will shift the focus of the Southeastern Ontario district mental health system from an illness based perspective to one of mental health promotion and prevention for the community and individuals.

Note: For definitions please refer to glossary in Volume 1 Appendix H pg. 277.

Chapter 2: Overview of Core Services

The First Line Working group could not complete the second goal. That task proved to be beyond the capacity of the First Line Working Group given the current information and data tracking system provided. For example, many General Practitioners (i.e. First Line care providers) also provide psychiatric and/or psychological counseling as part of their service package -- but exact, even approximate, information on how many GPs provide which services across what geographic catchment was not available. Secondly, the Ministry of Health and Long-Term Care has begun reinvesting in many aspects of the Mental Health service system across Ontario -- but at the time of this report's preparation it was impossible to be precise about which funds had been allocated to which programs, and in fact which programs do exist and where, when and in what amounts, and when those funds began to flow. An analysis of the present system service and program strengths and weaknesses was not completed.

Chapter 3: Overview of Best Practices

Introduction

What works in First Line Care? The existing mental health literature contains information on *best practices* for some, but not all, components of First Line service. Best practices are “activities and programs that are in keeping with the best possible evidence about what works” generally derived from randomized control studies (1). This chapter will review evidence on the most effective approaches to the delivery of current and future First Line services. It is structured to reflect the progression of a consumer through the mental health system, beginning with mental health education in the community, passing to triage when specific mental health needs arise, then reviewing treatment approaches ranging from initial crisis intervention to primary care participation in case management strategies care, and concluding with consideration of approaches to housing, education and employment by which to reintegrate consumers into the community.

Several caveats are worth noting about the mental health best practices literature. First, as the discussion on case management will show, terminology is not used in a consistent fashion across studies, making comparison difficult. Second, it is not unusual to find conflicting evidence on key issues. Third, the literature changes rapidly, rendering reviews from as little as half a dozen years ago out of date. Fourth, the effectiveness of approaches to service organization may be specific to the circumstances of the jurisdiction in which the interventions were evaluated. Fifth, some issues, specifically impact on clinical outcomes, are notable by their absence. Finally, for many aspects of service delivery there is simply no best practice literature available.

Community Information and Development

The full realization of the *Making It Happen* vision comprehends a multi-faceted information strategy incorporating a spectrum of public interventions ranging from school-based anti-stigmatization educational programs to prominently displayed mental health information telephone lines, internet web-sites and easily accessible information packages of various kinds. Anti-stigmatization, in particular, is necessary to cultivate and nurture a community environment that is welcoming and accommodating of people with mental illness (2,3). The First Line Working Group acknowledges the centrality of public and professional education and de-stigmatization. These issues are dealt with in detail by the reports of other committees.

Triage

It is important that persons with a mental illness or their surrogates are able to access the appropriate care provider or mental health service

in a timely manner, and that their relevant clinical information be readily available to the services to which they are referred. Since there are multiple First Line entry points to the mental health system, it is difficult to stipulate one set of best practices. However, three points should be made:

- * It is possible to provide concise but effective educational packages for all regional front line providers to standardize and enhance the accuracy of initial clinical assessments (4).
- * Triage instruments have been shown in emergency departments (5) and in mental health centers (6) to direct patients to the appropriate sources of care. Such instruments, however, may not be suited to prioritizing patients for service receipt (7).
- * Clear procedures on release of patient information, consistent with existing legislation, are necessary to protect patients but also to involve appropriately family and additional providers in the patient's care (8)

Crisis Response Systems/Psychiatric Emergency Services

A significant number of consumers make their first contact with the mental health system at a time of personal crisis. To meet such needs, crisis response systems (CRS) encompass a range of services integrated across various providers including mental health personnel, family practitioners, and the police. The goals of crisis services are to assist the consumer to remain in the community and to develop strong community-based supports suited to early intervention (9). Common components of a CRS germane to First Line Services are as follows:

The Telephone - 24/7 Universal Accessibility

Crisis response telephone and warm lines – which divert people from inpatient hospitalization using minimally intrusive options – are endorsed in the best practices literature. Telephone crisis lines are a particularly effective instrument for connecting the consumer – or the consumer's family – to the mental health care delivery system. A primary role for telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when indicated.

Walk-in Crisis Services

Walk-in services provide face-to-face assessment and intervention, typically including screening and assessment, stabilization, perhaps treatment and linking to relevant services. Hospital emergency rooms are often used for this service, though many do not have the relevant specialists or well-defined crisis management procedures in place.

Mobile Crisis Outreach

Mobile crisis services can intervene quickly day or night wherever needed and are particularly useful for linking previously unknown consumers to the existing system of help and support. The teams may operate out of community locations, crisis centres, multi-purpose community mental health centres or hospitals (10).

Crisis Residential Services

Residential crisis services provide the person-in-crisis with support in a calm, protected and supervised non-hospital environment under those circumstances when crisis resolution may require separation from the consumer's environment. During this respite, the person can re-stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings may be used as an alternative to hospitalization, including family-based crisis homes, crisis apartments, or group homes (11). A combination of crisis residence and day hospital was recently reported as effective and less expensive than in-hospital treatment (12,13)

Psychiatric Emergency/Medical Crisis Services

Some hospitals have developed special programs of multi-disciplinary teams who assess and provide immediate support and some have added 24 hour holding beds to permit more extended evaluation with the objective of referring more individuals to ambulatory services (14), urgent day clinics, day hospitals or community support programs. The preferred model is for hospital services to be integrated with CRS so that unnecessary admissions can be avoided, so that necessary admissions can proceed as quickly as possible, length of stay is minimized, discharge planning begins at admission and individuals are linked to support services upon discharge.

The evidence base for the above programs is limited; however, descriptive studies suggest the efficacy of crisis housing, diversion programs and crisis centres for people-in-crisis (1).

Primary Care

Many consumers make contact with First Line Services, not through CRS, but via a family physician. Often this will be the sole source or diagnosis and treatment, and will suffice for uncomplicated minor or self-limiting conditions. Family physicians deal with a variety of mental illnesses including anxiety and depression, grief, situational reactions, or alcoholism. In collaboration with psychiatrists they may participate in shared care for the severely mentally ill. They provide counseling and various types of short-term psychotherapy, prescribe medications, refer patients to psychiatrists and social agencies, screen for early signs of illness, and educate patients about services available in the mental health system.

There is evidence that from two American studies that psychiatric conditions are frequently poorly managed by non-specialists (15,16). Access to psychiatrists for collaborative care or chart reviews may enhance competency, as may targeted continuing education programs. Preliminary and descriptive studies suggest that integrating mental health professionals into primary care settings can (1,17,18):

- * enhance continuity of care;
- * increase accessibility to mental health services;
- * lead to more efficient use of mental health services;
- * provide new opportunities for continuing education for physicians;
- * and improve communication between mental health services and family practitioners.

Close integration may be more feasible in environments where family physicians are not paid by fee-for-service, such as Community Health Centres (salaried), Health Services Organizations (patient capitation payment), or Reformed Primary Care (capitation plus targeted incentives). Not only do physicians potentially have more time for patient encounters and continuing medical education programs under alternative funding arrangements, but also there are frequently associated programs available from which to fund additional mental health professionals as part of the primary care team.

Case Management

For consumers who are not in crisis but require intervention beyond the capacity of primary care providers alone, more specialized care in the form of Case Management (CM) may be appropriate. While at present most primary care physicians and other First Line providers have little role in the more sophisticated forms of case management, their roles will increase as a consequence of the shift in care provision from an institutional to a community focus. This is particularly likely in the context of current Primary Care Reform. As well, given the apparent shortage of psychiatrists, especially in fields such as psychogeriatrics, family physicians may be asked to play a larger role in mental health services. Given their community-base, familiarity with the critical importance of continuity of care, and a practice approach that stresses the need not only to treat the “whole person”, but also, to involve family as appropriate, family physicians may make an important contribution to case management.

The term CM lacks a specific definition, but generally signifies a multifaceted, multi-disciplined approach designed to help consumers function at the highest level possible with the least possible restrictions. It is based on close, long-term relationships with the consumer and offers services such as assessment, planning, monitoring, referral and advocacy. The *Expanded Broker Model* of CM uses a case manager to broker services for the client. Its outcomes are sufficiently poor to exclude it from a list of best practices (19). The *Rehabilitation Model*

focuses on improving client living skills through identification of deficits, while the *Personal Strengths Model* centers on making best use of the clients own resources. *The Full Support Model* or *Assertive Community Treatment* (ACT) provides clinical and social support through a multi-disciplinary team around the clock; it is the most widely replicated and studied form of CM. A recent review has labeled it the best practice approach (19). Closely related, *Intensive Case Management* is geared to high need individuals and is intended to assist them in remaining out of hospital. It involves frequent contact, proactive outreach, small case-loads, 24-hour availability, and a community-based practice venue.

This multiplicity of meanings to the generic term *case management* makes comparison of evaluation studies difficult. However, this review will focus on three common usages found in the literature:

i. Assertive Community Treatment (ACT)

The major findings concerning ACT include the following:

- * Reduced hospitalization for patients in ACT (20,21), though contrary findings have been reported (22,23);
- * Costs for patients receiving Act have been reported as less than alternative approaches (21,24) but such evidence is weak and may vary with the study setting.
- * The impact of ACT on client clinical status is insufficiently studied.
- * Client and family satisfaction and client social functioning appear superior with ACT exposure (22,25);
- * ACT programs are effective in maintaining clients in treatment (25,26).
- * Rural locations may impose barriers to the effective implementation of ACT programs (23,27).

ACT programs promote client retention, enhanced social functioning, and possibly reduced hospitalization.

ii. Community Care (CC)

Terminology may also includes *Intensive Community Care*, *Community Mental Health Teams*, and *Intensive Psychiatric Community Care*. This category, because of the diverse techniques and patient populations studied is difficult to summarize. However, current evidence suggests the following:

- * Managed community care programs lead to improved client retention and improved social functioning (28-30).
- * Opinion on clinical improvement (28,31) and impact on hospitalization (28,32) lacks consensus.

- * Costs have been found to be both greater than (29), and less than (31), conventional care models.

The major advantage of the above programs appears to be in the area of treatment continuity and social functioning.

iii. Intensive Case Management (ICM)

Additional terminology under this heading includes *Case Management*, and *Intensive Clinical Case Management*. The key findings appear to be:

- * ICM retains consumers in programs more effectively than standard approaches (33,34).
- * Social functioning, in some studies including consumer/family satisfaction and quality of life, is improved (33-37).
- * Opinion is divided on whether clinical improvement is (36,37) or is not (34,38) associated with ICM.
- * Some studies have shown reduced hospitalization rates (34,38).
- * Costs are higher than conventional approaches (33,35).

The above points are consistent with the conclusions of the most recent systematic review of case management studies (39).

In summary, various case management approaches appear suited to promoting continuity of client contact and enhanced social functioning and satisfaction. Such tactics may reduce hospital use, but cost impacts are variable. Clinical outcomes do not appear to improve. Community-based primary providers will increasingly be seen as appropriate members of multi-disciplinary case management teams.

Inpatient/Outpatient Care

First Line services do not extend to hospitalized patients, but may include the care of outpatients and partially hospitalized patients. Best practices show that improved social functioning is associated with discharge of long-stay patients, that individuals and families prefer community care to hospitalization and that clinical and social outcomes are as good for discharged individuals receiving community care as for matched counterparts remaining in hospital (1). It has been widely demonstrated that day hospitals are less costly with comparable outcomes, that they are able to offer more intensive treatment in a less restrictive environment, that shorter lengths of stay achieves outcomes similar to longer stay admissions, and that home-based treatment is effective for many patients.

Housing & Community Supports

Arranging appropriate housing is a key function of First Line services when a consumer presents in crisis or when consumers who are suffering from mental illness in the community find it necessary to move their residence but are not actively followed by an ACT team. This role will increase as more primary providers participate in case management programs. Not only may housing have direct therapeutic implications, but also stability of living arrangements is essential in ensuring continuity with patients. A distinction is made between two broad categories: custodial models - which tend to be larger facilities with little programming - and alternative housing models, which generally are rather small and focused on rehabilitation and community support services. The goal of all these programs is to attain a high enough level of functioning to move into independent living from residential services.

The supported housing options endorsed by the best practices literature share the following features:

- * Housing is generic and widely dispersed in the community;
- * The provision of flexible individualized supports varies by intensity and time;
- * Consumers have more, rather than fewer, housing choices;
- * Consumers get assistance in locating and maintaining housing;
- * There are no restrictions on tenure in residence;
- * Case management services follows the consumer, irrespective of housing re-location or hospitalization.

Evidence from the literature shows that alternative living arrangements, when combined with ACT, can successfully substitute for long-term inpatient care, often at lower cost for equal or better outcomes (13,30).

Vocational and Educational Initiatives

The clinical and social benefits of employment and training have been recognized for well over a century; without such support, reintegration into the life of the community would be compromised. First Line services may offer career counseling to assess consumer preferences and capacities, and placement services to begin the reintegration process. Sheltered work environments have a long history in mental health services, but supportive employment represents a more recent approach in the rehabilitation field. Clients work as regular and remunerated employees with flexible, ongoing support (1). This represents an effective compromise between sheltered employment and fully competitive employment, and is suited to the needs of even those with serious psychiatric illness.

Summary

This review has focused on best practices as they apply -- not to the clinical management of patients -- to the management of components of the mental health system. It applies equally to all consumers across the life cycle. Components of First Line Working Group not found in the current best practice literature are community counseling, non-medical detox, leisure and recreational services. The key best practices germane to First Line services are:

- * Successful intervention begins with the ability of the mental health system to ensure uniform and expeditious triage at multiple points of entry.
- * It is desirable to deploy the least intrusive approach to treatment necessary to achieve the best consumer outcome.
- * The role of First Line providers needs to be expanded to go beyond counseling and treatment to include prevention of illness, health promotion of individuals, families and the community.
- * First Line providers are found everywhere. (e.g. including but not limited to schools, community centers, community mental health centers, primary care services, self help groups and emergency departments). Shared clinical information and collaboration in treatment, prevention and health promotion is essential amongst all levels of provider.
- * Successful re-integration of consumers into the community requires healthy communities conducive to assist the individual in achieving housing, training, and employment.

References to Chapter 3: Overview of Best Practices

1. Health Systems Research Unit, Clarke Institute of Psychiatry. *Review of Best Practices in Mental Health Reform* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, 1997), XX.
2. National Health Service. Modern standards and service models, mental health. London: 1999.
3. World Health Organization. The world health report 2001, mental health: new understanding, new hope. Geneva:2001.
4. Obrien L. Fitzgerald M. Barber H. Henry J. Evaluating the effect of assessment education with community psychiatric nurses using a file audit tool. *International Journal of Psychiatric Nursing Research*. 5:516-525, 1999.
5. Smart D. Pollard C. Walpole B. Mental health triage in emergency medicine. *Australian & New Zealand Journal of Psychiatry*. 33:57-66,1999.
6. Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle 98195, USA. Field test of a tool for level-of-care decisions in community mental health systems. *Psychiatric Services*. 49:91-97,1998.

7. Phelan M. Seller J. Leese M. The routine assessment of severity amongst people with mental illness. *Social Psychiatry & Psychiatric Epidemiology*. 36:200-206, 2001.
8. Bogart T. Solomon P. Procedures to share treatment information among mental health providers, consumers, and families. *Psychiatric Services*. 50:1321-1325, 1999.
9. Goering P, Durbin J. *A Background Paper for Mental Health Reform in Ontario*. (Toronto: Ontario Ministry of Health. 1994).
10. Reding GR. Raphelson M. Around-the-clock mobile psychiatric crisis intervention. *Community Mental Health Journal*. 31:179-190, 1995.
11. Bond GR. Witheridge TE. Wasmer D. Dincin J. MacRae SA. Mayes J. Ward RS. A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hospital and Community Psychiatry*. 40:177-183, 1989.
12. Sledge WH. Tebes J. Rakfeldt J. Davidson L. Lyons L. Druss B. Day hospital/crisis respite care versus inpatient care, Part 1: Clinical outcomes. *American Journal of Psychiatry*. 153:1065-1073, 1996.
13. Sledge WH. Tebes J. Wolff N. Helminiak TW. Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *American Journal of Psychiatry*. 153:1074-1083, 1996.
14. Gillig PM, Hillard JR. Bell J. Combs HE. Martin C. Deddens JA. The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*. 146:369-372, 1989.
15. Anfinson TJ. Bona JR. A health services perspective on delivery of psychiatric services in primary care including internal medicine. *Medical Clinics of North America*. 85:597-616, 2001.
16. Wang PS. Berglund P. Kessler RC. Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine*. 15:284-292, 2000.
17. Von Korff M. Katon W. Bush T. Lin EH. Simon GE. Saunders K. Lundman E. Walker E. Unutzer J. Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosomatic Medicine*. 60:143-149, 1998.
18. Hemmings A. Counseling in primary care: a randomized controlled trial. *Patient Education & Counseling*. 32:219-230, 1997.
19. Bedell JR. Cohen NL. Sullivan A. Case management: the current best practices and the next generation of innovation. *Community Mental Health Journal*. 36:179-194, 2000.
20. Salkever D. Domino ME. Burns BJ. Santos AB. Deci PA. Dias J. Wagner HR. Faldowski RA. Paolone J. Assertive community treatment for people with severe mental illness: the effect on hospital use and costs. *Health Services Research*. 34:577-601, 1996.
21. Essock SM. Frisman LK. Kontos NJ. Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry*. 68:179-190, 1998.

22. Fekete DM. Bond GR. McDonel EC. Salyers M. Chen A. Miller L. Rural assertive community treatment: a field experiment. *Psychiatric Rehabilitation Journal*. 21:371-179, 1998.
23. Clarke GN. Herinckx HA. Kinney RF. Paulson RI. Cutler DL. Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*. 2:155-164, 2000.
24. Taube CA. Morlock L. Burns BJ. Santos AB. New directions in research on assertive community treatment. *Hospital and Community Psychiatry*. 41:642-647, 1990.
25. Lafave HG. de Souza HR. Gerber GJ. Assertive community treatment of severe mental illness: a Canadian experience. *Psychiatric Services*. 47:757-759, 1996.
26. Herinckx HA. Kinney RF. Clarke GN. Paulson RI. Assertive community treatment versus usual care in engaging and retaining clients with severe mental illness. *Psychiatric Services*. 48:1297-1306, 1997.
27. McDonel EC. Bond GR. Salyers M. Fekete D. Chen A. McGrew JH. Miller L. Implementing assertive community treatment programs in rural settings. *Administration & Policy in Mental Health*. 25:153-173, 1997.
28. Tyrer P. Simmonds S. Joseph P. Marriott S. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database of Systematic Reviews*. 1, 2002.
29. Thornicroft G. Wykes T. Holloway F. Johnson S. Szumukler G. From efficacy to effectiveness in community mental health services. PRiSM Psychosis Study 10. *British Journal of Psychiatry*. 173:423-237, 1998.
30. Sellwood W. Thomas CS. Tarrier N. Jones S. Clewes J. James A. Welford M. Palmer J. McCarthy E. A randomized controlled trial of home-based rehabilitation versus outpatient-based rehabilitation for patients suffering from chronic schizophrenia. *Social Psychiatry & Psychiatric Epidemiology*. 34:250-253, 1999.
31. Rosenheck RA. Neale MS. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*. 55:459-466, 1998.
32. Tyrer P. Evans K. Gandhi N. Lamont A. Harrison-Read P. Johnson T. Randomized controlled trial of two models of care for discharged psychiatric patients. *British Medical Journal*. 316:106-109, 1998.
33. Johnston S. Salkeld G. Sanderson K. Issakidis C. Teesson M. Buhrich N. Intensive case management: a cost-effectiveness analysis. *Australian & New Zealand Journal of Psychiatry*. 32:551-559, 1998.
34. Holloway F. Carson J. Intensive case management for the severely mentally ill. Controlled trial. *British Journal of Psychiatry*. 172: 19-22, 1998.
35. Issakidis C. Sanderson K. Teesson M. Johnston S. Buhrich N. Intensive care management in Australia: a randomized controlled trial. *Acta Psychiatrica Scandinavica*. 99:360-367, 1999.

36. Chan S. Mackenzie A. Jacobs P. Cost-effectiveness analysis of case management versus a routine community care organization for patients with chronic schizophrenia. *Archives of Psychiatric Nursing*. 14:98-104, 2000.
37. Chan S. MacKenzie A. Ng DT. Leung JK. An evaluation of the implementation of case management in the community psychiatric nursing service. *Journal of Advanced Nursing*. 31:144-156, 2000.
38. Wykes T. Leese M. Taylor R. Phelan M. Effects of community services on disability and symptoms. PRiSM Psychosis Study 4. *British Journal of Psychiatry*. 173:385-390, 1998.
39. Marshall M. Gray A. Lockwood A. Green R. Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. 1: 2002.

Chapter 4: Recommendations for Implementation

Systemic recommendations and First Line recommendations are offered in priority on pages 4 through 7. Detailed implementation requires further development with public consultation, adequate funding commitments, and evaluation.

Quality First Line Services in a Reformed Mental Health Care System

The following represents an effort to sum up the challenges facing planners of a reformed mental health care delivery system for Southeastern Ontario and to show where specific interventions can prepare the path for much greater innovations and system developments. The challenge facing the provision of quality First Line Service is to ensure the following criteria are met:

- 1. Accessible:** Care must be accessible on an as-needed basis. This means that consumers or their representatives must be aware of where to turn, and that the time taken to provide the services they require must be matched to the urgency of their need. Additionally, neither distance nor economic barriers should compromise access to the required service. Shared service models of care need to be thoroughly investigated and, where appropriate, innovated upon. General health staff – e.g. particularly GPs – must be, at a minimum, able to detect evidence that a person in their care may require more thorough and expert attention. Currently many GPs find it difficult to deal with persons with a mental illness, and the fee-for-service pay structure actually discourages GPs from spending the necessary time with a client.
- 2. Appropriate:** The care required should match the consumer's need. It should follow the principle of least intrusion, but equally should not substitute less intensive care than best practices have demonstrated to be optimal. In this context the term "optimal" captures both desired clinical outcomes and reasonable cost.
- 3. Integrated:** The provision of First Line care occurs at the inter-face of the community and the mental health system. The individual's health information must travel with the consumer as he or she enters the system and must, complete and up-to-date, accompany the consumer on return to the community. This requires communication amongst all care providers, pharmacists and mental health agencies.

To what degree are these three characteristics evident in current services and to what extent can they be incorporated into future First Line Services? At this time this question is impossible to address. It ought, for that reason, to be among the first priorities of the proposed research and evaluation unit which is articulated in the governance report. Massaging the current system of first line services into a system which (a) realizes the values and ideals embodied in *Making It Happen* and (b) meets the lived needs of people with mental health problems across Southeastern Ontario requires a great deal more – and more detailed – information than either the health care or mental health care

system is currently configured to supply. This is especially true of First Line services because – by definition – these are the first point of contact for most people who require the expertise of mental health care service providers.

Integration Priorities

A district-wide highly visible community information system which (a) makes the existing system of care visible to greater numbers of people and (b) begins the process of directing people to the service most accessible to them is a priority from the perspective of first line services. Getting the message will go some distance toward addressing existing need, but more importantly to capturing unmet psychiatric need – people with mental health problems and their families who are suffering in isolation or because of lack of knowledge of existing services. It is imperative that information systems be networked together in such a way that people who need mental health care need not be shuffled from agency to agency – but that every agency be plugged into and connected so that the consumer of mental health services experiences a seamless continuum from first encounter to final discharge.

Since programs and agencies tend to be dynamic, it is important that all publicly accessible information be updated on a regular basis – at least annually – and that display materials be similarly current. The delivery of mental health services – from a First Line perspective – begins with prevention and early detection and it is these elements of the public information system that need to be most assiduously developed.

Overview of Systemic Issues discussed by the Working Groups

Through the course of their deliberations the Working Groups discussed a wide range of issues that relate to the current system of mental health services in the District that need to be addressed in the design and implementation of a reformed mental health system. The content of the discussions can be categorized and summarized over a range of reoccurring themes.

Systemic Issues

These are issues that apply to the mental health service system and the community within which it exists. They indicate that the current level of understanding of the system both from within and without, needs to be enhanced if there is to be broader acceptance by the community and smoother functioning of the system itself. The issues are more formally addressed in the reports and recommendations of the Research, Human Resources, and Community committees of the Task Force. They are raised here to reflect concerns of the Working Groups and as indicators of the potential barriers to integration that apply equally to all services in a reformed Mental Health System. The Working Groups offered a number of recommendations which are systemic in nature.

Education

It is important to de-mystify terms and identify in clear, unambiguous and understandable language, the functions of the various specialized services, the definition of their roles, and the relationship between services. There is a need for a clear understanding by the public and by family members of consumers, on what the Mental Health system is, how it works, who it serves and to whom it is accountable for what.

Recommended: That public education, and particularly the education of family members of Mental Health consumers, be a priority initiative in the implementation of a reformed mental health system.

Systems organization and interface issues

The critical role of the family physician highlighted – their input into deliberations and role in the system is of primary importance.

- Providing vehicles and incentives to develop amicable relationships within a system's perspective
- Issues of accountability and advocacy need to be addressed
- Coordination challenges identified across specialized populations, across the age span, across the mental health system, across other relevant systems, which are unique for various specialized populations
- Changing needs of individual consumers over their life span present critical coordination issues for all service levels and need to be addressed in the process of Mental Health Reform. Eligibility for some selected programs and services changes with (sometimes) artificially created age requirements.

D) Systems management issues

All of the working groups converge on the urgency of built-in and rigorous accountability and evaluative mechanisms as guarantors of system functioning in the interests of consumers and families. Specifically, deliberations highlighted the necessity of integration efforts to ensure mechanisms for systems evaluation by consumer and others and system and agency accountability which is critical to continually improving the linkages and quality of mental health system.

Specialized services, for example, are currently provided through a variety of funding agencies, including the Ministry of Community and

Social Services, the Ministry of Education, The Ministry of Housing and the Ministry of Transportation. This creates access difficulties for consumers and coordination problems for the system and its agencies. First Line care is delivered through a multiplicity of providers and agencies some of which have only minimal contact with each other – though they may share a geographic catchment! There is a pressing need to explore appropriate models for coordination and the lead agency concept at the community level.

E) Systems Policy Issues

Few reforms would advance the interests of consumers than integration of primary care with mental health – this is the reform long overdue and the one that promises to deliver the largest benefits in the most efficient manner to the greatest number of people. Among the benefits to be realized are:

- 1) less stigmatization of patients and staff as mental health disorders are seen and managed alongside physical health problems;
- 2) improved screening and treatment, specifically improved detection for people presenting with vague somatic complaints which may be related to mental health disorders;
- 3) potentially improved treatment for the physical problems of those suffering from mental illness; and
- 4) better treatment of the mental aspects associated with physical problems.

F) Stigma Reduction and Public Reduction

Changing public attitudes one mind at a time, one family at a time, one community at a time, is a long and labourious process fraught with potential for setback. Yet it is essential as virtually every expert evaluation of mental health reform attests. It is imperative that this public educative role be taken up and carried forward by opinion leaders in all aspects of public life, including business, the arts and politics. Publicly prominent elites must exercise leadership in de-mythologizing mental health and reducing the stigma toward people who suffer from mental illness. Mothers Against Drunk Drivers (MADD) is often cited as a successful example how an intelligent and coherently organized information campaign can raise awareness, alter public opinion and transform popular perceptions of a social problem. Given the pervasiveness of mental health problems and their contribution to the global burden of disease -- mental illness is expected to visit 15% of the global population by the year 2020 -- it is urgent to begin society-wide re-education efforts early and to commit resources to them for the long term until stigmatization of people with mental illness is regarded with the same scorn as drunk driving.

G) Information Sharing & Standardized Assessment

Few things would expedite the progress of mental health reform more than the development of a modern, sophisticated and information and data-sharing infrastructure coupled to assessment instruments that talk to each other irrespective of which service happens to be the first point of contact for someone in a psychiatric crisis. Many such instruments exist and are in wide use, but service and referral patterns, lack of trust and incompatibility between program routines stand as obstacles to information sharing that -- properly integrated -- would benefit consumers, their families and their care providers. Privacy of patient records, of course, cannot be compromised -- but they need not be compromised if the information sharing protocols are intelligently conceived and designed. It takes time to research, develop, purchase (or upgrade) and install the required electronic infrastructure, therefore this initiative too should be set in motion early after thorough consultation with (1) the end users of mental health information and (2) the information system specialists who will operate, maintain and upgrade it.

Chapter Five: References

1. A Comprehensive Mental Health and Support Service System for Adults with Serious Mental Health Problems in Hastings & Prince Edward Counties (District Health Council, 1996).
2. Andrew, Gavin & Scott Henderson eds., (2000). *Unmet Needs in Psychiatry: Problems, Resources, Responses* (Cambridge University Press).
3. Anthony, W.A., Cohen, M., & Kennard, W., (1990). Understanding the current facts and principles of mental health systems planning. *American Psychologist*, 45(11): 1249-1252.
4. Barry, Kathy, "Mental Health Homelessness Initiative, Phase II – Southeastern Ontario District" (PowerPoint Presentation to the MHITF, January 2001).
5. Barry, Kathy, "Mental Health Programs and Services: Southeastern Ontario District," (PowerPoint Presentation to the MHITF, March 2001).
6. Berkeley Consulting Group, Directions for Change in Hastings and Prince Edward Counties (prepared for the Ministry of Health and Long-Term Care, April 2001)
7. Canadian Mental Health Association, Ontario Division, Submission to Darryl Sturtevant, Director, Mental Health and Rehabilitation Reform Branch, Ministry of Health, regarding *Making It Happen* (Implementation Plan for the Reformed Mental Health System & Framework for the Delivery of Mental Health Services and Supports), January 1999.
8. Dewa, Carolyn, *et al.*, Community Care for Individuals Moderately Affected by Mental Health Problems (MMI): Best Practices (Toronto: Centre for Addictions and Mental Health, Clarke Site, nd)
9. Direction for Change in Hastings & Prince Edward Counties (Berkeley Consulting Group, 2001).
10. Family Support & Involvement: Best Practices (British Columbia Ministry of Health and Ministry Responsible for Seniors,
11. Goering, Paula, *et al.*, Best Practices in Mental Health Reform: Discussion Paper (Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health by the Health Systems Research Unit of the Clarke Institute of Psychiatry, 1997).
12. Goering, Paula, *et al.*, Review of Best Practices in Mental Health Reform (Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health by the Health Systems Research Unit of the Clarke Institute of Psychiatry, 1997).
13. Hastings/Prince Edward Counties System Change Project (Centre for Community Change, 1998).
14. *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (Government of Ontario, 1999)

15. Marhaba, Mounir, "The Resident Assessment Instrument: Mental Health," (Powerpoint Presentation to the Provincial Forum of the Mental Health Implementation Task Forces, January 28, 2002)
16. National Health Service (Department of Health, UK), National Service Framework for Mental Health: Modern Standards & Service Models (1999) accessed at <<http://www.doh.gov.uk/nsf/mhnsf2a.htm>> on 14 March 2002.
17. Newman, Dan, "2000 and Beyond: Strengthening Ontario's Mental Health System - A Report on the Consultative Review of Mental Health Reform in the Province of Ontario," accessed on October 10, 2001 at <www.gov.on.ca/health/english/pub/mental/mentalreform.htm>.
18. Stuart, Heather, "A Framework For District-level Governance for Mental Health System Delivery," (Kingston: Prepared for the Southeastern Ontario Mental Health Implementation Task Force, February 2002)
19. Stuart, Heather, "Concurrent Disorders: An Integrated Service Delivery Plan for Southeastern Ontario," (Submitted to the Southeastern Ontario Mental Health Implementation Task Force and the Southeastern Ontario District Health Council on behalf of The Concurrent Disorders Champion Group, January 2002).
20. The Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report, 1996-2000* (March 2000).
21. *The World Health Report, Mental Health: New Understanding, New Hope* (Geneva: The World Health Organization, 2001)
22. Trainor, John, Ed Pomeroy and Bonnie Pape (1993) *Framework for Support* (Toronto: Canadian Mental Health Association) accessed at <http://www.cmha.ca/english/framework/framework_full.htm> as of October 28, 2002.
23. Ziglin, Alan, "Confidentiality and the Appropriate Uses of Data," (Washington, D.D., Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services, May 1995).

Southeastern Ontario District Mental Health Implementation Task Force

Intensive Services Working Group Report

September 2002

Members of The Intensive Services Working Group

The following members of the Intensive Working Group respectfully submit this Report to the Integration Committee of the Southeastern Ontario District Mental Health Implementation Task Force:

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Southeastern Ontario District Intensive Services

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1.0 Introduction

Mission

The mission of the Intensive Services Working Group was to formulate recommendations specific to Intensive Services which ensure implementation of an integrated, accessible and comprehensive reformed mental health service delivery system. This system incorporates many dimensions: age span, urban/rural issues and special populations. The needs and perspective of consumer and family members guided service recommendations. A recovery-based philosophy directed deliberations, which is humanistic and hopeful. This recognizes that people can develop positive social and family relationships, integrate successfully into community and learn to live beyond their illness. Psychosocial rehabilitation principles support the recovery philosophy and are integral to service provision.

The Integration Committee of the Southeastern Ontario District Mental Health Implementation Task Force coordinated and synthesized recommendations from the First Line, Intensive and Specialized Services Working Groups to formulate the substance of their report.

Key issues addressed within the Integration Committee's report:

- *□ Streamlined access;
- *□ Social/recreational needs;
- *□ Employment and educational supports;
- *□ Housing and supports;
- *□ Consumer and family initiatives;
- *□ Restructuring of PCCC-MHS and BPH/ROHCG;
- *□ Common assessment and referral tools;
- *□ Recommendations to achieve integration, (such as identification of lead agency, amalgamations and/or formal agreements incorporating three levels of care; first line, intensive and specialized); and
- *□ Development of a staged multi-year implementation plan, based on CAP findings, Ministry policy, best practices and HSRC directives.

Priority Population

Priority populations included:

- *□ Inpatients currently residing in the divested Provincial Hospitals: Providence Continuing Care Centre, Mental Health Services (PCCC-MHS) and Brockville Psychiatric Hospital, a Division of the Royal Ottawa Health Care Group (BPH/ROHCG); and
- *□ Outpatients and Homes for Special Care residents under the auspices of PCCC-MHS and BPH/ROHCG.

Process

The Intensive Services Working Group outlined six main objectives of the work plan:

1. To define Intensive Services and its component parts;
2. To recommend the role, scope and nature of Intensive Services necessary to meet individualized level of need;
3. To develop a conceptual model for Intensive Services;
4. To examine the current system in order to identify current strengths, present and projected gaps/barriers to implementing/accessing services, potential duplication of services and opportunities for improvements;
5. To provide direction regarding future system design and configuration; and
6. To submit a final report to the Integration Committee.

2.0 Definition of Intensive Services

Target Population

Making it Happen identifies the target population for services within the intensive level of need, as people with serious mental illnesses who have multiple and complex needs and are at risk for repeated or prolonged institutionalizations in health care or correctional facilities. (1)

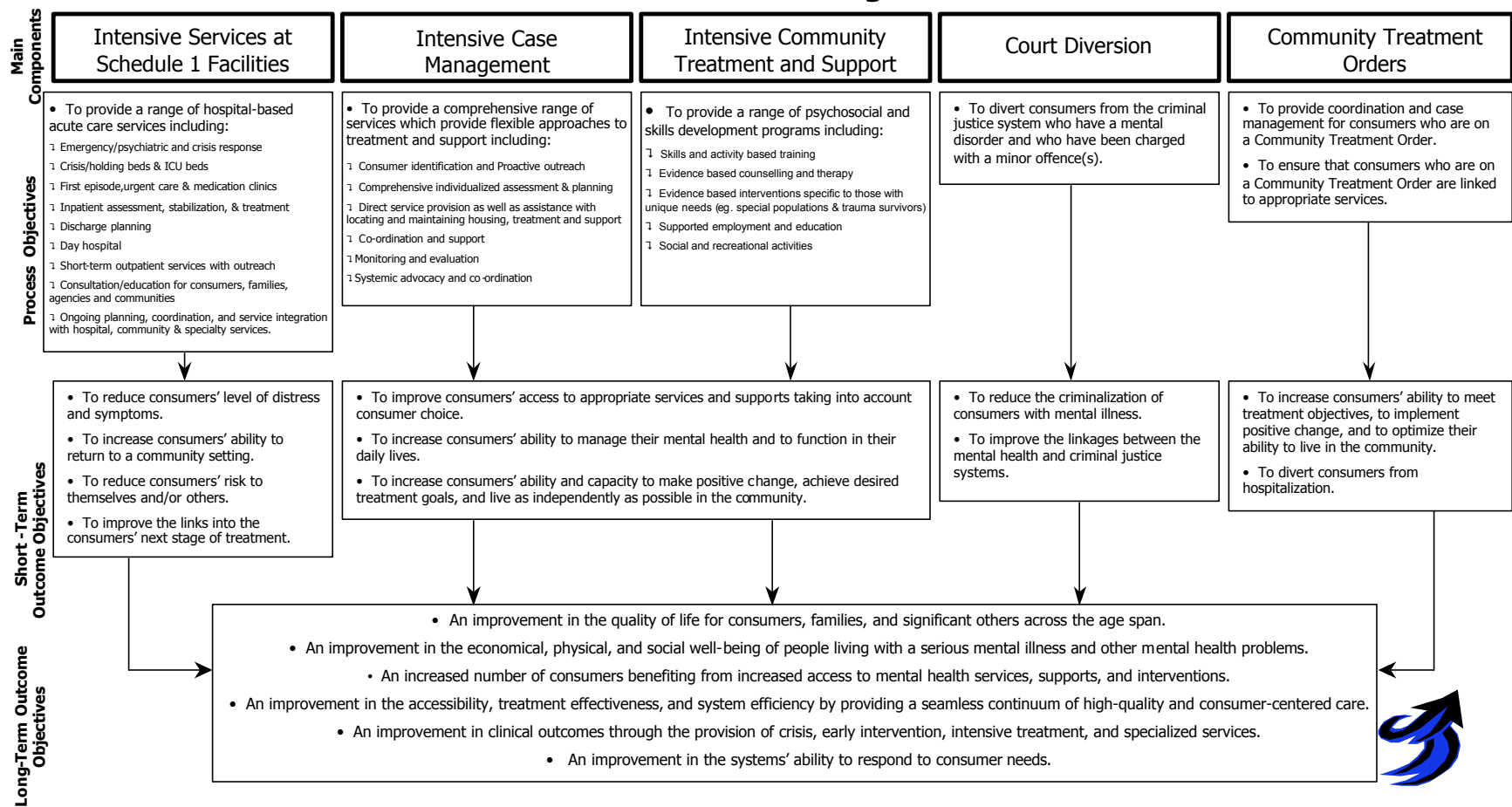
According to *Making it Happen*, Intensive Services include mental health assessment, treatment and support services, which are provided in community or hospital settings. Examples of Intensive Services cited by this document include: intensive case management, housing supports, skill development and psychosocial rehabilitation programs, medication clinics and Schedule 1 inpatient and outpatient services. Intensive Services "... provide on-going continuous contact to those people whose condition is sufficiently stable to require weekly, monthly or less frequent interventions" (1).

Intensive Service Components

The working group identified the main components of the intensive service system as:

- *☐ Intensive Services at Schedule 1 Facilities
- *☐ Intensive Case Management
- *☐ Intensive Community Treatment and Support
- *☐ Court Diversion and
- *☐ Community Treatment Orders.

3.0 Intensive Services Logic Model



4.0 Best Practices in Intensive Services

The existing mental health literature contains information on *best practices* for some, but by no means all, components of Intensive Services. The following section briefly highlights some interesting and relevant best practices.

Triage

Triage is a process, which effectively screens, assesses and prioritizes people, based on a review of risk factors and assessed level of need. Triage instruments have been shown in mental health centers (3) to effectively direct patients to the appropriate sources of care.

Crisis/Psychiatric Emergency Services

Holding beds, staffed by multi-disciplinary teams and located in acute inpatient units or near emergency departments have proven to be effective in permitting an extended evaluation, with the objective of referring more individuals to ambulatory services (4), urgent day clinics, day hospitals or community treatment and support programs. This service offers both less intrusive and restrictive alternative to hospitalization and can be more cost effective, assisting with psychosocial crises.

Home Care Crisis Treatment & Day Hospital

A combination of crisis residence and day hospital was recently reported as effective and less expensive than in-hospital treatment (5,6). Home care crisis treatment may also be effective on its own (7,8) and more cost effective than hospitalization (9).

It has been widely demonstrated that day hospitals are less costly with comparable outcomes; they are able to offer more intensive treatment in a less restrictive environment; shorter lengths of stay; achieve outcomes similar to longer stay admissions; and home-based treatment is effective for many patients.

Case Management

The varied use of the term *Case Management* in the literature makes comparison of evaluation studies difficult. Case Management models include:

- *□ The *Expanded Broker Model* uses a case manager to broker services for the consumer. Its outcomes are sufficiently poor to exclude it from a list of best practices (10);
- *□ The *Rehabilitation Model* focuses on improving consumer living skills through identification of deficits;
- *□ The *Personal Strengths Model* centers on making the best use of the consumers' own resources; and

- ? *Intensive Case Management* is geared to high need individuals and is intended to assist them in remaining out of hospital. It involves frequent contact, proactive outreach, small caseloads, 24-hour availability, and a community-based practice venue.

The most common usage of the term Case Management throughout the literature describes 2 categories that are relevant to Intensive Services: Community Care and Intensive Case Management.

I. Community Care

Terminology includes *Intensive Community Care*, *Community Mental Health Teams*, and *Intensive Psychiatric Community Care*. This category is difficult to summarize, due to the diverse techniques and patient populations studied. However, current evidence suggests the following:

- *□ Managed community care programs lead to improved consumer retention and improved social functioning (11-13);
- *□ Opinion on clinical improvement (11,14) and impact on hospitalization (11,15) lacks consensus; and
- *□ Cost has been found to be both greater than (12), and less than (14), conventional care models.

The major advantage of the above programs appears to be in the area of treatment continuity and social functioning.

II. Intensive Case Management (ICM)

Additional terminology under this heading includes *Case Management*, and *Intensive Clinical Case Management*. The key findings appear to be:

- *□ ICM retains consumers in programs more effectively than standard approaches (16,17);
- *□ Social functioning, in some studies including consumer/family satisfaction and quality of life, is improved (16-20);
- *□ Opinion is divided on whether clinical improvement is (19,20) or is not (17,21) associated with ICM;
- *□ Some studies have shown reduced hospitalization rates (17,21); and
- *□ Costs are higher than conventional approaches (16,18).

The above points are consistent with the conclusions of the most recent systematic review of case management studies (22).

Various Case Management approaches appear suited to promoting continuity of consumer contact and enhanced social functioning and satisfaction but clinical outcomes do not appear to improve. Such tactics may reduce hospital use, but cost impacts are variable.

Community Based Services

Contemporary best practices are designed to minimize the time spent by consumers away from their regular environment. A number of studies demonstrate improved social functioning associated with discharge of long-stay patients; individuals and families prefer community based services to hospitalization; and clinical and social outcomes are as beneficial for discharged patients receiving community based services as for matched counterparts remaining in hospital (1).

5.0 Current Status of Intensive Services

Intensive Services include mental health assessment, treatment and support services provided in the community or from hospital based settings (1). Intensive Services prioritize people with serious mental illness, who have needs that correspond to the Comprehensive Assessment Project's (CAP) Levels 2 and 3: community and intensive community support. Since 1995 significant developments have occurred in community mental health programming and more recently in 2000, with strategic reinvestment funding.

Service gaps exist across all levels of need in Southeastern Ontario. The former Kingston Psychiatric Hospital's CAP identified a need for more investment in psychosocial rehabilitation for the general adult population including life skills, social/recreational, vocational and educational supports and services. It also called for greater access to counselling services and peer support for consumers. The former Brockville Psychiatric Hospital's CAP identified gaps in the domains of self-care and activities of daily living, meaningful activities and social/recreational programs and vocational programs.

Initial Community Comprehensive Assessment Project (CCAP) results indicated that Intensive Services in our district (49 programs) currently serve some 5,000 unique consumers per year, reflecting about a thousand new consumers annually. It is the working group's understanding that the CCAP will provide a comprehensive service inventory and will highlight gaps within the Southeastern Ontario District.

6.0 Intensive Services Recommendations

The recommendations of the Intensive Services Working Group included the consideration of systemic issues, necessary to support the specific Intensive Service recommendations.

6.1 Systemic Considerations

Governance is a key issue that needs to be addressed from at least three critical points:

1) Provincial Service Management:

There is a need for a clearly delineated conceptual framework for mental health issues with visible links to policy, implementation, and funding.

2) Governance and Management of Local Boards and Services:

Transforming such a large and sensitive system may imperil local organizations and requires a revisiting of capacity and membership of local agencies. Preserving the service approaches and local integrity of community-based programs is critical throughout the process of reform. Services need to maintain their local and intimate linkage to consumers, families and communities.

3) Linkage/Co-ordination Mechanisms at a Local Level:

The system will retain its current flaws unless locally linked and co-ordinated to allied systems (e.g. legal services, training, municipalities, etc.).

6.2 Systemic Recommendations

The Health Services Restructuring Commission formulated recommendations regarding the number of long term mental health beds that will remain in the system. All necessary services and supports for current consumers need to be in place, before the number of beds is reduced. Consumers discharged into the community require suitable income, housing, and appropriate treatment and supports matching their individual level of need.

The following recommendations focus on systemic changes necessary to support the specific Intensive Service recommendations:

6.3 Service Integration Considerations

It is imperative to see each consumer as a consumer of the service system and not a consumer of an individual service or support program.

Services must be easily accessible. Consumers, primary care physicians, family members and anyone who works with consumers in any capacity should have quick and simple access to information about mental health services and be able to find help when it is needed. Services need to be provided as close to home as possible and transportation needs to be available.

Timely and effective information-sharing that respects individual preferences and privacy is essential to the development of a seamless system of care. Consumers

and family members should be able to provide personal information once without going through multiple, repetitive intake assessments.

Consumers have periods of wellness and relapse requiring the provision of individualized services and supports varying in intensity over time. There is a need for ease and flexibility in moving in and out of services, as needs and preferences change.

The concept of “Treatment Team” should be modified to include all the necessary services and supports that will facilitate recovery. As much as possible, consumers will have a choice in the services that they receive and will be active partners in collaboratively developing and determining treatment goals. It is essential that community mental health, specialized services and Schedule 1 facilities work together as a team, formally and informally, with each consumer (and family where appropriate) to ensure holistic care.

In order to create a seamless delivery system, there is a need for comprehensive networking, protocols and service agreements with key service providers. Protocols and service agreements support the integration of all relevant services and supports in the system and ensure individual needs of each consumer are addressed. Protocols need to incorporate services and supports funded by other related ministries, such as:

- *□ Justice Services: Corrections, Probation, Parole and Court Diversion (Ministry of Correctional Services, Ministry of the Attorney General);
- *□ Social Services, including Income Support, Developmental Services, Violence Against Women Services, Child Welfare and Children’s Mental Health, (Ministry of Community, Family and Children’s Services);
- *□ Educational services, including academic and vocational education services (Ministry of Education); and
- *□ Services offered by municipalities (e.g. daycare, recreation programs, etc.)

A “Complex Care Committee” needs to be established, to promote creative solutions where services gaps are identified. The committee’s composition should include multi-disciplinary, multi-agency people, who have the authority to make decisions.

Community partnerships need to be developed to assist individual consumers and families who may not, on their own, access mental health services. An example of this would be making treatment and support available to an individual who is living in a homeless shelter in a manner that is acceptable to them. This could mean providing *inreach* to the shelter and/or by providing support to the shelter staff to better assist this person.

6.4 Service Integration Recommendations

In order to address the above considerations, recommendations pertain to all components of the system regardless of governance issues. The working group has identified and discussed human resource implications, which have and will continue to have considerable impact upon consumers, communities, organizations, staff and service delivery throughout the transition process. Consequently, we are recommending strategic and careful phasing in of further integration modifications to the system:

- *□ Recognize that the two geographic areas, Brockville and Kingston, have the majority of the divested PPH hospital's population and allocate services and resources accordingly;
- *□ Acknowledge differences between urban and rural populations for benchmarking purposes;
- *□ Remove barriers to access, exit and re-entry, as service integration is imperative to facilitate consumer movement throughout the system, independent of level of need. Establish streamlined access points, ensuring entry to appropriate services;
- *□ Create an information database, ensuring that the sharing of the consumer's information occurs in a timely manner and conforms to legislative requirements;
- *□ Develop and implement standardized intake assessment, admission and discharge tools, protocols and outcome measures addressing all levels of need, independent of agency/hospital;
- *□ Develop protocols and community partnerships with organizations and institutions outside the formal mental health system, to identify and assist consumers and families who may not readily access mental health services;
- *□ Formally connect Consumer and Family Initiatives within the mental health system;
- *□ Establish and fund formal Consumer, Family Advisory and Advocacy mechanisms at all levels; and
- *□ Review the role of non-Schedule 1 hospitals, in terms of their potential to provide and/or link to the mental health service delivery system.

6.5 Comprehensiveness of Services Considerations

Community based services begin with access to appropriate housing, treatment services and supports.

It is often difficult for consumers to find a family physician to provide medical services and prescribe medication. Accessing dental care can also be a problem. This may be especially difficult for inpatients who will be moving into the community from former Provincial Psychiatric Hospitals that have, in the past, provided these services. Rigorous efforts must be made to ensure that the ongoing needs for medication, medical and dental care, etc. are met.

Telepsychiatry, consultation, support and training need to be made available to address special needs and provide timely support to consumers and professionals in the community. This would include consultation to family physicians, providing psychiatric support to consumers in community mental health programs, and providing support to Consumer Initiatives.

It is important that consumers and family members are made aware of peer support and self-help groups in the community. Independent self-help groups and Consumer and Family Initiatives should be welcomed to provide inreach to consumers in the hospital and through community mental health programs. This on-site personal contact allows consumers and families to learn what is available and makes it easier for them to get connected with these resources.

To address these and other identified systemic issues, the following recommendations were developed.

6.6 Comprehensiveness of Services Recommendations

Provide funding for services as close to home as possible. Satellite clinics are recommended and supported. Sharing locations with partners can reduce costs:

- *☐ Expand inreach and outreach transportation services to meet current, ongoing and projected needs;
- *☐ Fund critical resources such as consultation, sessional fees, support and training to address intensive needs and provide timely psychiatric support to consumers, families and professionals across the District;
- *☐ Invest in telepsychiatry and ensure provincial compatibility;
- *☐ Provide alternate professional compensation plans for mental health programs;

- *□ Ensure medication clinics are available and accessible to consumers across the District;
- *□ Ensure services are sensitive to different populations' abilities to access; and
- *□ Connect with housing and income support services as part of the mental health delivery plan.

6.7 Accountability and Evidence-Based Practices Considerations

Mental health and addiction services have witnessed considerable changes in the last several years, with a myriad of best practice literature, thanks to ongoing research. The ability of all agencies/hospitals to review and provide current best practice treatment varies throughout the District. It would be helpful to have information centralized at a provincial level, allowing easy access.

6.8 Accountability and Evidence-Based Practices Recommendations

Fund a centralized service for the easy access of best practice literature integrating all complex care consumer information. Endorse, fund and support interagency training initiatives:

- *□ Provide evidence-based treatment, rehabilitation and support, in a timely, efficient and effective manner;
- *□ Provide a range of services by regulated professionals and other skilled service providers including peer specialists, all of whom receive ongoing supervision, education and evaluation based on best practices;
- *□ Develop system wide consistent training and educational standards, as well as an integrated and standardized approach to education and continuing training for service providers;
- *□ Train, support and evaluate volunteers as a valuable and essential adjunct to the service delivery system. Volunteers are not surrogates for professional and/or other skilled service providers; and
- *□ Implement ongoing standardized program evaluation and outcome measures, as outlined in the accountability framework.

7.0 Schedule 1 Facilities

Intensive Services at Schedule 1 facilities include the inpatient and outpatient services provided by hospitals, as legislated in the *Mental Health Act*. Services are intended to be short-term and referred to as acute care. When safe and appropriate, strategies reducing inpatient stays, through the use of home treatment and outpatient services are recommended, as a less intrusive alternative to inpatient care.

Schedule 1 services must be capable of providing short-term inpatient assessment and stabilization to people of all ages and specialized needs and facilitate triage to appropriate community-based services.

Each Schedule 1 hospital must have both a family and consumer advisory council that work together. These councils could be part of or associated with community based advisory and advocacy groups and are formally linked with the “Trust”. The role of these councils is to listen to consumer and family concerns and bring issues to the attention of the appropriate people for discussion.

A “Community Connection and Service Plan” (discharge plan) is recommended for each individual who accesses Schedule 1 services. This template will identify and track pertinent issues such as planning for services and supports, contact numbers and agencies providing services, frequency of service, etc. as well as documentation of the outcome of all interactions. This plan will follow the consumers as they move to community-based programs or access specialized services.

7.1 Schedule 1 Facilities Recommendations

Identify and implement benchmarks for Schedule 1 facilities in the District, based on serving people of all ages, all levels of consumer/family need and considering: population base and projected changes, utilization rate, acuity, chronicity, etc. Consider benchmarks, which adequately allow for the appropriate multidisciplinary staffing and funding levels to provide a range of services. Fund Intensive Services including:

- *☐ Emergency/psychiatric and crisis response;
- *☐ Crisis/holding beds;
- *☐ ICU beds;
- *☐ First episode;
- *☐ Urgent care and medication clinics;
- *☐ Short-term inpatient assessment, stabilization and treatment;
- *☐ Discharge planning;
- *☐ Day hospital;
- *☐ Outpatient services, (short-term) with outreach capacity;
- *☐ Consultation/education for consumers/families, agencies and communities and;

- *□ Ongoing planning, co-ordination and service integration with hospital, community and speciality services.
- *□ Review the need for day hospitals and explore creative, alternative community options;
- *□ Integrate in/outpatient hospital and community based services to offer seamless, comprehensive service;
- *□ Define and integrate the roles of the scheduled, acute and specialized hospitals;
- *□ Ensure outpatient services are accessible through the use of satellite clinics, co-located and integrated with community partners;
- *□ Review the needs of complex care consumers including: concurrent, forensic, geriatric, child and youth, dual diagnosis, etc. and build in appropriate treatment and supports;
- *□ Formally link Consumer and Family Self-help support services with Schedule 1 programs. This could include on-site visits from community groups, providing information and making appropriate referrals;
- *□ Transfer Kingston and Brockville Schedule 1 services in a timely manner and ensure integration of these services within the continuum of health care. Adjust time lines to accurately reflect transition needs, synchronize changes to minimize impact on consumers/families and co-ordinate the downsizing of divested PPH facilities with the transfer of the Schedule 1 facilities; and
- *□ Reinforce the need for regulated health professionals and eliminate the use of security staff in clinical care.

8.0 Intensive Case Management

For consumers who no longer require crisis or stabilization services, but who do require ongoing intensive services, longer term care in the form of Intensive Case Management may be appropriate. Case Management generally refers to a multifaceted, multi-disciplined approach designed to help consumers' function at the highest level possible with the least possible restrictions. It is based on close, long-term relationships with the consumer and offers services such as assessment, planning, treatment, monitoring, referral and advocacy.

According to Ministry of Health and Long Term Care policy, the key features of Intensive Case Management services include:

- *□ Development of a caring supportive relationship;
- *□ Emphasis on continuity of care;
- *□ Flexibility in service provision;
- *□ Provision of supports to coordinate a fragmented system of care;
- *□ Provision of service on the basis of individual choice and need;
- *□ Broad referral sources and self-referrals;

Case Management is not a prerequisite for access to other services and supports. Consumers must have a reasonable choice in selecting case managers.

Functions of Intensive Case Management include outreach and consumer identification, comprehensive individualized assessment and planning, direct service provision, coordination and support, monitoring and evaluation, system advocacy and coordination and outreach functions.

Key components of intensive case management programs include: proactive outreach; caseloads of 15-20 or fewer; 20% of consumers being seen more than once per week; more than 50% of service provided outside of office; and 24-hour access to services within the system.

Intensive case management may be appropriate for some former Provincial Psychiatric Hospital consumers who are able to live independently in the community and do not require the level of service provided by and Assertive Community Treatment Teams.

Case management services need to provide both assertive outreach and inreach in the community to ensure that those who are not receiving services have easy access to care. Case Managers need to be assertive and make their services available without being intrusive.

8.1 Intensive Case Management Recommendations

Identify Intensive Case Management service benchmarks based on consumer need, population base and projected changes, utilization rate, acuity, chronicity, etc. Fund a comprehensive range of services which provide a flexible approach to treatment and support that is consistent with recovery, including:

- *□ Consumer identification and proactive outreach;
- *□ Comprehensive individualized assessment, treatment and planning;
- *□ Direct service provision, as well as assistance with locating and maintaining housing, treatment and supports;
- *□ Co-ordination and support;
- *□ Monitoring and evaluation; and
- *□ Systemic advocacy and co-ordination.

- *☐ Ensure the continuity of multidisciplinary Case Management services for the consumer changing accommodation or location;
- *☐ Develop mechanisms to link and integrate ACTT with case management programs as a *step-down* in order to facilitate client access to appropriate services based on changing level of need;
- *☐ Assign each consumer of case management services a primary case manager and a multi-disciplinary team;
- *☐ Ensure that each team includes staff with training, knowledge, skills, experience and abilities relevant to the holistic needs of individual consumers/families; and
- *☐ Prioritize consumers with the highest level of need.

9.0 Intensive Community Treatment & Support

Programs provide a range of treatment, rehabilitation, and support services to consumers in the least disruptive manner in the community and include; individual and group counselling and therapies, psychosocial rehabilitation and skill development programs, (e.g. vocational and educational services), and provide a bridge to crisis services. These programs also provide follow-up and aftercare services.

It is important to address the needs of consumers with a history of abuse, neglect and/or a history of violence. There is a need for a range of co-ordinated services including counselling and long-term support. Children who are being served by Ministry of Community, Family and Children's Services (MCFCS) may have parents who need treatment or support. Mental health services need to work closely with MCFCS, Sexual Assault Centres, Victims of Violence and Violence Against Women programs to ensure that people who need treatment and support have easy access to appropriate mental health services.

9.1 Intensive Community Treatment & Support Recommendations

Identify Intensive Community Treatment and Support Program benchmarks based on need, population base and projected changes, utilization rate, acuity and chronicity etc. Fund a range of psychosocial and skills development programs including:

- *□ Skills and activity based training;
 - *□ Evidence based counselling and therapy;
 - *□ Evidence based interventions specific to those with unique needs (e.g. special populations and trauma survivors).
 - *□ Supported employment and education; and
 - *□ Social and recreational activities.
-
- *□ Ensure that the teams skill mix include: social work, nursing, vocational supports, life skills, peer and family support, occupational and recreational therapy and have the ability to meet the complex needs of speciality populations; and
-
- *□ Build teams on the existing collaborative, integrative approaches that have been implemented to date.

10.0 Court Diversion

Court Diversion services focus on serving people who have a serious mental illness and are accused of committing minor criminal offences. The goal is to divert these people away from the criminal justice system and to provide appropriate community treatment and supports.

10.1 Court Diversion Recommendations

Review the data for the respective services and realign positions accordingly, based on consumer need and population projections:

- *□ Provide standardized policy and procedures for all of the Southeastern Ontario District, complete with intake, admission, after care plans; and
- *□ Develop interagency service agreements and protocols to integrate Court Diversion services with the local crisis response teams, community mental health agencies and their respective Schedule 1 facilities.

11.0 Community Treatment Orders

The Ministry of Health and Long Term Care has recently provided funding for case coordinators and case managers for individuals with community treatment orders. Case coordinators coordinate community treatment planning between hospitals, community programs and physicians to improve the integration between high volume Schedule 1 facilities and community agencies, to facilitate Community Treatment Orders and promote liaison with Emergency Rooms to assist consumers more efficiently.

Case managers ensure that services are available for persons on Community Treatment Orders as well as others requiring coordinated community treatment. This service emphasizes continuity of care (i.e. treatment and supports are provided as long as required and across services and program settings), with flexibility to meet a person's perceived and changing needs and choices over time.

11.1 Community Treatment Order Recommendations

Review the data from the one-year pilot project and realign the case management and case coordinator positions based on identified projected consumer need, with respect to geographical distribution. ACT teams may already service many of the consumers. Consider the appropriateness of attaching CTO services to ACT teams:

- *☐ Ensure that the services of the CTO staff are delivered in a co-ordinated fashion, and as one Southeastern Ontario District team, integrated within the service delivery system.

12.0 References

1. *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (Government of Ontario, 1999)
2. Health Systems Research Unit, Clarke Institute of Psychiatry. *Review of Best Practices in Mental Health Reform* (Ottawa: Federal/Provincial/Territorial Advisory Network on Mental Health, 1997), XX.
3. Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle 98195, USA. Field test of a tool for level-of-care decisions in community mental health systems. *Psychiatric Services*. 49:91-97, 1998.
4. Gillig PM, Hillard JR. Bell J. Combs HE. Martin C. Deddens JA. The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*. 146:369-372, 1989.
5. Sledge WH. Tebes J. Rakfeldt J. Davidson L. Lyons L. Druss B. Day hospital/crisis respite care versus inpatient care, Part 1: Clinical outcomes. *American Journal of Psychiatry*. 153:1065-1073, 1996.
6. Sledge WH. Tebes J. Wolff N. Helminiak TW. Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *American Journal of Psychiatry*. 153:1074-1083, 1996.
7. Joy CD. Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*. 1:2002.
8. Fenton WS. Mosher LR. Herrell JM. Blyler CR. Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. *American Journal of Psychiatry*. 155:516-522, 1998.
9. Knapp M. Marks I. Wolstenholme J. Beecham J. Astin J. Audini B. Connelly J. Watts V. Home-based versus hospital-based care for serious mental illness. Controlled cost-effectiveness study over four years. *British Journal of Psychiatry*. 172, 506-512, 1998.
10. Bedell JR. Cohen NL. Sullivan A. Case management: the current best practices and the next generation of innovation. *Community Mental Health Journal*. 36:179-194, 2000.
11. Tyrer P. Simmonds S. Joseph P. Marriott S. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database of Systematic Reviews*. 1, 2002.

12. Thornicroft G. Wykes T. Holloway F. Johnson S. Szumukler G. From efficacy to effectiveness in community mental health services. PRiSM Psychosis Study 10. *British Journal of Psychiatry*. 173:423-237, 1998.
13. Sellwood W. Thomas CS. Tarrier N. Jones S. Clewes J. James A. Welford M. Palmer J. McCarthy E. A randomised controlled trial of home-based rehabilitation versus outpatient-based rehabilitation for patients suffering from chronic schizophrenia. *Social Psychiatry & Psychiatric Epidemiology*. 34:250-253, 1999.
14. Rosenheck RA. Neale MS. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*. 55:459-466, 1998.
15. Tyrer P. Evans K. Gandhi N. Lamont A. Harrison-Read P. Johnson T. Randomised controlled trial of two models of care for discharged psychiatric patients. *British Medical Journal*. 316:106-109, 1998.
16. Johnston S. Salkeld G. Sanderson K. Issakidis C. Teesson M. Buhrich N. Intensive case management: a cost-effectiveness analysis. *Australian & New Zealand Journal of Psychiatry*. 32:551-559, 1998.
17. Holloway F. Carson J. Intensive case management for the severely mentally ill. Controlled trial. *British Journal of Psychiatry*. 172: 19-22, 1998.
18. Issakidis C. Sanderson K. Teesson M. Johnston S. Buhrich N. Intensive care management in Australia: a randomized controlled trial. *Acta Psychiatrica Scandinavica*. 99:360-367, 1999.
19. Chan S. Mackenzie A. Jacobs P. Cost-effectiveness analysis of case management versus a routine community care organization for patients with chronic schizophrenia. *Archives of Psychiatric Nursing*. 14:98-104, 2000.
20. Chan S. MacKenzie A. Ng DT. Leung JK. An evaluation of the implementation of case management in the community psychiatric nursing service. *Journal of Advanced Nursing*. 31:144-156, 2000.
21. Wykes T. Leese M. Taylor R. Phelan M. Effects of community services on disability and symptoms. PRiSM Psychosis Study 4. *British Journal of Psychiatry*. 173:385-390, 1998.
22. Marshall M. Gray A. Lockwood A. Green R. Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. 1: 2002.

SPECIALIZED SERVICES
INTERIM REPORT

Submitted For Consideration to

The Integration Committee of the Southeastern Ontario Mental Health Implementation
Task Force

July 2002

PREFACE

This report is respectfully submitted to the Integration Committee. It provides a vehicle and a foundation for discussion and outlines implementation directions and recommendations necessary to achieve a reformed system that is responsive to all diverse populations and across the life span.

The purpose, functions, activities, co-ordination and accountability of specialized services to achieve the goals of a Reformed Mental Health System, will require significant changes in philosophy and approach with implications in resource allocation, human resource knowledge, skills and experience, co-ordination and accountability and

Critical to these "Specialty" changes is a complementary shift and realignment in the first line and intensive mental health services, i.e. the locally based mental health program/services, and the associated health and social services.

The specialty populations and families/caregivers are diverse in their need and characteristics. This diversity demands two major important characteristics of our new reformed mental health system. We require a mental health system:

1. that is accessible, able, accountable, and responsive to all individuals with mental health needs, and
2. a mental health system appropriately linked with associated health and social services/programs.

These associated health and social services are significantly different in their form, functions and their array of services in terms of scope, depth, breadth and purpose for each specialty population. The mental health system, therefore, must be developed to be complementary and supportive to these different associated services. There must be accessible, able, co-ordinated and accountable development of the associated services with the mental health system for reform to be achieved. Without this, the primary goal of improving the quality of life, self-determination, recovery and decreased burden of illness for specialty populations will not be achieved.

In order for specialty services to move to community based, locally accessible and able mental health services for all populations, the local mental health services will need to evolve so that it is not an exception but an expectation that these diverse populations will be served.

Through reform, one mental health system will be developed for all those with mental health problems, thereby decreasing fragmentation and improving the utilization of the knowledge, skills, experience and services of all mental health providers.

Significant input and work was completed by the Specialized Working Group members. A special thanks to these members who shared their knowledge, time and, more important, their passion in identifying the challenges and critical directions required. The consumer and family representatives were critical to keep the Working Group's activities centered on consumer and family needs, and the service providers, academics and planners provided valuable insight and expert knowledge on "What needs to be built on, What needs to change, and the factors and challenges to "Make It Happen".

This report reflects the working group's thoughts, ideas and advice, and draws upon knowledge from key informants, the Champion Groups of the Southeastern Ontario Mental Health Implementation Task Force, Provincial Committees on Specialized Populations and Services, and literature provided by the Policy and Research support of the Task Force.

The report may not reflect all the diverse opinions of those involved, but represents a Best Practice driven consensus approach. It is the expectation that continued input and dialogue will occur and be critical in the next consultant phase of the Southeastern Ontario Mental Health Implementation Task Force. This consultation process will draw upon the thoughts, ideas, concepts and directions from a variety of individuals to help enrich and refine the recommendations and directions as they relate to the Specialty Services and Populations to ensure a comprehensive final submission.

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SPECIALIZED POPULATION HEALTH PROGRAMS AND SERVICES

KEY ISSUES AND KEY DIRECTIONS

THE RIGHT SERVICE

AT

THE RIGHT PLACE

AT

THE RIGHT TIME

FOR

THE RIGHT REASON

AT

THE RIGHT COST

CHAPTER I

INTRODUCTION; SPECIALTY POPULATION HEALTH SERVICES, A RESOURCE TO LOCALLY BASED MENTAL HEALTH

The mandate of the Specialized Working Group was to provide recommendations regarding an implementation plan for Specialized Services and a Reformed Mental Health System while taking into account Policy, Legislation and needs of varying populations of people in both urban and rural settings and across the life span ensuring a balance between people with severe mental illness and others with mental health problems.

The report provides

1. A Common Approach and Implementation Guidelines (overarching framework) for the delivery of Specialized Services for all populations for Southeastern Ontario
2. A set of directions and recommendations for each Specialty Population.

The report is based on input from the Specialized Working Group members, opinion leaders and key informants in the field, Provincial Policy documents and Panels, Champions of the Southeastern Ontario District Mental Health Task Force, and literature from the Policy and Research supports of the Task Force. In addition, previous legacy planning documents as well as existing service delivery and district and local studies were used to inform, guide and formulate the implementation directions.

The key directions and recommendations were driven by:

- ✍ needs of the diverse populations across the life span
- ✍ principles defined by *Making it Happen* and the MHI Task Force
- ✍ a consumer responsive, integrated, co-ordinated, accessible and knowledgeable based local mental health system
- ✍ best practices
- ✍ district co-ordination, locally driven approach
- ✍ consistency of approach
- ✍ multi-level complementary development and accountability at the consumer, service provider, and systems level
- ✍ co-ordination, accessibility and ability of the locally based mental health services and programs and associated services for each specialty population.

Definition of Specialty Services

Specialized services are described in *Making it Happen* as those specialized mental health services that are designed and delivered in the community or hospital settings to meet the needs of people with serious mental illness who have complex, rare and unstable mental disorders.

Specialized services are not necessarily long term services, but relate more to the level of service intensity at a given time for a given reason.

Making it Happen and other related Ministry Policy, Panels and initiatives emphasize the role of Specialty Services as providing not only direct services, but places increased emphasis on Specialty services role as a "resource" to the community.

Making it Happen, Policy Initiatives and Directions, identify that specialty services engage in direct services for the seriously mentally ill that cannot be served by first line and intensive mental health services, and provide increasing and focus on shared care, support, education, collaborative program and systems development with community agencies and organizations, both within the mental health systems and associated programs and services. Specialized Services have also been defined (where applicable) as providing academic leadership, ensuring the delivery of best practices and discovery and applying new knowledge and program evaluation.

Optimal arrangements for specialized services involve the provision of localized, integrated specialized services with relevant community partners in the mental health system and associated systems in so far as possible (Wasylenki, et al, 2000). It is with these principles, directions and best practices in mind that a "Common Framework and Implementation Guidelines" and set of recommendations have been developed.

Goals

The Specialized Working Group defined two major goals.

- A. Development of a Southeastern "Common Framework and Implementation Guidelines" for Specialized Services that defines generic operating principles, functions, core components, and strategic implementation directions and actions.
- B. Development of implementation strategies for specific specialty populations and groups across the age span.

The development of specific implementation recommendations were based on:

- ✍ The needs of varying populations in both urban and rural settings,
- ✍ A review of the present strengths, gaps and challenges
- ✍ Priorities for feasible strategic actions
- ✍ Existing and proposed policy and legislation related to Mental Health
- ✍ Meeting mental health service needs across the life span of the consumer
- ✍ Achieving a required balance of services to be available both to people with serious mental illness and to others with mental health problems.

Process

The Common Framework and Implementation Guidelines and Population Specific Directions and Actions were based on analysis and review of Principles and Values of *Making it Happen*, the MHI Task Force, review of present and future needs, previous

planning documents in the District, expert opinion and Best Practice literature as well as Policy Direction and Strategies of the MOH LTC.

The "Common Framework" was further refined by identifying the common themes and Best Practice models for specialty services in relationship to specialty populations.

This "Common Framework" provides a solid conceptual foundation for planning and implementation of specialty services for each specialty population.

As a part of its process the Working Group received and reviewed presentations, reports, and proposals related to Special Population Mental Health services including reports and presentations from Dual Diagnosis, Acquired Brain Injury, and Concurrent Disorders, Forensic, and Mental Health, Adult seriously mentally ill requiring specialty services, (including those with severe personality disorders).

CHAPTER 2

COMMON FRAMEWORK AND IMPLEMENTATION GUIDELINES FOR SPECIALIZED POPULATION HEALTH SERVICES IN SOUTHEASTERN ONTARIO

Making it Happen identifies the importance of developing a solid foundation for Specialty Populations. The move to community based, accessible service demands that Specialty Services perform the fundamental role of ensuring individuals with complex needs are served effectively and efficiently both locally and in all areas of the district. It has also been identified that the locally based services need to be able to deliver the Best Practices as they relate to these diverse populations.

Co-ordinated, linked, and accountable specialty services are therefore critical for comprehensive, locally based care to provide services for all populations. In addition, specialty services must engage in and with their locally based mental health partners, in ensuring that associated services are skilled, accessible and linked with the mental health system services and programs

Making it Happen also identifies the need for associated programs and services that provide care for complex diverse specialty population be linked, co-ordinated and developed in a complementary, mutually beneficial manner with mental health reform.

At present consumers, providers, planners and the public are often confused by the diverse roles, functions and often fragmented service delivery approaches of the varying specialty services for each population.

These issues speak to the need for the development of a "common" accessible, accountable, and able mental health system for all populations.

With these factors in mind an "overarching consistent approach" was developed for specialized services. The Common Framework and Implementation Guidelines for Specialty Services provides a "home" to define the goals, functions, service delivery approaches, co-ordination, accountability, accessibility components for all specialty programs and for each specialty service to develop.

The Common Framework and Implementation Principles Guidelines for Specialty Services is based on and consistent with a reformed set of concepts and approaches (see Appendix I) and outlines a set of required components (see Appendix II).

Why this Approach "A Common Framework and Implementation Guidelines for Specialty Services"?

Adopting a common framework and implementation guidelines will:

- a. Enable an understanding by all stakeholders of specialty population mental health programs, mandates, roles, functions and service delivery models
- b. Provide an opportunity for cross-exchange of innovative service knowledge and approaches discovered in one or other of the specialty population health programs

- c. Provide a vehicle for consistent evaluation and a development of a common vision, common language and common approach for specialized services throughout Southeastern Ontario
- d. Allow for a clearly defined set of roles, interfaces, implementation, and accountability structures for specialty services
 - a. Across the age span
 - b. Between and within specialty services
 - c. With associated relevant ministerial services for given populations
- e. Provide a consistent approach and a vehicle for reform to ensure consumer responsive, locally and community centered, accessible, able and accountable care for all populations
- f. Provide a conceptual approach and a framework for implementation of specific specialty population mental health implementation strategies
- g. Ensure a mechanism to look at a balance between direct services capacity enhancement strategies
- h. Provide a vehicle for health promotion, disability prevention and ensure that locally based delivery and a recovery approach is implemented.

THE COMMON FRAMEWORK AND IMPLEMENTATION GUIDELINES FOR SPECIALTY SERVICES FOR SOUTHEASTERN ONTARIO

Principles and Approach for Specialty Population Mental Health Services

A number of unique conceptual approaches have been identified as a foundation for the Common Framework and Implementation Guidelines. These conceptual foundations are derived from the needs of the populations, Ministry directions, Best Practices and in moving forward to allow specialty services to be a "resource" to locally based mental health systems in Southeastern Ontario.

Introduction

The Common Framework and Implementation Guidelines enable a reformed, accessible, able and viable mental health delivery system which will be able to serve the diverse populations with complex needs across the life span. The following section of the report details the

1. Present Realities/Issues
2. Reformed Principles and Approaches and Implications for a Reformed System

I Principle/Approach

1. Specialty Services as a resource (functions)

a. Present reality/issue

Focus of specialty services are on direct services

b. Reformed principle and approach- in the reformed system an increased emphasis on specialty service as a resource will be implemented in a phased in manner. Specialty services will provide support and education to locally based mental health and associated services through:

1. Direct care as required and necessary, but with an understanding of continued involvement as appropriate of locally based mental health and associated services and continuity of care by the locally based mental health and associated services.

2. Capacity enhancement and support

In addition to the direct provision of services which will include in patient service or short-term assessment and treatment services, specialty services as a resource will provide the following additional functions

- a. Shared care - involving the provision of augmented care, support and education by specialty services as appropriate to locally based mental health services and associated services.
- b. Education - the specialty services will deliver new knowledge and skills in mental health care to locally based programs and services. This will be accomplished through educational methods that have been shown to be effective and will include the utilization of adult learning principles, service/learning strategies, the establishment of specialty based resource centres, and other effective continuing educational activities.
- c. Program and systems development - specialty population mental health services will engage in a pro-active manner to work with locally based mental health and associated services to provide the continuing enhancement responsiveness and ability of programs and services to serve the needs of all the diverse populations across the life span.

II Specialty Population Health Services; Locally Based, Locally Delivered, Locally Driven and District-wide Supported and Co-ordinated.

- a. Present reality and issues: specialty services, for the most part, are centrally located and delivered. Furthermore, specialty services lack co-ordination and accountability as well as integration with locally based mentally health and associated programs.
- b. Reform Principle and Approach - Specialty population mental health services will be located as much as is feasible and viable within the locally based area, i.e. as close to home as possible. Specialty services will be co-located, linked, and integrated with locally based mental health services and associated systems.

Each specialty population health services will define a set of core services and programs for each specialty population that will be

1. Housed in the local community
2. Delivered in the local community
3. Provided on a district-wide basis but accessible to all areas in Southeastern Ontario

The delivery of all specialty population based mental health services will be prioritized along the following continuum.

Locally based services — locally delivered services — district-wide accessible services

As much as possible, services will be locally based and delivered. However, final determination will consider needs, best practices and viability of options for each of the specialty populations.

III Principle/Approach Specialty Services as a Resource to Serve all services and programs that are required and used by individuals with complex mental health needs, which will include both mental health services and associated services.

a. Present System/Issue

At present, many specialty services are focussed on direct, centralized services. Specialized services are often disconnected from their locally based mental health and associated systems. Mental health services are not well co-ordinated with associated services that are used by individuals with mental health needs who have complex problems.

There is a lack of co-ordination, accessibility and accountability of specialized services to both the mental health system and associated services and programs

b. Reform Principle/Approach

Specialty Population Mental Health Services will act as a resource not only to the mental health system but to other programs and services used by the consumer and family, and will provide leadership in linking associated services within the mental health system

IV Principle/Approach

Specialty Population Mental Services will, as a whole, be responsible and co-ordinated and accountable to locally based mental health systems and associated systems. There will be a designated lead organization that will be responsible for the overall co-ordination, accountability and delivery of services for each specialty population mental health service.

a. Present System and Issue

Specialty Services are not well co-ordinated and accountable to each other. This results in lack of effective utilization of specialty services as a whole for communities in Southeastern Ontario. Specialty Services are often available in one local community and not another. In addition, specialty services for each specialty population are, in some cases, fragmented and working poorly together to serve their communities.

b. Reformed Principle and Approach

Specialty Services will be reformed into a specialty population mental health program with a lead agency/organization responsible and accountable for the delivery and development of all specialized services for a given population.

V Principle/Approach, Specialty Population Mental Health focus from a Specialty Service focus.

a. Present System and Issue

At present, there is no accountability for a given specialty population within the mental health system. In addition, specialty populations have no agency, organization or lead responsible for the overall population health and well-being as it relates to mental health.

There is also a deficiency in terms of specialty services providing population focused services, but universal, targeted and overall community development strategies.

During their deliberations the Task Force it was also identified that there is "no avenue" for a consumer or a provider to provide feedback on the overall system of mental health for a given population.

b. Reform Principle and Direction

Specialty services will be designated as Specialty Population mental health programs that are responsible and accountable for overall mental health services for a given population in Southeastern Ontario.

Specialty Population Mental Health Services will engage and develop strategies with mental health and other partners to improve the well being, self-determination of specific populations through not only clinical services, but also community development strategies, (universal and targeted initiatives). Specialty Population Mental Health Services and Programs will provide increased emphasis on early detection, health promotion and disability prevention for each of the specialty populations.

VI Principle/Approach

Joint Collaborative Specialty Population Health Programs and Locally Based Mental Health Services

Specialty Population Health Programs will work jointly with locally based Mental Health Services and associated services.

The goal of this joint collaboration will be to ensure that the programs and services in a locally based mental health and associated services provide accessible and able care for diverse populations across the life span.

a. Present Approach/Issue

Locally based mental health services and associated services are often unable or unwilling to serve the diverse population with complex needs. In addition, specialty services are not co-ordinated or integrated with locally based mental health services and associated systems in their local community.

b. Reformed Principle/Approach

Specialty Services will be integrated, co-ordinated and engage in a collaborative manner with the locally based mental health programs and associated services to ensure that the diverse specialty population health services are served in a responsive, accessible and able fashion. There will be a shift from diverse populations being seen as the exception for locally based mental health and associated services to an expectation that these individuals will be served by these services and programs.

VII Principle/Approach Strategic Phased in Development

Priority phases of development of Specialized Population Mental Health Programs will follow the following priority continuum.

The priority:

- a. The establishment of specialty outreach services
- b. The establishment and implementation of community specialty direct stabilization and rehabilitation services for each of the complex populations
- c. The realignment of specialized inpatient services and development of facility based stabilization and rehabilitation programs.

a. Present Approach/Issue

At the present time there is a diversity of components of specialized services which vary across each of the specialty populations. Direct community specialty rehabilitation and stabilization services do not exist for some specialty populations and not others. ACT

teams which are direct community specialized rehabilitation and stabilization services often are unable or unwilling to serve the diverse populations.

b. Reformed Principle/Approach

Through the continuum of priority identified above, specialized outreach services will be implemented and developed as appropriate for each specialized population meeting the benchmarks that are required for the populations in Southeastern Ontario.

Specialty Direct Community Rehabilitation and Stabilization Services will then be implemented as appropriate for each population and linked and accountable to the specialized outreach services and lead agencies of the Specialized Population Mental Health Programs.

Specialized inpatient realignment and specialized facilities providing rehabilitation and stabilization (locally based and delivered as much as possible) will be provided only for those that cannot be served by other components of the specialized mental health.

CHAPTER II

COMMON FRAMEWORK AND IMPLEMENTATION GUIDELINES FOR ALL SPECIALTY SERVICES

IMPLEMENTATION RECOMMENDATIONS

The recommendations that create a common framework for specialized services are summarized . They build on the policy frameworks and guidelines issued by the MOHLTCⁱ and on the directions established by the Community, Research and Human Resources committees and incorporate many of the concepts for governance and accountability that have been recommended for the Task Force.

These recommendations are aligned with the Principles and Approaches defined previously.

Component I

Consumer centered and family/caregiver responsive
Population Health Strategy.

RECOMMENDATION 1

Each specialty service(s) for each specialty population develop and implement a template and implementation strategy that is consumer centered and responsive that provides:

- 1.1) *Individual:* Meaningful input at an individual level
- 1.2) *Program:* Appropriate, meaningful input at a program level, including among others, effective input in
 - Planning and development,
 - Feedback from all diverse populations within the specialized population group,
 - Across evolving service needs of each consumer group,
 - Ensuring input from all areas within the district.
- 1.3) *Systems input:* That an implementation strategy be developed to enable meaningful input and feedback on the continuum of services both across the health care journey as well as between components of the system by consumers, their families, and caregivers.

RECOMMENDATION 2

That a population health and general public health strategy be developed that:

- 2.1) Addresses issues of stigma surrounding mental illness by developing, among others, a method to
 - ✍ Obtain information about mental illness,
 - ✍ Obtain information about mental health services (see resource centre).
- 2.2) That specialty services with their partners develop a recruitment strategy that targets existing and future health providers, including young people (through the inclusion of a curriculum on special populations) and mid-career adults
- 2.3) That a strategy be developed to identify, educate and engage opinion leaders in the community to support mental health development and address stigma both inside and outside the mental health system
- 2.4) That each Specialty Population Mental Health Program develop and implement a District-wide Public Education/Human Resources Development

Component II

Specialty Services as a "Resource"; Key issues, Recommendations, Implementation and Strategic actions.

In line with Ministry Policy and Best Practices identified by the specialized working group, specialty services will provide a balance of direct services and collaborative service capacity enhancement activities. This approach will provide an enabling mechanism to move to community centered care and provide a vehicle for continual quality improvement as well as effective use and access of specialty inpatient services. This approach emphasizes a shift in the balance towards community development and support services.

RECOMMENDATIONS 3

- 3.1) Specialty services will provide a balanced set of activities and functions which promote the Principles and Directions of Mental Health Reform.
- 3.2) That the activities and roles of specialty service will include a balance of activities for each specialty population consisting of:
 - ✍ Direct specialty services (Inpatient and community),
 - ✍ Shared care,
 - ✍ Education of public, consumers/providers/programs, organizations and systems,
 - ✍ Collaborative program development,
 - ✍ Systems development,
 - ✍ Academic and program evaluation (as appropriate).

- 3.3) That the balance of activities will be determined by the needs of each specialty population, taking into account the associated services that support the mental health populations.
- 3.4) That the realignment from direct specialty services to increased emphasis on capacity enhancement activities occur in a phased process with increased emphasis on shared care, education and support of care providers, care programs, and care system development as the reform is implemented.

Implications and Strategic Action Recommendation

- 3.4.1) *Enhanced Allocations*: This will require enhanced allocations, reinvestments and incentives to ambulatory (support and capacity enhancement), outreach, and community-centered development and support activities.
- 3.4.2) *Recruitment and Development*: A human resource recruitment and development strategy with an emphasis on increasing knowledge and skills that will enable practitioners to be involved effectively in shared care education, community development approaches and evaluation, in addition to direct clinical care.
- 3.4.3) *Capacity Enhancement*: Realignment from direct services to increased emphasis on capacity enhancement activities will only be effective if appropriate dedicated resources and allocations exist within first line, intensive and associated services to enable the appropriate support by specialized care through their capacity enhanced roles (See Figure 1).

Figure I: Roles and Activities and Target Groups for Specialized Populations under the Reformed Mental Health System

Target Groups	Direct Clinical	Shared Care	Education	Joint Program Development	System Development	Academic/ Program Evaluation
Client/ caregivers	✍	✍	✍			
Care providers	✍	✍	✍	✍	✍	✍
Care Programs				✍	✍	✍
Care Systems		✍	✍	✍	✍	✍

Note: Joint Programs and system activities (community development) will be implemented through various modalities and approaches. Successful strategies have involved development assignments, joint service educational, program and organizational

projects, service learning agreements, projects that incorporate a focus on service education and program changes simultaneously as well as the establishment of Networks (to be described later).

- 3.4.4) *Benchmarks*: That each specialty service define benchmarks for the distribution of activities and resource allocation between direct service, support, and capacity enhancement strategies, and create a phased implementation plan that will meet these benchmarks (i.e. the geriatric psychiatry outreach has identified a 70% clinical shared care activity balanced with 30% involvement in education program and system development as an appropriate benchmark).
- 3.4.5) *Evaluation*: Each specialty mental health population program develop an evaluation framework that reflects and promotes the activities and directions defined above.

Component III

Specialty Services Locally based and driven; District-wide co-ordinated and supported

A responsive, accessible specialty service system that is locally based, integrated, co-ordinated and supported on a district level that provides a method to delivery on a continuous basis Best Practice information, education, expert support to the local regions and fosters co-ordination such that all district expertise is available throughout the geographic area.

RECOMMENDATION 4

District-wide Specialty Mental Health Population based programs develop such;

- 4.1) That for each specialty population a Specialty District-wide Specialty Population Mental Health Program be established and supports locally based and driven specialty activities and provides district-wide specialty support and co-ordination.
- 4.2) That this District-wide Specialty Program consists of two components - locally based and driven specialty services, and district-wide co-ordination and support services.
- 4.3) That for each District-wide Specialty Program:
 - 4.3.1) Establish a locally based community specialty service centre in each district that is integrated and co-ordinated with relevant local services ensuring geographical, and equitable access.
 - 4.3.2) District co-ordination, and support component; that these district-wide co-ordinated specialty services consist of 3 components:
 - 1. *Ambulatory Services* that are locally accessible and driven and provided as close to home as possible. The purpose of this

component is to: i) support locally based specialty services in an equitable manner, ii) co-ordinate district-wide activities, iii) ensure access of all specialty services no matter where they are located in Southeastern Ontario, iv) ensure continuing development, dissemination and delivery of Best Practices and new knowledge, v) co-ordinate and implement academic and program activities as appropriate,

2. *Resource Centres* will ensure access to the district of resource material, literature, as well as experts. These resource centres will utilize technologically supported methods including telepsychiatry, web based support structures and innovative service delivery mechanisms that provide advice and broker specialty information (both services and clinical information),

3. *District-wide Specialty Inpatient Services*

- 4.4) That a plan be submitted for specialty services for each population by the first year (2003) for review and approval by the Ministry of Health and Long Term Care.

Recommendation and Guidelines for Specialty Services re: Location and Integration of Specialty Services

- 4.5) That all services that should be provided in the district be provided as close to home as possible,
- 4.6) That all specialty services should be co-located and/or functionally integrated with local delivery mental health and associated services,
- 4.7) That all specialty services, wherever they are located, are considered part of an overall district-wide specialized service program for each population,
- 4.8) That district-wide services be provided on an ambulatory basis, as much as possible, and delivered in the local area,
- 4.9) That district-wide services are provided in an equitable, accessible, streamlined manner to all parts of the district,
- 4.10) That unique specialty services such as specialty inpatients provide equal access to, and be functionally integrated with, other community specialty services.

Component IV

Lead Agencies and Specialty Co-ordinating Networks

At the present time there is no accountability of designated lead to enable and ensure continued development and co-ordination of the system of care for each specialty population and/or specialty service.

It is recommended that a designated specialty population lead be established for each specialty population to ensure the co-ordination, strengthening, development, provision of advocacy and education for a given population and array of services is ensured.

RECOMMENDATION 5

- 5.1) That the Ministry of Health and Long Term Care designate a lead agency for each specialty service (i.e. specialty inpatient, outreach, ACTT, RTF) for each population,
- 5.2) To support the conceptual shift to locally driven and developed activities, the lead agencies and specialty services should be integrated and co-ordinated with the district lead agencies in terms of planning and delivery of services (as appropriate).
- 5.3) **NETWORKS:** District-wide and local network development or alternative operational planning and co-ordination strategies be implemented.
 - 5.3.1) *Networks:* That for each specialty population a local/district network be developed that involves specialty services for that population and relevant local stakeholders from mental health and relevant associated systems. The specialty designated lead and specialty services would be involved as partners and will enable the establishment and continued operations of these networks for each population.

These Networks would:

- ✍ Improving care through co-ordination and collaboration,
- ✍ Act as an advisory body for review and development of services related to this specialty population,
- ✍ Provide a forum for meaningful system input and development,
- ✍ Provide a mechanism for consumers and families to provide input and feedback on the system of care, as a whole.

- 5.3.2) *District-wide co-ordinating bdy:* It is further recommended that a district-wide co-ordinating council be established that brings together the three district networks and/or leadership for each population, and that an individual/body be designated to provide dispute mechanism resolution when issues arise in terms of hard to serve individuals and/or system wide issues.

Centres of Excellence

That for those Specialized Population Mental Health Programs that meet the criteria, Centres of Excellence be established that would;

1. Involve the designated Specialty organization/agency
2. The network of services providing care for the specialty population

3. Be formally affiliated with Queen's University, Department of Psychiatry

The Centre of Excellence would

1. Be affiliated with other relevant Southeastern Ontario Specialty Programs
2. University of Ottawa and Eastern Ontario Specialty Population Programs
3. Relevant Provincial Academic and Clinical Organizations

The Centre of Excellence would

1. Establish a comprehensive continuum of services that form an academic learning network
2. Engage in development, implementation and evaluation of state of the art education for present and future health care providers
3. Bring science to service and services to science (applied research)
4. Facilitate and implement system wide health service innovation and evaluation
5. Provide knowledge, skills, advocacy for improved well-being of specialized population.

Component V

Integration and Co-ordination

1. With mental health services first line and intensive,
2. Associated services,
3. Across age span,
4. Within and between specialty services.

Recommendations at the Ministry Level

- 6.1) That the Ministry of Health and Long Term care promote the immediate implementation of a process to develop a policy framework and implementation guideline Provincially to be implemented locally for specialty populations (as stated in *Making it Happen*, page 38).
- 6.2) That the Ministry of Health and Long term care implement a process of reviewing relevant policy in other associated systems who provide care to individuals with mental health needs, including harmonizing the policy directions and initiatives at the Ministry relevant to each of the specialty populations. This includes among others primary care reform, long-term care development, etc.
- 6.3) It is further recommended that the common framework for specialized services at the Provincial level be developed to draw on the knowledge, expertise and work done to date at the Provincial level for Specific Specialty Populations.

Recommendations at the District level:

Co-ordination, First line, Intensive Services, Mental Health Services

Best Practices in co-ordination and integration as well as collaborative care have identified the importance of

- a) Bilateral commitment,
- b) Bilateral joint allocation of resources in developing a comprehensive integrated system,
- c) Bilateral accountability,
- d) Importance of internal champions in each sector responsible and accountable for the integrating process,
- e) Concurrent activities of service, education, program changes and administrative support.

Given the above, the following Recommendations are suggested.

RECOMMENDATION 7

- 7.1) That first line and intensive services need to identify and develop internal champions or resources to support, develop, and enhance their services so they are sensitive to each specialized population,
- 7.2) That bilateral accountability be mandated to both specialty services and first line and intensive services to engage in joint development activities,
- 7.3) That evaluation and accountability frameworks be established to review, revise and monitor joint commitments of the various components and levels of service ensuring a consumer responsive system.

Integration and Co-ordination of Associated Services

- 7.4) That associated key service and systems be identified for each population,
- 7.5) That the partners identified and define a comprehensive continuum of services and interfaces,
- 7.6) That a multilateral accountability framework that promotes and ensures joint concurrent and complementary development across the health and social programs and services used by those with mental illness.

Integration and Co-ordination Across and within Specialized Services and Continuity across the age span

- 7.7) It is recommended that there be integration and co-ordination across and within specialized services and that there be continuity across the life span. It is recognized within specialty services that there are diverse populations with differing sets of needs. In addition, specialty services are defined not only in terms of age criteria but also in regards to needs. This results in a lack of understanding and appreciation, at times, of the roles and responsibilities of each specialized service. This may result in a lack

of appropriate collaborative-shared care approaches between specialty services across the age span.

- 7.7.1) That the lead agencies for each specialty population work together to define service agreements that will ensure continuity across the age span and between specialty services.
- 7.7.2) That these service arrangements be submitted to the Ministry of Health and Long Term Care and used to evaluate and monitor the system.
- 7.7.3) That the service agreements act as a basis for continued network review and be modified depending on Network Recommendations and consumer input.
- 7.7.4) That the service agreements act as a dispute resolution mechanism for hard to serve individuals.
- 7.7.5) That a district-wide dispute mechanism (e.g Clinical Director of the district-wide network) be designated as responsible for dispute resolution to ensure hard to serve individuals are matched with the appropriate services.

Component VI

Human Resource Strategy: from professional to performance and skilled based recruitment, education and development.

To move to specialty services as a resource to serve the diverse population needs and provide services that are community-centred and supportive will require the recruitment, retention and re-education of care providers so they are able to provide the array of direct services, as well as capacity enhancement activities including shared care, education, collaborative program systems development (community development), program evaluation and academic leadership (as appropriate).

RECOMMENDATION 8

That a Human Resource template be developed for each specialty service for each population to match the needs as well as the roles and activities of specialty services. Figure III.

Figure III: Human Resource needs to meet the Functions and Diverse Populations

Knowledge/Expertise	Specialty Population A	Specialty Population B	Specialty Population C
Direct services			
Shared Care			
Education			

Program & system development			
Program Evaluation			
Academic Activity			

Component VII

First line and Intensive Service (Development of Internal Resources)

RECOMMENDATION 9:

That First line and intensive services identify and develop internal resources that are sensitive to specialized populations and which specialty services will be able to link collaborate and support for each specialty population (i.e. internal champions).

Component VIII

Service Components: Aligned with Specialty Populations: see Logic Model

The diversity of specialty components defined for specialized services needs to be determined based on the needs of each specific population. The array, depth and balance of the specialized services defined in the Logic model will vary dependent on the needs of the population, as well as the associated services that support their needs, outside of the mental health system.

RECOMMENDATION 10:

That each specialty service develop a plan that defines specialty components compatible with the needs of the specialty population and the mental health associated systems (for each specialty population and that provides a vehicle for moving toward a reformed community mental health system.

Component IX

Evaluation Framework

RECOMMENDATION 11:

That an evaluation framework be developed for each specialty service/population that promotes and provides work load and outcome measures. This evaluation framework should be aligned and promote specialty activities such as shared care and capacity enhancement strategies

Component X

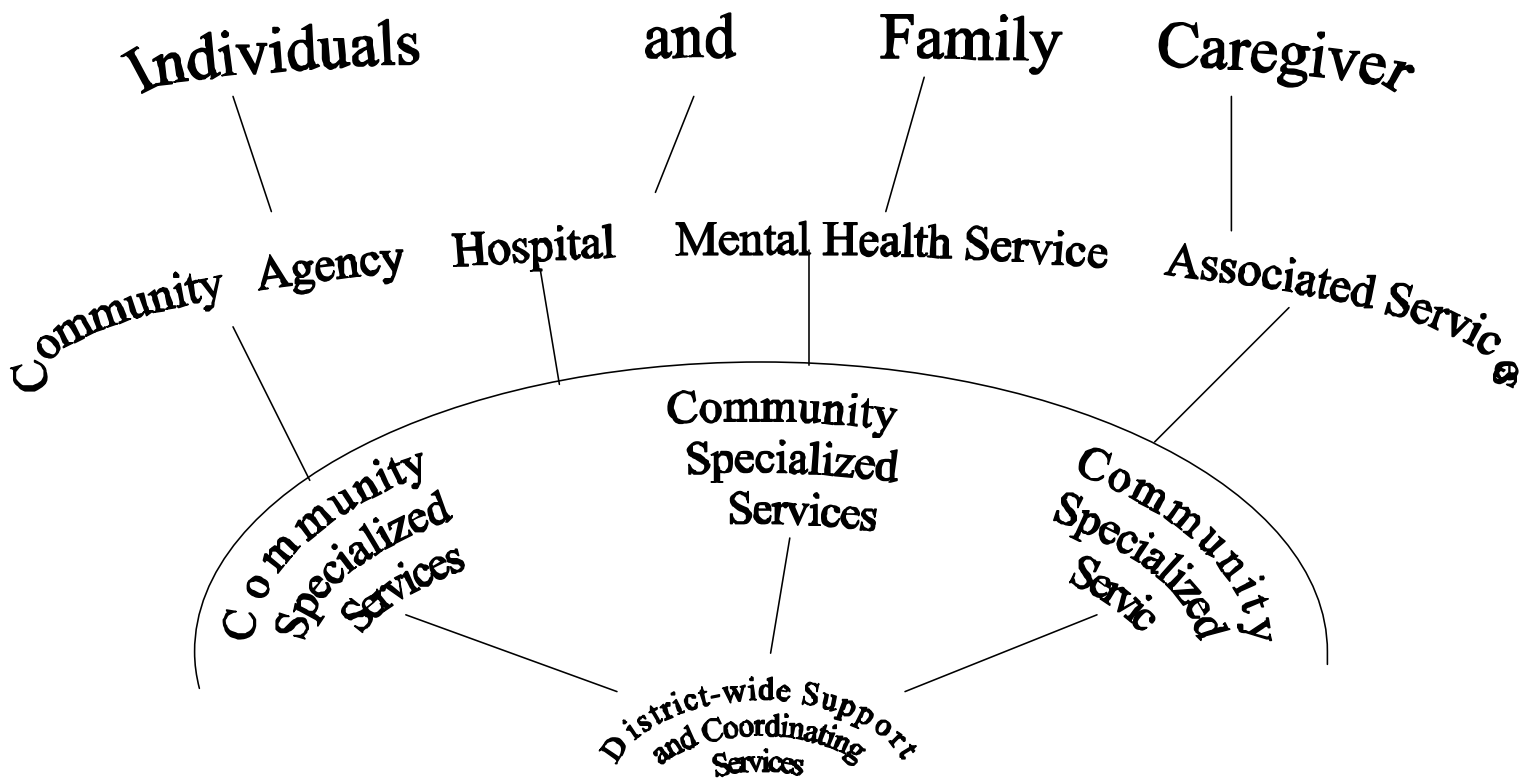
Joint Development and Continued Quality Improvement

The activities of direct services and capacity enhancement, shared care, education and program systems development with community partners provides a vehicle for continued education and continued delivery of Best Practices to the community.

RECOMMENDATION 12:

- 12.1) That specialized services develop service learning strategies for each population to ensure continued development,
- 12.2) That specialty services develop collaborations with colleges and universities to develop and implement the strategy for continuing improvement through education. The strategies used should draw on the best practice education literature that results in changes in practice and improved clinical outcome.

Figure II



District-wide Support and Co-ordinating Services

1. District-wide Ambulatory services
2. Resource centre
3. District-wide inpatient services

District-wide does not necessarily mean based centrally, in fact, these services should be based locally and should have district- accessibility.

BEST PRACTICES ALIGNED WITH FUNCTIONS AND SERVICES OF SPECIALIZED POPULATION HEALTH PROGRAM

The literature informing Best Approaches in Mental Health for Specialized Services is derived from work done in each of the Specialty Population mental health research areas.

The evidence and literature varies in terms of its depth, across specialty populations and service components. A more thorough review of "what we do know" and a summary of the literature can be found in the attached Specialty Reports.

There are, however, common themes and common approaches that can be derived from reviewing the literature across specialty populations and these have been used in developing the Common Framework and Recommendations.

Specialty services, as a resource, engage in shared care, education, program and system development. Literature on Shared Care provides useful insight into successful collaborative methods and approaches. A recent summary of shared care between Family Physicians and Psychiatrists has been completed by Craven *et al* and summarized by Kates. This literature identifies the critical importance of joint activities, cross sector programs, education and program administrative supports to foster effective change. It also identifies some of the critical elements in regards to collaborative care (Burley).

Best Practice in education also inform Specialized Population Mental Health Services as they increase their activity in education. Davis, *et al* in the New England Journal of Medicine analysed continuing educational initiatives that have been successful in changing practice or outcomes. These Best Practice initiatives involved strategies such as opinion leaders, academic detailing, and audit with feedback. Common to all the approaches was the combination of what he identified as precipitating, enabling and reinforcing components. This literature will be important in terms of informing specialized services about effective ways to implement capacity enhancing strategies necessary to develop the locally based mental health system. In addition, extensive literature exists within the Adult Educational Literature that will be useful in informing the education, function, and delivery of a reformed system.

Finally, Organizational Development and Change literature, as well as the Mental Health Consultation literature (Caplan), provide critical insights into approaches for program development and system change, which is a major focus for the Reformed Specialized Population Mental Health Programs activities.

These include the importance of combining and integrating service, education and administrative support, ensuring that there are joint accountability and internal champions in each of the organizations. In addition, the mental health consultation literature identifies the importance of non-hierarchical arrangements, the concept of marginality where the consultant is both within and outside the system so they can make meaningful

change and the importance of "psychological" match between programs engaging in collaborative development.

In summary, the Best Practice literature for Specialized Population Health Services involves not only the literature that has been developed for each of the Specialty Populations, but also involves the literature contained in organizational change and development, education, mental health consultation and shared care.

SUMMARY OF RECOMMENDATION TO IMPLEMENT SPECIALIZED POPULATION MENTAL HEALTH PROGRAMS

Provincial Level Recommendations	How	Who Responsible	Where	When
That the Ministry of Health and Long-Term Care move forward with developing a solid Provincial conceptual foundation for the work with <u>all</u> Specialty Populations to ensure a capable and sensitive set of services and programs within an integrated community treatment foundation.	(1) Set up a Ministry of Health and Long-Term Care Provincial Committee with community leaders and political leaders to develop the framework using best practices and through analysis of the submitted MHITF reports.	Ministry of Health and Long-Term Care	Provincial Level	In next three months
That the Ministry of Health and Long-Term Care consult with other program areas and Ministries as to the implications for specific populations and work to ensure consistent, compatible, and integrated policy directions.	That the Ministry of Health and Long Term Care with other relevant Ministries and community stakeholders convene in an Inter-ministerial Task Force.	Premier		Next six months

District Level Recommendations	How	Who Responsible	Where	When
That the Regional Office, in consultation with the Mental Health Implementation Task Group and/or Public Trust, appoint a lead organization/ agency for each Specialty Population Mental Health Program that will be responsible for the Specialty Population Health overarching, co-ordination and development.	Ministry of Health and Long-Term Care Regional Office in consultation with the Mental Health Implementation Task Force and/or Public Trust	Ministry of health and Long-Term Care Regional Office	District Level	September 2002
The District-wide Specialized Population Mental Health Programs will include: 1) Seniors 2) Children and Youth 3) Forensics 4) <u>Persistent and severely mentally ill adults</u> population including personality disorders 5) Acquired Brain Injury and Mental Health 6) Concurrent disorders 7) Dual diagnosis And that a Clinical Director be appointed for each District-wide Program	Ministry of Health and Long-Term Care Regional Office in consultation with the Mental Health Implementation Task Force and/or Public Trust Adults with severe and persistent mental illness requiring specialized services (includes personality disorders)	Ministry of health and Long-Term Care Regional Office	District Level	Dec. 2002

District Level Recommendations	How	Who Responsible	Where	When
That the District-wide Specialty Population Mental Health Programs be responsible and accountable for: a) Overall support of the local based community mental health programs and services in respect to their designated populations. b) Responsible and accountable with community partners, i.e. first line, and intensive services for ensuring that the overall capacity of the Local based mental health system has the capacity to serve their designated populations c) Be responsible and/or ensure implementation for their respective populations at four levels ? Community development ? Universal/Public ? Target ? Clinical Activities d) Provide leadership in the district and local development of relevant associated services and programs for each population e) Jointly engage with the locally based mental health services and support to ensure co-ordination and complimentary development of relevant associated services	Through the District-wide Specialized Population Health Programs development of Networks and other forums and/or other district and local consultation and collaboration develop structures including: 1. Engagement in and support of local planning and delivery 2. Investment in and support of capacity enhancement strategies through a shared care education program and systems development.	District-wide Specialized Population Health Programs	This will occur at the three local levels and the district level	Six months to two years

SPECIALIZED POPULATIONS HEALTH PROGRAMS (RE SPECIALIZED SERVICES)

Integration and Co-ordination

Recommendation	How	Who	Where	When
That the Specialized Population Based lead be responsible and accountable for overall co-ordination and development of all specialty services for a given population.	Designated by MOHLTC and the Mental Health Implementation Task Force. Through the development of service organizational protocols as well as networks that ensure access of individuals from one specialty service to another and ensure the specialty programs as a whole are responsive and accountable to the local community mental health services. The specialty population based programs would be responsible to develop a co-ordinating and integrating networks which ensured effective input and feedback from the local communities as far as the overall specialized service delivery for other populations.	MOHLTC Specialized population health program leads with partners	District level District level and local level	Next 3 months
That the specialized population health program lead be responsible and accountable for integration and co-ordination across the age span and with other specialty services	Designated agency in partnership with other specialized services develop service agreements and co-ordinating networks and dispute mechanisms to ensure the continuum of service over the age span between specialty services.	Specialized population health program with other specialized services and community partners	At the district and local level	6 months on
The specialized population health specialized lead be responsible and accountable for overall function of the specialized services resource to the local community mental health systems ensuring: 1. accessibility 2. local delivery and district co-ordination 3. District-wide information and referral	Through integration and planning and development and through collaboration with partners in the local community mental health system	First line intensive and specialized services across the district	At the district and local level	6 months on

SPECIALIZED POPULATIONS HEALTH PROGRAMS (RE SPECIALIZED SERVICES)

Integration and Co-ordination

Recommendation I	How	Who	Where	When
That the specialized population health program/lead develop an operational plan for specialized services that : 1. That each specialty service for each specialty population develop and implement a template and implementation strategy that is consumer centered and responsive providing for meaningful input of consumers and family members at an individual program and systems level. 2. That specialized services provide a balanced set of activities and functions which promote the principles of mental health reform and reflect the unique needs of each specialty population. That the activities and functions of specialty services will include a balance for each specialty population consistent with the needs of that population, i.e. direct care, shared care, education, program and system development and evaluation and academic leadership as appropriate. 3. That the services will include specialty outreach, specialty community direct rehabilitation and stabilization services, specialty facility rehabilitation and stabilization services, specialty inpatient services 4. That the balance of activities and functions will be determined by the needs of each specialty population and the unique needs of various sub groups within	Specialized population health program with its community partners develop a multi-year plan to phase in the recommendations that will meet the objectives identified from 1 - 9	Specialized population health program with mental health partners and other associated partners	At the district and local level	First year of operation

the specialty population groups. 5. That realignment from direct specialty services to increased emphasis on capacity enhancement activities will occur in a phased in process with increased emphasis on shared care, education and support of care providers and care programs, care system development as the reform is implemented. 6. That district-wide specialized programs be created for each specialized population consisting of two components: 1) a locally based and driven specialty services and 2) district-wide co-ordination and support services including inpatients. 7. That the priority continuum be aligned with development and implementation of - Specialty outreach - Specialty community direct rehabilitation and stabilization services - Specialty inpatient and facility based rehabilitation and stabilization unit. 8. Where appropriate, Centres of Excellence be established for specialty populations. These will provide leadership in service, education, research and planning for their specific populations and act as a resource both locally, regionally, provincially and internationally. These Centres of Excellence will develop inter-district collaborations and provincial collaborations with other Centres of Excellence as appropriate. 9. That the district-wide co-ordination and support components provide three district-				

wide services. i) Ambulatory services ii) Resource Centres iii) Inpatient services				

SPECIALIZED POPULATIONS HEALTH PROGRAMS (RE FIRST LINE INTENSIVE SERVICES)

Recommendation	How	Who	Where	When
That the specialized population health program in partnership with first line intensive services continually engage in the development of joint projects, activities and capacity enhancement strategies to ensure that the overall system is sensitive and capable of serving various population groups.	Designation within each of the agencies programs in the first line and intensive services of internal resources dedicated to each of the specialty populations who will be responsible and take leadership for ensuring capacity enhancement and development within their organization or level of care and to work in collaboration with the other components of the local and district community mental health system for that given population	Each organization within first line and intensive and specialized services as well as internal champions and those designated relevant associated services	At the district and local level and organization al level with support from the Regional office as well as with support of Public Policy at the Provincial level	Within the next year

INTENSIVE SERVICES

That each intensive service has the percentage of resources consistent with need, prevalence and population figures for each of the unique population groups

Recommendation	How	Who	Where	When
That for each of the specialty populations Schedule I facility the expectation (not exception) that all individuals will access Schedule I services and programs.	Through collaborative shared care approaches between the specialty population health program specialty services and the Schedule I facilities. Through network developments where issues of systems coordination dispute mechanisms and accessibility are addressed	The specialized population health program specialty services and first line services	At all Schedule I facilities	Within the next nine months

SPECIALIZED POPULATIONS HEALTH PROGRAMS (RE FIRST LINE)

Recommendation	How	Who	Where	When
That first line services have the capacity and internal resources to ensure capable, sensitive services for each of the specialty populations and that the specialized population health program ensure that the intensive and specialized services are integrated, co-ordinated and supportive of the continued capacity enhancement and support for the first line services for their population.	Through network development lead by the specialized population health program Internal champions identified and supported for each specialty population. Identification of challenges and barriers and addressing of those barriers	Led by the specialized population health program and partners with support from MOHLTC	At the district and local level	Six months on

D. CHAPTER 4

SPECIFIC POPULATION MENTAL HEALTH SERVICES

Specific population recommendations were formulated for 7 groups of specialized populations including: Child and Youth, Seniors, Dual Diagnosis, Concurrent Disorders, Acquired Brain Injury and Mental Health Problems, Adults with Severe and Persistent Mental Illness requiring specialized supports, and the Forensic populations.

What is the potential demand for Specialized Services?

Population change in the SEO District.

The Mental Health system in the Southeastern Ontario District serves a current population of 496,500 which is expected to grow to 525,500 in the next ten years. The composition of that population within the age groupings will also change, showing a decline in the population of children by 10,270 and an increase in the population of seniors by 10,040. For planning purposes it is important to anticipate population change when determining where and how much services will be provided.

SEODMHITF - POPULATION CHANGE SUMMARY

	<u>2001</u>	<u>2006</u>	<u>2011</u>	<u>Change</u>	<u>% Chg.</u>
Ontario	11,861k	12,536k	13,198k	1,337k	11%
District	496,500	511,600	525,500	28,500	5.90%
Hastings	125,000	129,900	133,900	8,900	7%
Prince Edward	26,600	27,700	28,500	1,900	7%
Lennox & Addington	40,800	41,600	42,500	1,700	4%
Frontenac	138,900	141,200	142,900	4,000	2.80%
Leeds & Grenville	100,600	103,600	106,300	5,700	5.60%
Lanark	63,900	67,600	71,400	7,500	11.70%
By Age					
0-14	88,920	82,450	78,650	-10,270	-12%
15-64	331,530	348,760	360,670	29,140	9.60%
65+	76,180	80,200	86,220	10,040	13%

Data extracted from "Ontario Population Projections" – Ont. Ministry of Finance, July 2000

The prevalence of Mental Illness among this population

There are a variety of estimates on the prevalence of mental illness and its various components that can be applied to the base population of the District. The Working Committee on Specialized Services reviewed a number of reports and proposals that included “prevalence” estimates for particular population groups. It should be noted that all such estimates come with strong warnings that estimating prevalence is not an exact science and that figures, produced mainly from sampling data with wide variability, should be used with caution. Prevalence data is often not well defined – it may reflect the prevalence of an illness during a lifetime, during a particular year, or at any given time. Different published estimates, used for different purposes, apply to different groups [e.g. the estimate that 2.5% of the population is seriously mentally ill is applied variously to the total population, the total population over 19 yrs old, or the total population aged 15-64] In order to use published prevalence estimates for planning purposes, it will be necessary for the Integration Committee, with the help of the research committee, to undertake a thorough analysis of the prevalence of mental illness in the Southeastern Ontario District.

Table 1: Prevalence Estimates of Mental Illness in the District for each Specialized Population.

PREVALENCE ESTIMATES - Southeastern Ontario

<u>Category</u>	<u>2001</u>	<u>2011</u>
All mental illness @ 18.6 %	92,349	97,743
Seriously Mentally Ill @ 2.5 %	12,414	13,137
Concurrent Disorders @ 50% Of SMI	6,208	6,568
Developmental Disability @ 1 %	4,965	5,360
Dual Diagnosis @ 40% of Dev. Dis.	1,986	2,140
Children and Adolescents with mental health problems @ 18.1%	16,094	14,235
Children SMI	Not known	Not known
Seniors @ 15%	11,427	12,933
Seniors Requiring Direct Specialty Care @ 2%	1524	1724

*

Note: These are estimated for mental illness. the prevalence for children is for a broader group of those individuals with mental health needs.

The Availability of Specialized Services

Table #2 below provides a generalized overview of the availability of specialized services on a county basis throughout the District. It does not, however, indicate the extent or volume of services provided. It indicates that a large component of the specialized services in the Districted are provided on a District-wide basis through the Providence Continuing Care Services and that some counties within the district have PCCC as their only identified source for some services. For example Prince Edward and Hastings counties rely on PCCC Geriatric Program assessments, and for MOHLTC sponsored Child and Adolescent services. Detailed planning of service distribution and location will require careful analysis to determine what, if any services will need to be present and

available in each county and the analysis will need to take into account the impact of the PPHs downsizing and the services established through the Strategic Re-investment funds.

Table # 1

Distribution of Specialized Services in Southeastern Ontario

	Hastings, Prince Edward	Lennox & Addington, Frontenac	Lanark, Leeds & Grenville	District-wide Service Available
ACTT	P	P	P	
Psychiatric Assessment Planning, Consultation	P	P	P	
Dual Diagnosis Assess./Referral/Consult.		P	P	
Psychogeriatric Assess./Referral/Consult.			P	P
Psychogeriatric Mobile				P
Residential Treatment				Addiction s System
Specialized Inpatient/Outpatient	P			PCCC
Child and Adolescent		P		Hdh,Cmh, CAS
Forensic Services	F	P		PCCC

(Legend: F is funded and P is planned)

POPULATION GROUP RECOMMENDATIONS

Seniors:

1. Outreach: Augmentation to reinvestment funding be provided to bring the Specialized Outreach Services to the Clarke Benchmarks.
2. Establish specialized direct care community stabilization and rehabilitation service, i.e. ACTT like, geriatric teams for the district that will 1) serve all groups except those with longstanding severe mental illness that grow old who will be served by the adult ACTT teams; 2) that the specialized direct community stabilization and rehabilitation services should be functionally integrated with the specialty outreach teams and the specialty outreach teams should act as a conduit before admission to the community stabilization and rehabilitation services and facilitate discharge to lower levels of intensity of care, as appropriate; 3) specialty stabilization and rehabilitation will provide direct services to not only maintain the people in the community, but also to facilitate discharge.
3. Maintain adequate beds for specialty inpatients for the target groups, i.e. beds for behavioral problems and dementia, beds for mood and psychotic disorders of late life; beds for those with medically ill psychiatric needs. It is further proposed that the number of beds in the long-term care mental health system be approximately 40% of the long-term care beds. This is aligned with benchmarks established in Britain and elsewhere and is consistent with the planning and implementation that is already occurring at the Royal Ottawa/Champlain district.

4. Reserve 5 bed equivalent to support inpatient services for medically ill with significant mental health problems combined with a designated GAU.
5. Maintain and develop district-wide, ambulatory support services that consist of:
 - a) District-wide ambulatory teams;
 - b) Specialized district-wide outpatient services;
 - c) Resource centers that are technologically supported; i.e. provide triage and support to access information, best practices, mental health services by experts, and resource material. This resource service should be developed in line with best practice resource center developments in the province and incorporate a brokerage and educational function.

Schedule I:

1. That there be dedicated resources/beds in Schedule I inpatient beds; that the dedicated resources beds be aligned with the population prevalence of the elderly and anchored to that rate over time.
2. Intensive community resources; that the intensive community resources have the capacity capability and dedicated resources for the elderly population; that the percentage of resources be again based on population prevalence figures over time.

Children and Youth

1. That the specialty services be consistent with the overall direction of specialty services identified in Southeastern Ontario and be consistent with the Logic Model developed for specialized services.
2. That specialized services for children and youth should include specialized inpatients. The Health Services Restructuring Commission designated eight beds for the Southeastern District.
3. District-wide specialized services should include specialty outpatients, district-wide unique services and a resource center.
4. Comprehensive outreach services need to be established to integrate seamlessly with intensive and first line services. The specialized spectrum of services (1 to 4 above) should foster reintegration into the community from more structured specialized services as well as prevent unnecessary hospitalization.
5. Better processes be undertaken to identify the need for Residential Treatment Facilities (Rehabilitation and stabilization services)

6. With the exception of the Canadian Academy of Child Psychiatry's Position Paper stipulating a ratio of one child and adolescent psychiatrist per 4,000 children and adolescents (or 6 per 100,000 population), there are no benchmarks with regard to the provision of the full spectrum of child and youth mental health services delivered by different disciplines of mental health professionals.
 - 6.1) In relation to child psychiatrists, this ratio applies to the clinical needs only and does not address the needs for research, teaching, training and administration. In tertiary care medical centers, child psychiatrists are available 0.6 FTE for clinical service. District population estimates indicate a recommendation that a minimum of 7 FTE tertiary care child psychiatrists are required to deliver the necessary service, teaching, research and administrative services
 - 6.2) It is recommended that the Southeastern Ontario District take the initiative, with other districts, in establishing benchmarks for service delivery in child and youth specialized mental health services.
7. Specialized psychiatric district-wide outpatient services should have sufficient clinical personnel and resources to provide:
 - 7.1) Assessment and intervention hospital-based clinic for client/consumers with neuropsychiatric and neurocognitive disorders, externalizing disorders, mood and anxiety disorders, eating disorders, psychotic disorders and forensic services (parenting capacity assessment/ YCJA assessments)
 - 7.2) A change in the MOHLTC funding model for child and adolescent forensic psychiatric services from the "separate vote" model to inclusion within the global budget of the host hospital
 - 7.3) Hospital-based day treatment
8. A seamless integration in service provision for 'transitional' youth moving because of age from child and adolescent to adult specialized psychiatric services
9. Specialized psychiatric district-wide consultative services to provide:
 - a. Hospital-based urgent (less than 72 hours) consultation for emergency department physicians and community referral agents e.g. MCSS agencies, schools and family physicians
 - b. Hospital-based consultation to the Department of Paediatrics inpatient services and specialty clinics
 - c. Outreach consultation via travelling clinics or telepsychiatry to district MCSS CMHC agencies and Children's Aid Societies and family physicians

Dual Diagnosis

I: RECOMMENDATIONS REGARDING SPECIALISED SERVICES

1. Mobile Consultation and Outreach Treatment Teams - multidisciplinary, accountable teams offering clinical consultation, assessment, education, client advocacy, linkage development between services, crisis intervention and treatment planning services to both first line and intensive service providers and to families - need to be established which are able to employ the facilities of generic mental health services (Including acute care beds and the spectrum of community resources). These teams would combine both the consultative and treatment and stabilization functions

- 1.1) The proposed Mobile Outreach Teams must be capable of outreach to rural areas,
- 1.2) Mobile Outreach Teams must, to be optimally effective, and include direct treatment, rehabilitation and stabilization components in their programming,
- 1.3) Mobile Outreach Teams must include a forensic psychologist to liaise between services for dual diagnosis and forensic/corrections services.
- 1.4) These services - which might be based upon the UK's Community Specialist Mental Health Services for People with Developmental Disabilities - will be available locally which means that such teams are needed for each of the three county areas to service the Districts' approximately 2140 clients.

2. That Queen's University evaluates the relative effectiveness of specialized (dual diagnosis) Assertive Community Treatment and Consultation & Outreach in providing dual diagnosis treatment services.

Assertive community treatment (ACT) is a defined approach to providing ambulatory services to people with mental health problems. An ACT team for the dual diagnosis population is in place in Lanark, Leeds & Grenville, and the plan is for funding to continue. Consultation and outreach treatment services will be established in the other two county groupings. As such, there is a unique opportunity to compare the effectiveness of the two approaches to providing services for people with a dual diagnosis.

3. The establishment of three purpose-built Stabilization and Rehabilitation Residential Facilities (Extended Residential Treatment)

- 3.1) Capital funding is needed to enable each of the hospitals in the three county groupings to sponsor 'purpose-built' accommodation for the extended treatment units and for professional teams providing ambulatory services.
 - 3.1.1) Extended Treatment Units - on the model of the UK's Mental Impairment Evaluation and Treatment Units -- should be

created for those individuals where specialized care requires a longer length of stay than is typically permitted under current guidelines for acute-care psychiatric units in general hospitals.

- 3.2) A lead agency for the Extended Treatment Units (stabilization and rehabilitation residential facilities) ought to be created for each of the three county areas.
 - 3.2.1) The *Making it Happen* document defines residential treatment as follows: “These facilities provide specialized services in a residential setting for people who require a higher level of support in order to be discharged from long term hospitalization. The function of the residential treatment facility is to facilitate transition to independent housing for the more complex and disabled provincial hospital residents. Long-term care is not synonymous with specialized care. Treatment, rehabilitation, and support services are integrated within each program/service type and provided through a multidisciplinary team approach.”
 - 3.2.2) For the population of individuals with a dual diagnosis, we project the need for specialized stabilization and rehabilitation residential facilities. Inpatient care in a specialized units should be reserved for situations where there has been a poor response to "intensive" acute-care psychiatric interventions and where specialized inpatient treatment entails a longer length of stay than is typically permitted under current guidelines for acute-care psychiatric units in general hospitals.
 - 3.2.3) Currently, much of this type of service is provided in tertiary institutions (e.g., Brockville Psychiatric Hospital). As access to these institutions becomes limited, there will be a need to establish a local alternative for people requiring longer inpatient care. If this part of the Framework is not established before the reduction of beds and provision of services from the psychiatric hospitals, we can expect increased pressure on existing components of the Ministry of Health's services (e.g., acute inpatient care, outpatient clinic).
- 3.3. Each county grouping (area) will need a "purpose-built" specialized stabilization and rehabilitation residential facilities to serve those with treatment goals that may take up to one year to achieve.
 - 3.3.1) Note that the "purpose-built" unit will accommodate professional staff that will attend patients in the hospital emergency department, in the acute inpatient units, and across the area through consultation and outreach activities. Also, the extended treatment unit, like the hospital's acute inpatient unit, will provide involuntary treatment as needed under the Mental Health Act.

4. Specialized inpatient services

Specialized inpatient services, within the general hospital setting, including a general psychiatry unit with ready access to specialized dual diagnosis consultation - should be established to treat individuals who are (a) fairly independent in the activities of daily life, (b) able to communicate to some extent, (c) medically stable and (d) not exhibiting extremely aggressive or self-injurious behaviour.

II ACCOUNTABILITY AND TRAINING

5. That Queen's University's Division of Developmental Disabilities is provided with operating funds to provide a district-wide program concerned with Human Resources & Training and Monitoring & Evaluation.

5.2. Queen's University is the only Academic Health Sciences Center in Southeastern Ontario. Through existing capacities, the university will be able to play a key role in the implementation, management, and monitoring services to individuals with a dual diagnosis. More specifically, Queen's will be able to:

- ✍ Address the recruitment, career path and retraining concerns related to success in providing treatment services, and
- ✍ Generate information relevant to the operation of the services provided in each area and to the development of comparable services across Ontario as mental health reform is implemented.

5.3. An education and training coordinator needs to be created to supervise education and training across the three county groupings and to deliver new knowledge to front line service delivery persons.

5.3.1) The education and co-ordination function needs also to ensure that formal service agreements will enhance capacity provision and that service providers will experience continuing enhancement of their capacity for effective service.

5.4. A monitoring and evaluation coordinator - a specialist in the field of Dual Diagnosis - will be required to continually assess the effectiveness of Services, to ensure the employment of standardized assessment instruments and outcome measures.

5.5. Queen's University should be funded to conduct district-wide programs of education and training, monitoring and evaluation of the treatment model here proposed.

Forensic Services:

1. Develop an all-encompassing district-wide forensic program that serves individuals across the lifespan including the diverse populations that are integrated with and are a subcomponent of the general mental health program. Such a program will cover the following:
 - a) An inpatient Forensic Unit that is more discerning of the type of patients it

accepts and capable to live within the allotted number of beds.

- b) Psychiatric services at Quinte Remand Centre.
- c) Triaging services to the courts in the area in order to decrease the number of requests for inpatient assessments, especially fitness assessments.
- d) Community Forensic Clinic with the following functions:
 - i. To provide follow-up of forensic patients discharged from the Forensic Unit and Corrections Canada, and consultation and treatment for cases brought in by parole and probation officers, police, Crown Attorneys, the courts, medical practitioners and community mental health agencies.
 - ii. To be the link to the general mental health services in order to make sure that forensic patients can be transferred to the community mental health agencies and ACT Teams once their level of risk is determined as minimal.
 - iii. To act as an educational powerhouse to train and maintain knowledge among mental health workers on forensic issues and on the management of forensic patients in the community
 - iv. To ensure and broker the acceptance and entry; of clinicians from the different mental health agencies into correctional systems so that they actively do “follow through” when their client enter a correctional institution.
- e) To provide logistical support to the HSJCC so that it become the backbone of community integration efforts for an ambulatory; community forensic subsystem.
– what about HSJCC in HPE and LLG?
- f) Integrate functions of “like workers” such as court diversion workers and CTO co-ordinators to become active members of the forensic subsystem
- g) Development of transitional half-way house for forensic clients after they leave prison, whether federal or provincial
- h) Maintenance of proper data about clinical and academic activities, levels of need of forensic clients, and staff utilization
- i) Utilization of advanced technologies such as Telepsychiatry for hard to access areas in the Region
- j) Co-operation and participation in academic activities including teaching to a variety of students and active encouragement of research initiatives.
- k) Work in close co-operation with the Royal Ottawa Hospital in relation to the forensic developments at Brockville

2. Examine the staffing ratios, workloads and funding available to the Forensic program in order to determine whether some functions and personnel could be transferred to the ambulatory and community functions described above.

3. Identify augmentation costs that will be required from the Provincial Government in order to make the District-wide Forensic Program a fully integrated community program.

4. Enter into arrangements with Corrections Canada in order to:

- a. Integrate follow-up of ex-inmates through use of a forensic half-way house
- b. Working out arrangements for proper “gating” procedures regarding the use of commitment clauses in the Mental Health Act
- c. Consultation services to national parole officers
- d. Ambulatory treatment options for ex-federal inmates
- e. Financial help regarding academic activities.

Concurrent Disorders

1. In order to provide access to a psychiatrist who is specialized in addictions, it is recommended that the Health Sciences Center at Queen’s university recruit one Addictions Psychiatrist to:

- 1.1 Ensure appropriate access to inpatient care through Queen’s University Department of Psychiatry affiliated teaching Hospitals for any individual in the District requiring highly specialized inpatient assessment, detoxification, stabilization, or treatment not available elsewhere in the district,
- 1.2 Co-ordinate a district-wide network of service for the standardize screening and treatment of persons with a concurrent disorder,
- 1.3 Develop a district-wide support and shared care services to mental health providers, including telepsychiatry outreach to under serviced areas,
- 1.4 Co-ordinate shared care models for primary care,
- 1.5 Teach psychiatric residents about concurrent disorders and co-ordinate and supervise community-based training opportunities in addictions for psychiatry residents,
- 1.6 Advocate for curriculum changes and ensure that best practices standards (such as those identified in project CREATE) are incorporated into the curriculum at every level of medical school training,
- 1.7 Conduct research into best practices and treatment outcomes,
- 1.8 Develop and support cross-training initiatives designed to improve the diagnostic and treatment skills of staff in both addictions and mental health services across the district,
- 1.9 Collaborate with community agencies to develop prevention and promotion initiatives to reduce the incidence of substance abuse among individuals with a mental disorder, and participate in wider initiatives designed to reduce the incidence of substance abuse and misuse in the population
- 1.10 Work with the Centre for Addictions and Mental Health, and other relevant bodies to co-ordinate education, training, research and prevention opportunities

- 2) To meet the needs the district's residents needs for specialized support, it is recommended that a specialized concurrent disorders community care team be established to provide:
 - 2.1 Highly specialized assessment and treatment services to the most difficult-to-treat clients in the Kingston area with the goal of returning them to standard mental health or addictions care as soon as possible
 - 2.2 Assertive outreach and engagement with high risk homeless and forensic populations in the Kingston area that do not fit well into the existing system support services for a concurrent disorder
 - 2.3 Shared care and supportive services to clients and agencies across the district – shared care
 - 2.4 In-reach services to mental health and addictions agencies in the district
 - 2.5 Training, specialized support and shared care to agencies across the district aimed at capacity building
 - 2.6 Specialized support to rural and outlying areas through telepsychiatry consultation and support
 - 2.7 Leadership and support for prevention/promotion initiatives designed to reduce substance abuse and misuse
 - 2.8 Mental health or addictions agencies not exclude persons who require treatment or support for a concurrent disorder

Acquired brain Injury and mental health problems

1. Establish a district team for KFLA, LLG and HPE with an interest and expertise in neuropsychiatry that could devote about 4 days per month to mental health and ABI. The team could include a nurse, social worker, psychologist and psychiatrist. This team's activities would:
 - 1.1 Improve timely access to mental health providers and communication and collaboration between ABI agency, family physician and mental health service providers.
 - 1.2 Develop district expertise in neuropsychiatry
 - 1.3 Provide timely access to secure mental health facility for observation and stabilization of behaviour. To facilitate return to community, ensure care is provided collaboratively with ABI service providers.
 - 1.4 This team will provide support for those across the age span and for diverse populations
2. Develop an education network that provides:
 - 2.1 Cross-training, including behaviour management, for mental health services providers in ABI.
 - 2.2 Cross training in mental health issues for ABI service providers.
 - 2.3 An understanding by mental health service providers of the unique issues involved in Minor Traumatic Brain Injury and Post-Concussive Syndrome.

Adults with Severe and Persistent Mental Illness that Require Specialized Services

1. That a lead for these specialty services be designated for the district-wide specialized services. This lead will be responsible for the overall co-ordination and development of specialized services for this population at both the local and district levels.
2. Enhancement and establishment of specialized case management/outreach services which are locally delivered and district co-ordinated in each of the local based mental health areas.
3. There should be equitable distribution of specialized direct community stabilization and rehabilitation services for each area within the district (ie ACT teams).
4. It is recommended that district-wide Specialized Outreach teams be established for individuals with personality disorders providing consultation, shared care, education, engaging in collaborative services and program development.
5. That district-wide services be realigned and developed including specialty adult inpatients and facility based rehabilitation and stabilization services, district-wide ambulatory services and a district-wide resource center.

E. MULTI YEAR PLAN (DISTRICT)

The implementation of a reformed system as it relates to specialized services is based on the set of "common approaches" previously detailed in this report and the enabling recommendation as well as specific Special Populations Recommendations contained in the reports attached.

The Multi Year Plan (MYP) provides a logic strategy of community based development. It is recommended that

"The organizational accountability initiatives and recommendations be implemented, followed by the implementation of community based specialty services in an incremental fashion focussing in on specialty outreach and specialty rehabilitation and treatment services in the community."

This will facilitate and provide the foundation for the third component which is the realignment of specialized inpatient services, district-wide services and facility based rehabilitation and stabilization services.

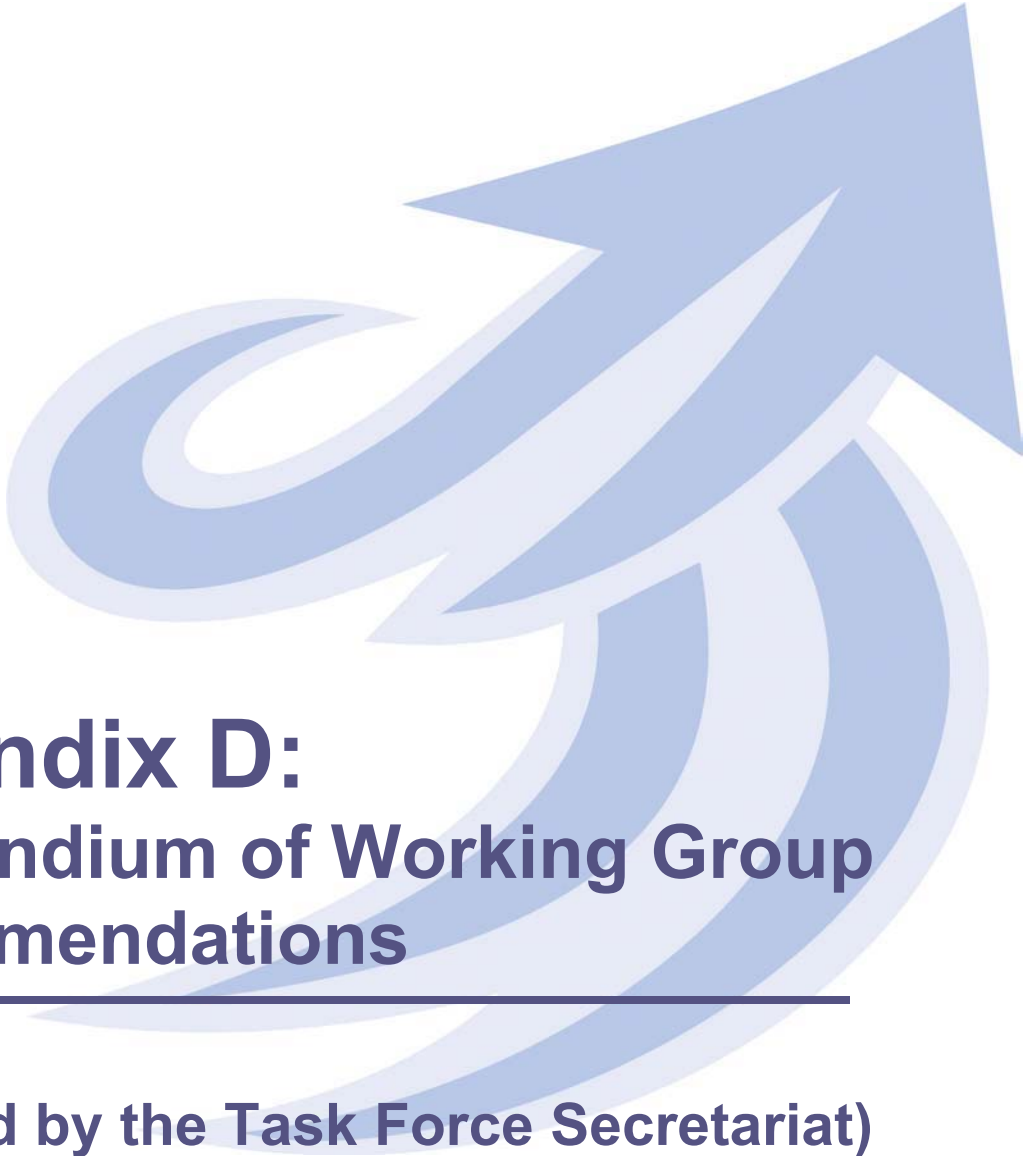
It is therefore recommended that

1. The organization and co-ordination initiatives and recommendations included in this report be implemented as soon as possible. This will include the identification of:
 - a. a lead agency by Ministry of Health and Long Term Care, for each specialty population
 - b. the identification and recruitment of clinical leaders of each of the Specialized Population Mental Health Programs,
 - c. submission of Operational Plans for each of the Specialized Services by the lead.
2. That a District-wide Specialty Mental Health Population Based Council be established involving the District-wide leaders identified for all Specialty Populations. That this Council will provide the initial structure for the development of Specialty Population Mental Health Program in the three areas of Hastings and Prince Edward, Frontenac and Lennox and Addington, Leeds Grenville and Lanark.
3. That a two year capacity enhancement strategy be implemented that involves 1.4 million dollars a year for two years which will enable the development of the Southeastern Specialty Mental Health System to:
 - a. Enhance the local Mental Health Services in the three districts to effectively serve the diverse populations

- b. Establish and strengthen linkages between specialty services and locally based mental health services.
 - c. Move specialized services to locally based delivery
 - d. Provide insights and effective, innovative methods for specialized community based delivery models
 - e. Prepare the community for bed reduction.
4. That a Multi Year Plan (MYP) defining priority, strategic actions, and implementation activities be completed within the next nine months for
- 1) overall specialty services
 - 2) each specialty population mental health program

That this plan be commissioned by the Regional Ministry of Health and Long Term Care office through the advice of a Task Group consisting of community leaders, specialty population mental health leads, and Ministry personnel.

This Task Group report would be submitted to the Ministry or Trust (when established). The foundation for the plan and template for development will be based on this report and the Specialty Champion Reports attached.



Appendix D: **Compendium of Working Group** **Recommendations**

(compiled by the Task Force Secretariat)

Appendix D

Compendium of Recommendations for Reform from the Southeastern Ontario Mental Health Implementation Task Force Working Groups & Integration Committee (Prepared by the Task Force Secretariat)

First Line Working Group Systemic Recommendations

1. That all recommendations forwarded to the Task Force be congruent with the prevention and recovery philosophy that puts the individual and family at the centre of the mental health system and which focuses on the development of healthy and accepting communities.
2. That a mental health policy be developed for Ontario that takes into account the needs of varying populations in both urban and rural settings -- across the life-span of the consumer regardless of the severity of illness -- while ensuring a balance between people with a serious mental illness and others with mental health needs.
3. That there be a long-term commitment to adequately fund First Line services and protect C-CAP-defined level 1 and level 2 funding for the mental health system across Ontario. (First Line Working Group)
4. That incorporation of quality assurance, program evaluation and accountability measures in every component of mental health care delivery is essential.
5. That there be a comprehensive range of client-centred services available to ensure that they are based on client need and provided in the least intrusive manner.

Intensive Working Group Systemic Recommendations

1. All parts of the mental health system need to be accountable for reinvestment strategies that support the mandated downsizing and closure of Provincial Psychiatric Hospitals.
2. During the downsizing and closing of psychiatric facilities, priority for all services is given to patients to be discharged from PCCC-MHS and BPH-ROHCG.
3. Treatment, rehabilitation and support be evidence-based and respond to new and emerging best practices in a constantly changing environment and delivered in a timely, efficient and effective manner.
4. Services be provided by a range of regulated professionals and other skilled service providers including peer specialists all of whom receive ongoing supervision, education and evaluation based on best practices. (Human Resources Committee mandate)
5. Volunteers are a valuable and essential adjunct to the service delivery system and they should be trained, supported and evaluated, however, they should not be surrogates for professional and other skilled service providers.

6. Ongoing standardized program evaluation and client outcome measures are critical and should be implemented as outlined in the accountability framework. (Research Committee)

Specialized Working Group Systemic Recommendations

1. That a population health and general public health strategy be developed that addresses issues of stigma, mental health professional recruitment, community leadership support and public education across the age span and spectrum of specialty populations. (Community Committee)

Integration Committee Systemic Recommendations

1. The Integration Committee of the Southeastern Ontario Mental Health Implementation Task force here recommends that the principles and goals enunciated in *Making It Happen* become the guiding principles and goals for the District's Mental Health Task Force Implementation Plan.
2. The Integration Committee of the Southeastern Ontario Mental Health Implementation Task force here recommends that while the needs of the seriously mentally ill are being addressed in the reform structure, attention be paid to the needs of all consumers and their families in need of mental health services. And further,
 - * that the unique culture of Aboriginal peoples residing in the Southeastern District be respected and recognized in the provision of mental health services
 - * that the development of mental health services for Aboriginal populations be developed collaboratively with Aboriginal people
 - * that a reformed mental health system include a detailed plan that addresses present and future individuals with unique mental health needs for all ages and across the spectrum of needs
 - * that a reformed mental health system be developed that is sensitive and responsive to the current and emerging ethno-racial composition of Southeastern Ontario
 - * that the mental health system find an optimal mix between universal, targeted and clinical programs – Also should evolve into some recommendations around Aboriginal population
3. The Integration Committee of the Southeastern Ontario Mental Health Implementation Task force here endorses the “recovery philosophy” as a guiding principle in the design and implementation of a reformed mental health system in Southeastern Ontario. Essential services of a recovery-oriented system must include treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic supports, self-help and wellness/prevention.
4. That community mental health, specialized services and Schedule 1 treatment programs work together -- formally and informally -- with each consumer (and family where appropriate) to ensure holistic care.

5. That each team include staff with knowledge and skills relevant to the needs of specialized populations.) (Human Resources)
6. That the new mental health system has to encourage front line workers to expand their skills and capacities to care for mental health clients. (Human Resources)
7. Need linkage and accountability (1) dual accountability for providing capability and quality of service. (Research Committee)
8. That the staff recruitment, training and development plan proposed by the Human Resources Committee be adopted as a guide to implementing the district reform plan. (Human Resources)
9. That the Mental Health Reform Implementation plan include a strategy to support mental health staff who are affected by the changes to the Provincial Psychiatric Hospitals and others who may be affected by organizational changes within the Community System. (Human Resources)
10. That the recommendations contained in the governance and accountability reports be accepted and guide the creation of the system model. (Research)
11. That a community information and education capacity – endorsed in the community report – be created for the district. (Community)
12. That the Integration Committee support the recommendations of the Community Committee relating to Community Partnerships. (Community)

Acquired Brain Injury Systemic Recommendations

1. Improve education, experience and expertise of mental health service providers in how to work effectively with those who have mental health issues in the context of an acquired brain injury
2. Cross training, including behavior management, for mental health service providers in ABI. Regional Community Brain Injury Services can provide training.
3. There is an urgent need in the case of children with ABI followed by the Child Development Centre whose behavior is a barrier to school participation.
4. An understanding by mental health service providers of the unique issues involved in Minor Traumatic Brain Injury and Post-Concussive Syndrome.
5. Cross training in mental health issues for ABI service providers. (Human Resources)

Children and Youth Systemic Recommendations

With the exception of the Canadian Academy of Child Psychiatry (CACP) Position Paper (see

reference below) stipulating a ratio of one child and adolescent psychiatrist per 4,000 children and adolescents or 96 per 100,000 population, there are no benchmarks with regard to staffing needs for other mental health professionals required to deliver a full spectrum of child and youth mental health services.

In relation to child psychiatrists this ratio applies to clinical needs only and does not address the need for research, teaching, training and administration. In a tertiary care medical centre, child psychiatrists are available 0.6 FTE for clinical service. District population estimates indicate a recommendation that a minimum of 7 FTE tertiary care child psychiatrists are required to deliver the necessary service, teaching, research and administration.

1. It is recommended that the SEO District take the initiative, with other districts, in establishing non-medical mental health professional staffing benchmarks for service delivery in child and youth specialized psychiatric services.

(Reference: Parker, Z., Steele, M., Junek, W., Morin, L., Davidson, S., Feisher, W., Macleod, R., Sande, T., White, H., Yates, T. "Child Psychiatry in Canada: Physician Resources. Position Statement," Canadian Academy of Child Psychiatry, January 2002.)

Consumer Champion Systemic Recommendations

1. That the following principles outlined in *Making It Happen* be implemented across the mental health care system:
 - * Services will be tailored to consumer needs. These are the real needs as identified by consumers.
 - * Consumer choice will be improved. Streamlined access should not preclude consumer choice.
 - * The rights of the consumer are to be respected in accordance with existing legislation.
 - * The principles of consent and confidentiality will be upheld. It is important that all mental health professionals understand and adhere to the Mental Health Act.
2. That the recovery philosophy be adopted across the system.

Dual Diagnosis Systemic Recommendations

1. That Queen's University be provided with operating funds to provide a district-wide program concerned with Human Resources and Training and Monitoring and Evaluation. (Human Resources)

Personality Disorders Systemic Recommendations

1. That clearer guidelines be developed and disseminated across the health care system distinguishing symptoms of severe mental illness in individuals with personality disorders from behavioral problems that are not well treated or even exacerbated by hospitalization, by prescribing medication upon medication and general placation. (Human Resources)
2. That networks be established consisting of agencies and professionals specializing in the treatment of personality disorders through the catchments area who meet regularly for professional education, information sharing, and creating connections to facilitate coordinated service delivery to clients. (Research)

Seniors Systemic Recommendations

1. It is recommended that, as a cornerstone, those working with any of the five specific geriatric mental health target populations identified in Figure 1 (Section 1.3), ensure that the following impacts are addressed for both the older individual, and the caregiver:
 - * Ability for timely, multi-dimensional, comprehensive assessment
 - * Cross-sectoral communication, assessment, treatment
 - * Need sensitivity to both the client and caregivers
 - * Involvement with both the individual and caregiver system in mental health and the overall health care system that services the individual and the caregiver
 - * Need to exchange, and to maintain an exchange, of information and to setup a mechanism for data exchange, recognizing the importance of confidentiality issues
 - * Need flexible/responsive/coordinated/options across the various sectors and areas
 - * Plan of consent re: confidentiality issues (Streamlined Access)
 - * Need case management to jointly manage both the client and caregiver's needs
 - * Need knowledgeable caregivers and health professionals (for the targeted populations) (Human Resources)
 - * Need to foster an appropriate process for risk assessment and care (Streamlined Access)
2. Acknowledge that within these target populations there are those clients who are frail individuals, and there are those who are ambulatory and physically well, each requiring a unique set of services, as they may pose a potential safety threat to each other.
3. That future planning use the defined target populations for older individuals with mental health problems so that one can clearly identify those served by the overall system, but also to define very clearly the population to be served by the Mental Health system. (Research Committee)
4. It is recommended that by working collaboratively with the Specialized Populations working group, that a clear vision be established for Specialized populations including a solid conceptualized framework for specialized populations as a whole, which would broadly integrate the specialized populations into the overall service system.

5. It is recommended that, in line with the principle of the consumer at the centre, consumers be involved with the planning and implementation and that all the services providing care for senior design development, implementation and support mechanisms for consumer and family input into the delivery and evaluation of care at an individual, program and systems level.
6. It is recommended that family members be involved with the planning and implementation and evaluation. (Research Committee)
7. It is recommended that there be an increased activities focus, incentives and supports for family and caregivers, as we move to a community-based system. (Family Initiatives)
8. It is recommended that implementation efforts ensure that there are appropriate human resources with knowledge, skill and experience to serve this diverse geriatric population across the mental health and associated system, and that the mix of workers reflect the skills required to implement direct services, education, shared care and program and systematic development and its evaluation. (Human Resources)
9. It is recommended that, in terms of planning services for older individuals and their families and caregivers with mental health needs, we need to shift from planning mental health services for this population, to planning services for older individual with mental health needs across the service system.
10. It is recommended that an accountability/evaluation framework be developed with respect to the proposed model and services. (Research Committee)
11. It is recommended that emphasis be placed on clarifying roles, benchmarks, resources and interfaces, as well as functions for the clients and their families and caregivers in two major areas:
 - * Specialized services, clarify and defining of the roles, functions and resources required for inpatient, ACTT-equivalent services, outreach and particularly the importance of defining residential treatment facilities for this population
 - * Within the levels of mental health services, i.e. first line and intensive, need to define specific activities, resources and interfaces. This includes human resources within each of the first and intensive services defined and benchmarked. In intensive this includes both community as well as Schedule 1 facilities. (Research Committee)
 - * It is recommended that cross-sectoral partnerships be developed, with acute care hospitals and specialized geriatric psychiatry services to work toward Senior Sensitive Hospitals and to ensure integration of hospitals with the senior's mental health networks. (Research Committee)

Seriously Mentally Ill Champion Systemic Recommendations

1. New initiatives, such as vocational and transportation programs, and existing programs should be allocated to existing services.

First Line Services - General First Line Recommendations

1. That minimum key components of a mental health system for First Line services must include prevention, community development primary care services, information and referral services, comprehensive crisis response (including but not necessarily limited to warm lines, telephone crisis lines, mobile crisis teams, trauma response capacity, holding and safe beds), mental health counseling, advocacy, hospital emergency services and outreach. (First Line Working Group)

Special Population Recommendations - Seniors

1. First Line Services to establish internal resources in each of relevant services that are capable and have dedicated resources for older individuals with mental health problems. That the amount of dedicated resources should be benchmarked to the population prevalence rate.

Information and Referral Services -- Crisis Services (crisis telephone lines, mobile crisis teams, Schedule 1 hospital emergency services, holding/safe beds)

1. That appropriately trained (e.g. in mental illness/mental health issues, suicide and crisis intervention, sensitivity to culture, religion, sexual orientation, etc.) triage personnel be available and recipients of ongoing professional cross-education and development. (First Line Working Group) – Human Resources
2. That a network of coordinated and accessible 24/7 crisis response services (a 1-800 line that links with Mobile teams) be established within the district to screen consumers for immediate needs, including a risk assessment, determine and refer to suitable services and follow up of the referral as needed. (First Line Working Group)
3. That training for crisis service workers be comprehensive across the age span and needs spectrum. (Integration Committee) – Human Resources
4. That a network of coordinated and accessible 24/7 hospital emergency services, linked with Schedule 1 facilities, be developed in such a manner that all hospital facilities will be able to draw upon Schedule 1 emergency mental health resource to ensure an appropriate first response. (Integration Committee).

Special Population Recommendations - Children and Youth

1. The mobile crisis service provided by MCSS within the district function in cooperation with the area MOHLTC hospital emergency departments for purposes of assessment, intervention and referral for specialized psychiatric services. Educational opportunities in

relation to the teams' functioning should be developed in the MCSS agencies and be supported by the specialized psychiatric service.

Concurrent

1. Emergency and best practice protocols in withdrawal management (such as those of the OMA) be used in all hospitals and Detoxification centers in the district.

Personality Disorders

1. That provision be made for very short-term (3 days) goal-centred residential care in the emergency departments of local hospitals – or similar units in the community where people in suicidal crisis can stabilize and get support without being admitted into psychiatric units (where they often regress or stay much longer than is necessary, or helpful, to their overall level of functioning).

Mental Health Counseling

1. That a range of accessible and publicly funded mental health counselling interventions for consumers and families be provided irrespective of severity of mental health issues. (First Line Working Group)

Hospital Emergency Services

1. That a network of coordinated and accessible 24/7 hospital emergency services, linked with Schedule 1 facilities, be developed in such a manner that all hospital facilities will be able to draw upon Schedule 1 emergency mental health resources to ensure an appropriate first response. (First Line Working Group)
2. The role of non Schedule 1 hospitals be reviewed in terms of their potential to provide or link to mental health services. (Intensive Working Group)

Inreach and Outreach

1. That a range of community-based and accessible outreach activities be developed including education and consultation in schools, municipal government, community agencies and social housing units. (First Line Working Group)
2. That outreach services be accessible in every community to enhance availability and accessibility of intensive and specialized services through the use of e.g. telepsychiatry, traveling clinics to provide consultation and assessment. (First Line Working Group)

Primary Care Service (primary care physicians, community health centers, health service organizations)

1. That the role of general practitioners be highlighted and the need for training and support with respect of mental health be addressed. (First Line Working Group)
2. That a system of multi-disciplinary primary care services which provide a range of assessment, treatment, counseling, stabilization and coordination services (e.g. early brief intervention, referral and consultation) be developed for consumer with mental health problems. (First Line Working Group)
3. That Primary Care reform and mental health reform be linked to Schedule 1 and First Line services and methods of payment for psychiatric consultation be addressed. (First Line Working Group)
4. That mental health reform and primary care reform be developed to complement each other through a linked and coordinated system design and development. (First Line Working Group)
5. That the sentinel role of general practitioners and psychiatrists be recognized and that funding be available for non-billable activities required for comprehensive treatment of the mental health client as well as for system development, integration and reform. (Integration Committee)
6. That alternate professional compensation schemes be administered through mental health program budgets. (Integration Committee)
7. That, given the prevalence of mental health conditions, family physicians have the opportunity to develop the necessary skill sets to deliver comprehensive mental health services across the age span and spectrum of specialty populations and needs. (Integration Committee)
8. That service delivery models link family physicians with mental health specialists

Seniors Recommendations

1. That at the Provincial level, the Ontario Family Health Care Network initiative review their support for primary care physicians caring for older individuals with mental health problems and identify and implement incentives to ensure internal capacity in this network to serve this population.
2. It is recommended that there be a policy framework and implementation strategy WITHIN Primary Care Reform to deal with older individuals with mental health problems.
3. It is recommended that there be steps taken to improve availability and access to family physicians for this population (e.g., at present it is very difficult for an older individual to get a family physician).
4. It is recommended that there be incentives to primary care physicians to encourage care of older individuals.

Schedule 1 Services (Schedule 1 psychiatric inpatient and outpatient services including triage to inpatient care, day hospital and home treatment and ambulatory outpatient)

1. Benchmarks for Schedule 1 facilities in the district be based on identified need, population base and projected changes, utilization rate, acuity and chronicity *etc.*, and that they be funded to provide a range of intensive services capable of serving people of all ages and specialized needs including;
 - * Emergency and crisis response services including the availability of a psychiatrist and triage to appropriate services
 - * Short-term inpatient assessment/holding beds
 - * Assessment, stabilization and short-term inpatient treatment (HSRC provided benchmarks)
 - * Discharge planning
 - * Day Hospital
 - * Therapeutic educational day treatment programs
 - * Outpatient services
 - * First episode clinics (MOHLTC has benchmarks)
 - * Consultation, education, coordination and integration (Intensive Working Group)
2. That all Schedule 1 facilities in the district be funded to provide a range of acute care services including;
 - * Emergency and crisis response services
 - * Short-term inpatient assessment/holding beds
 - * Assessment, stabilization and short-term inpatient treatment
 - * Discharge planning
 - * Outpatient acute care services, for those who do not need to be hospitalized, capable of treating persons of all ages and all specialized needs
 - * Therapeutic educational day treatment programs
 - * First episode clinics
 - * Consultation, education, coordination and integration (Integration Committee)
3. The transfers of Schedule 1 services in Kingston and Brockville occur as soon as possible and be integrated into the continuum of health care. (Intensive Working Group)
4. A review of the appropriateness of the use of security staff in a clinical setting be undertaken. (Intensive Working Group)

Special Populations - Dual Diagnosis

1. That Quinte Healthcare Corporation, Kingston General Hospital and the Brockville General Hospital be provided with operating funds for emergency, ambulatory, and inpatient dual diagnosis treatment services.

Seniors

1. That there be dedicated resources/beds in Schedule 1 inpatient beds; that the dedicated resources beds be aligned with the population prevalence of older individuals with mental health needs, and anchored to that rate over time.

Intensive Case Management/Housing Supports

1. Intensive Case Management service benchmarks based on identified need, population base and projected changes, utilization rate, acuity and chronicity etc., be funded to provide a range of services including:
 - * Outreach and client identification
 - * Comprehensive individualized assessment and planning
 - * Direct service provision
 - * Coordination and support
 - * Monitoring and evaluation
 - * Systemic advocacy and coordination
 - * Assistance with locating and maintaining housing (Intensive Working Group)
2. That intensive case management services be funded to provide a range of services including:
 - * Outreach and client identification
 - * Comprehensive individualized assessment and planning
 - * Direct service provision
 - * Coordination and support
 - * Monitoring and evaluation
 - * Systemic advocacy and coordination
 - * Assistance with locating and maintaining housing (Integration Committee)
3. The continuity of Case Management services be conserved for the consumer changing accommodation or location. (Intensive Working Group)
4. Mechanisms be developed to link ACTT with case management programs to facilitate access to appropriate services based on level of need. (Intensive Working Group)
5. Each consumer of case management services has a primary case manager and access to a multi-disciplinary team as required. (Intensive Working Group)
6. Each team will include staff with knowledge and skills relevant to the needs of individual consumers. (Intensive Working Group)
7. Priority is given those consumers with the highest level of need. (Intensive Working Group)
8. Each team include staff with knowledge and skills relevant to the needs of specialized populations. (Integration Committee)

Special Populations – Seniors

1. Intensive community resources; that the intensive community resources have the capacity, capability, and dedicated resources for the severely mentally ill older individuals who ages; that the percentage of resources be based on population prevalence figures over time.

Intensive Community Treatment and Support (skill development and psychosocial rehabilitation programs)

1. Intensive community treatment and support program benchmarks based on identified need, population base and projected changes, utilization rate, acuity and chronicity etc., be funded to provide a range of psychosocial and skills development programs including:
 - * Skills-based training
 - * Evidence based counseling and therapy
 - * Evidence based interventions specific to those with unique needs (e.g. special populations and trauma survivors)
 - * Supported employment and education
 - * Social and recreational activities (Intensive Working Group)
2. That intensive community treatment and support programs be funded to provide a range of psychosocial, skills and developmental programs including;
 - * Supported employment
 - * Supported education
 - * Social and recreational activities
 - * Skills-based training
 - * Counselling and therapy
 - * Interventions specific to those with specialized needs (e.g. special populations, trauma recovery) (Integration Committee)
3. Medication clinics be available and accessible to consumers across the District. (Intensive Working Group)

Population Specific – Seniors

1. Intensive community resources; that the intensive community resources have the capacity, capability, and dedicated resource for the severely mentally ill older individual who ages; that the percentage of resources be based on population prevalence figures over time.

Court Diversion

1. Consumers who have a mental illness and have been charged with a minor offence be diverted away from the criminal justice system. (Intensive Working Group)

2. Court diversion services be fully integrated into the mental health service system. (Intensive Working Group)

Community Treatment Orders

1. Consumers subject to a Community Treatment Order be provided with CTO coordination and case management services. (Intensive Working Group)
2. Community Treatment Order services be fully integrated into the mental health service system. (Intensive Working Group)

Specialized Services -- General Recommendations

1. That each specialized service for each specialized population develop and implement a template and implementation strategy that is consumer-centred and responsive, providing for meaningful input at an individual, program and system level. (Specialized Working Group)
2. That specialized services provide a balanced set of activities and functions which promote the principles of Mental Health. (Specialized Working Group)
3. That the activities and roles of specialty services will include a balance of activities for each specialty population. (Specialized Working Group)
4. That the balance of activities will be determined by the needs of each specialty population. (Specialized Working Group)
5. That realignment from direct specialty services to increased emphasis on capacity enhancement activities will occur in a phased-in process with increased emphasis on shared care, education and support of care providers and care program and care system development as the reform is implemented. (Specialized Working Group)
6. That Centres of Excellence (Regional Specialized Programs) be created for each specialized population consisting of two components (a) locally based driven specialty services and (b) regional tertiary coordination and support services. (Specialized Working Group)
7. Where appropriate, centers of excellence may be inter-district or regional in nature with access to provincial centers of excellence. (Integration Committee)
8. That the district coordination and support component provide three district-wide services; (1) ambulatory services, (2) resource centers, and (3) unique district-wide specialized services. (Specialized Working Group)

9. That outreach services be accessible in every community to enhance availability and accessibility of specialized services through the use of e.g. telepsychiatry, traveling clinics to provide consultation and assessment. (Integration Committee)
10. That the balance of direct specialty services shift to an increased emphasis on capacity enhancement activities. This will involve increased emphasis on shared care, education and support of care providers and care program and care system development as the reform is implemented. (Integration Committee)

Special Populations - Concurrent

1. In order to provide access to a psychiatrist who is specialized in addictions, it is recommended that the Health Sciences Centre at Queen's University recruit one Addictions Psychiatrist to:
 - * Ensure appropriate access to inpatient care through Queen's University Department of Psychiatry affiliated teaching Hospitals for any individual in the district requiring highly specialized inpatient assessment, detoxification, stabilization, or treatment, not available elsewhere in the district
 - * Ensure appropriate access to inpatient care through Queen's University Department of Psychiatry affiliated teaching hospital for Kingston-area consumers and concurrent disorders who are in need of inpatient care
 - * Coordinate a district-wide network of service for the standardized screening and treatment of persons with a concurrent disorder
 - * Develop district-wide support and shared care services to mental health providers, including telepsychiatry outreach to underserved areas
 - * Coordinated shared care models for primary care
 - * Teach psychiatric residents about concurrent disorders and coordinate and supervise community-based training opportunities in addictions psychiatry for psychiatric residents
 - * Advocate for curriculum changes needs to ensure that best practice standards (such as those identified in Project CREATE) are incorporated into the curriculum at every level of medical school training
 - * Conduct research into best practices and treatment outcomes
 - * Develop and support cross-training initiatives designed to improve the diagnostic and treatment skills of staff in both addictions and mental health services across the district
 - * Collaborate with community agencies to develop prevention and promotion initiatives to reduce the incidence of substance abuse among individuals with a mental disorder, and participate in wider initiatives designed to reduce the incidence of substance abuse and misuse in the population
 - * Work with the Centre for Addictions and mental health, and other relevant bodies to coordinate education, training, research and prevention opportunities

Seniors

1. Maintain and develop district tertiary, support services that consist of:

- * District-wide Specialty Services (Behavioural Assessment Services, Telepsychiatry, etc.)
 - * Specialized district outpatient services
 - * A Resource Centre, that technologically supports and provides triage and support to information on best practices, and to mental health service experts, and material. This resource centre should be developed in line with best practice resource centre developments in the province by public health and incorporate a brokerage educational function.
2. It is recommended that there be a shift from an approach of specialized services for older individuals as institutionally based, to a concept of specialized services as a “resource.”
 3. It is recommended that incentives and support be provided to move from an inpatient focus to a more balanced activity profile across services, education, collaborative community and systems development in and with local communities and, where appropriate, academic activities.
 4. That there be a move from a centralized approach to one where specialized services are involved in district coordination and support that focuses on locally driven system with support from the district for capacity enhancement and then, if required, inpatient and specialized direct services.
 5. It is also recommended that there needs to be centres of excellence for dissemination and distribution of Best Practices, as well as for local development.
 6. It is recommended that the district-wide geriatric psychiatry program be designated as a Centre of Excellence providing best practice through leadership in:
 - * Service Delivery
 - * Education
 - * Research
 - * Policy and Planning
 7. And that the Centre of Excellence establish an affiliation and collaborative relationship with
 - * Queen’s University
 - * Eastern Ontario District-wide Geriatric Psychiatry Programs
 - * University of Ottawa, Geriatric Psychiatry Division
 - * Regional Geriatric Medical Programs
 - * Other leading centres provincially, nationally, and internationally
 8. It is recommended that all specialty geriatric psychiatry services be coordinated and that an agency/organization be identified that is accountable and responsible for the overall specialty geriatric psychiatry services ensuring:
 - * Equitable access
 - * Coordination and integration between specialty geriatric psychiatry services

- * Overarching coordination and integration with First Line and Intensive services
 - * Coordination and integration with other specialty services across the age span
 - * Coordination and integration with associated services
9. It is recommended that as the system moves from planning to implementation, collaborative efforts and partnerships build on the local planning done to date to ensure continued consistency/congruency between regional, district and local services and supports. (Research Committee)

Special Populations -- Child and Youth

1. Specialized psychiatric inpatient services located in a tertiary care medical centre for children and youth include a hospital-based inpatient service. The Health Services Restructuring Commission has designated eight adolescent beds (age 13th to 18th birthday) for the Southeastern Ontario District.

Seniors

1. Maintain adequate beds for specialty inpatients for the target groups: for behavioural problems and dementia, and for mood and psychotic disorders of late life. It is proposed that the number of beds in the long-term care mental health system be approximately 40% of the long-term care beds. This is aligned with benchmarks established in Britain and elsewhere and is consistent with the planning and implementation that is already occurring at the Royal Ottawa/Champlain District (i.e. 25 beds/equivalent).
2. It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be sited in a manner that ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 beds/equivalent mentioned previously, and be funded with the resources accrued through the bed reduction plan.

Special Populations - Children and Youth

1. Residential treatment services are the services in the child and youth sector for clients/consumers with longer-term needs. They are provided from MCSS, which in this district has recently moved this function from facility-based services to treatment foster home services. A review process should be undertaken to identify the requirement for a care continuum involving residential treatment foster care and residential treatment facilities for client/consumer stabilization and rehabilitation services.

Dual Diagnosis

1. That capital funding is provided to enable each of the hospitals sponsoring a dual diagnosis treatment service, to establish “purpose-built” accommodation for the extended treatment unit and offices for the professional team providing ambulatory services.

Seniors

1. That 30 residential treatment facility beds be allocated to the Southeastern District for stabilization and rehabilitation and that an operational plan be developed and implemented for the residential treatment facilities, ensuring access, quality and viability.
2. Those in considering RTFs, the differing needs of the sub-populations (Figure 1) need to be considered. It was also recommended that access to specialized services be ensured including consideration of co-location with specialty services.
3. It is recommended that one needs to examine the 1988 report titled “Foundation for Defining Residential Treatment Facilities”, to assist in clarifying what a RTF could be.

Special Populations - Dual Diagnosis

1. That Queen’s University evaluate the relative effectiveness of specialized (dual diagnosis) Assertive Community Treatment and Consultation and Outreach in providing dual diagnosis treatment services.

Seniors

1. Direct specialty community services for direct care: specialized intensive services for the sub-population groups defined in Figure 1 be established, and that the ACTT Adult Teams provide services for the longstanding severely mentally ill who grow old.
2. In addition, that the specialized direct intensive services (ACTT equivalents) be accountable, aligned and linked with the specialized geriatric psychiatry teams that are locally based.

Outpatient, Mobile Inreach and Outreach teams

1. Establish specialized direct community treatment services for identified target populations (e.g. geriatric, concurrent, ABI, Dual Diagnosis, Youth, etc.) (Integration Committee)

Special Population Recommendations - Acquired Brain Injury

1. Establish a district team for KFLA, LLG and HPE with an interest and expertise in neuropsychiatry that could devote about 2 days per month to mental health and ABI. The team could include a nurse, social worker, psychologist and psychiatrist.
2. Improve timely access to mental health providers and communication and collaboration between ABI agency, family physician and mental health service providers.
3. Develop district expertise in neuropsychiatry
4. Provide timely access to secure mental health facility for observation and stabilization of behaviour. To facilitate return to community, ensure care is provided collaboratively with ABI service providers.

Consumers

1. That an effective, adequately and equitably resourced infrastructure be developed and implemented as a specialized service associated with the “Trust” to provide ongoing training and peer support to consumer groups and individual consumers who are working as service providers, advocates, planners, evaluators and governors of the mental health care system.

Children and Youth

1. District-wide specialized services should include specialty outpatients, district-wide unique services and a resource centre.
2. Specialized psychiatric outpatient services located in a tertiary care medical centre should have sufficient clinical personnel and resources to provide:
 - * Assessment and intervention hospital-based clinic for client/consumers with neuropsychiatric and neurocognitive disorders, externalizing disorders, mood and anxiety disorders, eating disorders, psychotic disorders and forensic services (parenting capacity assessment/ YCJA assessments)
 - * A change in the MOHLTC funding model for child and adolescent forensic psychiatric services from the “separate vote” model to inclusion within the global budget of the host hospital
 - * A hospital-based day treatment
 - * A seamless integration in service provision for ‘transitional’ youth moving because of age from child and adolescent to adult specialized psychiatric services
3. Specialized psychiatric consultative services located in a tertiary care medical centre to provide:
 - * Hospital-based urgent (less than 72 hours) consultation for emergency department physicians and community referral agents e.g. MCSS agencies, schools and family physicians
 - * Hospital-based consultation to the Department of Paediatrics inpatient services and specialty clinics
 - * Outreach consultation via traveling clinics or telepsychiatry to district MCSS CMHC agencies and Children’s Aid Societies and family physicians
 - * Comprehensive outreach services need to be established to integrate seamlessly with intensive and first line services. The specialized spectrum of services should foster reintegration into the community from more structured specialized services as well as prevent unnecessary hospitalization.

Concurrent

1. To meet the needs of Kingston-area residents for specialized community care, as well as the needs of district residents for specialized support, it is recommended that:

- * A specialized concurrent disorders community care team be established to:
- * Provide highly specialized assessment and treatment services to the most difficult-to-treat clients in the Kingston area with the goal of returning them to standard mental health or addictions care as soon as possible
- * Assertive outreach and engagement with high risk homeless and forensic populations in the Kingston area that do not fit well into the existing system support services for a concurrent disorder
- * Shared care and supportive services to clients and agencies across the district – shared care
- * In-reach services to mental health and addictions agencies in the district
- * Training, specialized support and shared care to agencies across the district aimed at capacity building
- * Specialized support to rural and outlying areas through telepsychiatry consultation and support
- * Leadership and support for prevention/promotion initiatives designed to reduce substance abuse and misuse
- * Mental health or addictions agencies not exclude persons who require treatment or support for a concurrent disorder

Dual Diagnosis

1. That Queen's University evaluate the relative effectiveness of specialized (dual diagnosis) Assertive Community Treatment and Consultation and Outreach in providing dual diagnosis treatment services.

Forensic

1. Develop an all-encompassing regional forensic program that is integrated with and is a subcomponent of the general mental health program. Such a program will cover the following:
 - * An inpatient Forensic Unit that is more discerning of the type of patients it accepts and able to live within the allotted number of beds.
 - * Psychiatric services at Quinte Remand Centre.
 - * Triaging services to the courts in the area in order to decrease the number of requests for inpatient assessments, especially fitness assessments.
2. Develop Community Forensic Clinic with the following functions:
 - * To provide follow-up of forensic patients discharged from the Forensic Unit and Corrections Canada, and consultation and treatment for cases brought in by parole and probation officers, police, Crown Attorneys, the courts, medical practitioners and community mental health agencies.
 - * To be the link to the general mental health services in order to make sure that forensic patients can be transferred to community mental health agencies and ACT Teams once their level of risk is determined as minimal.

- * To act as an educational powerhouse to train and maintain knowledge among mental health workers on forensic issues and on the management of forensic patients in the community
 - * To ensure and broker the acceptance and entry of clinicians from the different mental health agencies into the correctional system so that they actively “follow through” when their client enters a correctional institution.
 - * To provide logistical support to the HSJCC so that it becomes the backbone of community integration efforts for an ambulatory community forensic subsystem.
 - * Integrate functions of “like workers” such as court diversion workers and CTO coordinators to become active members of the forensic subsystem
 - * Development of a transitional half-way house for forensic clients after they leave prison, whether federal or provincial
 - * Maintenance of proper data about clinical and academic activities, levels of need of forensic clients, and staff utilization
 - * Utilization of advanced technologies such as Telepsychiatry for hard-to-access areas in the Region
 - * Cooperation and participation in academic activities , including teaching, to a variety of students and active encouragement of research initiatives.
 - * Work in close cooperation with the Royal Ottawa Hospital in relation to forensic developments at Brockville.
 - * Examine the staffing ratios, workloads and funding available to the Forensic Program in order to determine whether some functions and personnel could be transferred to the ambulatory and community functions described above.
 - * Identify augmentation costs that will be required from the Provincial Government in order to make the Regional Forensic Program a fully integrated community program
1. Enter into arrangements with Corrections Canada in order to:
 - * Integrate follow-up of ex-inmates through use of a forensic half-way house
 - * Work out arrangements for proper ‘gating” procedures regarding the use of the commitments clause in the Mental Health Act
 - * Provide consultation services to national parole officers
 - * Assure ambulatory treatment options for ex-federal inmates
 - * Secure financial help regarding academic activities.

Seniors

1. Outreach: Allocated incremental funding be implemented to bring the local Outreach Teams to the Clarke Benchmarks.

Employment

1. That supported employment programs be made available to consumers across SEO including those living in rural areas (Consumer Champions)

2. That the integration report addresses the fact that vocational opportunities are critical for people with a serious mental illness. (SMI Champions)

Education

1. That supported education programs be made available to consumers across SEO including those living in rural areas (Consumer Champions)

Housing and Related Supports

1. That more subsidized housing is made available for consumers. (Consumer Champions)
2. That boarding homes be regulated and brought up to reasonable standards. (Consumer Champions)
3. That support be provided to help people locate, secure and retain their housing. (Consumer Champions)

Consumer Initiatives and Supports

1. Consumer initiatives be integrated within the mental health system. (Intensive Working Group)
2. That Consumer Initiatives remain autonomous with their own boards of directors, that they be accessible to consumers across the region, adequately and equitably resourced and integrated into the mental health system as equal partners. (Consumer Champions)
3. That peer support be incorporated into all mental health services and agencies and that this be provided by peer specialists who are equitably paid. (Consumer Champions)
4. Formal consumer advisory and advocacy mechanisms be established and funded at all levels of mental health system. (Intensive Working Group)

Family Initiatives and Supports

1. Family initiatives be integrated within the mental health system. (Intensive Working Group)
2. Formal family advisory and advocacy mechanisms be established and funded at all levels of mental health system. (Intensive Working Group)

Transportation

1. Inreach and outreach transportation services be expanded to meet current, ongoing and projected needs and are sensitive to different populations ability to access and utilize. (Intensive Working Group)

2. That transportation services be expanded to meet current needs, that definitions of need be expanded to include mental health services or that individuals be enabled to purchase their own transportation resources. (Integration Committee)

Advocacy

1. That Consumer Advocacy programs be made available and adequately resourced to provide support to all consumers using mental health services including inpatient and community programs. (Consumer champions)

Income Supports and Services

1. Consumer needs medical and dental care in community. Barriers to access, exit and re-access should be removed to promote consumer movement throughout the system based on level of need. (Intensive Working Group)

Streamlined Access

1. Funding and services are to be provided as close to home as practical. (Intensive Working Group)
2. That the system be designed in a way that makes it easy for consumers to access appropriate care when it is needed. (Consumer Champions)

Centralized Information and Referral Functions

1. That an accessible universal community information system (not exclusively electronically based) be developed, updated regularly, linked to the full range of available services and co-coordinated with other services in the district, region and province as appropriate. (First Line Working Group)
2. That key elements of the community information system include, but not be limited to, a mental health information telephone line, web site and promotional materials designed to provide accessible information to the community about mental health promotion, mental illness prevention, early identification and intervention and the range of services available for all citizens in the Southeastern Ontario District. (First Line Working Group)
3. That there be a provincial 1-800 number that will provide callers with information about mental health services and supports in the province and will link callers to local information and referral services. (Consumer Champions)
4. That local information and referral services be established as an adjunct to 24/7 crisis services to provide information about local mental health resources and link callers with needed supports and services. (Consumer Champions)

Special Populations -- Personality Disorders

1. That centralized access and intake be established including up-to-date information regarding the services available and informed assistance in accessing these services in some centralized location.

Facilitating Access to Consultation Provided by Psychiatrists

1. Consultation, sessional dollars, support and training be available to address intensive needs and provide timely psychiatric support to consumers and professionals across the district. (Intensive Working Group)
2. An investment be made in telepsychiatry to support the above. (Intensive Working Group)

Minimizing the Number of Assessments

1. Standardized intake assessment, admission and discharge protocols based on level of need be developed and implemented across the health and social service system. (Intensive Working Group)
2. That minimal standardized assessment tools be established. (First Line Working Group)
3. That protocols be developed to ensure sharing of information between services providers based on client consent. (First Line Working Group)
4. That the Government of Ontario amend relevant legislation to facilitate appropriate information sharing and fund accordingly (First Line Working Group)
5. Recognizing the requirements of legislation, a client information database be created so as to ensure that multiple agencies serving the same consumer are able to share the consumer's information in a timely manner. (Intensive Working Group)
6. Standardized intake tools, admission and discharge protocols be created. (Integration Committee)
7. That a client information database be created so as to ensure that multiple agencies serving the same consumer are able to share the consumer's information and thereby reduce duplicate demands on the consumer to re-supply information on a continuing basis. (Integration Committee)

Special Population Recommendations -- Concurrent

1. In order to ensure that individuals with concurrent disorders are appropriately identified and diagnosed it is recommended that:

- * Standardized screening protocols for substance abuse, including standardized screening instruments, be implemented as part of the regular intake procedures for all first line mental health programs
 - * Standardized screening protocols for mental health problems, including standardized screening instruments, be implemented as part of the regular intake procedures for all first line substance abuse programs
 - * Protocols of care be implemented requiring consultation with an Addictions specialist for diagnosis and care planning whenever a predefined screening threshold is passed (this should go in section below)
 - * Promotion/prevention initiatives be undertaken to reduce the risk of substance abuse and misuse, particularly among high risk groups such as youth or young adults with a serious mental illness (community committee)
2. In order to promote identification of people with concurrent disorders and foster continuity of information (and therefore care) across programs, it is recommended that:
- * A registry of consumers with concurrent disorders be developed that is electronically accessible to all treating staff regardless of their location in the mental health or addictions systems, taking into consideration confidentiality and privacy issues with respect to sharing of treatment data
 - * A single unique identifier that is common to both mental health and addictions agencies (i.e. that used in the DATIS System) be used to collect standardized anonymized data to support district evaluation, research, and accountability processes
 - * Performance monitoring and outcome assessment be undertaken in accordance with district accountability and service evaluation initiatives to assess standards of care, particularly with respect to:
 - * The proportion of incoming clients who are not appropriately screened
 - * The proportion of those exceeding the screening threshold that are not appropriately referred for specialized care planning
 - * The proportion of clients requiring detoxification that are not managed according to the standardized care protocol

Seniors

1. It is recommended that a resource centre be established for education, that is be an accessible resource for practitioners. (Human Resources)
2. It is recommended that more emphasis be placed on early detection, and on strategies/programs to prevent disability. (Prevention should be community committee)
3. That an information system be developed that permits timely, confidential exchange of client information between those managing the clients' care/needs.

Special Populations -- Concurrent

1. In order to make sure that people with concurrent disorders receive concurrent treatment, it is recommended that:

- * Standardized screening protocols for substance abuse, including standardized screening instruments, be use as part of the regular intake procedures for all intensive mental health programs
- * Standardized screening protocols fro mental health problems, including standardized screening instruments, be used as past of the regular intake procedures for all intensive level substance abuse programs
- * Formal service agreements be implemented to require joint care planning by mental health and addictions workers for all individuals with a concurrent disorder
Consultation and referral protocols be implemented governing access to an Addictions Psychiatrist for specialty consultation and care planning (Shared Care and point 2 above)
- * Early intervention/prevention initiatives be implemented to target younger mental health consumers who are at high risk of developing abuse problems in later life (prevention – Community Committee)
- * Regular training sessions on the diagnosis and treatment of concurrent disorders be implemented in all agencies (Human Resources)
- * Clear points of accountability for concurrent disorders be established within each agency (Research)
- * Staff who are accountable for concurrent disorders within their respective agencies be networked to help coordinate district-wide resources (should go in specialized section under concurrent)

Seniors

1. That integration of planning and development for older individuals with mental health problems, be coordinated with local planning bodies through the leadership of the designated agency/organization responsible for specialty geriatric psychiatric care.

Fewer Points of Entry to Mental Health Services

1. Streamlined access points be established to ensure access to appropriate services based on level of need. (Intensive Working Group)
2. Barriers to access, exit and re-access should be removed to promote consumer movement throughout the system based on level of need. (Intensive Working Group)
3. Protocols and community partnerships be developed with organizations and institutions outside the formal mental health services to identify and assist consumers who may not, on their own, access mental health services. (Intensive Working Group)

Shared Service Models

1. That successful mental health reform requires change at the district, regional and the provincial government level. It is recommended that the Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, the Ministry of Correctional Services, the Ministry of Housing and the Ministry of Education (Colleges and

Universities) establish an inter-ministerial forum to address and resolve policy and organizational issues that mitigate against the integration of mental health services in the province.

- * that the Ministry of Health and Long-Term Care (MOHLTC) be responsible and accountable for all matters of mental health across the lifespan and spectrum of specialty populations and needs
 - * that the regional offices of these ministries, together with front line service representatives, create a coordinating structure through which the integration of mental health services in the SEO district can be achieved in a way that incorporates the principles and goals of mental health reform
 - * that the MOHLTC proceed with the development of a solid conceptual framework provincially for work with specialized populations across the lifespan
 - * that the MOHLTC consult with other program areas and ministries as to the implications of the implementation plan for specialty populations and the development of additional support policies. (Integration Committee)
2. Due to the high co-morbidity rates between physical and mental health care, community agencies should have easy access to adequate nursing care for their clients in the community, as close to home as possible. (SMI champions)
 3. Agencies have flexibility in the manner by which alternate professional compensation schemes are administered through mental health program budgets. (Intensive Working Group)

Special Population Recommendations -- Children and Youth

1. Establish a provincial task force to develop a common vision for child and youth mental health in Ontario
2. A comprehensive integrated child and youth mental health system incorporating firstline, intensive and specialized services across four Ministries is a necessity. There are different methods of achieving such an integrated system. These range from a provincial initiative mandating all child and youth mental health services to be delivered out of one Ministry, to a district-wide local organizational initiative that could achieve the same end.

Dual Diagnosis

1. That an advisory committee is established composed of hospital, agency and family representatives and reporting at least twice yearly to the Regional Director of MOHLTC and the Regional Director of MCSS.
2. That the Community Behavior Management Programs operating in the Southeast are strengthened, so as to eliminate long waiting lists and to ensure a collaborative working relationship with the dual diagnosis treatment services recommended above.

3. That those individuals from the Southeastern district currently living at the Rideau Regional Centre are assessed in relation to meeting their needs (including those for dual diagnosis treatment services) in community-based settings.

Seniors

1. It is recommended that CCACs' role in First line outreach should be clearly defined, including outreach to long-term care facilities, nursing homes, and retirement homes.
2. That each CCAC designate a specialty case management and service resource, as this population' complex geriatric psychiatric needs are not met with generic geographically based services.
3. It is recommended that Long-Term Care Facility enhancement occur to augment their capacity to serve older individuals with significant mental health problems.
4. It is recommended that LTC beds announced, but so far not yet awarded, in the long-term care facilities sector be designed to focus on the needs of older individual with mental health problems, and that there be options within the restructuring to link these beds with other services.
5. It is recommended that efforts be made to harmonize the following government directions that serve individuals with mental health needs:
 - * Mental Health Reform as undertaken by the Mental Health Implementation Task Forces
 - * The Alzheimer's Strategy
 - * Primary Care Reform (Family Doctors)
 - * Long Term Care Facility Development
 - * Specialty Geriatric Services
 - * CCACs
 - * Stroke Strategy
 - * Elder Abuse Strategy
 - * End of Life Care



Appendix E:

Table of New Investments in Mental Health Care by the Ministry of Health & Long-Term Care

Appendix E:

Ministry of Health and Long-Term Care Mental Health Reinvestments Across Southeastern Ontario, as of 4 July 2001

(Source: Ministry of Health & Long-Term Care Website)

Hastings & Prince Edward Counties		
Service Type	Agency	Funding
Crisis Response	Crisis Intervention Centre, Quinte Healthcare Corp, Belleville	495,000
Intensive Treatment/Case Management	Community Mental Health Program of H&PE (Belleville, Picton, Trenton, Bancroft & Tweed)	640,698
Community Treatment Order Case Manager	Community Mental Health Program of H&PE	79,200
Community Treatment Order Coordinator	Quinte Healthcare Corporation, Belleville	86,400
Peer Support	Club Freedom, Community Mental Health Program, Belleville	343,937
Court Diversion	Community Mental Health Program of H&PE	138,000
Intensive Treatment/Case Management	North Hastings Counselling Centre, Quinte Healthcare Corporation, Bancroft	158,912
Employment Support	North Hastings Counselling Centre, Quinte Healthcare Corporation,	62,754
Session Fees	Quinte Healthcare Corporation	107,761
Homelessness, Phase 2 (50 units)	Quinte & Region Community Homes, Belleville – Support Services	514,272
County Total		2,626,934

Lennox and Addington Counties		
Service Type	Agency	Funding
Crisis Response	L & A Community Mental Health Services (Napanee, Amherstview, Tamworth, Northbrook)	358,586
Intensive Treatment/Case Management (including peer support)	L & A Community Mental Health Services	466,229
Court Diversion	L & A Community Mental Health Services	69,000
Homelessness (Phase 2 – 12 units)	L & A Community Mental Health Services (does not include 850,000 for Capital purchase)	142,656
County Total		1,036,471

Frontenac County		
Service Type	Agency	Funding
Intensive Treatment/Case Management	Frontenac Community Mental Health Services (Kingston)	252,579
Court Diversion	Frontenac Community Mental Health Services	138,000
Community Treatment Order Case Manager	Frontenac Community Mental Health Services	79,000
Community Treatment Order Coordinator	Hotel Dieu Hospital, Kingston	86,000
Eating Disorder Initiative	Hotel Dieu Hospital, Kingston	102,890
Sessional Fees	Hotel Dieu Hospital, Kingston	127,912
Homelessness (Phase 2- 42 Units)	Frontenac Community Mental Health Services (does not include \$2.7 million for Capital Purchase)	499,296
County Total		1,286,277

**Ministry of Health and Long-Term Care Mental Health Reinvestments
Across Southeastern Ontario, as of 4 July 2001 (continued)**

Leeds & Grenville Counties		
Service Type	Agency	Funding
Crisis Response	Elmgrove Services, Brockville Psychiatric Hospital, (ROHCG), Brockville	500,000
Intensive Treatment & Case Management	Leeds & Grenville Rehabilitation & Counselling Services, Brockville, Kemptville, Gananoque, Elgin, Prescott	802,098
Peer Support	Consumer Health Advocacy Rights Movement, Brockville	64,303
Family Support & Transportation	Canadian Mental Health Association Leeds & Grenville, Brockville	182,748
Court Diversion	Canadian Mental Health Association Leeds & Grenville	69,000
Homelessness Phase 2 - 37 units	Leeds & Grenville Rehabilitation & Counselling Services	325,852
County total		1,944,001

Lanark County		
Service Type	Agency	Funding
Crisis Response	Lanark County Mental Health, Smiths Falls, Perth, Almonte, Carleton Place	500,000
Intensive Treatment & Case Management	Lanark County Mental Health	376,350
Court Diversion	Lanark County Mental Health	69,000
Homelessness Phase 2 - 13 units	Lanark County	211,000
County total		1,156,350

Geriatric Psychiatry - Rural	Providence Continuing Care Centre, Kingston	1,500,000
Dual Diagnosis	Providence Continuing Care Centre	1,000,000
Homes for Special Care	Providence Continuing Care Centre & Royal Ottawa Health Care Group	
Total		2,622,458



Appendix F:

District Health Council Demographic Survey of Southeastern Ontario

Demographics of Southeastern Ontario

An Overview from the 1996 Census of Population

Demographics of Southeastern Ontario

An Overview

This document presents a demographic profile of the 6 Census Divisions that comprise the geographic boundaries of the Southeastern Ontario District Health Council. The statistics referred to in this document are derived from the 1996 Census of population. They provide a profile of the population intended to highlight the districts age/sex structure and socio-economic characteristics. The analysis compares statistics from the Census Divisions across the district to comparable Provincial indicators and in some instances highlights variations across the district. In this fashion the statistics presented emphasize the Southeastern situation in relation to the province and in turn identify heterogeneity across communities and areas within the district.

The tables, maps and charts are presented in an Appendix at the end of this document to allow them to be printed on overhead transparencies if desired. Additional information is available for individual municipalities from the Southeastern Ontario District Health Council, the three Public Health Units in the district or on Statistics Canada's community profiles website (<http://ww2.statcan.ca/english/profil>).

The Southeastern District: Size, Population and Growth

The new Southeastern Ontario DHC covers a broad area that stretches north along the eastern end of Lake Ontario and the western section of the St. Lawrence River. The area encompasses over 20,000 km² and is home to approximately 475,000 people (see Map: *The Southeastern Ontario District Health Council*, pg. A1). Demographic profiles and planning activities have historically been compiled according to the boundaries of the three DHCs that previously covered the district. Sub-regions were identified within each of these previous DHCs and used for planning purposes to recognize heterogeneity within each district.

Traditionally, the Hastings and Prince Edward area has been divided into six smaller areas for planning purposes (see Map: *Planning Areas: Hastings and Prince Edward Counties*, pg. A2). There are a number of towns and villages interspersed throughout the Counties. The population density is highest in the Southern end of Hastings County along the Highway 401 corridor and considerably lower in the northern reaches of the H&PE area. The KFL&A area has been divided into three areas for planning purposes: an urban core consisting of the city of Kingston and two surrounding townships, the urban fringe consisting of surrounding townships, and a largely rural section stretching to the Health Unit boundaries (see Map: *Urban Regions – Frontenac, Lennox & Addington Counties*, pg. A3). The population density across the area follows this urban pattern with a higher density along the Lake Ontario /Highway 401 corridor to the south. The Leeds, Grenville & Lanark region is a largely rural region interspersed with small towns and villages with

the City of Brockville being the largest urban centre (see Map: *Urban Regions – Leeds, Grenville & Lanark Counties*, pg. A4). The population density across the area is higher along the St. Lawrence River/Highway 401 corridor to the south and along the eastern edge of the area heading up to Ottawa.

Population growth between 1991 and 1996 in the Southeastern district was slightly lower than the provincial average. The population of the area grew by 5.3% between 1991 and 1996 (see Table: *Population Growth – Census Divisions in Southeastern Ontario*, pg. A5). This compares to a growth rate of 6.6% for the entire province. Population growth was limited in Hastings and Prince Edward Counties. The population of H&PE Counties grew by 2.6% between 1991 and 1996 with a higher rate of growth in the central and northern areas. However, ten municipalities in the H&PE area experienced population decline over this time period (see Map: *Population Change, 1991 to 1996 – CSDs in Southeastern Ontario*, pg A6). These areas include the City of Belleville and several of the Towns and villages in the area (Marmora, Deloro, Tweed, Frankford, Deseronto & Bloomfield). In KFL&A the former townships surrounding the City of Kingston (pre-amalgamation) experienced high rates of growth (over 10%). However, the former City of Kingston, Amherst Island, and South Fredericksburgh township experienced population decline over this period. Lanark and Leeds & Grenville Counties had the highest rates of growth over the last 5 years among the counties within the District Health Council. The population of Leeds & Grenville United Counties grew by 6.7% between 1991 and 1996 while the population of Lanark County grew by 9.2%. Across the tri-county area population growth is highest in the northern and western sections with generally slower growth in the southern sections of the St. Lawrence River. Prescott, Smiths Falls and the village of Lanark experienced negative growth over this period.

Population pyramids provide a detailed look at the age distribution of the population within a region. A population pyramid for the Southeastern district reveals several facets of the population – most noticeably the bulge of the baby boom generation (see Chart: *Population Pyramid, 1996, Southeastern Ontario*, pg. A7). Born between 1947 and 1966, the dominance of the baby-boomers in the age distribution is not exclusive to the Southeastern district. This cohort dominates the age distribution for all regions in Canada and other developed nations. This period of ‘booming’ fertility rates were followed by a precipitous decline in fertility rates – the baby bust. Finally, the ‘echo-effect’ of the baby-boom generation is clearly evident in the graph. The higher population counts below the age of 20 are not a function of an increasing fertility rate but rather the sheer number of women in the baby-boom generation within their child-bearing years. One additional feature evident in the chart is the much higher number of females among the elderly age group. The effect of differences in life-expectancy result in approximately 2.5 times more females in the 85+ population.

Comparing the age distribution of the Southeastern population to the provincial average reveals a slightly older population with higher percentages of the population in the ‘elderly’ (65+) and ‘near-elderly’ age groups (see Chart: *Age Distribution by Selected Age Groups, Southeastern Ontario and the Province*, pg. A8). The age distribution is not homogeneous over the district. Differences are evident in the age structure of the

population even across the crude geographic designations of the districts planning areas (see Table: *Population in Selected Age Groups - Planning Areas in Southeastern Ontario*, pg. A9).

In Hastings & Prince Edward, Prince Edward County and the City of Belleville have a particularly high percentage of their populations among the elderly age groups. In KFL&A the urban core has the highest percentage of young adults within the area and a relatively high proportion of elderly persons. The rural area has a relatively high percentage of children and teenagers as well as the highest percentage of elderly persons. These high percentages are offset by a low relative percentage of young adults in the rural population. The rural area has the lowest percentage of its population between the ages of 20 and 44. 'Suburban families' can generally characterize the urban fringe in KFL&A. The urban fringe has high percentages of older adults (23.4% between ages of 45 and 64) and young children (28.0%) and a much lower percentage of elderly persons than the other areas. These discrepancies illustrate the fact that local age distributions may vary widely from the picture presented by the KFL&A area as a whole. In Leeds, Grenville & Lanark a more detailed look reveals differences in the age distribution across townships and municipalities. In particular, the villages, towns and city in the area have a much higher percentage of elderly than the 'rural' areas.

A map of the Southeastern district illustrates that a number of the small municipalities across the region have very high percentages of their populations among the elderly age groups (see Map: *Percentage of the Population Aged 65 and Over – CSDs in Southeastern Ontario*, pg A10). On the map, any shaded region represents an area with a higher percentage of the population over the age of 65 than the province. In the H&PE area, Bancroft, Madoc, Marmora, Tweed, Wellington and Picton as well as the townships of Bangor, Wicklow & Mclure and North Marysburgh have over 1 in 5 of the population among these senior age groups. Across KFL&A there is generally an older population in the northern rural portions of the area. The map also illustrates the discrepancy in the percentage of seniors in the pre-amalgamated City of Kingston and the surrounding Census Sub-divisions. The township of Palmerston and North and South Canonto has by far the highest percentage of seniors in the KFL&A area with just fewer than 30% of the population within this elderly age group. In LG&L the map indicates a generally younger population in the NorthEast portion of the area toward Ottawa. The map also illustrates the very high percentages of seniors in some of the small towns in the area. Westport has over 30% of their population among these elderly age groups while in Gananoque, Perth, Prescott and Merrickville over 1 in 5 persons are senior citizens.

Socio-Economic Indicators

Several socio-economic indicators are designed to give an overview of populations-at-risk in the Southeastern district and compare these local values to provincial averages. These indicators include the percentage of families with children that are headed by a lone-parent and the percent of these with a female lone-parent (see Chart: *Living Arrangements: Populations at Risk*, pg A11). In the Southeastern District these values are very close to the provincial average. However, a closer look uncovers across the district. Hastings and Prince Edward had a higher percentage than the province of lone parent families particularly in the City of Belleville (see Table: *Living Arrangements: Populations at Risk – Planning Areas in Southeastern Ontario*, A12). This percentage is much higher in the ‘urban’ areas across the region with values over 30% in Belleville, Trenton, Picton as well as the Township of Limerick. In KFL&A the ‘lone-parent’ indicators display a higher percentage within the urban core. The percentage of lone-parent families in the pre-amalgamation City of Kingston was much greater than the provincial average at over 38%. In LG&L there is evidence of a similar gradient of increasing percentages in larger urban regions. The percentage of lone-parent families in the towns in the region and the City of Brockville are greater than the provincial average.

The Southeastern District displays not only a larger percentage of the population who are elderly but also a higher percentage of seniors who live alone. The distribution of this population is not equal across the region. In H&PE the percentage of seniors who live alone is very high in the villages and towns in the region as well as the City of Belleville. In the villages of Stirling, Tweed and Madoc as well as the Town of Picton and the Township of Limerick over 40% of the seniors live alone. In KFL&A the percentage of seniors who live alone is very high in the urban core and rural areas in the region. In each of these environments close to 30% of the seniors live alone. In LG&L, the percentage of seniors who live alone is very high in the villages and towns in the region as well as the City of Brockville. In each of these environments over 36% of the seniors live alone

The unemployment rates across planning areas in the district are presented as well as the employment classifications of the population. The unemployment rate for the youngest segment of the labour force in the Southeastern district is higher than the provincial average at 18.9% (see Chart: *Unemployment Rates for Population 15+ and 15-24*, pg A13). The unemployment rate across all age groups at 9.6% was higher than the provincial average of 9.1%.

In H&PE the unemployment rate is lowest in Prince Edward County and the Southeast section of Hastings County (see Table: *Unemployment Rates among the Population 15 and Over, Planning Areas in Southeastern Ontario*, pg A14). The North Hastings area has the highest unemployment rate of all the planning areas with almost 15% of the population unemployed. In KFL&A, the rate of unemployment is low in the Urban fringe with only 7% unemployment. However, the unemployment rate is particularly high among the rural regions with the townships of Oso and Palmerston & North & South Canonto having over 20% unemployment. In LG&L, the unemployment rate across all age groups at 8.4% is

the lowest in the region. However, the unemployment rate was higher than the provincial average in many of the villages and towns and the City of Brockville.

The employment levels within various industry classifications also vary across the region (see Table: *Employment by Industry Classification - Planning Areas in Southeastern Ontario*, pg A15). A higher percentage of the rural population is employed in Primary industry with a corresponding low percentage employed in the Tertiary sector. This relationship is particularly evident in Prince Edward County and the Northern areas of Hastings County. Primary industry includes occupations related to agriculture, mining & quarrying, fishing and trapping, and logging and forestry, while the Tertiary sector includes service industries.

Statistics detailing the Southeastern populations' education levels indicate a lower percentage who have less than a grade 9 education (see Chart: *Highest Level of Schooling, Population 15 and Over*, pg A16). The population has a slightly lower percentage of the population with a University degree. The aggregate impact of these factors is a vast majority of the population having some high-school education or some non-university education. Across the district, education levels are generally higher in and around the City of Kingston where Queen's University is located (see Table: *Highest Level of Schooling - Planning Areas in Southeastern Ontario*, pg. A17). In the new City of Kingston (City of Kingston, Kingston Township and Pittsburgh Township) and Amherst Island each of which have more than 25% of the population with a university degree.

Finally, the incidence of low-income in the region is slightly lower than the provincial average. Approximately 15.0% of individuals in private households in the region live below the Statistics Canada low-income cutoffs (see Chart: *Incidence of Low-Income, Percent Below Low-Income Cutoffs*, pg A18). This compares to 17.7% for the province. However, this percentage varies considerably across the different 'urban environments' in the region. For example, in KFL&A while the percentage is 18.4% in the urban core and 17.0% in the rural regions it is much lower at 9.1% in the urban fringe. A closer look at low-income populations across municipalities in the region illustrates considerable variation even within these crude categories. For example, the high percentage of 18.4% for the KFL&A urban core is misleading. This percentage is dominated by the City of Kingston as the two surrounding townships, which combine to create the urban core, have less than 6% of the populations living below the low-income cut-offs. The percentage living below the low-income cutoffs is higher in many of the urban areas in the district. Over 20% of the population lives below the low-income cutoffs in urban areas (see Map: *Percent of the Population Living Below Statistics Canada's Low-Income Cutoffs - CSDs in Southeastern Ontario*, pg A19). In addition, a high percentage of the rural population in Central and North Hastings was living below the low-income cutoffs at the time of the 1996 Census of Population.

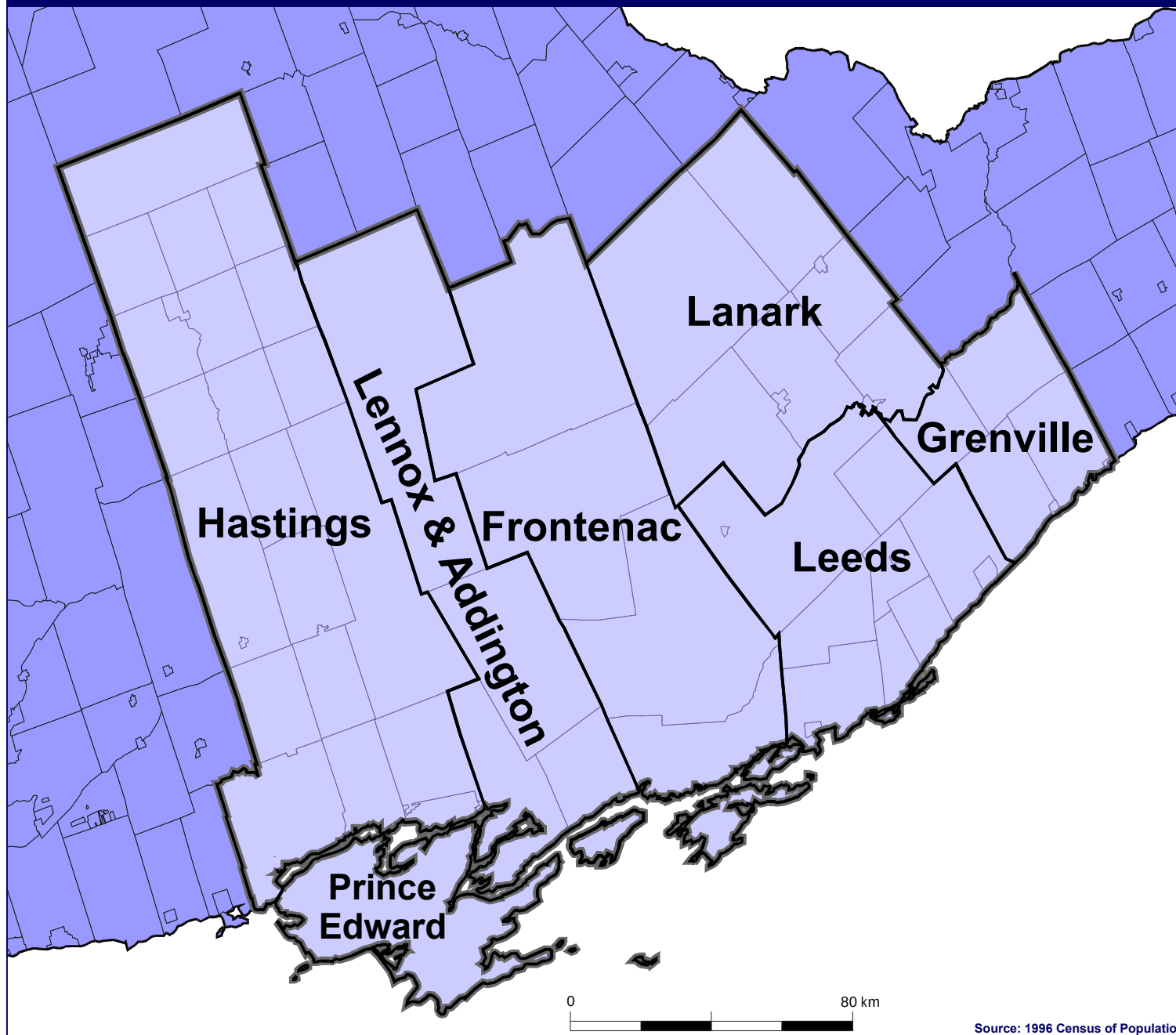
Summary

This document is intended to not only give an overview of the characteristics of the population in the Southeastern district but to foster a realization of the heterogeneity across local areas. What are the implications of the aging of the baby-boom cohort? How will this vary across local communities? One implication of these differing local populations is a need to identify the strengths and weaknesses in these local communities in enhancing the quality of life within the community and the region as a whole. The DHC has identified that social, economic and environmental factors are all related to health and ultimately the quality of life in a community. The DHC is committed to soliciting feedback from local communities concerning the factors that are of vital importance to increasing the quality of life within the region.

Appendix: List of Tables and Figures

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A1	Map	The Southeastern Ontario District Health Council
A2	Map	Planning Areas – Hastings & Prince Edward Counties
A3	Map	Urban Regions – Frontenac, Lennox & Addington Counties
A4	Map	Urban Regions – Leeds, Grenville & Lanark Counties
A5	Table	Population Growth – Census Divisions in Southeastern Ontario
A6	Map	Population Change, 1991 to 1996 – CSDs in Southeastern Ontario
A7	Chart	Population Pyramid, 1996, Southeastern Ontario
A8	Chart	Age Distribution by Selected Age Groups, Southeastern Ontario and the Province
A9	Table	Population in Selected Age Groups - Planning Areas in Southeastern Ontario
A10	Map	Percentage of the Population Aged 65 and Over – CSDs in Southeastern Ontario
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A13	Chart	Unemployment Rates for Population 15+ and 15-24
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A16	Chart	Highest Level of Schooling, Population 15 and Over
A17	Table	Highest Level of Schooling – Planning Areas in Southeastern Ontario
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A19	Map	Percent of the Population Living Below Statistics Canada's Low-Income Cutoffs - CSDs in Southeastern Ontario

The Southeastern Ontario District Health Council



Vital Statistics

Leeds & Grenville United Counties

Area: 3,390 km²
Population: 96,284

Lanark County

Area: 3,064 km²
Population: 59,845

Frontenac County

Area: 3,820 km²
Population: 136,365

Lennox & Addington

Area: 2,841 km²
Population: 39,203

Hastings County

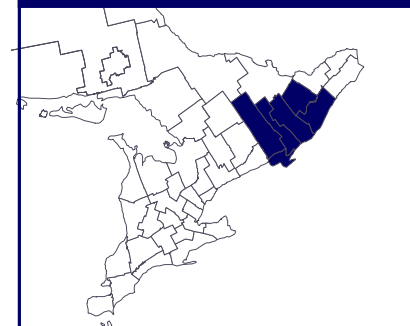
Area: 5,697 km²
Population: 118,744

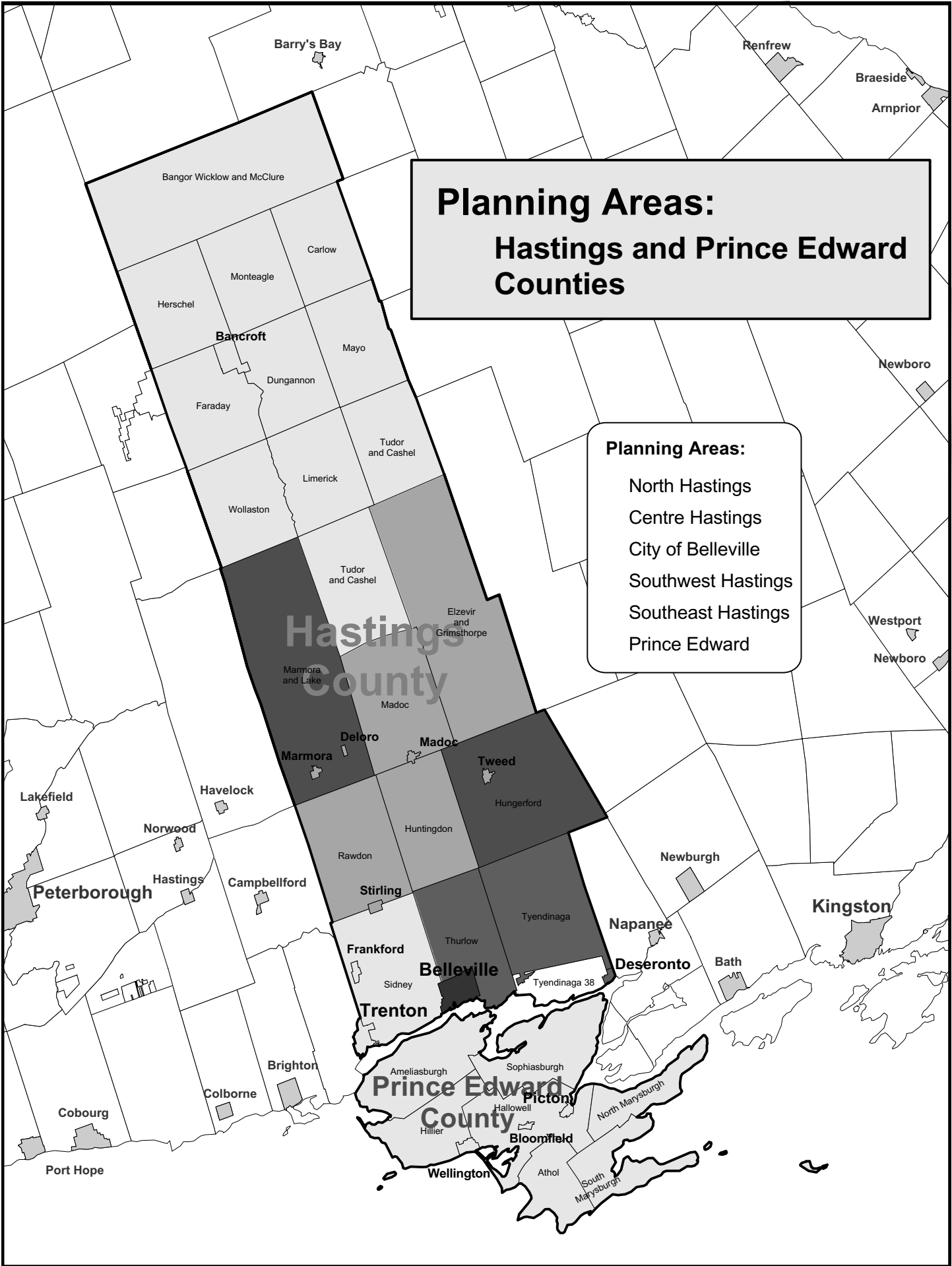
Prince-Edward County

Area: 1,048 km²
Population: 25,046

Southeastern Ontario District Health Council

Area: 20,130 km²
Population: 475,487

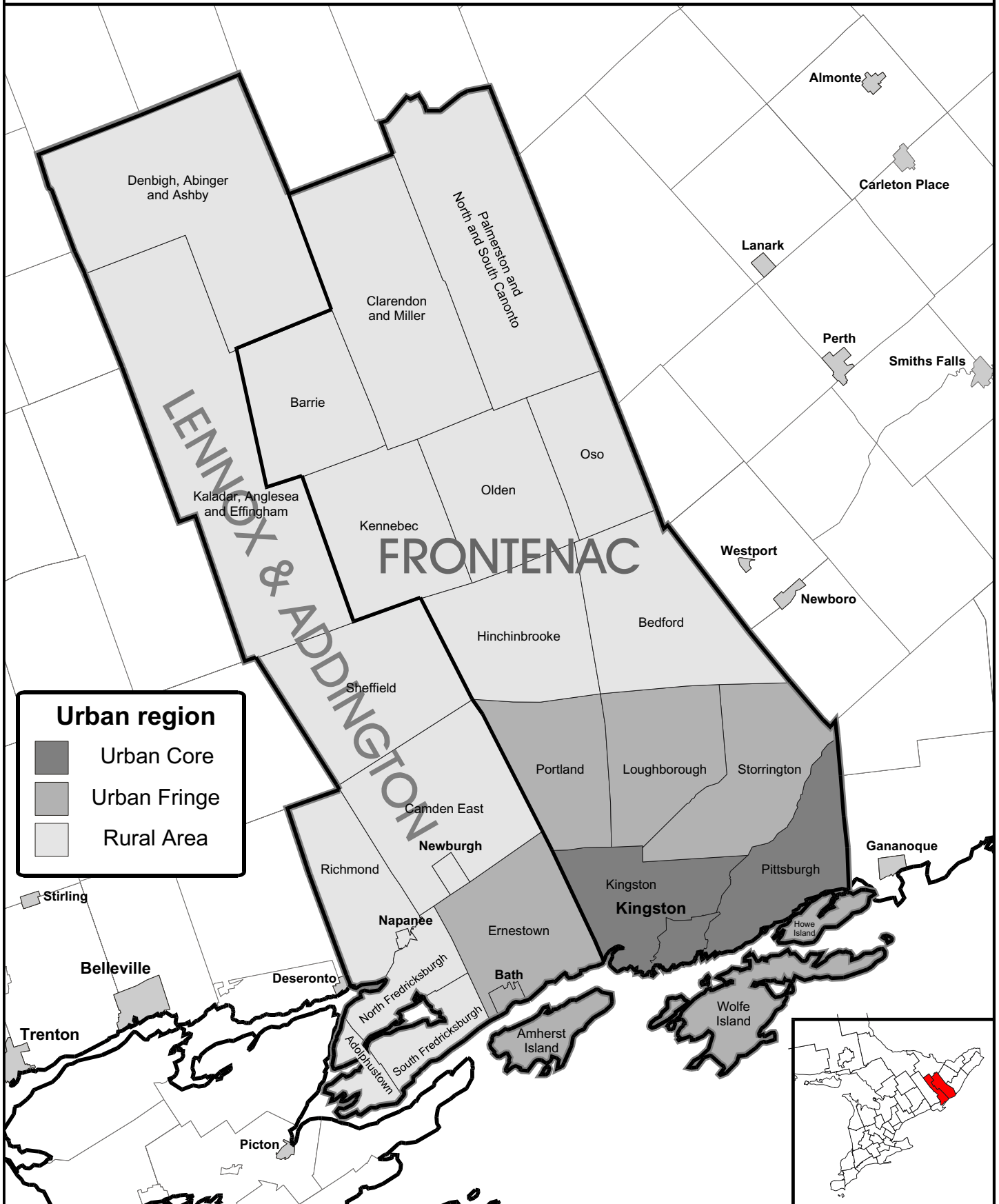




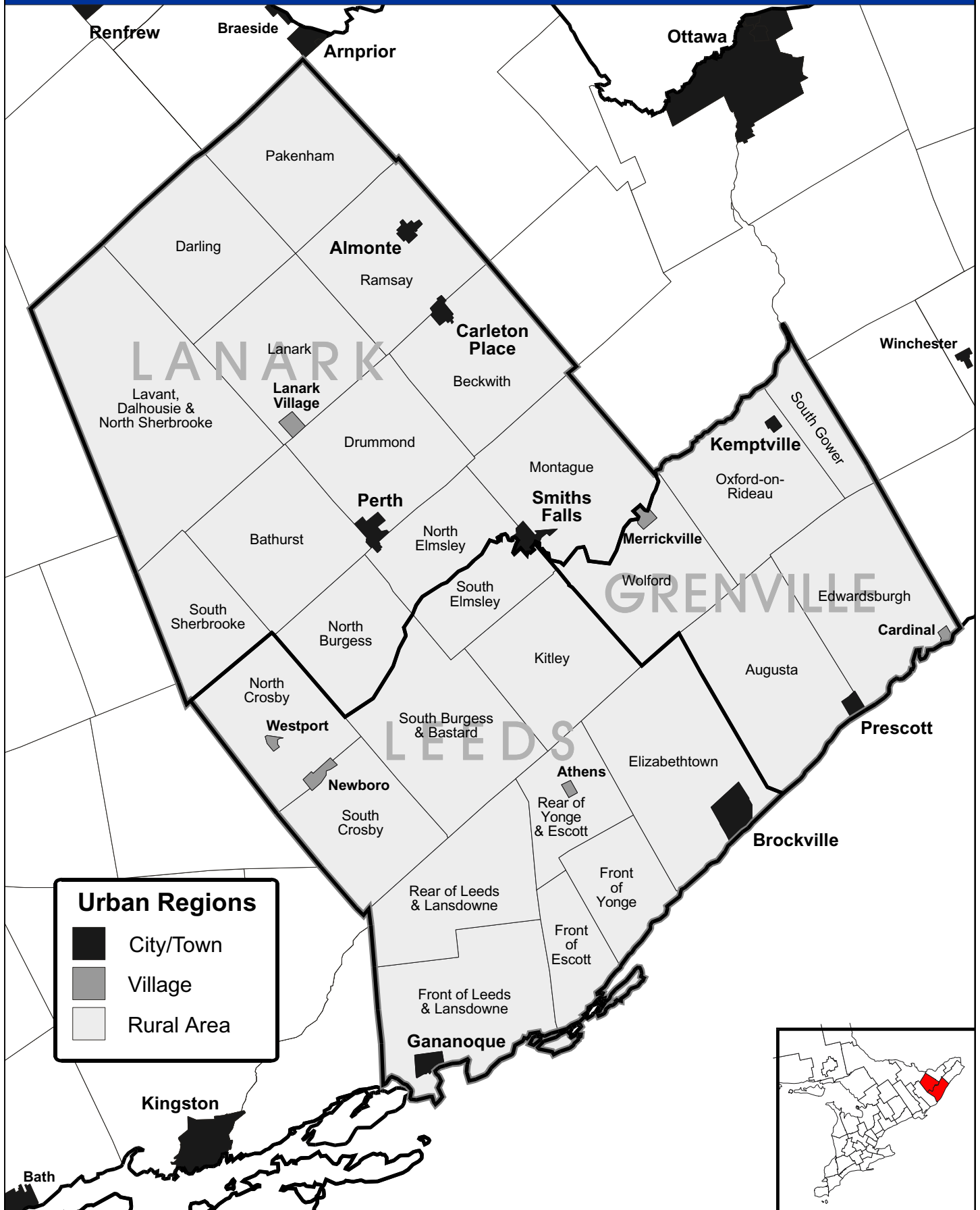
Planning Areas:
Hastings and Prince Edward
Counties

- Planning Areas:**
- North Hastings
 - Centre Hastings
 - City of Belleville
 - Southwest Hastings
 - Southeast Hastings
 - Prince Edward

Urban Regions: Frontenac, Lennox & Addington Counties



Urban Regions - Leeds, Grenville and Lanark Counties



Population Growth, 1991-1996

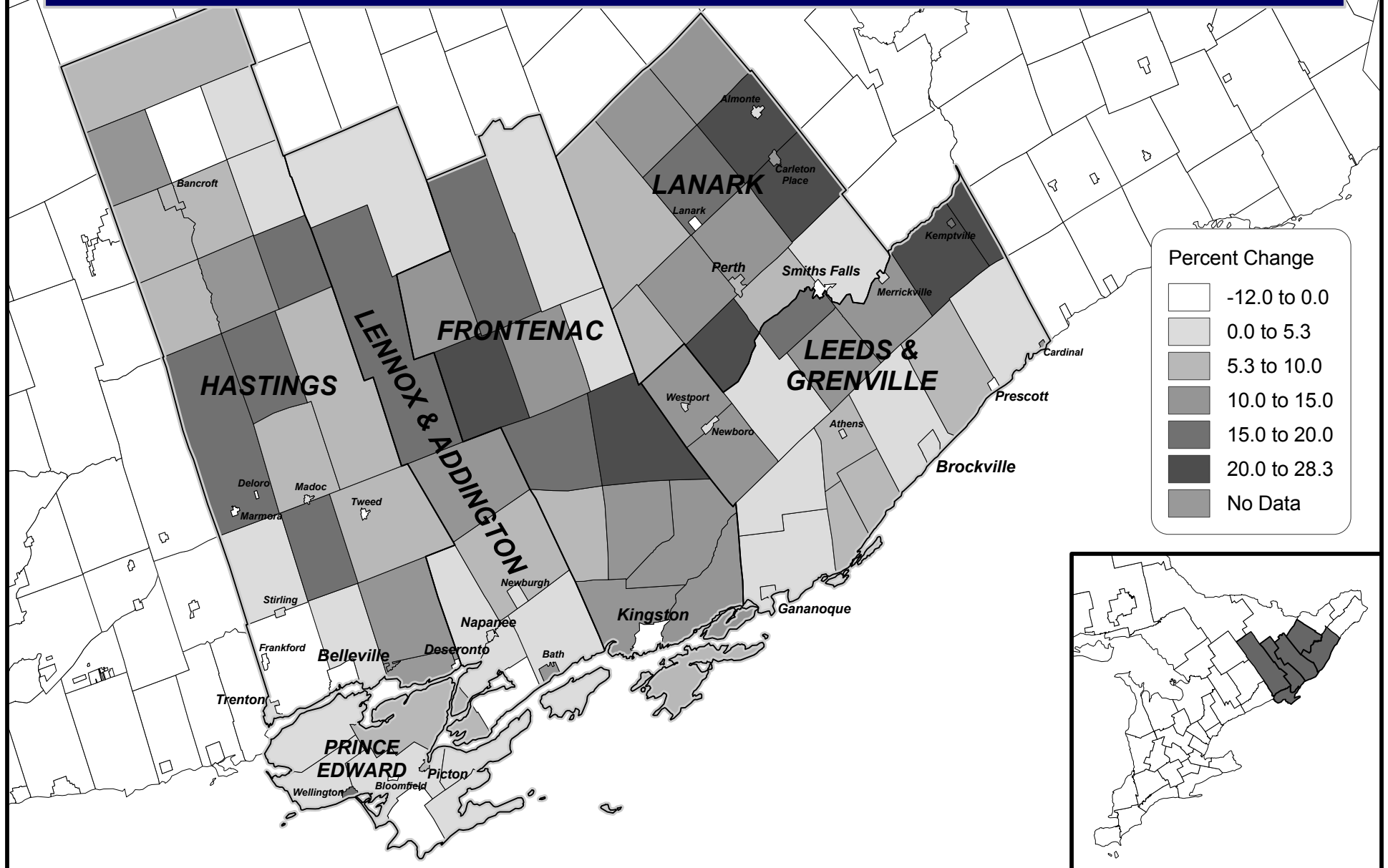
Census Divisions in Southeastern Ontario

	Population		Percent
	1991	1996	Change
Lanark	54,803	59,845	9.2%
Leeds & Grenville	90,235	96,284	6.7%
Frontenac	129,089	136,365	5.6%
Lennox & Addington	37,243	39,203	5.3%
Hastings	116,434	118,744	2.0%
Prince Edward	23,763	25,046	5.4%
Southeastern Ontario	451,567	475,487	5.3%
Ontario	10,084,885	10,753,573	6.6%

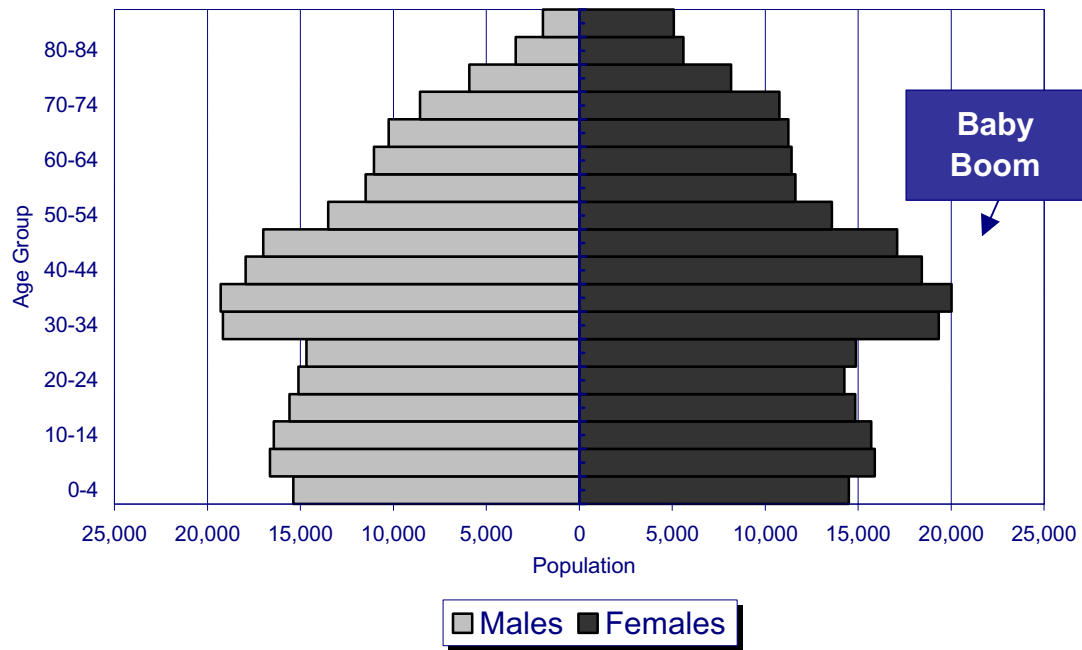
Source: Statistics Canada Census of Population, 1996

Population Change, 1991 to 1996

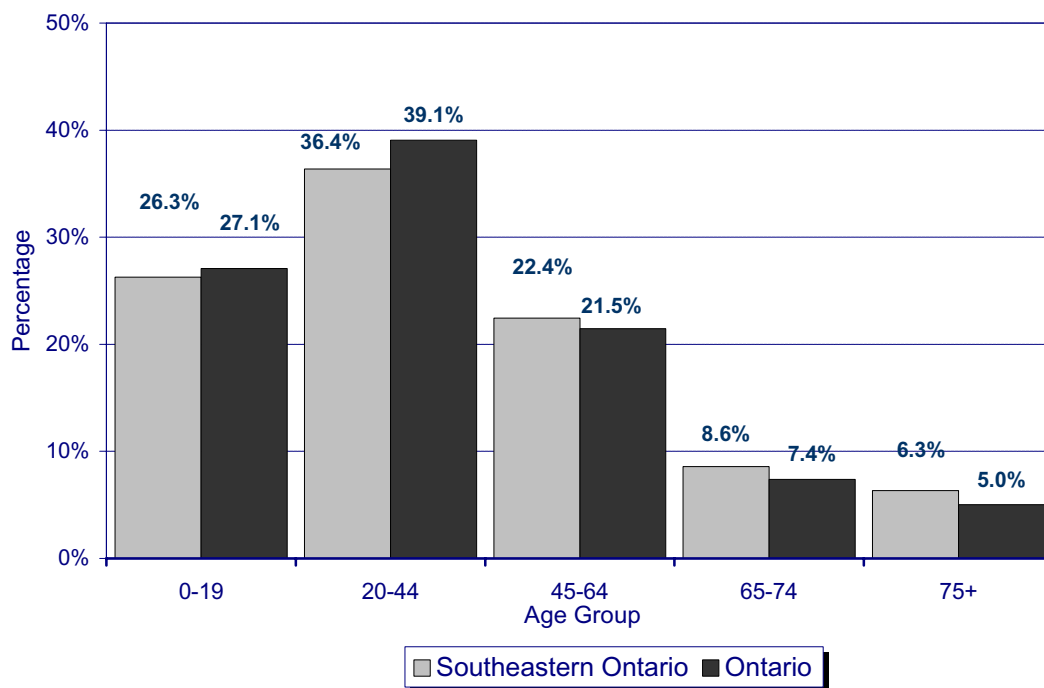
CSDs in Southeastern Ontario



Population Pyramid - 1996 Southeastern Ontario



Age Distribution by Selected Age Groups Southeastern Ontario and the Province



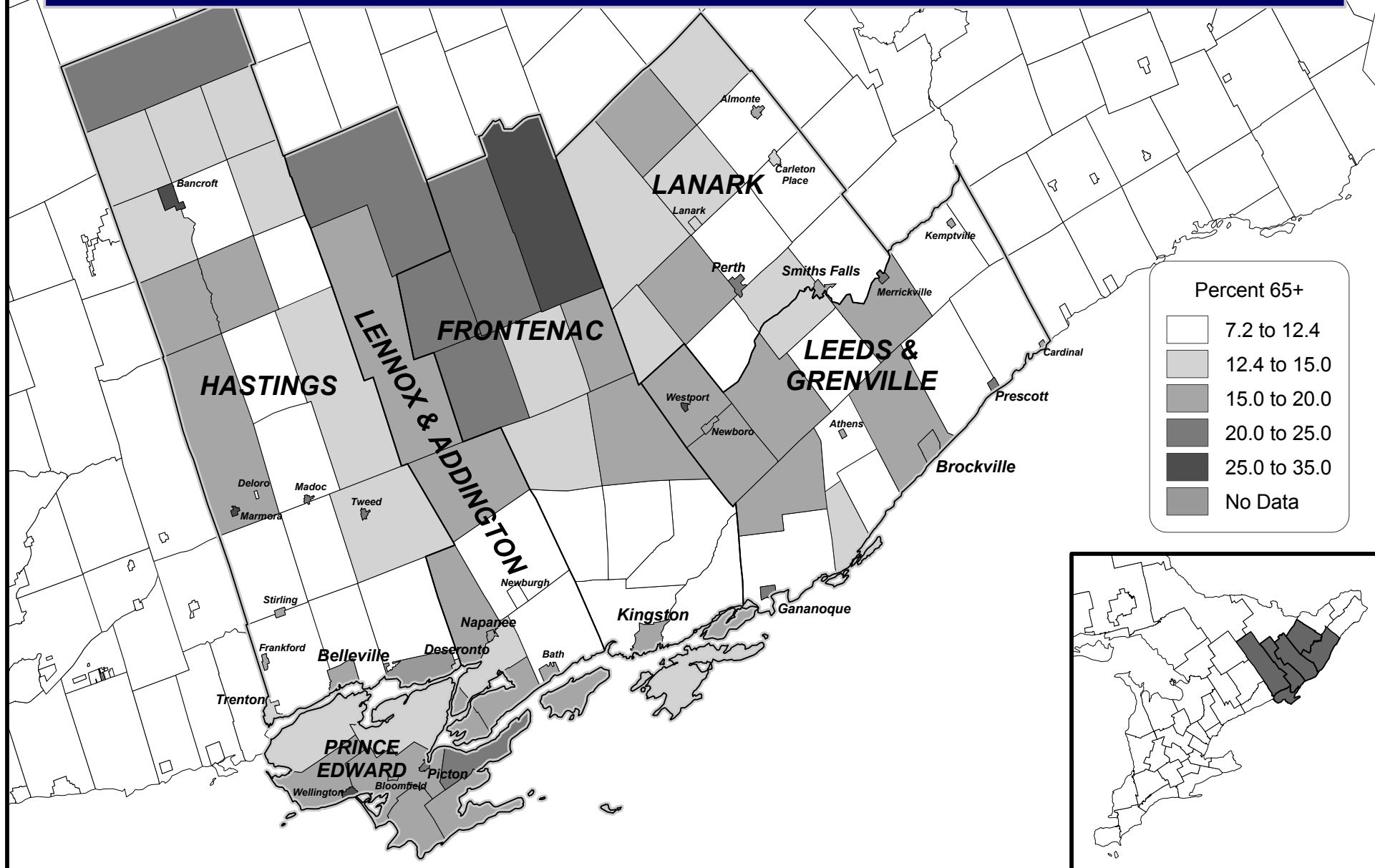
Population in Selected Age Groups

Planning Areas in Southeastern Ontario

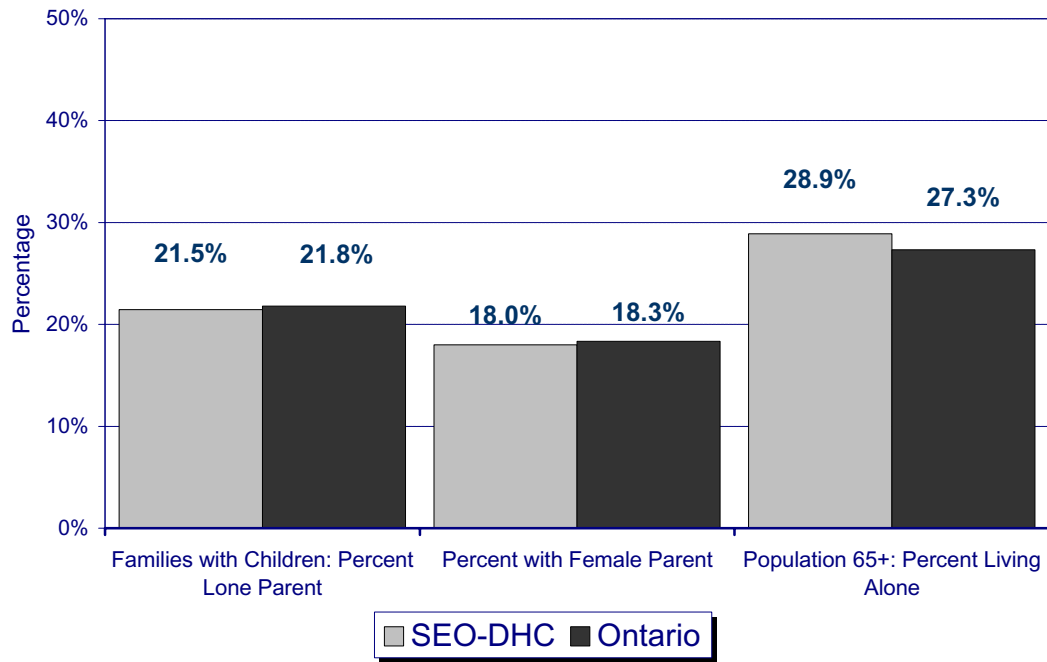
Planning Areas	Age Groups				
	0-19	20-44	45-64	65-74	75+
Leeds, Grenville & Lanark Planning Areas					
City/Towns	25.5%	35.1%	20.7%	9.7%	9.0%
Villages	24.7%	33.1%	22.9%	10.1%	9.4%
Rural Townships	27.5%	35.2%	24.7%	7.8%	4.8%
LG&L	26.6%	35.1%	23.0%	8.6%	6.6%
Kingston Frontenac, Lennox & Addington Planning Regions					
Urban Core	24.6%	40.8%	20.8%	7.9%	5.8%
Urban Fringe	28.0%	38.0%	23.4%	6.5%	4.1%
Rural	26.4%	33.1%	24.1%	9.6%	6.9%
KFL&A	25.5%	38.9%	21.9%	8.0%	5.7%
Hastings and Prince Edward Planning Regions					
North Hastings	26.0%	30.4%	25.8%	10.7%	6.6%
Centre Hastings	27.8%	33.2%	23.0%	9.2%	6.4%
Belleville	25.2%	36.4%	20.5%	9.7%	8.3%
Southwest Hastings	28.0%	36.8%	21.7%	8.0%	5.5%
Southeast Hastings	30.6%	35.8%	22.3%	7.0%	4.2%
Prince Edward County	25.0%	31.3%	25.0%	11.1%	7.7%
H&PE	26.8%	34.6%	22.5%	9.3%	6.7%
Southeastern Ontario	26.3%	36.3%	22.4%	8.6%	6.3%

Source: Statistics Canada Census of Population, 1996

Percent of the Population Aged 65 and Over, 1996 CSDs in Southeastern Ontario



Living Arrangements Populations at Risk



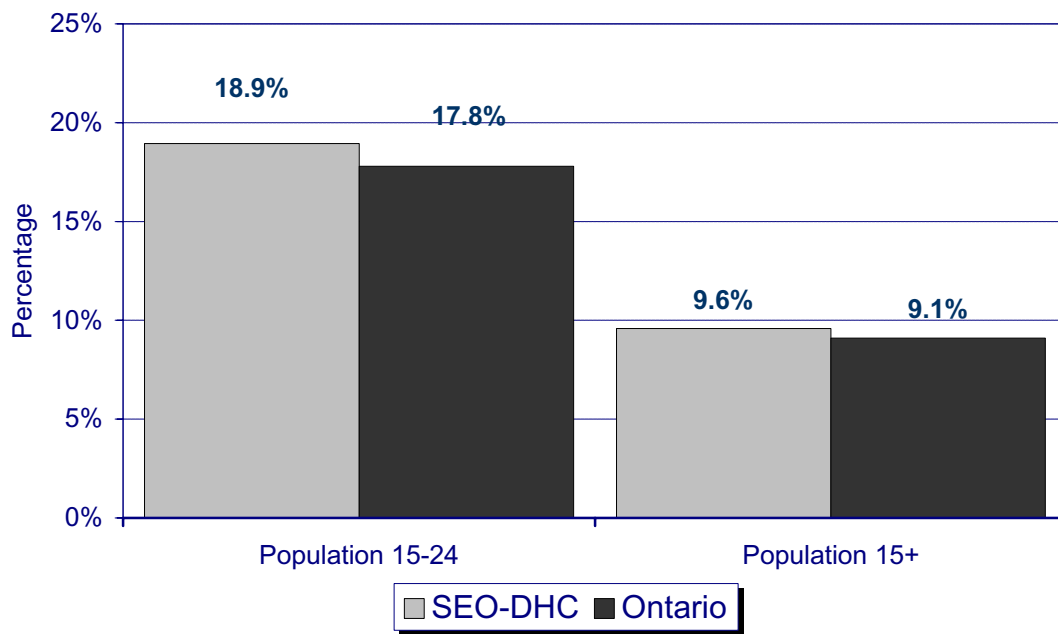
Living Arrangements: Populations at Risk

Planning Areas in Southeastern Ontario

	Families with Children		Pop. 65+
	% Lone Parent	% Female Lone Parent	Living Alone
Leeds, Grenville & Lanark Planning Areas			
City/Towns	27.1 %	23.7 %	36.2 %
Villages	20.9 %	18.1 %	36.5 %
Rural Townships	12.9 %	10.0 %	19.7 %
LG&L	18.7 %	15.6 %	28.7 %
Kingston Frontenac, Lennox & Addington Planning Regions			
Urban Core	26.5 %	22.8 %	30.7 %
Urban Fringe	16.3 %	13.2 %	18.0 %
Rural	18.7 %	15.4 %	27.7 %
KFL&A	23.1 %	19.6 %	28.3 %
Hastings and Prince Edward Planning Regions			
North Hastings	21.1 %	16.1 %	27.5 %
Centre Hastings	18.2 %	13.8 %	29.4 %
Belleville	30.1 %	25.1 %	37.2 %
Southwest Hastings	21.5 %	17.8 %	27.7 %
Southeast Hastings	15.3 %	13.5 %	21.3 %
Prince Edward County	20.6 %	17.4 %	24.5 %
H&PE	22.4 %	18.4 %	29.7 %
Southeastern Ontario	64.2 %	17.9 %	28.9 %
Ontario	21.8 %	18.3 %	27.3 %

Source: Statistics Canada Census of Population, 1996

Unemployment Rates for the Population 15+ and 15-24



Unemployment Rates Among the Population 15 and Older Planning Areas in Southeastern Ontario

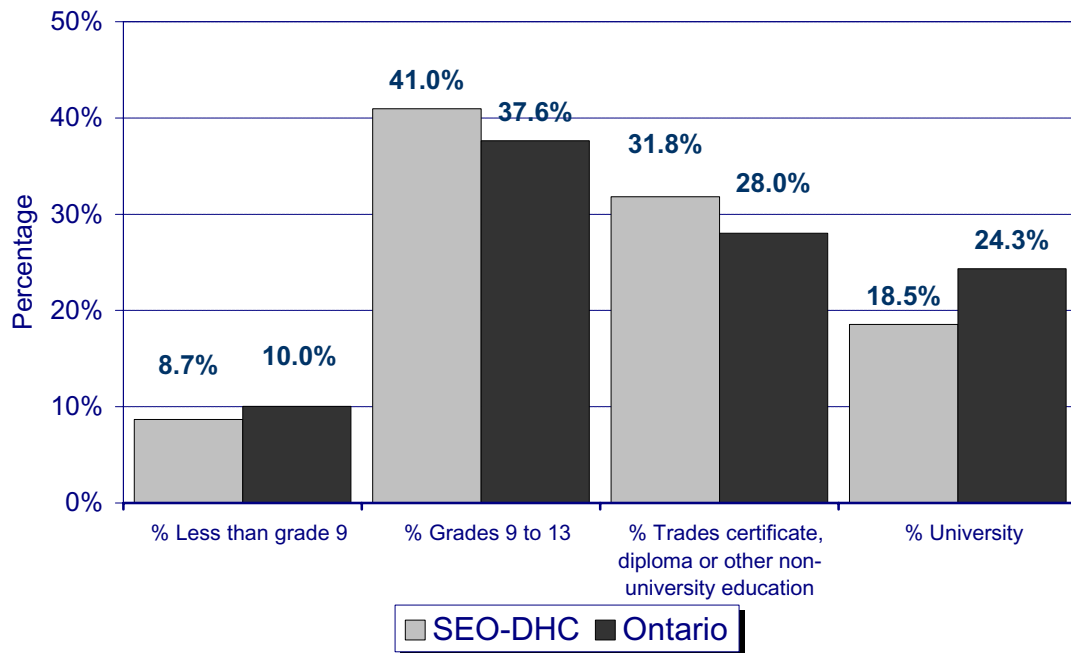
	Total Population	Labour Force Population			Unemployment Rate	Participation Rate
		Employed	Unemployed	Total		
North Hastings	9,735	4,445	770	5,230	14.8%	53.6%
Centre Hastings	16,010	8,680	1,020	9,695	10.5%	60.6%
Belleville	29,805	15,560	2,105	17,660	11.9%	59.3%
Southwest Hastings	27,245	15,100	1,845	16,940	10.9%	62.2%
Southeast Hastings	10,160	6,290	575	6,870	8.4%	67.6%
Prince Edward County	19,785	11,185	1,085	12,280	8.8%	62.0%
H&PE	112,740	61,260	7,400	68,675	10.8%	60.9%
Urban Core	88,415	51,615	5,755	57,375	10.0%	64.9%
Urban Fringe	23,120	15,225	1,145	16,375	7.0%	70.8%
Rural	25,320	13,295	1,690	14,965	11.3%	59.2%
KFL&A Region	136,855	80,135	8,590	88,715	9.7%	64.8%
City/Towns	49,495	26,785	2,990	29,780	10.0%	60.2%
Villages	4,495	2,345	290	2,640	11.0%	58.6%
Rural Areas	67,185	43,070	3,340	46,410	7.2%	69.1%
Tri-County Area	121,180	72,210	6,630	78,840	8.4%	65.1%
Southeastern Ontario	370,770	213,595	22,610	236,220	9.6%	63.7%
Ontario	8,429,210	5,077,670	509,305	5,586,975	9.1%	66.3%

Employment by Industry Classification Planning Areas in Southeastern Ontario

	Industry Classification			Total Workers
	Primary	Secondary	Tertiary	
North Hastings	9.6%	19.2%	71.3%	4,905
Centre Hastings	10.9%	23.7%	65.4%	9,255
Belleville	1.2%	19.3%	79.5%	16,875
Southwest Hastings	1.9%	21.4%	76.6%	16,260
Southeast Hastings	6.0%	26.8%	67.2%	6,610
Prince Edward County	10.3%	18.7%	70.9%	11,915
H&PE	5.5%	21.1%	73.4%	65,820
Urban Core	1.1%	12.2%	86.7%	55,315
Urban Fringe	4.2%	18.6%	77.2%	16,040
Rural	6.8%	21.5%	71.7%	14,255
KFL&A Region	2.6%	15.0%	82.4%	85,610
City/Towns	1.2%	24.3%	74.4%	28,645
Villages	2.3%	25.6%	72.0%	2,555
Rural Areas	7.7%	26.1%	66.2%	45,320
Tri-County Area	5.1%	25.4%	69.5%	76,780
Southeastern Ontario	4.3%	20.2%	75.5%	227,905
Ontario	3.2%	22.5%	74.4%	5,401,395

Source: Statistics Canada Census of Population, 1996

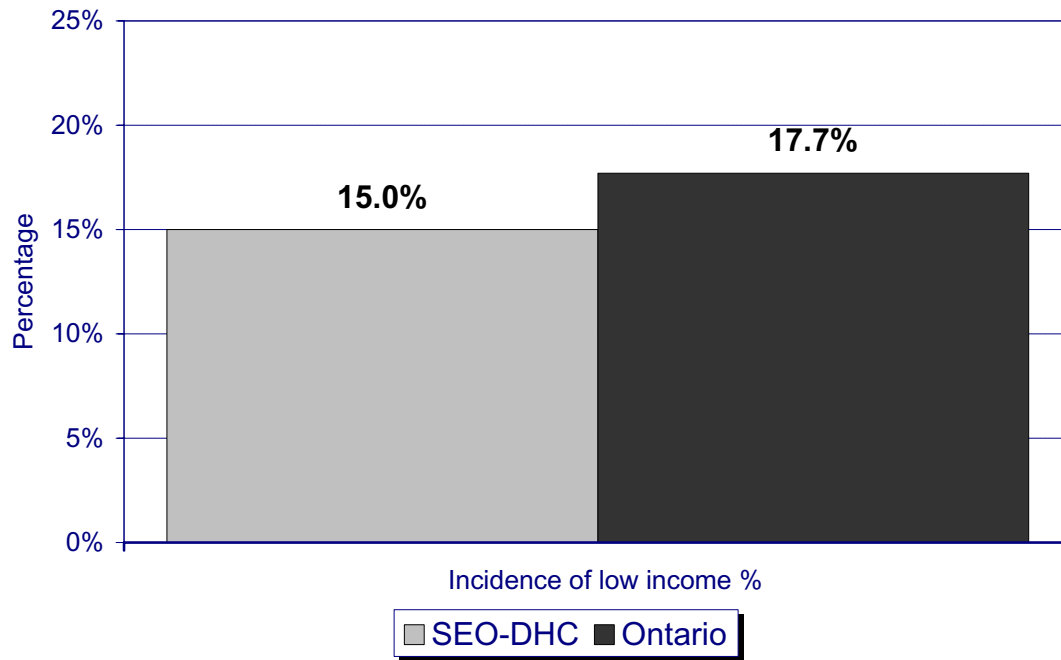
Highest Level of Schooling Population 15 and Over



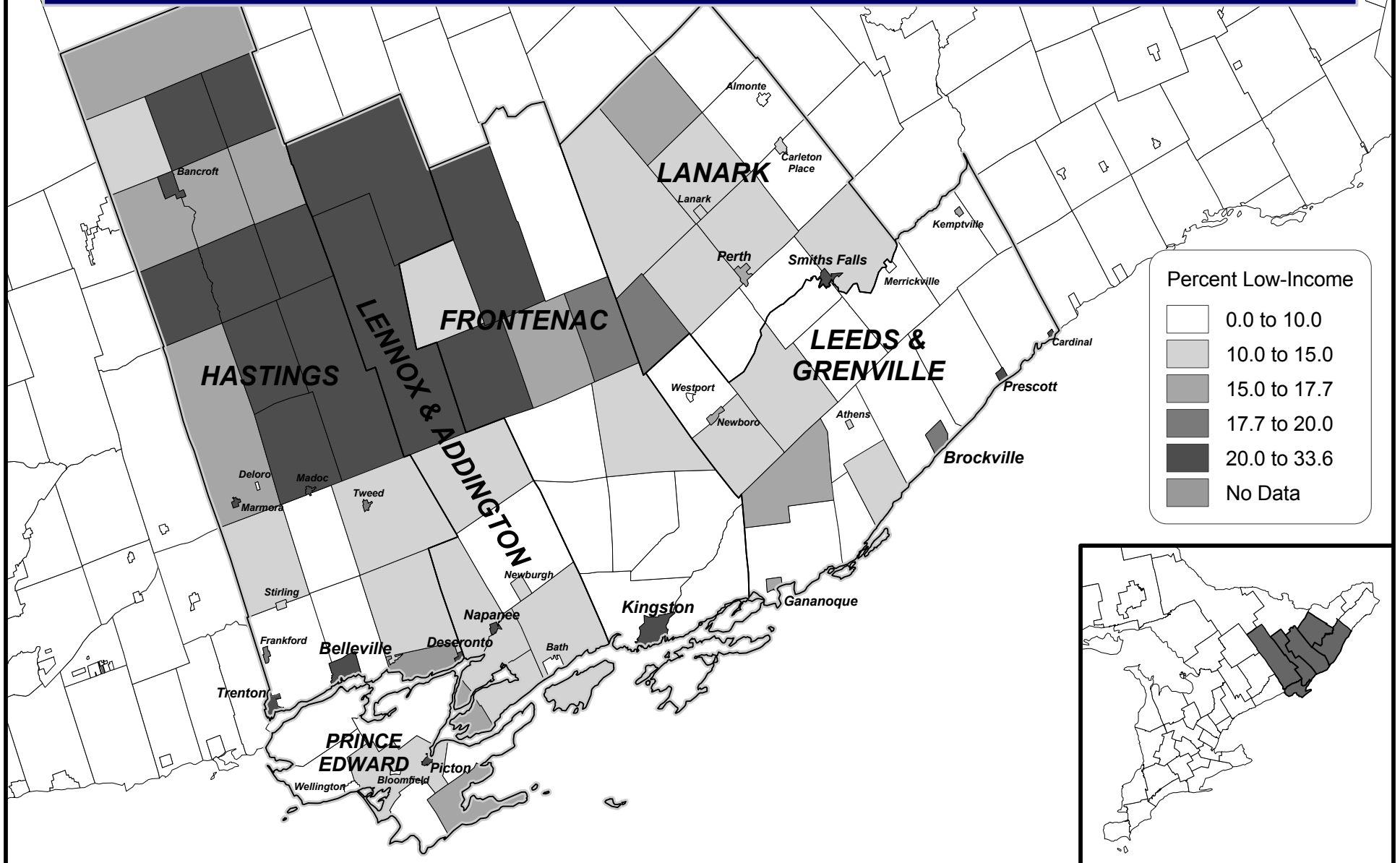
Highest Level of Schooling Planning Areas in Southeastern Ontario

	< Gr. 9	Gr. 9-13	Trades Certificate or Non-Univ	University
North Hastings	16.6%	45.0%	27.8%	10.6%
Centre Hastings	13.0%	47.6%	28.2%	11.0%
Belleville	8.7%	42.9%	32.1%	16.3%
Southwest Hastings	8.1%	45.9%	33.7%	12.3%
Southeast Hastings	10.1%	42.8%	35.0%	12.0%
Prince Edward County	11.2%	42.2%	31.8%	14.7%
H&PE	10.4%	44.3%	31.8%	13.4%
Urban Core	6.7%	33.6%	29.0%	30.7%
Urban Fringe	6.9%	41.4%	34.6%	16.9%
Rural	12.3%	47.1%	29.0%	11.6%
KFL&A Region	7.8%	37.4%	30.0%	24.8%
City/Towns	8.6%	42.5%	33.0%	16.0%
Villages	9.9%	46.7%	28.7%	14.6%
Rural Areas	7.5%	41.0%	35.0%	16.4%
Tri-County Area	8.0%	41.8%	33.9%	16.2%
Southeastern Ontario	8.7%	41.0%	31.8%	18.5%
Ontario	10.0%	37.6%	28.0%	24.3%

Incidence of Low-Income Percent Below Low-Income Cutoffs



Percent of the Population Living Below Statistics Canadas Low-Income Cutoffs CSDs in Southeastern Ontario



A large, stylized blue arrow graphic that curves upwards and to the right, with a lighter blue shadow or outline following its path. It is positioned in the upper right quadrant of the page.

Concurrent Disorders: An Integrated Service Delivery Plan for Southeastern Ontario

CONCURRENT DISORDERS

PROPOSAL FOR AN INTEGRATED SERVICE DELIVERY PLAN FOR
SOUTHEASTERN ONTARIO FOR

Concurrent Disorders

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force
and
The Southeastern Ontario District Health Council

On Behalf Of:
The Concurrent Disorders Champion Group

January 2002

Prepared By:

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CONCURRENT DISORDERS

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Chapter 1

Introduction & Purpose

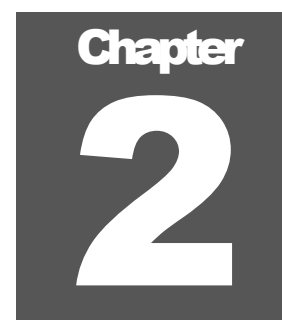
This report is submitted to the Mental Health Implementation Task Force and the Southeastern Ontario District Health Council on behalf of the Concurrent Disorders Working Group.

This project began prior to the Task Forces in response to a perceived need for integrated programming for people with concurrent disorders and was funded by the Southeastern Ontario District Health Council. A small advisory group of key stakeholders were charged with the development of a proposal for integrated services for persons with concurrent disorders in the region. When the Task Force was appointed, the District Health Council amalgamated this project into the Task Force planning structure. With ongoing financial support from the District Health Council, the original Advisory Committee was joined by the Task Force Concurrent Disorders Champions and the focus changed to take a more systemic view based on the goals outlined in *Making it Happen*.

This report reflects the best thinking of this joint working group. It outlines key components of an integrated district program for persons with concurrent substance abuse and psychiatric disorders with respect to:

- First line services;
- Intensive services;
- Specialized community services;
- Academia; and
- Information management.

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Chapter 2

Scope of The Problem

People with concurrent disorders are complex and difficult-to-treat.

Addictive and mental disorders commonly co-occur. Half of those with a history of alcohol abuse or dependence will have had a mental disorder at some point in their lives. Three out of every four clients receiving treatment for a substance abuse disorder will have a concurrent psychiatric disorder. Similarly, up to half of those receiving treatment for a psychiatric disorder will have a concurrent substance abuse disorder. The mental disorder usually occurs first, often beginning in adolescence—predating the substance abuse disorder by as much as a decade—making prevention of substance misuse a high priority for youth and young adults with a serious mental illness (Brown & Saura, 1996; Kessler, Nelson, McGonagle, Edlund, & Frank, 1996; Wu, Kouzis, & Leaf, 1999).

People with serious mental illnesses are more sensitive to the effect of alcohol and other psycho-active substances. As a result of the community mental health movement, they are now more likely to be exposed to substances and experience social pressures to use them. People with severe mental illnesses report using psycho-active substances (usually alcohol) to combat loneliness, social anxiety, boredom, and insomnia, rather than the symptoms of their illness, or the side effects of their medications (Drake & Mueser, 2000).

People with concurrent disorders present substantial treatment problems (Minkoff, 1993). Substances aggravate psychiatric conditions and interfere with psychiatric medications. Therefore, persons with concurrent disorders are a complex and difficult-to-treat population. They:

- have more severe psychiatric symptoms,
- express more self-destructive and disruptive behaviours,

- experience greater housing instability and homelessness,
- are less accepting of treatment,
- are at greater risk of relapse and revolving-door hospitalizations, and
- demonstrate difficulties in engaging treatment and community support systems designed to maximize their community integration.

However, the consequences of concurrent disorders are not just limited to increased illness severity, treatment complexity, and reduced community adjustment. They may also result in significantly higher health care costs. Those with concurrent disorders are more frequent users of expensive hospital and emergency services (Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998). In one study of psychiatric outpatients from the Veterans Administration System in the United States, for example, health care costs for outpatients with concurrent disorders were 25% higher than costs for outpatients with a single disorder. Higher costs were related to their greater use of inpatient care, outpatient services, and medical care (Hoff & Rosenheck, 1998).

Because each disorder can aggravate the course and outcome of the other, both must be treated effectively for the individual to have the best chance of recovery (Woody, 1996; Young & Grella, 1998).

Integrated Treatment as Best Practice

Integrated programs are increasingly viewed as the optimum standard of care.

The existence of separate mental health and addictions systems has posed significant problems for persons with concurrent disorders. One of three things has happened:

- they have been excluded from both treatment systems because of the complicated nature of their treatment needs,
- they may be treated for one disorder but not the other, or
- they may be treated in both systems simultaneously, but without any integration across treatment modalities or services; many times with contradictory treatment approaches.

In one study, 61% of concurrently disordered clients receiving outpatient mental health treatment were not getting concurrent substance abuse treatment. The remaining clients were receiving only minimal attention to their substance abuse problem and had not been in any formal substance abuse treatment program (Sciacca, 1991). As a

result, in the United States, The National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse have recommended integrated treatment programs for people with concurrent disorders.

In an integrated program, clients are treated for both their substance abuse and mental disorder concurrently. Service providers adopt a consistent approach, philosophy, and treatment plan so that services appear to be seamless. The need for the client to negotiate with separate and competing treatment systems to obtain concurrent care is eliminated (Drake & Mueser, 2000). Therefore, integrated treatment approaches reduce conflict between providers, decrease the burden and costs associated with attending two separate treatment programs, and eliminate the possibility of obtaining conflicting messages about treatment and rehabilitation (Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998; Drake & Mueser, 2000).

In 1987 the US National Institute of Mental Health sponsored thirteen demonstration projects to evaluate different approaches to specialized treatment programs for concurrent disorders. The approaches evaluated included: collaboration across mental health and substance abuse systems; creation of integrated programs within either system; and the development of independent programs outside of either system. The best results were achieved when treatment was integrated (Drainoni & Bachman, 1995).

There is growing evidence that appropriate treatment for persons with concurrent disorders can result in long term cost savings by reducing the use of expensive acute care services. Savings of up to 40% over an eighteen month period have been reported, largely due to reductions in hospital and emergency room use (Jerrell & Hu, 1996). In the short term, however, costs may increase until previously unmet psychosocial needs are fully addressed (Mitchell, Robertson, & Weber, 1992).

Integrated programs for the treatment of concurrent disorders are now viewed as the optimum standard of care. They are intended to overcome historical barriers between mental health and addictions systems and improve both the clinical and social outcomes for persons who have serious mental illnesses and concurrent substance abuse disorders.

Integrating Treatment Philosophies

While abstinence may be a long-range goal, harm reduction is a more realistic treatment philosophy.

Historically, the philosophies underlying the treatment of psychiatric and substance abuse disorders have differed. Substance abuse recovery programs have adopted a social perspective emphasizing a self-help recovery model, confrontational approaches to treatment, and complete abstinence from all substances; including psychotropic medications. Psychiatric programs, on the other hand, have used a medical model emphasizing pharmacotherapies, supportive therapies, and total abstinence from alcohol and street drugs (Drainoni & Bachman, 1995). However, research has shown that concurrent disorder clients are seldom ready for abstinence-oriented interventions, and they require intensive motivational interventions to elicit, cultivate, and sustain their involvement in substance abuse treatment (Mercer-McFadden, Drake, Brown, & Fox, 1997). Therefore, while abstinence from substances may be the long range goal, day-to-day harm reduction is more relevant to the majority of people with concurrent disorders, particularly those who receive their treatment in community based settings. A harm-reduction philosophy requires a treatment style that is oriented toward negotiation (rather than confrontation) and a practical, more flexible approach to medication compliance (Wingerson & Ries, 1999).

Local Needs

Integrated care for concurrent disorders in the Southeastern Ontario has been more a result of the negotiating skills of the consumer, than any attempt to integrated service delivery systems.

Table 1 (below) estimates the number of persons in the Southeastern Ontario Mental Health Implementation planning district with a severe mental illness and a concurrent substance abuse disorder. County populations were identified from figures reported by the Ontario Ministry of Finance population projections for the years 1999-2028 (Ontario Ministry of Finance, 2000). A prevalence of 2.5% for serious mental disorder was taken from a Ministry of Health and Long Term Care directive provided to the Mental Health Implementation Task Forces. The prevalence of concurrent disorders among those with a severe mental disorder was estimated from epidemiologic data presented in the literature to be approximately 50%, although this has been reported to be higher and lower depending on the study and the consumer population surveyed (Brown & Saura, 1996; Kessler, Nelson, McGonagle, Edlund, & Frank, 1996; Wu,

Kouzis, & Leaf, 1999). This table shows that there may be some 6,000 concurrently disordered individuals the Southeastern Ontario Mental Health planning district.

Table 1: Estimated Prevalence of Concurrent Disorders

County	2001 Population	Serious Mental Disorder (2.5%)	Concurrent Disorders (50%)
Hastings & Prince Edward	152,300	3,808	1,904
Lennox & Addington	40,800	1,020	510
Frontenac	138,900	3,473	1,737
Leeds & Grenville	100,600	2,515	1,258
Lanark	63,900	1,598	799
Total	496,500	12,414	6,208
Notes: Based on 2001 Population Projections, Ontario Ministry of Finance, 2000. Projections are for all of Lanark county.			

In 1995/96, a survey was conducted of all mental health and addictions services in Ontario to ask what services were provided to those with concurrent disorders (Melinyshyn, Christie, & Shirley, 1996). A total of 426 surveys were returned describing 483 programs. This was a response rate of 62%.

Virtually all programs surveyed (97%) reported having concurrently disordered clients. This would be consistent with the high prevalence figures noted above. A conservative estimate made by program staff was that one in four clients were concurrently disordered. Despite this, less than 10% indicated they had services specifically designed for concurrent disorders. Indeed, only 55% of addictions programs and 25% of mental health sector programs indicated that they undertook comprehensive assessment for concurrent disorders. Similarly, 77% of addictions programs and 38% of mental health programs conducted intake screening of clients for concurrent disorders. Outside information from past service contacts (rather than a standardized screening or intake assessment) was the main source of information for identifying clients with concurrent disorders. Once identified, the most frequent action taken was to refer the client elsewhere. This occurred in 87% of mental health sector agencies and 91% of addictions sector agencies. Eighty-five percent of programs surveyed indicated that there were instances when they would not treat a concurrently

disordered individual, most often because of inappropriate or violent behaviour (79%). Virtually all programs (96%) indicated that they needed more staff training to deal with the needs of this specialty population effectively. Half of the programs surveyed also identified greater integration of services and specialized programming as important unmet needs. While these unmet needs were pervasive, only 11% of programs reported that they would like to increase their capacity to serve those with concurrent disorders. These findings indicate that persons with concurrent disorders will continue to be marginalized without significant system-level interventions prohibiting their exclusion from programming.

A second source of information documenting local unmet needs comes from the Ontario Comprehensive Assessment Projects. In preparation for mental health restructuring and reform, the Ontario Ministry of Health and Long Term Care funded a series of assessment projects throughout Ontario.¹ These projects were conducted to document the spectrum of supports and services needed by individuals receiving services from provincial psychiatric hospitals. They also made explicit recommendations for optimizing community-based care in each project area.

The Kingston Comprehensive Assessment Project or “CAP Study” (Palmer, Macfarlane, Stuart, Durbin, Cochrane & Goering, 2000) surveyed all inpatients and a 10% sample of outpatients of Kingston Psychiatric Hospital, and those residing in Homes for Special Care. A total of 454 clients were studied, reflecting 94% of all of those eligible to be included. Client service needs were evaluated using a structured tool that was completed by a clinician who knew the client well.

Clinicians used a nine point scale to categorize the severity of the substance abuse problem, ranging from no problem to an extreme problem. In a reanalysis of this data for this report, close to one third of mental health clients sampled were identified as having a substance related problem (N=78; 32%) and three quarters of these were considered to require specialized substance abuse programming (N=56; 72%). However, only 31% (N=24) had been formally diagnosed with a substance abuse disorder. If a formal diagnosis is the first step in the development of a comprehensive treatment plan for persons with concurrent disorders (and the literature indicates it is), then these data reveal that up to three quarters of those receiving psychiatric hospital care may not be receiving adequate concurrent treatment for their concurrent disorders. It is also important to note that close to 60% (N=45) were also considered to have a concurrent medical illness.

The Kingston CAP report also recognized the high needs for intensive community and residential support services for those with concurrent disorders. The report also noted that there were sufficient numbers of patients in need of community treatment

¹ At the time of writing this report the subsequent Community Comprehensive Assessment Project for the Southeastern Ontario district was not yet complete. Therefore, comparable community-based assessment data are not yet available.

(approximately 50) to support the development of a specialized concurrent disorders program in Kingston. Finally, it was recommended that mental health and addictions programs be integrated at the system and program levels, and that adequate concurrent disorder training be made available to staff in both mental health and addictions programs.

Concerning inpatient care, 12 beds staffed by clinicians with specialized expertise in providing integrated treatment were recommended. Since this time, the Kingston Psychiatric Hospital has been divested to the Providence Continuing Care Centre. In collaboration with the Ministry of Health and Long Term Care, formal bed reduction goals have been set and the development of resettlement plans are now underway. It is likely that a large number of the remaining 100-120 beds will be targeted to specialty programs such as the Forensic Program and the Geriatric Psychiatry Program. However, a smaller number of non-specialty beds will be preserved to meet the district's needs for non-acute hospital care, including those with a concurrent substance abuse disorder. In addition, those with concurrent disorders will have access to acute care psychiatric beds through the General hospital psychiatric unit.

The Brockville CAP report also made recommendations for integrated training and service delivery for concurrent disorders (Palmer, Macfarlane, Cochrane, Durbin & Goering, 2000). A key recommendation was to build into the foundation of both mental health and addictions services, the capacity to identify, diagnose, and treat those with concurrent disorders. This report also recognized the limited expertise available in mental health and addictions systems to address the complex needs of this group, and further recommended that additional resources be invested to increase the expertise of front-line workers in the diagnosis and treatment of concurrent disorders, including those working with geriatric, dual diagnosis, and forensic populations. For the most complex cases, a specialized (tertiary-level) program with outreach and consultation capacities was envisioned—a theme that was echoed in the Kingston CAP report.

Finally, in a local record linkage study conducted by Woogh and colleagues (personal communication, 2001), a cohort of 751 clients who received services at Kingston's Detox Centre between April 1997 and March 1998 were tracked to determine how many had had an inpatient hospital admission to either the provincial psychiatric hospital or general hospital psychiatric unit. Twenty-seven percent of the Detox clients had been admitted in both systems (N=201). Of those seen in the psychiatric system, 39% were not diagnosed with a substance abuse problem. Under-diagnosis was a particular problem for women with concurrent disorders who were receiving psychiatric services.

Findings from these local studies highlight the importance of developing an integrated service delivery plan for persons with concurrent disorders in the Southeastern Ontario mental health planning district.

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**Chapter
3**

Service Delivery Plan

Concurrent care for concurrent disorders.

This section of the report outlines the Working Group's recommendations for an integrated service delivery system for people with concurrent disorders who reside in the Southeastern Ontario Mental Health Planning District. In addition, a logic model has been created from these recommendations to show how they relate to the short and long term mental health system objectives (Sullivan, 2001).

Given the high prevalence of concurrent disorders, the main goal must be to provide concurrent care to persons with concurrent disorders, regardless of their location in the mental health or addictions systems. Therefore, the proposed service delivery plan builds on existing facilities and programs, wherever possible, and emphasizes joint responsibility through formal service and network agreements, district-level accountability structures, and academic leadership in providing specialized psychiatric expertise and cross-training. In addition, this report makes recommendations for specialized services required to provide meet the most complex needs of this group.

1: First Line Care

In order to insure that individuals with concurrent disorders are appropriately identified and diagnosed it is recommended that:

- standardized screening protocols for substance abuse, including standardized screening instruments, be implemented as part of the regular intake procedures for all first line mental health programs,
- standardized screening protocols for mental health problems, including standardized screening instruments, be implemented as part of the regular intake procedures for all first line substance abuse programs,

- protocols of care be implemented requiring consultation with an Addictions specialist for diagnosis and care planning whenever a pre-defined screening threshold is passed,
- promotion/prevention initiatives be undertaken to reduce the risk of substance abuse and misuse, particularly among high risk groups such as youth or young adults with a serious mental illness,
- emergency and best practice protocols in withdrawal management (such as those of the Ontario Medical Association) be used in all hospitals and Detoxification centres in the district.

2: Intensive Care

In order to make sure that people with concurrent disorders receive concurrent treatment, it is recommended that:

- standardized screening protocols for substance abuse, including standardized screening instruments, be used as part of the regular intake procedures for all intensive mental health programs,
- standardized screening protocols for mental health problems, including standardized screening instruments, be used as part of the regular intake procedures for all intensive level substance abuse programs,
- formal service agreements be implemented to require joint care planning by mental health and addictions workers for all individuals with a concurrent disorder,
- consultation and referral protocols be implemented governing access to an Addictions Psychiatrist for specialty consultation and care planning,
- early intervention/prevention initiatives be implemented to target younger mental health consumers who are at high risk of developing substance abuse problems in later life,
- regular training sessions on the diagnosis and treatment of concurrent disorders be implemented in all agencies,
- clear points of accountability for concurrent disorders be established within each agency,
- staff who are accountable for concurrent disorders within their respective agencies be networked to help coordinate district-wide resources.

3: Specialized Community Care

The Kingston Comprehensive Assessment Project (Palmer, Macfarlane, Stuart, Durbin, Cochrane & Goering, 2000) estimated that there were sufficient numbers of clients in need of specialized community based intervention to support the development of a specialized concurrent disorders program in Kingston. Therefore, to meet the needs of Kingston-area residents for specialized community care, as well as the needs of district residents for specialized support, it is recommended that:

- a specialized concurrent disorders community care team be established to
 - provide highly specialized assessment and treatment services to the most difficult-to-treat clients in the Kingston area with the goal of returning them to standard mental health or addictions care as soon as possible,
 - assertive outreach and engagement with high risk homeless and forensic populations in the Kingston area that do not fit well into the existing system,
 - shared care and supportive services to clients and agencies across the district.
 - in-reach services to mental health and addictions agencies in the district,
 - training, specialized support, and shared care to agencies across the district aimed at capacity building,
 - specialized support to rural and outlying areas through tele-psychiatry consultation and support,
 - leadership and support for prevention/promotion initiatives designed to reduce substance abuse and misuse.
- mental or addictions agencies not exclude persons who require treatment or support services for a concurrent disorder.

4: Academia

In order to provide access to a psychiatrist who is specialized in addictions, it is recommended that the Health Sciences Centre at Queen's University recruit one Addictions Psychiatrist to:

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- ensure appropriate access to inpatient care through Queen's University Department of Psychiatry affiliated teaching hospitals for any individual in the district requiring highly specialized inpatient assessment, detoxification, stabilization, or treatment, not available elsewhere in the district,
- ensure appropriate access to inpatient care through Queen's University Department of Psychiatry affiliated teaching hospitals for Kingston-area consumers with concurrent disorders who are in need of inpatient care,
- coordinate a district-wide network of services for the standardized screening and treatment of persons with a concurrent disorder,
- develop district-wide support and shared care services to mental health providers, including tele-psychiatry outreach to under-served areas,
- coordinate shared care models for primary care,
- teach psychiatric residents about concurrent disorders,
- coordinate and supervise community-based training opportunities in addictions psychiatry for psychiatric residents,
- advocate for curriculum changes needed to insure that best practice standards (such as those identified in Project CREATE) are incorporated into the curriculum at every level of medical school training,
- conduct research into best practices and treatment outcomes,
- develop and support cross-training initiatives designed to improve the diagnostic and treatment skills of staff in both addictions and mental health services across the district,
- collaborate with community agencies to develop prevention and promotion initiatives to reduce the incidence of substance abuse among individuals with a mental disorder, and participate in wider initiatives designed to reduce the incidence of substance abuse and misuse in the population,
- work with the Centre for Addictions and Mental Health, and other relevant bodies to coordinate education, training, research, and prevention opportunities.

5: Information Management

In order to promote identification of people with concurrent disorders and foster continuity of information (and therefore care) across programs, it is recommended that:

- a registry of consumers with concurrent disorders be developed that is electronically accessible to all treating staff regardless of their location in the mental health or addictions systems, taking into consideration confidentiality and privacy issues with respect to sharing of treatment data,
- a single unique identifier that is common to both mental health and addictions agencies (i.e. that used in the DATIS System) be used to collect standardized anonymized data to support district evaluation, research, and accountability processes,
- performance monitoring and outcome assessment be undertaken in accordance with district accountability and service evaluation initiatives to assess standards of care, particularly with respect to:
 - the proportion of incoming clients who are not appropriately screened,
 - the proportion of those exceeding the screening threshold that are not appropriately referred for specialized care planning,
 - the proportion of clients requiring detoxification that are not managed according to the standardized care protocol.

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Chapter 4

Estimated Budget

The following budget reflects preliminary estimates of the protected annualized resources that would need to be invested (or reinvested) in the Southeastern Ontario mental health planning area in order to implement the assessment and treatment services proposed in this implementation plan. The budget is offered with the following caveats and assumptions in mind:

- Resources for tele-psychiatry support would be factored into the tele-psychiatry operating budget and that any expansion of the tele-psychiatry program to other sites would district-wide services and supports for concurrent disorders programming,
- Resources necessary to fund network administration would be factored into the governance costs and reflected in that operating budget,
- Resources necessary to fund accountability monitoring, information management, and analyses would be factored into the accountability costs and reflected in that budget.
- A detailed budget based on a clearly delineated operational plan would be required should the recommendations in this report be acceptable to the Task Force and the Ministry of Health and Long Term Care.
- Resources for a specialized community care team have been broadly estimated based on the costs of an Assertive Community Treatment Team since many of the specialized assessment, outreach, and treatment functions would be comparable.
- This is likely to reflect the minimum amount of new resources that would be required to support integrated concurrent disorder programming as additional

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costs (such as benefits or other indirect staff-related costs) have not been factored in.

- The lack of integrated treatment opportunities for individuals with concurrent disorders suggests that significant reinvestment funding will be required, at least at the outset, to meet the complex and currently unmet needs of this population. It should be noted, however, that appropriate care for persons with concurrent disorders should result in a longer term savings in both emergency and acute hospital care.

Table 2: Estimated Annualized Protected Budget – Concurrent Disorders

Item	Description	Cost
Specialized Community Outreach Treatment Team	Estimated based on funding for Assertive Community Treatment Team.	\$900,000
Academic Department & Allied Teaching Hospitals	Academic Department – figures based on figure for 1 FTE psychiatrist paid under the Alternative Funding Plan with appropriate clerical and operational supports (including travel) for consultation-liaison outreach activities.	\$350,000
Telepsychiatry	Telepsychiatry support required but it is expected that these costs will be factored into the Telepsychiatry program budget	N/A
Accountability	Costs associated with information collection, management, and analysis are expected to be factored into regional accountability budgets	N/A
Governance	Costs associated with network administration for district programs are expected to be factored into district governance operating budgets.	N/A
TOTAL		1,250,000

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References

- Brown L, Saura KM: Vocational rehabilitation needs of individuals dually diagnosed with substance abuse and chronic mental illness. *Journal of Applied Rehabilitation Counselling* 1996; 27:3-10.
- Drainoni ML, Bachman SS: Overcoming treatment barriers to providing services for adults with dual diagnosis. *Journal of Disability Policy Studies* 1995; 6:44-55.
- Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, Bond GR: Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 1998; 24:589-608.
- Drake RE, Mueser KT: Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin* 2000; 26:105-118.
- Hoff RA, Rosenheck RA: Long-term patterns of service use and cost among patients with both psychiatric and substance abuse disorders. *Medical Care* 1998; 36:835-843.
- Jerrell JM, Hu TW: Estimating the cost impact of three dual diagnosis treatment programs. *Evaluation Review* 1996; 20:160-181.
- Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG: The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 1996; 66:17-31.
- Melnyshyn M, Christie R, Shirley M. Travelling the same road: A report on concurrent disorders in Ontario. Toronto: Addiction Research Foundation, 1996.
- Mercer-McFadden C, Drake RE, Brown NB, Fox RS: The community support program demonstrations of services for young adults with severe mental illness and substance abuse disorders, 1987-1991. *Psychiatric Rehabilitation Journal* 1997; 20:13-24.

Minkoff K: Intervention strategies for people with dual diagnosis. *Innovation and Research* 1993; 2:11-17.

Mitchell GD, Robertson S, Weber G: A care management project for young adults with dual diagnoses of severe mental illness and substance abuse: A service for people with dual diagnoses. *Journal of Mental Health* 1992; 1:363-366.

Ontario Ministry of Finance. Ontario population projections, 1999-2028. Queen's Printer for Ontario, 2000. <http://www.gov.on.ca/FIN/hmpage.html>.

Sullivan C. Concurrent Disorders: Logic Model for an integrated service delivery plan for Southeastern Ontario. 2002.

Palmer HP, Macfarlane D, Cochrane J, Durbin J, and Goering P. Comprehensive assessment project: Brockville Psychiatric Hospital. 2000. Toronto, Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

Palmer HP, Macfarlane D, Stuart H, Durbin J, Cochrane J, and Goering P. Kingston Psychiatric Hospital Comprehensive Assessment Project. 2000. Toronto, Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

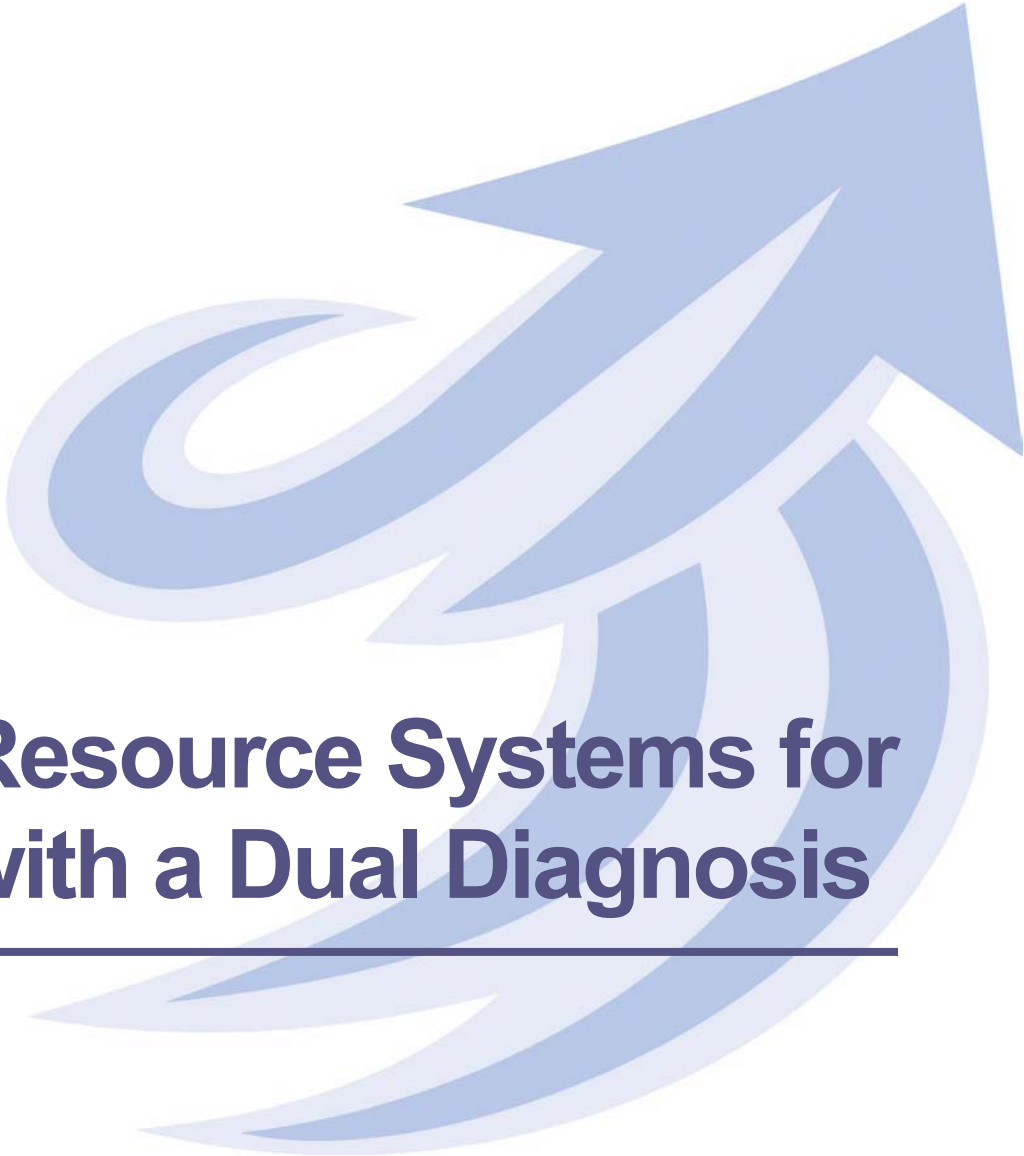
Sciacca K: An integrated treatment approach for severely mentally ill individuals with substance disorders. *New Directions for Mental Health Services* 1991; 50:69-84.

Wingerson D, Ries RD: Assertive community treatment for patients with chronic and severe mental illness who abuse drugs. *Journal of Psychoactive Drugs* 1999; 31:13-18.

Woody G: The challenge of dual diagnosis. *Alcohol, Health & Research World* 1996; 20:76-80.

Wu LT, Kouzis AC, Leaf PJ: Influence of comorbid alcohol and psychiatric disorders on utilization of mental health services in the National Comorbidity Survey. *American Journal of Psychiatry* 1999; 156:1230-1236.

Young NK, Grella CE: Mental health and substance abuse treatment services for dually diagnosed clients: Results of a Statewide survey of county administrators. *The Journal of Behavioral Health Services & Research* 1998; 25:83-92.

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Building Resource Systems for Persons with a Dual Diagnosis

Building Resource Systems for Persons With a Dual Diagnosis

A report prepared for
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EXECUTIVE SUMMARY

This report records the results of the Developmental Consulting Program's (DCP) consultation for the Southeastern Ontario District Health Council (SEODHC) on how to provide community-based treatment for adults with a dual diagnosis. "Dual diagnosis" refers to persons who have a developmental disability and mental health disorder(s).

In Ontario, the Ministry of Community and Social Services (MCSS) is the lead Ministry for sponsoring support services for persons with developmental disabilities. The establishment of community-based alternatives to traditional institutional care has been its primary policy direction since 1974. Rideau Regional Centre (RRC) in Smiths Falls, the only institution that remains open in the southeast, provides care for 70 persons from the counties of interest to the District Health Council.

Forty percent of those with a developmental disability have mental health problems. Programs sponsored by the Ministry of Health and Long-Term Care (MOHLTC) are responsible for the provision of treatment services that will minimize the personal impact of these problems and the additional burden of care borne by family and agency caregivers. In the implementation of Mental Health Reform, those with a dual diagnosis have been identified as a "special population". It is now widely accepted that specialized expertise is required to meet their needs. Unfortunately, there is a serious shortage in all the relevant disciplines given that dual diagnosis has often been neglected in professional training programs.

To date, neither provincial nor local planners have been successful in creating comprehensive treatment services for persons with a dual diagnosis. Current arrangements for providing care are best described as ad hoc. The need to do a better job, especially as regional psychiatric hospitals are downsized, is acknowledged by all those who were consulted.

DCP began work on this consultation project in April 2001 with a final report submitted to the SEODHC on September 14, 2001. DCP's consultation involved three approaches to collecting information:

1. A review of the professional literature focussed on identifying "services that work" and on the training and retention of teams of mental health professionals to staff these services;
2. Interviews with key informants from the health and social services sectors about important planning issues; and
3. Round table discussions with family and agency caregivers about current and proposed treatment services across the region.

An advisory committee was established that assisted the DCP team in developing the protocols for consultation and fine tuning the report and its recommendations. For the purpose of the consultation and given the desirability of locally accessible rather than regional services, DCP divided the district into three planning areas. Each area is served by a public hospital with the mandate to provide emergency, ambulatory and inpatient psychiatric services under the Mental Health Act. The projected numbers of adults with a dual diagnosis who require these services in

the three planning areas are as follows: 650 adults in Hastings, Prince Edward counties; 790 adults in Frontenac, Lennox & Addington counties; and 700 adults in Lanark, Leeds & Grenville counties.

After reviewing the professional literature and the goals of Mental Health Reform, DCP prepared a Framework of Services That Work for use during the consultation. It encompasses:

1. Emergency, Assessment and Treatment Services;
2. Ambulatory Treatment Services, including an outpatient clinic, a consultation and outreach treatment service for agencies, and the MCSS-funded Community Behaviour Management program;
3. Inpatient Treatment Services, including acute inpatient care and an “extended treatment” unit.

The key informant interviews identified a number of important issues to be considered in future planning. The issues include:

- ☐ the need for up-front funding for community-based treatment services before the planned downsizing of regional psychiatric hospitals;
- ☐ the need to develop and provide cost estimates for the support and treatment plans of the 70 individuals from the district who currently reside at Rideau Regional Centre, before any further depopulation there;
- ☐ the need to evaluate the role of specialized (dual diagnosis) Assertive Community Treatment now operating in Lanark / Leeds & Grenville, preferably contrasting its effectiveness with consultation and outreach treatment services being planned for other counties in the district;
- ☐ the need to eliminate unacceptably long waiting lists in the district’s Community Behaviour Management programs; and
- ☐ the need to ensure that persons with a dual diagnosis in conflict with the law are diverted from incarceration in correctional facilities to relevant support and treatment programs.

As well, there was a consensus amongst the key informants that the Queen’s University Academic Health Sciences Centre (AHSC) be mandated to provide district-wide support in Human Resources & Training and in Program Monitoring & Evaluation. The importance of a concerted effort to attract experienced staff displaced from downsized regional psychiatric hospitals to newly established community-based treatment services was noted.

The round table discussions held in Kingston, Belleville and Brockville identified common themes in each geographic area. There are:

- ☐ major gaps in the current provision of treatment services;

- interface problems between agencies in the health care and social services sectors in defining roles and responsibilities;
- extreme worries that beds will be closed in regional psychiatric hospitals before alternative community treatment services are available.

In addition participants at the round table discussions expressed:

- general support for DCP's Framework of Services That Work; general support for expanded Queen's University AHSC responsibilities in the provision of district-wide support in Human Resources & Training and Program Monitoring & Evaluation;
- a plea for better coordination of effort by the MCSS and MOHLTC regional offices responsible for Southeastern Ontario.

DCP has formulated seven recommendations that reflect the important observations and suggestions brought forward during the consultation. Since these recommendations have funding implications for the MOHLTC and MCSS, they are listed below in a manner that accommodates respective Ministry roles in providing treatment services and social support.

Recommendations Specific to the Ministry of Health and Long Term Care:

- Recommendation #1: That Quinte Healthcare Corporation, Kingston General Hospital and the Brockville General Hospital be provided with operating funds for emergency, ambulatory, and inpatient dual diagnosis treatment services.
- Recommendation #2: That capital funding is provided to enable each of the hospitals sponsoring a dual diagnosis treatment service, to establish "purpose-built" accommodation for the extended treatment unit and offices for the professional team providing ambulatory services.
- Recommendation #3: That Queen's University is provided with operating funds to provide a district-wide program concerned with Human Resources & Training and Monitoring & Evaluation.
- Recommendation #4: That Queen's University evaluate the relative effectiveness of specialized (dual diagnosis) Assertive Community Treatment and Consultation & Outreach in providing dual diagnosis treatment services.

Recommendations Specific to the Ministry of Community and Social Services:

- Recommendation #5: That the Community Behaviour Management Programs operating in the Southeast are strengthened, so as to eliminate long waiting lists and to ensure a collaborative working relationship with the dual diagnosis treatment services recommended above.

- Recommendation #6: That those individuals from the Southeastern district currently living at the Rideau Regional Centre are assessed in relation to meeting their needs (including those for dual diagnosis treatment services) in community-based settings.

Recommendation Relevant to both MOHLTC and MCSS/Developmental Service Branch:

- Recommendation #7: That an Advisory Committee is established, composed of hospital, agency and family representatives which reports at least twice yearly to the Regional Director of MOHLTC and the Regional Director of MCSS.

Taken together, these seven recommendations constitute a comprehensive plan to provide locally accessible and self-sufficient treatment services for adults with a dual diagnosis in the Southeastern district. The plan ensures the availability of “services that work” and operational support from the district’s Academic Health Sciences Centre at Queen’s University. The operating costs for the district-wide treatment program (including the operational support component of the AHSC) are estimated to be in the range of 10 to 11 million dollars annually.

The plan is consistent with contemporary government policy that promises each citizen of Ontario the treatment and support needed for a dignified life in the community. Finally, it creates an advisory mechanism to promote meaningful communication between key government representatives and family/agency caregivers as these important services are established.

CHAPTER 1:

An Orientation

This report records the results of the Developmental Consulting Program's (DCP) consultation for the Southeastern Ontario District Health Council (SEODHC) on how to provide community-based treatment for adults with a dual diagnosis. "Dual diagnosis" refers to persons who have a developmental disability and mental health disorder(s).

DCP began work on this consultation project in April 2001 with a final report submitted to the SEODHC on September 14, 2001. DCP's consultation involved three approaches to collecting information:

1. A review of the professional literature focussed on identifying "services that work" and on the training and retention of teams of mental health professionals to staff these services;
2. Interviews with key informants from the health and social services sectors about important planning issues; and
3. Round table discussions with family and agency caregivers about current and proposed treatment services across the region.

For the purpose of the consultation and given the desirability of locally accessible rather than regional services, DCP divided the district into three planning areas. Each area is served by a public hospital with the mandate to provide emergency, ambulatory and inpatient psychiatric services under the Mental Health Act. The projected numbers of adults with a dual diagnosis by county planning area are as follows: 650 adults in Hastings, Prince Edward counties; 790 adults in Frontenac Lennox & Addington counties; and 700 adults in Lanark, Leeds & Grenville counties.

An advisory committee assisted the DCP team in developing the protocols for consultation and in fine tuning the report and its recommendations. A representative from each of the three planning areas participated on the advisory committee. In Appendix A, there is a list of all who contributed to this project including the DCP Team members, the Advisory Committee Members, Key Informants and Round Table Participants.

About This Report

Since many who will review this report may be unfamiliar with "dual diagnosis" (i.e. mental retardation/developmental disability and mental disorder coexistent in the same individual), **Chapter 1**, provides an orientation to developmental disabilities

and dual diagnosis. This chapter also provides an outline of how services for individuals with dual diagnosis have evolved to date. A brief description of the “Framework of Services That Work” is given.

In **Chapter 2** a review of the professional literature is provided. The review focuses on identifying effective services and on the training and retention of teams of mental health professionals to staff these services.

Consultation in Southeastern Ontario regarding treatment services for adults with dual diagnosis included interviews with key informants from the health and social service sectors. In **Chapter 3**, a consolidated summary of the informants’ views and opinions on important planning issues is provided. **Chapter 4** records the results of round table discussions held with family members and agency representatives. This chapter provides information on existing services for persons with a dual diagnosis and those that are required. The information collected at these sessions includes an inventory of services, a description of the current gaps in treatment and response to the proposed framework of services.

The report concludes with **Chapter 5, Analysis and Recommendations**. In this chapter important observations and suggestions brought forward during the consultation are presented in a way that constitutes a comprehensive plan to provide locally accessible treatment services for adults with dual diagnosis. **Appendices** to the report include references, a list of the more than 100 people who participated in this consultation process, slides used for the consultation sessions and further details on proposed services.

Understanding Developmental Disabilities and Dual Diagnosis

Mental health problems are usually categorized into subgroups of “mental disorders” such as depression, schizophrenia, dementia and mental retardation. In Ontario, mental retardation (along with disorders like autism) is now referred to as a “developmental disability.” Developmental disabilities are characterized by impairments in intellectual functioning and ability to perform everyday living skills. Approximately 1% of the general population has a developmental disability (Ouellette-Kuntz & Paquette, in press). In the Netherlands, 8.1% of health care costs are directed to serving people with developmental disabilities/mental retardation. (Meerding et al., 1998)

The mental impairments in these individuals tend to persist causing failure to develop the adaptive skills needed for self care, progress at school, and work/family responsibilities later in life. Those who are severely impaired remain dependent on others throughout their lives, whereas those with mild impairments may become almost completely self-sufficient at maturity. Developmental and educational interventions are aimed at maximizing adaptation and social services provide support for those with a continuing disability.

When developmental disability and another mental disorder coexist in the same person, the individual is described as having a “dual diagnosis.” It is well known that people with developmental disabilities are more susceptible to experiencing mental disorders than people in the general population. The reported prevalence of the comorbidity of mental disorder and developmental disabilities, through the use of carefully conducted studies, has been recently

reported at approximately 39% in the United States (Reiss, 1990), and at 41% in the United Kingdom (Bouras & Drummond, 1992) or approximately four people per 1,000 of the general population, Yu & Atkinson, 1993). It appears that individuals with deficits in intellectual abilities and social competence may have greater coping difficulties in a complex environment (Menolascino & Stark, 1984; Rojahn & Tassé, 1994). This increased risk to mental disorder is associated with health care costs almost equal to that for schizophrenia and dementia combined (Fraser, Sines & Kerr, 1993).

Any mental disorder that occurs in members of the general population (e.g. depression, schizophrenia, etc.) can also occur in persons with developmental disabilities. A comparison of large-scale studies of morbidity suggests that across the spectrum of mental disorder, the pattern of prevalence is somewhat different from the general population (Moss, 1997). In this study, people with developmental disabilities were reported as showing higher rates for psychoses and autism, and a very high rate for behaviour disorders.

“A small proportion of people with a dual diagnosis have severe challenging behaviours. A survey in two London, England boroughs confirmed “around 20 persons per 100,000 of the population have developmental disabilities and severe challenging behaviours or mental health needs, that is approximately 6 % of the learning disabled population. These people tend to be in their 20s and 30s with more men than women having challenging behaviour, mainly in the form of aggression and sexually inappropriate behaviours” (McConkey, R., 2000, p.492).”

A treatment plan for a person with a dual diagnosis must distinguish the features of the mental disorder from the cognitive and adaptive impairments associated with the developmental disability. Treatment aims to eliminate or reduce the severity of the individual's mental disorder thereby preventing an additional burden of care for family members or agency staff. Assessment and treatment require relatively more professional time for the individual with a dual diagnosis. In addition, there is often confusion of roles for professionals from the social service and health care sectors.

The Evolution of Services for People with Dual Diagnosis

The second half of the twentieth century involved a major shift in how the needs of persons with developmental disabilities were met. Prior to that time, large multi-purpose institutions were seen as providing the best approach. However, those institutions at mid century were overcrowded, had impossibly long waiting lists, and research was showing that community-based alternatives were associated with better outcomes. A strong advocacy movement lobbied successfully for a policy of deinstitutionalisation. Community-based alternatives were supported as traditional institutions were reduced in size and closed. As we enter the 21st century, there are few institutions still operating and a variety of residential alternatives, schools, day programs and other supports are available to persons with developmental disabilities in local communities.

While the community-based approach has been associated with significant improvements in the quality of life of persons with developmental disabilities, it has created new challenges in serving those with dual diagnosis. The deinstitutionalization effort envisaged integration of those with a dual diagnosis in mainstream mental health programs. This aim has not been realised, particularly for the more severely impaired who are unable to communicate with mental health professionals. The training of professionals in dual diagnosis has been sadly deficient and, despite some recent improvements, remains so.

Meeting the special needs of people with a dual diagnosis in the community is a formidable challenge. Hospitals and agencies funded by the Ministry of Health and Long-Term Care (MOHLTC) to provide emergency, ambulatory and inpatient treatment for people with mental disorders are currently ill-equipped to provide adequate care to people with a dual diagnosis. This situation is partly due to mental health professionals having received little or no instruction about developmental disabilities in their training. As well, this special population requires more professional time per patient; there is often confusion about roles and responsibilities from staff in the health and social services sectors.

Policy and Services in Ontario

In Ontario, government responsibility for all people with developmental disabilities was vested with the Ministry of Community and Social Services (MCSS) in 1974, when the Legislature passed the Developmental Services Act. Under this Act, financial support is provided to families and caregiver agencies to provide residential supervision, day programs, income support and behaviour management.

MCSS policy directed at community living has fostered the gradual depopulation and closure of the province's regional institutions (MCSS Schedule 1 Facilities) for people with developmental disabilities. In this part of the province, only Rideau Regional Centre in Smiths Falls continues to operate.

Ontario's Ministry of Health and Long Term Care (MOHLTC) is currently revisiting its mental health services. Guided by the *Making It Happen* (1999) policy document, the Ministry along with Task Forces set up throughout the province, is reviewing the structure of the mental health system in Ontario, and will recommend changes to reflect its new policies. The guidelines for reform in the *Making it Happen* document outline six characteristics of a reformed mental health system. They are:

1. A comprehensive continuum of services ensures that clients receive the services needed when and where they need them;
2. Streamlined access to the mental health system through fewer entry points and centralized information and referral mechanisms;
3. Clients with multiple service needs served better through shared service models of care;
4. Mental health service capacity that is enhanced based on reinvestments reflecting best practices and meeting systems needs;
5. Clear system/service responsibility and accountability achieved based on consumer need;
6. Decentralized regional structures responsive to local and regional needs.

Government of Ontario (1999) *Making it Happen, Operational Framework for the Delivery of Mental Health Services and Supports*. MOHLTC, 1999, page 7.

Dual Diagnosis Population Statistics for Southeastern Ontario

The policy of integration in mainstream mental health services means that people will no longer have access to specialized tertiary services previously available only in regional psychiatric hospitals. Therefore, mental health reform must ensure the provision of relevant expertise. Areas with a general population of 150,000-200,000 are large enough to support these highly specialized services.

Accordingly, for the purpose of this consultation, the Southeastern Ontario District was divided into three county groupings, each with a population within the desired range. The geographic planning areas are: Hastings, Prince Edward Counties; Frontenac, Lennox & Addington Counties; and Lanark, Leeds & Grenville and Counties.

From general population statistics, prevalence estimates for the dual diagnosis population by county grouping are given (see Table 1).

Table 1: Population Estimates for the Southeastern Ontario District, and Projected 2003 Dual Diagnosis Adult Population by County Grouping

COUNTY GROUPING	POPULATION* (2001)	POPULATION* PROJECTION (2003)	NUMBER OF INDIVIDUALS	
			DEVELOPMENTAL DISABILITY (1%)	DUAL DIAGNOSIS (40%)
Hastings and Prince Edward	152,296	162,952	1,630	650
Frontenac, Lennox & Addington	179,735	197,612	1,980	790
Lanark and Leeds & Grenville	164,515	175,359	1,750	700
Southeastern District TOTAL	496,546	535,923	5,360	2,140

* Source: Ministry of Health and Long-Term Care Provincial Health Planning Database (2001)

There are currently an additional 70 residents at Rideau Regional Centre (RRC) who will be repatriated to communities in the Southeastern District as the deinstitutionalization process continues. It is estimated that half of these people have a dual diagnosis (Bruce McCreary, personal communication, June 2001).

In the Southeastern district, the 2003 closure of the regional tertiary dual diagnosis service located at the Brockville Psychiatric Hospital (BPH) will mean that the specialized Dual Diagnosis Unit will no longer be available on a regional tertiary basis. Locally based services will have to be established in order to serve the clients who will be leaving BPH. Considerable attention is now focussed on how to serve this high needs group as Mental Health Reform is implemented.

Comprehensive Assessment Projects at both Kingston Psychiatric Hospital and Brockville Psychiatric Hospital estimate that 209 individuals with a dual diagnosis were receiving services on an inpatient and outpatient basis in the year 2000 (BPH CAP & KPH CAP, 2000). More recent estimates from the Assessment, Diagnosis and Stabilization Unit at Kingston Psychiatric Hospital revealed that, on any given day, 7-8 patients on this ward met the criteria for a developmental disability. Moreover, this figure has increased over a one-year period (Judy Fair, 2001, unpublished observations).

A Framework of “Services that Work”

There is rapidly growing interest in identifying the treatment services that are effective in meeting the needs of people with a dual diagnosis in the community. DCP’s review of the professional literature revealed a number of “services that work” when serving adults with a dual diagnosis. These services were grouped into the following categories:

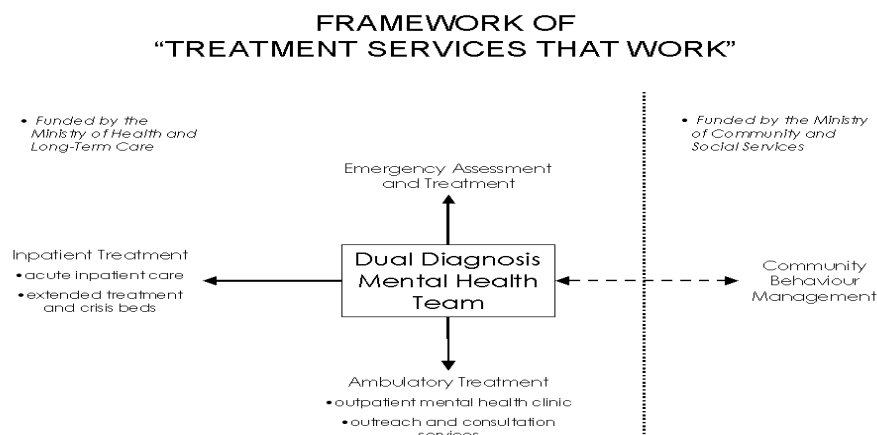
1. Emergency, Assessment and Treatment,
2. Ambulatory Treatment (i.e., outpatient mental health clinic, outreach treatment and consultation services, community behaviour management), and
3. Inpatient Treatment (i.e., acute inpatient care, extended treatment and crisis beds).

The categories were then used to develop the Framework for Services That Work illustrated in Figure 1 (page 8). The framework can be implemented in a population area of 150,000 to 200,000 people, in order to be large enough for a critical mass of patients but small enough for local self-sufficiency. Applying prevalence estimates of dual diagnosis (40% of the population with developmental disabilities or four people per 1,000 of the general population), the framework of services could therefore serve 600 to 800 individuals. For the Southeastern Ontario District, the framework would be implemented in each of the three county groupings.

DCP used the framework of services during the key informant interviews and round table consultation sessions to identify what services are presently available and the gaps or access problems known to exist. As well, it was possible to gather opinion about the potential impact of proposed reforms in the mental health sector and about the hospital downsizing recommended by the Hospital Restructuring Commission.

The Framework and the definitions of the services within it are illustrated in Figure 1 on page 496.

Figure 1: The Framework of Treatment Services That Work



DEFINITIONS OF TREATMENT SERVICES

1. EMERGENCY ASSESSMENT AND TREATMENT

This 24-hour/7 days a week assessment service takes place in general hospital emergency departments, and includes the availability of a psychiatrist with specialized skills in dual diagnosis for assessment.

2. AMBULATORY TREATMENT

An ambulatory patient is one who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment.

Outpatient Mental Health Clinic

This clinic is a hospital-based, ambulatory service that provides ongoing clinical treatment to a roster of severely affected clients / patients living in the community, and is involved in their care if admitted to the hospital.

Consultation and Outreach Treatment Services

The outpatient mental health team would also provide outreach treatment and consultation services to day programs and agencies, and intensive clinical treatment through home / day program visits. Assertive community treatment (ACT) and mobile outreach and consultation are examples of this type of service.

Community Behaviour Management

Community behaviour management programs, sponsored by the Ministry of Community and Social Services, promote positive behaviours and self-help skills in people with developmental disabilities. Behaviour therapists determine individual problem areas and create behavioural support plans.

3. INPATIENT TREATMENT

An inpatient is a hospital patient who receives lodging and food as well as treatment.

Acute Inpatient Care

This inpatient treatment service takes place in general hospital acute psychiatry wards. Two beds within the ward would be designated for people with a dual diagnosis. Treatment includes diagnosis and stabilization, with an optimum length of stay of 2 to 3 weeks.

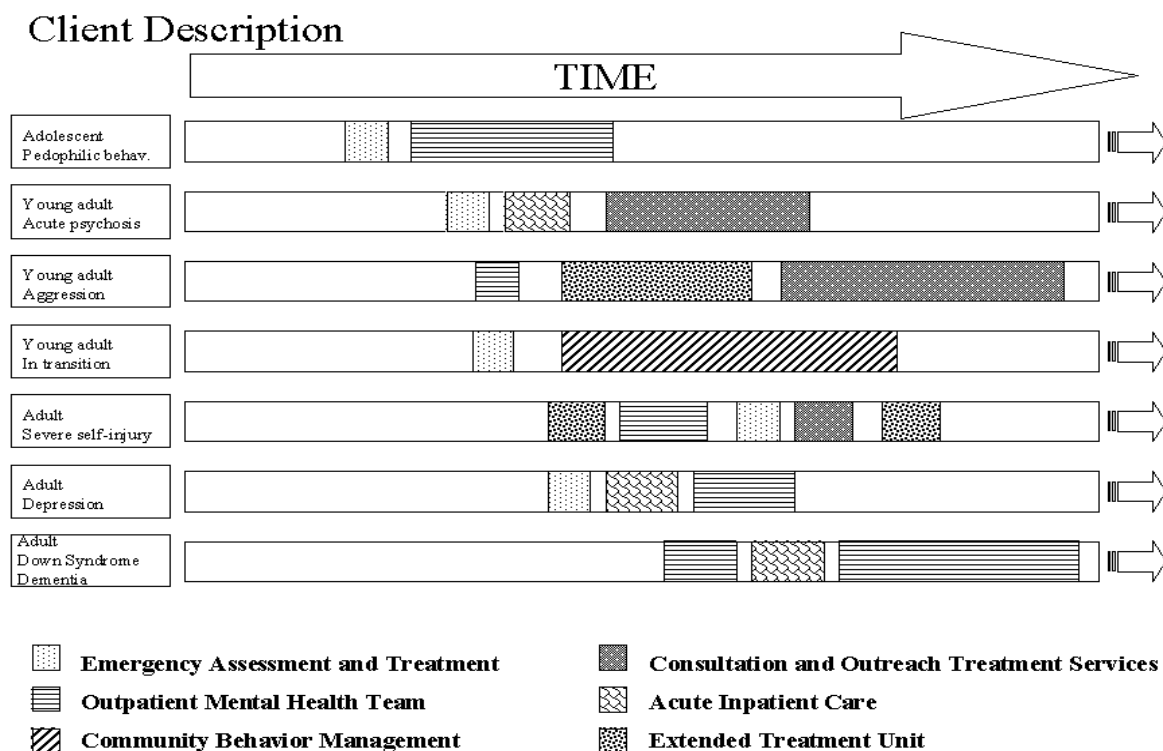
Extended Treatment and Crisis Beds

This 8-bed inpatient treatment unit provides both crisis services and extended treatment. Two beds are designated for crisis stays, ideally lasting up to 3 days. The remaining 6 beds are for extended treatment lasting up to 1 year. Comprehensive assessments and active treatment would be part of the extended treatment. Also, unit staff would liaise with residential service providers and behaviour management programs to plan services and ensure a smooth transition from the hospital to the community. The unit can be either hospital-based or community-based.

Treatment Needs Will Vary Over Time

People with a dual diagnosis have varying service needs over time. Some may require only emergency services in order to be maintained in the community, while others will need access to a full range of clinical treatment services including inpatient care. Figure 2 illustrates this concept. At any given time, the mental health service system will need to provide access to the entire continuum of treatment services. Also, it is critical that people within the system can move seamlessly from one service to the next, as their needs evolve over time. These factors must be considered when planning for this population.

Figure 2: Treatment Needs of Persons With Dual Diagnosis



In the chapters that follow, findings and observations from the literature review, the key informant survey and the round table discussions are provided.

CHAPTER 2:

The Literature Review

The driving force behind the literature review for this project was a concern for gathering information about evidence-based practices for treatment of individuals with dual diagnosis. A full review of the literature was conducted using databases including MEDline, PsychInfo, the Cochrane Review and PUBdocs, in order to select peer-reviewed articles, opinion papers, meta-analyses, policy documents and books that were concerned with treatment of individuals with a dual diagnosis (see References).

There is very little Canadian literature concerned with providing care for persons with a dual diagnosis. Fortunately, there are publications from other jurisdictions and these sources can be used to guide future efforts in Southeastern Ontario. This chapter provides information on current trends in service provision, the challenges involved in ensuring the availability of skilled staff, “services that work” and finally, the implications of these observations for planning.

Current Trends in Service Delivery

The presence of dual diagnosis is often associated with the breakdown of community placements and retention in residential environments that are more restrictive than otherwise required (Bouras & Holt, 2000, Davidson et al, 1995). Behavioural or psychiatric disorders that may have been accepted in institutions are not manageable in community placements. Consequently, persons with dual diagnosis need treatment and social support if community-based care is to be successful.

Over the past twenty years, policy makers and researchers have been struggling to develop comprehensive models of service that combine best practices and evidence-based treatment (Bouras and Holt, 2000). Whether to provide specialized treatment services or to integrate those with dual diagnosis in mainstream mental health services is a recurrent theme. A UK expert (Day, 1993, p. 7) has concluded that attempts to “provide for mental health needs of people with [developmental disabilities] within generic psychiatric services, whether by design or default, has been obviously unsuccessful.” Bouras and Holt (2001, p. 400) have observed that the complex behaviour problems of people with severe developmental disabilities could not be handled by generic psychiatric services and that no attempt was made to negotiate the associated service issues between mental health and social service providers.

There is now published opinion on how to best resolve the issue of specialized vs. generic provision of care. According to the Mansell Report (UK Department of Health, 1993), the aim of service planning should be to “develop and expand the capacity of local services for people with developmental disabilities, to understand and respond to challenging behaviour” and to “provide specialized services locally which can support good mainstream practice as well as directly serve a small number with the most challenging needs” (p.17). North American contributors (Davidson, et al, 1995, Gapen et al, 1996) emphasized that specialized interdisciplinary mental health services should be available in local communities; this arrangement provides not only needed expertise, but also a bridging between the health care and social services sectors.

There are also other clear advantages in establishing specialist support services. Given the frequent exclusion of challenging individuals from services, such developments clearly demonstrate commitment to serving the client group. Moreover, they also allow for the “accumulation of knowledge and the development of expertise in managing challenging behaviours, which can act as a focus for research and development of clinically effective practices, and also serve an advocacy function” on behalf of individuals with challenging behaviour (Allen & Felce, 1999, p.285).

With a growing consensus on both sides of the Atlantic that the optimal approach involves the availability of local expertise and good coordination of effort between the health and social services sectors, there is an obvious need to consider how much expertise and how best to ensure good coordination between agencies. The UK survey by Bailey and Cooper (1997) is useful from this perspective in terms of both the desirable size and composition of local teams and the optimal number of treatment beds required to serve those needing specialized inpatient care. The survey canvassed NHS Trusts in England and Wales (i.e. agencies providing care to persons with developmental disabilities) to establish the number of professionals assigned to community care per 100,000 population. The relevant categories are listed below:

	MEAN	MODE
Psychiatrists	1.1	0.8
Community Nurses	3.1	2.5
Occupational Therapists	0.9	0.7
Clinical Psychologists	0.9	0.7
Support Workers	4.7	0.8

Similarly, the number of beds directly assigned by NHS Trusts per 100,000 population is listed below:

	MEAN	MODE
Assessment and Treatment Beds	2.9	1.8
“Long Stay” Beds	23.6	10.3

Achieving coordination of effort between sectors can be enhanced simply by providing locally accessible (vs. regional) mental health services. Linkages to generic mental health services facilitate the use of established emergency and inpatient services and coordination of effort with other hospital services (e.g. x-ray, laboratory, EEG, etc.). With this kind of help local social service agencies can count on the available expertise and, at the same time, improve their own skills in serving persons with dual diagnosis (Bouras and Szymanski, 1997).

In Ontario, providing treatment for persons with dual diagnosis is now regarded as “specialized” or “tertiary” care. (Government of Ontario, *Making it Happen*, 1998). However, it is also observed that such care is not necessarily long term or provided regionally; indeed, the optimal arrangements involve the provision of localized expertise and integration, insofar as this is possible, of secondary and tertiary levels of care (Wasylenki et al, 2000).

Human Resources and Training

There is growing awareness that training and supporting frontline staff who care for persons with dual diagnosis is a critical issue. Mansell (1993, p.6) observes:

“Although staff are not permanently on duty as family carers [sic] can be, they are still subject to considerable stress, both physical and psychological, when caring for persons with challenging behaviour. This is true in settings which aim to do no more than contain people [...] the higher aspirations often found in progressive services impose extra strain on staff and here too it is important to balance the demands of working constructively with people who can be very difficult, day in and day out, with the needs of individual staff for emotional and practical respite and ongoing support.”

It is perhaps not surprising that in the Ontario developmental service sector, annual staff turnover was recently found to be 22% (KPMG, 2000).

Authors including Bouras and Holt (2000) note that providing skills training for staff allows them to manage, with support, individuals with dual diagnosis and “enables them to find this work more rewarding” (p.2011). They recommend flexible training materials, which can be used by staff, followed by specialist training sessions where professionals work with staff teams in order to develop ways to work with specific clients. Training, they state, should be part of the culture of an organization and that without the constant reinforcement of and building on training, its effects on practice are likely to be minimal.

If professional staff are envisaged as representing a necessary support for frontline staff, the availability of professional staff becomes an important issue in ensuring the provision of quality services. Unfortunately, there is ample evidence that there are major gaps in training mental health professionals about dual diagnosis across Canada (Catalysts for University Programs in Developmental Disabilities, DCP, 2001). Amongst the challenges in reversing this shortcoming is the establishment of formal linkages between the service sectors and university departments, either as the US model of university-affiliated programs (now named the Centres of Excellence in Developmental Disabilities Education Research and Services) or the UK model of Professorial Departments (Bouras and Szymanski, 1997, p.69).

Useful observations are also found in a May 1995 report published by Ontario’s Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) on strategies relevant to recruitment for underserved areas/domains. They outline principles and recommendations for recruiting and retaining health care professionals including:

1. Reduce personal and social isolation;
2. Enhance continuing education opportunities;
3. Decrease excessive workloads;
4. Decrease professional isolation;

5. Increase comfort in rural settings;
6. Introduce alternative remuneration and innovative service delivery models;
7. Coordinate and enhance recruitment efforts, and
8. Build health care infrastructure to support practice.

As can be appreciated, provision of training and the creation of attractive career paths are most important in the development and maintenance of mental health services for people with dual diagnosis.

Services That Work

In this section, published information on studies of various services for persons with dual diagnosis is considered. As well, observations on a community-based extended treatment unit in the UK, visited by DCP's Dr. Nathalie Garcin and MOHLTC officials are included. Because care in the regional psychiatric hospitals will be discontinued, the extended treatment element in the Framework of Services is of extreme importance to future planning. The elements of the Framework, as outlined earlier, serve as headings for subsections.

1. EMERGENCY, ASSESSMENT AND TREATMENT

Each general hospital with Schedule 1 status under the Mental Health Act is mandated to provide an emergency service. They provide assessment, emergency treatment and triage for other services. In the UK, patients are usually seen "out of working hours" by generic mental health services who may liaise with an "on-call" psychiatrist through the hospital (Bouras, 2001, personal communication). Most models of treatment in dual diagnosis will rely on general hospital emergency rooms as a first point of access for appropriate triage of their clients. From there, clients with a dual diagnosis are sent to more specialized services, depending on their needs.

2. AMBULATORY TREATMENT

Outpatient Clinic

Holden and Neff (2000) studied the services provided by an outpatient clinic in a Health Sciences Centre; outpatient treatment was shown to reduce the number of hospitalizations and the length of stay when hospitalization was needed. Davidson, et al (1995) observed the clinics help increase the capacity of direct care staff and families to deal with individuals with dual diagnosis and improve coordination of care.

Consultation and Outreach Treatment

Coelho et al (1993) described increases in functional behaviours and decreases in maladaptive behaviour for persons provided with "active community treatment"; outcomes were better when contrasted with simple case management.

In the UK, Community Specialists Mental Health Services provide consultation and

outreach. These multidisciplinary teams provide help in a variety of settings including the individual's home or usual environment, or the outpatient clinic, and, if necessary, as an inpatient (Bouras and Holt, 2000, p2010).

In the Netherlands, a controlled study of outreach treatment for persons with dual diagnosis revealed that this approach, when compared with hospital treatment, was less costly and usually avoided the need for hospitalization (VanMinnen, et al, 1997).

Community Behaviour Management Programs

Community Behaviour Management Programs (provided in Ontario by agencies funded by MCSS) aim to “bring about desirable change in the behaviour of the individual and their carers in situ, and in doing so, increase the likelihood that improvements will be maintained after the intervention has ceased” (Lowe, et al, 1996, p.337). Lowe, et al (1996) argued that residential settings need to be adequately staffed in order to make best use of external specialists and avoid the common negative scenario of overworked staff resenting the additional work demands resulting from specialist's involvement.

While there is good evidence to support the use of behavioural interventions, there is little published information on how to organize and deliver behavioural services in the community. A study in Wales evaluated two specialist intervention teams over a three year interval; there was no significant impact on the subjects' behaviour or quality of life but one team achieved some reduction in problem behaviours, gains that were sustained over time (Lowe, et al, 1996). The cost of the care for three clients with challenging behaviour averaged approximately \$ 84,744 per year, per client (Allen and Lowe, 1995, p.78). This cost did not include the costs of medical care, day services, medication and input from specialist teams.

3. INPATIENT TREATMENT

Acute Inpatient Care

Acute inpatient care “may be helpful in stabilizing a patient in crisis, giving an initial assessment and providing referral to specialized units” (Cochrane, et al, 2000, p.189). If residential settings or extended treatment options are available for backup, concerns about undue length of stay (compared with other patients) appear to be unfounded (Addington, et al, 1993). Typically the average length of stay is 2-3 weeks in these settings.

Extended Treatment and Crisis Beds.

Although “extended treatment” is now provided in institutional settings across Canada, there are unfortunately no published studies to guide planning for local communities. If beds at ROH-BPH and PCCC-MHS are closed, community care alternatives will be required: “For individuals with concurrent disorders, hospitalization in an integrated unit should be considered when behaviour continues to be dangerous or highly disrupted, where diagnosis remains unclear, and where there is marked inability to maintain psychiatric stability (Cochrane, et al, 2000, p.189).

The MIETS (i.e., Mental Impairment Evaluation and Treatment Unit) visited in London,

England, has operated for several years and has monitored both outcomes and the costs of care. It provides individualized treatment programs involving, as needed, cognitive behavioural therapy, anger management, sex education, family therapy, psychopharmacology, life and social skills training. The staffing is intensive (forty three staff for twelve beds) and “multidisciplinary” in keeping with the wide range of interventions needed for success. The average length of stay is twelve months. The total operating cost is \$800 per day, per patient. In a forthcoming publication, it will be reported that only two readmissions (of 196 first time admissions) were necessary. It seems reasonable to conclude that this kind of community-based intensive extended treatment works and that sustained improvement compatible with community living can be achieved.

Implications for Future Planning Efforts in Southeastern Ontario

Observations from the literature have implications that relate to how to plan and implement a service system for persons with dual diagnosis. Davidson, et al (1999), having reviewed community-based services for persons with dual diagnosis in the UK, US, Canada and Australia, outlined the characteristics of an ideal model which will:

- use consensus among providers, individuals and funders in establishing a comprehensive service network.
- involve staff trusted by both mental health and developmental disabilities personnel to enhance access across sectors.
- maintain links with tertiary care centres such as university hospitals.
- employ staff well trained in both developmental services and mental health systems.
- involve “direct funding” to avoid the shortcomings of traditional “fee for service.”

Finally, the following considerations (adapted from Mansell, 1993) are noteworthy as stakeholders move forward with service planning and development in Southeastern Ontario.

Commitment

The population with dual diagnosis has greater needs for service than most. Quality evidence-based services result in marked improvement. The failure to develop local as opposed to regional services threatens the policy of community care and an added benefit that local services foster learning within the community.

Shared Responsibility

Both MOHLTC and MCSS and their funded services provider agencies need to cooperate in planning and to coordinate service provision through formal agreements or committees. Services and programs should reflect the respective Ministry or agency areas of competency.

Service Development Issues

In all jurisdictions investment in services is needed to achieve two aims:

- To develop and expand the capacity of local agencies to understand and respond to challenging behaviours, and

- ☐ To provide specialist services which support best practices at the local level.

Services should be tailored to meet individual needs, coordinated with other services within the community and able to provide access to independent advocates who can represent clients who are receiving care.

Monitoring and Evaluation

The literature suggests the need to assess the benefits and outcomes of service. The focus should be on five areas of accomplishments that relate to:

- ☐ Community presence - avoiding segregation of services.
- ☐ Choices for clients – which encourage autonomy.
- ☐ Competence – allows opportunity for clients to perform meaningful activities.
- ☐ Respect – recognizes the need for having a valued place within community.
- ☐ Community participation – encourages creating a network of relationships.

Furthermore, monitoring and evaluation should explore costs associated with care or the lack of it. Hidden costs of failure should be recognized (handling crises and placement breakdowns).

Conclusion

The most salient research in mental health treatment services for people with a dual diagnosis has been considered in this chapter. The insights and information from the literature led to the formulation of the framework of services that work. A full list of references reviewed for this project may be found in the References at the end of this report.

CHAPTER 3:

The Key Informant Survey

Mental health reform is a rapidly evolving process. The purpose of the key informant interviews was to get a “snapshot” of the present service system and some indication of the next steps to be taken as reforms in mental health proceed. The eleven people interviewed for the survey were from the following organizations: the Ministry of Community and Social Services (including Rideau Regional Centre), the Ministry of Health and Long Term Care, the Southeastern Ontario District Health Council, the three area public hospitals with Schedule 1 status under the Mental Health Act, and the Queen’s University Academic Health Science Centre (see Appendix A).

To structure the interviews, the DCP team identified six key issues relevant to understanding the context of the present service system and relevant to planning improved services for those with dual diagnosis. Interviews were kept open-ended to encourage discussion of issues beyond those identified.

The results of each interview were consolidated and are presented in this chapter. The issues discussed were:

1. Shared Ministerial Responsibilities In Southeastern Ontario
2. Achieving Local Self-Sufficiency In Providing Dual Diagnosis Services
3. Solving Professional Work Force Problems
4. Learning About Services That Work
5. Persons In Conflict With The Law
6. Monitoring To Improve Patient Care

Issue #1:

Shared Ministerial Responsibilities In Southeastern Ontario

The provincial Ministries of Community and Social Services and Health and Long-Term Care have shared responsibilities in funding services for people with a dual diagnosis. We asked informants to consider how to optimize the provision of coordinated services locally and regionally.

Except for a joint MCSS-MOHLTC guideline issued in 1997 to define joint roles and responsibilities in the care of persons with dual diagnosis and regular dialogue involving regional staff from both Ministries, there is little evidence of the kind of systematic planning needed for this “special population.” Neither Ministry has estimated the cost of providing community-based services for persons with dual diagnosis.

Since 1974, MCSS has been establishing community-based alternatives to traditional institutional care. Apart from their sponsorship of community behaviour management programs, an apparent assumption by MCSS has been that mainstream mental health services would simply add persons with dual diagnosis to their caseloads, indeed that all their needs for health care

would be met by “generic” providers. While the assumption is a reasonable one for some with mild intellectual impairment and normal abilities to communicate with professional advisors, it clearly is not valid with respect to the more severely impaired who often have multiple disabilities and major problems in communicating. When specialized Dual Diagnosis Units were established in several provincial psychiatric hospitals, including those at Whitby and Brockville in the east, some of the more severely impaired were provided with needed “extended care,” finding suitable residential placements and psychiatric follow-up for those ready for discharge is a continuing problem, particularly since MCSS closed several Southeastern Ontario institutions.

Mental Health Reform includes attention to special needs populations like the dually diagnosed but, with the exception of the Champlain region, adequate planning for those with dual diagnosis has been spotty or even non-existent. The projected closure of the Dual Diagnosis Unit in Brockville and the proposed bed reductions at PCCC Mental Health Services in Kingston raise major concerns in ensuring the availability of extended treatment in the Southeast Region. While representatives of hospitals with Schedule I psychiatry programs are open to suggestions as to how they might help out, they are very concerned that institutional beds will be closed without community placement alternatives being made available in advance. As well, some are concerned about role definition within the mental health sector for Schedule I and community mental health programs.

During this consultation, DCP received various suggestions from key informants about how inter-ministerial cooperation could be usefully enhanced:

1. Joint funding for innovative approaches to care.
2. Establishment of local service agreements and protocols with and between hospitals and agencies.
3. “Upfront” funding of residential and assertive community treatment options when beds are closed/reduced in Brockville and Kingston.
4. Establishment of a conflict resolution process (possibly part of 2 above).
5. Designating a CCAC role in coordinating service delivery at the agency/hospital level.

The future of RRC in Smiths Falls, operated directly by MCSS, was identified as an important factor in planning. At the time of the consultation there was no Ministerial decision as to its possible closure but, given the added burden to the mental health system represented by the influx of 50-60 “new” dually diagnosed patients, there was opinion either to:

- ☐ Delay its closure until Mental Health Reform activities were completed, or
- ☐ Ensure that the extra residential and treatment options were provided by MCSS/MOHLTC.

Issue #2:

Achieving Local Self-Sufficiency In Providing Dual Diagnosis Services

Both MCSS and MOHLTC are implementing policies that shift the focus of tertiary care from regional institutions to local community-based services. The informants were asked to consider how to ensure local self-sufficiency in providing services for people with a dual diagnosis as this reorientation is established.

An outline of “services that work” placed in a framework compatible with local self-sufficiency in serving persons with dual diagnosis from general population units of 150,000-200,000 is acceptable “in principle” to our key informants. However, three concerns were identified in relation to successful implementation of this approach:

1. Recruitment and retention of staff may be an issue.
2. The role of specialized assertive community treatment vs. integration of the dually diagnosed in generic ACT services needs to be determined.
3. Regional “tertiary care” beds may be required to provide backup to local extended treatment units.

The staff issue is considered in the next section. Currently, MOHLTC is supporting continuity of specialized ACT in Lanark, Leeds Grenville (at least until its evaluation is complete) and recommending “consultation and outreach” for the balance of the Southeast district. The provision of six extended treatment beds for each area is consistent with epidemiological projections from the United Kingdom.

Informants responsible for acute inpatient care in the district voice special concern about their inability, at times, to discharge patients to MCSS-funded residential settings. In practice, this scenario, i.e. a patient ready for discharge has no place to go, reflects a simple lack of group home placements in the community. There is a consensus that provision of \$55,000 per annum per resident in group homes is inadequate and a figure of (at least) \$100,000 was suggested as appropriate to the needs of those leaving MCSS institutions. Acute inpatient units, currently under pressure to provide an average stay of two to three weeks, must be in a position to discharge dually diagnosed patients when their acute treatment needs have been met.

A final issue identified during the consultation is a long waiting list for service in Community Behaviour Management Service programs. A suggestion was made that the mandate of these programs should be reviewed in relation to the projected availability of other ambulatory treatment options, especially assertive community treatment and outpatient services. A broader multidisciplinary approach appears desirable, the importance of the “behavioural” interventions notwithstanding.

Issue #3: Solving Professional Work Force Problems

Because developmental disabilities /dual diagnosis has been neglected in the training of mental health professionals, most agencies are ill-equipped to meet the special needs of those with a dual diagnosis and their families. Informants were asked to consider how this state of affairs can be remedied as part of a comprehensive regional plan.

Concern about training, recruitment and retention of frontline and professional staff prepared to serve persons with dual diagnosis is regarded as a major issue. All informants agreed that dual diagnosis has been viewed as an unattractive career path and that special efforts will be needed to build on achievements to date in Southeastern Ontario. The presence of an academic program at Queen's and the projected availability of expertise as inpatient programs in Brockville and Kingston are downsized provide some degree of optimism that these challenges can be met.

A continuing and enhanced role for the Queen's AHSC (i.e. Queen's and its affiliated hospitals and agencies) is desirable. Specifically, it was suggested that ongoing monitoring of staffing needs be coupled with traditional training responsibilities, thereby ensuring that gaps in expertise are quickly identified and remedied. Although most informants recognized that higher levels of remuneration were desirable for under-serviced domains of professional practice like dual diagnosis, others noted the importance of educational leaves and opportunities for secondments to other social service and health care sector agencies to achieve personal upgrading or renewal.

The shortages of family physicians, dentists and pharmacists in caring for patients with mental health problems were noted by some informants as having a potential impact on the area of dual diagnosis. In some communities there is difficulty recruiting and retaining the services of general psychiatrists. The problem is compounded in relation to excessive on-call responsibilities, a further deterrent in terms of recruitment.

The key informants identified topics particularly relevant for in-service education and upgrading. These include:

- ☐ Medical fragility
- ☐ Behaviour management, including the use of restraint procedures
- ☐ Interdisciplinary teamwork
- ☐ Community services, particularly for staff who to date have worked in institutional settings.

These topics are especially relevant to the care of "high needs" clients who have been or will be transferred to community settings from MCSS/MOHLTC institutional programs.

Finally, some informants noted the important educational role of consultation and outreach treatment services whereby each specialized consultation represents an opportunity for the consultant to educate frontline staff about issues illustrated in the patient who has been referred for an opinion. Providing adjunct faculty appointments for consultants is seen as a mechanism to reinforce the educational contributions of clinical service.

Issue #4:

Learning About Services That Work

The DCP team reviewed the professional literature on "services that work" in providing care to people with a dual diagnosis, and outlined a framework that could meet needs in various

Southeastern Ontario communities. We asked informants to comment on the services found to be effective, and to inform us of any other innovative programs that were not covered in the review.

In keeping with the specialized nature of services to persons with dual diagnosis it was not surprising that many informants were not aware of published experience from other jurisdictions about services that work. However, it should be noted that there was general support for providing services hitherto provided in institutions in local communities provided that the necessary resources were in place prior to closure of institutional beds. If there is continuing skepticism in the group of informants, it is focussed on concerns about human resources and achieving positive outcomes when properly staffed extended treatment settings are established. Many were concerned about continuing ambiguity regarding the future of specialized ACT (for the dually diagnosed and for other “special populations,” e.g. forensic, psychogeriatric, etc.).

The consultation, as well as enabling DCP to collect opinion important to success in further planning, also revealed that:

- ☐ crisis intervention can prevent the ultimate need for extended care;
- ☐ most stays in acute inpatient units resemble those for the non-disabled population served there,
- ☐ provision of outpatient treatment options reduces requests for and the length of stay in acute inpatient units; and,
- ☐ waiting lists for Community Behaviour Management services were long and growing.

Many informants are now supportive of planning for clusters of persons with similar needs (e.g. medically fragile, conflict with the law, etc.) vs. the traditional emphasis on individualized and “wrap around” approaches. As well, the need for MCSS transfer payment agencies to increase their programming skills to include restraint and confinement time-out was noted.

A UK visit by MOHLTC officials and DCP’s Dr. Nathalie Garcin occurred during this consultation. The aim was to become more familiar with “extended treatment”. In general, in spite of various sociologic differences, the extended treatment option appears to be viable and may successfully include some clients with a background of conflict with the law that previously had been excluded from the program. The issues relevant to serving those in conflict with the law are described next.

Issue #5:

Persons In Conflict With The Law

In all jurisdictions where community-based dual diagnosis services are being established, there is opinion and experience that individuals who set fires and who engage in paedophilic behaviour are best served in regional forensic programs.

The key informants had several suggestions about this important subgroup of persons with dual diagnosis:

1. Risk management considerations were more important than diagnostic categories like paedophilia and arson in planning services for individuals.

2. Diversion to health care/social service agencies should occur as soon as possible to optimize outcomes and to limit risks to those who are themselves vulnerable.
3. Integration of those in conflict with the law in local services should take priority over transfer to (planned) regional inpatient/custodial programs.

It is clear that the area of forensic services is receiving further study across Ontario. Professor Arboleda-Flórez is chairing a province-wide study group and the Human Services and Justice Coordination Project is continuing its activities.

Issue #6:

Monitoring To Improve Patient Care

Program monitoring and feedback to agencies and regional decision-makers appears to be a critically important element. The informants were asked to consider how program monitoring can be implemented and the kind of regional advisory group that might best receive this feedback.

All informants are supportive of monitoring innovative approaches, especially since there has been little research on these matters in the province of Ontario. Indeed, some decried the contemporary approach to provision of funding if and only when a crisis arises, a crisis that might have been predicted and prevented if appropriate research and program monitoring were already in place. Such monitoring can be seen as relating to service outcomes for individual patients, to defining staffing needs in agencies, and to planning service delivery systems. While a province-wide approach would be desirable, there was a general view that regional initiatives were more likely to be viable, especially if a particular role were to be assigned to the AHSC. The GRiDD initiative at Queen's was seen as providing an excellent basis for studying service outcomes/patient careers for individual clients.

Other suggestions about monitoring included a study of the present service needs of those from the Southeastern district currently living at Rideau Regional Centre (so that their future needs in the community could be forecast) and the use of CAP data to ensure that projected needs for patients from facilities in Brockville and Kingston would be met after discharge.

There was no consensus about the optimum site to receive and study data obtained from monitoring apart from the obvious observation, that both Ministries need better information to plan how to best provide services for this needy group of patients. Establishment of a district advisory group received little support, especially since there is a perceived need to monitor all mental health services vs. simply those provided to a small but obvious "high needs" group of patients like those with dual diagnosis. A need to be aware of adolescents with dual diagnosis who will "graduate" to the adult system was highlighted.

CHAPTER 4:

The Round Table Discussions: Community Consultation

Families and agencies in the developmental service sector presently bear much of the burden of care for people with a dual diagnosis, excluding only those living at Rideau Regional Centre or currently hospitalized. The round table discussions with representative groups of these stakeholders and representatives of the mental health care sector gathered information and opinions on existing services and those that are required.

One round table discussion was held in each of the three planning areas. The Frontenac / Lennox & Addington session occurred in Kingston on June 14th. Belleville was the site for the Hastings / Prince Edward discussion, on June 27th and the session for the Lanark / Leeds & Grenville area was held in Brockville on June 28th, 2001. A list of the more than 75 participants is provided in Appendix A.

Each round table session began with a presentation by Dr. Bruce McCreary of the DCP (see presentation slides in Appendix B). He began with a review the evolution of services that support people with dual diagnosis. He described 3 separate eras: an institutional era (prior to 1974), a “regional tertiary care” era (involving the provision of specialized treatment services by provincial psychiatric hospitals), and the current era (focussed on the provision of “local self sufficiency” in the community). He then outlined the Framework of “Services That Work”. The following aspects were noted:

- ☐ Any local population of persons with dual diagnosis has needs for emergency, ambulatory and inpatient treatment options
- ☐ Since the services are “specialized”, ensuring the availability of adequate numbers of skilled staff is a key element for success
- ☐ Since the “services that work” have been evaluated individually in other jurisdictions rather than collectively in Ontario, monitoring and evaluation with regular feedback to planners and government is a necessary consideration.

Participants were then asked to:

- ☐ Create a list of the services that are currently available in their area;
- ☐ Describe how accessible each service is to people with a dual diagnosis; and
- ☐ Give overall comments on the components of the framework.

After discussing these topics in small, cross-sector work groups, participants joined in the plenary session to give overall comment on the framework, and setting priorities for action.

The key points emerging in the plenary discussions by the round table participants are listed below:

1. Across the district there are major problems faced by family and agency caregivers in accessing treatment services for persons with dual diagnosis. The projected closure /downsizing of extended treatment options now provided by regional psychiatric hospitals enhances concern about how to best serve those who have the highest needs.
2. Neither Assertive Community Treatment Team for Persons with Developmental Disabilities (ACTT-DD) nor the proposed “consultation and outreach” approach are viewed as sufficient to meet the wide range of treatment needs in each area without the other components of the Framework of Services That Work. In particular, extended treatment options must be in place in each area before the projected changes in regional psychiatric hospitals are implemented.
3. The possible closure of Rideau Regional Centre should proceed only after a careful evaluation of the needs and costs of care for the 70 individuals living there who would be expected to live in the Southeastern district following closure.
4. There is district-wide support of the human resources and training and monitoring and evaluation roles envisaged for provision by Queen’s University in the district system of “local self sufficiency” programs.
5. The various ad hoc arrangements for dual diagnosis clients established by some MCSS funded agencies should be continued and MCSS needs to enhance the level of care provided by Community Behaviour Management Services.
6. Improved co-ordination of planning by the Ministry of Health and Long Term Care and the Ministry of Community and Social Services is necessary.

Tables 2, 3 and 4 summarize the results of the small group exercises in each area. These tables provide the reader with a “snapshot” of current services, access issues, and commentary relevant to future planning. Although other services were mentioned during the course of the consultation, these tables present those existing services that are specific to people with a dual diagnosis.

Table 2: Observations from Community Round Table Consultation in Frontenac, Lennox & Addington

"SERVICES THAT WORK"	CURRENT PROVISION	ACCESS	COMMENTS
EMERGENCY ASSESSMENT AND TREATMENT	KGH and HDH	Readily available. Some back-up by Queen's DD Mental Health Team. *	More specialized expertise needed.
AMBULATORY TREATMENT			
Outpatient Clinic	DD- Mental Health Team provides clinic at KGH; Community Mental Health Clinic	Waiting list 6/12 months.	Some specialized expertise from DD-MH Team.
Consultation and Outreach	Nil	Nil	PCCC-MHS exploring establishment of regional consultation and outreach
Community Behaviour Management Services	Ongwanada CBMS; Counselling Services of Belleville and District Behaviour Management Service	Waiting list 6/12 months	Staffing levels are inadequate
INPATIENT TREATMENT			
Acute Inpatient Care	Two designated Dual Diagnosis beds on Johnson 3 HDH	Functioning well. Admission and discharge planning by outpatient clinic DD-MH Team	To be transferred to KGH
Extended Treatment & Crisis Beds	ROH-BPH Dual Diagnosis Unit;	To be closed 2002;	No future options is major concern
	PCCC-MHS Admission Unit	To be eliminated	
RELATED "AD HOC" ARRANGEMENTS	Ongwanada has consulting psychiatrist		Assumption that current MCSS funded services will continue
	University Faculty support practicum settings for clinical psychology interns and for psychiatry postgraduate trainees		

* The Mental Health Team members are part of the Division of Developmental Disabilities, Department of Psychiatry at Queen's University.

Table 3: Observations from Community Round Table Consultation in Hastings and Prince Edward

"SERVICES THAT WORK"	CURRENT PROVISION	ACCESS	COMMENTS
EMERGENCY ASSESSMENT AND TREATMENT	QHC (Belleville site)	Readily available. No specialized dual diagnosis component.	Specialized expertise needed.
AMBULATORY TREATMENT			
Outpatient Clinic	Nil	Nil	Major Gap
Consultation and Outreach	Nil	Nil	PCCC-MHS exploring establishment of regional consultation and outreach
Community Behaviour Management Services	Counselling Services of Belleville & District Behaviour Management Service	Long waiting list	Staffing level is inadequate
INPATIENT TREATMENT			
Acute Inpatient Care	QHC (Belleville site) No Dual Diagnosis designated beds.	Lack of specialized expertise limits accessibility	Specialized expertise needed
Extended Treatment & Crisis Beds	ROH-BPH Dual Diagnosis Unit;	To be closed 2002;	No future options is major concern
	PCCC-MHS Admission Unit	To be eliminated	
RELATED "AD HOC" ARRANGEMENTS	Pathways to Independence has consulting psychiatrist.		Assumption that current MCSS funded services will continue

Table 4: Observations from Community Round Table Consultation in Lanark, Leeds & Grenville

"SERVICES THAT WORK"	CURRENT PROVISION	ACCESS	COMMENTS
EMERGENCY ASSESSMENT AND TREATMENT	Elmgrove Unit of ROH-BPH	Readily available. No special "dual diagnosis" component	Specialized expertise needed. To be transferred to Brockville General Hospital
AMBULATORY TREATMENT			
Outpatient Clinic	Nil	Nil	Major gap
Consultation and Outreach	ACTT-Dual Diagnosis provided by ROH-BPH	Waiting list, ACT criteria limit access to "severe mental illness", frequent hospitalizations.	PCCC-MHS exploring establishment of regional consultation and outreach
Community Behaviour Management Services	DSLГ and Lanark Community Services serve LG and L respectively	Long waiting lists for service.	Need enhancements to reduce waiting lists
INPATIENT TREATMENT			
Acute Inpatient Care	Elmgrove Unit of ROHBPH. No dual diagnosis dedicated beds.	Lack of specialized expertise limits accessibility	Excellent working relationship with community and with ACT Dual Diagnosis. To be transferred to Brockville General Hospital.
Extended Treatment & Crisis Beds	ROH-BPH Dual Diagnosis Unit.	To be closed 2002.	Projected closure implies no options for extended treatment -- major concern
	DSLГ provides "crisis home"	Length of stay extends beyond "crisis".	
RELATED "AD HOC" ARRANGEMENTS	DSLГ has consulting psychiatrist DSLГ provides 24-hour "crisis intervention". RRC Non-residential Services provides consulting psychiatrist for Lanark. RRC provides Behaviour Modification Unit and consulting psychiatrist for its residents.		Assumption that these MCSS funded services will continue

CHAPTER 5:

Analysis and Recommendations

During DCP's consultations with key informants, agency staff and family members concerned with the care of persons with developmental disabilities, we heard about widespread dissatisfaction at being unable to access treatment for those with dual diagnosis. This dissatisfaction borders on panic when the projected closure of the Dual Diagnosis Unit in Brockville and the planned reductions in inpatient beds at PCCC-Mental Health Services in Kingston are discussed. In addition to expecting more from the health care sector, MCSS funded agencies noted a need for more training in the care of persons with a dual diagnosis for their own staff.

Representatives of hospitals and agencies in the health care sector are also concerned. In particular, they are often frustrated by the inability to find residential and other supports for persons visiting the emergency department or ready for discharge from acute inpatient programs. They agree that dual diagnosis has been an unattractive career path for mental health professionals and that without the availability of relevant expertise they can do little to correct the current problems.

The present scenario reflects an evolution in the patterns of care provided to persons with developmental disabilities over the past half century in Ontario. It represents success in closing regional institutions but a failure to provide adequate supports for community-based alternatives. Specifically, with respect to those with dual diagnosis, the concerns expressed in both the social service and health care sectors are the result of deficient interministerial and interagency planning and neglect of the need to train and retain the services of staff with the skills necessary to serve persons who are dually diagnosed.

Despite very significant challenges involved in achieving local self-sufficiency in providing services and regional support in training and program evaluation, representatives of both sectors are prepared to proceed, assuming appropriate financial resources are applied to the task. The Framework of "Services That Work" drafted by DCP (see page 8) is acceptable to those consulted and provides the basis for the specific recommendations that follow. In presenting these recommendations DCP notes the importance of understanding and support from the District Health Council as the results of the consultation are considered by the Mental Health Reform Implementation Task Force and both the Ministry of Health and Long Term Care and the Ministry of Community and Social Services.

If the key players fail to act in correcting the current problems, it is inevitable that those with dual diagnosis will continue to experience neglect of their special needs for treatment, that many will find their way "inappropriately" into the correctional stream and that planners in both sectors can expect increasing criticism from members of various communities across Southeastern Ontario.

The Recommendations For Action

DCP has formulated seven recommendations as a response to the important observations and suggestions brought forward during the consultation. Since these recommendations have funding

implications for the MOHLTC and MCSS, they are presented in this chapter in a manner that accommodates respective Ministry roles in providing treatment services and social support.

Recommendations Specific to Ministry of Health and Long Term Care

- **Recommendation 1: Establishing the Framework**

That Quinte Healthcare Corporation, Kingston General Hospital and the Brockville General Hospital be provided with operating funds for emergency, ambulatory, and inpatient dual diagnosis treatment services.

The three public hospital facilities in the district that have Schedule 1 status under the Mental Health Act are uniquely situated to provide the complete range of treatment services for people with a dual diagnosis as identified in the Framework (except Community Behaviour Management, which is funded by MCSS). No other organizations are currently capable of providing emergency, ambulatory and inpatient services. As such, it is recommended that additional funding is provided to the three public hospital Schedule 1 facilities in the area to develop their services for people with a dual diagnosis.

In relation to the present consultation, note that the proposed dual diagnosis treatment services will:

- ☐ ensure local self-sufficiency;
- ☐ link with existing mental health services and community support programs;
- ☐ facilitate the successful closure of beds in regional psychiatric hospitals; and
- ☐ resolve the problems described in accessing needed treatment services in each area. They will not resolve the existing shortfalls in community residential alternatives and behaviour management that are the primary responsibility of MCSS (see below).

Detailed information on the services to be provided by each hospital and cost estimates for each category of service can be found in Table 5 (see Appendix C). The operating funds are to be dedicated to dual diagnosis and not reassigned to other hospital functions.

This recommendation is at variance with the recent decision to fund PCCC Mental Health Services (Dual Diagnosis Mobile Outreach Consultation Services Team). The consultation service envisioned by the MOHLTC to serve clients with a dual diagnosis is expected to provide only limited treatment services, secondary to meeting other priorities. While helping individuals and agencies through such “consultation and outreach” is important, the professionals involved must provide treatment as well. Treatment should be offered in both in a clinic setting and, as needed, in other locations across the area served.

- **Recommendation 2: Extended Treatment**

That capital funding is provided to enable each of the hospitals sponsoring a dual diagnosis treatment service, to establish “purpose-built” accommodation for the extended treatment unit and offices for the professional team providing ambulatory services.

Extended treatment is an important element in the Framework of Services. Currently, much of this type of service is provided in tertiary institutions (e.g., Brockville Psychiatric Hospital). As access to these institutions becomes limited, there will be a need to establish a local alternative for people requiring longer inpatient care. If this part of the Framework is not established before the elimination of tertiary services, we can expect increased pressure on existing components of the framework (e.g., acute inpatient care, outpatient clinic).

Each county grouping will need a “purpose-built” extended treatment unit to serve those with treatment goals that may take up to one year to achieve. In relation to the present consultation, note that the “purpose-built” unit will accommodate professional staff who will attend patients in the hospital emergency department, in the acute inpatient units, and across the area through consultation and outreach activities. Also, the extended treatment unit, like the hospital’s acute inpatient unit, will provide involuntary treatment as needed under the Mental Health Act.

- **Recommendation 3: The Role of Queen’s University**

That Queen’s University is provided with operating funds to provide a district-wide program concerned with Human Resources & Training and Monitoring & Evaluation.

Queen’s University is the only Academic Health Sciences Centre in the catchment area of the Southeastern Ontario District Health Council. Through existing capacities, the university will be able to play a key role in the implementation, management, and monitoring of the Framework of Services. More specifically, Queen’s will be able to:

- ☐ address the recruitment, career path and retraining concerns related to success in providing treatment services, and
- ☐ generate information relevant to the operation of the services provided in each area and to the development of comparable services across Ontario as mental health reform is implemented.

Table 6 (see Appendix C) provides further detail on the services to be provided by Queen’s University and the cost estimates for each category of service.

- **Recommendation 4: Consultation and Outreach Treatment Services**

That Queen’s University evaluate the relative effectiveness of specialized (dual diagnosis) Assertive Community Treatment and Consultation & Outreach in providing dual diagnosis treatment services.

Assertive community treatment (ACT) is a defined approach to providing ambulatory services to people with mental health problems. An ACT team for the dual diagnosis population is in place in Lanark, Leeds & Grenville, and the plan is for funding to continue. Assuming that Recommendation 1 is accepted, consultation and outreach treatment services will be established in the other two county groupings. As such, there is a unique opportunity to compare the effectiveness of the two approaches to providing services for people with a dual diagnosis.

Recommendations Specific to Ministry of Community and Social Services

- **Recommendation 5: Community Behaviour Management Services**

That the Community Behaviour Management Programs operating in the Southeast are strengthened, so as to eliminate long waiting lists and to ensure a collaborative working relationship with the dual diagnosis treatment services recommended above.

Many individuals with a dual diagnosis need behavioural interventions such as those presently provided by MCSS-funded Community Behaviour Management Programs. It is important to note that the current waiting lists for services are at least 6 months long and that there is often little coordination of effort between these and existing ad hoc mental health services.

- **Recommendation 6: Depopulation of Rideau Regional Centre**

That those individuals from the Southeastern district currently living at the Rideau Regional Centre are assessed in relation to meeting their needs (including those for dual diagnosis treatment services) in community-based settings.

Approximately 70 people at Rideau Regional Centre will be repatriated to the Southeastern Ontario District as deinstitutionalization continues. At least half will have a dual diagnosis. It is recommended that the community-living needs of these individuals be assessed immediately, in order to effectively plan for their arrival in our communities.

This recommendation implies continuation of the present policy of deinstitutionalization, and also allows an opportunity to develop realistic cost projections for community-based care by both social service and health care sector agencies.

Also note that this recommendation does not reverse the contemporary shortfalls in residential and activity programs that complicate appropriate disposition of those who appear in hospital emergency and acute inpatient settings; a recommendation that might correct this problem is beyond the scope of the present consultation.

A Recommendation Relevant to both MOHLTC and MCSS / Developmental Service Branch

- **Recommendation 7: Establish an Advisory Committee**

That an advisory committee is established composed of hospital, agency and family representatives and reporting at least twice yearly to the Regional Director of MOHLTC and the Regional Director of MCSS.

If the recommendations made here are recognized as supportable by the DHC, the Mental Health Reform Implementation Task Force, and the Ministries of Health and Long Term Care and Social Services, an interval of active planning and of implementation of new initiatives will follow. An advisory group will be required as this planning interval occurs. The group will reverse past and contemporary deficiencies in interministerial co-ordination and planning. Also, its deliberations would be shaped by district-wide information (from Queen's) on human resources and training and monitoring and evaluation.

Conclusion

Taken together, these recommendations constitute a comprehensive plan to provide locally accessible and self-sufficient treatment services for adults with a dual diagnosis in the Southeastern district. The plan ensures the availability of “services that work” and operational support from the district’s Academic Health Sciences Centre at Queen’s University. The operating costs for the district-wide treatment program and the operational support component of the AHSC are estimated to be in the range of 10 to 11 million dollars annually.

The plan is consistent with contemporary government policy that promises each citizen of Ontario the treatment and support needed for a dignified life in the community. Finally, it creates an advisory mechanism to promote meaningful communication between key government representatives and family / agency caregivers as these important services are established.

References and Appendices

She has been in the BPH Dual Diagnosis Unit for 2 years. Without their help, she can't adjust. Where will she get help when the unit closes?

I took him to the emergency department. I think they were afraid of him. All I got was a prescription and the pills didn't help at all.

John has been hospitalized 4 times at KPH and the psychiatrist says he will likely need readmission in the future. Will that be possible?

Since March she's become depressed and withdrawn. My doctor can't locate a psychiatrist who sees patients with developmental problems.

I had no training about developmental disabilities in medical school. Without a clinic or a consultant psychiatrist to help – I really don't know what to do with these patients.

REFERENCES

- Allen, D. & Felce, D. (1999). Service responses to challenging behaviour. IN N. Bouras (Ed.) *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Pp. 279-294. Cambridge University Press, Cambridge, UK.
- Allen, D. & Lowe, K. (1996). Providing intensive community support to people with learning disabilities and challenging behaviour: a preliminary analysis of outcomes and costs. *Journal of Intellectual Disability Research*, 39 (1), 67-82.
- Bailey, N.M., & Cooper, S-A. (1997). The current provision of specialist health services to people with learning disabilities in England and Wales. *Journal of Intellectual Disability Research*, 41(I), 52-59.
- Bouras, N. & Holt, G. (2001). Community mental health services for adults with learning disabilities, pp. 397-406. IN: Thornicroft, G. & Szumukler, G. (Eds.) *Textbook of Community Psychiatry*. Oxford University Press. Oxford, UK.
- Bouras, N. & Holt, G. (2000). The planning and provision of psychiatric services for people with mental retardation, pp. 2007-2012. IN: Gelder, M., Lopez-Ibor, J.J., Andreasen, N. (Eds.) *New Oxford Textbook of Psychiatry*. Oxford University Press. Oxford, UK.
- Bouras, N. & Drummond, C. (1992). Behaviour and Psychiatric Disorders of People with Mental Handicaps Living in the Community. *Journal of Intellectual Disability Research*, 36, 349-357.
- Bouras, N., and L. Szymanski. 1997. Review article: services for people with mental retardation and psychiatric disorders: US-UK comparative overview. *International Journal of Social Psychiatry*, 43(1), 64-71
- Cochrane, J., Goering, P., Durbin, J. Butterill, D., Dumas, J. & Wasylenki. (2000). Tertiary Mental Health Services: II. Subpopulations and Best Practices for Service Delivery. *Canadian Journal of Psychiatry*, 45, 185- 190.
- Coelho, R.J., Kelley, P.S. & Deatsman-Kelley, C. (1993). An Experimental Investigation of an Innovative Community Treatment Model for Persons with a Dual Diagnosis (DD/MI). *Journal of Rehabilitation*, April, 37- 42.
- Davidson, P.W., Cain, N.N., Sloane-Reeves, J.E., Giesow, V.E., Quijano, L.E., VanHeyningen, J.V. & Shoham, I. (1995). Crisis Intervention for Community-Based Individuals With Developmental Disabilities and Behavioral and Psychiatric Disorders. *Mental Retardation*, 33 (1), 21-30.
- Davidson, P.W., Morris, D. & Cain, N.N. (1999). Community services for people with developmental disabilities and psychiatric or severe behaviour disorders. IN N. Bouras (Ed.) *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Pp. 359-372. Cambridge University Press, Cambridge, UK.

Day, K. (1993). Mental Health Services for People with Mental Retardation: A framework for the Future. *Journal of Intellectual Disability Research*, 37 Supplement, 7-16.

Dockrell, J.E., Gaskell, G., Normand, C. & Rehman, H. (1995). An economic evaluation of the resettlement of people with learning disabilities and challenging behaviour. *Social Science in Medicine*, 7, 895-901.

Fair, J. (2001) Patients Diagnosed as having a Developmental Disability/Mental Retardation on the Assessment, Diagnosis & Stabilisation (ADS) Service, Part II. Unpublished document.

Fraser, W., Sines, B., Kerr, M. (1998). Pg.5, Chapter 1 in Halles' The Care of People with Developmental Disabilities. Butterworth Heinemann, Oxford.

Gapen, B., McGregor-Clewes, M., Mohamid, S. & Morris, S. (1996). Creating a Continuum of Supports and Services: A Resource Document. Metro Agencies Treatment Continuum for Mental Health (MATCH).

Government of Ontario (1999) *Making it Happen, Operational Framework for the Delivery of Mental Health Services and Supports*. MOHLTC, Ontario.

Holden, P. & Neff, J.A. (2000). Intensive Outpatient Treatment of Persons with Mental Retardation and Psychiatric Disorder: A Preliminary Study. *Mental Retardation*, 38 (1), 27-32.

Jacobson, J.W. (1999). Dual Diagnosis Services. In: Bouras (Ed.) *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Pp. 279-294. Cambridge University Press. Cambridge, UK.

Lowe, K., Felce, D., & Blackman, D. (1996). Challenging behaviour: the effectiveness of specialist support teams. *Journal of Intellectual Disability Research*, 40 (4), 336-347.

Mansell, J.L. (1993) *Services for people with learning disabilities and challenging behavior or mental health needs*. Her majesty's Stationery Office.

Marshall, M., Gray, A., Lockwood, A., & Green, R. (2001) Case management for people with severe mental disorders (Cochrane Review). In: The Cochrane Library, Issue 2, 2001. Oxford: Update Software.

McConkey, R. (2000) Community care and resettlement. *Current Opinion in Psychiatry* 2000, 13, 491-495.

Menolascino, F.J. & Stark, J.A., Eds. (1984). *Handbook of Mental Illness in the Mentally Retarded*. New York: Plenum Press.

Meerding, W.J., Bonneux, L., Polder, J.J., Koopmanschap, M.A., Vander Maas, P.J. (1998). Demographic and epidemiologic determinants of health care costs in the Netherlands: cost of illness study. *British Medical Journal*, 317, 111-5.

Moss, S., Emerson, E., Bouras, N., Holland, A. (1997) Mental disorders and problematic behaviours in people with intellectual disability: Future directions for research. *Journal of Intellectual Disability Research*, 41(6), 440-447.

Ouellette-Kuntz, H. & Paquette, D. (*in press*). The Prevalence of Developmental Disabilities in Lanark County, Ontario. *Journal of Developmental Disabilities*.

Palmer, H.P., MacFarlane, D., Stuart, H. Durbin, J., Cochrane, J., Goering, P. (2000). Kingston Psychiatric Hospital Comprehensive Assessment Project: Final Report. Toronto: Centre for Addiction and Mental Health.

Palmer, H.P., MacFarlane, D., Cochrane, J., Durbin, J., Goering, P. (2000). Brockville Psychiatric Hospital Comprehensive Assessment Project: Final Report. Toronto: Centre for Addiction and Mental Health.

PCCCAR Reports. (1995). Equitable Health Human Resources Distribution: Fulfilling Underserved Area Needs. Prepared by the Subcommittee on Underserved Area Needs.

Reiss, S. (1990). Prevalence of Dual Diagnosis in community-based day programs in the Chicago metropolitan area. *American Journal on Mental Retardation*, 94, 578-585.

Reiss, S., Levitan, G., & Szyszko, J. (1982). Emotional Disturbance and mental retardation: Diagnostic Overshadowing. *American Journal on Mental Deficiency*, 86, 567-574.

Rojahn, J. & Tassé, M.J., (1994) Psychopathology in Mental Retardation. IN J.W. Jacobson & J.A. Mulick (Eds.) *Diagnosis and Professional Practice in Mental Retardation*. Washington, DC: American Psychological Association.

Rush, J.A. & Frances, A. (2000). Treatment of Psychiatric and Behavioural Problems in Mental Retardation. Expert consensus series. *American Journal on Mental Retardation*, 105 (3), Special Issue.

Szymanski, L & King, B.H. (1999). Practice Parameters for the Assessment and Treatment of Children, Adolescents and Adults with Mental Retardation and Comorbid Mental Disorders. AACAP Official Action. *American Academy of Child and Adolescent Psychiatry*, 38 (12) supplement, 5S- 31S.

Van Minnen, A., Hoogduin, C.A.L., Broekman, T.G. (1997). Hospital vs. Outreach treatment of patients with mental retardation and psychiatric disorders: a controlled study. *Acta Psychiatrica Scandinavica*, 95, 515-522.

Wasylenki, D. Goering, P., Cochrane, J., Durbin, J., Rogers, J., & Prendergast, P. (2000). Tertiary Mental Health Services: I. Key Concepts. Review Paper. *Canadian Journal of Psychiatry*, 45, 179-184.

Yu, D., Atkinson, L. (1993). Developmental disability with and without psychiatric involvement: prevalence estimates for Ontario. *Journal on Developmental Disabilities*, 2:9229.

APPENDIX A: Contributors

THE DEVELOPMENTAL CONSULTING PROGRAM (DCP) TEAM MEMBERS

The members on the Developmental Consulting Program Team were: Bruce McCreary, Professor of Psychiatry at Queen's University and Chair of the Division of Developmental Disabilities; Philip Burge, a social worker and Assistant Professor of Psychiatry; Julia Frei; Nathalie Garcin, a psychologist and Assistant Professor of Psychiatry; Haider Saeed, Research Associate with the Division of Developmental Disabilities and DCP, and Barbara Stanton, DCP Coordinator.

THE ADVISORY COMMITTEE MEMBERS

Margrit Choy: Frontenac, Lennox & Addington Counties
Geoff McMullen: Lanark, Leeds & Grenville Counties
Michael Park: Southeastern Ontario District Health Council, and
Susan Seaman: Hastings, Prince Edward County.

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Quinte Healthcare Belleville General

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Providence Continuing Care Centre

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Hastings And Prince Edward

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Janet Christie North Hastings Community Integration Association	Alan Mathany Community Mental Health Program	Linda Peever Providence Continuing Care Centre- MHS
Jacki Evans Crisis Intervention Centre	Ron McCauley Trenton & District Association for Community Living	Evonne Rashotte William R. Kirk School
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Lanark / Leeds & Grenville

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Quinte & Region Community
Homes

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North Grenville Association
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Lori Tozer
Developmental Services of
Leeds & Grenville

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Lanark Community Living
Association

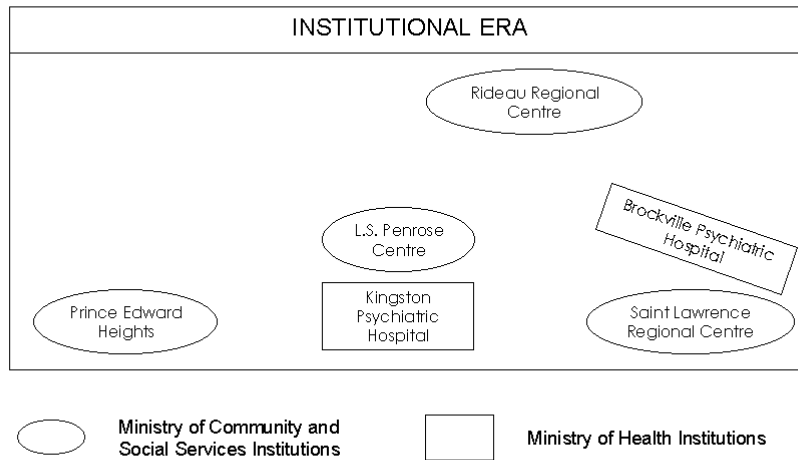
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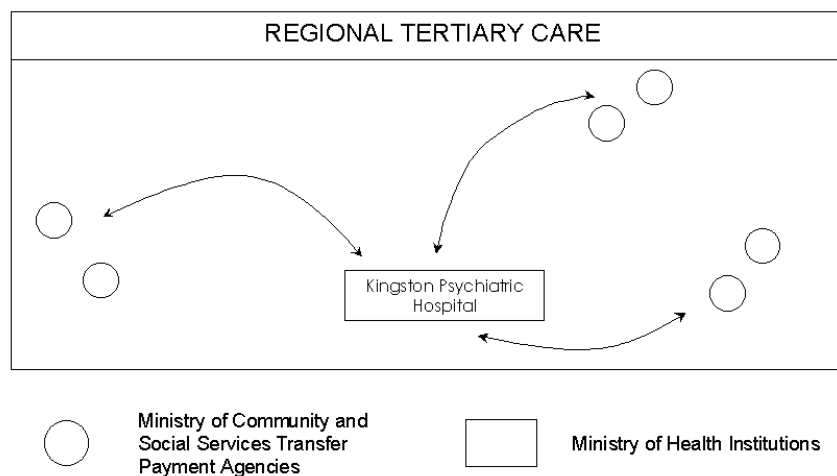
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APPENDIX B: Slide Presentation from Round Table Discussions

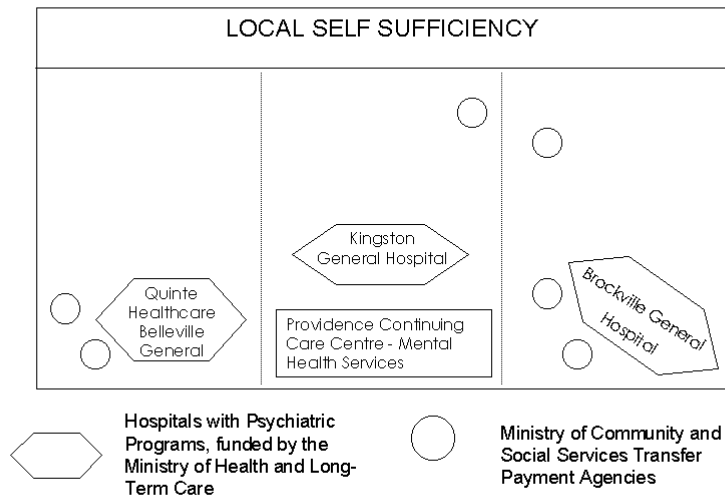
AN HISTORICAL PERSPECTIVE



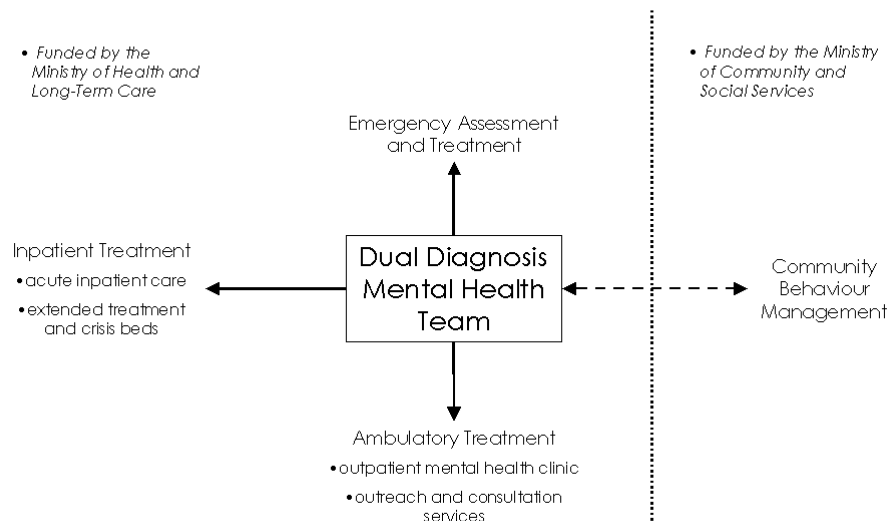
AN HISTORICAL PERSPECTIVE



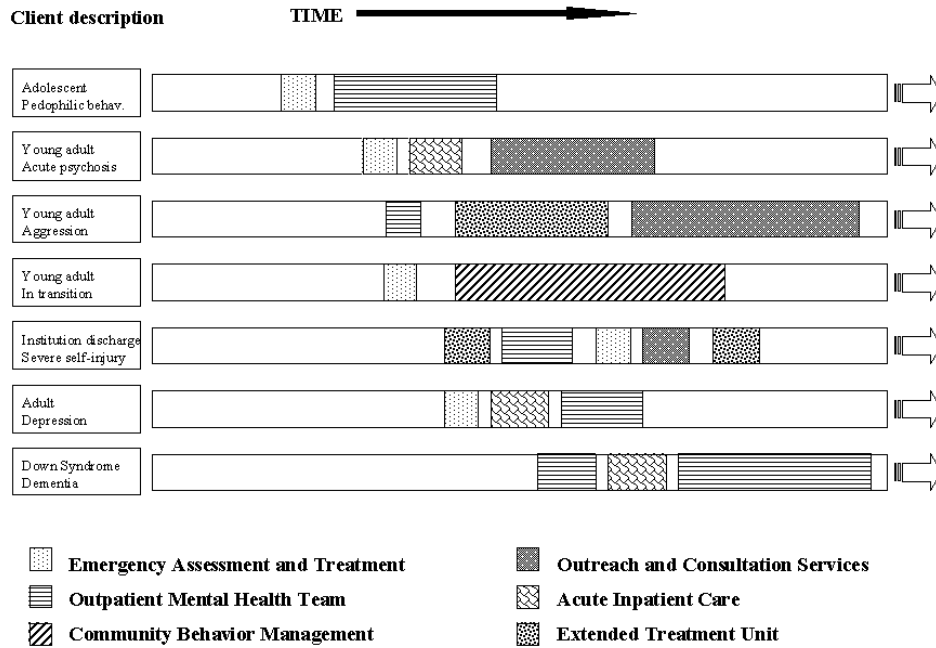
AN HISTORICAL PERSPECTIVE



FRAMEWORK OF “TREATMENT SERVICES THAT WORK”



Dual Diagnosis Planning: Service Needs Profiles



HIGHLIGHTS OF KEY INFORMANT CONSULTATION (To Date)

Issue #1 Shared Ministerial Responsibilities

- ▶ Little evidence of real inter-ministerial cooperation, i.e. The silo approach continues!
- ▶ Mental Health Reform provides an opportunity to address contemporary and projected challenges.
- ▶ “Up front” funding is needed for community alternatives before institutional beds are closed.

Issue #2 - Local self-sufficiency

- ▶ “Services that work” observations can be utilized to establish a local service delivery framework.
- ▶ More MCSS \$’s for residential/day program activities and for CBMS programs.
- ▶ need to rationalize “specialized” vs. “generic” ACT for persons with dual diagnosis.

Issue #3 - Specialized Manpower

- ▶ Continuing perception as an unattractive career path.
- ▶ Enhanced role for AHSC in manpower planning and training.
- ▶ Staff from institutions that are phasing down/out can provide expertise in innovative community programs.

Issue #4 - Services that Work

- ▶ Literature is not widely understood.
- ▶ UK visit to extended treatment program confirmed our thoughts.

Issue #5 - Clients in Conflict with the Law

- ▶ A special concern in Ontario.
- ▶ Risk Management is more important than diagnostic labels.
- ▶ Diversion to mental health and social services is preferred approach.

Issue #6 - Monitoring to improve services

- ▶ A special role for AHSC (building on GRiDD)
- ▶ Study projected needs of RRC clients from region.
- ▶ Use CAP data as a baseline to ensure predicted service needs are met in the community.

PROJECTED QUEEN'S AHSC CONTRIBUTION

I. MANPOWER (Monitoring) and TRAINING

“Attracting, Preparing, Retraining”

→ Frontline and Professional Staff

→ Training and Retraining

II. MONITORING AND EVALUATION

→ Patient Outcomes (Build on GRiDD initiative)

→ Service Planning (MCSS/MOHLTC-funded agencies)

APPENDIX C: Notes and Detailed Service Information in Tables 5 and 6 from Chapter 5

Notes Related to Table 5: Services To Be Provided By Each Hospital With Preliminary Cost Estimates

1. In Lanark / Leeds & Grenville, “consultation and outreach” will be replaced by continuation of the existing Dual Diagnosis Assertive Community Treatment Team; sponsorship is expected to shift to the Brockville General Hospital.
2. Bed allocations for inpatient care represent those projected from application of UK data and existing referral rates for acute inpatient and extended treatment in the Southeast.
3. Projected Costs for Emergency: the allocation represents on call fees for any psychiatrist on the emergency department roster (including the psychiatrist from the dual diagnosis service) and for a member of the ambulatory team. (on rotation)
4. Projected costs for Ambulatory: the staffing allocation for each hospital represents an application of the UK standards per 100,000 general population. Since hospitals will serve areas with larger populations, these allocations are minimal estimates. However some MCSS supported agencies have established “ad hoc” arrangements for mental health care. (e.g. consulting psychiatrists, clinical psychologists on staff etc.) and some MOHLTC sponsored mental health agencies provide limited treatment: the projections made here assume continuation vs. replacement of these arrangements. Salary estimates are based on ranges presently competitive in Ontario for the various disciplines involved.
5. Projected Costs for Inpatient Care: the allocation assumes no increased costs for acute inpatient care and a per diem of \$800 per patient (from the UK consultation) for extended treatment. It assumes a 50% occupancy rate for the crisis beds. The per diem includes the cost of professional and frontline staffing for extended treatment.

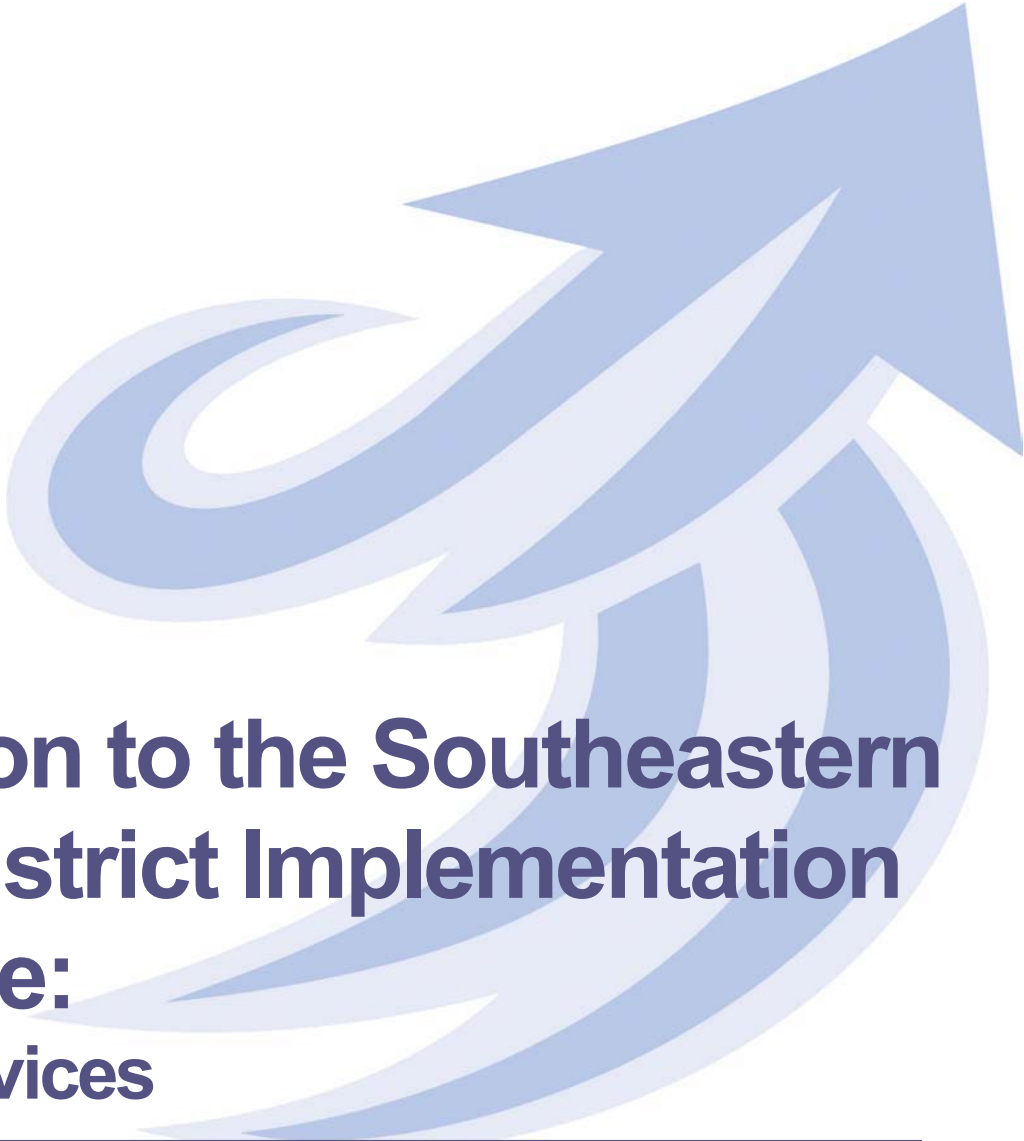
Please see Table 5 on the next page.

Table 5: Services to be provided by each hospital with preliminary cost estimates

SERVICE COMPONENT	STAFF ALLOCATIONS	ESTIMATED COSTS (NOT INCLUDING BENEFITS OR OVERHEAD COSTS)
1. EMERGENCY DEPARTMENT Assessment, emergency treatment and triage provided by psychiatrists and ambulatory team members "on call" 24 hours a day, 7 days a week.	Psychiatrist and one team member (on rotation from ambulatory team)	Stand By Fees @ \$50/24 hours TOTAL ESTIMATED COST: \$36,500
2. AMBULATORY TREATMENT Outpatient Clinic Traditional outpatient clinic open 9:00 to 5:00, 5 days a week Consultation and Treatment Outreach On site in agencies, nursing homes, client homes, etc. Specialized assessments and advice to other caregivers, follow-up as needed *9:00 to 5:00, 5 days a week	Psychiatrist (1), Clinical Psychologist (1), Social Worker II (1), Psychological Associate (1), Occupational Therapist (1), Community Nurses (3), Mental Health Workers (2)	Psychiatrist (\$175, 000), Clinical Psychologist (\$83,900), Social Worker II (\$64,900), Psychological Associate (\$56,000), Occupational Therapist (\$58,400), Community Nurses (\$62,000 x 3), Mental Health Workers (\$41,600 x 2) TOTAL ESTIMATED COST: \$707,400
3. INPATIENT TREATMENT Acute Inpatient Unit Two dedicated beds in presently operating acute inpatient unit. Average length of stay: 2 to 3 weeks Extended Treatment Unit Six beds and two crisis beds. Comprehensive treatment and rehabilitation program. Average length of stay: 2 to 15 months, *48 to 72 hours for crisis beds	Acute inpatient beds already staffed Staff included (with other operating funds) in UK per diem figure	\$800 per patient per day TOTAL ESTIMATED COST: \$2,044,000
Administrative and Support Staff	Administrative Secretary (1), Clerk /Typist (1), Receptionist /Data Clerk (1)	Administrative Secretary (\$45,000), Clerk /Typist (\$36,000), Receptionist / Data Clerk (\$34,500) ESTIMATED TOTAL: \$115,500

Table 6: The Role of the Academic Health Sciences Centre of Queen's University and Estimated Costs

SERVICE ROLE	DESCRIPTION	ESTIMATED COSTS (NOT INCLUDING BENEFITS OR OVERHEAD COSTS)
Human Resources and Training	Monitors staffing levels and recruitment in 3 areas of Dual Diagnosis Services. Assists with provincial, national, and international efforts in recruitment. Facilitates and contributes to staff training/re-training programs. Provides feedback and advice to proposed regional director (i.e. MCSS, MOHLTC) advisory committee.	Coordinator's salary \$75,000 Admin. Assistant (1) salary \$42,800 TOTAL COST: \$117,800
Monitoring and Evaluation	Receives and analyzes patient care and outcome information from 3 area Dual Diagnosis Services. Evaluates trends in services and persons with developmental disabilities/dual diagnosis across the district. Provide feedback and advice to proposed regional director (i.e. MCSS, MOHLTC) advisory committee.	Coordinator's salary \$75,000 Admin. Assistant (1) salary \$42,800 TOTAL COST: \$117,800

A large, stylized blue arrow graphic that curves upwards and to the right, with a smaller, lighter blue arrow following its path. The graphic is composed of several overlapping, curved segments.

Submission to the Southeastern Ontario District Implementation Task Force: Forensic Services

**SUBMISSION TO THE SOUTHEASTERN ONTARIO MENTAL HEALTH
IMPLEMENTATION TASK FORCE
FORENSIC SERVICES**

General

Legislative changes affecting the criminal law process in regard to mentally ill offenders introduced in 1992 and policy changes affecting the mental health delivery system have been given as reasons for the increase of forensic psychiatric services in the country. The data show that the number of persons ordered for a fitness assessment and those found not criminally responsible because of a mental disorder have grown disproportionately ever since Bill C-30 (amendments to the Criminal Code pertaining to mentally ill offenders, 1992). In addition, the number of mentally ill persons in federal and provincial correctional institutions has also grown to the point that many prisons have to organize specialized psychiatric services and some have become *de facto* mental institutions. Often, mental patients are discharged from correctional facilities without any plans for treatment in the community so that it does not take too long before they are back within the forensic system or in prison. Unfortunately, forensic systems are not too well organized and do not respond to the needs of those mental patients who are in trouble with the law. Furthermore, forensic systems seem to have been organized in isolation from the regular mental health system so that, instead of being a subsystem of the mental health system, forensic has become a major competitor for funds and facilities. The lack of integration between the two systems is cumbersome and difficult to understand given that, often, it is the same patients who are found either in prison or in hospital.

A mature mental health system will seek a full integration of forensic psychiatry within a system in which patients are not lost to follow-up once they enter a forensic unit or a prison. An integrated system will reserve highly specialized forensic resources for those who have the need not for everybody who gets labeled “forensic” on account of having *any* criminal record. Such a system will also seek to mobilize patients from one system to the other and vice versa thus avoiding keeping mental patients forever in the “forensic ghetto.” Unfortunately, as currently organized the mental health system closes the door on the mental patient once such a patient is labeled “forensic.” Return to community mental health services is practically impossible and housing and other entitlements become harder to obtain. This situation is not made easier by the fact that forensic services are usually identified as locked facilities usually found in mental hospitals. Few forensic services in the country offer a gamut of ambulatory and community alternatives

that could prevent hospitalization. This lack of alternatives affects most forensic services in the country and is found in Kingston and adjacent communities as well.

Mandate

As part of the overall review of mental health systems set up by the Southeastern Ontario Mental Health Implementation Task Force (SEOMHITF), a group of “forensic champions” was constituted under the leadership of J. Arboleda-Flórez, the *unterschreiben*. The mandate of this Forensic Group was to review the forensic system in the area, identify strengths and gaps and provide recommendations to the Task Force.

Members of the Forensic Group are:

J. Arboleda-Flórez, Chair

Wayne Barnett

Nick Delva

Dale Forbes (later replaced by Donna Joyce)

Dorothy Cotton

David Simourd

Bob Napier

Wolf Tausendfreund

Ex-officio:

Sandra Lawn

Jane Banbury

Situational Analysis

There are two forensic systems in the area, the one operated by Corrections Canada and that includes the penitentiaries and the Regional Treatment Centre, and the Forensic Unit at Providence Continuing Care Centre-Mental Health Services (PCCC-MHS). Apart from individual arrangements or private service contracts, there are no organizational relationships between the two. The Federal system, however, occasionally releases inmates into the community who require further psychiatric treatment and follow-up. In regard to the Forensic Unit, it is usually overly subscribed and waiting for a bed could take months. The Unit, which is part of a Regional Program, offers only a modicum of ambulatory or community services and some psychiatrists and psychologists provide follow-up, but mostly on a private basis, not as an organized programmatic structure. Thus, the Regional Program is only a name. Although it offers services to the Remand Centre at Quinte for triaging, apparently, these services are not part of the obligatory deliverables of the program. Again, although some services are provided through individual arrangements, the Program itself does not have working arrangements with National Parole or probation officers, police, Crowns or Judges. The Program, however, has a semi-developed ambulatory program, which is minimally staffed; it provides occasional consultation to some referral sources and follow-up to some patients discharged from the Unit. Occasionally, on request, the Program provides some training or educational services for mental health workers in the different mental health agencies

in the district and there is a sprinkle of research activities specifically relating to forensic populations.

A review of the data from the Forensic Unit shows that a great number of admissions to the Unit are for fitness assessments many of which would, possibly, not be required if proper triage is conducted at the court level. In addition, if an assessment is truly needed, many of them could be done on an ambulatory basis thus protecting the utilization of beds at the Unit and elsewhere at PCCC-MHS.

On the positive side, the clinical services provided at the Forensic Unit and at Corrections Canada are of the best quality and follow proper legal procedures and ethical canons to protect the rights and preserve the dignity of mental patients in their respective institutions. The Forensic Unit serves as a training ground for a host of students including psychiatric residents, forensic fellows, medical, psychology, and nursing students. On its part, Corrections Canada provides the largest portion of a Fellowship in Forensic Psychiatry and conducts world level research on risk scales and risk management.

Apart from these two systems, there are other levels of forensic client interactions in the Region. The Human Services Justice Coordinating Committee (HSJCC) has been very active in Kingston and has taken a leadership role in integrating the number of agencies that might be accessed by these clients. The Committee, however, needs some structural logistical support to function properly and it needs to become integrated with a Forensic Subsystem as recommended in this proposal. The work of the Committee and its functionality should be part and parcel of the community interactions of a forensic community subsystem. Unfortunately, the good work of the HSJCC has not been duplicated in other communities (Belleville, Brockville, Bancroft) and this is a matter of major concern that has to be remedied in each community.

Another level of interaction with forensic clients is with police authorities or at court. To this effect, the Province has funded several initiatives such as “court diversion workers” and Community Treatment Orders (CTO) Coordinators. Some of these persons are already in place in our area, but they are not connected and not integrated. These positions are vital for divestment purposes and their integration with a forensic community system should, therefore, be a priority.

Finally, the plans for a super jail at Brockville associated with a major forensic component organized from Ottawa is a development that has to be factored in regarding forensic clients in the Region. A number of prisoners from super jails tend to remain in the area at the end of their sentences as happens with some of those leaving the federal correctional facilities in Kingston. Some of these persons will need mental health services and associated support facilities such as housing.

Recommendations

It is granted that Canada Corrections has no obligation to provide medical services once a prisoner is released into the community. However, given the concentration of penitentiary institutions in the area, good regional citizenship would dictate that they be involved in, at least, the planning and organization, if not financial support, of academic forensic activities and forensic services integration. It could also be granted that PCCC-MHS Regional Forensic Program has not been given a clear mandate, or provided with the funds, to set up a truly regional forensic network of services. Therefore, based on what exists and on the identified gaps, the Forensic Group makes the following recommendations to the SEOMHITF:

1. Develop an all-encompassing regional forensic program that is integrated with and is a subcomponent of the general mental health program. Such a program will cover the following:
 - a. An in-patient Forensic Unit that is more discerning of the type of patients it accepts and capable to live within the allotted number of beds.
 - b. Psychiatric services at Quinte Remand Centre.
 - c. Triaging services to the courts in the area in order to decrease the number of requests for inpatient assessments, especially fitness assessments.
 - d. Community Forensic Clinic with the following functions:
 - i. To provide follow-up of forensic patients discharged from the Forensic Unit and Corrections Canada, and consultation and treatment for cases brought in by parole and probation officers, police, Crown Attorneys, the courts, medical practitioners and community mental health agencies.
 - ii. To be the link to the general mental health services in order to make sure that forensic patients can be transferred to the community mental health agencies and ACT Teams once their level of risk is determined as minimal.
 - iii. To act as an educational powerhouse to train and maintain knowledge among mental health workers on forensic issues and on the management of forensic patients in the community.
 - iv. To ensure and broker the acceptance and entry of clinicians from the different mental health agencies into correctional systems so that they actively do “follow-through” activities when their clients enter a correctional institution.
 - e. Provide logistical support to the HSJCC so that it becomes the backbone of community integration efforts for an ambulatory community forensic subsystem.
 - f. Integrate the functions of “like-workers” such a court diversion workers and CTO Coordinators to become active members of the forensic subsystem.
 - g. Development of transitional half-way house for forensic clients after they leave the prison, whether federal or provincial.
 - h. Maintenance of proper data about clinical and academic activities, levels of need of forensic clients, and staff utilization.

- i. Utilization of advanced technologies such as Telepsychiatry for hard to access areas in the Region..
 - j. Cooperation and participation in academic activities including teaching to a variety of students and active encouragement of research initiatives.
 - k. Work in close cooperation with the Royal Ottawa Hospital in relation to the forensic developments at Brockville.
- 2. Examine the staffing ratios, workloads and funding available to the Forensic Program in order to determine whether some functions and personnel could be transferred to the ambulatory and community functions described above.
- 3. Identify augmentation costs that will be required from the Provincial Government in order to make the Regional Forensic Program a fully integrated community program. Provisionally, such costs have been identified as:
 - a. One forensic psychiatrist
 - b. One forensic psychologist
 - c. One nurse
 - d. Secretary approximately **\$400,000.00**
 - e. Plus non-recurrent costs (furniture, computers, miscellaneous) amounting to approximately **\$ 80,000.00** for a total of.....approximately **\$480,000.00**
- 4. Enter into arrangements with Corrections Canada in order to:
 - a. integrate follow-up of ex-inmates through use of a forensic half-way house
 - b. working out arrangements for proper “gating” procedures regarding the use of commitment clauses in the Mental Health Act
 - c. consultation services to national parole officers
 - d. ambulatory treatment options for ex-federal inmates
 - e. financial help regarding academic activities.

Respectfully submitted on behalf of the Forensic Group,

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A Plan and Model for Meeting the Needs of Older Individuals with Mental Health Problems

A Plan and Model For Meeting the Needs of Older Individuals with Mental Health Problems

Prepared by:
The Seniors Champions Group, MHITF

April 5, 2002

EXECUTIVE SUMMARY

Introduction

This project is a joint undertaking between the Southeastern Ontario District Health Council and the Seniors' Champions Group of the MHITF. Its purpose is to provide advice to the Southeastern Ontario District Health Council and to the Mental Health Implementation Task Force (MHITF) with respect to a strategic plan for the development of a district system that meets the needs of older individuals with mental health problems, including the identification of next steps in the process.

The deliverables for the project include a synopsis of legacy work and strengths/gaps in service and a preferred model for a district system. The terms of reference for the project outline specific objectives, the planning process and timeframe, and are attached as Appendix C.

Major Influences

Major influences considered in developing this report include:

- Needs of the target population (characteristics, needs and implications) (see Fig 1)
- Developing a consumer and family centred responsive system which is accessible, coordinated, integrated and accountable, and that provides services in an equitable manner to the catchment area
- Provide services for older individuals with mental health needs vs. mental health services for older individuals with severe mental illness
- A conceptual shift from specialty programs as services to specialty programs as a "resource" involved in the provision of direct clinical activities, with increased emphasis on shared care, education, collaborative program, and system development.
- Support and integration of specialty programs with knowledgeable, accountable and able first line and intensive services.

Target Population:

It has been estimated that up to 30% of individuals have mental health problems (CMA). It has been estimated that approximately 15% of those over the age 65 have specialized mental health needs, with 2% requiring direct specialty care (Clarke Report/Ministry of Health and Long-Term Care). The population of older individuals served is often diverse in its characteristics and may require different sets of services to meet the differing needs of each of its sub-population groups.

The target population of those with mental health needs is outlined in Figure 1 (section 1.3) followed by critical factors and implications in terms of a comprehensive responsive quality system of care.

It should be emphasized that the populations defined in Figure 1 reflect older individuals with mental health problems served by the continuum of services, not only the services of specialized mental health.

The target populations are individuals who have complex needs, often combined with complex physical health care needs associated with aging. The focus of specialized geriatric psychiatry programs is on meeting these unique and complex needs and is not based on age alone.

Consistent with the Policy Framework and Implementation Guidelines of the Ministry of Health and Long-Term Care the major function of geriatric psychiatry services is to support the primary and secondary systems of care, both in mental health and the associated systems that serve these population groups.

In theory, those served by geriatric psychiatry are individuals over 65 with complex late onset needs. In practice, however, most individuals are over age 75. This is of particular importance in terms of the group that is served by geriatric and mental health services, as the over age 80 group is the fastest growing group of individuals in Ontario. Some individuals, younger than 65, have a degree of complexity and similar range of issues to those more typical of an older group presentation and are viewed as an important population to be serviced by the geriatric mental health system.

Older individuals with longstanding or early onset psychiatric problems who grow old may require access to adult specialty geriatric psychiatry services. The Policy Framework and Implementation Guidelines identify that the generic psychiatry specialized adult services are more appropriate for this population and the specialized geriatric psychiatry services will provide support if complexities of old age occur. Individuals will be transferred to the geriatric mental health system when and if appropriate (criteria for transfer are outlined in the Policy Framework and Implementation Guidelines).

What Do We Know About the Prevalence of Older Individuals with Mental Health Problems?

Older individuals with mental health needs are found throughout the health care system. It is therefore, imperative that a continuum of services be developed in which geriatric mental health services are an integral part.

In long-term care facilities, it has been estimated that 17-23% have depression; 18% are admitted with psychotic problems and 60-80% have dementia of some type. Zimmer has identified that 70% have behavioral problems; 30% severe.

In the community sector, 15% of older individuals have been estimated to have mental health problems requiring specialized services; 2% requiring direct specialized services (Clarke). Blazer has also identified 14.9% of older individuals dwelling in the community have depression severe enough to significantly affect their functioning. It is noteworthy that almost half of these individuals have significant associated medical problems.

The percentage of those with psychosis has been estimated at 4% and the number of individuals with dementia in the community is significantly more than in the facility sector.

Older individuals also are significant users of our hospital and acute health care system. It has been estimated that of those admitted to hospital with a medical disorder that approximately 50% have a diagnosable psychiatric disorder (Lipowski).

Estimates in the number of those with dementia in each of the southeastern Ontario counties now and in the future can be found in Hopkins et al. Prevalence estimates for depression are detailed in the survey of outreach services document of the Ministry of Health and Long-Term Care. These projected estimates underscore the need to plan and develop now for this increasing population group.

How Do We See the Development of the Four Specialized Services in Regards to the Target Population?:

1. Direct Community Specialized Services (ACTT Equivalents)

Assertive community treatment services provide specialized and community intensive specialized services including direct treatment. There is a need for direct specialty intensive services for older individuals in the community, both for maintaining those with high complex needs so that they do not enter into the hospital system inappropriately and to ensure an ability to foster re-integration into the community sector of those in specialized inpatient or other structured environments.

It is proposed that direct community specialized services (or ACTT-like services) be established in Southeastern Ontario for older individuals; that these services be part of the specialized geriatric psychiatry service network and provide support for all target populations except those individuals with longstanding mental health disorders who grow old. (See below)

It is proposed that the direct specialized intensive services link closely with the specialized geriatric psychiatry outreach services and that the conduit for admission, as well as facilitating discharge from these services, be the specialized outreach component of the specialized geriatric psychiatry services.

It is proposed that the present ACTT teams or "the Adult ACTT Teams" support older individuals with severe mental illness that grow old and that the geriatric psychiatry direct specialty services support the other target groups defined in Figure 1.

2. Inreach and Outreach Teams:

It is proposed that the re-investment dollars that have been implemented in the district, be the core resources that are utilized to establish the core community-centered specialized geriatric psychiatry services. That these outreach teams are anchored in each of the areas (ie. Hastings/Prince Edward; Frontenac/Lennox & Addington; Lanark/Leeds Grenville) in Southeastern Ontario. It is further proposed that these teams be incrementally resourced to reach the benchmarks established by the Clarke Report.

In addition, it is recommended that there be realignment and maintenance of existing district-wide tertiary services, as well as expansion of these services. The direct district-wide services will include:

- Ambulatory support to the community geriatric psychiatry locally-based teams
- Specialized unique services that are best served district-wide, including specialty outpatient services.
- A Resource Centre; this will centre provide triage, education, information, and support through technologically based and supported methods. This Specialty Resource Centre will provide triage to assist in helping individuals connect to the right services, at the right time, for the right reason. It will collect and disseminate information both on mental health services as well as best practices.

The Resource Centres should be integrated and accountable to other locally based resource activities focussing on supporting these centres in terms of seniors with mental health needs.

3. Residential Treatment:

It has been identified that a critical element within Southeastern Ontario to ensure hospital restructuring and implementing mental health reform, is the establishment of residential treatment facilities for “stabilization and rehabilitation” of the older individuals with severe mental illness. It is proposed that 30 residential treatment facility beds/equivalent be allocated to the Southeastern Ontario district.

It should be noted that the type and format of residential treatment facilities services for older individuals with mental health problems are different than those for other populations (and needs to take into consideration the heterogeneous nature of this population).

It is proposed that the residential treatment facilities benchmarks and activities be developed using as a foundation, the Ministry of Health and Long-Term Care Interface document.

4. Specialized Inpatient Services:

➤ Dementia with Behavioral Problems and Mood and Psychotic Disorders

It is proposed that there be specialized inpatient services aligned with best practice benchmarks established through the international literature and be aligned with the Champlain/Royal Ottawa benchmarks formulations for long-term care specialty services for the geriatric psychiatry population. These benchmarks translate into approximately 40% of the non-forensic specialized mental health long-term care beds within a district.

The target population served by specialized inpatient beds proposed for the tertiary/specialized centre includes those with dementia with behavioural problems and mood and psychotic disorders. It is proposed that 25 beds/equivalent be aligned to support these two sub-population groups.

➤ Physically Ill with Associated Severe Mental Illness

Long-term inpatient psychiatric services are scheduled to be reduced as part of the HSRC directions to Kingston. This will greatly impact on the ability of geriatric psychiatry services to serve the full range of mental health needs for older individuals. Inpatient beds for older individuals with mental health needs will be reduced and, as proposed, there is a requirement for 25 beds/equivalent for dementia with severe mental illness and mood and psychotic disorders, and 30 beds/equivalent for residential treatment facilities.

One group of special concern includes older individuals with both medical and mental health co-morbidities who would benefit from the joint involvement of both Geriatric Medicine and Geriatric Psychiatry expertise. These individuals, often suffering from mood disorders, require a similar diagnostic and rehabilitative approach to those seen within inpatient Geriatric medicine services.

Unfortunately the Southeastern region is already severely limited in its inpatient geriatric medicine capacity with only 16 beds currently available as opposed to the 26 beds identified through regional planning initiatives as essential to meet the medical needs of the older individuals in our community. As a result, it would not be possible to meet the needs of those individuals with marked mental health issues within the geriatric medicine service. *An additional 4-5 beds/equivalent are needed for this group.*

It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be sited in a manner which ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 long term mental health beds mentioned previously, and be funded with the resources accrued through the bed reduction plan.

These 4 to 5 beds/equivalent resources would be added to the geriatric medical inpatient (GAU) capacity (26 beds) to develop a combined service (31 beds/equivalent). This will require the designation of the geriatric medical inpatient beds in Southeastern Ontario separate from the Complex Continuing Care envelope.

How Do You See The Specialized Function of Direct Service, Education, Capacity and Enhancement, Education, and Development Dissemination and Delivery Of New Knowledge Occur For The Population:

a) Direct Services:

The implementation of direct services will occur through the inpatient services as described above, as well as through the design, development, and implementation of direct intensive specialized services (ACTT equivalents).

Direct specialized services, whether it be inpatient or ambulatory direct intensive community services, will be aligned with the principles and implementation framework of ACTT Teams but with increased emphasis on shared care approached and increased emphasis on utilizing these

services during the period requiring specialized intensive support. This may be as short as 2-3 weeks or for an extended period, depending on the needs of the individuals and the service support systems available to them.

Specialized services will be provided in a most of cases through a shared care approach. This will be a cornerstone to specialized programs and will provide a mechanism not only for clinical support to older persons with severe mental illness, but provide a mechanism to provide education to consumers, families, providers and care program developers, and organizations.

The shared care clinical support will be targeted to both first and intensive services within mental health, as well as associated services that provide care for older individuals with mental health problems across health sectors. This approach will be provided by all components of the specialized services with increased emphasis in the ambulatory components.

b) Education:

Education will be an integral part of all specialized geriatric psychiatry services. This will be provided through the shared care and other service learning strategy. More formal education will occur through district-wide educational and local educational initiatives. These strategies will provide a mechanism to disseminate best practices and be important in terms of defining a common set of values, languages and approaches to older individuals with mental health problems. This will ensure streamlined access and appropriate collection of information that will enable providers to more effectively provide care. This approach in terms of education has been initiated by the Alzheimer's Strategy and specialty services will be critical to maintain this process. In addition, education will be provided in conjunction with the newly hired psychogeriatric consultants.

c) Capacity and Enhancement, Evaluation and Accountability: Specialty programs major focus will be on capacity enhancement. This will occur through the various functions of service learning and shared care, education, program and systems development. Although all components of the program will be invested in this process, the regional ambulatory services and community outreach programs that are now being established will have a major focus in this particular activity.

In terms of evaluation, it is recommended that the specialty programs provide a resource for program and system wide evaluation for the district. Program evaluation will occur at two levels; one on a district-wide basis to ensure the effective use of specialized resources in the enhancement of support to this population for projects and activities in which the specialized services jointly engage with their first line and intensive partners, as well as associated services.

The Model for Specialized Geriatric Psychiatry Service:

The model suggested for specialized geriatric psychiatry services is aligned with the consumer-centered and responsive system, and access to the entire district. The services are also aligned with the best practices which identify the importance of anchoring core specialized services in the region supported and coordinated by district-wide activities.

The model suggested for implementation includes:

The establishment of core locally based services, which include district ambulatory services, i.e. the community specialized geriatric psychiatry Outreach teams, supported by district-wide services and activities and coordination.

It is therefore recommended that in each community Community Specialized Geriatric Psychiatry teams be established, i.e. Hastings, Prince Edward; Frontenac, Lennox, and Addington; and Lanark, Leeds, and Grenville Counties. That these specialized teams consist of a mix of individuals that have the knowledge and skills to provide the specialty functions of geriatric psychiatry outreach teams, including direct service, education, shared care, program and systems development, and evaluation.

The second component of the model is the establishment of the district-wide coordinating and support services that have been defined above and include specialty inpatient services, direct specialty intensive services (ACT equivalent), residential treatment facilities, and district-wide ambulatory services, i) including specialized outpatients, ii) a Resource Centre, and, iii) unique programs which are best provided in a district manner.

For the implementation of the district-wide services, is recommended that they occur through planning with the community to establish the best means of implementing them, including siting of residential treatment facilities and district ambulatory services so that they ensure access, quality, and are viable and economically appropriate for the district.

Emphasis on situating or implementing the services within the local areas should be a major principle in the planning along with quality and viability.

In addition, it is recommended that all specialty services be coordinated and that an agency/organization be identified that is accountable and responsible for the overall specialty services in the district. The designated agency/organization also would be responsible to local planning and development bodies in respect to the senior population.

Describe the Ideal Integration, Other Levels in Need of Mental Health Services, and Associated Systems:

The Provincial Mental Health and Long-Term Care Interface Group has established the need for looking at the continuum of services, both within mental health, as well as associated services in primary care, long-term care, hospital based services, etc.

It will be essential that each of the services that provide care for older individuals with mental health problems have sufficient internal capacity and accountability for this population.

It is recommended that the first line and intensive services allocate a percentage of their resources and dedicate them to this population, so that joint collaborative projects can occur with specialty services. This will be specifically critical for Schedule I facilities, both inpatients and outpatients, as well as in the crisis services.

In terms of intensive services in the community, it will be also be important that a percentage of core resources be identified to facilitate, foster and promote the services for older individuals with mental health problems within their organizations.

At the present time, this population uses a large array of other associated services in long-term care and in the hospital sector. It will be therefore critical that internal resources be established in each of these sectors, ensuring knowledge skills, and capability including among others, the primary care family practice sector, LTC facilities, hospitals, community care, among others. Shared care approaches with these sectors, as well as implementing the other activities of capacity enhancement of specialized services will only occur if there are internal, collaborative resources.

Joint Accountability

To ensure integration, there must be a joint accountability framework, such that all organizations are evaluated in the context of their activities and successes with utilizing their internal resources with specialized services in joint development activities.

Summary of Recommendations

Recommendations Regarding First Line Services:

1. First line services to establish internal resources in each of relevant services that are capable and have dedicated resources for older individuals with mental health problems. That the amount of the dedicated resources should be benchmarked by the population prevalence rate.
2. That at the Provincial level, the Ontario Family Health Care Network initiative review their support for primary care physicians caring for older individuals with mental health problems and identify and implement incentives to ensure internal capacity in this network to serve this population.
3. That each CCAC designate a specialty case management and service resource, as this populations' complex geriatric psychiatric needs are not met with generic geographically based services.

Recommendations Regarding Intensive Services:

Schedule I:

1. 1. That there be dedicated resources/beds in Schedule I inpatient beds; that the dedicated resources beds be aligned with the population prevalence of older individuals with mental health needs, and anchored to that rate over time.
2. Intensive community resources; that the intensive community resources have the capacity, capability, and dedicated resources for the severely mentally ill older individual who ages; that the percentage of resources be based on population prevalence figures over time.

Specific Recommendations Re Specialized Services:

1. Outreach: Allocated incremental funding be implemented to bring the local-based Specialty Geriatric Psychiatry Outreach Teams to the Clarke Benchmarks.
2. That 30 residential treatment facility beds be allocated to the Southeastern district for stabilization and rehabilitation and that an operational plan be developed and implemented for the residential treatment facilities, ensuring access, quality, and viability.
3. Direct specialty community services for direct care: specialized intensive services for the sub-population groups defined in Figure 1 be established, and that the ACTT Adult Teams provide services for the longstanding severely mentally ill who grow old.
4. In addition, that the specialized direct intensive services (ACTT equivalents) be accountable, aligned, and linked with the specialized geriatric psychiatry teams that are locally based.

Specialty Inpatient (ie dementia with behavioral problems and mood disorders)

5. Maintain adequate beds for specialty inpatients for the target groups: for behavioral problems and dementia, and for mood and psychotic disorders of late life. It is proposed that the number of beds in the long-term care mental health system be approximately 40% of the long-term care beds. This is aligned with benchmarks established in Britain and elsewhere and is consistent with the planning and implementation that is already occurring at the Royal Ottawa/Champlain district (ie. 25 beds/equivalent).

Specialty Inpatient (ie physically ill with associated severe mental illness)

6. It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be sited in a manner which ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 beds/equivalent mentioned previously, and be funded with the resources accrued through the bed reduction plan.
7. Maintain and develop district-wide tertiary support services that consist of:
 - a. Regional ambulatory teams;
 - b. Specialized district outpatient services;
 - c. Resource centre that are technologically supported; and provide triage and support to access information, best practices, mental health services by experts and resource material. This resource service should be developed in line with best practice resource centre developments in the province and incorporate a brokerage model, (see Public Health Model Province of Ontario).

A list of recommendations put forward by the Seniors Champions committee is summarized in Section 3.3. This list expands and adds to the set of recommendations prescribed above.

SECTION 1: SCOPE OF PROJECT

1.1 Introduction

This project is a joint undertaking between the Southeastern Ontario District Health Council and the Seniors' Champions Group of the MHITF.

Purpose:

To provide advice to the Southeastern Ontario District Health Council and to the Mental Health Implementation Task Force (MHITF) with respect to a strategic plan for the development of a district system to meet the needs of older individuals with mental health problems, including the identification of next steps in the process.

The deliverables for the project include a synopsis of legacy work and strengths/gaps in service and a preferred model for a district system. The terms of reference for the project outline specific objectives, the planning process and timeframe, and are attached as Appendix C. In addition, a more detailed work plan for the project is also appended to this report (Appendix D).

Major Influences and Foundation

Major influences considered in developing this report include:

- Needs of the target population (characteristics, needs and implications) (see Fig 1)
- Developing a consumer and family centred responsive system which is accessible, coordinated, integrated and accountable, that provides services in an equitable manner to the catchment area
- Provide services for older individuals with mental health needs vs. mental health services for older individuals with severe mental illness
- A conceptual shift from specialty programs as services to specialty programs as a "resource" involved in balance of direct clinical activities with increased emphasis on shared care education collaborative program and system development.
- Support and integration with a knowledgeable, accountable and able first line and intensive services.

Foundations

- a) Needs and Characteristics of the Diverse Target Population
- b) Best Practices (WHO and World literature)
- c) Overall Provincial Health Care Policy
- d) Making it Happen (MHS)
- e) Policy Framework and Deliberation of Provincial Advisory Committee on Mental Health for Older Person
- f) Legacy Documents
- g) Building on Strengths
- h) Related Government Initiatives (Specialized Geriatric Services, Alzheimer's Strategies, LTC Facility Development among others)

1.2 Assumptions / Principles

The Seniors' Champions Group endorsed the mission statement and principles of the MHITF (Mental Health Implementation Task Force).

Mission Statement (MHITF Working Statement as of March 2002)

The Southeastern Ontario Integrated Mental Health Services System will be an integrated, accessible coordinated Best Practice continuum of services and supports across three levels of service (i.e. first line, intensive, specialized) taking into account the needs of varying populations of people in both urban and rural settings across the lifespan of the individual while ensuring a balance between people with a serious mental illness and others with mental health problems.

Set of Principles: Integration Committee

- the consumer is at the center of the mental health system
- services will be tailored to consumer needs with a view to increased quality of life
- consumer choice and access to services will be improved
- services will be linked and coordinated so that consumers will move easily from one part of the system to another
- services will be based on best practices

Guiding Principles

(from SEO Reformed MH System – SLM, July 2001 Draft)

- accessible
- integrated
- accountable
- affordable
- coordinated
- responsive (timely)
- understanding/knowledge

CONSUMER CENTERED

Balance ----- Collaboration

INTEGRATED – ACCESSIBLE – ACCOUNTABLE – AFFORDABLE – CO-ORDINATED – RESPONSIVE - KNOWLEDGE

In addition, the Seniors Champions group endorsed the inclusion of the following additional sources of principles for this project. These are outlined in Appendix E:

- WHO General Principles
- WHO Specific Principles
- Clarke Best Practice Assumptions

In addition to endorsing the above assumptions/principles (Dec 17/01 mtg), the Seniors Champions also emphasized that:

Assumptions from Clarke Benchmark document, although targeted for specialized outreach services they are appropriate for this project. (See Clarke Report)

Members requested that other assumptions/areas of emphasis be added including: reducing the episodes of disease and emphasizing prevention. This to include prevention of stigma, prevention of premature institutionalization, health promotion, disability prevention and early detection.

These additional principles are supportive/congruent with the MHITF's emphasis on a full continuum of services and supports, including health promotion/prevention, and broader focus than just seriously mentally ill.

1.3 Target Populations / Features / Systems Impact

Older individuals with mental health problems are not a homogeneous group. The Seniors' Champions defined several groups of seniors with mental health needs, and described the distinguishing features of each. Also, columns were the common system impact and unique system impact for each of the target populations were identified. (refer to Figure 1 on next page)

This process laid the foundation for defining the overall system requirements to meet the needs of seniors and their caregivers and the unique considerations required for each sub population group. The foundation also provided a framework for the recommendations for reform.

In older individuals, "later life/late onset" refers to conditions that generally develop as a function of age and are traditionally defined as over age 65. It is not uncommon however for onset to be earlier for some and later for others. For this reason, arbitrary age boundaries have not been used. It is felt that access should be determined by the needs of the population and the expertise and services to meet those needs. Arbitrary age limits should not limit an individual's access to services. nor should age alone be the criteria for seniors services or to exclude individuals from adult services.

Please refer to Figure 1 on the next page.

Figure 1: Target Populations, Distinguishing Features, and System Impacts

Target Population:	Distinguishing Features:	Common System Impacts	Unique System Impacts
1. Dementia of late onset with associated behavioral or mental health problems, and their caregivers.	- prone to acute decompensation often due to multiple (physical, intellectual, emotional, functional, and environmental and social areas), interdependent causes - have often simultaneous changes in emotions, cognition, perception, function, thinking and behavior - common patterns of presentation and subsequent decline over a relatively short time-frame - rarely reversible, but may have remedial components	<u>Note: the following 11 points were identified as common to all 5 target populations:</u> 1. Ability for timely, multi-dimensional, comprehensive assessment; 2. Cross-sectoral communication, assessment, treatment; 3. Need involvement of both caregiver system and MH/health care system; 4. Need sensitivity to needs of both caregivers and older individuals* 5. Need to exchange, and to maintain an exchange, of information: setup a mechanism for data exchange (and maintain), recognizing the importance of confidentiality issues, etc; 6. Need flexible /responsive coordinated / options across the various sectors and areas; 7. Plan of consent re: confidentiality issues; 8. Need case management to manage both the older individual's* and caregiver's needs; 9. Need knowledgeable caregivers and health professionals (need targeted initiatives)	- the dementia condition is progressive, stageable, predictable (timeframe is months to a few years) - there are often other simultaneous physical/health needs (often remedial) that must be treated along with the dementia (but are often missed) - along with dementia care, almost always need advanced care due to conditions associated with advanced age: issue of progression along care continuum in progressively more secure settings until death - remedial components may be based on assessment, education and modification of

		10. Need to foster an appropriate process for risk assessment and care. 11. Acknowledge that within these target populations there are those older individuals* who are frail individuals, and there are those who are ambulatory and physically well, but each require a unique set of services, as they may pose a potential threat (safety threat) to each other.	medical/psychosocial consequences - A unique set of services and environments are needed: there is a need for a collaborative approach with other health sectors
2. Severe mental illness and/or MH problems (non-dementia) including concurrent disorders that develop in late life, and their caregivers. (e.g. mood and psychotic disorders)	- symptoms often misinterpreted as consequences of normal aging - physical health symptoms may often present with symptoms interpreted as mental health problems and vice versa - disorders often result in significant decline and problems in physical, functional, social, and psychological well-being - reversible, with or without relapses - late onset alcohol and substance abuse problems are often associated with losses in old age and/or mental health problems		- need to clarify the availability and role of first line and intensive services - this population often shows up in similar settings to those in group #1, but the two populations do not mix well when cared for simultaneously in the same setting - frequently need immediate responsive intervention for behavioral reasons
3. Older individual* with Chronic MH problems, including concurrent disorders, who develop age-related complications, and their caregivers.	- Symptoms due to chronic SMI (including MH problems) may be inappropriately identified as due to aging, or vice-versa		- need to establish collaboration with other services/sectors

(eg. chronic alcoholic, with brain damage, who also has MH/dementia-related problems)			
4. Older individual* with significant physical illness (eg. Parkinson's disease) who have developed associated mental health problems in late life, and their caregivers.	- Insidious onset - Mental health symptoms often falsely identified as due to physical health illness		- always have significant physical health care needs with concurrent MH needs - most are not independently ambulatory
5. Aging Caregivers of the older individual*. (eg. 88 yr old mother caring for 56 yr old schizophrenic)	- decline (insidious or acute) in the capacity of the aging caregiver, and/or the older individual* - limited options and suitable available resources for where to go (for both the older individual*, and the caregiver)		- system ability/capacity to deal with these needs (of older individual* and caregiver) - limited choices of where to get assistance

Footnote: For clarity, any reference to “Older Individuals*” within this table refers to “Older Individuals with SMI, and Older Individuals with mental health problems”.

Footnote: An age threshold alone is not the primary determining factor: It is necessary but not sufficient; Late onset, age-related complications, and complexity are key factors.

1.4 System Logic Model (SLM)

The MHITF as part of its planning has defined a continuum of services and supports for the reformed mental health system: this has been articulated in the form of a System Logic Model (SLM). The SLM defines the services components, functions, and outcomes. This has been central, and a consistent foundation to the work done by the various committees (and workgroups/champion groups). For this reason it is referenced here in our report, as our work is consistent/congruent and builds upon this framework (Appendix F).

In addition, some of the MHITF committees have developed their own specific SLMs, and these have been attached in Appendix F for your information. Further, the Provincial MOH Seniors Committee has been developing a provincial SLM for seniors with mental health needs. This is included in draft form in Appendix G.

1.5 First line, Intensive, Specialized

To ensure consistency of language when talking about the range of services, the following levels of service definitions have been adopted from Making It Happen:

Comprehensive Continuum of Services

Within Making It Happen: Implementation Plan for Mental Health Reform three levels of need were identified for a reformed mental health system. Each level refers to a combination of services that differ in terms of resource intensity, specialization and/or service duration. The term "levels of need" was chosen to reflect the range of client needs which then determines the service required. The three levels are:

- First Line (previously referred to as primary care) refers to prevention, assessment and treatment provided by front line health care providers. For most clients this level is their first contact with mental health service. First line services include family practitioners, CCACs, mental health services, social services, hospital emergency services and hospital primary care services.
- Intensive (previously referred to as secondary) refers to mental health assessment, treatment and support services provided in community or hospital settings focused on people with serious mental illness. Examples for the target population would include intensive case management and Schedule I inpatient and outpatient services. Individuals needing this level of service often require ongoing, long-term support from service providers, but not daily contact.
- Specialized (previously referred to as tertiary) refers to specialized programs in community or hospital settings serving those with more complex or unstable serious mental illness. These individuals may require daily contact with service providers across a continuum of services.

Within each district of service development, existing resources supporting the target population will need to be identified across the three levels of need. The new specialty geriatric psychiatry resources must be integrated within this continuum of care. In partnership with the existing resources, service gaps and needs will be identified across this continuum to assist the communities in their ongoing strategic planning to meet the needs of the target population of older individuals with mental health problems.

SECTION 2: DRIVERS

2.1 Provincial Directives

The Seniors' Champions committee reviewed several relevant provincial directives/documents that would have impact on the development of a plan for Southeastern Ontario. These documents included:

- Making It Happen
- Policy Framework and Implementation Guidelines for Mental Health and Long Term Care Interface for Older People with Mental Health Needs
- Alzheimer Strategy
- Primary Care Reform
- Draft (confidential): Summary Report of The Expert Panel on Specialized Geriatric Services (SGS)
- Guidelines for Provincial Outreach Teams
- Ministry of Health Survey of Outreach Teams

A synopsis of the focus of some of these documents is included in Appendix H.

2.2 Best Practices

The Seniors' Champions committee reviewed several relevant Best Practices documents that would have impact on the development of a plan for Southeastern Ontario. These documents included:

- WHO Document: In countries with limited resources it will be necessary to establish sensible priorities: these are articulated in this document.
- Clarke benchmark document: Establishing Benchmarks for Psychogeriatric Outreach Programs.
- Review of Best Practices in Mental Health Reform. 1997.
- Lausanne Technical Consensus Statements on Psychiatry of the Elderly

Relevant sections from the above documents are included in Appendix E.

2.3 Legacy Documentation

Several key legacy documents have been developed in Southeastern Ontario, over the past few years, which have sections relevant to older individuals and mental health reform. Summary sheets have been prepared on the following key legacy documents developed in Southeastern Ontario. The summary sheets (2 to 3 pgs in length) focus on:

- the objectives/scope;
- content/inventory;
- and conclusions/recommendations for each legacy document.

Also, relevant sections are attached as appendices to the summary sheets.

The Key Legacy Documents for Southeastern Ontario

The key legacy documents for Southeastern Ontario include:

- “Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future” – SEO DHC 1999.
- “The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs” 1998.
- “Meeting the Local Need for Psychogeriatric Services: A Proposal for maintaining service as close to home as possible in Leeds, Grenville and South Lanark” 1999
- “Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox and Addington” 1998
- “Annual District Service Plan for Long-Term Care Community Services, 1998/99, Rideau Valley DHC”
- “Implementation of Mental Health Reform: A Regional Plan for Eastern Ontario” 1997.
- “Kingston Psychiatric Hospital Comprehensive Assessment Project (CAP)” 2000.
- “Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital” 2000.

Common Themes from Legacy Documentation:

The following highlights the common themes identified in the legacy documents:

- consumer at the centre
- planning grounded in Graham report, Putting People First, Making It Happen, and other provincial directives
- recommendation that future planning build on the rich/comprehensive legacy work completed to date
- include consideration to BPH and KPH restructuring
- enhance the availability of psychogeriatric services (full continuum). A full continuum of services and supports is required (see fns, SLM)
- access to a full range of services and supports
- increase psychogeriatric outreach/consultation teams
- access to regional specialized geriatric psychiatry services/ regional expertise
- concern regarding the capacity of current long term care facilities
- education/training
- increase awareness
- cross-sectoral collaboration: mechanisms
- consideration to funding/resource allocations

These legacy documents have been considered by the Seniors Champions committee in their development of this report. The specific summaries of each of these legacy documents have been included in Appendix I.

2.4 Data

A considerable amount of data with respect to existing services, program types, client utilization, and benchmark projections, etc. has been compiled within the previous studies completed in the SEO District (See Appendix summaries for specific details).

In addition, the Seniors Champions committee has submitted and received the following data from the MOHLTC:

- Location of long term care facilities in Southeastern Ontario
- Bed capacity figures for each long term care facility
- Locations of new long term care beds
- Number and location of complex continuing care beds
- Demographic profile and data for the Southeastern Ontario district
- Hospital admission data for patients 65 and over (SEO)
- Hospital emergency data
- Dementia projections
- CCAC Data (pending)

These data received have been summarized in Appendix J.

Also of note is that a Community Comprehensive Assessment Project (CCAP) is presently underway (MHITF function), and that this will provide additional agency data/profiles, as well as information from a consumer survey instrument. Therefore, next steps in this planning should include mechanisms for incorporating this information, when it becomes available, into the district planning process.

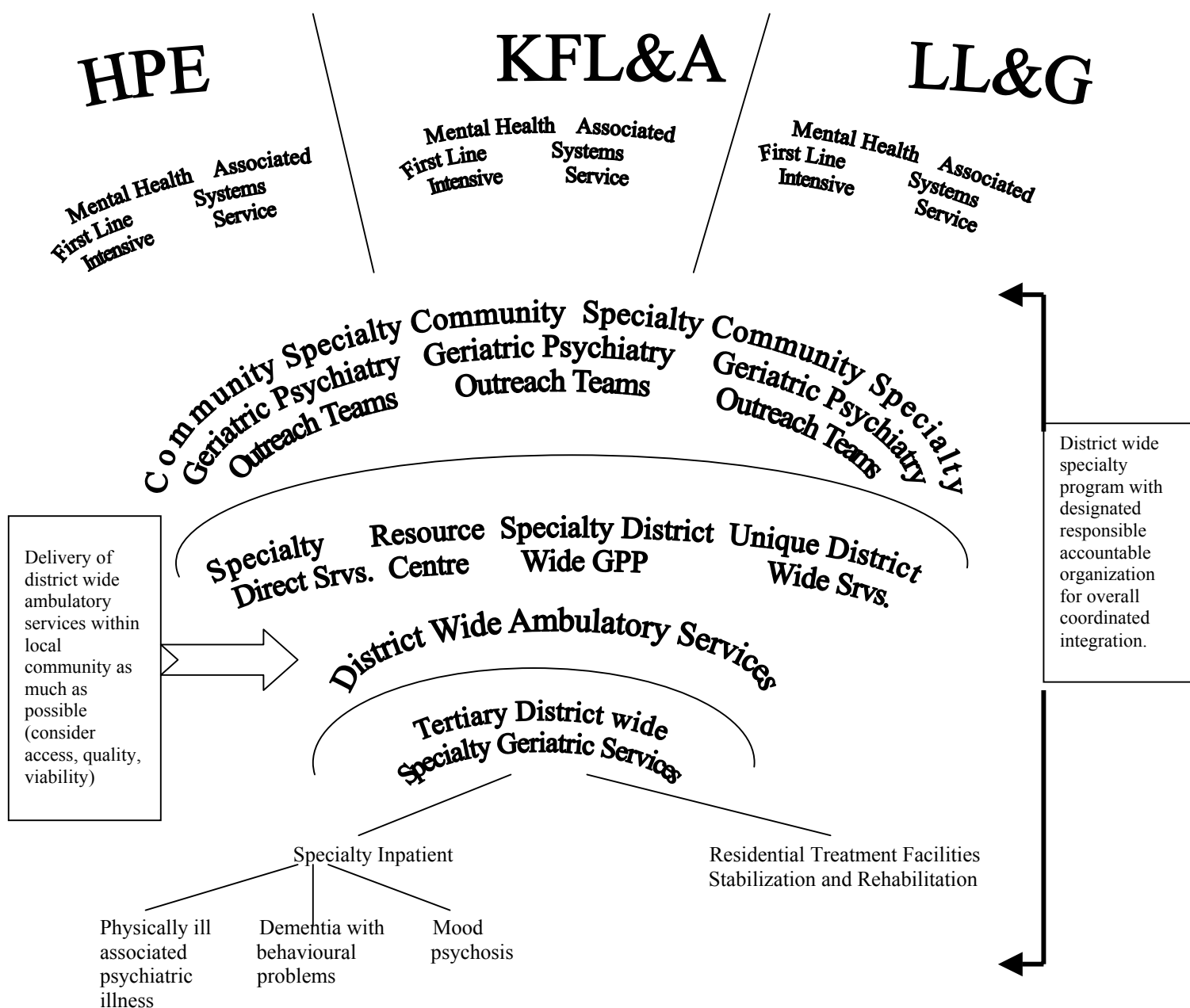
***Statement of Limitations:** The CCAP surveyed all current clients of intensive level mental health programs. This excluded anyone seen exclusively by a psychiatrist, first line services, and specialized services. The sample was stratified to oversample youth and older individuals so will be able to say something about their needs. The main methodological plan is that the sample is limited to older individuals who are receiving services from intensive level mental health multi-disciplinary programs, which is limited. These limitations to be taken into consideration when these data become available in the future.

SECTION 3: SYSTEM DESIGN, DISCUSSION, RECOMMENDATIONS

3.1. Overall Design – Model

The model proposed in this report is based on the committee's review and consideration of: model directives/deliberations captured in the legacy documentation; rural and urban proposals; provincial directives; and best practices.

The Model for Services for Seniors with Mental Health Needs



3.2 Discussion

The discussion is structured so as to elaborate on components within the model, and the continuum of services and supports required to meet the needs of older individuals with mental health problems. As such the discussion includes sections on specific target populations, specialized services, intensive services, first line services, education, capacity development, evaluation/accountability and integration.

As noted earlier, the committee had dedicated a considerable amount of time to defining the heterogeneous target populations, their distinguishing features and common and unique system impacts. This then set the stage for developing the continuum of services and supports within the model to meet the needs of older individuals with mental health problems.

Target Population:

Each population with severe mental illness requires specialized mental health services. It has been estimated that approximately 15% of those over the age 65 have specialized mental health needs, with 2% requiring direct specialty care (Clarke Report/Ministry of Health and Long-Term Care). The population of older individuals served is often diverse in its characteristics and may require different sets of services to meet the differing needs of each of its sub-population groups.

The target population of those with mental health needs is outlined in Figure 1 (section 1.3) followed by critical factors and implications in terms of a comprehensive responsive quality system of care.

It should be emphasized that the populations defined in Figure 1 reflect older individuals with mental health problems served by the continuum of services, not only the services of specialized mental health.

The target populations are individuals who have complex needs, often combined with complex physical health care needs associated with aging. The focus of specialized programs is on meeting these unique and complex needs and is not based on age alone.

Consistent with the Policy Framework and Implementation Guidelines of the Ministry of Health and Long-Term Care the major function of geriatric psychiatry services is to support the primary and secondary systems of care, both in mental health and the associated systems that serve these population groups.

In theory, those served by geriatric psychiatry are individuals over 65 with complex late onset needs. In practice, however, most individuals are over age 75. This is of particular importance in terms of the group that is served by geriatric and mental health services, as the over age 80 group is the fastest growing group of individuals in Ontario. Individuals, however, are also seen who though younger than 65, have a degree of complexity and similar range of issues to those more typical of an older group presentation.

Older individuals with longstanding or early onset psychiatric problems who grow old may require access to adult specialty geriatric psychiatry services. The Policy Framework and Implementation Guidelines identify that the generic psychiatry specialized adult services are more appropriate for this population and the specialized geriatric psychiatry services will provide support if complexities of old age occur. Individuals will be transferred to the geriatric mental health system when and if appropriate (criteria for transfer are outlined in the Policy Framework and Implementation Guidelines).

What Do We Know About the Prevalence of Older Individuals with Mental Health Problems?

Older individuals with mental health needs are found throughout the health care system. It is therefore, imperative that a continuum of services be developed in which geriatric mental health services are an integral part.

In long-term care facilities, it has been estimated that 17-23% have depression; 18% are admitted with psychotic problems and 60-80% have dementia of some type. Zimmer has identified that 70% have behavioral problems; 30% severe.

In the community sector, 15% of older individuals have been estimated to have mental health problems requiring specialized services; 2% requiring direct specialized services (Clarke). Blazer has also identified 14.9% of older individuals dwelling in the community have depression severe enough to significantly affect their functioning. It is noteworthy that almost half of these individuals have significant associated medical problems.

The percentage of those with psychosis has been estimated at 4% and the number of individuals with dementia in the community is significantly more than in the facility sector.

Older individuals also are significant users of our hospital and acute health care system. It has been estimated that of those admitted to hospital with a medical disorder that approximately 50% have a diagnosable psychiatric disorder (Lipowski).

Estimates in the number of those with dementia in each of the southeastern Ontario counties now and in the future can be found in Hopkins et al. Prevalence estimates for depression are detailed in the survey of outreach services document of the Ministry of Health and Long-Term Care. These projected estimates underscore the need to plan and develop now for this increasing population group.

How Do We See the Development of the Four Specialized Services in Regards to the Target Population?:

1. Direct Community Specialized Services (ACTT Equivalents)

Assertive community treatment services provide specialized and community intensive specialized services including direct treatment. There is a need for direct specialty intensive services for older individuals in the community, both for maintaining those with high complex needs so that they do not enter into the hospital system inappropriately and to ensure an ability to

foster re-integration into the community sector of those in specialized inpatient or other structured environments.

It is proposed that direct community specialized services (or ACTT-like services) be established in Southeastern Ontario for older individuals; that these services be part of the specialized geriatric psychiatry service network and provide support for all target populations except those individuals with longstanding mental health disorders who grow old. (See below)

It is proposed that the direct specialized intensive services link closely with the specialized geriatric psychiatry outreach services and that the conduit for admission, as well as facilitating discharge from these services, be the specialized outreach component of the specialized geriatric psychiatry services.

It is proposed that the present ACTT teams or "the Adult ACTT Teams" support older individuals with severe mental illness that grow old and that the geriatric psychiatry direct specialty services support the other target groups defined in Figure 1.

2. Inreach and Outreach Teams:

It is proposed that the re-investment dollars that have been implemented in the district, be the core resources that are utilized to establish the core community-centered specialized geriatric psychiatry services. That these outreach teams are anchored in each of the areas (ie. Hastings/Prince Edward; Frontenac/L&A; Lanark/Leeds Grenville) in Southeastern Ontario. It is further proposed that these teams be incrementally resourced to reach the benchmarks established by the Clarke Report.

In addition, it is recommended that there be realignment and maintenance of existing district ambulatory tertiary services, as well as expansion of these services. The direct ambulatory services will provide:

- Ambulatory support to the community geriatric psychiatry locally-based teams
- Specialized unique services that are best served district-wide, including specialty outpatient services.
- Establishment and development of a Resource Centre; this will provide triage, education, information, and support through technologically based and supported methods. This Specialty Resource Centre will provide triage to assist in helping individuals connect to the right services, at the right time, for the right reason. It will collect and disseminate information both on mental health services as well as best practices.

This service will involve the cadre of specialized experts throughout the district to ensure they are available for community needs.

The Resource Centres should be integrated and accountable to other locally based resource activities for the older individual population.

3. Residential Treatment:

It has been identified that a critical element within Southeastern Ontario to ensure hospital restructuring and implementing mental health reform, is the establishment of residential treatment facilities for “stabilization and rehabilitation” of the older individuals with severe mental illness. It is proposed that 30 residential treatment facility beds/equivalent be allocated to the Southeastern Ontario district for stabilization and rehabilitation.

It should be noted that the type and format of residential treatment facilities services for older individuals with mental health problems are different than those for other populations (and needs to take into consideration the heterogeneous nature of this population).

It is proposed that the residential treatment facilities benchmarks and activities be developed using as a foundation, the Ministry of Health and Long-Term Care Interface document to meet the diverse needs of all the sub-populations defined in Figure 1.

4. Specialized Inpatient Services:

➤ Dementia with Behavioral Problems and Mood and Psychotic Disorders

It is proposed that there be specialized inpatient services aligned with best practice benchmarks established by the international literature and aligned with the Champlain/Royal Ottawa benchmarks for long-term care specialty services for the geriatric psychiatry population. These benchmarks translate into approximately 40% of the non-forensic specialized mental health long-term care beds within a district.

The target population served by specialized inpatient beds proposed for the tertiary specialty centre includes those with dementia with behavioural problems and mood and psychotic disorders. It is proposed that 25 beds/equivalent be aligned to support these two sub-population groups.

➤ Physically Ill with Associated Severe Mental Illness

Long-term inpatient psychiatric services are scheduled to be reduced as part of the HSRC directions to Kingston. This will greatly impact on the ability of geriatric psychiatry services to serve the full range of mental health needs for older individuals. Inpatient beds for older individuals with mental health needs will be reduced and, as proposed, there is a requirement for 25 beds/equivalent for dementia with severe mental illness and mood and psychotic disorders, and 30 beds/equivalent for residential treatment facilities.

One group of special concern includes older individuals with both medical and mental health co-morbidities who would benefit from the joint involvement of both Geriatric Medicine and Geriatric Psychiatry expertise. These individuals, often suffering from mood disorders, require a similar diagnostic and rehabilitative approach to those seen within inpatient Geriatric medicine services.

Unfortunately the Southeastern region is already severely limited in its inpatient geriatric medicine capacity with only 16 beds currently available as opposed to the 26 beds identified through regional planning initiatives as essential to meet the medical needs of the older individuals in our community. As a result, it would not be possible to meet the needs of those individuals with marked mental health issues within the geriatric medicine service. *An additional 4-5 beds/equivalent are needed for this group.*

It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be sited in a manner which ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 long term mental health beds mentioned previously, and be funded with the resources accrued through the bed reduction plan.

These 4 to 5 beds/equivalent resources would be added to the geriatric medical inpatient (GAU) capacity (26 beds) to develop a combined service (31 beds/equivalent). This will require the designation of the geriatric medical inpatient beds in Southeastern Ontario separate from the Complex Continuing Care envelope.

How Do You See The Specialized Function of Direct Service Education Capacity and Enhancement Education and Development Dissemination and Delivery Of New Knowledge Occur For The Population:

a) Direct Services:

The implementation of direct services will occur through the inpatient services as described above, as well as through the design, development, and implementation of direct intensive specialized services (ACTT equivalents).

Direct specialized services, whether it be inpatient or ambulatory direct intensive community services, will be aligned with the principles and implementation framework of ACTT Teams but with increased emphasis on shared care approached and increased emphasis on utilizing these services during the period requiring specialized intensive support. This may be as short as 2-3 weeks or for an extended period, depending on the needs of the individuals and the service support systems available to them.

Specialized services will be provided in a most of cases through a shared care approach. This will be a cornerstone to specialized programs and will provide a mechanism not only for clinical support to older persons with severe mental illness, but provide a mechanism to provide education to consumers, families, providers and care program developers, and organizations.

The shared care clinical support will be targeted to both first and intensive services within mental health, as well as associated services that provide care for older individuals with mental health problems across health sectors. This approach will be provided by all components of the specialized services with increased emphasis on the ambulatory component.

b) Education:

Education will be an integral part of all specialized geriatric psychiatry services. This will be provided through the shared care and other service learning strategy. More formal education will occur through district-wide educational and local educational initiatives. These strategies will provide a mechanism to disseminate best practices and be important in terms of defining a common set of values, languages and approaches to older individuals with mental health problems. This will ensure streamlined access and appropriate collection of information that will enable providers to more effectively provide care. This approach in terms of education has been initiated by the Alzheimer's Strategy and specialty services will be critical to maintain this process. In addition, education will be provided in conjunction with the newly hired psychogeriatric consultants.

c) Capacity and Enhancement, Evaluation and Accountability: Specialty programs major focus will be on capacity enhancement. This will occur through the various functions of service learning and shared care, education, program and systems development. Although all components of the program will be invested in this process, the regional ambulatory services and community outreach programs that are now being established will have a major focus in this particular activity.

In terms of evaluation, it is recommended that the specialty programs provide a resource for program and system-wide evaluation for the district. Program evaluation will occur at two levels; one on a district-wide basis to ensure the effective use of specialized resources in the enhancement of support to this population, for projects and activities in which the specialized services jointly engage with their first line and intensive partners, as well as associated services.

The Model for Specialized Geriatric Psychiatry Service:

The model suggested for specialized geriatric psychiatry services is aligned with the consumer-centered and responsive system, and access to the entire district. The services are also aligned with the best practices which identify the importance of anchoring core specialized services in the region supported and coordinated by district-wide activities.

The model suggested for implementation includes:

The establishment of core locally based services, which include district ambulatory services, i.e. the community specialized geriatric psychiatry outreach teams, supported by district-wide services and support activities and coordination.

It is therefore recommended that in each community, Community Specialized Geriatric Psychiatry Teams be established in Hastings, Prince Edward; Frontenac, Lennox, and Addington; and Lanark, Leeds, and Grenville Counties.

That these specialized teams consist of a mix of individuals that have the knowledge and skills to provide the specialty functions of geriatric psychiatry outreach teams, including direct service, education, shared care, program and systems development, and evaluation.

The second component of the model is the establishment of the district-wide coordinating and support services that have been defined above and include specialty inpatient services, direct

specialty intensive services (ACT equivalent), residential treatment facilities, and district-wide ambulatory services, including 1) specialty outpatient clinics; 2) Resource Centres, and 3) unique programs which are best provided in a district manner.

For the implementation of the district-wide services, it is recommended that they occur through planning with the community to establish the best means of implementing them, including siting of residential treatment facilities and district ambulatory services so that they ensure access, quality, and are viable and economically appropriate for the district.

Emphasis on situating or delivering the services in local areas should be a major principle in the planning along with quality and viability.

In addition, it is recommended that all specialty services be coordinated and that an agency/organization be identified that is accountable and responsible for the overall specialty services in the district. The designated agency/organization also would be responsible to local planning and development bodies in respect to the senior population.

Describe the Ideal Integration, Other Levels in Need of Mental Health Services, and Associated Systems:

The Provincial Mental Health and Long-Term Care Interface Group has established the need for looking at the continuum of services, both within mental health, as well as associated services in primary care, long-term care, hospital based services, etc.

It will be essential that each of the services that provide care for older individuals with mental health problems have sufficient internal capacity and accountability for this population. It is recommended that the first line and intensive services allocate a percentage of their resources and dedicate them to this population, so that joint collaborative projects can occur with specialty services. This will be specifically critical for Schedule I facilities, both inpatients and outpatients, as well as in the crisis services.

In terms of intensive services in the community, it will be also be important that a percentage of core resources be identified to facilitate, foster and promote the services for older individuals with mental health problems within their organizations.

At the present time, this population uses a large array of other associated services in long-term care and in the hospital sector. It will be therefore critical that internal resources be established in each of these sectors, ensuring knowledge skills, and capability including among others, the primary care family practice sector, LTC facilities, hospitals, community care, among others. Shared care approaches with these sectors, as well as implementing the other activities of capacity enhancement of specialized services will only occur if there are internal, collaborative resources.

Joint Accountability

To ensure integration, there must be a joint accountability framework, such that all organizations are evaluated in the context of their activities and successes with utilizing their internal resources with specialized services in joint development activities.

Recommendations Regarding First Line Services:

1. First line services to establish internal resources in each of relevant services that are capable and have dedicated resources for older individuals with mental health problems. That the amount of the dedicated resources should be benchmarked by the population prevalence rate.
2. That at the Provincial level, the Ontario Family Health Care Network initiative review their support for primary care physicians caring for older individuals with mental health problems and identify and implement incentives to ensure internal capacity in this network to serve this population.
3. That each CCAC designate a specialty case management and service resource, as this populations' complex geriatric psychiatric needs are not met with generic geographically based services.

Recommendations Regarding Intensive Services:

Schedule I:

1. 1. That there be dedicated resources/beds in Schedule I inpatient beds; that the dedicated resources beds be aligned with the population prevalence of older individuals with mental health needs, and anchored to that rate over time.
2. Intensive community resources; that the intensive community resources have the capacity, capability, and dedicated resources for the severely mentally ill older individual who ages; that the percentage of resources be again based on population prevalence figures over time.

Specific Recommendations Re Specialized Services:

1. Outreach: Allocated incremental funding be implemented to bring the local based specialty geriatric psychiatry outreach teams to the Clarke Benchmarks.
2. That 30 residential treatment facility beds be allocated to the Southeastern district for stabilization and rehabilitation and that an operational plan be developed and implemented for the residential treatment facilities, ensuring access, quality, and viability.
3. Direct specialty community services for direct care, specialized intensive services for the sub-population groups defined in Figure 1 be established, and that the ACTT Adult Teams provide services for the longstanding severely mentally ill who grow old.
4. In addition, that the specialized direct intensive services (ACTT equivalents) be accountable, aligned, and linked with the specialized geriatric psychiatry teams that are locally based.

Specialty Inpatient (ie dementia with behavioral problems and mood disorders)

5. Maintain adequate beds for specialty inpatients for the target groups: for behavioral problems and dementia, and for mood and psychotic disorders of late life. It is proposed that the number of beds in the long-term care mental health system be approximately 40% of the long-term care beds. This is aligned with benchmarks established in Britain and elsewhere and is consistent with the planning and implementation that is already occurring at the Royal Ottawa/Champlain district (ie. 25 beds/equivalent).

Specialty Inpatient (ie physically ill with associated severe mental illness)

6. It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be sited in a manner which ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 beds/equivalent mentioned previously, and be funded with the resources accrued through the bed reduction plan.
7. Maintain and develop district tertiary, ambulatory support services that consist of:
 - a. Regional ambulatory teams;
 - b. Specialized district outpatient services;
 - c. Resource centre that are technologically supported; and provide triage and support to access information, best practices, mental health services by experts, and resource material. This resource service should be developed in line with best practice resource centre developments in the province and incorporate a brokerage model (see Public Health & McMaster Best Practice Resource Centres).

A list of all recommendations put forward by the Seniors Champions committee is summarized in Section 3.3. This list expands and adds to the set of recommendations presented above.

3.3 Recommendations

The list of recommendations put forward in this section represents several months of deliberations by the Seniors Champions committee in the development of this model and plan: consideration was given to committee meeting discussions, workgroup deliberations, legacy documentation, provincial directives, best practices, and provincial network discussions regarding the needs of older individuals with mental health problems.

Many of these issues/priorities have already been referred to in the body of this report, and the intent here was to create a more formal recommendation format for the key issues identified.

Key Recommendation Regarding Common System Impacts and Target Populations

- It is recommended that, as a cornerstone, those working with any of the five specific geriatric mental health target populations identified in Figure 1 (section 1.3), ensure that the following impacts are addressed for both the older individual, and the caregiver:
 1. Ability for timely, multi-dimensional, comprehensive assessment;
 2. Cross-sectoral communication, assessment, treatment;
 3. Need sensitivity to both the client and caregivers
 4. Involvement with both the individual and caregiver system in mental health and the overall health care system that services the individual and caregiver;
 5. Need to exchange, and to maintain an exchange, of information: setup a mechanism for data exchange, recognizing the importance of confidentiality issues;
 6. Need flexible /responsive coordinated / options across the various sectors and areas;
 7. Plan of consent re: confidentiality issues;
 8. Need case management to jointly manage both the client and caregiver's needs;
 9. Need knowledgeable caregivers and health professionals (for the targeted populations). (see Figure I)
 10. Need to foster an appropriate process for risk assessment and care.
 11. Acknowledge that within these target populations there are those clients who are frail individuals, and there are those who are ambulatory and physically well, each requiring a unique set of services, as they may pose a potential threat (safety threat) to each other.

Recommendations Regarding First Line Services:

- First line services to establish internal resources in each of relevant services that are capable and have dedicated resources for older individuals with mental health problems. That the amount of the dedicated resources should be benchmarked by the population prevalence rate.
- That at the Provincial level, the Family Health Care Network initiative review their support for primary care physicians caring for older individuals with mental health problems and identify and implement incentives to ensure internal capacity in this network to serve this population.

- That each CCAC designate a specialty case management and service resource, as this population's complex geriatric psychiatric needs are not met with generic geographically based services.
- It is recommended that there be a policy framework and implementation strategy WITHIN Primary Care Reform, to deal with older individuals with mental health problems.
- It is recommended that there be steps taken to improve availability and access to family physicians for this population (eg, at present it is very difficult for an older individual to get a family physician).
- It is recommended that there be incentives to the primary care physicians to encourage the care for older individuals.
- It is recommended that a resource centre be established for education, that it be an accessible resource for practitioners.
- It is recommended that more emphasis be placed on early detection, and on strategies/programs to prevent disability.
- It is recommended that CCACs' role in First line outreach should be clearly defined, including outreach to long term care facilities, nursing homes, and retirement homes.

Recommendations Regarding Intensive Services:

Schedule I:

- That there be dedicated resources/beds in Schedule I inpatient beds; that the dedicated resources/beds be aligned with the population prevalence of older individuals with mental health needs, and anchored to that rate over time.

Intensive Community Services

- Intensive community resources; that the intensive community resources have the capacity, capability, and dedicated resources for the severely mentally ill older individual who ages; that the percentage of resources be based on population prevalence figures over time.

Long-term Care Facilities

- It is recommended that Long Term Care Facility enhancement occur to augment their capacity to serve older individuals with significant mental health needs.
- It is recommended that LTC beds announced, but so far not yet awarded, in the long term care facilities sector be designed to focus on the needs of older individuals with mental health problems, and that there be options within the restructuring to link these beds with other services.

Specific Recommendations Re Specialized Services:

Outreach

- Outreach: Allocated incremental funding be implemented to bring the local Outreach Teams to the Clarke Benchmarks.

RTFs

- That 30 residential treatment facility beds be allocated to the Southeastern district for stabilization and rehabilitation and that an operational plan be developed and implemented for the residential treatment facilities, ensuring access, quality, and viability.
- That in considering RTFs, the differing needs of the sub populations (Figure I) need to be considered. It was also recommended that access to specialized services be ensured including consideration of co-location with specialty services.
- It is recommended that one needs to examine the 1988 report titled “Foundation for Defining Residential Treatment Facilities”, to assist in clarifying what a RTF could be.

Direct Community Specialized Services (ACTT Equivalents)

- Direct specialty community services for direct care, specialized intensive services for the sub-population groups defined in Figure 1 be established and that the ACTT Adult Teams provide services for the longstanding severely mentally ill who grow old.
- In addition, that the specialized geriatric psychiatry direct intensive services (ACTT equivalents) be accountable, aligned, and linked with the specialized geriatric outreach psychiatry teams that are locally based.

Inpatient:

Specialty Inpatient (ie dementia with behavioral problems and mood disorders)

- Maintain adequate beds for specialty inpatients for the target groups, for behavioral problems and dementia, and for mood and psychotic disorders of late life. It is proposed that the number of beds in the long-term care mental health system be approximately 40% of the long-term care beds. This is aligned with benchmarks established in Britain and elsewhere and is consistent with the planning and implementation that is already occurring at the Royal Ottawa/Champlain district (i.e. 25 beds/equivalent).

Specialty Inpatient (ie physically ill with associated severe mental illness)

- It is recommended that an additional 4-5 beds/equivalent be made available to individuals with medical and mental health co-morbidities who would benefit from joint involvement of both Geriatric Psychiatry and Geriatric Medicine in their treatment. These beds should be

sited in a manner which ensures optimal efficiency and effectiveness. These beds should be identified in addition to the 25 beds/equivalent mentioned previously, and be funded with the resources accrued through the bed reduction plan.

District-Wide Specialized Services

- Maintain and develop district tertiary, support services that consist of:
 - a. District-wide Specialty Services (Behavioural Assessment Services, Telepsychiatry, etc.)
 - b. Specialized district outpatient services;
 - c. Resource centre, that is technologically supported; and provide triage and support to access information on best practices, and to mental health service experts, and material. This resource service should be developed in line with best practice resource centre developments in the province by public health and incorporate a brokerage educational function.

Specialized Geriatric Psychiatry Services Activities

- It is recommended that there be a shift from an approach of specialized services for older individuals as institutionally based, to a concept of specialized services as a "resource".
- It is recommended that incentives be provided and support to move from an inpatient focus to a more balanced activity profile across services, education, collaborative community and systems development in and with local communities, and, where appropriate, academic activities.
- That there be a move from a centralized approach to one where specialized services are involved in district coordination and support that focuses on locally driven system with support from the district for capacity enhancement and then if required, inpatient and specialized direct services.
- It is also recommended that there needs to be centres of excellence for dissemination and distribution of Best Practices, as well as local development.

Target Population

- That future planning use the defined target populations for older individuals with mental health problems (developed within this project, see Figure I), so that one can clearly identify those served by the overall system, but also to define very clearly the population to be served by the Mental Health system.
- It is recommended that by working collaboratively with the Specialized Populations working group, that a clear vision be established for Specialized populations including a solid conceptualized framework for specialized populations as a whole, which would broadly integrate the specialized populations into the overall service system.

Consumer/Client

- It is recommended that, in line with the principle of the consumer at the centre, consumers be involved with the planning and implementation and that all the services providing care for senior design development, implementation and support mechanisms for consumer and family input into the delivery and evaluation of care at an individual, program and systems level.

Family

- It is recommended that family members be involved with the planning and implementation and evaluation.
- It is recommended that there be an increase activities focus, incentives and support for family and caregivers, as we move to a community based system.

Human Resources

- It is recommended that implementation efforts ensure that there are appropriate human resources with knowledge, skill and experience base to serve this diverse geriatric population across the mental health and associated system, and that the mix of workers reflect the skills required to implement direct service, education, shared care and program and systematic development and its evaluation.

Coordination

Silos to Systems for Older Individuals

- It is recommended that, in terms of planning services for older individuals and their families and caregivers with mental health needs, we need to shift from planning mental health services for this population, to planning services for older individuals with mental health needs across the service system.

Harmonizing Government Directions

- It is recommended that efforts be made to harmonize the following government directions that serve individuals with mental health needs:
 - a) Mental Health Reform as undertaken by the Mental Health Implementation Task Groups.
 - b) The Alzheimer's Strategy
 - c) Primary Care Reform (Family doctors)
 - d) Long Term Care Facility Development
 - e) Specialty Geriatric Services
 - f) CCACs
 - g) Stroke Strategy
 - h) Elder Abuse Strategy

- i) End of Line Care
- j) Among others

Clarifying Roles

- It is recommended that emphasis be placed on clarifying the roles, benchmarks, resources and interfaces, as well as functions for the clients and their families and caregivers in two major areas:
 - a) Specialized services, clarity and defining of the roles functions and resources required for inpatients, ACTT equivalent services, outreach and particularly the importance of defining residential treatment facilities for this population.
 - b) Within the levels of mental health services, i.e. first line and intensive, need to define specific activities, resources and interfaces. This includes human resources within each of the first and intensive services defined and benchmarked. In intensive this includes both community as well as Schedule I facilities.

Hospital Sector

- It is recommended that cross-sectoral partnerships be developed, with acute care hospitals and specialized geriatric psychiatry services to work toward Senior Sensitive Hospitals and to ensure integration of hospitals with the senior's mental health networks.

Integration of Planning

- It is recommended that all specialty geriatric psychiatry services be co-ordinated and that an agency/organization be identified that is accountable and responsible for the overall specialty geriatric psychiatry services ensuring:
 - a. Equitable access
 - b. Coordination and integration between specialty geriatric psychiatry services
 - c. Overarching co-ordination and integration with First line and intensive services
 - d. Co-ordination and integration with other specialty services across the age span
 - e. Co-ordination and integration with associated services.
- That integration of planning and development for older individuals with mental health problems, be coordinated with local planning bodies through the leadership of the designated agency/organization responsible for specialty geriatric psychiatry care.
- It is recommended that as the system moves from planning to implementation, that collaborative efforts and partnerships build on the local planning done to date (see legacy summaries) to ensure continued consistency/congruency between regional, district, and local services and supports.

Information Systems / Evaluation

Information Systems

- That an information system be developed that permits timely, confidential exchange of client information between those managing the clients' care/needs.

Accountability / Evaluation Framework

- It is recommended that an accountability / evaluation framework be developed with respect to the proposed model and services.

Centres of Excellence

It is recommended that the district-wide geriatric psychiatry program be designated as a Centre of Excellence providing best practice through leadership in

1. Service delivery
2. Education
3. Research
4. Policy and planning

And that the Centre of Excellence establish affiliation and collaboration with

1. Queen's
2. Eastern Ontario District-wide Geriatric Psychiatry Programs
3. University of Ottawa, Geriatric Psychiatry Division
4. Regional Geriatric Medical Programs
5. Other leading centres provincially, nationally, and internationally.

SECTION 4: Appendices

- A: References
- B: List of Membership: Seniors Champion Group
- C: Psychogeriatrics Project: Terms of Reference
- D: Psychogeriatrics Project: Work plan
- E: WHO Principles / Clarke Assumptions
- F: MHITF SLMs
- G: Provincial MOH Seniors Committee Draft SLM
- H: Provincial Directives Summaries
- I: Individual Southeastern Ontario Legacy Document Summaries
- J: Additional Data received

Appendices to Accompany Report

- A: References
- B: List of Membership: Seniors Champion Group
- C: Psychogeriatrics Project: Terms of Reference
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- H: Provincial Directives Summaries
- I: Individual Southeastern Ontario Legacy Document Summaries
- J: Additional Data received

Appendix A: References

Blazer, D., Hughes, D.C., and George, L.K. (1987). The epidemiology of depression in an elderly community population. *Gerontologist*. 1987;27: 281-287.

Clarke Consulting Group. (1996). Final Report - Establishing Benchmarks for Psychogeriatric Outreach Programs.

District Health Councils of Eastern Ontario – Eastern Region Mental Health Planning Forum. (1997). Implementation of Mental Health Reform: A Regional Plan for Eastern Ontario.

Hastings and Prince Edward Counties District Health Council. (1998). The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs.

Health Canada. (1997). Review of Best Practices in Mental Health Reform.

Health Systems Research and Consulting Unit (CAMH). (2000). Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital.

Health Systems Research and Consulting Unit (CAMH). (2000). Kingston Psychiatric Hospital Comprehensive Assessment Project.

Hopkins, R.W. and Hopkins, J.F. (2000). Dementia Projections for the Counties, Regional Municipalities, and Districts of Ontario.

KFLA District Health Council. (1998). Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox and Addington.

Ministry of Health. Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports.

Ministry of Health. (1999). Ontario's Strategy for Alzheimer Disease and Related Dementias.

Ministry of Health. (1995). Policy Framework and Implementation Guidelines for Mental Health and Long Term Care Interface For Older People with Mental Health Needs.

Rideau Valley District Health Council. (1998/99). Annual District Service Plan for Long-Term Care Community Services.

Rideau Valley District Health Council. (1999). Meeting the Local Need for Psychogeriatric Services: A Proposal for maintaining service as close to home as possible in Leeds, Grenville and South Lanark.

Appendix A: References cont'd

Southeastern Ontario District Health Council. (1999). Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future.

World Health Organization – Department of Mental Health. (1999). Lausanne Technical Consensus Statements on Psychiatry of the Elderly.

World Health Organization. (1999). Mental Health: A Call for Action by World Health Ministers.

Zimmer, J.A., Watson, N., Treat, A. (1984). Behavioral problems among patients in skilled nursing facilities. Am. J. of Public Health 1984 75: 1118-1121.

Appendix B: List of Membership: Seniors Champion Group

Dr. Ken Le Clair – chair

Betty Ann McGrath

Nancy Sears

Cathy Dunne

Jackie Redmond

Paul Rosenbaum

Dr. John Puxty

Jane Banbury (ex officio)

Sandra Lawn (ex officio)

Matt Melinyshyn - Consultant

Appendix C: Psychogeriatrics Project: Terms of Reference

Southeastern Ontario District Health Council & Mental Health Implementation Task Force Psychogeriatrics Project

Purpose:

To provide advice to the Southeastern Ontario District Health Council and to the Mental Health Implementation Task Force (MHITF) with respect to a strategic plan for the development of a district psychogeriatrics system, including the identification of next steps in the process.

Objectives:

1. To develop/finalize a set of guiding principles/assumptions for the psychogeriatrics project.
2. To review legacy studies completed in each of the former three district health council catchment areas plus regional work [Regional Plan for Eastern Ontario (1997) and KPH Comprehensive Assessment Project (Oct 2000)].
Use the legacy work as a baseline to continue this work on a district system (ie. build on what has already been done.)
 - review previous inventory of existing services (in each of former three districts)
 - inventory of proposed new services with reinvestment monies (MH)
 - previously identified needs/gaps with respect to overall population, districts, and region
 - issues facing organizations
 - needs/support to “collateral partners”
3. With respect to resources, identify existing resources, those from reinvestment, and the need for additional resources to meet unmet needs.
4. Validation of previously identified unmet needs, and further delineation of other needs not captured/addressed yet.
5. To examine potential models for system delivery of urban and rural psychogeriatrics services across the district (Hastings/Prince Edward, KFLA, Leeds/Grenville and south Lanark). To develop a short list of preferred models to present to and obtain feedback from the collaborative partners/community (via existing coordinating groups). (Regional model developed to link with local models)

Planning Process:

The SEO DHC will work with the Champions Group for Psychogeriatrics (of MHITF). The Champions Group will have a chair from their membership. Consultant's role: facilitation of activities/functions of Champions group of the MHITF for psychogeriatrics.

The planning process will be community driven, and will build on the legacy of work already accomplished in the district.

Matthew J. Melinyshyn Consulting will be the project manager/facilitator, reporting to Heather Stuart, who is coordinating other DHC-sponsored mental health studies under the direction of the MHITF.

Membership:

Champions Group for Psychogeriatrics (of MHITF)
Resource persons: MOHLTC, MHITF

Decision Making:

The Champions Group for Psychogeriatrics, advisory to the Mental Health Implementation Task Force.

Meetings:

Meetings will be at the call of the Chair.

Timeframe:

September 2001 to March 2002

It is estimated that the core planning workgroup will meet five times during the project.

Deliverables:

1. Inventory of legacy work, and gaps in service. (as per objectives)
2. Paper discussing preferred model(s) for a district psychogeriatrics system.

Reporting Relationship:

The Champions Group for Psychogeriatrics will report to the MHITF.

Matthew J. Melinyshyn Consulting will report to the Heather Stuart (MHITF Research Coordinator), who is coordinating other DHC-sponsored mental health studies under the direction of the MHITF.

Appendix D: Psychogeriatrics Project: Work plan

The following outlines initial considerations to the development of a workplan for the Psychogeriatrics project, building on the Terms of Reference for the project

Components From The Terms of Reference to be Incorporated in the Workplan

- Develop/finalize a set of Guiding Principles/Assumptions for the project
- Review Legacy Studies:
 - In each of former three district health council catchment areas
 - Regional work (Regional Plan, BPH CAP, KPH CAP)
 - Review previous inventories of existing services
 - Previously identified needs/gaps, and outstanding recommendations
 - Additional issues
 - Resources: existing, those from reinvestment, additional resources identified as required
- Validation of previously identified unmet needs and priorities (with further delineation of others not captured yet)
- Examine potential models for system delivery of urban and rural psychogeriatrics services across the district
 - To develop a short list of preferred models, with feedback from collaborative partners

Workplan

1. Terms of Reference for Psychogeriatric Project Finalized
(Oct /01)
2. Initial Meeting with Ken Le Clair, Heather Stuart, Jane Banbury
(Oct 25/01)
3. Interim Preparation for first meeting of Psychogeriatrics Workgroup
(Nov /01) (Ken Leclair, Nancy Sears, Matt) including:
 - finalizing legacy documents summaries
 - inventory review and considerations
 - meeting with Heather Stuart's CCAP Program Profile Advisory Committee
 - background work re: key principles/assumptions
 - prepare draft workplan for discussion
 - draft agenda for next full meeting of Senior's Champions Group (specific to this project)
 - scheduling of workgroup (Nov 20th) and Full committee (Dec 17th) mtgs
4. November 20/01, 3:30 to 5 pm: Psychogeriatrics Workgroup meeting
 - Identify details/tasks/responsibilities out of the review of above components
 - Provide feedback following mtg discussion to Heather on: CCAP, additional data needs of Psychogeriatrics Project, workplan, etc

5. Prepare for the initial/orientation meeting of the full Seniors Champions group (as per the discussions of the Nov 20th mtg) (including finalizing agenda, draft workplan, presentations re: legacy documents and recs, draft assumptions/principles, consideration to provincial directives, and best practices, etc) (to Dec 17th)
6. December 17/01: Seniors Champions Group meeting (as per items articulated in #5)
7. Review additional documentation flagged by committee members. Review any additional Inventory related materials flagged by committee - synopsis. (Dec/Jan)
8. Convey additional Data Needs to Heather Stuart. (ongoing: Nov – Jan)
9. Prepare an Update Summary on the Status of Recommendations reviewed from legacy documents (ie. which recommendations are still outstanding)
Plus do summary of needs/gaps from all the legacy work
PLUS addition of other priorities discussed
(Dec/Jan)
10. Obtain updates on what is happening in the field (Dec)
11. Literature/Documentation Review – scope/focus, don't reinvent the wheel (Dec/Jan)
12. Review of Model Options: from district legacy work, from other areas of the province, from "work in progress", etc
(Dec/Jan)
13. Incorporate additional Data, as information requested is received (eg from request to MOH, from CCAP, fiscal info re: reinvestment, etc)
(ongoing: Dec – Feb)
14. ** Schedule small planning workgroup meeting (early January)
In preparation for this, the following tasks would be tackled:
 - pull model options (in light of principles, and discussions at Dec 17th mtg)
 - Preparation of background material and agenda for next Champions mtg
15. Second Meeting of Seniors Champions group (est Jan 21/01)
 - focus of this meeting on completion of legacy synopsis, outstanding recs, etc
 - Plus begin MODELS discussion (note: the workgroup to have met again in early January to narrow down / focus on smaller number on potential model options, from review of legacy work, etc)
16. Prepare Draft discussing preferred Model(s)
(Feb) Meet with Planning Workgroup.

17. Third Meeting of Seniors Champions group (est Feb 22/01),
focus would be to:
 - Complete preferred Model(s) discussion and selection
 - Finalize draft as per two deliverables
 - Consideration to “consultation”
18. Draft Revision (Feb/March)
19. Fourth (Final) Mtg of Seniors Group (March 21/01)
Tasks at this mtg would include:
 - Finalize report, as per T of Ref, recommendations to MHITF, DHC, etc
20. March 31/01 Submit Final Report to MHITF and DHC

APPENDIX E: Additional Assumptions and Principles

(WHO General Principles, WHO Specific Principles, Clarke Assumptions)

WHO General Principles

(excerpt)

Good health and life of good quality are fundamental human rights. This applies equally to people of all age groups and to people with mental disorders.

All people have the right of access to a range of services that can respond to their health and social needs. These needs should be met appropriately for the cultural setting and in accordance with scientific knowledge and ethical requirements.

Governments have a responsibility to improve and maintain the general and mental health of older people and to support their families and carers by the provision of health and social measures adapted to the specific needs of the local community.

Older people with mental health problems and their families and carers have the right to participate individually and collectively in the planning and implementation of their health care.

Services should be designed for the promotion of mental health in old age as well as for the assessment, diagnosis and management of the full range of mental disorders and disabilities encountered by older people.

Governments need to recognize the crucial role of non-governmental agencies and work in partnership with them.

Preparing for increasing life expectancy and ensuing health risks call for significant social innovations at the individual and societal level, which must be founded on a knowledge base drawn from contributions by, and collaboration among, the medical, behavioural, psychological, biological and social sciences.

In developing countries it may be difficult to provide resources for the provision of care. This, however, does not invalidate the aims of helping the elderly by the application of the principles listed above and the specific principles that follow.

SPECIFIC PRINCIPLES

Following principles have been derived from the World Health Organization's Statement on Psychiatry for the Elderly. These include Comprehensiveness; Accessibility; Responsiveness; Individualized; Trans-disciplinary; Accountability; Systemic.

Good quality care for older people with mental health problems is characterized by:

A **comprehensive** service should take into account all aspects of the patient's physical, psychological and social needs and wishes and be patient-centered. An **accessible**

service is user-friendly and readily available, minimizing the geographical, cultural, financial, political and linguistic obstacles to obtaining care.

A **responsive** service is one that listens to and understands the problems brought to its attention and acts promptly and appropriately.

An **individualized** service focuses on each person with a mental health problem in her/his family and community context. The planning of care must be tailored for and acceptable to the individual and family, and should aim wherever possible to maintain and support the person within her/his home environment.

A **transdisciplinary** approach goes beyond traditional professional boundaries to optimize the contributions of people with a range of personal and professional skills. Such an approach also facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community oriented services.

An **accountable** service is one that accepts responsibility for assuring the quality of the service it delivers and monitors this in partnership with patients and their families. Such a service must be ethically and culturally sensitive.

A **systemic** approach flexibly integrates all available services to ensure continuity of care and co-ordinates all levels of service providers including local, provincial and national governments and community organizations.

(Reference: Lausanne Technical Consensus Statements on Psychiatry of the Elderly. World Health Organization Department of Mental Health, Geneva, 1999.)

BEST PRACTICE ASSUMPTIONS (CLARKE BENCHMARK DOCUMENT 1996)

1. New Community Specialty Geriatric Psychiatry Teams need to operate within a continuum of care that includes in-patient and outpatient services, general physicians, LTC facilities and a wide range of community services.
2. Service providers in the LTC, general medical and mental health sectors that provide care to this population are positioned and committed to assume an important role in their mental health care. It is clear those older persons with mental health problems and their families can achieve improvements with appropriate intervention.
3. Health needs of older persons are clearly intertwined and multidimensional. Specialized knowledge and experience is required in order to understand and to manage the complex problems that this population presents.
4. The new Community Specialty Geriatric Psychiatry Teams must endeavour to provide care to the target client group, as much as possible in their usual place of residence.
5. The new Community Specialty Geriatric Psychiatry Teams must endeavour to provide considerable support to family members who assume the major care-giving role to this client group. Support must go beyond education to include counselling and formal therapy if and when required.
6. The expected benefits to the target group of this proposal are:
 - improved disease management
 - improved client and family quality of life
 - clients are maintained in the least restrictive and most independent environment for as long as possible
 - a reduction in inappropriate admissions to hospital
7. Many caregivers in the LTC, general medical and the mental health sectors, need additional knowledge in order to work effectively with this target group. The proposed Psychogeriatric Team must protect a portion of its human and financial resources for professional education and development and related activities that will enhance local knowledge and skills.

Appendix F: MHITF System Logic Models

Southeastern Ontario District Reformed Mental Health System

Grounding Question

What type of system do we want in place for ourselves and our families?

Mission Statement

The development of an integrated, accessible, coordinated Best Practice continuum of services and supports across three levels of service (i.e., first line, intensive, specialized) taking into account policy, legislation, and the needs of varying populations of people in both urban and rural settings across the lifespan of the consumer while ensuring a balance between people with a serious mental illness and others with mental health problems.

Guiding Principles

Consumer Centered

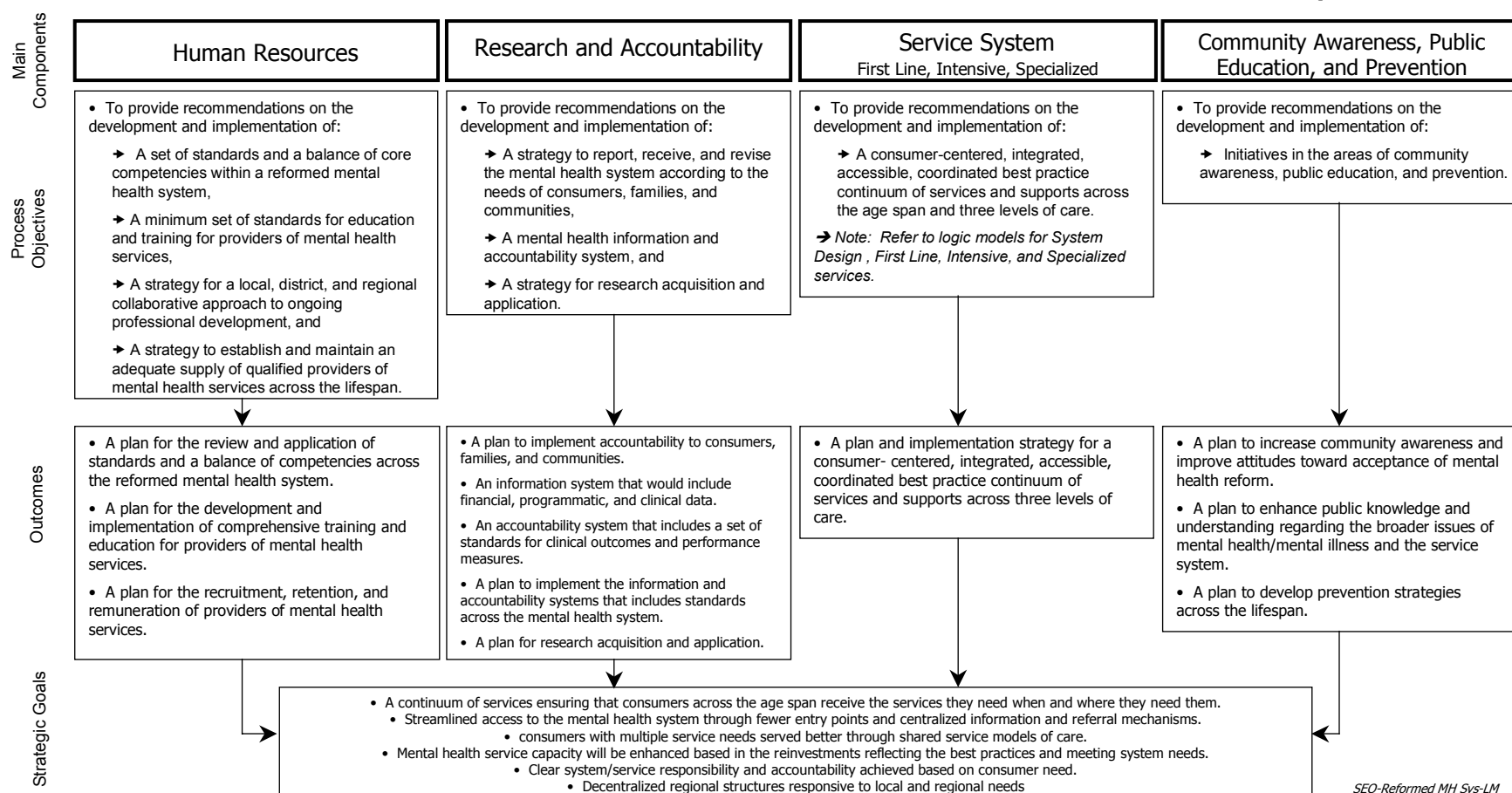
Balance ← ————— → Collaboration
Integrated – Accessible – Accountable – Affordable – Coordinated – Responsive (timely) – Understanding/knowledge

Originally Prepared on: July 20, 2001

This reformed mental health system design was developed by the Southeastern Ontario District Mental Health Implementation Task Force. The Task Force acknowledges the valuable contribution made by Chris Sullivan, member of the SEO-MHITF Integration Committee and a Senior Program Consultant with the Centre for Addiction and Mental Health, for facilitating the development of this reformed mental health system design.

*SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002*

Southeastern Ontario District Reformed Mental Health System



SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002

Southeastern Ontario District Integrated Mental Health Services System Design

Originally prepared: September 2001

Prepared by: The Southeastern Ontario District Mental Health Implementation Task Force

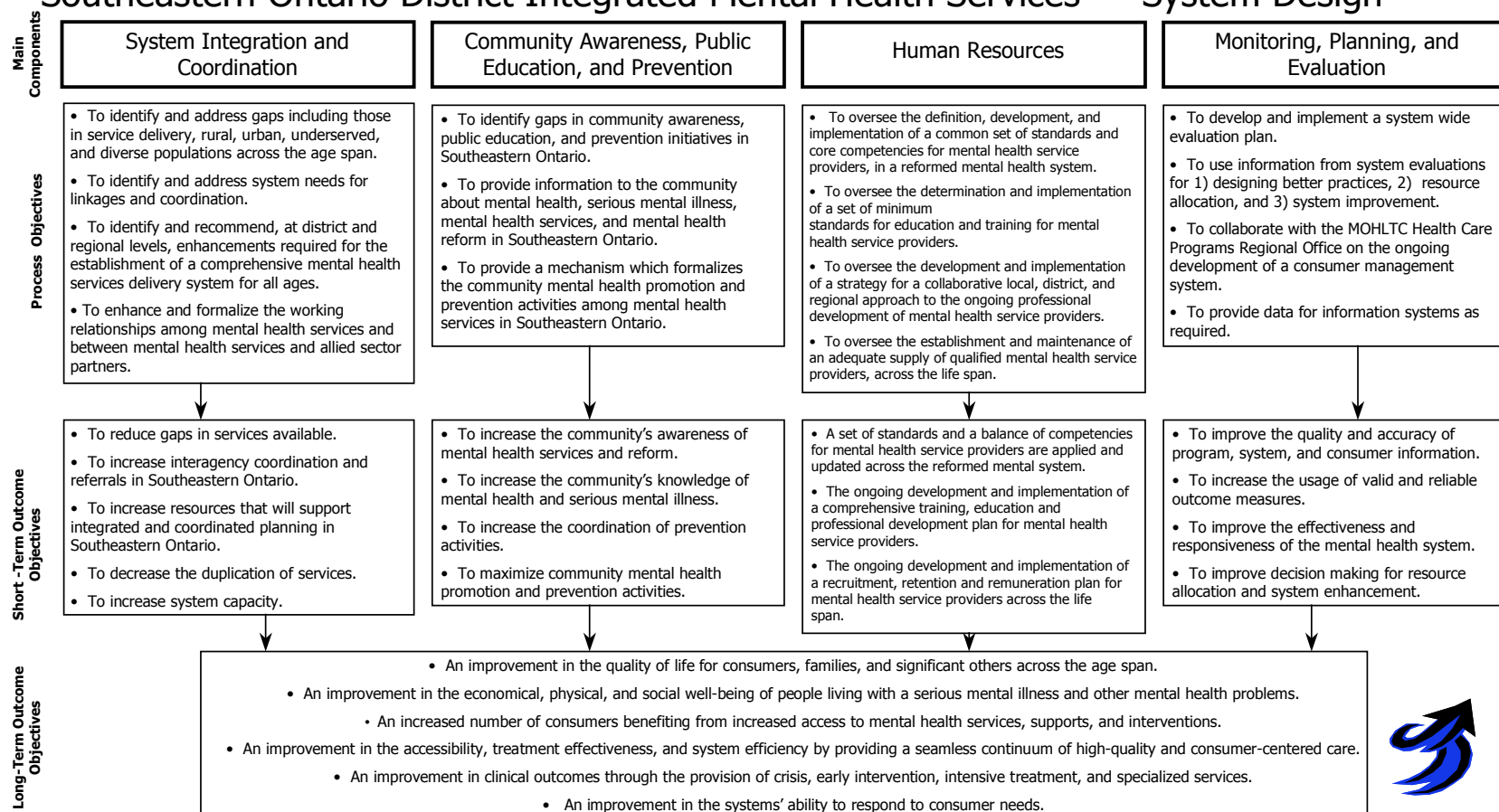
Levels of Service definitions as per *Making it Happen*, pages 11-12:

- **First Line Services:** Refers to prevention, assessment, and treatment provided by frontline health care providers including general practitioners, mental health services, social services and hospital primary care clinics.
- **Intensive Services:** Refers to mental health assessment, treatment and support services which are provided in community or hospital settings and are focused on people with serious mental illness.
- **Specialized Services:** Refers to highly specialized mental health programs provided in community or hospital settings and which focus on serving people with serious mental illness who have complex, rare, and unstable mental disorders. Long term care is not synonymous with specialized care. Treatment, rehabilitation, and support services are integrated within each program/service type and provided through a multi-disciplinary team approach.

SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002

Southeastern Ontario District Integrated Mental Health Services -- System Design

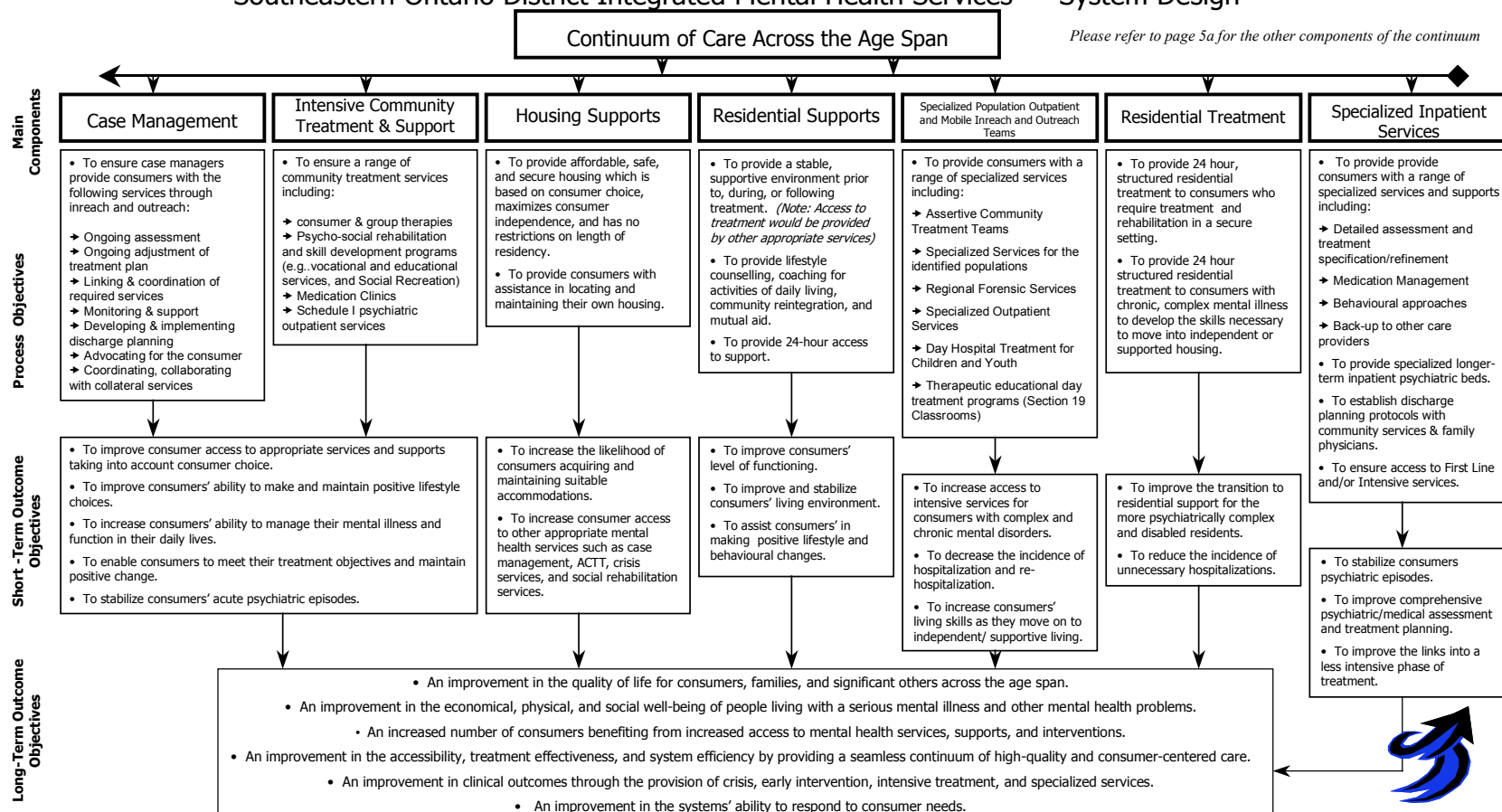
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SEO-Reformed MH Sys-LM
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Southeastern Ontario District Integrated Mental Health Services -- System Design

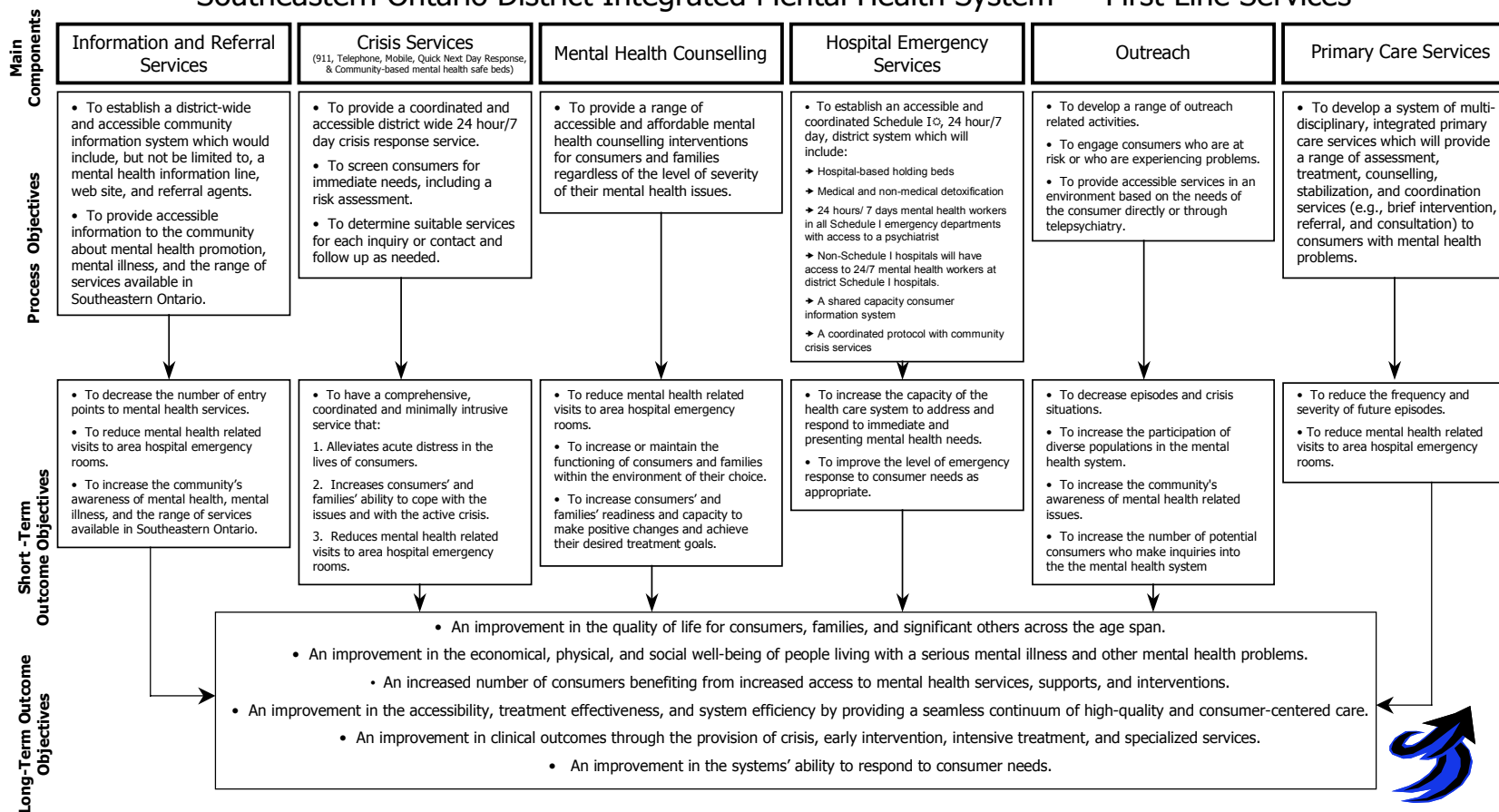
Page 5b



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Southeastern Ontario District Integrated Mental Health System -- First Line Services

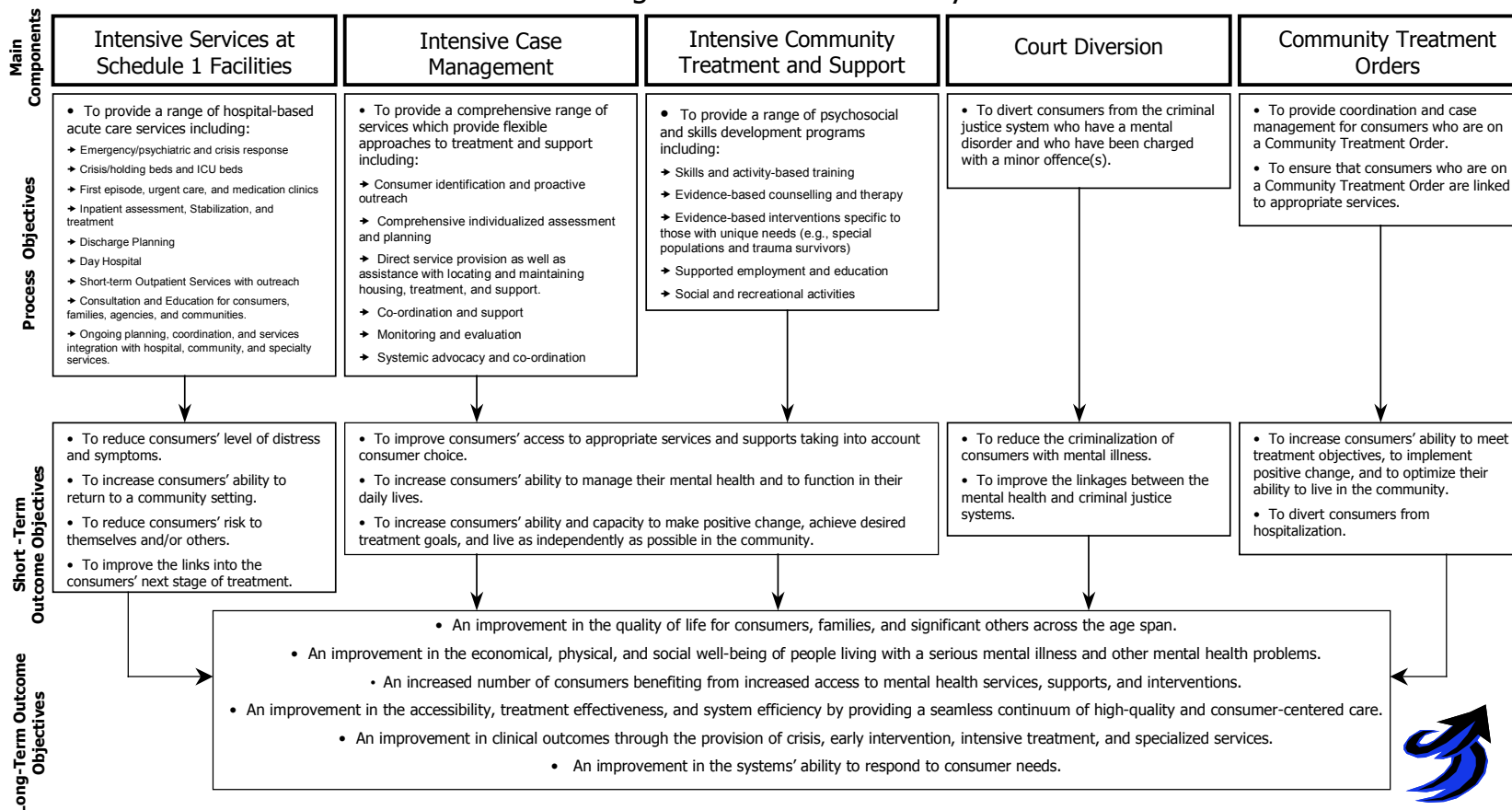
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*SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002*

Southeastern Ontario District Integrated Mental Health System -- Intensive Services

Page 7

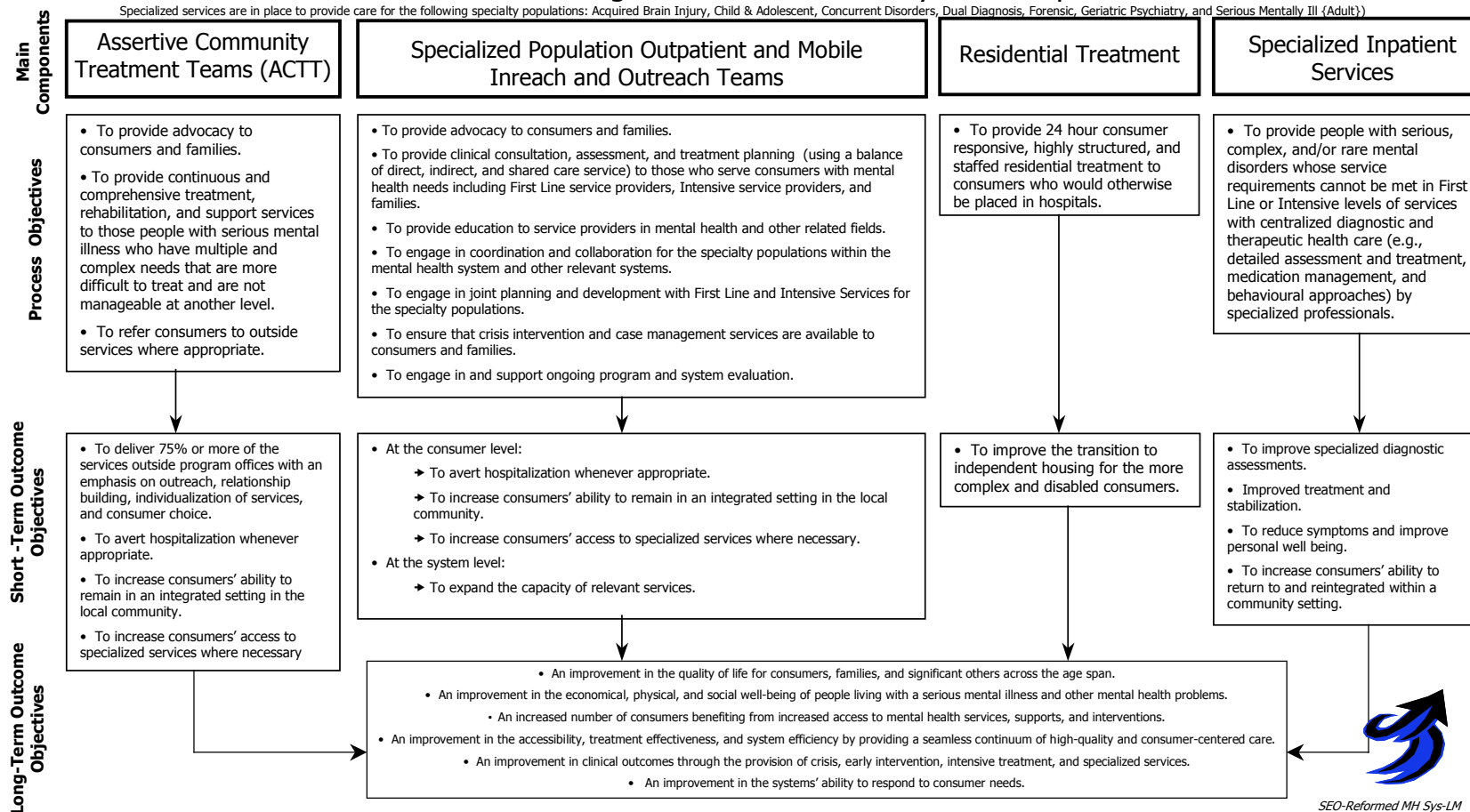


SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002

Southeastern Ontario District Integrated Mental Health System -- Specialized Services

Page 8

Specialized services are in place to provide care for the following specialty populations: Acquired Brain Injury, Child & Adolescent, Concurrent Disorders, Dual Diagnosis, Forensic, Geriatric Psychiatry, and Serious Mentally Ill (Adults)



SEO-Reformed MH Sys-LM
Ver 9; September 18, 2002

Appendix G: Provincial MOH Seniors Committee Draft SLM

Continuum of Health and Long-Term Care Services for Seniors with Mental Health Needs and their Carers/Caregivers

□

Prepared October 2002 by the Ministry of Health and Long Term Care Advisory Committee□

□

For the complete document, please contact the office of:□

□

Paul Secord □

Senior Program Analyst, Health Care Programs □

Department of Mental Health and Addictions □

5th Floor, 80 Grosvenor Avenue□

Toronto, ON□

Appendix H: Provincial Directives Summaries

Government Strategies Related to Care of Seniors – Background Document

□

Prepared by Marg Harrington, Council of Ontario Universities as
Background for the Forum Discussion being hosted by the Ontario
Interdisciplinary Council for Aging & Health on May 23, 2002.

□

Please contact the Ontario Interdisciplinary Council for Aging and
Health for more information on this document

Appendix I: Individual Southeastern Ontario Legacy Document Summaries

The Summaries of the following key legacy documents for Southeastern Ontario are attached:

- “Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future” – SEO DHC 1999. (Appendix Ia)
- “The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs” 1998. (Appendix Ib)
- “Meeting the Local Need for Psychogeriatric Services: A Proposal for maintaining service as close to home as possible in Leeds, Grenville and South Lanark” 1999. (Appendix Ic)
- “Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox and Addington” 1998. (Appendix Id)
- “Annual District Service Plan for Long-Term Care Community Services, 1998/99, Rideau Valley DHC” . (Appendix Ie)
- “Implementation of Mental Health Reform: A Regional Plan for Eastern Ontario” 1997. (Appendix If)
- “Kingston Psychiatric Hospital Comprehensive Assessment Project (CAP)” 2000. (Appendix Ig)
- “Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital” 2000. (Appendix Ih)

Appendix Ia

Title:	<i>Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future</i>
Prepared by:	Southeastern Ontario District Health Council (SEODHC)
Date:	January 27, 1999
Objectives/Scope/Planning Process:	
The report is intended to serve as a status report for future planning and direction for the SEODHC on mental health reform with attention to certain specific planning issues, e.g., Mental Health/Long Term Care Interface; Human Services and Justice Coordination Project; Dual Diagnosis Planning; Substance Abuse Planning; and Homelessness. In articulating recommendations, the report draws from the rich legacy of mental health planning undertaken by the three former DHCs (Rideau Valley DHC, Hastings and Prince Edward Counties DHC, and Kingston, Frontenac & Lennox & Addington DHC).	
Content/Inventory:	

Title:	<i>Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future</i>

The report includes a section on Mental Health/Long-Term Care Interface Planning.

This section refers to the 1995 MOH Policy Framework and Draft Implementation Guidelines as well as the DHC's legacy planning documents. Reference is made to the British Columbia Benchmarks for Mental Services for the Elderly. These suggest that approximately 40 FTEs would be required for SEO to staff Psychogeriatric Outreach Teams. The B.C. benchmarks also suggest service targets for residential and institutional inpatient supports.

The impacts of hospital restructuring and the downsizing of the provincial psychiatric hospital system are highlighted. The report mentions the consistent concern across SEO regarding the capacity of current long term care facilities to support persons with the level of intense needs represented by elderly persons within provincial psychiatric hospitals.

The report refers to a number of existing mechanisms/committees for coordination and linkages across the mental health and long term care sectors across the SEO district.

The report summarizes the former DHCs' system redesign efforts which all put the consumer at the centre of the care plan supported by a set of function supports from informal and formal resources. It notes that changes to local service systems include the amalgamation of community based transfer payment programs in Leeds and Grenville as well as in Kingston. In Hastings and Prince Edward Counties a facilitated process to link existing community based transfer payment programs has recently concluded. One product of this process is an algorithm to guide service linkages from non-hospital community based services to services available at the Belleville hospital site of the Quite Health Care Corporation.

Conclusions/Recommendations:

The report recommended that the Ministry Implementation Team-System Design incorporate into their planning the legacy of recommendations provided by the former DHCs and the Southeastern Ontario DHC including:

- Specific recommendations contained in "Meeting the Local Needs for Psychogeriatric Services: A proposal for maintaining services as close to home as possible in Leeds, Grenville and South Lanark"; and
- The comprehensive planning provided by "A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs" which could serve as a template for needs across Southeastern Ontario.

It further recommended that:

- The SEODHC continue to participate in the Hastings and Prince Edward Mental Health Long Term Care Task Force and the KFLA Long Term Care and Geriatric Services Group to facilitate service linkages and utilize these groups as one reference point for advice on the

Title:	<i>Mental Health Reform Planning in Southeastern Ontario: Our Legacy, Our Future</i>
LTC/MH interface. • The Ministry Implementation Team-System Design address the needs represented by the projected significant growth of the elderly population over the next two decades.	

Appendix Ib

Title:	<i>The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs</i>
Prepared by:	Hastings & Prince Edward Counties District Health Council
Date:	January 21, 1998
Objectives/Scope/Planning Process:	
The objective of the HPE district plan was to define the present and future service needs of older adults with mental health needs in the district and outline a plan to meet those needs, including strategies to ensure a coordinated interface between the mental health and long-term care systems. The Plan is divided into 3 sections: Section 1: Environmental Scan Section 2: Program Design Section 3: Implementation Plan and Funding request Four planning workshops were held; over 50 community stakeholders participated. The draft Program Design was widely circulated and feedback incorporated. An implementation planning workshop was held in October 1997 where over 30 participants reviewed the recommendations. The Implementation Plan was developed based on an integration of feedback from written feedback, an ad hoc review task force, and the DHC's Mental Health and Long-Term Care Planning Committees.	
CONTENT/INVENTORY:	
A comprehensive overview of existing MH and LTC services, supports and opportunities in the district is found in Appendix 3 (Att. A). Needs Assessment in Appendix 2 (Att. B) provides data on: • Dementia projections using the 1995 Hopkins study rates for Hastings County and for Prince Edward County 1992-2021 • Hospital Utilization by elderly persons with MH primary diagnosis: - o Hospital separation data by hospitals in HPEC (94/95) - o Hospital separation data for residents of HPEC (94/95) - o Belleville General Hospital, Schedule 1 separation data for 95/96, 96/97 (projection) Note: Residents of the eastern portion of Northumberland County utilize health services within HPEC. Therefore, service targets based on population must include the resident populations of Murray Township, the village of Brighton and the Township of Brighton. • Results of a survey of LTCF in the district estimating that 20% or 233 residents in LTCF in HPEC have MH problems. The role of existing psychogeriatric services in HPEC in Appendix 4 (Att. C). Table 1, Section 2, (Att. D) summarizes the B.C. Benchmarks targets for HPEC, including: • # of FTEs for the psychogeriatric outreach workers – case managers/coordinators (10.8 FTEs);	

Title:	<i>The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs</i>
• # of FTE physicians – Geriatric Psychiatrists or family physicians (3.75) • Inpatient beds: - o Emergency/Intensive Txt (5) - o Assessment & Txt (12-13) - o Tertiary/Specialty Txt (8) The schematic in Section 2, (Att. E) 7 provides an overview of the regional and district resources and supports for persons with mental health needs and their caregivers. A Psychogeriatric Care Model: Primary Components and Pathways is produced in Section 2, (Att. F).	
CONCLUSIONS/RECOMMENDATIONS:	
Recommendations are grouped around the 4 key issues areas as identified in the MOH's 1995 Guidelines for LTC/MH Interface: Issue A: The need to enhance the availability of psychogeriatric services for HPEC. 1. Develop a Psychogeriatric (PG) Core Team. ➤ 10.8 FTEs psychogeriatric outreach workers/case managers: North Hastings (2 FTEs); Centre Hastings (2 FTEs); South Hastings/ Quinte/East Northumberland (4.8 FTEs); PEC (2 FTEs); and 3.75 FTEs geriatric psychiatrists and/or physicians with gerontology expertise (sessional fees or other funding required to recruit and remunerate). ➤ A community contact point and/or site in each planning area. ➤ Team to work in a coordinated / partnership model (Section 3, Att. G). ➤ Core team to be “mobile” and provide services in a variety of settings (community, LTCF, hospital). ➤ Services to be integrated with local adult mental health subsystem to ensure access, equitable availability and 24 hour crisis management. 2. Develop a continuum of supportive and secure living environments. ➤ The number of LTCF beds to provide care and support to older adult with MH needs TBD. ➤ Supportive housing targets TBD. ➤ Based on B.C. benchmarks, 25 long-term security/treatment beds are needed. The PG Team, Regional Geriatric Psychiatry Program and other partners to develop/identify these specialized long-term housing options. 3. Develop specialized acute treatment and long term treatment sites. ➤ The PG Team to formalize agreement with Belleville General Hospital and regional services providers to ensure access to beds for stabilization, assessment and treatment planning. ➤ Other beds as described in B.C. study. 4. Ensure access to the Regional Specialized Geriatric Psychiatry Services. ➤ Services and supports include: - o Speciality assessment on an outreach basis.	

Title:	<i>The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs</i>
○ Joint assessments with the Regional Geriatric (Medical) Program, if needed. ○ Specialized/tertiary txt on inpatient or outreach basis. ○ Follow-up on discharge with district service providers. ○ Training and educational opportunities for district providers. ➤ To be available a minimum of 1 day/month in each planning area (i.e., 4 days per month in the district). Issue B: The need to increase awareness levels and education, training and skill building opportunities for service providers and caregivers supporting older adults with mental health needs. 5. Ensure training, education and skill building opportunities for service providers. ➤ A variety of formats and strategies to be explored (videos, resource libraries, staff replacement costs, etc.) ➤ The PG Team, Regional Geriatric Psychiatry Program, MH service providers and education service partners to develop strategies and identify resource needs for LTCFs, home care service providers and staff in chronic care/continuing units. 6. Ensure education, training and skill building opportunities for family members and caregivers. ➤ The PG Team together with family and caregiver support organizations (AS, CMHA, MH Family Support Network, VON, etc.) to develop strategies and identify resources needed. 7. Ensure that related services and supports and the community-at-large are aware of the services and support available and how to access them. ➤ The PG Team to develop and implement public education and awareness strategies. 8. Ensure the availability of opportunities for physicians to enhance their skill level with respect to the service and support needs of older adults with mental health needs- and the services and supports available in the district. ➤ The Regional Geriatric Psychiatry Program and the Academic Health Sciences Centre, Queen's University to develop and implement educational/information strategies and opportunities to assist FP/GPs in their care of older adults with MH needs and support their role as a member of the service team. Issue C: The coordination of MH and LTC services to ensure timely access to services and information when it is needed. The importance of including the creation of effective partnerships between the outreach tertiary/specialty tertiary psychiatry program and the Regional Geriatric Assessment Program is highlighted. 9. Ensure that provincial strategies are implemented related to integrated information systems and coordinated transportation opportunities. 10. Develop formalized referral process & procedures between LTC & MH services (district & regional). (Section 2, Att. H) 11. Ensure that the system is open, accessible and accountable to consumer and their caregivers.	

Title:	<i>The Long-term Care/Mental Health Interface: A District Plan for Enhancing Services for Older Adults in Hastings and Prince Edward Counties with Mental Health Needs</i>
Issue D: The need to develop an implementation plan and identify financial resource requirements. 12. Implement the enhanced psychogeriatric program in keeping with the District Plan program design, implementation plan and request for funding. ➤ The recommended governing sponsor for the PG program is the Access Centre for Hastings & Prince Edward Counties. (criteria listed in Section 3, pg 3; Role & responsibilities described in Section 3 pg 4-5). (Att. I) ➤ A Program Developer to be hired for up to 24 months. ➤ Proposed budget: PG Team = \$1,504,780; Admin & Development Costs (incl. \$35K for client transportation) = \$401,939 (Section 3, pg 7; Att J); Other Related Costs re: Training & Education = \$81K; Grand Total PG Team & Related Costs = \$1,987,719 (Section 3, pg 20; Att K). ➤ Inpatient Bed Costs = \$4,654,250 – 7,446,000 (Section 3, pg 10-12 & 20; Att. L). ➤ One time costs for communication & IT (Section 3, pg 17-18; Att. M). ➤ Key Principle: <i>Resources allocated to serve HPEC should be proportionate to the proportion of the total population of the regional catchment area who are residents of HPEC.</i> ➤ Note: PG Team to be supported by about 3 FTE specialty nurses from the Regional Geriatric Psychiatry Program.	

Appendix Ic

Title:	<i>Meeting the Local Need for Psychogeriatric Services: A proposal for maintaining services as close to home as possible in Leeds, Grenville and South Lanark</i>
Prepared by:	Rideau Valley District Health Council (RVDHC) – Revised and endorsed by the Lanark, Leeds and Grenville Mental Health Coalition
Date:	Initial Report: Feb. 1998; First Revision: Oct. 16, 1998; Second Revision: Jan. 19, 1999
Objectives/Scope/Planning Process:	
The goal of the planning process was: “To establish the feasibility for a program transfer from Brockville Psychiatric Hospital (BPH) to St. Vincent de Paul Hospital which will meet the current and emerging needs of the population of Leeds and Grenville and 50% of Lanark for medium and longer term psychogeriatric inpatient and outpatient/community services as represented by the current programs delivered by BPH.” The impetus for this study originated from the HSRC’s preliminary report on the <i>Brockville Community: Health Services Restructuring Report</i> of November 1997 which recommended that “the Rideau Valley DHC undertake a study to determine the feasibility of the transfer of the 18 geriatric mental health beds and the Geriatric Psychiatry Community Outreach Program to the St. Vincent Hospital.” However, in the HSRC’s second report released in February 1998, the reference to the requested study noted that: “Psychogeriatric beds, however, are found in both long-term care and longer-term mental health beds. Patients associated with this inpatient program should be transferred to other levels of care according to their needs and respecting the convenience of their families and friends.” The Lanark, Leeds and Grenville Mental Health Coalition reviewed and endorsed the earlier work of the RVDHC. The intent of the stakeholders in Lanark, Leeds and Grenville was to build on the previous work of the former DHC and provide input to the Ministry implementation process. Following the decision by the HSRC in July 1998 to include the referral population of Leeds and Grenville as well as half of Lanark for longer-term mental health services in Kingston, the Coalition updated its recommendations in January 1999 to include reference to the Kingston Psychiatric Hospital as well as the Brockville Psychiatric Hospital.	
Content/Inventory:	
The study builds a case for the need for locally based medium term (i.e., lengths of stay <90 days) and longer term inpatient/residential psychogeriatric resources as a vital adjunct to outreach services to allow individuals to be assessed, treated and stabilized so that they can maintain longer periods of residency within their living environment.	

Title:	<i>Meeting the Local Need for Psychogeriatric Services: A proposal for maintaining services as close to home as possible in Leeds, Grenville and South Lanark</i>
The study examined current utilization and provided inpatient admission data for residents of LLG to the BPH Psychogeriatric Service for 1997 (Att. A): • For the 5 admissions from Lanark: 3 were < 30 days and 2 were 91-180 days. • For the 57 admissions from Leeds and Grenville: 27 were < 30 days; 24 were 30-90 days (i.e., medium term); 3 were 91-180 days and 3 were 6 months to 1 year. Existing Psychogeriatric Services are described: • The 1997/98 <u>Psychogeriatric Inpatient</u> Program at BPH prorated for the catchment of Leeds, Grenville and half of Lanark includes 18 beds, a budget of \$2,081,000 and 33 FTEs. (Att. B) The report identified that 50% of the current 21 inpatients from LLG who were assessed for recommended placement require hospitalization. Extrapolating from current use, and taking into account demographic pressures and service reconfigurations, the report suggested the need for a service of 8-18 beds within the complex continuing care psychogeriatric inpatient service proposed for St. Vincent de Paul. • The report provides an outline of the principal functions of the Outreach Team (Att. C). In addition, the 1997/98 budget and FTE breakdown for the existing <u>Geropsychiatry Outreach Team</u> (serving Leeds, Grenville, SDG and sessional fees for Prescott and Russell) is provided: \$1.146M and 17 FTEs. (The report notes that divestment of SDG and P-R resources to local sponsors is appropriate. The HSRC has since directed that these resources are to be transferred to the ROH/CGH and the Montfort Hospital.) The information is also provided for Lanark: \$270,000 and 4.7 FTEs. (Att. D) In addition, the report calculated requirements for Leeds and Grenville and ½ of Lanark for some components of a comprehensive system of care for the elderly using the B.C. Benchmarks and the > 65 population estimates for 2003 (Att. E). From these calculations, 12 FTEs are required for the Geriatric Program Service Team. • Details are provided on the existing <u>Psychogeriatric Day Program</u> offered at 10 Oxford Ave in Brockville serving Leeds and Grenville: 1997/98 budget = \$819,800; there are 15 FTEs. Future planning includes establishing satellite services outside of Brockville. (Att. F)	
Conclusions/Recommendations:	
There are two recommendations : 1. That the Ministry of Health recognize the need for psychogeriatric inpatient/residential and associated outpatient services to remain within the Brockville community to serve Leeds and Grenville and part of Lanark.	

Title:	<i>Meeting the Local Need for Psychogeriatric Services: A proposal for maintaining services as close to home as possible in Leeds, Grenville and South Lanark</i>
2. That the Ministry of Health work with the hospital executive steering committee and other stakeholders to ensure the efficient transfer of resources from Brockville Psychiatric Hospital and/or Kingston Psychiatric Hospital to: • Providence Continuing Care, St. Vincent de Paul site for enhanced mental health services within the planned complex continuing care service to meet the need for longer term mental health inpatient geropsychiatric supports; and • To Brockville General Hospital for related acute inpatient and outpatient/community-based services for all adults.	

Appendix Id

Title:	<i>Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox & Addington</i>
Prepared by:	Kingston and Frontenac, Lennox & Addington District Health Council
Date:	February 1998
Objectives/Scope/Planning Process:	
The report is an update to the 1996 Multi-Year Plan. A LTC Community Services Planning Committee developed the annual service plan for 1998/99. Its objectives included a review of current information regarding the target populations, service levels and availability of resources; a literature review; an examination of the impact of recent government restructuring on LTC services; consultation with key stakeholders about changing priorities, resource utilization and service delivery issues; and the development of recommendations for the annual service plan based on these reviews and consultations. The report is divided into four major sections corresponding to the following target groups for the planning exercise: seniors, people with physical disabilities, children with long term care health needs, and caregivers. The sections of the report on <i>Seniors</i> and on <i>Caregivers</i> touch upon issues related to psychogeriatrics, in particular Alzheimer Disease and dementia. There is, however, no section of the report specific to the LTC/MH interface.	
Content/Inventory:	
A Vision of LTC adapted from the HSRC is provided: <i>“LTC is an integral component of the overall health system. LTC will be provided in different settings depending on the desires, level of dependence and care requirements of each person, and the availability of compensating informal and formal systems of support. LTC settings will include private residences, communities, schools, retirement homes, supportive housing and facilities (HFA, NH, chronic hospitals and units).</i> Each person will have timely and equitable access to affordable and appropriate LTC services regardless of geography, income, age, gender or background. Adults and children in need of LTC services will be supported in their own homes and communities for as long as possible. Families will receive the support they require to make this possible. People who cannot be supported in their own homes will receive care in the least restrictive, least intrusive alternate setting feasible. In all settings, LTC will focus on maximizing each person’s health, participation in decision-making, functioning, and quality of life.” Key themes emerging from the community consultations and committee deliberations were: 1. Quality of life, quality of decision-making, and quality of care. 2. ‘Customized’ care based on shared responsibility; in this approach to care the case manager works with the consumer, family caregivers and the providers to develop a plan which	

Title:	<i>Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox & Addington</i>
identifies each participant's role and responsibilities in the provision of support and care. 3. Service flexibility. 4. Local solutions. Identified pressures on LTC system: reduction in rehab beds and chronic care beds; closure of chronic psychiatric beds; and earlier discharge from hospital. Sociodemographic data provided: population 75+ and projections; dependency ratios, living arrangements. LTCF resident profile: average age 88; Alzheimer rates = 60% CCAC Respite Care Study in 1997 revealed that of the clients receiving respite, 11.5% are frail elderly and 5.5% have dementia. There are 10 LTCFs in the district; 1,145 beds; higher per capita number of beds than the provincial average; inequitable distribution of beds (Att. A) Victorian Order of Nurses C.A.R.E. Program provides case management, respite, counselling and education to family who care for people with Alzheimer Disease (AD) or other dementias. Families receive 3.5 – 6 hours of regularly scheduled respite per week. Stats from 96/97 Service Plan: \$262,573 expenditures; 122 people received respite (10,355 hours); 160 people received training and education; and 160 people received counselling; 77% of clients are residents of the Kingston area, 13% from Napanee and 10% from northern parts of the county. Special Concerns: Transportation is always an issue but is of particular concern for those with AD who also need escorts. Special attention needs to be given to Meals-on-Wheels for people with dementia. Lack of training for caregivers and volunteers to provide care for people with AD, acquired brain injury, and personality changes.	
Conclusions/Recommendations:	
Many of the recommendations, while not specific to the LTC/MH interface or to psychogeriatrics, have relevance for planning in these areas. • That the MOH and DHC and the LTC agencies develop a public education program to inform seniors about the changes and improvements in the health care system. • That the hospitals develop a single 'who to call' pamphlet to accompany the medical information provided at the time of discharge from day surgery and/or hospital. • That community support programs enhance the volunteer transportation services, and include caregivers' need for escorts and support in the service continuum. • That the CCAC's information and referral service provide support and direction for caregivers. • That the CCAC consider developing specialized case management supports and 'customized' care plans for families with significant caregiving responsibilities. • That the CCAC provide specialized case management for caregivers who support people	

Title:	<i>Long Term Care Community Services Annual Plan, Kingston and Frontenac, Lennox & Addington</i>
with dementias if this specialized services transfers to the Community Care Access Centre. • That the volunteer training programs focus on the special needs of people with dementias, children with disabilities, and people with disabilities, accessing expertise from service providers and educators in the community as necessary.	

Appendix Ie

Title:	<i>Annual District Service Plan for Long-Term Care Community Services 1998/99, Rideau Valley</i>
Prepared by:	Rideau Valley District Health Council
Date:	January 1998
Objectives/Scope/ Planning Process:	
The Ministry of Health asked District Health Councils to develop multi year plans as well as annual plans for long term care services. The Rideau Valley DHC prepared an Annual District Service Plan (ADSP) 1998/99 which included a section on mental health services. The section provides an overview of relevant provincial, regional and district policy and planning documents. In addition, the report summarizes the results of a community consultation on the ADSP as it relates to the MH/LTC interface. Recommendations put forward are tied to two of the goals of the long term care service system in Lanark, Leeds and Grenville.	
Content/Inventory:	
A brief description of available MH services in LLG is provided: • 7 community MH programs deliver MH services and supports to the elderly although there are no separately funded programs for the elderly. • 2 PPHs (BPH = Leeds and Grenville; KPH = Lanark); • Figure 4.1(Att. A) summarizes the target group, geographic area and services provided by the 2 PPHs' outpatient psychogeriatric assessment, consultation and treatment services. • In-patient services offered in PPHs, and schedule 1 hospitals; One finding of a review of utilization: elderly persons with MH problems use community inpatient services with no psychiatric units more than they do schedule 1 acute MH services or specialty hospital services. • In 1997, BPH began offering a 20 space Geropsychiatry Day Treatment Program in Brockville. • Psychogeriatric training and education of LTCF staff began in the summer of 1997 (funding of \$125,000) through a partnership of ROH and BPH. A complementary tele-video implementation pilot involving Queen's was approved for SEO. • Targets and benchmarks for SEO for the Year 2003 from the Regional Mental Health Plan are listed: Acute beds = 134; LT Beds (PG & Rehab) = 96; Case Managers = 142; Supportive Housing Units = 1,340; PG Outreach = 66 FTEs. • HSRC benchmarks and directives are referred to. Comments from community consultation on 4 Key Strategies from the MOH Policy	

Title:	<i>Annual District Service Plan for Long-Term Care Community Services 1998/99, Rideau Valley</i>
Framework for the LTC/MH Interface: Comprehensive and coordinated systems of LTC, MH and chronic care services and supports in the districts and regions: Strengths in the existing system: • Regular contact with MH professionals in LTCFs supports capacity of services to respond and is very productive. • Lanark County MH “Seniors’ Resource Team” (a partnership between the Lanark Community Mental Health Service and the BPH Geropsychiatry Community Outreach of BPH) has explicit service agreements which commit resources and define roles and relationships; and referral protocols are available which clearly outline the nature of the service for other service providers. Weaknesses in the existing system: • LTCFs need the physical plant, service resources and training to provide appropriate care to PG population. • Problem areas: Many changes in the system - need education about these changes; lack of appropriate connections to available resources; inconsistent use of chronic care beds; need earlier identification of problems to avoid crises. • Gaps: respite services for individuals residing in community based settings; home care services for people with chronic MH problems; with closure of BPH expect there will be limited availability of some in-patient tertiary level MH services for special populations. Education and training requirements for support workers, service providers and volunteers in LTC and MH systems. • Training needed to: address fears; shift values and attitudes; improve capacity of community hospitals to respond. • Training needed for: home support workers; other LTC/health workers; in-home providers and family caregivers. • Need: appropriate ratio of trainers to trainees (2: 30 is not satisfactory); a convenient place to hold sessions; training sensitive to context (e.g. in home , LTCF); resources to backfill staff to participate. • Where is the expertise? Who should do the training? Find way to connect the resources of RGP, KPH, BPH. Linkages with appropriate services, programs and supports which also provide supports and services. • Develop common assessment tool and process. • Explicit formal linkages (including referral protocols defining roles and	

Title:	<i>Annual District Service Plan for Long-Term Care Community Services 1998/99, Rideau Valley</i>
responsibilities, a statement of commitment and an evaluation process) needed between: LTCFs and MH resources; MH resources and specialized PG services; physicians and LTC/MH providers; chronic care facilities and MH resources. • Generic discussions needed between multi-disciplinary team providing in-home care and MH resources. Funding/resource allocation to develop and maintain successful and ongoing coordinated systems of care of older people with MH problems and their families. • Current LTCFs will not meet the needs of all persons with LTC/MH needs. • Resources currently in the MH system in LLG need to continue to be available.	
Conclusions/Recommendations:	
LTC Goal : That there will be sufficient capacity within the long-term care service system in LLG to respond to identified needs, and that capacity will be equitable to the capacity of other long-term care service systems in Ontario. <u>Recommendation:</u> • That the MOH allocate funds for the development of specialized skills and programming to support the delivery of long term care services for persons with complex medical needs and/or mental health problems. LTC Goal: That long term care community services in LLG will be effectively linked and coordinated with services in the broader health system. <u>Recommendations:</u> • That the Access Centre for Community Care work with other community partners in LLG and the Health Science Centres (Kingston and Ottawa) on the development of a comprehensive service directory including explicit referral protocols. • That the mental health service providers develop explicit protocols with hospitals, long term care facilities and other long term care service providers explicitly describing the service agreements between the agencies. • That the Ministry of Health provide funding and policy direction to the development of a comprehensive information system to support the development of integrated delivery of care to the consumer regardless of the care setting.	

Appendix If

Title:	<i>Implementation of Mental Health Reform: A Regional Plan for Eastern Ontario</i>
Prepared by:	Eastern Region Mental Health Planning Forum on behalf of The DHCs of Eastern Ontario
Date:	February 1997

Objectives/Scope/Planning Process:

This comprehensive report constitutes the Eastern Region's planning foundation in response to the MOH's policy document, "Planning for the Implementation of Mental Health Reform", August 1995.

It incorporates three major components:

- Needs Assessment, February 1996
- System Design, December 1996
- Implementation Plan, February 1997

The Plan was prepared by all six former DHCs in the Eastern Region under the guidance of a "Regional Mental Health Planning Forum" composed of 30 voting members, with broader participation and consultation through sub-committees and the work at the former DHC district levels.

Content/Inventory:

The report provides hospital utilization and benchmark data and applies funding/needs formulas for the two sub-districts in the Eastern Region (the Northeast-now called Champlain district- and the Southeast). Of particular note is the calculation for Psychogeriatric outreach of 66 FTEs (this includes Peterborough, Northumberland and Haliburton) based on a benchmark of 5.5 FTEs/10,000 population 65+ (not a stated policy benchmark).

All districts identified additional needs in the area of mental health supports for elderly persons. The target population for long-term geriatric psychiatry (gero-psychiatry, psychiatric) beds is described as:

- Older persons with dementia and with severe and ongoing disruptive behaviour.
- Older persons with severe unstable ongoing disruptive behaviour associated with a mental health problem/illness but who do not have a significant dementia, e.g., older persons with longstanding serious psychiatric disorders, elderly individuals with late-onset serious psychiatric disorders.
- Older persons with dementia and severe ongoing symptoms which exceed the capacity of other residential settings.

Title:	<i>Implementation of Mental Health Reform: A Regional Plan for Eastern Ontario</i>
Special programs for geriatric psychiatry are listed for BPH, KPH, ROH, OGH with the general comment that they “can act as back-up and consultation service to district psychiatric units, long-term care beds, and community supports. The B.C. benchmark for this service is 3 beds per 10,000 elderly population.”	
Conclusions/Recommendations :	
The Regional Plan makes reference to the LTC/MH Interface Provincial Task Force work still to be released at that time. It contains three recommendations specific to psychogeriatrics: • That the long-term inpatient geriatric psychiatry services be located in both the North East and South East service areas. • That once long-term inpatient geriatric psychiatry services have been established and the system of care evaluated within each of the service areas, further dispersion of services to the local level be investigated. • That a specialized geriatric psychiatry program, focussing on complex cases, be maintained and/or created in each service area and function as a supportive service to geriatric psychiatry services.	
Updates :	
This Plan is an important precursor to other policy and Ministry directives which followed including: • HSRC directives for hospitals throughout the Eastern Region and in particular the PPHs and the ROH. • “Making It Happen” , Operational Framework for the Delivery of Mental Health Services and Supports and Implementation Plan for Mental Health Reform, 1999. • Champlain District Mental Health Implementation Task Force, established June 2000 (covering Renfrew County, Stormont, Dundas, Glengarry, Prescott and Russell Counties, Northern Lanark County and the City of Ottawa). • Southeastern Ontario Mental Health Implementation Task Force, established July 2001 (covering Kingston, Frontenac, Lennox and Addington, Leeds and Grenville, Hastings, Prince Edward, and South Lanark).	

Appendix Iq

Title:	<i>Kingston Psychiatric Hospital Comprehensive Assessment Project (CAP)</i>
Prepared by:	Health Systems Research and Consulting Unit (Clarke Consulting Group) Centre for Addiction and Mental Health under the guidance of a Steering Committee chaired by the Southeastern Ontario DHC
Date:	October 2000
Objectives/Scope/Planning Process:	
To assist the Mental Health Implementation Team-System in planning for the restructuring of mental health services in the nine counties that constitute the catchment area of the Kingston Psychiatric Hospital (KPH), a comprehensive assessment project (CAP) was undertaken. The objectives of the project were: • To provide qualitative and quantitative information about the type of hospital and community services and support needed by KPH patients/clients based on the current patient/client population; • To train KPH inpatient and community-based staff and oversee the conduct of the assessment of the current level of functioning and support/service requirements of all KPH inpatients and a representative sample of KPH outpatients and Homes for Special Care (HSC) residents; • To develop a process and oversee the conduct of a consumer focused assessment that elicits client preferences concerning their future treatment, rehabilitation and supports; • To formulate recommendations concerning the development and/or enhancement of mental health services and supports required to meet the needs of individuals currently using the services of KPH subsequent to downsizing; • To identify community educational requirements and strategies for service providers to increase the capacity of existing services to meet the needs of the individuals who have traditionally accessed the services of KPH; and • To develop an evaluation framework and define a project to assess transitional and long-term impacts associated with the continued implementation of Mental Health Reform in the Kingston region. This CAP was different from other similar projects completed in the province as it involved the most extensive community consultations (seven locations, over 230 participants) and a full evaluation proposal was developed as part of the project.	
Content/Inventory:	
All individuals receiving inpatient services on March 28, 2000 were assessed as were a sample of those receiving outpatient services and HSC residents within the three months prior to March 28. The study examined a number of client sub-groups including the geriatric population (i.e., >65) which totalled 198 inpatients/clients. Well over half (56%) were from Kingston-Frontenac, about ¼ from the other counties, and the balance from out of the catchment area. Note: Additional information recently (July 2001) requested from the Clarke Consulting Group, shows that of the total population over 65 years of age, 34 were from Hastings and Prince Edward Counties and Renfrew County. Levels of care were assigned to 188 of the 198 geriatric population: • 15 of 188 need Level 1 (Self Management) = 8%	

Title:	<i>Kingston Psychiatric Hospital Comprehensive Assessment Project (CAP)</i>
• 36 of 188 need Level 2 (Community Support) = 19% • 54 of 188 need Level 3 (Intensive Community Treatment and Support) = 29% • 82 of 188 need Level 4 (Residential Treatment) = 44% These represent 66 (73%) of current inpatient population and 16 (17%) of current outpatient population. • 1 of 188 needs Level 5 (Inpatient Treatment) The sizeable inpatient geriatric population requiring residential treatment facilities requires particular attention to address issues of security and safety management; and physical co-morbidity in addition to severe mental problems. Special programming and environmental design features as well as planning and coordination around relocation will be required. The majority of geriatric clients requiring levels 1, 2 or 3 are already being served in outpatient settings. Only 20 of the inpatient geriatric population were assessed at Levels 2 or 3. Level 2 and possibly level 3 care needs could probably be served by secondary care providers (e.g., nursing and long-term care staff) with appropriate access and support from regional specialized expertise of a psychiatric outreach team and other tertiary services. It is unlikely that existing nursing and long-term care staff could cope with the large bulk of inpatient geriatric clients within existing environmental staffing constraints.	
Conclusions/Recommendations:	
The study included 8 recommendations specific to the geriatric population: 1. That co-ordination within and across the long-term care system be improved. 2. That enhanced access to specialized psychogeriatric consultation expertise be made available to the long-term care system. 3. That adequate and accessible specialized acute inpatient assessment and treatment services be developed in anticipation of the downsizing of KPH beds. 4. That the number of psychogeriatric teams be increased to ensure more access to this expertise in remote areas. 5. That the findings of the CAP project be taken into account in the regional psychogeriatric planning process. 6. That more partnership activities be fostered between specialized psychogeriatric services and supports and local Community Care Access Centres (CCAC). 7. That appropriate planning be done to ensure that the needs of individuals and their families residing in Leeds and Grenville are met after the closure of BPH. (note: see also BPH CAP report) 8. That planning between the mental health and long-term care systems be conducted to ensure that an appropriate number of long-term care facilities have the physical capacity and resources to serve clients with mental health problems/behaviours. In addition to the report's recommendations, the Steering Committee highlighted a number of concerns:	

Title:	<i>Kingston Psychiatric Hospital Comprehensive Assessment Project (CAP)</i>
• The basic foundation of services and supports needed for an effective service system (Levels of Care Continuum 1-5) is not in place in many areas of the district. • There is a need for an integrated comprehensive vision and plan for the reformed system (district and system designs exist but are not yet integrated). • An additional process to assess the needs of individuals in the community, not currently in or outpatients of KPH, needs to be undertaken. • Communities need to be informed about the reform process and opportunities for involvement must be provided. • An evaluation process needs to be in place before any changes, bed reductions, etc. are implemented.	

Appendix Ih

Title:	<i>Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital Final Report</i>
Prepared by:	Health Systems Research and Consulting Unit (Clarke Consulting Group) Centre for Addiction and Mental Health in collaboration with the Steering Committee chaired by the Champlain DHC
Date:	March 2000

Title:	<i>Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital Final Report</i>
Objectives/Scope/Planning Process:	
To assist the Mental Health Implementation Team-System in planning for the restructuring of mental health services in the Eastern Region, a comprehensive assessment of the needs of individuals currently serviced by Brockville Psychiatric Hospital (BPH) was undertaken. The objectives of the project were: • To provide qualitative and quantitative information about the type of hospital and community services and support needed by BPH patients/clients, based on the current patient/client population; • To train BPH inpatient and community-based staff and oversee the conduct of the assessment of the current level of functioning and support/service requirements of all BPH inpatients and a representative sample of BPH outpatients and Homes for Special Care (HSC) residents; • To develop a process and oversee the conduct of a consumer focused assessment that elicits client preferences concerning their future treatment, rehabilitation and supports; • To formulate recommendations concerning the development and/or enhancement of mental health services and supports required to meet the needs of individuals currently using the services of BPH subsequent to closure of BPH and the restructuring of the Royal Ottawa Hospital (ROH) and the Montfort Hospital; * • To identify community educational requirements and strategies for service providers to increase the capacity of existing services to meet the needs of the individuals who have traditionally accessed the services of BPH; and • To develop an evaluation framework and define a project to assess transitional and long-term impacts associated with the continued implementation of Mental Health Reform. The report represents the efforts of the consulting team and the members of the Steering Committee and includes two new components not previously undertaken as part of a CAP: the development and implementation of a Consumer Preference Survey and the inclusion of 5 community consultations concerning the findings and preliminary directions of the Steering Committee. * In September 1998, the Minister of Health responded to the recommendations of the HSRC and one of the decisions made was that the residents of South Lanark, Leeds and Grenville County will access longer-term mental health services in Kingston.	
Content/Inventory:	
All individuals receiving inpatient services on September 15, 1999 were assessed as were a sample of those receiving outpatient services and HSC residents within the three months prior to September 15. The study examined a number of special sub-populations including	

Title:	<i>Comprehensive Assessment Project (CAP) – Brockville Psychiatric Hospital Final Report</i>
the geriatric population (i.e., >65) which totalled 237 inpatients/clients. It is important to note that these CAP data include information on individuals from South Lanark, Leeds and Grenville who, in the restructured mental health system will be receiving services in Kingston. Additional information recently requested (July 2001) from the Clarke Consulting Group shows that of the total population over 65 years of age, 173 (73%) were from South Lanark, Leeds and Grenville: • 149 out of 166 outpatients or 90% • 23 out of 38 inpatients or 61% (Note: Information for this request was extracted from the raw data set.) 221 out of the total 237 geriatric population were classified into Levels of Care, with the following breakdown: • 29 of 221 need Level 1 (self management) = 13% • 58 of 221 need Level 2 (Community Support) = 26% • 78 of 221 need Level 3 (Intensive Community Support) = 35% • 50 of 221 need Level 4a (Residential Support and Supervision/Treatment) = 23% Currently 26 (52%) are residing in a LTCF and 14 (28%) are in BPH. Most of the Level 4a patients in this sub-group are currently cared for either in a LTCF or a hospital. Most LTCFs do not have either the physical or clinical capacity to serve this population and generally there is a significant waiting list and a waiting period of 1-2 years.	
Conclusions/Recommendations:	
The study included 5 recommendations specific to the geriatric population: • New resources should be targeted to the support/service needs of Levels 1, 2 and 3 and some of Level 4a. • Investment in psychiatric outreach/consultation teams across the Region will increase the capacity of the existing system. • Existing and new “adult” Level 3 supports and services including ACT Teams should have access to the expertise of the psychogeriatric outreach/consultation teams. • Efforts should be made to ensure the needs of those in Level 3 are met as one way of reducing the pressure on residential-based resources. • There will need to be an expansion of residential capacity, and resources should also be allocated to develop and enhance both the physical and clinical capacity of existing LTCFs.	

Appendix J: Additional Data Received

Location of LTC Facilities, and Bed Capacity:

(as of Dec 13/01)

Location/By County	# of LTC Homes	# of Beds (capacity)
Frontenac	5	749
Lennox and Addington	5	416
Hastings	10	931
Prince Edward	5	354
Lanark	6	573
Leeds Grenville	8	746

- It has been proposed that a mapping of LTC facilities (and other health services) be undertaken (by Queen's?)

Location of New LTC Beds

(as of March 19/02 – MOH website)

Location/By County	# of NEW LTC Beds
<u>Frontenac/Lennox/Addington:</u>	
Helen Henderson Nursing Home	32
Fairmount Home	32
Providence Manor	30
Specialty Care East Inc. - Kingston	96
Friendly Manor Nursing Home	2
<u>Hastings/Prince Edward:</u>	
Versa Care Hallowell House	4

Number and Location of Complex Continuing Care Beds

(as provided by MOH dated 10/01/2000)

Institution Name	County	Beds
L and A General Hospital	L and A	0
PCCC	Frontenac	110
Quinte Health Care Corp	Hastings	71
Kemptville District Hosp.	Leeds Grenville	17
St Vincent De Paul Hosp.	Leeds Grenville	42
Perth Smiths Falls Hosp.	Lanark	17
Almonte General Hospital	Lanark	26
Total:		283

Demographic Profile

- refer reader to demographic profile produced by DHC for use by MHITF (ie contained in larger MHITF documentation)

Hospital Admission Data (for patients 65 and over in SEO)

(Source: Provincial Health Planning Database, MOHLTC, all hospitals, Fiscal Yr 2000-01)

County	Direct through Admitting dept	Emergency Department	Via Clinics in Reporting hosp	Via Day Surgery/etc	Total
Frontenac	1,041	2,447	16	114	3,618
L & A	400	890	3	32	1,325
Hastings	1,707	3,165	15	65	4,952
PrinceEdward	492	862	4	14	1,372
Lanark	908	1,510	8	33	2,459
LeedsGrenville	1,473	2,249	223	56	4,001
Totals:	6,021	11,123	269	314	17,727

Demographic and Utilization Synopsis

(provided by Dr. John Puxty)

Census data indicate that there were approximately 70,000 people over age 65 in South-eastern Ontario in 1996. The percentage over 65 years of age in all three counties was higher than the provincial average of 12.4% (LLG 15.2%, FL&A 13.6%, HPE 16%). The proportion of those over 75 years of age is also higher than the provincial average of 5% (LLG 6.7%, FL&A 5.7%, HPE 6.7%) This raises a special concern as it is the very old who are expected to have the fastest growth rate of the next decade and expected to have increased by 28% from 1996 to 2003 (38,524 compared to 30,090).

Older individuals as a group appear to use a disproportionate amount of health care services relative to their numbers. For example in 1995-96 when the 65-74 age group accounted for just 7.2% of population they were responsible for 18-22% of emergency room use and 14% of hospital separations. For the same period those 75 and over accounted for just 5.6 % of population but were responsible for 22-26% of emergency room use and 23% of hospital separations. Older individuals on attending the emergency room have a higher number of tests performed than other age groups but with less diagnostic accuracy and are more likely to re-attend with two weeks with the same diagnosis.

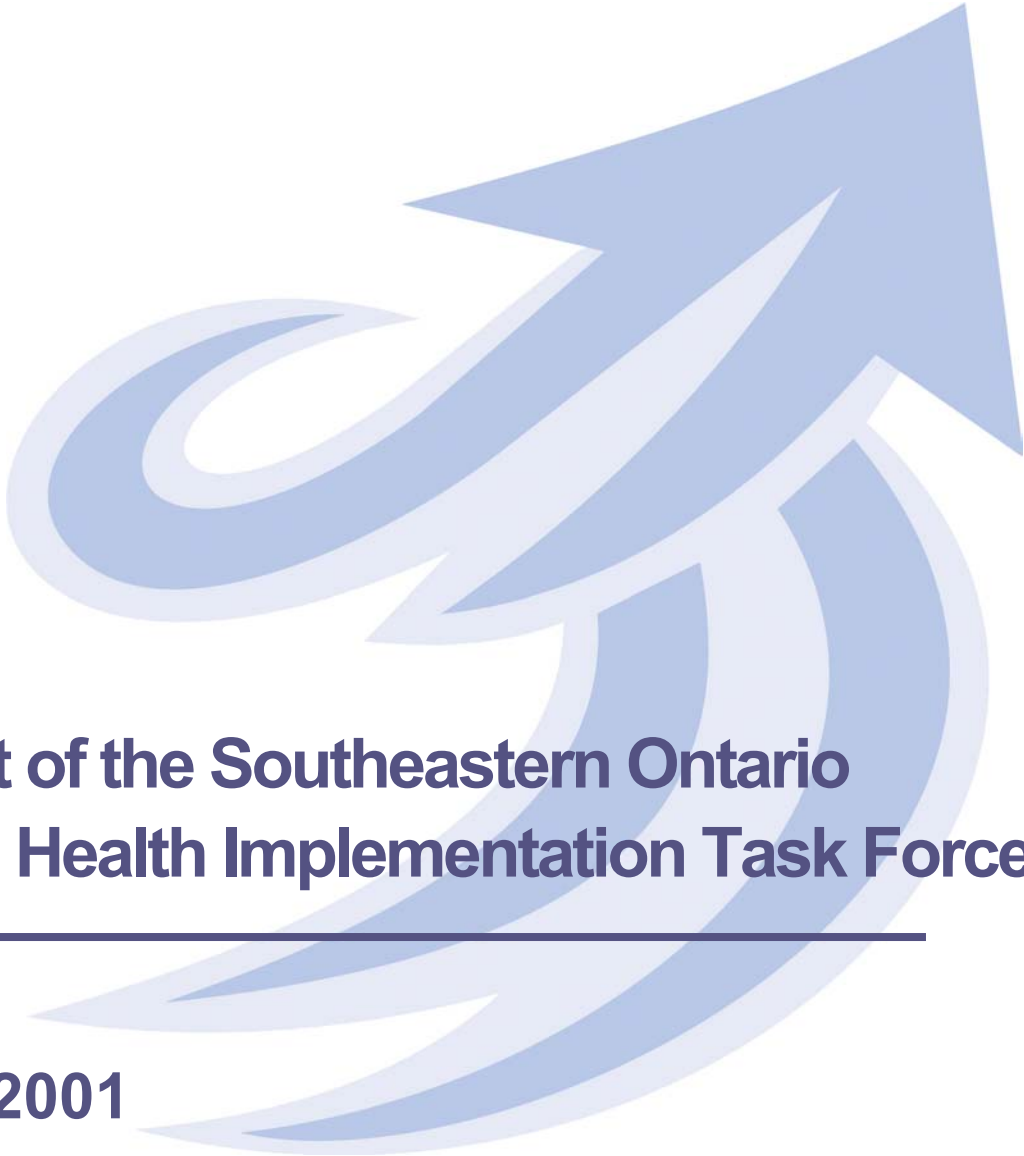
Local experience appears to be consistent with that of the provincial and national picture. Individuals over 65 years of age in 1998-99 accounted for just 21 % of all KGH emergency room use but resulted in 48.6% of admissions from emergency. Furthermore the 75 years and over age group although accounting for only 11% of attendance, resulted in 28% of all admissions. Over 40% of those 75 and over attending emergency were admitted ,compared to less than 12% of those below 65 years of age. Aging demographic trends therefore threaten to swell demand for hospital admissions through the emergency room.

Dementia Projections

Reader is referred to the Rural and Urban proposals, as well as the original document produced by Hopkins, for projections used in SEO.

CCAC Data

(*not available at this point and time)

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Grand Summit of the Southeastern Ontario District Mental Health Implementation Task Force

December 4, 2001



Proceedings of the Grand Summit

Southeastern Ontario District Mental Health Implementation Task Force

Tuesday, December 4, 2001

***The Donald Gordon Centre
Queen's University
Kingston, Ontario***

Proceedings of the Grand Summit
Donald Gordon Centre, Queen's University, Kingston, ON
Tuesday, December 4, 2001
10:00am – 3:00pm

Present: Dr. Julio Arboleda-Florez, Ms. Jane Banbury, Mr. Wayne Barnett, Ms. Kathy Barry, Mr. Jim Blackler, Ms. Belia Brandow, Mr. Philip Burge, Ms. Catherine Cleary, Mr. Bill Cooney, Dr. Dorothy Cotton, Dr. Simon Davidson, Dr. Nick Delva, Mr. Henry DeSouza, Mr. Dwight Druick, Ms. Cathy Dunne, Mr. Bill Dwyer, Ms. Della Faulkner, Mr. Peter Finkle, Ms. Sybil Foley, Mr. Ken Fuller, Dr. Nathalie Garcin, Dr. Charles Gardner, Mr. Rick Gajnorio, Mr. Gerry Gregory, Mrs. Wilma Guest, Ms. Margot Hamblen, Ms. Alia Hogben, Dr. Jane Howard, Ms. Vicky Huehn, Ms. Sheila Irvine, Mr. Craig Jones, Ms. Donna Joyce, Ms. Sandra Lawn, Dr. Ken LeClair, Ms. Lori-Ann Leggett, Dr. John Leverette, Mr. Ken Macdonald, Ms. Joanne Maltby, Mr. Ray Marshall, Mr. Alan Mathany, Ms. Ruth McCullouch, Ms. Betty Ann McGrath, Mr. Matt Melinyshyn, Mr. Bob Napier, Dr. Kola Oyewumi, Mr. Rocci Pagnello, Ms. Sheryl Pedersen, Ms. Linda Peever, Mr. Mike Piercy, Mr. Mike Poulin, Ms. Jackie Redmond, Mr. Bill Reinhart, Mr. Paul Rosenbaum, Mrs. Katie Rutledge, Ms. Sandra Schentag, Ms. Janine Schweitzer, Ms. Nancy Sears, Ms. Colleen Small, Dr. Heather Stuart, Ms. Eleanor Suboski, Mr. Chris Sullivan, Mr. Dennis Timbrell, Ms. Carol Wannamaker, Dr. Brenda Wattie, Mr. Jeff Wing, Ms. Nadia Zurba, Dr. Kumiko Ando

Regrets: Ms. Joanne Trew, Ms. Maryanne Takala, Ms. Debbie Hoefler, Ms. Shauna Kingstone, Dr. Terry Krupa, Suzanne Brant, Mr. Lloyd MacDonald, Dr. Rob Malone, Mr. Michael Park, Ms. Hersh Sehdev, Dr. David Simourd, Mr. Wolf Tausendfreund, Mr. Ingo Ritums

Absent: Mr. Colin Slack, Mr. John Puxty, Ms. Marilyn Nicholson, Mr. Rick Williams

1. Call to Order:

Sandra Lawn, Chair, SEO MHITF

2. Welcome and Introductions

Sandra Lawn welcomed everyone, particularly people new to the work of the Task Force and special observer from Japan, Dr. Kumiko Ando.

3. **Opening Address**

Sandra Lawn, Chair, SEO MHITF – Please refer to presentation notes circulated.

4. **Committee Progress Reports:**

- **Research Committee Interim Progress Report:** presented by Chuck Gardner. Please refer to presentation handouts. There were no questions.

- **Integration Committee Interim Report:** presented by Chris Sullivan and Nathalie Garcin. Please refer to presentation handouts.

Question: Concerning the Interim Report of March 15, 2002 and the Final Report of April 30, 2002, is your plan to consult on the Interim Report?

Answer: The Interim Report will be reviewed by all of the various committees and consultations would take place after that. One of the questions we are asking you to think about is how some of the ideas in the system redesign, etc. need to be presented to the public. So we are looking for your input. There will be consultations and they will be meaningful – the process is not yet set in stone.

- **First Line Working Group Interim Progress Report:** presented by Belia Brandow. Please refer to presentation handouts.

Question: A comment was made regarding how the reports given so far seem to miss the concept of “Inreach” –

Answer: That is a very good point in that it does highlight the work that the Champion groups will have to do this afternoon. For example, when the forensic champions meet and consider the various questions, that will be the perfect place to emphasize the concept of “Inreach”.

Comments:

- In the new revised system design, we did put “Inreach” in.
- “Inreach” came up at the Intensive Working Group meeting as well, and we are adding it to all of our documents.

- **Intensive Working Group Interim Progress Report:** presented by Sheryl Pederson. Please refer to presentation handouts.

Question: I was wondering how you would be examining the current system, referring to your goal #4 in your presentation?

Answer: That is a work in progress. We gather information as it comes to us through presentations. We need to develop a more formalized way of gathering information. A big piece of what we will be looking at is the Community

Comprehensive Assessment Project and that will give us a detailed inventory of what is out there. So now we are developing a dream system and will be matching that to the current system and comparing the two.

- **Specialized Working Group Interim Progress Report:** presented by Ken LeClair. Please refer to presentation handouts. There were no questions.
- **Human Resources Committee Interim Progress Report:** presented by Jackie Redmond and Vicky Huehn. Please refer to presentation handouts.
 - Question:** Are you including family initiatives in the planning for human resources?
 - Answer:** Yes we are trying to make sure we have all of the specialty areas involved as well.
 - Question:** Do you have a strategy that includes and embraces family practitioners?
 - Answer:** Yes that issue has definitely come up.
 - Question:** A question about the determination of core competencies for professional groups? Is that a necessary task considering most of them have colleges who would determine that type of thing? Would it be duplication?
 - Answer:** Yes, there are the colleges but we are trying to go past what the norm is now and ask what other [competencies] are needed that are not happening? We also need to look at what else out there is working really well, that we need to be aware of in mental health.
 - Question:** Is there any discussion about what the job satisfaction is in relation to making our work generic rather than specialty?
 - Answer:** We have examined how we will retain people and how we will attract them to the field. We have looked at it in terms of management styles, job satisfaction, and further education.
 - Question:** My question goes back to core competencies – and how can we tell professional colleges what core competencies they require?
 - Answer:** We are not talking about requirements. It is beyond our scope to tell the College of Physicians or Nurses what their requirements should be. We are looking at qualification and how to ensure that people working in the field of mental health have certain qualifications and that they have an opportunity to improve those qualifications as they work – through the work place.
 - Question:** Given the comment that everyone has to buy in, has there been any consideration to involving staff associations or labour along the way?
 - Answer:** Yes, we have talked about that in terms of organizing those meetings with the human resources managers.

Question: Along those same lines, the labour adjustment agreements and the restructuring of the hospital sector were fundamental to resolving some of those problems, so that people had a chance to participate. Is a recommendation along those lines going to come out of this? I don't know where it might be applicable, perhaps in Prince Edward and Hastings? For instance, labour adjustments so that people can move to a new employer should there be a new employer, with ease.

Answer: In terms of the collective agreement? We haven't gone that far here in our case. We are waiting for information that we can go ahead.

Comment:

- There is a model you might want to check on. Many agreements were negotiated and signed across the province.
- The specifics would come out of the Task Force in terms of what they were going to decide on. We were just trying to provide some guidelines.

Question: It is probably an issue of where we bring this up within the mental health implementation task force. It may be as we begin to define core functions that are important across the system – they need to be transmitted into core competencies which then spin out as far as your human resources frameworks. That probably will help us. It doesn't look at qualifications but at the function of qualifications. The question I had is, and I am not sure whether this rests with your committee or with the research committee, are you tackling the issue of the process of evaluation so that we can be sure that core competencies are made a part of the human resources framework?

Answer: We were hoping that we could look at this with the human resources managers.

Question: There are studies that have been done at the University of Ottawa on core competencies. Have you included that in your deliberations?

Answer: No but we will check that out

Question: Once the core competencies are there and defined, the issue of recruitment is a critical one. Competency based interviews and competency based recruitment deals with the how. The person may have the technical knowledge and the skills but how do they deliver the service? It requires the organization to redo their thinking in terms of how they recruit their professionals.

Answer: In terms of core competency, the issue of recruitment, interviewing and tracking people's jobs takes on a whole different flavour. Hopefully that is where we will be able to tap into the human resources managers or community, the people who are already doing that.

- **Community Committee Interim Progress Report:** presented by Alan Mathany. Please refer to presentation handouts.
 - Question:** What are the outside parameters of these three elements: public education, prevention, and community awareness? Do those three elements refer particularly to mental illness or do you take a broader slice of this and addressed mental health promotion as well?
 - Answer:** Primarily we started out with the focus on seriously mentally ill, however, in our discussions everybody realized that we had to take it beyond that, so we have asked Dr. Stuart for a fairly broad range of information to analyze. We talked about prevention, [children and] youth and how important it is to get into the high schools and particularly the younger grades and have presentations on mental health, mental illness and as much as possible to reduce the stigma related to mental illness. Definitely we have broadened those discussions and I don't know where we stop!
 - Question:** As a practitioner in community health with a background in prevention, what is really known about prevention in terms of mental health?
 - Answer:** There is a lot more information out there than the committee is accessing and analyzing
 - Comment:**
 - There is not as much information in mental health as in other areas. There is some good work underway right now at the international level involving twenty countries working on things like stigma. There has been some work done through the Panamerican Health Organization on prevention and promotion, things that you would understand in terms of healthy public policy, that level of prevention.
 - There is more to prevention in psychiatry than we think about, as we see in prevention at the primary level and secondary level. Looking at thing like: the treatment of syphilis, depression in adults, and drinking associated with unplanned pregnancies
 - There is an awful lot of information and we hear the word information overload. Actually we take the information, turning it into knowledge, and take that knowledge and turning it into wisdom.
- **Wrap-up**
 - **Introduction:** Sandra Lawn introduced Cathy Cleary, the new executive assistant to the SEO Mental Health Implementation Task Force and thanked her for her assistance with coordinating the Grand Summit.
 - **Brian's Law Binders** – Sandra invited everyone to take a copy of the Brian's Law Binders located on the display table in front.
 - **Champion Groups** – Sandra invited everyone to regroup into their champion groups, for fifteen minutes before lunch is served, so that the transition after the lunch break is smooth and timely. Champion chairs were asked to brief their groups on vignettes for the afternoon presentation.

5. Lunch: was served in the Donald Gordon Centre dining room

6. Champion Groups:

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
Vignette	• 15 year old male • Dysfunctional family • Parenting problems • His father – severe mood disorder • He is ++ bright • Refuses to attend school • Outstanding break and enter charges against him • Presenting problem: alleged physical abuse by father • Depressed and suicidal Systems involved: • Transition to adult • MCSS • MOHLTC • Education (psychoed)	• Gerry is 35 yrs. old , in a small town, recently divorced, unemployed, 2 children • Depression and alcohol dependence. • Dealing with homelessness, lack of financial support, isolation, past regular user of services, untreated, noncompliant and suicidal	• Single Mom just moved to Gananoque, no car, no family, can't get a family doctor, • Working p-time, no benefits, three children – one with chronic health problems • History of depression, • Personal history of child abuse & spousal abuse • Substance abuse with ativan and alcohol • Suicidal	• Young adult – 18 to 21yrs old • Developmental disability, depressed and acting out sexually • Question about family integrity • Attempting to get into developmental services system. Trying to access residential support • Transition from school to residential. • Developmental services having difficulty dealing with his challenging behaviours and mental health	• We have learned about mental illness in a very different way - by living it! • We are not adversaries, we are advocates • We are not going to describe a vignette as we have each lived a situation where the system has failed the consumer and the family through a lack of understanding, stigma, and a lack of knowledge about where to turn

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
	• Legal system • Child welfare • Police			issues.	• Please refer to the minutes from the family meeting from October that were included in your package – As far as we are concerned – this describes what we would like to see and the rational for it
Desirable Outcomes	• Case manager – look at suicidality, crisis response • He needs housing, supervision and a place to stay • Needs a court assessment • Plan for longer term care – CAS investigation, school reentry, alternative schooling, transition to adult services • Treatment for father • Early identification	• Improved quality of life • Improved mental/physical health, and symptom reduction • Reduction in alcohol usage and associated risk behaviours • Employability increases • He acquires a social network and housing	• Access to talk therapy • Access to family doctor linked to psychiatrist • Ongoing support for decreasing addiction eg. AA • Daycare for children and parental relief • Peer support and ongoing encouragement • 24 hour helpline for problems with	• Quality of Life • Access to education and/or transition planning to adult life (vocational supports) • Control of behaviours that are causing problems • Treatment for depression • Ongoing health and psychiatric monitoring • Quality of life	• Education is the very key to an effective system in the broadest sense where the public is educated to overcome the stigma, the personal to question the symptoms, and the professional to understand the symptoms. • Access – having access is

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
	system based on his father's illness – and that the family would be high risk for subsequent services	access	children • Income support - while she gets training and then can return to work full time • Need for recreation • Good quality of life	indicators: housing, independent living, appropriate supports, meaningful activities, connected to family and friends • These supports need to be achieved locally • Individualized focussed plan	important • We as families want to be partners from beginning to end
Components of reformed system	Case manager with a protocol to identify all ministerial issues.	• Accessible and Coordinated treatment and support	• Easy access to system • Available family doctors linked to mental health services	• Collaboration between all aspects of the system – mental health, justice, education, MOHLTC, MCSS • Single point access/entry	
Components of reformed system -	• Adequate, integrated and shared resources • Local governance system that promotes the above two issues	• comprehensive assessment • Services coordinator to look at housing,	• Advocate to be sure all of her needs are met • Education and training that are	• Comprehensive assessment and care plan development with client and one	

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
continued	• Community development, wrap around, kinship care • Professionals working collaboratively throughout all ministries	employment / education, social, recreational, and financial issues. • Integrated treatment: medical, psychiatry, addiction, crisis/detox •	supportive and that accommodate her needs. • Good links to child services and income support • Transportation • Long term talk therapy	primary case manager (key player) • Mobile crisis capacity, mobile consultation and outreach • Housing and supervision • Health promotion and prevention • Behaviour management in the community • Collaboration between systems	
Strengths in current committee/ working group plans	• Chair of Task Force is a c & y champion • Committee reps with a child view • We bring a systemic view to the Task Force • Pushing beyond the mandate of SMI • Passionate and conscientious representation for child and youth	• Best practice focus on concurrent disorders , and specialty populations • Inventory presently being done with CCAP – to identify gaps.	• Assurance that there will be easy access to resources and services • Continuity of care • Early identification and prevention • Accountability	• Working groups- a great strength • Commitment of participants • Continuum of services very important • Collaboration also very important • System needs to be locally driven • Research done on Best practices • Increased	• We are glad to see that the Task Force is on track. The reports are wonderful and have detailed things very, very well • We are anxious to see what the outcome will be – what will be the fruit of our labours?

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
				accountability for existing services • Integrated services • HR keeps tabs on staffing • Health promotion • Evaluation planning	
Elements still needing to be addressed	• Funding for child/youth services even lower than for adults – need for \$ • Inter-ministerial integration is fundamental to the care of youngsters • Shared care with primary practitioners – make the process for child mental health user friendly to family doctors • Preventative medicine should focus on children • Health promotion, wellness strategy and focus is a \$\$\$ commitment • Develop a province	• Cross training on every level of the system - mental health and addictions • Restrictive timelines limit the depth of the process	• What does this accountability mean and who are we accountable to • Are these changes we are making in the best interest of the consumer – who will monitor that? • Education and vocational supports geared to people with mental illness • Standard of care not the same in different localities	• Dollars \$ • Need for concrete plans and actions – we are talking at a very abstract level still – we need concrete examples of how between the various ministries (MOHLTC, MCSS, TPA's) and organization we can make this work • Evaluation strategy to be sure we look at what is going on and get feedback to be sure we are heading in the right direction • Attitude of caregivers –	• SMI family members need to be able to achieve their very best potential • What about those not defined as SMI? • It could be said that the emphasis on SMI misses the whole point of education and prevention – that is just a thought • Family education regarding mental illness is essential thereby diminishing the possibility that family members

	Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
	wide strategy for child and youth mental health and mental illness – we need high level representation			receptive to work and this specialized service - referring to HR	themselves will become consumers.
Other items to highlight	• None discussed	• None discussed	• Remember to carry the ideas from these proceedings to your committee work	• Historical relationship between people with developmental handicap and mental health system needs to be expanded on. This population has gone back and forth between the ministries	• None discussed

Children and Youth	Concurrent	Consumer	Dual Diagnosis	Family
			• Acquired Brain Injury – where does it fit? • DHC proposal that relates directly to this proposal – we will speak to the next Task Force meeting on this issue. • Concern about the governing body in the Brockville area for psychiatric services – there is a dialogue between ACTT and the Royal Ottawa hospital. We would like to see this fast tracked. You need to know who you are talking to. • The closure of BPH should take a leave from this exercise rather than the other way around thus responding to some time frame pressure.	

	General Public	Seniors	Seriously Mentally Ill	Forensic
Vignette	September 11th – Public Traumatization	- Mrs. J is 78 yrs. old - Married for 40 years - Husband died one month ago - Living in community - Hx of mild depression - Family states memory changes past 2 yrs. - History of arthritis, congestive heart failure, hypertension, scotch at bedtime - Presenting problem: Daughter finds Mother withdrawn, wishes she died with her husband Daughter is bewildered SIX YEARS LATER: - Mrs. J admitted to LTC facility one month ago	- Young man – late teens, potential SMI, living with his mother - Mother calls police after son has assaulted her - First episode - Brand new to the system - Failing at school, socially withdrawn, violent outbursts, dramatic personality change recently - Experimenting with substance abuse - Paranoid	- John is Canadian born 37 yrs. old, single white male, homeless with no known relatives in town - History of numerous psychiatric admissions, 6 in past 18 months - First admission at 22, last one 3 months previous - Dx. Schizophrenia, APD, substance dependence - RX. Antipsychotic/discontinued after last admission / side effects - Charge: food by fraud, ACBH (victim seriously hurt – bystander) - Crim. Record: B&E x 2, ACBH x 4, Exhibiting x 1. Two previous inpatient forensic assess. for Fitness. 30 months (federal time) - Symptoms: disheveled, unkept, malnourished, unresponsive, talks to self re 9/11 and Nichodemus prediction of end of world. Offers self as saviour through “megalactic transpersonal fusion”. - Court order: psych forensic assessment for fitness / Finding: Unfit

	General Public	Seniors	Seriously Mentally Ill	Forensic
		month ago - Initially agitated but has settled - Last 5 days- hitting out at staff, suspicious, barricaded herself in her room, sexually aggressive, exhausted		assessment for fitness / Finding: Unfit - Effect: hospitalization for 6 months, ordered back to court by ORB - Court decision: NCRMD / Effect: Indefinite hospitalization under ORB jurisdiction - Concerns: ORB hearings; adversary contentiousness among legal advisors; psychiatrists batching by patient's legal counsel; ORB Chair responsive to legal needs, unresponsive to personnel/system needs; hearings scheduled for following periods; overlegalization of mental health system; risk assessments - Final Outcome: Discharge after 3 years – improved. Spotty follow-up; homelessness; further clinical relapses; inaccessible gmhs; further criminality; back to court – new order for a Fitness Assessment. Found hanging in his cell while awaiting available bed at forensic unit – R.I.P.

	General Public	Seniors	Seriously Mentally Ill	Forensic
Desirable Outcomes	• Alleviation of post traumatic stress including symptoms of anxiety, sleep disturbance, increased substance abuse, depression, worsening of existing conditions, absenteeism • Heightened awareness and understanding • Mutually supportive social environment • Key practitioners on the alert	• Grief identified and appropriately resolved • Comprehensive health assessment • Individual able to access and understand the system • Address needs of individual and family • Strategies to enable her to stay where she is – at home SIX YEARS LATER: • A care/treatment plan that addresses the behavioral problems in the least restrictive fashion so the person is able to stay in place • Also phase one outcomes are also applicable (see above)	• Individualized and timely assessment (physical, psychiatric, social) • Information and family support • Recommended immediate care plan – providing recommendations based on the care plan – not too much or too little in the care plan • Immediate access to services to respond to immediate needs • Develop plan of care for the future – ongoing plan of care	• A better integrated MHS-forensic a subsystem • Police diversion • Court diversion • Community Ambulatory Forensic Psychiatric Clinic • Forensic-Probation/parole interaction • Step-down capacity (priority protected beds) • Easier communications and transfers between gmhs and forensic; accessibility of ACTT • Ghettos and the shirking off program/system responsibilities • Patient first??
Components of reform	• Communication / psychosocial response plan i.e. brochures, web-	• Primary / medical care more knowledgeable . All workforce informed	• Informed police response - where police make informed decisions and are able to access mental	

	General Public	Seniors	Seriously Mentally Ill	Forensic
d system	sites, info pack. to target populations	as to what resources are available –	health system easily in order to make good decisions in crisis	
Components of reformed system - continued	• Training in post traumatic stress – stress reduction in various populations for health and education • Team responsible for organization, evaluation and renewal of such a plan (preparedness)	• Knowledgeable public and communication system –public awareness of early signs of depression & cognitive disorders, • Integration and coordination between medical - mental health • A continuum of service • Clearly defined roles for all staff • Need for community support, volunteers and identified case management. • Crisis intervention • Available multi-disciplinary teams • Protocols for shared expertise • Single access points / common	• Crisis response 24/7 linked to the rest of mental health services as well as to other sectors which we need to work with. Also, as described in the logic model, there should be a link to first line services, intensive services and specialty services.	

	General Public	Seniors	Seriously Mentally Ill	Forensic
		/ common assessment practice • Skill set / training for core competencies		
Strengths in current committee/ working group plans	• We will have evidence based best practices – at least one jurisdiction has already put a plan in place after the Ice Storm • Public education and awareness	• Defining of core competencies to be available across the system • Workplace elements are in place	• The required services are articulated in the logic model • Willingness to make the system better • We have not strayed from the vision of mental health reform • Families are included in every step of the way – in the plan	
Elements still needing to be addressed	• Who will be responsible for implementing and monitoring the plan • Where would the general public go for counseling • Continued development and coordination of crisis response	• Issues of primary care – GP's having the knowledge, interest and configuration • Funding formulas to address this population • Medical / mental health interface – re: could it be the cardiac or respiratory	• A mechanism to increase / decrease / start / end treatment and support as appropriate • A mechanism to continually apply best practice to update practice • A mechanism to ensure	• We in forensics have succeeded in grabbing more and more territory because the mental health system has failed • Integrated health care systems • Less fear around issues of forensic psychiatry

	General Public	Seniors	Seriously Mentally Ill	Forensic
	teams already in existence • How to deal with thousands of traumatized people	drugs causing the cognitive dysfunction? • Education of the public	services and supports are coordinated, accessible and responsive to client and family needs. Are services coordinated and integrated? • Recommendations for action need to be made	
Elements still needing to be addressed-continued	• Debriefing techniques and approaches need to be developed		• We need to articulate change • Increase integration of services • When the system is defined we need to educate the community at large • Need to maintain the focus on SMI as a priority population – they are not good at accessing services	
Other items to highlight	• None Discussed	• None discussed	• None discussed	• None discussed

7. Words of Encouragement: adapted from the Haudinasuane
presented by Sandra Lawn, Chair, SEO MHITF

- We have done our best today – each and every one of us.
- If we have left something out or if there are some who have other needs that were not met, let them send their voices to the Creator in their own ways. (And let them pay very close attention to the tickets out the door – so that you may make any points that you feel may have been missed).
- Let us feel we have gone as far as possible to fulfil our responsibility today.
- Now, our minds are one.
- Is there anyone here who does not agree?
- Then we are agreed.

8. Meeting is adjourned.

Original Signed

Sandra Lawn, Chair
Southeastern Ontario District
Mental Health Implementation Task Force

Original Signed

Catherine Cleary, Executive Asst.
Southeastern Ontario District
Mental Health Implementation Task Force

Appendix One: Tickets out the Door – Results

1) What was the best idea of the day?

- Opportunity to see what other groups are doing and see similarities – to see the complete picture (needs to happen again) – 7 responses
- Integration of mental health and other inter-ministerial services – 4 responses
- First line working group to expand beyond SMI group – 3 responses
- Single point of entry – 3 responses
- Single point of entry – 3 responses
- Accountability – 2 responses
- The grounding question – 2 responses
- Promoting education and prevention – as a means of decreasing the need for SMI services – 2 responses
- Child and Youth Mental Health panel / Province wide strategy for child/youth mental health and mental illness
- Setting up meetings with educators, HR managers, consumers, families
- Importance of “Inreach”
- “If there were no gaps we would never see the light”
- Clients come first
- The importance of life span
- Need for more \$
- Need for concrete action
- Local services for clients
- Individualized plan of action by one key player (case manager)
- Need for specific HR strategies – recruitment, retention, remuneration, key competencies
- Sensitivity to other health care providers – family physicians, health needs
- “The best way to predict the future is to create it.”
- Generic model for specialty services
- Planning on native principles
- Planning on recovery
- No idea stood out as better than any others
- Right services – right time – right place for the right reason

2) Effective community consultations would include:

- General public – with a specific and open forums for comment – 10 responses

- Consumers and consumer groups - 8 responses
- Affected agencies (employers, managers, and staff) - 7 responses
- Public presentation of the draft product and feedback - 3 responses
- Longer timeline - to be inclusive and allow for discussion - 3 responses
- Family - 3 responses
- Media - 2 responses
- Community groups not just from mental health services - 2 responses
- Comprehensive education within the public schools continuing throughout university - 2 responses
- General practitioners - 2 responses
- Total information sharing among all people concerned - 2 responses
- Strong connection between front line and specialized
- Complex case studies and integration to other services
- Explanations of who does what
- Acquired brain injury groups
- Only written responses from professionals / oral responses from family/consumers. At this point committee work would end.
- Allow written responses from others to allow for non-public input
- Peer support groups
- Less bureaucratic / professional language
- All geographic locations
- Presentations to coalitions, professional groups, staff groups
- Seniors
- Teachers
- Medical staff at hospitals
- Survey consumers who have used the system successfully and unsuccessfully
- Police / courts
- Effective use of direction
- Description of end state of mental health system after reform implementation
- Implementation steps and appropriate time table.

3) The next step should be:

- A draft model / making recommendations and ensuring MOH follow through / developing a concrete product / plan of action / getting the necessary work done - detailed planning and decision making - 15 responses
- Community consultation and consumer feedback and family feedback - 4 responses
- Report to members and input back on report - 2 responses
- Reassess the emphasis on SMI - 2 responses
- Sharing of current working group recommendations and committee information - 2 responses

- To not simply say something is outside of our mandate or control
- Simplified set of recommendations
- Clarify mandate, outcome and evaluate progress
- Connections with Champlain district
- Meeting of the chairs of the committees to integrate committee work, stay focussed / on task
- Coordination of this complex system
- Establish timelines and keep moving forward
- Inventory of current regional services
- Results from research committee to other committees
- Detailed info regarding existing services to all committees
- Synopsis of approved reinvestment plan to all working groups

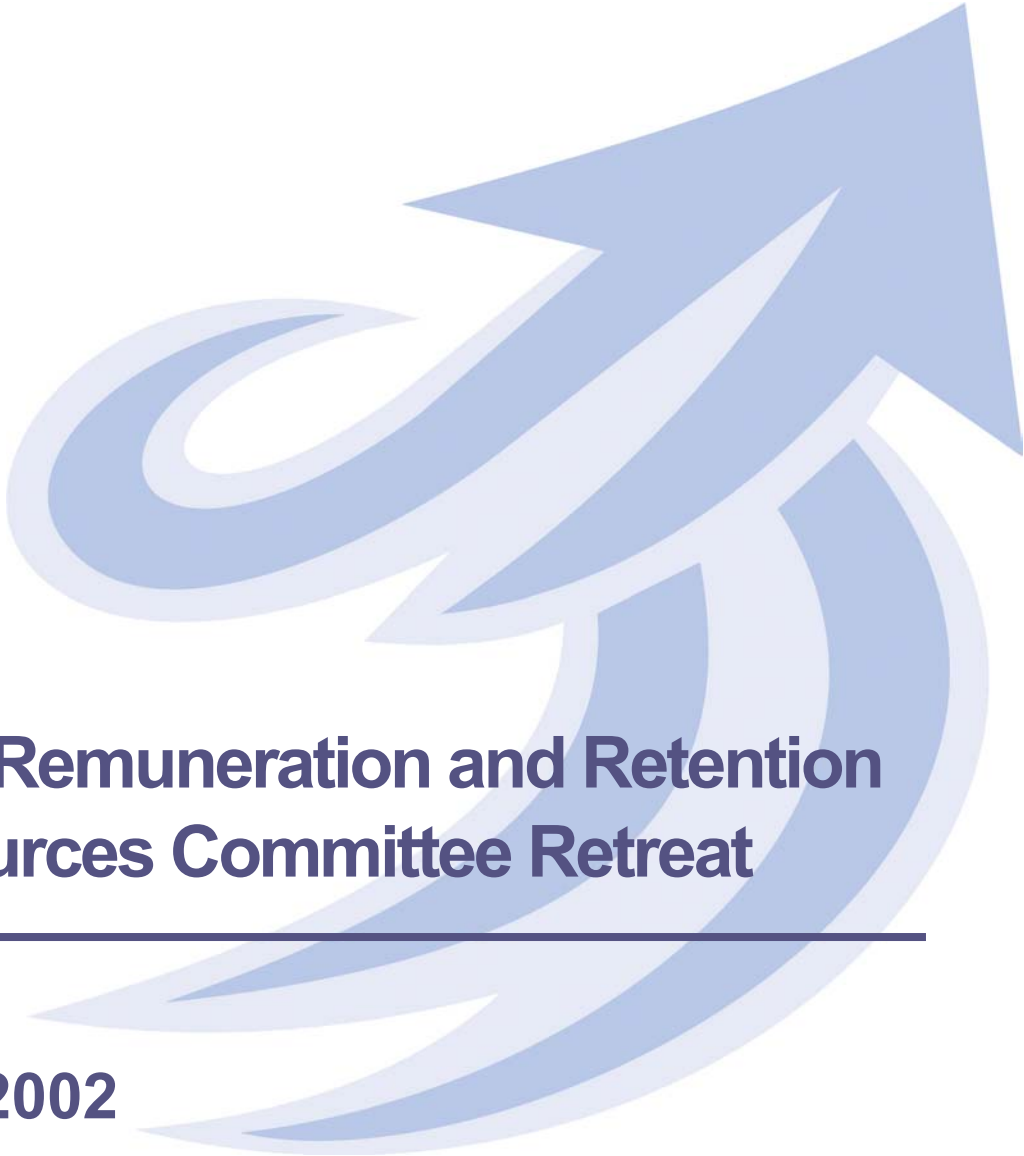
4) I require more information on:

- Other Task Force models of accountability and governance - 2 responses
- Logic model and its application in system design - 2 responses
- Resources for counseling the moderately mental ill
- Best Practices - would appreciate a more global approach
- What is not negotiable? How does the MOHLTC see the right outcome design?
- How other regions planning will predetermine decisions?
- What is currently working in this area? Innovative programs and approaches
- How streamlined access will occur?
- How will our recommendations be reviewed by the MOHLTC? Will they actually be implemented?
- Info re existing services
- Results of strategic reinvestment plans from all counties
- Assurance that recommendations are within the provincial standards and governance structures.
- Why concurrent disorders are not highlighted in each group - First line, Intensive and community committee seem to miss the linkages between mental health and addictions
- How do we measure accountability without killing direct service time?
- Specific plans and decisions being made by MOHLTC, MCSS, agencies,

Other comments / questions / ideas:

- Great day! - 4 responses
- Vignettes helped to ground us - 2 responses
- Concerned that the time allowed might be too short to get all of the work done - we need to make good decisions that will not get shelved. Example - Housing study has questionable results due to timelines - 2 responses

- The grounding question- misses the whole point of education and prevention
- Limited to SMI - what about the idea of 'regardless of severity'? Needs to be revisited - what do we want outside the traditional boxes?
- Is there a political will to overcome organizational self-interest?
- Presentation graphics were excellent - overheads superimposed
- Can we create a graphic of projected new system for community education/
- Need more time for group work - too strictly adhering to time lines
- Where is education in the discussion?
- Need to work more closely with Champlain district
- Smaller agencies are feeling the distress of numerous meetings and special projects
- Move away from so much emphasis on literature and onto practicalities
- Further collaboration between ministries
- Another day like this would be useful when recommendations are formulated
- Who addresses those in agitated or psychotic states that don't get taken to emergency or hospital? Also those who are non-compliant?
- Case management for MH is not different from existing case management - It simply needs more attention and recognition
- Appreciate the willingness of people to work together as one
- Can we implement these ideas or will it become just talk?
- What about the moderately mentally ill?
- Quality (not mentioned very much) balanced with access - quality is a function, in part, of critical mass and coherence

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Recruitment, Remuneration and Retention Human Resources Committee Retreat

February 12, 2002



Recruitment, Retention, Remuneration In a reformed mental health system

Proceedings of the Human Resources Retreat

February 12, 2002

9:00am – 12:00pm

St. Mark's Lutheran Church

263 Victoria Street

Kingston, Ontario

Present: Kathy Barry, MOHLTC – Kingston; Sandra Carlton, Providence Continuing Care Centre – Kingston; Gerry Gregory, Detox Centre – HDH - Kingston; Sandra Lawn, MHITF – Prescott; Wayne Barnett, MOHLTC – Kingston; Alan Mathany, Community Mental Health – Napanee; Belia Brandow, Leeds & Grenville Rehab. & Counselling Serv. – Brockville; Constance Couch, Ongwanada – Kingston; Dwight Druick, L & A CMH - Napanee; Jackie Redmond, Access Centre for HPE - Belleville; Kingston; Roque Sager, Quinte & Region Community Homes - Belleville; Sheila Irvine, Brockville Psychiatric Hospital – Brockville; Colleen Small, KGH, HDH - Kingston; Susan Cross, Options for Change – Kingston; Donna Joyce, Community Mental Health – Napanee; Sandra Carlton, PCCC – Kingston; Mary Beth McMahon, KGH – Kingston; Bob Seaby, Ongwanada – Kingston; Robin Holland, Westgate Lodge – Belleville; Barbara Howard, Westgate Lodge – Belleville; Vicky Huehn, Frontenac Community Mental Health Services – Kingston; Roque Lefebvre, MOH&LTC – Ottawa; Wendy McCoy, Caressant Care – Marmora; Linda Merkley, Caressant Care – Marmora; Gail Poirier, St. Lawrence College – Kingston; Ingrid Headrick, St. Lawrence College – Kingston; Sheldon Feener, Salvation Army – Kingston; Della Faulkner, HR Planner – Kingston; Jennifer Wood, Frontenac Community Mental Health Services – Kingston; Cathy Cleary, MHITF – Kingston; Trina McGarvie, KGH – Kingston; Stafford Murphy, L & A Addiction Services – Napanee; Louise Thompson, Sexual Assault Crisis Centre – Kingston; Jo Lu, Hastings Manor – Belleville; Cathy West, Youth Abilitation – Belleville.

Regrets: Dianna O'Connor, Queen's University – Kingston, Carole Nelson, PSOK – Kingston; Linda Peever, PCCC-MHS – Kingston; Terry Krupa, Queen's University – Kingston; Kim Charlebois, Sexual Assault Crisis Centre for Quinte District – Belleville; Joan Bennett, Sherwood Park Manor – Brockville; Janice Wilkes, Versa Care Hallowell House – Picton; Eleanor Suboski, HR Committee Member – Kingston; Jane Banbury, MHITF – Kingston; Mike Caitlin, OPSEU President – Kingston; Doug Chinnery, St. Mary's of the Lake Hospital Employees Union Local 3001 – Kingston; Sally Wills, Child & Youth Wellness Centre - Brockville; Joanne Maltby, Pathways for Children – Kingston; Jeff McMullen,



Southeastern Ontario District Mental Health Implementation Task Force

Distress Centre; Brenda Wattie, HR Committee Member – Kingston; Dianne Hoskin, HR Committee member – Trenton; Jackie Evans, Crisis Intervention Centre; Lynn Spense, Sexual Assault Crisis Centre – Kingston.

□ Several others were invited but unable to respond.

1. **Welcome and Introductions** – Jackie Redmond, Chair, Human Resources Committee, SEO MHITF.
 - Jackie welcomed everyone and thanked Vicky Huehn and Debbie Hoeffler for their hard work.
 - Jackie pointed out how the Task Force realized that in order to have a reformed mental health system, we need a human resources plan, looking at issues of recruitment, retention and remuneration. The HR committee was created to do this.
 - Those in the field were invited here today to give input and direction, which will be used to form the final recommendations to the Task Force.
 - A reminder was given to hand in your Ticket out the Door, to assist in evaluating the Retreat today.
2. **Presentation: Overview of Southeastern Ontario District Mental Health Implementation Task Force** – Sandra Lawn, Chair, SEO MHITF
 - Sandra gave a presentation outlining the structure, vision, and goals of the Task Force both in our district and across the province. See presentation notes attached.
3. **Presentation: Recruitment, Retention, Remuneration – Collaborative Approaches** – Dr. Sandy Cotton, Queen's University – Please see handout circulated at the meeting.
 - Introduction by Vicky Huehn.
 - Sandy spoke to the group about the importance of using a collaborative process when working towards a reformed mental health care system.
 - Sandy used a number of group activities to help the group see the importance of teamwork and the need to see and incorporate new ideas. Also the ability to work through conflict as a positive method of resolution and growth.
 - Sandy asked three specific questions and everyone was asked to respond on green, orange and white cards. The responses are summarized in Appendix A at the end of the proceedings.
 - He used the model of an iceberg when describing how groups work. You can only see 10% of an iceberg – the rest is out of sight – the shared values, mind sets, sense of direction, etc. It is the same with organizations. We need to be aware and sensitive to this.
 - Using geese, as a metaphor, he explained how geese are productive in their group work.



- Sandy mentioned the book “Building the Emotional Intelligence of Groups” as being an excellent resource.

4. **Break**

5. **Small Group Discussions and Plenary:** The group was broken into three smaller groups. Each group was directed to discuss either retention, recruitment or remuneration. A synopsis of those discussions follow:

Group A – Recruitment

- Pros – need to look at job sharing, flexibility, the process of student placements and the hiring of those students afterward.
- Barriers – within nursing – there is a perception that mental health nursing is not real nursing work.
- Remuneration – there needs to be pay equity in nursing, both in the institutions and within the community.
- Retention –look at marketing retention – Prove how valued your current employees are and that will increase both recruitment and retention.
- Marketing strategies and advocacy are essential for human resources within the mental health system in the community – How to get new people and current employees on board.
- The general public needs to know about mental health in order to get on board.
- Marketing is essential – market your agency and what you have to offer – intangible benefits, perks of your agency, etc.
- Make sure that the information that we put together today does not get lost. Perhaps we need a report card of sorts for tracking progress.
- Distribute this report card to those who hold the purse strings – to show progress and accountability.
- Sharing of techniques that the various organizations and agencies currently use.

Group B – Retention

- Retention starts with recruitment.
- Community mental health organizations do not have retention problems – people often stay a long time – how do you keep them motivated, interested, growing – how to manage absenteeism, leaves, etc.
- There is not always the funding to keep abreast of technology and innovations. User friendly knowledge management is an effective tool.
- Students placements, peer support, job shadowing, mentorship, secondments and temporary assignments help provide variety in people’s work.



- Employee wellness initiatives, career advancement opportunities, encouraging creativity, and flexibility are critical to retention
- Turn over of employees is an issue. People are very mobile – they may commit 5-7 years and then move on. Organizations need to value portability, and people need to be able to easily move between agencies.
- Barriers – there is a lack of connectivity between agencies – if we can keep people in the community we can keep them working together through the various agencies – their experience and knowledge will add to each agency they are employed by.
- Educational support is essential to retention of employees.
- Value all staff regardless of differences within the person, organization or community. Use of Recognition and Reward.
- Strained resources with competing priorities can be a barrier to retention.
- Part time work can make retention of people difficult. Organizations need to respond to this issue.
- What is unique to the agencies in our community regarding mental health services?
- Look at retention through the eyes of recruitment.

Group C – Remuneration

- What is working in the region? – there is a need for more funding focused on the community sector. Funding for specific items seems to be the current practice. (eg. housing)
- Barriers - pay scale inequities between agencies and organizations.
 - issues of union vs. non union
- Some agencies get increased funding and others do not.
- Look at remuneration as an aspect of recruitment and retention – we are not able to attract those we want with the salary we are able to provide. Employees may want to stay but the difference in salary will take them elsewhere.
- Difference between compensation for nurses in institutions and within the community.
- ACTT teams – they have some flexibility as to how funding is distributed. Different ACTT teams may spend more on salaries for one profession than others.
- Standardization:
 - There is no standardization within the various ministries.
 - We need standardization of job functions, salaries and qualifications.
 - There needs to be standardization between hospitals, institutions and community organizations.



Southeastern Ontario District Mental Health Implementation Task Force

- Model of services need to be systematically applied to the whole province.
- Salaries need to reflect experience, workload and academic credentials.
- Set benchmarks by seeing the region as an entire system – how many social workers do we need? How many addiction counselors? – What do our human resources need to look like within this community?
- Non profit – pay equity was forced upon organizations while budgets remained the same.
- Easy solution with government funding – if there is standardization between agencies then some agencies will need to have their budgets increased in order to cover pay equity.
- Rural areas have different barriers and complications (eg. attracting people).
- There is a problem with doctors billing OHIP for mental health services provided where they maybe not be serving the most needy population – An audit would help to evaluate this situation.
- We need to question funds spent on administration. Perhaps some of this money needs to be funneled into front line work.
- Budget – Agencies are not permitted to ask for what they need but are told what they may operate with.
- Attracting and keeping qualified staff is difficult.

6. **Wrap-up:**

- Jackie Redmond thanked everyone for attending and asked that each person hand in their “Ticket out the Door” evaluation.

Original Signed

Jackie Redmond
Chair, Human Resources Committee
SEO MHITF

Original Signed

Catherine Cleary
Executive Assistant
SEO MHITF



Appendix A – Most Popular Responses

Questions posed by Sandy Cotton and responded to, in writing, by those in attendance on the orange, white and green cards

- 1. What is the purpose of this group? List 1-3 products this group will produce.**
 - A strategy to collaboratively and collectively face the challenges and deal with recruitment, retention, remuneration. (6 responses)
 - Brainstorming and networking - exploration of possible solutions. (6 responses)
 - Providing and ensuring all mental health needs are met. (2 responses)
 - Direction. (2 responses)
 - To give the best service possible. (2 responses)
 - Creative recruitment techniques to attract professionals to work in mental health and keep the good staff we have. (2 responses)
 - Types of retention strategies. (2 responses)
 - Produce recommendations (ie. Remuneration) to send to MOH&LTC. (2 responses)
 - Understand the shared or differing vision/ issues of human resources. (2 responses)
 - Plan of action for achieving cooperation and consensus. (2 responses)
- 2. What do we need as a group to accomplish our purpose?**
 - Freedom to speak, network and brainstorm collaboratively without judgement. (9 responses)
 - Shared resources, less duplication, acknowledge of different methods working with different consumers. (4 responses)
 - Trust, time, commitment, knowledge, desire to change and share. (3 responses)
 - Focussed direction, topics and solutions. (3 responses)
 - Listening and learning from each other. (2 responses)
 - Available resources to change services. (2 responses)
 - Ascertain the needs of Long Term Care are and develop solutions. (2 responses)
 - Being clear about what can accomplish in time allotment. (2 responses)
 - To provide quality mental health service to SEO. (2 responses)
- 3. What are the roadblocks? What will interfere with the production of this group?**
 - Fear / Predestined plan / Lack of Power / Suspicious of group purpose / Competing interests / Lack of Trust (12 responses)
 - Personal situations/challenges and agendas. (5 responses)
 - Failure to collaborate. Unwillingness to change. (5 responses)
 - Sectors not agreeing on standards of practice and not having equal resources. (4 responses)
 - Lack of time is a major problem in all the task force work. (3 responses)
 - Budgets, Government. (2 responses)
 - No right way / All disciplines are valued. (2 responses)



Southeastern Ontario District Mental Health Implementation Task Force

- Lack of Focus. (2 responses)
- Burn out. (2 responses)
- Financial constraints and lack of resources. (2 responses)
- Differing philosophies about human resources. (2 responses)
- Lack of remuneration and recognition (other than monetary). (2 responses)
 - Failure of agencies and personnel to work together. (2 responses)

Ticket out the Door Results

**Human Resources Retreat
February 12, 2002**

1. The best idea related to recruitment was:

- Public awareness to attract – placement students – flexibility – follow-up (6 responses)
- Marketing – political lobby – make agencies attractive to professionals (3 responses)
- Public awareness to alleviate stigma re: mental health issues (2 responses)
- Need to look at SEO – possible Mental Health Job Fair
- Equitable and uniform pay scales within the region/district
- Collaboration and sharing of Ideas
- Using current employees to sell the organization – word of mouth
- Retention should be used as a recruitment techniques – Market mental health, advocate and become more political to get a balance of what we need and what we are providing
- An open, flexible workplace – one that has a reputation for promoting professional growth
- Volunteers/placement as a pool from which to recruit – marketing agency
- Complex issue (Please no “pat” answers)
- Pay attention to 90% of ice burg – attitudes/characteristics/hopefulness
- Collaboratively work together in the S East to design bench marks for all core services required. i.e. ACTT/per population base; crisis service, etc.; housing; identify function required – type of staff needed; standardized job; pay/remunerate the same (some variation needed for under services areas, provide education/professional development- standardize.
- Need for provincial standards.

2. The best idea related to retention was:

- Starts with recruitment – maintain culture as new recruits come onboard. Flexible employees, value portability (8 responses)



Southeastern Ontario District Mental Health Implementation Task Force

- Spend more time, effort, money on staff “Wellness” (3 responses)
- Organizational fit is critical to best recruitment. Realistic job profile prevents turnover. (2 responses)
- Advocate politically for equal pay for community workers. (2 responses)
- The importance of connecting among agencies. (2 responses)
- Recognizing staff - Pay, benefits, emotionally, psychologically, with a valuable culture, training, professional development, health & wellness. (2 responses)
- Retention is based on good recruitment and strong agency support from staff, e.g. staff training, autonomy, support new ideas, program development.
- Starts with recruitment. How do you help long-term employee grow within the agency? View as keeping the employee in the district, rather than in own service.
- Community mental health does not have high turnover – how do you keep them from psychologically leaving you. I.e. how do you manage absenteeism? Ability to offer full time work.

3. The best idea related to remuneration was:

- Consistency around pay scales across agencies, across community and institutional settings. (6 responses)
- Standardization of job. (5 responses)
- Post education.
- Linkage of Mental Health and Addictions.
- Establish benchmarks – go across from the hospitals to the community for relevant/appropriate coverage contributing to quality care.
- Although good salaries are important, wellness programs, benefits, EAP's, staff development opportunities, etc. are equally noted.
- Review of OHIP dollars and how they are being used especially in general practice of physicians – how to divert funds to our sector.
- More political advocated/marketing for community Mental Health workers..
- As a result of fiscal constraints, need to become more creative in what organizations offers - flexible time, flexible benefits, corporate fitness memberships, opportunities for continuous learning, etc.
- Investigate treating Southeastern Ontario as a system – to decrease overlap.
- Fund money to front line work. Inequities exist between mental health sectors and other sectors.
- Becoming more politically inclined- labeling the decision makers and those who hold the purse strings.
- Standardization across ministries re skills, knowledge, scopes of practice.
- Equalize community sector for unification.

4. The best idea of the entire day was:



Southeastern Ontario District Mental Health Implementation Task Force

- We all need to work together. Ideas need to be shared.(3 responses)
- Getting the group, with similar vested interests, together to begin the dialogue re: recruitment, retention, remuneration. (3 responses)
- All three R's are connected – need to think outside the box (2 responses)
- Geese analogy – working for the good of the group. (2 responses)
- The idea that in the human resource field, we need to work as a system.
- Ice burg theory - idea that feelings and values really are important issues.
- Look at wellness issues related to your staff.
- Overcome the “Last Taboo” by providing “Marketing” to everyone.
- Sandy Cotton.

5. Other comments:

- Day was a good start – Good discussion.
- Excellent opportunity to share ideas, especially between institutions and community sector.
- How do we get these through to the MOH? Need to meet again and continue discussion. Need to meet as a group more regularly.
- Very enriching and a great resource tool for everyone.
- A pleasure to be invited. A very valuable learning experience. Thank you.
- Excellent idea to bring all sectors together.
- Discussion was good, but I really don't know if much is going to change.
- Dr. Cotton good!
- Without Ministry support regarding reaching for an equitable wage for the full range of disciplines essential to Mental Health Source Provision, we're in trouble.

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Let's Talk About Children and Youth - Retreat

March 4, 2002



Let's Talk About Children and Youth Proceedings

Monday, March 4, 2002

**Southeastern Ontario District Mental Health
Implementation Task Force**

Introduction

The children and youth champions of the Southeastern Ontario District Mental Health Implementation Task Force (SEO MHITF) undertook the planning and implementation of a forum regarding children and youth. The group hoped that important consultative information provided by key stakeholders would enrich the deliberations of the Task Force committees and working groups. Please refer to **Appendix A** for a complete list of invitees.

Those present at the event included; Paul Adamsthwaite, Patricia Brown, Morley Burwash, Nicki Collins, Simon Davidson, Matt Drouillard, Sybil Foley, Lynne Gardiner, Gayle Grass, Sandra Hassler, Alia Hogben, , Vicky Huehn, Kevin Kapler, John Leverette, Joanne Maltby, Kathy McKinnon, Rocci Pagnello, Joanne Payne, Sheryl Pedersen, Susan Seaman, Lorraine Vandenberg, Brenda Wattie, Sandra Lawn, Jane Banbury, Ruth MacCulloch and Cathy Cleary.

Welcome and Introductions

Dr. Simon Davidson, Chair of the SEO MHITF Child and Youth Champions welcomed everyone to the retreat and invited participants to introduce themselves.

Overview of Southeastern Ontario District Mental Health Implementation Task Force

- Sandra Lawn, Chair of the SEO MHITF provided participants with a brief overview of the Task Force which included a discussion of:
- concept of across the lifespan
- current vs. reformed mental health system
- levels of need as outlined in *Making it Happen*
- overview of Task Force planning and organizational structure
- overview of champion concept – role of the children/youth champions

Overview of Goals and Outcomes for the Day

Simon Davidson provided participants with an overview of goals and outcomes for the day, which included:

- a. Orientation
 - I. nine Mental Health Implementation Task Forces across the province
 - II. SEO MHITF through the leadership of Sandra Lawn has ensured planning for children and youth
 - III. Sandra working on initiative with other Task Force Chairs to involve relevant Ministries in designing a provincial Task Force with a mandate for children and youth
- a. Children and Youth Champions of the SEO MHITF
 - I. Simon Davidson (Integration Committee and Task Force Member)
 - II. Sybil Foley (Intensive Working Group)
 - III. John Leverette (Specialized Working Group)

- IV. JoAnne Maltby (First Line Working Group)
- V. Rocci Pagnello (Research)
- VI. Brenda Wattie (Human Resources)
- VII. Sandra Lawn (Chair)
- VIII. Jane Banbury (Coordinator)
- IX. Ruth MacCulloch (Support to Child and Youth Champions)
- a. Retreat Objectives
 - I. best interest practice
 - II. re-look at the 'system'
 - III. make a difference in the lives of our children and youth
- a. Hopes for the Day
 - I. consult the experts
 - II. input to TF and enshrine in Report
 - III. enhance the system
 - IV. advocate for children, youth and their families
- a. Agenda
 - I. presentation by Dr. John Leverette
 - II. small group discussions
 - III. development of 3-5 key issues in this area and 3-5 key objectives
- a. Hoped for Goals
 - I. understanding existing system linkages, partnership mechanisms, gaps
 - II. implication of impact of early developmental problems and disorders on outcomes across the age span
 - III. address red flags/high risk groups e.g. abuse, offspring of ill parents
 - IV. planning inclusive of transitional youth, dual disorders, young offenders, long-term treatment needs
- a. Hoped for Outcomes
 - I. recommendations about resourcing of the system
 - II. identify service gaps
 - III. across sectors
 - cohesion, collaboration
 - language that works
 - IV. system design/redesign
 - inclusive caregivers, parents, consumers, professional referrals including GPs
 - user friendly
- a. Hoped For – Future Directions
 - I. new partnerships
 - II. local initiatives
 - III. funding
 - IV. cross training opportunities
 - V. integrated treatment plans

- VI. joint case resolution
- VII. research initiatives (? New epidemiological study)
- VIII. best practices
- IX. program evaluation

Where Are The Children's Mental Health Resources?

Dr. John Leverette provided participants with an overview of the current children's mental health system in the Southeast District. Please refer to presentation notes (**Appendix B**).

Small Group Discussions and Large Group Feedback

Four questions were posed to small groups of participants who were then asked to discuss and report back to the larger group. A list of questions, small group responses and the larger group feedback are outlined in (**Appendix C**).

Small Groups Address Specific Question and Large Group Feedback

Participants were asked to divide into three groups in order to address one specific question as outlined below:

Starting from scratch, how do you design a service system that works? Is it possible to achieve a balanced system, including elements of health promotion, prevention and effective intervention, taking into account universal, targeted and clinical programming options?

Please identify gaps and strengths in the current mental health service delivery system for children, youth and families. Please give examples of positive and negative practices associated with these gaps and strengths.

Please develop practical and/or procedural elements that would be necessary if we were to develop a more effective system. Let your imagination take wing and use this list of items to give suggestions, each with a rational, to significantly enhance our existing system. You may add or subtract from the list:

- accessibility
- timeliness
- integration of services
- level of intensity/need for integration
- seamlessness – continuity of care
- closeness to home versus best expertise
- coordination of care, regardless of ministerial jurisdiction or funding base
- effectiveness
- efficiency: best practices, for example, diagnosis and assessment, planning for treatment, staff training and professional development

Do your conclusions and recommendations mirror your values and visions for children and youth?

Small group responses, recommendations and the larger group discussions are outlined in **Appendix D**

It was then requested that the small groups identify 3 –5 prioritized issues for child and youth mental health and to provide a recommendation for each priority issue. Please refer to **Appendix E** for responses.

Synthesis and Final Comments

Dr. Simon Davidson lead the group through a discussion synthesizing the day's proceedings as outlined below:

ISSUE	RECOMMENDATION
Resourcing	System enhancement – need local / inclusive enhancements – partnerships
Fragmentation	Need for cooperation, linking of ministries
Focus: System centred?	Need to be consumer centred and friendly
Traditional education	Students learn traditional approaches – need for new approaches and professional development
Stigma	Deal with it – it is easy to de-stigmatize youth about mental illness
Research	Need to know what does work, use program evaluation and best practices
Talk the talk	If we say children and youth are our future we must figure out ways to back this up – protect funding, give them the services they need
Clinical programs	How do we extend our reach and use our dollars wisely. Find the optimal mix. Programming = universal:targeted:clinical.

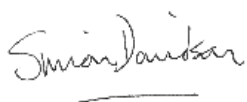
Closing comments

The child and youth champions of the SEO MHITF were asked to take the information provided today to the deliberations of their respective Task Force Committees and Working Groups. Participants agreed to take new insights from the day and be missionaries and advocates in order to keep the ball rolling. It was noted that a multi-pronged attack is required to make a difference in the lives of children and youth (e.g. KidNet).

Attendees were thanked for participating and asked to complete a “Ticket out the door”. Results are compiled in **Appendix F**.

A handwritten signature in black ink that reads "Sandra S. Lawn". The script is fluid and cursive, with the first letters of each word being capitalized and prominent.

Sandra Lawn
Chair
SEO MHITF

A handwritten signature in black ink that reads "Simon Davidson". The signature is written in a cursive style with a horizontal line underneath the name.

Simon Davidson
Chair
Child and Youth Champions

Appendix C – Small Group Discussions

Group One

Question	Youth and transitional ages: can we do better? - As children grow into teens and into early adulthood they change service systems. How well do we handle this situation? - Are there approaches we can use with youth that are more useful and friendly? (e.g. Youth Net) - Can mental health workers working with teens in trouble connect with Children's Aid, schools and Corrections to build a comprehensive approach?
Group Response	- yes, we can do better - barriers—difference in children and adult mental health definitions – who needs services, who is eligible for support, who can access the system, Seriously Mentally Ill, etc - access – the adult system is not friendly to immature teens and young adults - financial barrier to private mental health- \$ for private counselors – the parents of children accessing children's services also need help with parenting issues - parents cannot get help in children's mental health and the assistance offered in the adult system is not sufficient - no resources to see private counselors in the community - stigmatizing – kids as young adults – transitional age youth – when thinking about themselves and their problems are very afraid of the adult mental health system, as it is seen as a system for people who are crazy. Kids are unwilling to access services which may be available to them due to stigma - linkage to family doctors is very poor
Recommendations	- change definitions around adult mental health - i.e. seriously mentally ill - bring the issues of youth mental health into the open – public information campaigns to increase consciousness to all people, especially children and youth - staff working with family doctors could be of assistance in providing information and education - nurses, reception, etc. - build a society with positive role models for youth
Large Group Discussion	- accessibility of family doctors – need to look at tertiary & secondary care providers, many of whom are not doctors, and to increase family doctors awareness in this area - family doctors need to make a leap in relating to other providers - may be interesting to find out the differences between doctors who are comfortable getting information from providers other than doctors and those who prefer to speak only to other doctors - family doctors get little or no training in child and youth mental health - doctors apply adult approaches to children and youth - curriculum of family practice residents requires enhancement

Clarification of the system we devised	- in this system, underneath the minister of health and the minister of the child there is that whole group of people – health, education, Ministry of Attorney General, Ministry of Community and Social Services, etc. One of the purposes of this group was to ensure that when new initiatives were brought forth – they looked at other ministries and other services - not just problem solving thing but an integrated service - won't have the situation where one agency gets money and another loses money - another option mentioned was that children's mental health could go to the Ministry of Health - it was asked what would happen in this system if a lot of money had been pulled out of the system and the answer given was that what happens now, and it can be perceived as arbitrary, is all done on very tight programs lines. So looking at the impact of constraints, look at it across the board and be in a better position to make clearer decisions

Group Two

Question	We have a fragmented system between ministerial jurisdictions – Health, Ministry of Community and Social Services, Education, Corrections, and Recreation. Can we achieve a comprehensive and integrated service system which works? - What are the problems? e.g. split between child workers and those working with the parents. How can we provide effective help to parents who are not among the seriously mentally ill? - Children's Aid Societies: What is their contribution to work on the mental health of children and youth? Should we recognize them as one of the group of mental health agencies? - What are our expectations of a Children's Mental Health Centre? e.g. what degree of disturbance in child and family can we expect them to handle? What types of treatment? Psychiatric input? - Can we develop a balance between universal, targeted and clinical programs? - What steps should we recommend to governments and local ministry offices? - What are our expectations of hospital-based specialized psychiatric and mental health services? What level of severity can we expect them to manage? What types of treatment? - Can we create a continuity of care between agencies?
Group Response:	- need a standardized approach - difficulties for children to move from children mental health to adult mental health – may not have a diagnosis and therefore do not fit into the adult system - need to see kids in the context of their families - the family may have mental health issues and not be seriously mentally ill but still require support and assistance - does Children's Aid play a role in children mental health? - can see an increase in the number of kids in care as we see a decrease in funding (e.g. Ministry of community and Social Services, Education, Child and Adult mental health, social assistance, etc.) - for kids in care with Children's Aid Society, the foster parent is the parent – they need to provide mental health care for children
Recommendations	- create a child/youth mental health ministry with secure funding – there is no current legislation - frequent references to better coordination of services and agencies – and there is no acknowledgment for the time and effort required for this crossover of ministries - is there enough attention paid to ramifications across ministries? - how do funding decreases in one agency impact on services delivered by agencies funded by other ministries? - need to ask what the cost benefit is to treating children earlier in the process? (i.e Healthy Babies, Healthy Children) - planning is important at the regional and provincial levels – across the ministries - regional boundaries are different for each ministry and would work better if these boundaries were coordinated across ministries and agencies
Large Group Discussion	regarding services which are Ministry of Community and Social Services – the Children's Aid Society has a legislative mandate and the

	Children Mental Health Services has no legislation or mandate – Children's Mental Health Services is therefore not protected if funding is withdrawn by any government ○ in the last five to six years where cuts, in education for example, usually affect the most vulnerable kids ○ react to the cuts in services by bringing more children into Children's Aid Society care and trying to make up the difference later on in life ○ need a Child/Youth ministry so that one fiscal envelope can develop a comprehensive, integrated mental health system focusing on best-interest practices for children and youth ▪ the question was asked could effectively create a ministry within our region and it was suggested that the regional offices within each ministry have the capacity to work together ○ at a local level, providers and ministry officials are doing it ○ regional offices could do more to make sure there is good representation at the ministry level ○ it is possible to have better coordination and concrete planning in this region ○ in this region, there are planning bodies that exist that do not have adequate funding, others that exist that do not have a clear mandate ○ it would be ideal if in every region there was a planning body that had real teeth, funding, and an adequate mandate that everybody felt was appropriate • in this region, Ministry of Community and Social Services, Ministry of health and Long term Care and the two Mental Health Implementation Task Forces have had a first meeting exploring the feasibility of more collaboration ○ there isn't a program supervisor in MOHLTC in the same way there is in Ministry of Community and Social Services • it doesn't matter how each ministry is organized - want to create a system that has continuity for children and youth and want the Ministries to get themselves organized • as things stand it is impossible to ask for a government-wide action plan for children from the current government • let's see what Sandra (Lawn) can do

Group Three

Question	Can we use our knowledge of how experiences effect growing children from infancy to adulthood? ▪ Can we trace the links between what happens in early childhood and late adult problems? ▪ Is chronic abuse in childhood the major experiential factor in serious mental health problems? ▪ What role do other environmental factors play? What role does genetics play? ▪ Who are the children and youth needing care and/or attention? ▪ Is early prevention effective to improve later outcomes? ▪ Is therapy effective as an intervention with troubled families?
Group Response	▪ education system leaves little accommodations for non-academic needs – teachers and general practitioners need to be able to access supports • 'mental' stigma prevents early intervention • when the parent is mentally ill the child needs assistance and when the child is mentally ill the parent needs assistance

	• emphasis is on the acting out child and the isolated child often gets forgotten • therapy needs to be defined - forced help does not work
Recommendations	• need more funding for better intervention with families • need funding for effective good early prevention • need better education for educators, general practitioners, corrections and the whole justice system - need to be able to access what is needed • look at services that are working and augment them– Intensive outreach, parent aides, etc. • avoid pathologizing and make services more accessible • there are gatekeepers in our system and we need to look at these barriers to people accessing the system
Large Group Discussion	• people see kids in trouble everywhere (school, child services, family doctors) – it is hard to know what to do – need one place to call to find out where to get information (i.e. the DART system for addictions) • why do children have to be pathologized and labeled in order to access the system? ▪ it affects a child's identity ▪ need to use different language and different approaches • need to define more clearly what services work and which do not ▪ we waste service time and initiatives i.e parents ask for individual psychotherapy for children when it will not be effective • in the past when a medication was suggested the resistance was pervasive from parents and teachers ▪ teachers and parents are now asking for it ▪ things change and we really do need to know what works • in the educational system there is a real bottle neck ▪ no one will look at the child until the child has a psycho-educational assessment ▪ in this district it takes a year to access this assessment and those children are just waiting and are unable to go anywhere ▪ a long wait for a formal diagnosis

Group Four

Question	Has the time come for a new epidemiological survey? ▪ Should we consider the prevalence of psychiatric disorder – are things getting worse for young people? ▪ Should we pay attention to the red flags? – 40% increase in numbers of children in care, increase in suicides, increase in family stresses, increase in patients/clients seeking care. ▪ What social changes have we seen in the last few decades that have had negative effects on children and youth? (e.g. universality of drugs)
Group Responses	• what did we do with the last study – poverty was a real issue and we never did anything about that
Recommendations	▪ need a survey with defined parameters ▪ need to look at the tiered services that exist –marginalized groups need to be included. ▪ need to look at what works. ▪ survey needs to educate as well – not just to be about numbers ▪ survey needs to be politically cost effective, doable, defined, carried out and updated (like a report card) ▪ need inter-sectoral buy-in – education, children and youth mental health, psychiatry, psychology, general practitioner's, families, and aboriginals ▪ funding has to be right across the board and inclusive ▪ haven't talked about the ministry of the attorney general and when judges sentence youth that is the ministry of the attorney general ▪ youth probation is going over to corrections and will no longer be part of Ministry of Community and Social Services • target groups need to be more inclusive of those in the buy-in – general practitioners, schools, Children's Aid Society, Ministry of Community and Social Services • things are not getting worse – assessments and services are better but the resources are not ▪ need for a principle to define the difference between needs and public expectations – e.g. the public does not want to see the homeless but that does not serve the needs of the homeless
Large Group Discussion	• in a unified approach need to include all ministries as well as recreation and youth centers funded by the municipalities • how would it work to have education at the same time as you do a survey where surveyors spend time talking about mental health, stigma, the system • need to update, have a baseline but we also want to use the information too • in the immediate aftermath of the survey – if this information can be made public – it will create change ○ any well informed society tends to be a healthier society ○ people are hungry for information but the quality they get is not very good ○ use the survey to look at outcomes and look at prevention • extend our reach? As professionals how do we reach more than 1 in 6? • have no way in this conglomerate of those devoted to kids to even compare (across data bases – and don't all have data bases) ○ do not know where these kids cross between services • have an example of an epidemiological survey in Leeds and Grenville – have a pilot of how to get a general idea of the mental health state of youth and are looking at closer to 1 in 3 or 4 kids ○ need to establish benchmarks and move from there • McMaster is beginning to undertake a new study – wouldn't it be great to involve two universities • there is a very broad study coming out on child and youth from Queen's - a broad base Canadian study to better understand youth and adolescent mental health • there is funding to be accessed for research, the problem is finding how to access it • need to get big business interested in children's mental health. IBM, Bell – have funding for children's mental health

	○ need a whole trust for kids mental health • need to think outside the box especially when looking for funding • do not feel there are the same resources as at the beginning of the decade • cannot get a child help without a psycho-social assessment but with funding cuts getting the assessment is difficult • children may eventually get identified but then there may not be the resources for them to get help Ministry of Community and Social Services needs to be congratulated on bringing some data collection across – but it cannot be at the expense of clinical assistance

Appendix D

	Responses	Recommendations	Large Group Discussion
Group One	▪ need a vision – A comprehensive system, integrated, full age-ranged, accessible to children and families, early identification and early intervention. ▪ gaps: • research to implementation • networking among child workers • transitional age youth going between sectors • government legislation • education ▪ strength: partnerships that exist informally within the community – Children's Aid Society, children's	▪ need to create a new system ▪ Minister of Health and Minister of the Child – equal strength, money and teeth • under these ministries is a provincial committee – includes health, Ministry of Community and Social Services, education, corrections,	

	- mental health, foster care initiative - strength and/or weakness of our region is that we are very small and informal - stream lined funding	Ministry of the Attorney General - problem solving at the individual case level - then the regional level then the provincial level - need a formal method to problem solve and that is what this is - research issue is very important	
Group Two	- gaps: - lack of education for people in the system - stigmatization and labeling - lack of services for dually diagnosed - lack of family doctors - inadequate community resources - strength – restructuring of children’s mental health is a good thing (from 0 to 18), and with fewer agencies we are forced to work together and have a single access point - group did not agree by consensus that the recent children’s mental health restructuring was a strength Responses	- interministerial collaboration at whatever level is most effective and required to ensure coordination and continuity of care. - adequate resources should be made available for professional development and good assessment practices Recommendations	Large Group Discussion

Group Three	▪ two main areas - Funding and Designing within constraints. ▪ child psychiatry had no money within health ▪ MCSS has had repeated attacks and is downsizing it's system ▪ Ministry of Education has had a loss of special services ▪ need a prod to go forward pushing for funding and resources across sectors ▪ in agreement with Group One regarding the need to go regional and bring our regional administrators together onto a forum • have regional administrators in MCSS and MOH but not in education - may be someone in Corrections • this forum along with informed consumers and front line providers was needed to look at building a regional in-home model that fits ▪ good history of trying to work together to try to understand each others needs. ▪ need to recognize \$ are very shallow and need to look to best		▪ system cannot be based on assessment and gate keeping – too much focus on assessment forgets about service. ▪ waiting list is inevitable – what does the waiting list cost in terms of keeping these kids and the cost of permanent trauma to the kids while they are waiting that cannot be undone • can politicians be given a \$ amount? • Lafleur, in 1990, figured out for all youth and children that dropped out of school in a given year, the cost to Canadian taxpayers was

	practices • need to evaluate whether some programs are effective or not as this could have a bearing on funding ▪ with a small group of service providers you cannot be as accessible – but can tell people when they will get service ▪ meeting organized with Ministry of Health and Long term Care, and Ministry of Community and Social services and the two Mental Health Implementation Task Forces is a good start ▪ frustration of the education system – some ideas were: • one stop shopping • better trained teachers, and social workers • more psychiatrists • outreach into schools, homes, youth centers • important to have the educators at the table		four billion dollars. ▪ Children’s Mental Health Ontario – price of treatment for one child is startling: ▪ important to look at the #'s of mentally ill people in jail who are not treated effectively ▪ University of Western Ontario has studied the cost to business of depression, which is 11 billion and affects the bottom line in productivity • gets the attention of Big Business. ▪ urgency that what we do is important. ▪ looking at funding for the ISIS system – special education kids in the classroom • this region is likely to suffer more losses in the way the

			Ministry is looking at funding at per capita funding for special education • smaller regions will suffer most in a funding per capita funding system • these things need to be identified and addressed

Appendix E

	Priority Issues and Recommendations
Group One	• make it 'matter' to sell the idea of mental health – public promotion of tolerance, de-stigmatize • prevention and early intervention are first steps - more resources for community based services including professional development and counseling • education – resources are too short, curriculum needs modification, the number of available social workers and counselors has decreased to an unacceptable level • family education and parental aid –parents need to be in the loop as kids are treated – adult

	mental health services need to be opened so parents get the assistance needed • information to General Practitioners and Family Doctors. – need more information - determine how best to get information to them – workshops, newsletters, etc ▪ collaboration between the ministries resulting in coordination of services, continuity ▪ case resolution, as seen from the workers point of view shows there is no coordination between ministries ▪ coordinate report cards or outcome analysis to look at whether success is achieved
Group Two	• idea of a service system and need for increased awareness and knowledge re-services – kids need to tell kids and parents need to tell parents about available services • need to increase public awareness of children’s mental health, so that it is an issue that people care about • increase resources to direct services – enough services to provide appropriate coordination • need increased respect between sectors – a system where there is mutual respect of assessments, no duplication • increase cooperation between ministries • develop a Provincial Forum for children and youth
Group Three	• best practice research – promote epidemiological research – request ministries engage in best practice research – advocate for funding to enhance best outcomes ○ huge amount of information that can be accessed and utilized to give a broad perspective. • intersectoral collaboration – develop local, regional and provincial partnership agreements in a formal way • enhance access to services – funding services that enhance outcomes for kids, check accountability, need infrastructure to support services (transportation, in home services,) • address the issue of stigma – develop awareness campaigns, go into the high schools, use education to promote awareness • regarding the subject of best practice research or outcomes it was asked if best practice research can be used as a means of regulation or of writing protocols – to say how things should be done rather than looking back in hindsight

	○ a much broader issue– need to be comprehensive - ask what is the process and what is the outcome ○ process is as important as the outcome ○ need for establishing protocols. • a lot of reviews done but without analysis – need critique, studying positive outcomes or asking if there are positive outcomes ○ do the analysis – i.e. how many moves should a kid have in care ○ use the information we already have in terms of best practices. ○ the commonality between all responses is useful

Appendix F

Let's Talk About Children and Youth

Ticket Out the Door Results

1. **The best idea related to improving the system I work in was:**
 - united Child and Youth Mental Health system
 - networking
 - education of Doctors, Justice System workers and School employees
 - making access easy - streamlining - one place to call
 - breaking down barriers
 - promoting child and youth entitlements
 - ensure that each sector understands the mandate and service delivery model as it pertains to children mental health/education issues
 - partnerships with MCSS, Education, Health, Corrections and Recreation
 - effect of an assessment focus where you need a diagnosis to access services
 - delivery system that is fully, regionally based and budgeted
 - implement design model created by Group one
 - consumer centered system
 - prevention
 - community services
 - rural site of multi-disciplinary organizations
 - prevention and Intervention services offered for 0-12 years
 - selling the idea - early intervention (education), identification and risk management
 - long term - outcome based, best practice research to be the basis of funding for program services
 - intersectoral planning and partnerships
 - linkages
 - best practices across sectors - determine interventions that work so that resources aren't wasted

- improve networking with adult and education systems
- make adequate resources available for prevention and early intervention

2. The best idea related to “defragmenting” or streamlining services to children and youth was:

- put together a transition plan for youth to adult care
- main information line/office
- centralizing/general referral form/info
- cross sectoral facilitation of good service delivery
- funding cuts clarify real impact regardless of sector
- include reps from child/youth services in formal MH Networks including MCSS/ CAS/ Education
- ministry for Children and Youth / set same up locally
- regional coordination of services from all ministries for problem solving case by case and streamlining access from youth to adult services
- recognizing the costs needed to ensure this happens - more funding/resources needed
- no best idea - Creating all the necessary links was the whole point - creating a solid structure would help
- cross ministry coordination
- implementing best practices in alternative settings
- accountability practices utilized - service coordination
- working together between ministries
- developing local “body” or “authority” to coordinate and problem solve issues relating to children/youth
- looking at the child as a person and not over label/stigmatize/include the family
- cross sectoral participation and policies that work to encourage streamlining services
- regional leadership - don't wait for provincial strategy but use regional administration across sectors MOHLTC, MCSS, MOE, Corrections, consumers and providers to develop SEO system
- real continuity of care between systems

3. I am concerned about the system as it relates to special populations of children and youth e.g. dually diagnosed children and youth, concurrent, forensics, the seriously mentally ill. My idea(s) for improving the system for these children is:
- get a data base system incorporated - create it in such a way that it can be linked to data base for adult mental health
 - alternative programs
 - residential treatment/long term
 - dual diagnosis
 - transitional age youth
 - adults with minimal or moderate mental health illness but raising children with inadequate support
 - networking/partnerships at a local/regional/provincial level
 - pool within a comprehensive mental health system for children and youth with a FULL continuum of services prevention/health promotion and intervention
 - continue and increase partnership agreements between education and health - education and mental health (Com Soc) ie Section 19 programs
 - children with FASD (formerly FAS/FAE) continue to have trouble accessing services. The notion of the need for a diagnosis to access services rises again
 - four ministries MOH, MCSS, Education and Corrections - should also include i.e. Boys and Girls Club, Artillery Park Kingston
 - increased funding for 1) coordination of services 2) dissemination of information on best practices for these groups.
 - research and practice - link closer with formal structure
 - prevention and Education
 - rural preschoolers - rural sites for services
 - acceptance of mental illness like any other illness and positive approaches towards presenting and curing it
 - children who are failing/suspended/expelled and disenfranchised from their right to education - These children and youth are generally the most vulnerable and disadvantaged in our society and grow up without the capacity to effectively parent themselves.

More cooperation, planning and creative use of funds to help these C&Y succeed

- see #1's proposal for governance
- mental health reform needs to consider the needs of children and youth with a dual diagnosis - break down barriers based on diagnosis and prevalence (which came 1st)
- dually diagnosed ??
- dually diagnosed children and youth - we need to keep talking. We need to continually jointly plan and offer professional development related to this topic
- good diagnosis and assessment of family environment. This requires well trained staff, possibly also child psychiatrists

4. Other comments/ideas:

- perhaps actual legislation needs to be changes to address the MH needs of C&Y e. g. Ed, Act, YOA, etc
- good start
- children's mental health is a health issue. Stigmas is a barrier to accessing services. Parents need support/treatment that is not available - interventions need to be evaluated for effectiveness.
- joint training of front line staff from health, mental health agencies, education and child protection
- well put together forum
- resources / Ministry of children and Youth (secretarial)
- how or What is the role of Family Resource Centres in supporting CMOH
- web site - local for resources
- thanks for the opportunity
- good day!
- great day
- many concerns and many good ideas to analyze

John Leverette's presentation for □
"Let's Talk About Children and Youth"

*WHERE ARE THE
CHILDREN'S MENTAL HEALTH
RESOURCES ?*

SEOMHITF Specialized Working Group

Feb. 4, 2002

John Leverette, MD

Chair, Division of Child and Adolescent Psychiatry

Queen's University

What's the need?

- OHCS(1989) ages 4 – 16 (6 month prevalence)
 - prevalence of psychiatric disorder = 18.1 %
(conduct disorder, hyperactivity, emotional disorder, somatization)
- Co-morbidity is high
 - 68% had 2 or more of these diagnoses
 - other concurrent morbidities include ↓ school performance, chronic health problems, substance use, suicidal behaviour

What's the need?

- H/PE, FL&A, L&G, South L have
 - ~ 85,000 youth under 19
 - 35,000 between 13 and 19
 - 50,000 under 13
- = somewhat less than 15,385

***Lets say 13,000 with
psychiatric disorder***

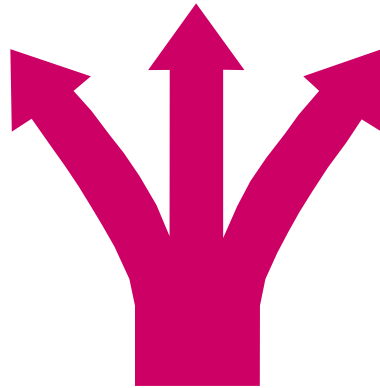
Who's providing care?

- OCHS (1989)
 - 60% of ambulatory medical services were provided by GPs and pediatricians
 - fewer than 1 in 5 children with psychiatric disorder were reached by specialized mental health services /social services

***? 2600 out of 13000
affected children reached***

SERVICES IN ONTARIO

- Family Practice (MOHLTC)
- Children's Mental Health Services Pathways (MCSS)
- Child & Adolescent Psychiatry (MOHLTC)
- ?education, corrections



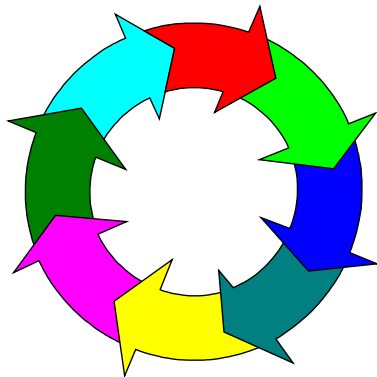
LOOKS GOOD - SO WHAT'S WRONG?

- THIS SYSTEM LACKS INTEGRATION
- MCSS is a non-medical ministry and fails to recognize the fundamental role of family physicians
- child & adolescent psychiatrists are scarce and have not been responsive to the needs of family physicians/community pediatricians
- children's mental health is underfunded
- key players are not included (MOE, MCorr)

Is Anyone Trying to Fix It?

- **Only us –
the SEOMHITF**

Comprehensive Intervention
WRAPAROUND/SHARED CARE



- Shared care linkages
to the Family Doctor
e.g. to school services,
CASs, non-medical
CMHCs, drug &
alcohol rehab services,
behavioral pediatrics,
child & adolescent
psychiatrists, general
psychiatrists

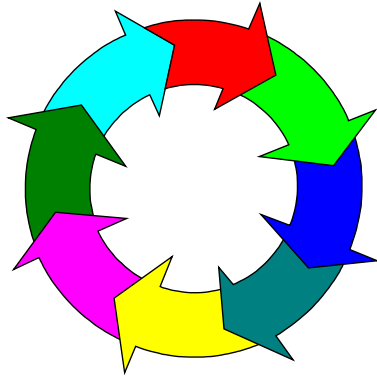
Which patients go where?

- Impaired $\Rightarrow$ 2 ° MENTAL HEALTH CARE (non-medical agencies)
- Severe mental disorder $\Rightarrow$ 2 ° and 3 ° PSYCHIATRIC CARE
- ***BUT THERE IS ALWAYS OVERLAP***

Impaired

- Early childhood problems in troubled families
 - Parenting problems
 - behavioural problems
 - learning problems
 - abuse
 - family dysfunction
 - drug & alcohol use
 - psychosocial trauma
 - adjustment reactions requiring counseling
- [DBD, V Codes, Adjustment Dis, Alcohol & Substance Dis]**

Use linkages
WRAPAROUND/SHARED CARE



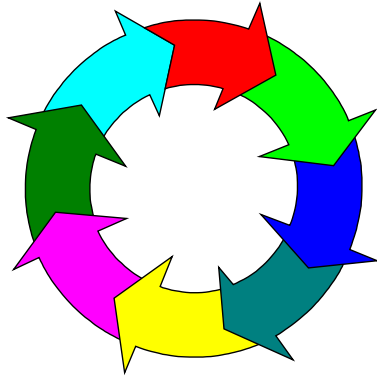
- **IMPAIRED**
 - **school services** (testing, counselling)
 - **CASs** (parental support /relief)
 - **non-medical CMHCs** (behavioural/family Rx)
 - **drug & alcohol rehab services** (limited help)

Severe Mental Disorder

• Neuropsychiatric Disorders - e.g. ADHD, LD, PDD, Tourette's , (↓IQ)	• Somatoform Disorders
• Anxiety Disorders	• Dissociative disorders
• Mood Disorders	• Eating Disorders
• Early onset psychosis	• Sleep Disorders

Use Linkages

WRAPAROUND/SHARED CARE



- MENTAL DISORDER
 - non-medical CMHCs
 - drug & alcohol services
 - behavioral paed/child & general psychiatrists[Dx, medications, shared care, 2° psychiatric care, (inpat/outpat), emergency intervention]

Overlap.....Co-morbidities, Mimicking Conditions & Trajectories

- Behaviour / parent-child problems /abuse/ neglect / psychosocial trauma can coexist with any mental disorder
- Suicidal/Homicidal behaviour as a function of DBD or depression/psychosis
Emotional outbursts/hypersensitivity can be a symptom of neuropsychiatric conditions e.g. Tourette's, PDD
- ADHD/ODD/CD

The Need for TRIAGE!

- A complicated system- getting patients to the right venue for help is necessary
- The family practitioner can't do it all
- The 2° and 3° services need to help
- ***There are fail safes*** i.e. psychiatric consultation at the CMHCs / referrals between child psychiatry and the CMHCs

Who's who in these places?

Non -medical CMHCs

- social workers
- cyws/bsts
- psychologists (limited)
- teachers (LDSB)
- onsite consultation by child psychiatrists /pediatricians

Child & Adol Psychiatry

- psychiatrists
- nurses
- psychologists
- social workers
- occupational therapists
- cyws/bsts
- teacher (LDSB)

CMHC Programs/Interventions

- urgent/crisis referral (0-4 days)
- counselling / problem solving skills - child, parent-child, family
- parent management skills (at agency, in-home)
- advocacy with providers for multi-problem families
- Specific programs e.g. Autistic Services
- psychological assessment (limited)
- Section 19 classrooms in local schools for DBDs
- Treatment foster homes with agency and psychiatric support

C & A Psychiatry Programs/Interventions

- Urgent referral (0-72hr)
- OPD clinics - general, mood & anxiety, eating disorders (3-4 wks) psychopharmacology, CBT, family therapy, supportive therapy, group therapy, OT, FACT (multidisciplinary)
- Section 19 classroom Day Rx at HDH (neuro-psych, school refusal) assess, rx
- Adolescent Inpatient Service (8 beds) serves region, ALOS 17days
- hospital & community agency consultations

Is there any Integration between the CMHC's and Child Psychiatry?

- psychiatric consultation services - weekly /monthly (Kingston, Brockville, Smiths Falls)
- direct referrals for urgent assessment
- discharge planning protocol from adolescent inpatient unit
- case by case wraparound care (GP, CMHC, child psychiatry)

Where are the Service Gaps?

CMHC's

- ↓ residential services
- variable user friendliness for GPs (referrals, feedback)
- limited interventions - family rx, psych tests
- addictions expertise & resources

Child & Adolescent Psychiatry

- child inpatients
- ↓ emphasis on the psychotherapies
- ↓ primary psychiatric care
- addictions expertise & resources

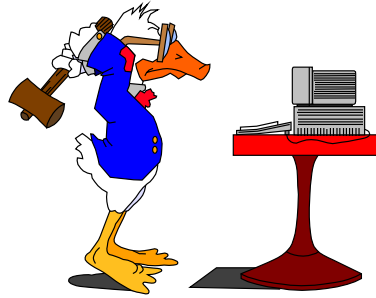
Current Problems in Seamless Care

- Getting patients to the right place for help
- GP referrals to CMHCs /communication
- psychiatric consultation in the CMHCs is at request of their workers
- ‘Making It Happen’ doesn’t fit well in this age group and across Ministries

Problems for Children with ‘Making it Happen’

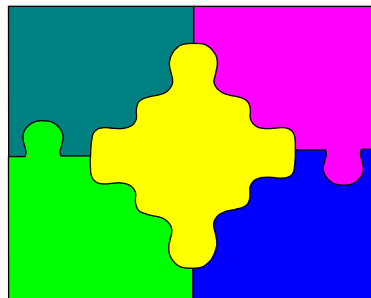
- little communication within current multi-ministry system (no overarching strategy)
- each ministry has what it would consider 1st line, intensive and specialized services
- GPs are not well represented
- not all ministries get to the table in the SEOMHITF process i.e. education, corrections

- Don't get too frustrated!



SEOMHITF, Children & Adolescents

- it will be up to regional ministry reps and frontline providers to design a system of care within these constraints



Leeds & Grenville

Youth Mental Health Survey

June 2001 - an Excerpt

Stress & Distress Among High School Youth

Results of the Leeds/Grenville Youth Survey

Heather Stuart, PhD
Queen's University

Acknowledgements

Funder:

- Bedwell Trust

Initiation, Planning & Research Support:

- Leeds Grenville Youth Mental Health Improvement Board
- Lanark Leeds Grenville Health Unit
- Leeds Grenville High Schools
- Matt Drouillard, Queen's University, Project Coordinator
- Steve Cove, Queen's University, Research Assistant

Purpose

- Mental health promotion project for high school youth
- Youth-centred and participatory
- Evidence-based (Survey)
- Develop youth-centred solutions

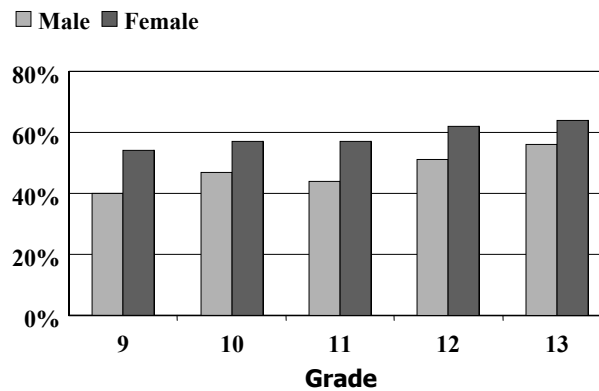
Sample

- All high school students in Leeds & Grenville Counties in Southern Ontario
 - Nine high schools
 - All students in class on the day of the survey were eligible
- Responses from 3,421 students, or 72% of those registered at the first of the year
 - 48% male
 - 52% female

Survey Questionnaire

- 23-item paper and pencil
- Distributed by teachers during class time
- Emphasis on global ratings and open-ended questions
 - Stress, depression, self-confidence
 - Sources of stress
 - Coping strategies
 - Service utilization

Attention Given to Mental Health

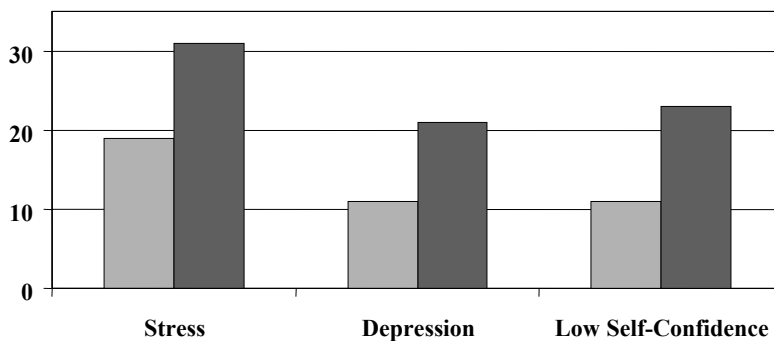


What Works?

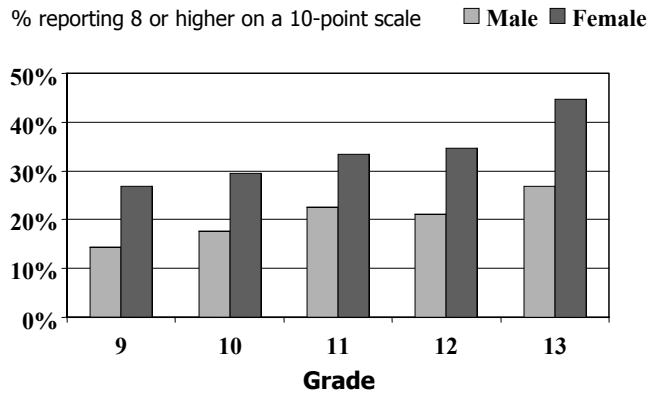
- Have a positive attitude
- Relax
- Healthy diet
- Eat
- Exercise
- Leisure
- Sleep
- Talk to others
- Prayer
- Laughter
- Medications
- Doctor

Stress & Distress by Gender

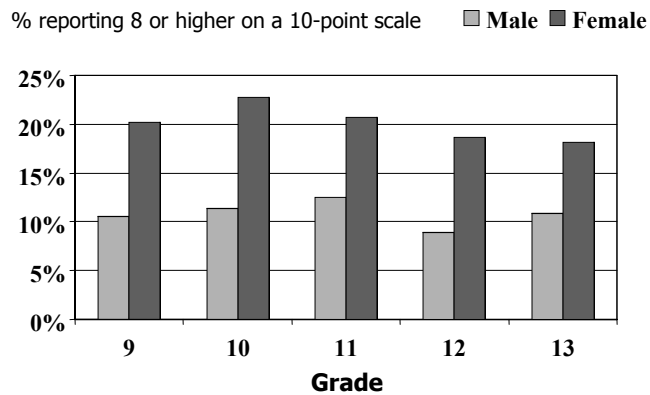
% scoring 8 or higher on a 10-point scale ■ Male ■ Female



Stress by Grade and Gender

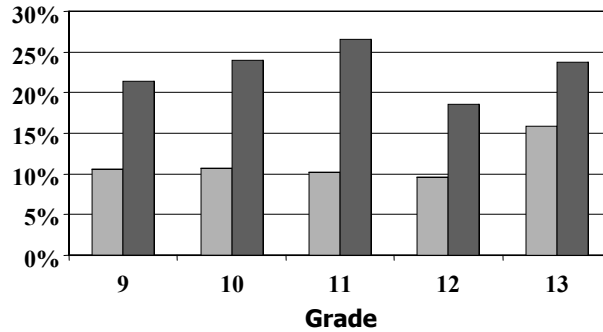


Depression



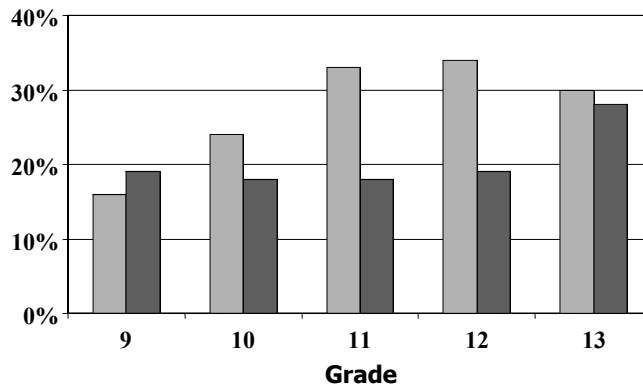
Low Self Confidence

% reporting 8 or higher on a 10-point scale ■ Male ■ Female

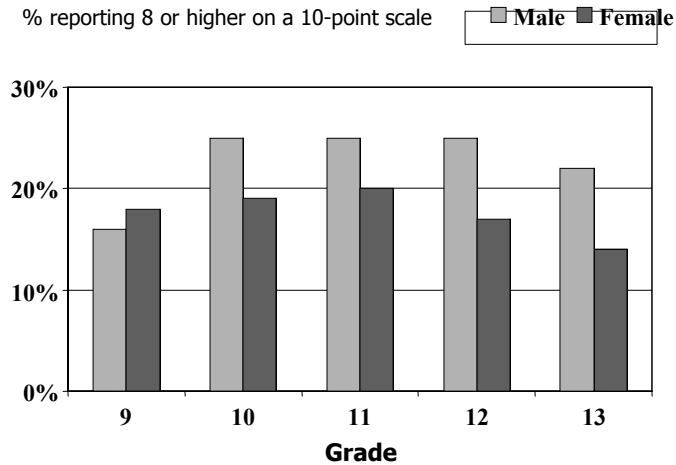


Daily or Weekly Use of Alcohol by Grade & Gender

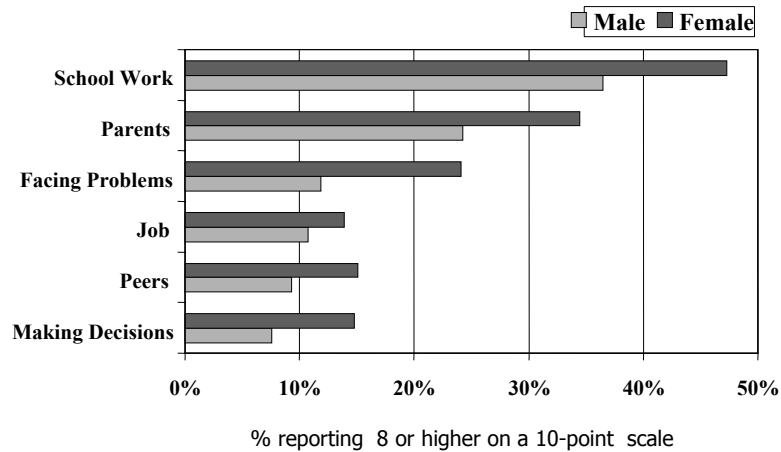
% reporting 8 or higher on a 10-point scale ■ Male ■ Female



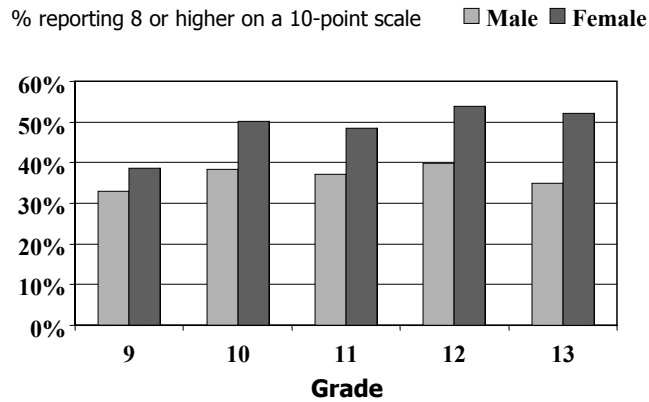
Daily or Weekly Use of Non-prescription (Illicit) Drugs by Grade & Gender



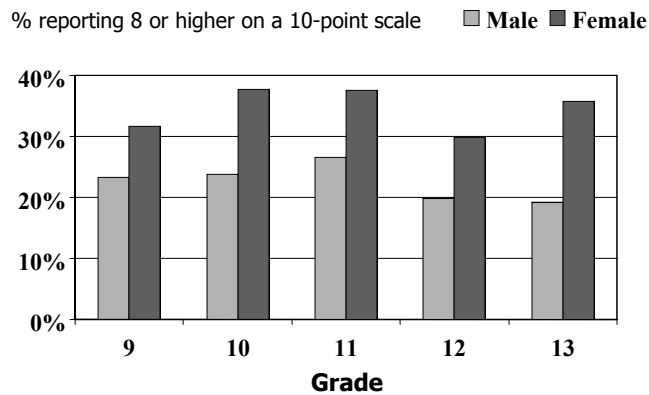
Stress Producers by Gender



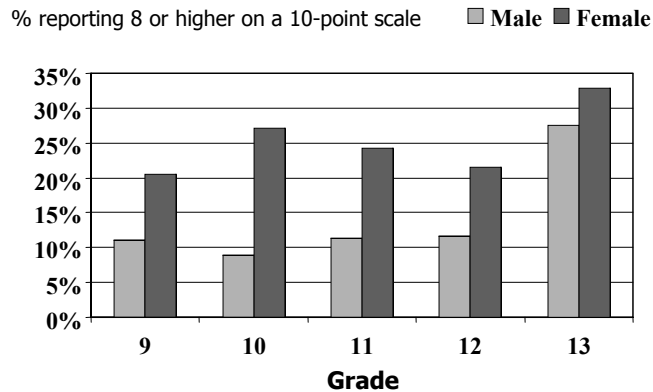
Stress from School Work by Grade & Gender



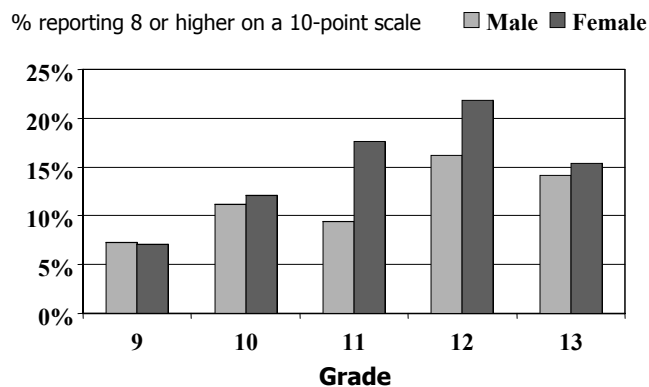
Stress from Parents by Grade & Gender



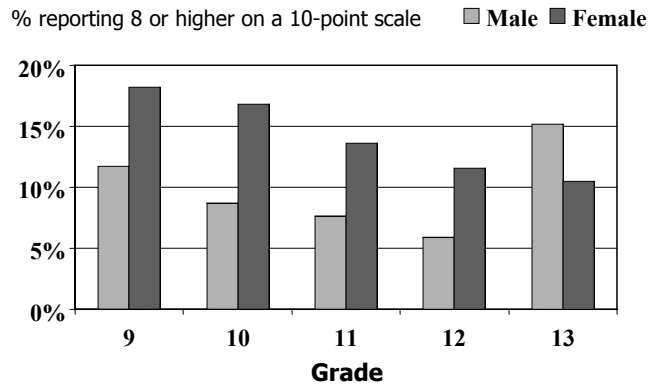
Stress from Facing Problems by Grade & Gender



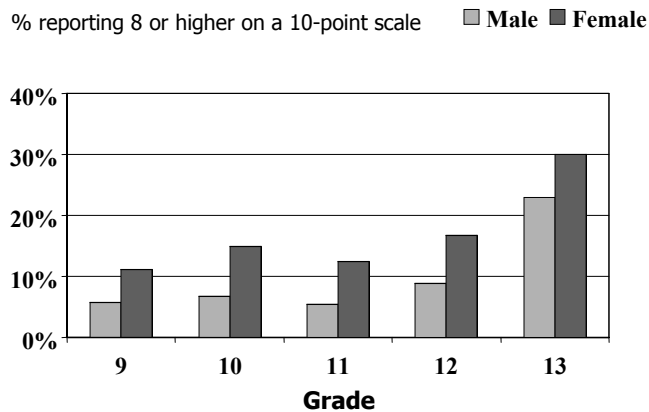
Job Stress by Grade & Gender



Peer Pressure by Grade & Gender

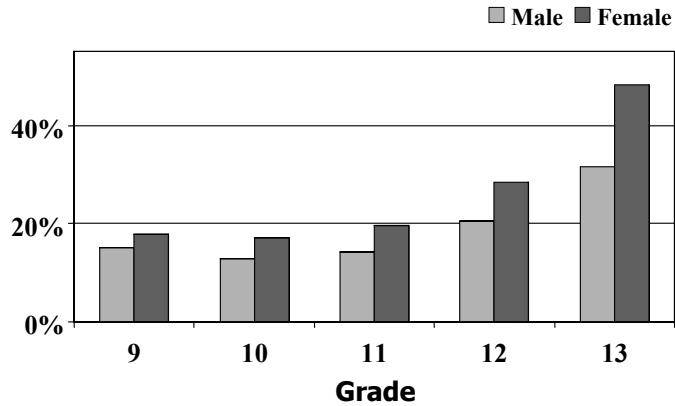


Decision-making stress by Grade & Gender



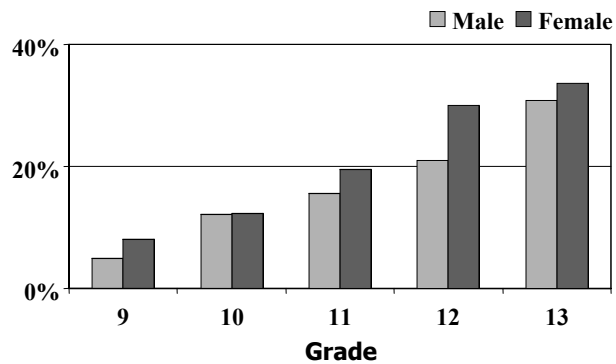
Stress due to Social Pressure by Grade & Gender

Responses to an open ended question

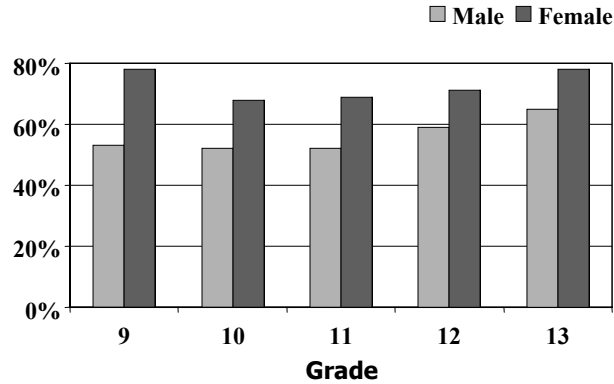


Stress due to Extra Curricular Activities by Grade & Gender

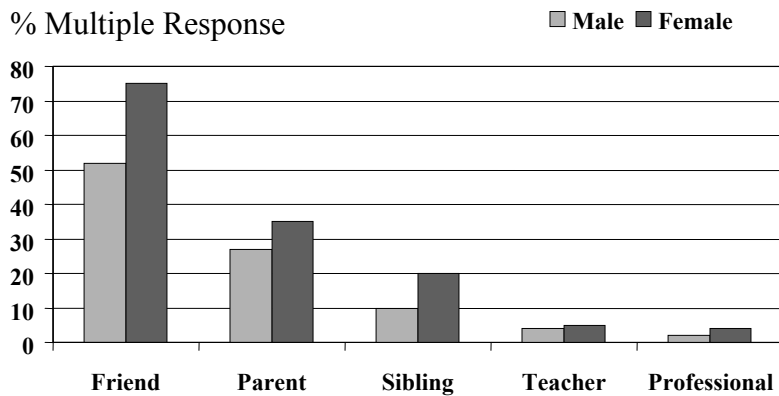
Multiple response to an open ended question



Tells Someone About Problems by Grade and Gender



Talks to Others About Problems by Gender



Summary of Findings

- At least half of the students said they paid attention to their mental health; slightly more young women than young men
- Attention to mental health increased slightly by grade for both sexes

Summary of Findings

- One quarter of all high school students surveyed reported experiencing high levels of stress & distress
- Stress & distress increased with grade for both male and female populations.
- Young women reported higher levels of stress & distress than young men.

Summary continued...

- School work, parental stress, and facing problems were most frequently reported as stress producing
- Jobs, peers, and making decisions were least often reported as stress producing

Summary continued...

- A significant proportion (20%) consume alcohol and illicit or non-prescription drugs on a daily or weekly basis, even as early as grade 9
- Youth men are more likely to be frequent consumers of substances

Summary continued...

- Half or more of students will talk to others about their problems, most often then friends
- Students are less likely to share problems with their parents and rarely approach teachers or counselors

Recommendation

- Develop youth-centred school-based stress reduction program(s)
 - Based on a philosophy of shared care (i.e. sharing care with students),
 - Emphasis on early identification and prevention of stress through the enhancement of positive coping strategies
 - Include an ongoing monitoring and evaluation strategy

Some Issues to Consider

- Peer-based, youth centred interventions
- School-based interventions among teachers and local health officials
- Linkages with local mental health and public health experts
- Shared-care systems that link experts with those who need to know

The Brain:

Dr. Julio Arboleda-Florez

THE BRAIN

The mind resides in the brain – Alex Bonkalo

Julio Arboleda-Flórez MD, PhD, FRCPC, FAPA,
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Professor and Head, Dept of Psychiatry,
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Adjunct Professor Epidemiology,
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Chief-of-Psychiatry, Queen's Affiliated Hospitals,
Kingston, ON, SEOMHITF, March 5, 2002

Introduction

- Objectives:
- To identify basic anatomical brain structures
- To provide general information on brain physiology (functioning)
- To relate anatomy and physiology to psychopathology

Topics of Discussion

- Gross anatomy of brain – real brain and plastic model – and dissection of major brain components
- Histology
- Neurophysiology
- Neuropsychopathological processes

Gross anatomy

- Meninges (dura, arachnoid, pia)
- Cerebrum and cerebellum
- Gray and white matter
- Two hemispheres
- Lobes (frontal, parietal, temporal and occipital)
- Basal ganglia
- Ventricles
- Limbic system/hippocampus

Hystology

- Glia matter
- Neurons
- Dendrites
- Synapses

Physiology

- Electrical functioning
- Energy consumption
- Cooling system
- Computing wiring
- Neurotransmitters

Neuropsychopathology

- **Infections**
 - ◆ Syphilis
 - ◆ AIDS
- **Genes**
- **Biochemistry**
- **Neurodevelopmental damage**
- **Anatomical**
 - ◆ Tumors
 - ◆ Dementia
 - ◆ Epilepsy

Functions

- **Frontal Lobe**
 - **Goal formulation**
 - New planned activities, sudden situational cues (spontaneous)
 - **Planning**
 - Conceptualize changes, conceive alternatives, set priorities, frame action
 - **Implementing**
 - Goal-direct behaviour (initiate, maintain, switch, stop sequencing of complex behaviours in orderly-integrated manner)
 - **Monitoring**
 - Ability to monitor, self-correct & regulate qualitative aspects such as attitude towards performance
- Kosaka, CPA Bull, Feb, 2002

...Functions

- **Temporal Lobe**
 - Visual integration, ideomotor, ideopraxia, memory, verbal recalls
- **Parietal Lobe**
 - Somatosensory, visual coordination
- **Occipital Lobe**
 - Visual fields
- **Limbic Structures**
 - Autonomic, endocrine, feeding, drinking, sex, aggression, defense-flight, temperature

What This Means

- The Brain is the substratum of our existence, our consciousness, our personhood, (our soul?)
- From normal fluctuations of affect and minor reactions to living to major mental conditions ALL take place in the brain
- LTC and talking therapies do not cure everything nor do biological treatments
- Biopsychosocial is not addition, but agglutination

The future

- **More research:**
 - Electrophysiology
 - Neurotransmitters
 - Receptor sites
 - Behavioural loci
 - Personality determinants
 - Relationship “vivencia-experience-emotion-psychopathology”
- **Through:**
 - Epidemiology
 - Neurodevelopmental correlates
 - Neuroimaging
 - Radioactive compounds
 - Psychophysiological correlates

The magic of it all...

- *There are still many things hidden in that sealed box*



A large, stylized blue arrow graphic that curves upwards and to the right, with a smaller, lighter blue arrow following its path, creating a sense of movement and direction.

Program Profile

Comprehensive Community Assessment Project

COMPREHENSIVE COMMUNITY ASSESSMENT PROJECT

Program Profile

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On behalf of:
The Research Committee

April 2002

Prepared By:

© Heather Stuart, PhD
Queen's University
Kingston, Ontario

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Dr. Nick Delva, Forensic Champion

Ken Fuller, Dual Diagnosis Champion

Rocci Pagnello, Children and Youth Champion

Mike Piercy, Concurrent Disorders Champion

Sandra Schentag, Family Champion

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Jane Banbury, Coordinator, Southeastern Ontario District Mental Health Implementation Task Force (Ex-Officio)

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Maryanne Takala, Southeastern Ontario District Mental Health Implementation Task Force (resource)

Gail Lock, Southeastern Ontario District Mental Health Implementation Task Force (resource)

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UNIT**

This project obtained external consulting support from the Health Systems Research Unit Consulting Unit of the Centre for Addictions and Mental Health, Toronto. The members of the consulting team included:

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Janet Durbin, MSc (Scientific Support)

Catlin Aitchison-Drake

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Tess Sheldon

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Dr. Heather Stuart, Queen's University, Study Director

Dianne Davies, MSc, Queen's University, Research Associate

A C K N O W L E D G E M E N T

This was a complex project that required a significant contribution of staff time from participating agencies. The extent to which agency involvement in this project has been instrumental in its success cannot be underestimated. Thanks are therefore extended to the many agency administrative staff who took time out of their busy schedules to complete this our survey questionnaire.

Executive Summary

This survey targeted agencies providing community mental health care, regardless of whether their parent agency was a hospital or a community-based service, who were involved in the Community Comprehensive Assessment Project (C-CAP). Thirteen agencies involving 49 separate programs responded. In addition, we surveyed all agencies providing community-based services to children and youth. Nine Ministry of Health and Long Term Care funded agencies responded. The four Ministry of Community and Social Services funded agencies providing services to children and youth did not return questionnaires.

Summary – C-CAP Programs:

Results highlight the fact that the bulk of community mental health development in the Southeastern Ontario region has occurred recently with the most intensive period of growth occurring since 1995. There was considerable diversity in community based programming represented in this survey. By far, the most frequently occurring type of community service was the more traditional counselling and treatment service. Just over one quarter of all programs surveyed provided intensive community based services such as assertive community treatment or case management. Social/recreational programs and housing programs were underrepresented. Crisis and emergency services were also under-represented but this was because first line agencies were excluded from our sampling plan.

With respect to access by specialty groups, most programs did not specifically target complex or specialty populations. Nor did they explicitly exclude them from treatment, the only exception being persons with dual diagnoses. The majority of programs were able to provide treatment within one month of referral. In the remainder of cases, clients may wait up to two years. Certain cultural barriers were also identified that may hinder access to programs for First Nation's Peoples, Francophone, Immigrant/Refugee, and hearing impaired. While not considered to be major or pervasive, barriers were identified by a small number of programs.

With respect to utilization, programs identified a total of 4,700 clients who were registered and active during the three study months. The average program size was 75 clients and the average number of new admissions in the year prior to the survey was 25. In total, there were 1,000 new admissions over all of the study programs. Programs undertake a considerable amount of community-outreach and out-of-program service delivery. Over half of the programs have fewer than 20% of their client contacts in their home base. One out of four programs was primarily office-based.

Long stay clients, defined as having spent five or more years in the program were not uncommon. Almost half of the programs had clients that had been receiving services for over five years. Seventeen percent of programs reported that 60% or more of their clients had been receiving services for five years or more.

Programs had developed a number of active partnerships and service arrangements both within the formal mental health system and outside of it. Partnerships were for a variety of purposes including treatment delivery, sharing of clinical information, and training.

With respect to consumer input, half of the programs surveyed had a consumer advisory groups with consumer representation. . While these were well populated with clients, family members were often absent. Forty percent of programs did not have family representation in their consumer advisory groups. Agency Boards did have consumer input but they were more heavily weighted toward community members. Consumers, care providers, and family members tended to be in the minority. In addition, a number of additional tools were used, ranging from consumer satisfaction surveys, to employing consumers as volunteers, consumer councils, and shared treatment planning.

With respect to staffing, the direction of change in the year prior to the survey was to add staff. Indeed, most programs added new positions. Staff turnover was about 11%. Administrative and management positions amounted to 24% of the total FTE's. The majority of direct treatment is provided by staff who are trained at the Bachelor or diploma level.

Many programs did not have regular access to psychiatrists and wished more. When psychiatrists were involved in programs, most often it was with respect to the provision of direct clinical care—assessment, diagnosis, treatment, follow-up, and discharge planning. They were less often involved in education, training, evaluation, research, or program planning, despite the fact that many programs would appreciate their input in this regard.

With respect to staff training and continuing professional education, most programs engaged in continuing education and provided incentives for their staff to attend conferences and educational events. Top priorities for additional education were similar across the lifespan and related to forensic, legal issues; disturbed or violent behaviour; and concurrent disorders. There was a lack of district-based or program-based approaches evident in determining staff educational needs. Suggestions for district-based continuing educational activities included better use of local experts. Not only would this make better use of existing resources, it would reduce the costs of educational activities. A district-based plan was recommended that could include regular conferences.

Recommendations—C-CAP Programs:

Continued System Monitoring Through Regular Program Surveys

This program survey was the first of its kind in the Southeastern Ontario district. Much of the information provided by this survey was not known and should be fundamental to system planning. Therefore, it is recommended that program inventories be conducted on a regular basis in order to monitor system change, assess the extent to which we are expanding the community treatment system, and our progress toward mental health reform goals. Alternatively, key pieces of information contained in this survey should become part of an ongoing accountability and monitoring system.

Managing Long Stay Clients:

A significant number of programs reported having a large long stay population defined as people who had been receiving services for five years or more. Given the extended nature of these services, and the possibility of creating dependencies, it is recommended that:

- Programs regularly monitor the extent to which services provided match client needs using the C-CAR or similar instrument.
- Programs develop and apply discharge policies to ensure that clients who have less intensive service needs are moved to less intensive service environments.

Managing Complex Clients:

While few programs actively excluded complex or specialty clients, none actively targeted them. With increasing deinstitutionalization, the complexity of clients receiving services from community based programs is expected to increase. Staff training for many of these populations was considered to be in need of improvement, and few programs have regular access to medical and psychiatric expertise or the sessional funding to support this. Therefore, in preparation for bed closures and community re-settlement, it is recommended that:

- financial arrangements be adjusted such that community agencies have regular access to psychiatric and medical expertise, as necessary for consultation and direct treatment, as well as for continuing professional education.
- all staff be systematically reviewed for core competencies and educational needs be determined based on these reviews,
- educational and professional development programs be coordinated at the district level drawing on local experts.

Consumer and Family Involvement in Advisory Groups:

In a system that is moving toward putting the consumer first, one way of accomplishing this is through active program advisory groups that represent the views of both consumers and family members. This cannot be the function of Agency Boards which may be heavily weighted toward community representation and may not address specific program issues. Therefore it is recommended that all programs develop program advisory groups composed of both consumers and family members. Wherever appropriate and feasible, advisory groups should be specific to individual programs, although it is recognized that this may not be possible in smaller agencies.

Summary – Programs Serving Children and Youth

Nine programs that received the bulk of their funding from the Ministry of Health and Long Term Care responded to this survey. Ministry of Community and Social Service funded agencies did not participate in this survey. Consequently results are not representative of all programs serving children and youth.

Mental health system programs targeting children and youth largely provided intensive and specialized services. Like the C-CAP programs, there was a heavy emphasis on counselling and treatment but there was also a greater emphasis on providing family support and education, promotion/prevention, and public education.

Compared to C-CAP programs, the programs serving children and youth had shorter wait-times between referral and treatment. All clients would typically receive treatment within one month of referral. Clients also moved through these programs faster and there were fewer longer stay clients (staying over two years). This would be expected given that children would typically transfer to adult agencies as they grew older.

The majority of programs could not estimate the number of current clients they had. Survey comments indicated that this may be a particular problem with hospital-based record keeping systems. Respondents indicated that these systems do not permit out-reach/off-site clients to be officially registered, so they do not appear in the statistics, making it impossible to estimate current case-loads.

Eight programs provided information on the number of admissions they had had during the previous year. A conservative estimate of the number of children and youth receiving services in the mental health system during any given year would be at least 1,400.

With respect to access, few programs reported exclusions, however, when they did, exclusions pertained to individuals with concurrent substance abuse disorders, those with acquired brain damage, and youth over the age of 16 years. The lack of individuals trained in American Sign Language in one catchment area was also identified as a potential barrier to the large deaf population living there.

Though no explicit barriers were identified with respect to cultural sub-groups, no program indicated that materials were available in French, and none reported that they provided services specifically geared to cultural groups such as First Nation's Peoples. Only one program reported that any staff had received cultural sensitivity training. However, it is difficult to assess the extent of need for culturally sensitive programming in this district.

All programs reported having formal partnerships with other agencies. The majority of these were within the mental health system for purposes of clinical management or staff training. Virtually no formal partnerships were identified between Ministry of Community and Social Service agencies, and comments indicated that children and youth treated in the MCSS system may benefit from greater psychiatric input. Without comparable information from MCSS services, however, this is difficult to judge.

All programs indicated that they employed mechanisms designed to obtain consumer feedback, either from children/youth or their parents. Yet, formal consumer advisory groups were rarely employed. Agency Boards had some representation of consumer interests but often tended to be more heavily oriented to the general public and professional staff. This would be expected in a hospital-based service.

Agencies providing services to children and youth used approximately 23% of their FTE time on administrative and management activities. This is comparable to C-CAP agencies. However, whereas C-CAP agencies had gained staff positions over the past year, programs serving children and youth reported that they had lost positions; approximately 7% of their FTE work force. Similarly, child and youth programs had

significantly higher staff turn-over; over a third of their program staff in the year prior to the survey. It is not clear from the survey comments why this is the case; however it is of considerable concern and warrants more detailed evaluation.

Although child and youth programs currently access over 4 FTE psychiatrists, five programs indicated that they would benefit from greater psychiatric input. Only one third of the programs surveyed indicated they had regular input of psychiatrists, mostly for clinical functions. Psychiatric input into non-clinical functions was less available. Greater access to psychiatric input across ministries was also raised as a concern.

Finally, with respect to professional development, the top two areas identified for both sub-populations (children under 16 and youth aged 16-24) were research and evaluation, and concurrent disorders. For children under 16, professional development with respect to disturbed behaviour was also considered a priority. The heavy emphasis on research and evaluation may be a function of the fact that a significant portion of the programs were university based so would have a clear mandate to contribute to scientific knowledge in this area.

Recommendations – Children and Youth:

Better Inter-Ministerial Linkages:

The four Ministry of Community and Social Service agencies providing services to children and youth in this district did not participate in this project, making it difficult to estimate the district's capacity to provide services to this population.

Meetings with representatives from these agencies revealed that their desire not to participate in this survey had both a philosophical and a practical base. Philosophically, MCSS agencies do not segregate programs for children with mental illnesses so as to avoid labeling and stigma. Consequently, in practice, diagnostic labels are not used in record keeping or captured in existing information systems. Thus, it is impossible to provide data on this sub-population of children and youth receiving psychiatric care, or even guesstimate its size. This situation undermines our ability to plan mental health services across the life span, particularly those for transitional children and youth who will ultimately require the services of the mental health system

as they grow older. Comments provided by MCSS staff indicated that the needs of this population are not well addressed as there is no system-to-system interface.

Given our inability to collect planning data across ministries, and concerns about the extent to which the other ministries may have appropriate access to psychiatric expertise, an important recommendation has to be to improve inter-ministerial linkages with respect to mental health issues. Therefore, it is recommended that the Ministry of Health and Long Term Care take primary responsibility for making inter-ministerial linkages with respect to children and youth mental health programming.

Staffing:

The staffing pattern noted in this survey seems to portray a sector under stress. Whereas the C-CAP programs gained staffing positions in the year prior to the survey, programs serving children and youth lost them. Perhaps, as a consequence they reported significantly higher staff turn-over. As detailed information concerning the origins of these problems was not part of this survey, it is difficult to make any specific recommendation with respect to a possible solution. Rather, it is recommended that Ministry of Health representatives undertake a full review of programs providing services to children and youth with an eye to better understanding the volume of services provided to this sector and the extent to which current staffing patterns meet the needs of the clients being served.

Improved Data Management and Data Sharing:

In both Ministry of Community Services and Ministry of Health agencies, it was provided impossible to quantify even basic population characteristics such as current case-loads. Lack of standards for dealing with diagnostic data, as well as issues concerning how to capture off-site contacts were some of the problems noted. The lack of information on the size of the population to be served poses a significant impediment to planning. Good data is all the more important given the complexity of planning for this population across several ministries. Therefore, it is recommended that:

C-CAP PROGRAM PROFILE - PRELIMINARY RESULTS

- Ministry of Health funded agencies improve their data systems so as to accurately capture the number of clients served by their program staff, whether or not these contacts occur off-site.
- The Ministry of Health and Long Term Care take the initiative to develop mechanisms to standardize and link data across ministries for purposes of district planning mental health services for children and youth.

Chapter 1

Introduction & Purpose

The Community Comprehensive Assessment Project, or C-CAP was funded by the Southeastern Ontario Mental Health Implementation Task Force in collaboration with the Ministry of Health and Long Term Care as part of a multi-region evaluation to support mental health reform. The main purpose of the project was to formulate recommendations concerning the care needs of clients who access community mental health programs.

The C-CAP was part of a multi-centre initiative coordinated by the Health Services Research and Consulting Unit of the Centre for Addictions and Mental Health in Toronto. The Research Committee of the Southeastern Ontario Mental Health Implementation Task Force steered the project and defined local study parameters. The objectives of the Southeastern Ontario C-CAP were to:

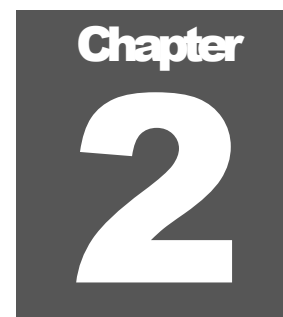
- Survey consumers for their perspectives on mental health service use and needs;
- Survey staff about the care needs and current service use of a representative sample of recipients of community based mental health services, and
- Develop a standardized service profile of participant C-CAP agencies.

This Report

This report is submitted to the Mental Health Implementation Task Force of behalf of the Research Committee. It provides the results of the program profile portion of the

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C-CAP. The purpose of this component of the study was to survey the community mental health agencies contributing data to the needs assessment portion of the C-CAP. In addition, it provides information on agencies within the formal mental health system that provide services to children and youth.



Chapter 2

Background & Methods

In preparation for psychiatric hospital downsizing and mental health reform, the Ministry of Health and Long Term Care funded six comprehensive assessment projects focusing on clients of psychiatric hospitals across the province (termed H-CAPs). In addition to the needs assessment portion of these projects, the Kingston H-CAP was funded to design a strategy to evaluate the outcomes of hospital downsizing. Part of this evaluation was a strategy for assessing system capacity via a program inventory.

Since the completion of the hospital CAP projects, there has been growing interest in the further evaluation of needs for care for community mental health programs and system capacity. The Community Comprehensive Assessment Projects, C-CAPS, are the response. These projects are underway in virtually every district in the province. They use the standardized methodology developed for the hospital CAPs to assess the fit between community client needs and available resources. An important component of these projects is to describe the characteristics of the programs providing community currently providing community mental health services. Over time, similar evaluations could be used to document system change and movement toward mental health reform goals.

Target Population for the Program Profiles

The programs targeted for the program profile component of the C-CAP were those that participated in needs assessment portion. They were community mental health programs that provided services to individuals 16 years of age or over. The following populations (and programs) were excluded from the C-CAP needs assessment study:

- Clients who received services from programs targeting specialty populations—forensic, dual diagnosis, concurrent disorders, and psycho-geriatric—as separate planning efforts were underway for these groups.
- Clients who received services outside of the formal mental health programs in Community Access Centres, Community Health Centres, Ministry of Health and Social Service agencies for children and youth, family practice settings, non-program based psychiatrists, and private mental health providers.
- Programs providing crisis services were excluded, as the staff considered they would have insufficient knowledge of the client to complete the study questionnaire. Since crisis services are the main portal of entry into mental health treatment programs, these clients were likely not lost to the study but captured through other program affiliations.

Thirteen agencies met the inclusion criteria and all agreed to participate in this study. Therefore, results are representative of community-based treatment and support programs in the Southeastern Ontario mental health planning district. More specifically, programs that participated were:

- Brockville Psychiatric Hospital Elmgrove Facility – Royal Ottawa Health Care Group
- Canadian Mental Health Association of Hastings and Prince Edward
- Canadian Mental Health Association of Leeds and Grenville
- Community Mental Health Program of Hastings and Prince Edward
- Frontenac Community Mental Health Services
- Lanark Community Mental Health Program
- Leeds Grenville Rehabilitation and Counselling Services
- Lennox and Addington Community Mental Health Services
- Quinte Healthcare

- Quinte and Region Community Homes
- Queen's University Department of Psychiatry Affiliated Teaching Hospitals and Programs:
 - Hotel Dieu Hospital
 - Providence Continuing Care Mental Health Services
- Youth Habilitation Quinte Incorporated

Programs For Children and Youth:

Many of the mental health services for children and youth are provided through the Ministry of Community and Social Services. While these programs remain outside of the direct planning mandate of the Task Force, there is growing concern that the needs of transitional youth—youth who grow into the formal mental health system—are not adequately planned for or met. In an effort to promote needs-based planning for this group, and to support mental health planning across the life span, all agencies providing mental health services to children and youth were invited to participate in this program profile, regardless of their funding source. Programs funded by the Ministry of Community and Social Services declined participation in this survey. Therefore, results reflect only those programs funded by the Ministry of Health and Long Term Care.

Survey Questionnaire:

All agencies were sent a standardized questionnaire that could be completed and returned electronically. They were instructed to complete one survey for each separate community-based program component. Since many of the agencies participating in the C-CAP were multi-service, surveys were completed on a range of services including first line, intensive, and specialized. Forty-nine surveys were returned by the 13 C-CAP agencies. An additional nine surveys were returned by programs targeting children and youth. A copy of the survey questionnaire is available from the principal author upon request.

In most cases, surveys were completed by a senior administrative official (such as a Director or Coordinator). In a minority of cases, surveys were completed by senior clinical staff.

Unless otherwise stated, missing data are excluded from calculations of percents.

Chapter 3 presents the results of the C-CAP portion of the program inventory while Chapter 4 presents the results of the inventory of Ministry of Health and Long Term Care funded programs for children and youth.

Chapter 3

Results – C-CAP Agencies

Figure 1 plots the year in which each program was established.

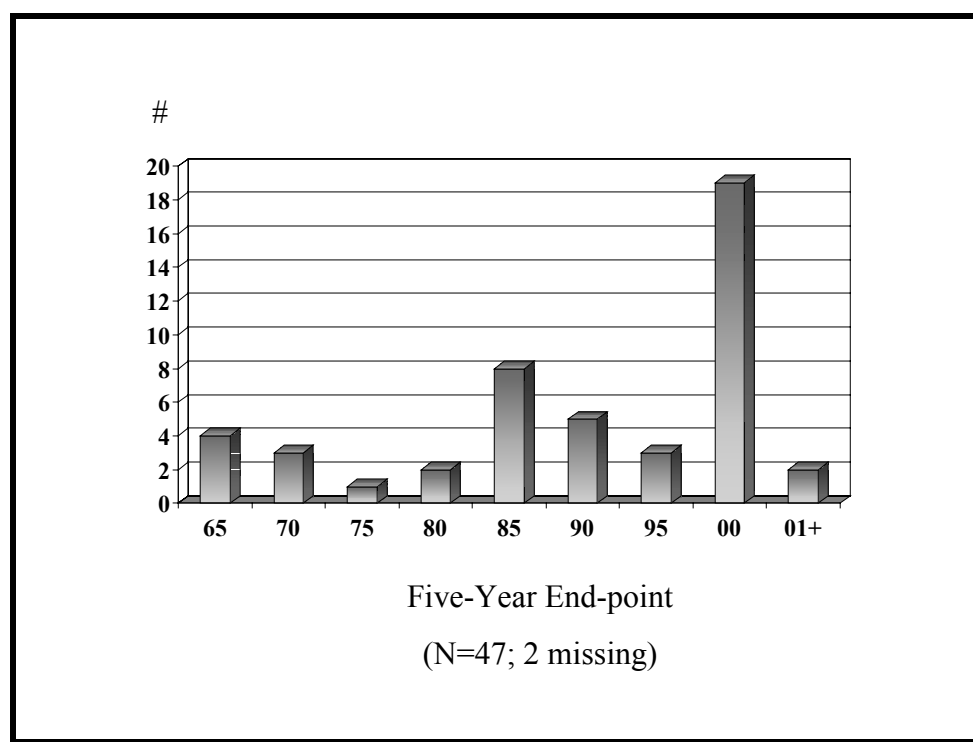


Figure 1: Program Initiation Date

The earliest program began in 1964. The most recent was developed this year, in 2002. The growth in community programming roughly corresponds to broad trends in deinstitutionalization which began in Canada during the decade of the 70's. By 1985, there were eighteen community mental health programs available throughout the

district. Within the next decade an additional eight programs would be developed. By far the most intense period of program growth has been since 2000 when twenty-one programs have been developed.

Program Type:

The majority of programs identified a single main mandate as either first line, intensive, or specialized care. Two programs identified dual mandates and one program did not specify (N=50 programs). The majority (74%) provided intensive mental health services defined as assessment, treatment, and support services provided in the community or hospital setting focused on people with serious mental illness. Fourteen percent provided first line mental health services such as crisis or emergency services. Twelve percent identified their main mandate as providing specialized mental health services. These focus on people with serious mental illnesses that are complex or rare. The most common primary program type was counselling and treatment (**Table 1**). Intensive and assertive programs, such as assertive community treatment, case management or day hospital were the next most frequently occurring (22%). Social and recreational programs were the least represented program type.

Table 1: Primary Program Type		
Program Type	N	%
Assertive community treatment	5	9
Case management	5	9
Counselling & treatment	18	33
Day hospital	2	4
Crisis/emergency	6	11
Vocational	5	9
Housing/housing support	4	7
Homes for special care	2	4
Social/recreational	2	4
Other	5	9
Total	54	100
Note: several programs identified more than one type so the total N exceeds 49.		

Table 2 shows the range of services available in this group of programs and whether these were provided on or off-site. Fourteen programs (29%) provided services both on and off-site, so are counted once in each column.

Table 2: Range of Services Provided		
Service	Same Site % (N)	Different Site % (N)
Assertive community treatment	14% (7)	12% (6)
Case management	45% (22)	33% (16)
Crisis	33% (16)	29% (14)
Mobile Crisis	10% (5)	14% (7)
Counselling & Treatment	55% (27)	55% (27)
Family Support & Education	43% (21)	29% (14)
Housing & Housing Support	25% (12)	12% (6)
Vocational	33% (16)	20% (10)
Social & recreational	33% (16)	25% (12)
Clubhouse	4% (2)	--
Inpatient	8% (4)	4% (2)
Day Hospital	10% (5)	2% (1)
Consumer directed peer support	16% (8)	12% (6)
Geriatric	18% (9)	14% (7)
Outreach	35% (17)	31% (15)
In-reach to correctional facilities	6% (3)	10% (5)
Promotion & prevention	41% (20)	24% (12)
Public education	38% (18)	29% (14)
Note: Programs may be in multiple categories. All percents are calculated out of 49.		

What is striking about this table is the large proportion of programs that offer services off-site, outside of their parent agency or program base. Looking down the columns, it is clear that a wide range of services are offered both in the program and in other

community settings. A second point to note is that traditional mental health diagnostic and treatment services are fairly well represented in comparison to community supports and social/recreational and vocational services. In-reach services to correctional facilities and consumer services were among those least frequently provided.

Access:

To assess barriers to accessing treatment services, programs indicated the amount of time clients typically wait between referral to their program and first clinical assessment, and between referral to their program and treatment (**Table 3**). Fifty percent of programs provide the first assessment within one week of referral. Although the majority are assessed within the first month, clients may wait up to eight months for an assessment.

Table 3: Waiting Times for Assessment and Treatment		
Wait Time	First Assessment % of 47	First Treatment % of 47
same day	12%	6%
under 1 week	43%	18%
1-3 weeks	20%	35%
3-4 weeks	8%	8%
1-4 months	2%	8%
4-8months	2%	2%
1-2 years	--	2%
not applicable	8%	16%
Missing data = 2		

One in five programs typically treat clients within a week of referral, and three quarters within a month. However, twelve percent of programs had waiting times for treatment that typically exceeded one month and could last up to two years.

With respect to access by special populations, a number of programs specifically targeted special populations such as children and youth (22%), concurrent disorders (22%), homeless (20%), dually diagnosed (16%), geriatrics (12%), forensic (10%), and First Nations Peoples (6%).

Fourteen programs (29%) indicated they had used professional trained interpreters in the past year. Most often this was infrequent (1-6 times) but one program used interpreters on more than 50 occasions. Similarly, fourteen programs (29%) indicated that their staff had received cultural sensitivity training. In seven programs 50% or more of the staff had been trained to be culturally sensitive. However, only 8 programs (16%) responded that they provided culturally appropriate programs or services and only two programs (4%) offered printed materials in another language; both French.

Respondents were asked to indicate whether they believed that selected cultural groups encountered barriers in accessing their services. Five programs (10%) indicated that First Nation's peoples encountered barriers, six programs (12%) identified barriers for Francophone populations, and five (10%) noted barriers for immigrants and refugees. Several programs noted that one barrier may be the lack of staff members from these cultural groups. In some cases the barrier was thought to be one of language. In others, it was noted that individuals may prefer to use existing cultural services. Three programs made note of barriers for the deaf and hearing impaired populations and noted that there were large numbers of these clients in certain areas of the district.

Utilization:

Three programs were unable to provide utilization data. Therefore, the following estimates are based on 46 programs. The average program size was approximately 75 clients, although almost half of the programs were small, having under 50 clients (**Table 4**). It was estimated that there were a total of 4,700 clients registered in these programs, virtually all of these having had a contact within the previous three months.

New admissions over the previous year ranged from none, to over 1,000, with an average (median) of approximately 25. Number of yearly discharges ranged from none, to over 900, with an average (median) of approximately 70.

Table 4: Current Clients Registered		
Total Current Clients	N	%
Under 50	20	44%
50-100	8	17%
101-200	9	20%
200+	9	20%
Total Programs	46	100%
Total Clients	4,704	

Most often programs assigned new clients to an individual staff member (66%), rather than a team (34%). Approximately one quarter of the programs surveyed provided services through individual consultations, one quarter through group, and the remainder used a combination. **Table 5** shows the proportion of client contacts that occurred in the office or program setting. It indicates a considerable amount of community out-reach. Over half of the programs had fewer than 20% of their client contacts occur in their office or program setting. One in four programs were primarily office based.

Table 5: % Contacts Occurring in the Office		
Total Current Clients	N	%
Under 20%	26	53%
21-49%	6	12%
50-74%	6	12%
75-100%	11	22%
Total Programs	49	100%

Three programs (6%) reported that their staff never traveled to deliver services and 27% of programs reported that in a typical week, their staff were on the road more than 15% of the time.

Eight programs (16%) estimated that half or more of their clients had frequent contact with staff, several times a week or more. **Table 6** shows that the majority of client contacts are planned in advance by staff members.

Table 6: % Contacts Planned in Advance or Initiated by the Client		
% Contacts	Planned in Advance	Initiated by the Client
Under 25%	31% (15)	17% (17)
26-50%	6% (3)	11% (5)
Over 50%	63% (30)	72% (33)
Total	48	46

Clients could remain in a program for over five years. Nineteen of the 46 programs responding to this question (41%) reported that they had clients that had been receiving services for over five years. Eight of these (17% of 46) reported that 60% or more of their clients had been receiving services for five years or more suggesting that a significant portion of community mental health clients are long term users.

Partnerships and Collaborations:

Programs were asked to provide information on any formal partnership agreements that they had with other community programs and organizations. For each partnership and collaboration, programs were asked to describe whether the partnership or collaboration was with a mental health agency or another community services, and the purpose of the partnerships, recognizing that partnerships could be for more than one reason.

Table 7 shows there were a total of 171 inter-agency partnerships or collaborations for an average of approximately three per agency. The majority of these were with other mental health agencies. Partnerships were for multiple reasons—470 different reasons. The most frequent reason for partnerships with other agencies was to make and accept referrals, share treatment planning and delivery, or for staff training. The least common reason for creating a partnership was to share intake assessment and referral. Partnerships with agencies outside of the mental health system often were for social, vocational, or support services, such as housing, employment, financial, or transportation. In addition, other arrangements were made for purposes of conducting legal assessments, prevention or promotion activities, and discharge planning.

Table 7: Partnerships & Collaborations		
Type of Partnership	Total	%
Program Type:		
▪ Mental health agency	129	75%
▪ Other agency	42	25%
▪ Total	171	100%
Purpose of Partnership:		
▪ Make/accept referrals	137	29%
▪ Shared treatment planning & delivery	92	20%
▪ Inter-agency training	68	14%
▪ Shared client information	59	13%
▪ Crisis/emergency service	56	12%
▪ Shared intake assessment & referral	31	7%
▪ Other	27	6%
▪ Total	470	100%

Formal partnerships and collaborations were also reported with inpatient psychiatric services. The most commonly cited reason was for protocols to involve agency staff in client care. Fifty-five of the 116 collaborations (34%) were for this purpose. Collaboration in support of inpatient admission was cited in 39 instances (47%). Partnerships for other reasons occurred in 22 instances (19%) such as crisis and emergency assessment, training, and consultation.

Consumer Involvement:

Twenty-five programs (51%) had a client advisory group. In all cases, mental health consumers were represented. Ten programs (40% of 25) did not have representation from family members on their advisory group. Seven programs (28% of 25) had representation from other groups.

Respondents were asked to describe any additional mechanisms used by their program to ensure consumer involvement in planning and service delivery. These included:

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- Regular client satisfaction surveys
- Client representation on agency boards
- Consumer councils and consumer initiated program activities
- Consumer employees and volunteers
- Shared treatment planning
- Involvement of consumers in program planning
- Consumer involvement in accreditation activities
- Client advocacy
- Linkages to consumer coalitions and peer support groups
- Consumers representation on the Board
- Suggestion box

Programs were also asked to specify the composition of their agency's Board with respect to consumer and family membership. Thirty-eight programs responded to this question. Consumer involvement on Agency Boards ranged from none, to approximately one third, with the average (median) being about 20%. Six programs (16% of 38) reported that their Agency Boards did not have any consumer representation. Family representation ranged from none, to approximately 25%, with the average (median) being about 10%. Eight programs (26%% of 38) reported that their agency Board did not have any family representation. All but three programs had service providers represented on their Board, the average (median) being about 10%. Community representation on Boards ranged from 16% to 100% with the average (median) being approximately half.

Staffing:

Programs reported a total of 301 Full Time Equivalent (FTE) staff positions filled by 343 individuals. The majority were program staff providing direct clinical care services (Table 8).

Table 8: Staffing Complement		
	# Funded FTE's % (Total)	# of Individuals % (Total)
Administrative/clerical	12% (36)	17% (60)
Management	12% (35)	13% (44)
Program	77% (230)	70% (240)
Total	301	343

Eighty-percent were program positions (55 FTE's), 10% were for management positions (7 FTE's) and 10% were for administrative and clerical staff (97 FTE's). A number of programs added staff positions in the year prior to the survey totaling 69 FTE's and virtually no staff positions were lost. Staff turnover was approximately 11% during the year prior to the survey with turnover in 2 FTE administrative/clerical positions, 1.5 FTE manager and 30 FTE program staff.

Table 9 summarizes disciplines and specialties represented among programs in terms of FTE equivalents. This includes program staff that are funded through agency budgets as well as some 8% of staff that are available through funding arrangements and special inter-agency agreements. Nursing staff made up 22% of the work force. Mental health practitioners such as addictions specialists, behavioural technologists, or child and youth workers accounted for 28% of the workforce. More than one third of the workforce were diploma trained, although it is difficult to estimate this precisely given the combined bachelor/diploma categories. There were 21 FTE psychiatrists but the bulk of these were general adult psychiatrists. Only one FTE child and one

FTE forensic psychiatrist were available. There were no geriatric or addictions psychiatrists regularly accessible to these programs.

Table 9: Disciplines & Specialties Represented Among Programs	
Discipline/Specialty	FTE's
Nurses:	
Clinical Nurse Specialists (Masters level with Registration)	1
Registered Nurses (Bachelor Level with Registration)	17
Registered Nurses (Diploma with Registration)	37
Registered Nursing Assistants (College with Registration)	13
Mental Health Practitioners:	
Addictions Specialist (Bachelor/diploma with specialized training in addictions)	3
Mental Health Practitioner (Bachelor/diploma)	30
Pastoral Associate (Masters degree with theological training or ordination)	7
Behavioural Technologist (Diploma)	20
Child and Youth Worker (Diploma)	20
Clinical Dietician (Bachelors in Nutrition with Approved Internship)	4
Psychology:	
PhD-trained Psychologist (registered in Ontario)	8
Psychological Associate (Masters level with Registration)	1
Psychometrist (Masters level with training in test scoring)	9
Psychiatrists:	
General Adult Psychiatrists	19
Child Psychiatrists	1
Forensic Psychiatrists	1
Geriatric Psychiatrists	.2
Addictions Psychiatrists	--
Social Workers:	
Social Worker – Masters level	45
Social Worker – Bachelor level	5
Vocational and Rehabilitation:	
Occupational Therapists (Registered)	8
Recreational Therapists (Bachelor trained)	4
Vocational Specialists (Bachelor level or diploma)	9.2
Peer Support Workers (History of mental illness & three years experience in psychosocial rehabilitation)	4.5
Other	38

Access to Psychiatrists:

Almost 60% of the programs surveyed (N=29) thought that they would benefit from having greater access to psychiatrists. **Table 10** summarizes the extent to which programs currently have frequent psychiatric input. Frequent input was defined as using input from psychiatrists often or always.

Table 10: Frequent Psychiatric Input in Program		
	Total	%
Intake Assessment & Diagnosis	28	57%
Treatment & Follow-up	26	44%
Discharge Planning	18	31%
Education & Training	14	29%
Evaluation & Research	10	20%
Program Planning	10	20%
Note: Each item reflects a percent of 49 programs.		

Psychiatrists frequently provide input into intake, diagnosis, and treatment (in 50-60 percent of programs). They are frequently involved in discharge planning or education and training (in about a third of the programs), but are used less frequently for evaluation research and program planning.

Continuing Professional Education:

Most programs provided some incentive for staff to engage in continuing professional education. Most often this took the form of financial assistance to attend conferences or other educational events (63%). In a minority of instances, programs provided time from work to attend conferences (6%), or worked with staff members to develop individual development profiles (8%). Eleven programs (22%) reported they did not provide incentives for continuing professional education. However, virtually every program provided educational opportunities internally. A third (29%) provided educational opportunities for external providers as well. **Table 11** summarizes the

various means used by programs in determining staff continuing professional educational needs. As programs could use more than one strategy, each row provides the percentage of all programs using this strategy as a planning option.

Table 11: How Educational Needs Of Staff Are Determined		
	Total	%
Individual provider choice	38	78%
Survey of provider's self-identified needs	21	43%
Indirect means (chart audits, comparison of clinical approaches to evidence based care, etc)	22	45%
Staff requests	49	100%
Other	11	22%
Note: Multiple response items. Each percent is calculated based on 49 programs.		

Approaches based on individual staff requests figured prominently. Less obvious were approaches that matched staff training and continuing professional educational needs to broad organizational objectives or district level needs.

Table 12 reviews the continuing professional educational needs across the life span for six key areas. Program staff reported fewer educational need with respect to children, likely because children fall outside of the mandate of most mental health programs. The highest need was identified in the areas of disturbed or violent behaviour and forensic/legal issues with respect to both adults and youth. Educational needs in the area of concurrent disorders was also high.

Table 12: Continuing Education

Area	Children (under 16)	Youth (16-24)	Adult (25-64)	Geriatric (65+)
Concurrent disorders	6% (3)	82% (40)	88% (43)	67% (33)
Developmental disabilities	6% (3)	59% (29)	61% (30)	45% (22)
Disturbed or violent behaviour	8% (4)	82% (40)	90% (44)	59% (34)
Forensic & legal issues	6% (3)	86% (42)	94% (46)	67% (33)
Mental health legislation	8% (4)	76% (37)	84% (41)	65% (32)
Research & evaluation	4% (2)	74% (36)	82% (40)	59% (29)

A number of additional educational and training opportunities were identified, such as:

- Consumer and family initiatives
- Information technology
- Selected illnesses such as personality disorders, acquired brain injury, mood disorders, schizophrenia
- Use of psychotropic medication
- The recover strengths model
- Staff safety

A number of suggestions were also made for district-based approaches to continuing education including:

- A 3-5 year educational plan based on identified needs of hospital and community sectors,
- Dedicated funding for staff educational opportunities including pooling of resources,

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- Semi-annual seminars on high interest topics,
- Greater use of local experts to provide in-service training.
- Greater access to psychiatrists and other specialized staff (GP's, addictions specialists, etc).

Chapter 4

Results - Children & Youth

Mental health services for children and youth are organized through two Ministries: the Ministry of Community and Social Services, and the Ministry of Health and Long Term Care. In an attempt to better understand the scope of these programs and their patterns of utilization, surveys were sent to all children and youth agencies, regardless of their funding source. Four agencies representing all those funded by the Ministry of Health and Long Term Care responded:

- Canadian Mental Health Association, Hastings and Prince Edward Branch (1 program)
- Division of Child and Adolescent Psychiatry, Hotel Dieu Hospital (4 programs)
- Quinte Healthcare Corporation (3 programs)
- Youth Habilitation Quinte Incorporated (1 program)

The range of services provided by these programs included first line (N=1), intensive (N=3), and specialized (N=4), including a specialized forensic assessment clinic, and one community outreach program. Five programs offered intensive case management services. Four programs were established prior to 1980 (as early as 1965), one was established in the 1980's, and the remaining four were established between 1990 and 2000.

The range of services available is shown in **Table 13**. Family support and education, health promotion/prevention, counselling and treatment, and public education were provided by the majority of programs. Housing support, consumer directed peer support and vocational programs were least represented. No programs provided assertive community treatment, mobile crisis, or social/recreational services.

Table 13: Services Offered to Children and Youth	
Service	Total of 9 Programs
Case management	5
Crisis	4
Counselling & Treatment	7
Family Support & Education	8
Housing & Housing Support	1
Social & recreational	1
Consumer directed peer support	1
Outreach	2
In-reach	2
Promotion & prevention	6
Public education	6

Access:

Table 14 summarizes the time clients typically wait between referral and first assessment, and between their referral to the program and their first treatment contact. The majority of programs were able to assess clients within a month of their referral. The longest wait for a referral was 4-8 months. All programs were able to provide treatment within one month.

Table 14: Waiting Times for Assessment and Treatment		
Wait Time	First Assessment Total of 9	First Treatment Total of 8*
same day	1	1
under 1 week	1	2
1-3 weeks	2	3
3-4 weeks	1	1
1-4 months	2	--
4-8months	1	--
not applicable		1
* Missing = 1		

One program had used trained interpreters within the year prior to the survey, and one program reported that one quarter of their staff had cultural sensitivity training. No programs provided materials in another language and none reported offering culturally sensitive programming. Language was identified as a potential access barrier by two programs, particularly with respect to immigrants and refugees. One program also identified a large deaf population in the community that experienced barriers accessing care.

Regarding special populations, three programs indicated that they excluded clients with concurrent substance abuse and psychiatric disorders and two excluded clients with acquired brain damage. Clients with a history of disruptive behaviour, serious personality disorders, mild to moderate mental retardation, or forensic clients were not excluded from any of the programs. Two programs excluded children who were over the age of 16.

Utilization:

Five of the nine programs did not provide utilization data describing the number of current clients. The total number of clients reported by the remaining four programs

was 305, three quarters of which had had a program contact within the last three months.

Eight programs were able to report on the number of admissions they had had in the previous twelve months. The smallest programs admitted 40 clients whereas the largest admitted 352. Altogether they admitted 1,353 clients.

Most of the programs provided the majority of services from their offices, although two programs provided all of their contacts in a community setting. Home visits were also identified but these were infrequent. Six of the nine programs assigned clients to an individual care provider; two assigned clients to teams, and in one case this question was not applicable. Typically, clients were in contact with program staff once or twice per month. In all cases, the majority of contacts (60-100%) were planned in advance and so seldom initiated by the client. Four programs reported that the majority of their clients (80-100%) stayed in the program less than one month. One program indicated that the majority of their clients stayed with the program for one year or more. Otherwise, clients were somewhat evenly spread between one month and one year. Very seldom did program contacts extend beyond two years and no clients were reported to spend more than five years in any program.

Partnerships:

The nine programs surveyed reported eighteen formal partnership agreements they had with other community programs and organizations. Twelve of these were with other mental health agencies. Most frequently, partnerships were to make and accept referrals (N=15 partnerships), share clinical information (N=12), share treatment planning and service delivery (N=11), or for miscellaneous other reasons (N=11). Other reasons for partnering included emergency or crisis support (N=6), inter-agency training (N=6), or shared intake (N=5). In addition, three programs reported formal partnerships with inpatient psychiatric services.

Consumer Involvement:

Two of the nine programs reported having a consumer advisory group and both indicated that it included consumers, family members, and others. Parental meetings,

client surveys, having consumer representatives on team meetings, suggestion boxes, and client fora were identified as additional mechanisms for soliciting consumer input. One or another of these was identified by all nine programs. Four programs outlined the composition of their agency's Board. Consumers and family members were represented but in small numbers, usually 10% or less. Service providers were more frequently represented, and community members were most often represented.

Staffing:

Table 15 shows that the total reported staff complement was approximately 31 full time equivalents. About a third of these were mental health practitioners with either a bachelor or diploma training.

Approximately 12% of the FTE's reported were assigned to management roles, an additional 11% to administrative clerical roles, and 77% to program roles. In the year prior to the survey, no new positions were added in any of these categories. However, 2.16 full time equivalents were eliminated from program staff.

With respect to staff turnover, two FTE management positions changed in the year prior to the survey and 7.5 FTE program staff changed positions—approximately 34% of all program staff.

Table 15: Disciplines & Specialties Represented Among Programs Serving Children and Youth

Discipline/Specialty	FTE's
Nurses:	
Clinical Nurse Specialists (Masters level with Registration)	--
Registered Nurses (Bachelor Level with Registration)	--
Registered Nurses (Diploma with Registration)	1
Registered Nursing Assistants (College with Registration)	--
Mental Health Practitioners:	
Addictions Specialist (Bachelor/diploma with specialized training in addictions)	--
Mental Health Practitioner (Bachelor/diploma)	1.4
Pastoral Associate (Masters degree with theological training or ordination)	1
Behavioural Technologist (Diploma)	--
Child and Youth Worker (Diploma)	4.3
Clinical Dietician (Bachelors in Nutrition with Approved Internship)	5.2
Psychology:	
PhD-trained Psychologist (registered in Ontario)	2.3
Psychological Associate (Masters level with Registration)	--
Psychometrist (Masters level with training in test scoring)	4.9
Psychiatrists:	
General Adult Psychiatrists	1
Child Psychiatrists	2.2
Forensic Psychiatrists	1
Geriatric Psychiatrists	--
Addictions Psychiatrists	--
Social Workers:	
Social Worker – Masters level	4.5
Social Worker – Bachelor level	1
Vocational and Rehabilitation:	
Occupational Therapists (Registered)	.5
Recreational Therapists (Bachelor trained)	--
Vocational Specialists (Bachelor level or diploma)	--
Peer Support Workers (History of mental illness & three years experience in psychosocial rehabilitation)	--
Other - Teacher	1

Access to Psychiatrists:

Table 15 also shows that children and youth programs have access to 4.2 FTE psychiatrists; one FTE adult psychiatrist, 2.2 child psychiatrists, and 1 FTE forensic psychiatrist. They were primarily funded through salary arrangements through Queen's University. Two programs accessed psychiatrists through sessional funding arrangements.

Programs were asked to indicate to what extent they regularly use input from psychiatrists with respect to intake assessment and diagnosis, treatment and follow-up, discharge planning, education and training, evaluation research, and program planning. Slightly more than one third indicated that they often or always use psychiatrists, however they were used largely for input into clinical services and less so for input into discharge planning, evaluation, and education. The remaining programs seldom used psychiatric input in any of these areas. Five programs indicated they would benefit from greater input from psychiatrists. Comments provided also indicated that greater involvement of psychiatrists across Ministries would be of benefit.

Continuing Professional Education:

Continuing professional education was not mandatory for any of the programs surveyed. Five programs provided incentives for staff to pursue continuing professional education. In four cases, programs were affiliated with the University so had access to development funding. In the remaining program, staff could have time off to attend educational activities or their costs covered.

The most common method of identifying the educational needs of staff was through individual provider choice (N=8), or through staff requests (N=8). Programs less frequently surveyed staff needs (N=3) or used indirect means such as chart audits (N=3). Three programs indicated that educational means were identified in the context of a broader development strategy.

Programs identified a number of areas where staff would benefit from continuing education. For educational opportunities pertaining to children under 16, in order of importance these were, research and evaluation (N=6), disturbed or violent behaviour (N=4) concurrent disorders (N=4), mental health legislation (N=3), developmental disabilities (N=1), and forensic/legal issues (N=1). For opportunities pertaining to

youth aged 16-24, these were research and evaluation (N=4), concurrent disorders (N=2), developmental disabilities (N=1), disruptive and violent behaviour (N=1), and forensic/legal issues (N=1). No program identified legislation as an important area for continuing professional development related to youth. In addition, four programs commented on the need for district wide strategies, particularly those that could integrate professional educational needs across Ministries (Community and Social Services or Corrections). However, they noted that much more integration would first be necessary across these Ministries in order to determine areas of overlapping need.



Discussion & Recommendations

Summary – Programs Serving Adults

This survey targeted agencies providing intensive community mental health care, regardless of whether their parent agency was a hospital or a community-based service, who were involved in the C-CAP project. Thirteen agencies involving 49 separate programs responded.

Results highlight the fact that the bulk of community mental health development in the Southeastern Ontario region has occurred recently with the most intensive period of growth occurring since 1995. There was considerable diversity in community based programming represented in this survey. By far, the most frequently occurring type of community service was the more traditional counselling and treatment service. Just over one quarter of all programs surveyed provided intensive community based services such as assertive community treatment or case management. Social/recreational programs and housing programs were underrepresented. Crisis and emergency services were also under-represented but this was because first line agencies were excluded from our sampling plan.

With respect to access by specialty groups, most programs did not specifically target complex or specialty populations. Nor did they explicitly exclude them from treatment, the only exception being persons with dual diagnoses. The majority of programs were able to provide treatment within one month of referral. In the remainder of cases, clients may wait up to two years. Certain cultural barriers were also identified that may hinder access to programs for First Nation's Peoples, Francophone, Immigrant/Refugee, and hearing impaired. While not considered to be major or pervasive, barriers were identified by a small number of programs.

With respect to utilization, programs identified a total of 4,700 clients who were registered and active during the three study months. The average program size was 75 clients and the average number of new admissions in the year prior to the survey was 25. In total, there were 1,000 new admissions over all of the study programs. Programs undertook a considerable amount of community-outreach and out-of-program service delivery. Over half of the programs had fewer than 20% of their client contacts in their home base. One out of four programs was primarily office-based.

Long stay clients, defined as having spent five or more years in the program, were not uncommon. Almost half of the programs had clients that had been receiving services for over five years. Seventeen percent of programs reported that 60% or more of their clients had been receiving services for five years or more.

Programs had developed a number of active partnerships and service arrangements both within the formal mental health system and outside of it. Partnerships were for a variety of purposes including treatment delivery, sharing of clinical information, and training.

With respect to consumer input, half of the programs surveyed had a consumer advisory groups with consumer representation. . While these were well populated with clients, family members were often absent. Forty percent of programs did not have family representation in their consumer advisory groups. Agency Boards did have consumer input but they were more heavily weighted toward community members. Consumers, care providers, and family members tended to be in the minority. In

addition, a number of additional tools were used, ranging from consumer satisfaction surveys, to employing consumers as volunteers, consumer councils, and shared treatment planning.

With respect to staffing, the direction of change in the year prior to the survey was to add staff. Indeed, most programs added new positions. Staff turnover was about 11%. Administrative and management positions amounted to 24% of the total FTE's. The majority of direct treatment is provided by staff who are trained at the bachelor or diploma level.

Many programs did not have regular access to psychiatrists and wished more. When psychiatrists were involved in programs, most often it was with respect to the provision of direct clinical care—assessment, diagnosis, treatment, follow-up, and discharge planning. They were less often involved in education, training, evaluation, research, or program planning, despite the fact that many programs would appreciate their input in this regard.

With respect to staff training and continuing professional education, most programs engaged in continuing education and provided incentives for their staff to attend conferences and educational events. Top priorities for additional education were similar across the lifespan and related to forensic, legal issues; disturbed or violent behaviour; and concurrent disorders. There was a lack of district-based or program-based approaches evident in determining staff educational needs. Suggestions for district-based continuing educational activities included better use of local experts. Not only would this make better use of existing resources, it would reduce the costs of educational activities. A district-based plan was recommended that could include regular conferences.

Summary—Programs Serving Children and Youth

Nine programs, all those funded through the Ministry of Health and Long Term Care responded to this survey. Ministry of Community and Social Service (MCSS) agencies declined participation in this project. Meetings with representatives from these agencies revealed that this had both a philosophical and a practical basis.

Philosophically, MCSS agencies do not segregate mental health programs and services for children with mental illnesses to avoid labeling and stigma. Consequently, in practice, diagnostic labels are not used in record keeping or in existing information systems. Thus, it is impossible to provide data on this sub-population of children and youth, or even guesstimate its size. This has important implications for Task Force planning across the life span, particularly for transitional children and youth who will ultimately require the services of the mental health system as they grow older. Without some estimate of the numbers leaving the Ministry of Community and Social Services, we will be unable to assess the extent to which clients may not make the transition or effectively plan for their future needs.

Mental health system programs targeting children and youth largely provided intensive and specialized services. Like adult programs, there was a heavy emphasis on counselling and treatment but there was also a greater emphasis on providing family support and education, promotion/prevention, and public education.

Compared to the C-CAP adult programs, programs serving children and youth had shorter wait-times between referral and treatment. All clients would typically receive treatment within one month of referral. Clients also moved through these programs faster and there were fewer longer stay clients (over two years). This would be expected given that children would typically transfer to adult agencies as they grew older.

The majority of programs could not estimate the number of current clients they had. Survey comments indicated that this may be a particular problem with hospital-based record keeping systems that seemed not to permit out-reach or off-site clients to be officially registered in the statistics. Nevertheless, eight programs provided information on the number of admissions they had had during the previous year. Given these caveats, a conservative estimate of the number of children and youth receiving services in the mental health system during any given year would be approximately 1,400.

With respect to access, few programs reported exclusions. When they did, exclusions pertained to individuals with concurrent substance abuse disorders, those with acquired brain damage, and youth over the age of 16 years. The lack of individuals trained in American Sign Language in one catchment area was seen as a barrier to the large deaf population living there.

Though no explicit barriers were identified with respect to cultural sub-groups, no program indicated that materials were available in French, and none reported that they provided services specifically geared to cultural groups such as First Nation's Peoples. Only one program reported that any staff had received cultural sensitivity training. However, it is difficult to assess the extent of need for culturally sensitive programming in this district.

All programs reported having formal partnerships with other agencies. The majority of these were reported to be within the mental health system for purposes of clinical management or staff training. Virtually no formal partnerships were identified between Ministry of Community and Social Service agencies and comments indicated that children and youth treated in the MCSS system may benefit from greater psychiatric input. Without comparable information from MCSS services, however, this is difficult to judge.

All programs indicated that they employed mechanisms designed to obtain consumer feedback, either from children/youth or their parents. Formal consumer advisory groups were rarely employed. Agency Boards had some representation of consumer interests but tended to be more heavily oriented to the general public and professional staff.

Agencies providing services to children and youth used approximately 23% of their FTE time on administrative and management activities. This is comparable to C-CAP agencies. However, whereas C-CAP agencies had gained staff positions over the past year (some 24% of their current workforce overall), programs serving children and youth reported that they had lost positions; approximately 7% of their FTE work force. Similarly, child and youth programs had significantly higher staff turn-over; over a third of their program staff in the year prior to the survey. It is not clear from the survey comments why this is the case; however it is of considerable concern and warrants more detailed evaluation.

Although child and youth programs currently access over 4 FTE psychiatrists, five programs indicated that they would benefit from greater psychiatric input. Only one third of the programs surveyed indicated they had regular input of psychiatrists, mostly for clinical functions. Psychiatric input into non-clinical functions was less available. Greater access to psychiatric input across ministries was also raised as a concern.

Finally, with respect to professional development, two areas were identified as important in both children under 16 and those 16-24. These were research and evaluation and concurrent disorders. For children under 16, professional development with respect to disturbed behaviour was also considered a priority. The heavy emphasis on research and evaluation may be a function of the fact that a significant portion of the programs were university based so would have a clear mandate to contribute to scientific knowledge in this area.

Recommendations:

Continued System Monitoring Through Regular Program Surveys

This program survey was the first of its kind in the Southeastern Ontario district. Much of the information provided by this survey was not known and should be fundamental to system planning. Therefore, it is recommended that program inventories be conducted on a regular basis in order to monitor system change, assess the extent to which we are expanding the community treatment system, and our progress toward mental health reform goals. Alternatively, key pieces of information contained in this survey should become part of an ongoing accountability and monitoring system.

Managing Long Stay Clients:

A significant number of C-CAP programs reported having a large long stay population defined as people who had been receiving services for five years or more. Given the extended nature of these services, and the possibility of creating dependencies, it is recommended that:

- Programs regularly monitor the extent to which services provided match client needs using the C-CAR or similar instrument.

- Programs develop and apply discharge policies to ensure that clients who have less intensive service needs are moved to less intensive service environments.

Managing Complex Clients:

While few programs actively excluded complex or specialty clients, none actively targeted them. With increasing deinstitutionalization, the complexity of clients receiving services from community based programs is expected to increase. Staff training for many of these populations will need to be improved. Few programs have regular access to medical and psychiatric expertise or the sessional funding to support this. Therefore, in preparation for bed closures and community re-settlement, it is recommended

- that financial arrangements be adjusted such that community agencies have regular access to psychiatric and medical expertise, as necessary for consultation and direct treatment, as well as for continuing professional education.
- all staff be systematically reviewed for core competencies and educational needs be determined based on these reviews,
- educational and professional development programs be coordinated at the district level drawing on local experts.

Consumer and Family Involvement in Advisory Groups:

In a system that is moving toward putting the consumer first, one way of accomplishing this is through active program advisory groups that represent the views of both consumers and family members. This cannot be the function of Agency Boards which may be heavily weighted toward community representation and may not address specific program issues. Therefore it is recommended that all programs develop program advisory groups composed of both consumers and family members.

Wherever appropriate and feasible, advisory groups should be specific to individual programs, although it is recognized that this may not be feasible in smaller agencies.

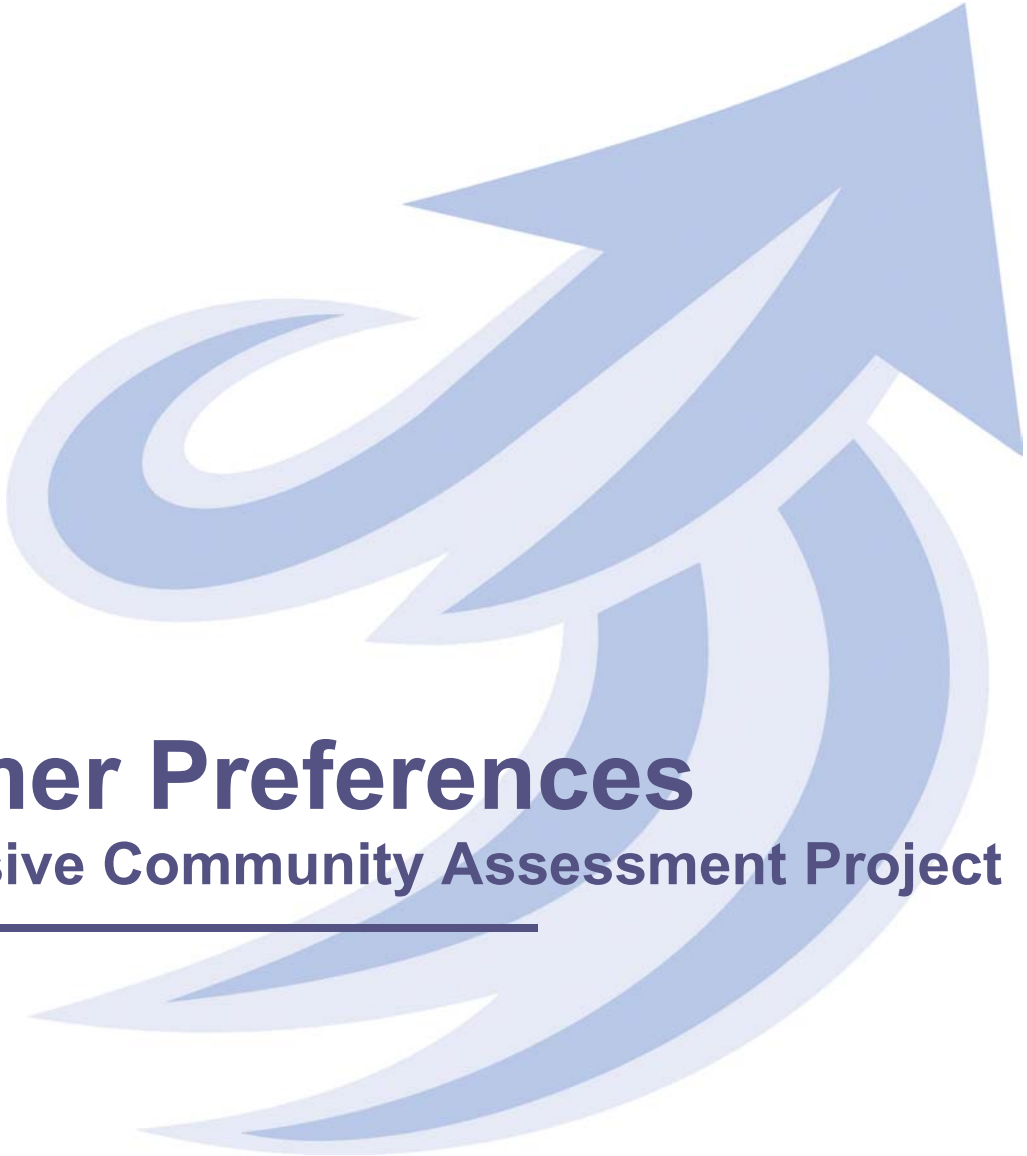
Better Inter-Ministerial Linkages:

Given our inability to collect planning data across ministries, and questions raised by survey respondents concerning the extent to which other ministries may have appropriate access to psychiatric expertise an important recommendation has to be to improve inter-ministerial linkages with respect to mental health issues. One difficulty was the lack of district-based structures, comparable to the Task Force, with which the Task Force could relate. This impeded planning. Philosophical differences also posed problems for local planning initiatives. Therefore, it is recommended that

- the Ministry of Health and Long Term Care take primary responsibility for making inter-ministerial linkages with respect to children and youth mental health programming
- a monitoring and accountability system be established to provide feedback to the Ministry of Health and Long Term Care on the extent to which joint-initiatives are functioning to full their objectives.

Staffing for Programs Serving Children and Youth:

The staffing pattern noted in this survey portrays a sector under stress. Whereas community mental health programs serving adults gain positions, programs serving children and youth lost them. Perhaps, as a consequence they also reported significantly higher staff turn-over. It is recommended that Ministry of Health representatives undertake a full review of programs providing services to children and youth with an eye to better understanding the volume of services provided to this sector and the extent to which current staffing patterns meet the needs of the clients being served.

A large, stylized blue arrow graphic that curves upwards and to the right, with a lighter blue shadow or outline following its path. It is positioned in the upper right quadrant of the page.

Consumer Preferences

Comprehensive Community Assessment Project

SOUTHEASTERN ONTARIO COMMUNITY COMPREHENSIVE
ASSESSMENT PROJECT

Consumer Preferences

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On Behalf Of:
The Research Committee

November 2002

Prepared By:

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A C K N O W L E D G E M E N T

This project benefited from the extensive support provided from consumers allowed us to interview them. Thanks are also extended to the staff of community mental health agencies who facilitated access to clients and who were instrumental in recruiting interview subjects. Finally, thanks are extended to the dedicated team of consumer interviewers who worked hard to make this project a success.

Executive Summary

Summary of Project

This study was part of a multi-centre planning initiative targeting community mental health programs in the Southeastern Ontario mental health planning district. It follows a long and growing legacy of such projects now completed in most of the mental health planning districts in the Province. This project was funded by the Southeastern Ontario Mental Health Implementation Task Force to assist them in making recommendations to the Ministry of Health and Long Term Care in support of mental health restructuring and reform.

The results of this study must be interpreted in light of the specific group of clients that were targeted—current users of community-based mental health treatment programs in the Southeastern Ontario mental health planning district. Programs addressing the needs of specialty populations, such as geriatric, forensic, concurrent disorder, or dual diagnosis populations were excluded, as were agencies and services outside of the formal mental health system.

In using these data, decision-makers should also be aware that clients from Brockville Psychiatric Hospital community services were excluded. During the course of this project, Brockville Psychiatric Hospital was divested to the Royal Ottawa Hospital Group in the Champlain mental health planning district. The Royal Ottawa Hospital Group has a separate process for obtaining ethics approval. Although this study was approved by Queen's University (and other universities throughout the province where it was conducted), we were unable to obtain approval from the Royal Ottawa Ethics Committee. The objections that were raised could not be overcome within the time lines allocated for this project. Although we have included clients from Providence Continuing Care Centre Mental Health Services (so have incorporated the views and preferences of a psychiatric hospital community population), the exclusion of the Brockville Psychiatric Hospital clients is considered to be an unfortunate study limitation.

We used a quota sampling procedure that allowed each agency to recruit respondents proportionate to their size. Small agencies contributed fewer clients than large agencies. A total of **324 clients** were recruited. Agency staff were instructed to approach current clients defined as those who attended treatment during the course of the study months (May-August 2002). The aim was to approximate the cross section of clients who were current users of community mental health services such that the full range of preferences and views were expressed. Subsequently we found that our quota sampling procedure resulted in a sample that was representative to the population of community mental health users with respect to age and gender.

Key Findings:

With respect to living arrangements, the majority of individuals were living in their own apartments. Women were more likely to be living with a spouse and more likely to be living in their own homes and men were more likely to be living alone. Most did not have supervision or support where they lived. Men reported receiving significantly higher levels of support, possibly because they were more likely to be living alone. One quarter had moved in the last year at least once and a third would move if they could.

The majority were not working for pay and reported their main source of income to be a disability pension or other government subsidy. Fewer than one in ten identified a job as their major source of income. Almost half indicated that they seldom or never had enough money to get through the month, most often those receiving disability pensions.

Most were intensive service users. Three quarters had a care coordinator to help them coordinate their care and solve problems. The majority had had their care coordinators for over six months.

Two thirds had a regular psychiatrist which they had had for over six months and saw on a regular basis (such as monthly or weekly). Women were significantly less likely to report having a regular psychiatrist than men.

Most had a family doctor and visited them for mental health treatment on a monthly basis, although women reported significantly more visits than men. Approximately one third indicated they also had a worker, other than a doctor, that helped them manage their medications, usually on a weekly or monthly basis. Men were significantly more likely to report this additional support.

Most of those surveyed had been hospitalized at some time for their mental health problems, significantly more men than women. Approximately 40% of these had been hospitalized involuntarily. Ten percent reported using a hospital emergency in the six months prior to the survey and 60% of these reported multiple visits.

Less than one fifth of consumers reported they were members of a consumer/survivor initiative. Those who were members reported frequent contact once or twice a week.

One quarter of the sample reported having difficulties communicating with a health professional about their needs during the past year, often because their views were not taken into consideration. Half reported delaying seeking treatment at some time in the past because they were afraid of being stigmatized. Most often this happened more than a year ago and less than one if five reported delaying treatment because of fear of stigma in the past six months.

One in three individuals reported having difficulty affording their medications when they were not in hospital and approximately 15% had difficulty all of the time.

Consumers rated a number of services according to whether their needs were being met. For most (approximately three quarters) services were generally being provided in the right amount, however, this varied depending on the service. For example, few reported needing more help with medication management. However, a quarter identified a greater need for treatment and diagnosis services, psychotherapy and counselling, help with managing upsets and crises, and finding out what services are available. The majority (90%) felt they did not need substance abuse counselling. Virtually no one indicated they were receiving services in excess to their needs.

Less than a quarter indicated they were receiving inadequate community supports. The most problematic areas were in obtaining skills and educational training, finding a job, and obtaining transportation. Women reported significantly less support in a number of areas: helping agencies to work together, obtaining benefits and income supports, getting and maintaining housing, and to a lesser extent, getting help with legal problems.

The majority of clients (85%) indicated they were generally satisfied with the services they received. Less than one in ten were generally dissatisfied and a small number (6%) were unsure. Satisfaction with the provision of clinical services and the process of clinical care was the highest. The majority reported that their ideas and opinions counted, they had a treatment plan, their services fit their needs, and they were treated with respect and

dignity. Women were more likely to report that they did not know where to go when they were dissatisfied with treatment.

There was greater variability concerning system-level characteristics. Fifteen percent indicated that services did not work together to meet their needs, one quarter said they had to deal with too many agencies and professionals, and a third of women and 40% of men thought that they would have difficulty accessing a hospital bed if they needed it. About a quarter indicated they felt stigmatized by health professionals.

Close to half of those surveyed reported that they had worries about mental health reform in their region. The major worry was associated with a perceived loss of access to care due to cut-backs and bed closures.

Study Limitations:

The results of this survey should be used taking the following issues into consideration.

This project benefited from the support of agency staff who were instrumental in recruiting clients to be interviewed, and in some cases, in transporting the interviewer to the client. Whenever agency staff play such an instrumental role in recruitment, the question may be raised as to whether they referred only those clients whom they believed would paint the best picture of program or system functioning. If this had been a pervasive problem, we would have expected that our sample would not be representative of the population of current users. The fact that the sample was representative with respect to age and gender suggests that sampling for this study was not biased.

By design, this survey was limited to current clients of community mental health services. These results do not provide planning information on clients who are transient or marginally housed who may be excluded from regular community programming because they are difficult-to-serve.

In a handful of instances, case workers were present during the interviews. Often this was at the request of the client when interviews were conducted in the home and the client felt more comfortable having the case-worker present. The interviewers who conducted these interviews did not feel that the presence of the case-worker in any way hampered responses, however, this must always be kept in mind as a possibility. None of the questions on the interview schedule asked the client to rate the case-workers services specifically, but in rural areas, that may have been the only service obtained.

Clients had a number of responses to the questionnaire. Interviewers reported that many clients, particularly those in rural and under-serviced areas did not know what consumer/survivor initiatives were, and were unfamiliar with the mental health reform initiatives underway in the province and in the district. Many clients were dissatisfied with our use of the word “mental” to describe disorders and would have preferred a less reactive term such as “emotional” problems.

Finally, it should be pointed out that this survey was conducted part way through the divestment process. In some locations, staff burnout was reported to be high. In others, reinvestment dollars had already been provided to improve community services. Satisfaction ratings of services may have suffered in the context of these upheavals. In addition, the divestment of Brockville Psychiatric Hospital to the Royal Ottawa Hospital Group and the resulting transfer of responsibility for ethics review to the Royal Ottawa Hospital was a significant impediments to this study. Despite the fact that the study protocol had received ethics approval from Queen’s University, and several other universities in the Province, it did not receive ethics clearance from the Royal Ottawa Hospital. This meant that clients of Brockville Psychiatric Hospital could not be included in this planning effort. Information from clients of Providence Continuing Care Mental Health Services was included so the perspective of clients of psychiatric hospitals in the district is not entirely lost.

Conclusions and Recommendations:

The key findings of this survey echo the findings from the other components of the C-CAP projects. Clients are generally satisfied with the clinical services they receive, but feel under-serviced with respect to the recovery supports they need to support their independent community living and system-level functioning. Therefore, system integration and the implementation of recovery supports in the following areas must remain a priority for mental health reform and reinvestment funding:

- safe, affordable, and stable housing that can be maintained over periods of hospitalization;
- income benefits that provide incentives for working taking the episodic nature of many illnesses into consideration;
- employment opportunities (including supported employment where appropriate);

- better drug benefits; and
- transportation supports for those living in rural areas who feel particularly isolated.

Given that the first time many consumers had heard about mental health reform was during this interview, it is imperative that community consultation efforts focus on consumers who are receiving treatment, as well as consumer advocacy groups in order to address reform issues. In particular, it will be important to provide information on the view held by many that mental health reform is synonymous with bed reductions and reduced access to hospital services.

Secondly, clients must know what avenues of accountability are available to them if they have any kind of problem with mental health including access problems. District-wide accountability mechanisms, once developed, need to be widely communicated to clients and their families. Local area and district-wide information resources concerning system functioning and access to clinical and rehabilitation services also deserve high priority.

Routinely conducted consumer preference surveys should be used on an ongoing basis (e.g. every 2-3 years) as one form of accountability at both the program and the system levels and to ensure that representative cross-sections of consumers views are incorporated into mental health planning. Each time the survey is given, additional questions can be added to the core to delve deeper into a particular issue.

Finally, stigma and discrimination were common experiences of mental health consumers in this survey. Consumers often lower their expectations and settle for second best, and in so doing stigmatize themselves. Thus, in addition to efforts that are directed toward the community, there should also be anti-stigma efforts that are directed toward consumers that teach self-management of stigma through empowerment, affirmation, education, and self-worth.

Introduction & Purpose

This Community Comprehensive Assessment Project, or “C-CAP” was funded by the Southeastern Ontario Mental Health Implementation Task Force and undertaken in collaboration with the Ministry of Health and Long Term Care to support mental health planning for reform. Its purpose was to formulate recommendations concerning the community care needs of mental health clients in the Southeastern Ontario planning district by assessing the match between needs and services provided.

The C-CAP was part of a Provincial multi-centre, provincial initiative coordinated by the Health Services Research Unit of the Centre for Addiction and Mental Health in Toronto (the Coordinating Centre). To develop local evaluation capacity, the project was conducted by a research team led from Queen’s University. The Research Committee of the Southeastern Ontario Mental Health Implementation Task Force steered the project and defined the local study parameters.

The empirical objectives of the Southeastern Ontario C-CAP were to:

- Survey consumers for their perspectives on mental health service use and needs;
- Survey staff about the care needs and current service use of a representative sample of recipients of intensive-level community mental health services; and
- Develop a standardized service profile of participating C-CAP agencies.

This Report:

This report is submitted to the Mental Health Implementation Task Force on behalf of the Research Committee. It describes the results of the consumer preference assessment. The results of other two C-CAP components—the CCAR assessment matching services to needs, and the program inventory—are described in separate reports.

Background & Methods:

Background

Making it Happen, the Ontario Government's policy document describing mental health reform goals, explicitly identifies consumer focus as a key feature of the reformed mental health system. This means that consumers will have streamlined access to the services they need to support their recovery and community participation, they will be active partners in all aspects of treatment, program delivery, system development, and research, and their preferences will be taken into account. The Community Preference Survey was one of several similar projects conducted throughout the province to assess consumer views.

Target Population for the C-CAP:

The target population for all components of the C-CAP project was pre-defined by the Coordinating Centre to be current clients of community mental health programs who were 16 years of age or older. A current client was someone who had received services within three months of the survey. Clients who received specialty services from programs targeting forensic, dual diagnosis, concurrent disorder, and psycho-geriatric populations were excluded from the Comprehensive Assessment project in Southeastern Ontario as separate planning efforts were underway for these groups. Clients who received services outside of the formal mental health programs such as in Community Access Centres, Community Health Centres, Ministry of Health and Social Service agencies for children and youth, family practice settings, non-program based psychiatrists, or private mental health providers were also excluded.

There were thirteen community based agencies in Southeastern Ontario that were eligible to participate in the C-CAP project:

- Brockville Psychiatric Hospital Elmgrove Facility – Royal Ottawa Health Care Group
- Canadian Mental Health Association of Hastings and Prince Edward
- Canadian Mental Health Association of Leeds and Grenville
- Community Mental Health Program of Hastings and Prince Edward
- Frontenac Community Mental Health Services
- Lanark Community Mental Health Program
- Leeds Grenville Rehabilitation and Counselling Services
- Lennox and Addington Community Mental Health Services
- Quinte Healthcare Incorporated
- Quinte and Region Community Homes
- Queen’s University Affiliated Teaching Hospitals and Programs
 - Hotel Dieu Hospital
 - Providence Continuing Care Mental Health Program
- Youth Habilitation Quinte Incorporated

Brockville Psychiatric Hospital did not participate in the Consumer Preference portion of the C-CAP project for reasons that are described in the Ethics Section of this report.

Recruitment

In order to protect client confidentiality, clients must consent to have a researcher that is external to the program approach them in order to seek their study participation. In the Consumer Preference survey, agency staff first approached eligible clients to tell them

about the project and to ask for their consent to have an interviewer contact them. If they agreed to be contacted, the agency staff member passed along the contact information to a designated interviewer who would then seek and arrange an interview. The consent procedure was approved by the Queen's University Research Ethics Board. Details of the informed consent procedures that were used are available from the Principal Investigator on request. Interviewees were paid a nominal fee for their participation in this project.

Sampling Procedures:

Previous attempts in other parts of the province to obtain a random selection of clients from community based agencies proved to be problematic. In the three locations using this sampling procedures, response rates were low, in the range of 30% to 40%. The resulting samples were small and unrepresentative. Therefore, it was uncertain whether the full range of consumer views and preferences were reflected. This significantly diminished their value for local planning.

In order to ensure a larger sample size and approximate the cross section of clients who would have been chosen if a random sampling procedure had proved feasible, we used a quota sampling procedure that allowed each agency to recruit respondents proportionate to their size. Small agencies contributed fewer clients than large agencies. A total of **324 clients** were recruited reflecting an 80% response rate. Agency staff were instructed to approach current clients defined as those who attended treatment during the course of the study months (May-August 2002).

Table 1 evaluates the representativeness of our sample to the population of current users of mental health programs with respect to age and gender. Population figures were obtained from the sampling frame used in the needs assessment portion of the C-CAP and reflects current users of the thirteen community mental health services that were eligible for this portion of the study. It shows that consumers in the preference survey were slightly younger, although the differences were not considered to be statistically important. Therefore, the sample appears to be broadly representative of the population, at least for age and gender, and any preference factors that correlate with these.

Table 1: Comparison of Sample and Population Characteristics*						
Gender	16-24 Years % (Total)		25-64 Years % (Total)		65 + Years % (Total)	
	Sample	Pop**	Sample	Pop**	Sample	Pop**
▪ Male	41% (7)	34% (101)	48% (134)	40% (1232)	41% (11)	44% (99)
▪ Female	59% (10)	66% (200)	52% (143)	60% (1860)	59% (16)	56% (127)
* $\Pi^2_{(5,df)} = 7.46, p = .188$ ** reflects the population of current users of intensive community services (within 3 months) as identified in the sampling frame used for the CCAR assessments.						

Questionnaire Design:

A consumer preference assessment survey was available from prior CAP projects. This survey was pre-tested with a core team of consumer-interviewers for ease of administration (both in face to face or telephone interviews), understandability, and content. It was also reviewed for content by members of the Research Committee of the Southeastern Ontario Implementation Task Force. The survey instrument was re-designed to make it shorter, more focussed on local planning issues, and to improve the ease of administration while retaining core similarities with the original instrument. As a result, findings will be broadly comparable to the other consumer preference assessments conducted throughout the Province. It was pre-tested by consumer-interviewers during practice interview sessions and refined until it could be administered easily and reliably. A copy of the survey instrument is available from the Principal Investigator upon request.

Interviewer Training and Quality Control:

Twenty-one interviewers collected the consumer preference data. In order to realize the participatory goals outlined in *Making it Happen* all interviewers were current or past users of mental health services. Many had worked in previous CAP projects so were familiar with the interview process. Others had extensive interview experience in other university-

based research projects. Some had no prior experience and were trained specifically for this project.

All interviewers were trained in a 1-2 day training session, depending on the location and the number of interviewers to be trained. The session included an overview of the study goals, an interactive item-by-item review of the survey instrument, and practice sessions. Interviewers were carefully instructed in research ethics as they applied to this project, particularly in the consent procedure that was required.

A Study Coordinator was available throughout the project to address questions as they arose and interviewers maintained close contact with this individual. The Study Coordinator reviewed all returned surveys to ensure that they were complete and unambiguous. In this way, problems were immediately identified and resolved.

In order to ensure that consumers living in rural and outlying areas were appropriately represented in the sample, interviewers were hired from areas outside of Kingston and traveled to various locations throughout the district to conduct personal interviews, many times traveling with local case managers on their rounds. When travel was logistically difficult interviews were conducted by telephone. Approximately a third of the interviews were conducted throughout Hastings and Prince Edward Counties (33%), 46% throughout Frontenac, Lennox, and Addington Counties, and 21% throughout Leeds, Grenville, and Lanark counties. Forty-two percent of the interviews were telephone interviews.

Data Management and Reporting

Data were entered and analyzed by the local research team. For ease of presentation, all percents have been rounded to the nearest whole number, resulting in some small rounding error. Statistical tests have been performed in order to assess the extent to which gender differences are statistically important, or could have simply occurred by chance. A probability level of less than .05 is considered to reflect a statistically significant result. Exact p-values are shown. Statistical testing could not be performed when there were tables with small or empty cells. A good rule of thumb in these cases is to consider differences of 10% or greater to be important, and differences of between 5% and 10% to be potentially important. It is important to note that too much emphasis should not be placed on a single significant result, given that a large number of comparisons have been made and these will inflate our chances of finding statistically significant differences.

Rather, emphasis should be placed on the patterns that consistently emerge throughout the data.

Ethics Clearance:

In order to ensure that data were collected and handled in ethically appropriate ways, clearance was obtained from the Queen's University Research Ethics Board. This study was considered to pose minimal risk as no individuals would be personally identified in the results, and data would be kept securely with access restricted to all but project staff.

During the course of this project, Brockville Psychiatric Hospital was divested to the Royal Ottawa Hospital Group, changing the process of ethics clearance. The Royal Ottawa Hospital Group has a separate process for obtaining ethics approval. Although this study was approved by Queen's University (an other universities throughout the province where it was conducted), we were unable to obtain approval from the Royal Ottawa Hospital Ethics Committee. The numerous objections that were raised by the Committee could not be overcome within the time lines allocated for completion of this report. Thus, clients from Brockville Psychiatric Hospital programs are not included in this report. It should be noted that clients from Providence Continuing Care Centre Mental Health Services are included in this study so the views and preferences of psychiatric hospital clients will not be entirely lost. Nevertheless, the exclusion of the Brockville Psychiatric Hospital clients is considered to be a significant and unfortunate study limitation considering that these clients will receive their mental health services from within the Southeastern Ontario mental health planning district.

Results

This chapter reports the results of the consumer preference survey of a quota sample of **324 current clients** who were recent and frequent users of community mental health programs. Most (72%) had last visited their mental health program within the week of the interview, 21% within the month of the interview, and 7% within three months of the interview. One quarter (26%) reported that they were in contact with their program approximately twice per week over the previous three months. An additional 42% reported weekly contact, 20% reported monthly contact, and 12% reported contact less often than once per month. Virtually all (98%) identified English as their preferred language. One third (34%) lived in rural communities outside of the city centres in the district. Regarding cultural background, 92% identified themselves as Caucasian, 4% as aboriginal, 3% as non-Caucasian, and 1% did not specify.

Living Arrangements:

Table 2 presents living arrangements by gender. Women were more likely to be living with someone (usually a spouse or partner) and men were more likely to be living alone. The majority lived in their own home or apartment but this was more often the case for women. No one was living on the street or in a shelter. Other living situations included group homes and friendship homes.

Table 2: Living Situation by Gender			
Living Situation	Male % (N)	Female % (N)	Total % (N)
Living With			
▪ Alone	46% (70)	30% (51)	38% (121)
▪ Unrelated person	30% (45)	17% (29)	23% (74)
▪ Spouse/Partner	16% (25)	35% (60)	26% (85)
▪ Other relative	4% (6)	13% (22)	9% (28)
▪ Parents	4% (6)	5% (8)	4% (14)
$\Pi^2_{(4df)} = 29.3, p < .001$			
Living Situation			
▪ House/Apartment	84% (127)	91% (155)	88% (282)
▪ Rooming/Boarding Home	3% (4)	4% (6)	3% (10)
▪ Other	14% (21)	6% (9)	9% (30)
$\Pi^2_{(2df)} = 7.0, p = .03$			
On site supervision & support			
▪ None	76% (116)	89% (151)	83% (267)
▪ During the day	9% (13)	2% (4)	5% (17)
▪ During the evening	1% (2)	1% (1)	1% (3)
▪ 24-Hour	8% (12)	5% (9)	7% (21)
▪ Other (as needed)	6% (9)	3% (5)	4% (14)
$\Pi^2_{(4df)} = 10.28, p = .04$			
Moved in the Last Year			
▪ None	71% (108)	73% (124)	72% (232)
▪ One	20% (30)	19% (32)	19% (62)
▪ Two	6% (9)	6% (10)	6% (19)
▪ Three or more	3% (5)	2% (4)	3% (9)
$\Pi^2_{(3df)} = .33, p = .954$			
Would you move if you could?			
▪ Yes	33% (50)	35% (60)	34% (110)
▪ No	60% (91)	56% (95)	58% (186)
▪ Uncertain	7% (11)	9% (15)	8% (26)
$\Pi^2_{(3df)} = 2.0, p = .573$			

The majority of consumers did not have supervision or support. Of those who did, most often this was partial support, during the day, the evening, or as needed. Less than one in ten had 24-hour supervision. Men received significantly higher levels of support.

One quarter had moved in the year prior to the survey. Approximately 10% had moved more than once and third reported they would move now if they could. Close to 60% of would not move even if they could.

Employment and Income Situation:

Table 3 summarizes employment and income information. The majority were not working for pay at the time of the survey and less than one in ten had a full time job. Approximately one in ten had a regular part-time job. Just over half indicated they were generally satisfied with their employment situation. A small proportion (approximately one in ten) were uncertain.

Although not shown in Table 3, satisfaction with employment was significantly associated with employment status ($\chi^2_{(2df)} = 12.76, p = .001$). Those who were working were more likely to report that they were satisfied. For example 78% of those who were unemployed were dissatisfied with their working situation compared to 57% of those who indicated they were employed in some capacity.

The majority of consumers identified some form of disability pension as their main source of income, mostly from the Ontario Disability Support Program but, occasionally through private disability insurance. Significantly more men received disability supports. Various government subsidies were identified as the second most frequent source of support. Canada Pension Plan was the most frequent, however a small number of individuals indicated they received employment related benefits (such as through Worker's Compensation or Unemployment Insurance), or welfare supports. Women were more likely to receive supports from a family member (usually a spouse).

Less than one in ten identified a job as their major source of income, slightly more women than men. The "other" category included individuals who could not report a main source of income (either because they didn't know or didn't have an income), as well as miscellaneous other sources (such as investment income). Although not shown, approximately one third (35% men and 32% women) reported additional income over and above the main source that they indicated. Often this was an additional government subsidy or a part-time job.

With respect to adequacy of income, almost half indicated they seldom or never have enough money to get them through the month. Although not shown on the table, inadequate income was most frequently reported by individuals receiving a disability pension (47% reported inadequate income) or another government subsidy (48% reported inadequate income). Only 10% of those who were working and 27% of those who were supported by family members indicated that they had inadequate funds to make it through the month.

Table 3: Employment Situation by Gender			
Employment Situation	Male % (N)	Female % (N)	Total % (N)
Employed:			
▪ Full-time	3% (5)	8% (13)	6% (18)
▪ Part-time regular	9% (14)	9% (15)	9% (29)
▪ Part-time casual	14% (21)	10% (17)	12% (38)
▪ Unemployed	74% (112)	73% (124)	74% (236)
$\Pi^2_{(3df)} = 3.73, p = .291$			
Satisfaction with Employment:			
▪ Generally satisfied	49% (60)	56% (80)	53% (140)
▪ Generally unsatisfied	36% (44)	33% (47)	34% (91)
▪ Uncertain	15% (19)	11% (15)	13% (34)
$\Pi^2_{(2df)} = 2.08, p = .354$			
Main Source of Income:			
▪ Disability Pension	67% (102)	50% (85)	58% (187)
▪ Other Government Subsidy	23% (35)	23% (40)	23% (75)
▪ Family	1% (1)	12% (21)	7% (22)
▪ Job	5% (7)	8% (14)	7% (21)
▪ Other	5% (7)	6% (11)	6% (19)
$\Pi^2_{(4df)} = 22.24, p < .001$			
Enough money to get through the month			
▪ Most of the time	43% (66)	53% (90)	48% (156)
▪ Often	13% (20)	6% (10)	9% (30)
▪ Seldom	19% (29)	17% (29)	18% (58)
▪ Never	24% (37)	25% (42)	25% (79)
$\Pi^2_{(3df)} = 6.25, p = .100$			

Service Use:

Table 4 shows the mental health and health services used by respondents. Three quarters reported having a care coordinator, defined as someone they saw regularly to coordinate their care, help solve problems, assess needs, provide services, and make referrals to other community services and supports. Although not shown on the table, the majority (80%) reported having had their care coordinators for over six months. A small minority (13%) reported having changed their care coordinators in the six months prior to the survey.

Frequency of contact with a care coordinator differed significantly by gender. Men reported more intensive contacts. Although not shown, in the majority of cases (93%)

the programs in which the care coordinators worked were the programs that consumers visited most often. Most consumers (86%) also reported that care coordinators were able to provide additional support at times when they needed more support than usual. Only 7% reported that more support was not forthcoming, 2% reported not needing extra support and 5% didn't know if additional support would be provided should they need it.

Two thirds reported they had a regular psychiatrist; 13% percent fewer women than men. This difference was a statistically significant difference. Two thirds saw their psychiatrists frequently, on a monthly or weekly basis. The majority (about 85%) had been seeing their psychiatrist for over six months. Less than one in ten had changed their psychiatrist in the six months prior to the survey. The majority (70%) reported that their psychiatrist was able to provide more support when needed. Only about 15% of both men and women thought that their psychiatrist could not provide additional support when needed. The remainder either didn't have times when they needed extra support or didn't know.

Virtually everyone had a family doctor. However, women visited their family doctors significantly more often than did men. Close to half of the women surveyed reported that they saw their family doctor at least once a month compared to 27% of men. The majority of consumers reported receiving mental health treatment from their family doctor such as help with medications or counselling less than once per month suggesting that family doctors are not used for intensive (i.e. weekly) services.

Women were significantly more likely to receive regular (monthly) mental health services from their family doctors. Although not shown, only 6% of those surveyed had changed their family doctor in the six months prior to the survey with no gender differences. Seventy percent indicated their family doctors were able to provide more intensive support when needed. Only 16% thought that their family doctors could not provide additional support, and the remainder had never needed additional support or did not know.

One quarter to one third of consumers reported that they also relied on a worker other than a doctor to help them manage their medications. Men were significantly more likely to use additional supports. Most often additional support workers were members of the clinical support team (such as a nurse or a social worker), but on occasion, they were housekeepers or, in one instance, a home owner. In most cases (80%) they provided intensive supports (once or twice a week).

Table 4: Service Use by Gender

Service	Male % (N)	Female % (N)	Total % (N)
Care Coordinator			
▪ Yes	76% (115)	74% (127)	75% (242)
▪ No	24% (37)	26% (44)	25% (81)
$\Pi^2_{(1df)} = .08, p = .773$			
Frequency of Contact with Care Coordinator			
▪ Less than once per month	4% (4)	9% (11)	6% (15)
▪ Once per month	34% (38)	27% (34)	31% (72)
▪ Once per week	38% (42)	51% (64)	45% (106)
▪ Twice per week or more	25% (27)	13% (16)	18% (43)
$\Pi^2_{(3df)} = 10.07, p = .02$			
Psychiatrist			
▪ Yes	74% (113)	62% (106)	68% (219)
▪ No	26% (39)	38% (64)	32% (103)
$\Pi^2_{(1df)} = 5.3, p = .02$			
Frequency of Contact with Psychiatrist			
▪ Once per year or less	7% (8)	4% (4)	6% (12)
▪ Twice per year	5% (6)	8% (8)	6% (14)
▪ Every 3-4 months	26% (29)	21% (22)	23% (51)
▪ Once per month	52% (58)	57% (60)	54% (118)
▪ Once per week or more	10% (12)	11% (12)	11% (23)
$\Pi^2_{(4df)} = 2.49, p = .645$			
Family Doctor			
▪ Yes	93% (141)	95% (163)	94% (304)
▪ No	7% (11)	5% (8)	6% (19)
$\Pi^2_{(1df)} = .95, p = .329$			
Frequency of Contact with Family Doctor			
▪ Once per year or less	21% (29)	11% (18)	16% (47)
▪ Twice per year	17% (24)	15% (23)	16% (47)
▪ Every 3-4 months	35% (49)	27% (42)	31% (91)
▪ Once per month	25% (34)	41% (65)	33% (99)
▪ Once per week or more	2% (3)	6% (10)	4% (13)
$\Pi^2_{(4df)} = 15.46, p = .003$			
Mental health services from family doctor:			
▪ Less than once a month	71% (85)	62% (88)	66% (173)
▪ Once a month	21% (25)	33% (47)	28% (72)
▪ Once a week	3% (3)	4% (6)	3% (9)
▪ Twice a week	6% (7)	1% (1)	3% (9)
$\Pi^2_{(3df)} = 10.50, p = .01$			

Other worker to help with meds			
▪ Yes	38% (58)	25% (42)	31% (100)
▪ No	59% (89)	74% (127)	67% (216)
▪ Not taking medications	3% (5)	2% (2)	2% (7)
$\Pi^2_{(2df)} = 9.45, p < .003$			

Hospital Service Profile:

Table 5 summarizes use of hospital services.

Table 5: Hospital Service Profile by Gender			
Hospital Service	Male % (N)	Female % (N)	Total % (N)
Ever hospitalized for mental health problem			
▪ Yes	82% (125)	70% (120)	76% (245)
▪ No	18% (27)	30% (51)	24% (78)
$\Pi^2_{(1df)} = 6.39, p = .01$			
Type of hospital			
▪ Psychiatric Hospital	76% (92)	53% (61)	65% (153)
▪ General Hospital	24% (29)	47% (54)	35% (83)
$\Pi^2_{(1df)} = 13.67, p = .002$			
Ever involuntarily committed			
▪ Yes	39% (47)	40% (47)	40% (94)
▪ No	61% (73)	60% (71)	60% (144)
$\Pi^2_{(1df)} = .01, p = .917$			
Hospitalized in last 6 months			
▪ Yes	14% (17)	13% (16)	14% (33)
▪ No	86% (106)	87% (103)	86% (209)
$\Pi^2_{(1df)} = .01, p = .932$			
Used hospital emergency in past 6 months			
▪ Yes	11% (16)	11% (19)	11% (35)
▪ No	89% (135)	88% (151)	89% (286)
$\Pi^2_{(1df)} = .03, p = .868$			
Member of consumer/survivor initiative			
▪ Yes	22% (34)	14% (23)	18% (57)
▪ No	78% (118)	86% (148)	82% (266)
$\Pi^2_{(1df)} = 4.40, p = .04$			

Frequency of contact with consumer/survivor initiative			
▪ Less than once a month	19% (6)	14% (3)	17% (9)
▪ Once a month	9% (3)	18% (4)	13% (7)
▪ Once a week	38% (12)	41% (9)	39% (21)
▪ Twice a week	34% (11)	27% (6)	32% (17)
$\Pi^2_{(3df)} = 1.23, p = .745$			

Most had been hospitalized at some time for a mental health problem. However, significantly more men reported a prior mental health related hospitalization. Half of the women and only about a quarter of the men reported that they had been hospitalized in a general hospital. The remainder had been hospitalized in a psychiatric hospital. This difference was statistically significant. Most (60%) have never been involuntarily hospitalized. A minority had been hospitalized because of a mental health problem within the six months prior to the survey. One in ten reported using a hospital emergency in the six months prior to the survey.

Although not shown, approximately 40% of those having emergency visits had only one, 6% reported multiple visits, ranging from two to nine. Just under one in five reported that they were members of a consumer/survivor initiative; more often the men. The majority (70%) of consumer/survivor group member reported frequent contact; once or twice a week.

Difficulties in Accessing Treatment:

Table 6 examines difficulties in accessing treatment and supports. One quarter indicated that they had had difficulty communicating with a health care provider about their health care needs in the past year. Most often (40%) this was because their views were not taken into consideration. It was seldom because of language difficulties (3%) or cultural insensitivity (6%). The remainder reported a number of issues, ranging from problems such as shyness or difficulty opening up, to problems with the health professionals (such as their being rude or lacking knowledge), to system-level problems (such as inability to access a professional due to a long waiting list).

Almost half of those surveyed reported that they had delayed seeking mental health treatment at some time in the past because they were afraid of being stigmatized. The majority of those reporting treatment delays indicated that this was more than one year ago. Less than one in five reported fear of stigma causing a treatment delay in the past six months.

Approximately one in three respondents reported having had difficulties affording medications when they were not in hospital. About 15% experienced difficulty affording medications often or most of the time. This problem was experienced equally by men and women.

Table 6: Difficulties Accessing Treatment by Gender			
Type of Difficulty	Male % (N)	Female % (N)	Total % (N)
Difficulty communicating with health professional - Yes - No $\Pi^2_{(1df)} = 6.39, p = .01$	26% (39) 74% (112)	22% (37) 78% (133)	24% (26) 76% (245)
Delayed seeking treatment because of stigma - Yes - No $\Pi^2_{(1df)} = 2.26, p = .133$	41% (62) 59% (90)	49% (84) 51% (87)	45% (146) 55% (177)
When delayed because of stigma - In past six months - In past year - Over one year ago $\Pi^2_{(2df)} = 2.19, p = .907$	16% (10) 13% (8) 71% (43)	18% (15) 15% (12) 67% (55)	18% (25) 14% (20) 69% (98)
Difficulty affording medication when not in hospital - Most of the time - Often - Seldom - Never $\Pi^2_{(3df)} = 6.03, p = .11$	8% (5) 8% (5) 10% (6) 74% (45)	11% (9) 2% (2) 22% (18) 65% (54)	10% (14) 5% (7) 17% (24) 69% (99)

Perceived Adequacy of Mental Health Services and Supports:

To assess perceived adequacy of mental health services, respondents were asked to rate a number of services according to whether they were getting the amount they needed. These results are presented in **Table 7**. Unlike previous tables, results total to 100% across the rows (e.g. by males, females, and the total survey sample).

Table 7 shows that few services are provided in excess of consumer needs. The proportion of services provided that were considered to be adequate to meet consumer needs varied widely, from less than ten percent to over sixty percent.

Table 7: Perceived Adequacy of Mental Health Services

Service	Amount of Service Needed % (Total)*			
	Not Needed	Right Amount	More than Needed	Less than Needed
Managing Medication				
▪ Male	52% (32)	37% (23)	5% (3)	7% (4)
▪ Female	50% (42)	42% (35)	1% (1)	7% (6)
▪ Total	51% (74)	40% (58)	3% (4)	7% (10)
Assessment & Diagnosis				
▪ Male	26% (16)	53% (33)	--	21% (13)
▪ Female	29% (24)	48% (40)	1% (1)	22% (18)
▪ Total	28% (40)	50% (73)	1% (1)	21% (31)
Psychotherapy & Counselling				
▪ Male	13% (8)	60% (36)	--	27% (16)
▪ Female	16% (13)	54% (45)	--	30% (25)
▪ Total	15% (21)	57% (81)	--	29% (41)
Substance Abuse Treatment				
▪ Male	88% (53)	7% (4)	--	5% (3)
▪ Female	89% (75)	6% (5)	--	5% (4)
▪ Total	89% (128)	6% (9)	--	5% (7)
Managing Upsets & Crises				
▪ Male	11% (7)	65% (40)	--	24% (15)
▪ Female	12% (10)	60% (50)	1% (1)	27% (23)
▪ Total	12% (17)	62% (90)	1% (1)	26% (38)
Finding out what services are available				
▪ Male	26% (40)	49% (74)	--	25% (38)
▪ Female	26% (45)	49% (83)	1% (2)	24% (41)
▪ Total	26% (85)	49% (157)	1% (2)	25% (79)
Finding a drop-in centres or self-help group				
▪ Male	50% (76)	32% (49)	2% (3)	16% (24)
▪ Female	49% (83)	28% (48)	1% (1)	22% (38)
▪ Total	49% (159)	30% (97)	1% (4)	19% (62)
* Results total to 100% across the rows, (e.g. by males, females, and the total survey sample).				

Few consumers felt they needed more help in managing their medications. Approximately one quarter identified a greater need for treatment and diagnosis services, psychotherapy and counselling, help with managing upsets and crises, and getting help

with finding out what services are available. The majority of consumers (close to 90%) felt that they did not need substance abuse and counselling services. Virtually no one indicated they were receiving services in excess to their needs. Thus, for the majority of consumers (approximately three quarters) mental health services were being provided in approximately the right amount.

Perceived Adequacy of Community Supports:

Table 8 summarizes the perceived adequacy of community supports. In most cases, about a quarter reported they were receiving fewer supports than they needed. The most problematic areas were in obtaining skills and educational training, finding a job, and in obtaining transportation. Important gender differences emerged in four areas. Females reported that they received less support than then needed in helping agencies to work together, in obtaining benefits and income supports, in getting and maintaining housing, and, to a lesser extent, in getting help with legal problems.

Table 8: Perceived Adequacy of Community Supports				
Support With:	Amount of Service Needed % (Total)*			
	Not Needed	Right Amount	More than Needed	Less than Needed
Daily Tasks				
▪ Male	56% (85)	32% (49)	1% (2)	11% (16)
▪ Female	67% (115)	18% (49)	2% (3)	14% (23)
▪ Total	62% (200)	25% (79)	2% (5)	12% (39)
Skills Training and Education				
▪ Male	48% (72)	25% (30)	1% (1)	27% (40)
▪ Female	52% (86)	21% (35)	2% (3)	26% (43)
▪ Total	50% (158)	23% (73)	1% (4)	26% (83)
Finding a Job				
▪ Male	61% (90)	18% (27)	--	22% (32)
▪ Female	68% (111)	14% (22)	--	18% (30)
▪ Total	64% (201)	16% (49)	--	20% (62)

Table 8: Continued

Support With:	Amount of Service Needed % (Total)*			
	Not Needed	Right Amount	More than Needed	Less than Needed
Planning Leisure Activities				
▪ Male	56% (85)	29% (44)	--	15% (22)
▪ Female	58% (99)	24% (41)	1% (1)	18% (30)
▪ Total	57% (184)	26% (85)	1% (1)	16% (52)
Relationships				
▪ Male	59% (88)	27% (40)	1% (1)	14% (21)
▪ Female	47% (80)	30% (51)	2% (3)	21% (35)
▪ Total	53% (168)	29% (91)	1% (4)	18% (56)
Legal Issues				
▪ Male	69% (104)	20% (30)	1% (2)	9% (14)
▪ Female	72% (122)	14% (24)	1% (1)	14% (23)
▪ Total	71% (226)	17% (54)	1% (3)	12% (37)
Getting benefits & income support				
▪ Male	46% (69)	42% (64)	--	12% (18)
▪ Female	52% (88)	24% (40)	1% (2)	24% (40)
▪ Total	49% (157)	32% (104)	1% (2)	18% (58)
Finding and keeping housing				
▪ Male	61% (92)	33% (50)	1% (1)	6% (9)
▪ Female	69% (116)	21% (35)	--	11% (18)
▪ Total	65% (208)	27% (85)	1% (1)	8% (27)
Transportation				
▪ Male	37% (56)	40% (60)	1% (1)	23% (35)
▪ Female	50% (86)	22% (38)	3% (5)	25% (42)
▪ Total	45% (142)	30% (98)	2% (6)	24% (77)
Getting agencies to work together				
▪ Male	50% (75)	32% (47)	--	18% (27)
▪ Female	55% (92)	22% (36)	3% (4)	21% (35)
▪ Total	53% (167)	26% (83)	1% (4)	20% (62)
* Results total to 100% across the rows, (e.g. by males, females, and the total survey sample).				

Satisfaction with Services:

The majority (85%) of consumers reported they were “generally satisfied” with the services and supports they were receiving. Nine percent were “generally dissatisfied” and 6% were unsure.

Table 9 shows the results of questions designed to identify satisfaction with key aspects of mental health service delivery. The first section deals with treatment services and the care process. The second section deals with system-level processes.

Table 9: Satisfaction with Services			
	Agree	Disagree	Not Sure
Treatment Services			
You know who to go to when you are dissatisfied with your care			
▪ Male	70% (106)	16% (24)	14% (21)
▪ Female	59% (100)	23% (39)	18% (31)
▪ Total	64% (206)	20% (63)	16% (52)
Your ideas and opinions count in your care			
▪ Male	80% (121)	11% (16)	10% (15)
▪ Female	78% (134)	13% (22)	9% (15)
▪ Total	79% (255)	12% (38)	9% (30)
You have a treatment plan			
▪ Male	75% (113)	13% (20)	12% (18)
▪ Female	74% (126)	17% (28)	9% (16)
▪ Total	75% (239)	15% (48)	11% (34)
Your treatment fits your needs			
▪ Male	78% (118)	13% (19)	9% (14)
▪ Female	76% (129)	16% (27)	8% (14)
▪ Total	77% (247)	14% (46)	9% (28)
You have been treated with dignity and respect			
▪ Male	86% (130)	10% (15)	4% (6)
▪ Female	81% (137)	12% (21)	7% (11)
▪ Total	83% (267)	11% (36)	5% (17)

Table 9 continued			
	Agree	Disagree	Not Sure
System Characteristics			
Services work together to meet your needs			
▪ Male	76% (116)	11% (16)	13% (20)
▪ Female	69% (118)	18% (31)	12% (21)
▪ Total	73% (234)	15% (47)	13% (41)
You have to deal with too many agencies and professionals to have your needs met			
▪ Male	25% (37)	67% (103)	7% (10)
▪ Female	20% (34)	76% (129)	4% (7)
▪ Total	22% (71)	73% (232)	5% (17)
You could easily access a hospital bed if you needed it			
▪ Male	40% (61)	32% (48)	28% (43)
▪ Female	39% (66)	29% (97)	32% (55)
▪ Total	39% (127)	30% (97)	30% (90)
You are stigmatized by people working in health care			
▪ Male	23% (34)	70% (106)	7% (11)
▪ Female	28% (48)	64% (109)	8% (13)
▪ Total	26% (82)	67% (215)	8% (24)
* Results total to 100% across the rows, (e.g. by males, females, and the total survey sample).			

This table shows that consumers are generally satisfied with the level of clinical care they receive. The majority (75% to 80%) reported their ideas and opinions count, they have a treatment plan, their services fit their needs, and they are treated with respect and dignity. Women were more likely to report that they did not know where to go when they were dissatisfied with their treatment.

There was greater variation in opinion when it came to system-level functioning. For example, whereas three quarters of those surveyed reported that services worked together to meet their needs, 15% disagreed and 13% were unsure. Similarly, approximately one quarter reported they had to deal with too many agencies and professionals to have their needs met. Only a third of women and 40% of men

thought that they would have access to a hospital bed if they needed it and approximately one quarter indicated they were stigmatized by health professionals.

Although not shown on a table, 40% of consumers reported that they had worries about mental reform in this region. Just over a third (36%) had no worries and 23% did not know anything about mental health reform. Although expressed in various ways, the major worry seemed to be associated with loss of access to care because of general cut-backs and bed closures.

Discussion & Recommendations

Summary of Project

This study was part of a multi-centre planning initiative targeting community mental health programs in the Southeastern Ontario mental health planning district. It follows a long and growing legacy of such projects now completed in most of the mental health planning districts in the Province. This project was funded by the Southeastern Ontario Mental Health Implementation Task Force to assist them in making recommendations to the Ministry of Health and Long Term Care in support of mental health restructuring and reform.

The results of this study must be interpreted in light of the specific group of clients that were targeted—current users of community-based mental health treatment programs in the Southeastern Ontario mental health planning district. Programs addressing the needs of specialty populations, such as geriatric, forensic, concurrent disorder, or dual diagnosis populations were excluded, as were agencies and services outside of the formal mental health system.

In using these data, decision-makers should also be aware that clients from Brockville Psychiatric Hospital community services were excluded. During the course of this project, Brockville Psychiatric Hospital was divested to the Royal Ottawa Hospital Group in the Champlain mental health planning district. The Royal Ottawa Hospital Group has

a separate process for obtaining ethics approval. Although this study was approved by Queen's University (and other universities throughout the province where it was conducted), we were unable to obtain approval from the Royal Ottawa Ethics Committee. The objections that were raised could not be overcome within the time lines allocated for this project. Although we have included clients from Providence Continuing Care Centre Mental Health Services (so have incorporated the views and preferences of a psychiatric hospital community population), the exclusion of the Brockville Psychiatric Hospital clients is considered to be an unfortunate study limitation.

We used a quota sampling procedure that allowed each agency to recruit respondents proportionate to their size. Small agencies contributed fewer clients than large agencies. A total of **324 clients** were recruited. Agency staff were instructed to approach current clients defined as those who attended treatment during the course of the study months (May-August 2002). The aim was to approximate the cross section of clients who were current users of community mental health services such that the full range of preferences and views were expressed. Subsequently we found that our quota sampling procedure resulted in a sample that was representative to the population of community mental health users with respect to age and gender.

Key Findings:

With respect to living arrangements, the majority of individuals were living in their own apartments. Women were more likely to be living with a spouse and more likely to be living in their own homes and men were more likely to be living alone. Most did not have supervision or support where they lived. Men reported receiving significantly higher levels of support, possibly because they were more likely to be living alone. One quarter had moved in the last year at least once and a third would move if they could.

The majority were not working for pay and reported their main source of income to be a disability pension or other government subsidy. Fewer than one in ten identified a job as their major source of income. Almost half indicated that they seldom or never had enough money to get through the month, most often those receiving disability pensions.

Most were intensive service users. Three quarters had a care coordinator to help them coordinate their care and solve problems. The majority had had their care coordinators for over six months.

Two thirds had a regular psychiatrist which they had had for over six months and saw on a regular basis (such as monthly or weekly). Women were significantly less likely to report having a regular psychiatrist than men.

Most had a family doctor and visited them for mental health treatment on a monthly basis, although women reported significantly more visits than men. Approximately one third indicated they also had a worker, other than a doctor, that helped them manage their medications, usually on a weekly or monthly basis. Men were significantly more likely to report this additional support.

Most of those surveyed had been hospitalized at some time for their mental health problems, significantly more men than women. Approximately 40% of these had been hospitalized involuntarily. Ten percent reported using a hospital emergency in the six months prior to the survey and 60% of these reported multiple visits.

Less than one fifth of consumers reported they were members of a consumer/survivor initiative. Those who were members reported frequent contact once or twice a week.

One quarter of the sample reported having difficulties communicating with a health professional about their needs during the past year, often because their views were not taken into consideration. Half reported delaying seeking treatment at some time in the past because they were afraid of being stigmatized. Most often this happened more than a year ago and less than one if five reported delaying treatment because of fear of stigma in the past six months.

One in three individuals reported having difficulty affording their medications when they were not in hospital and approximately 15% had difficulty all of the time.

Consumers rated a number of services according to whether their needs were being met. For most (approximately three quarters) services were generally being provided in the right amount, however, this varied depending on the service. For example, few reported needing more help with medication management. However, a quarter identified a greater need for treatment and diagnosis services, psychotherapy and counselling, help with managing upsets and crises, and finding out what services are available. The majority (90%) felt they did not need substance abuse counselling. Virtually no one indicated they were receiving services in excess to their needs.

Less than a quarter indicated they were receiving inadequate community supports. The most problematic areas were in obtaining skills and educational training, finding a job, and

obtaining transportation. Women reported significantly less support in a number of areas: helping agencies to work together, obtaining benefits and income supports, getting and maintaining housing, and to a lesser extent, getting help with legal problems.

The majority of clients (85%) indicated they were generally satisfied with the services they received. Less than one in ten were generally dissatisfied and a small number (6%) were unsure. Satisfaction with the provision of clinical services and the process of clinical care was the highest. The majority reported that their ideas and opinions counted, they had a treatment plan, their services fit their needs, and they were treated with respect and dignity. Women were more likely to report that they did not know where to go when they were dissatisfied with treatment.

There was greater variability concerning system-level characteristics. Fifteen percent indicated that services did not work together to meet their needs, one quarter said they had to deal with too many agencies and professionals, and a third of women and 40% of men thought that they would have difficulty accessing a hospital bed if they needed it. About a quarter indicated they felt stigmatized by health professionals.

Close to half of those surveyed reported that they had worries about mental health reform in their region. The major worry was associated with a perceived loss of access to care due to cut-backs and bed closures.

Study Limitations:

The results of this survey should be used taking the following issues into consideration.

This project benefited from the support of agency staff who were instrumental in recruiting clients to be interviewed, and in some cases, in transporting the interviewer to the client. Whenever agency staff play such an instrumental role in recruitment, the question may be raised as to whether they referred only those clients whom they believed would paint the best picture of program or system functioning. If this had been a pervasive problem, we would have expected that our sample would not be representative of the population of current users. The fact that the sample was representative with respect to age and gender suggests that sampling for this study was not biased.

By design, this survey was limited to current clients of community mental health services. These results do not provide planning information on clients who are transient or

marginally housed who may be excluded from regular community programming because they are difficult-to-serve.

In a handful of instances, case workers were present during the interviews. Often this was at the request of the client when interviews were conducted in the home and the client felt more comfortable having the case-worker present. The interviewers who conducted these interviews did not feel that the presence of the case-worker in any way hampered responses, however, this must always be kept in mind as a possibility. None of the questions on the interview schedule asked the client to rate the case-workers services specifically, but in rural areas, that may have been the only service obtained.

Clients had a number of responses to the questionnaire. Interviewers reported that many clients, particularly those in rural and under-serviced areas did not know what consumer/survivor initiatives were, and were unfamiliar with the mental health reform initiatives underway in the province and in the district. Many clients were dissatisfied with our use of the word “mental” to describe disorders and would have preferred a less reactive term such as “emotional” problems.

Finally, it should be pointed out that this survey was conducted part way through the hospital divestment process. In some locations, staff burnout was reported to be high. In others, reinvestment dollars had already been provided to improve community services. Satisfaction ratings of services may have suffered in the context of these changes. In addition, the divestment of Brockville Psychiatric Hospital to the Royal Ottawa Hospital Group and the resulting transfer of responsibility for ethics review to the Royal Ottawa Hospital was a significant impediments to this study. Despite the fact that the study protocol had received ethics approval from Queen’s University, and several other universities in the Province, it did not receive ethics clearance from the Royal Ottawa Hospital. This meant that clients of Brockville Psychiatric Hospital could not be included in this planning effort. Information from clients of Providence Continuing Care Mental Health Services was included so the perspective of clients of psychiatric hospitals in the district is not entirely lost.

Conclusions and Recommendations:

The key findings of this survey echo the findings from the other components of the C-CAP projects. Clients are generally satisfied with the clinical services they receive, but feel under-serviced with respect to the recovery supports they need to support their

independent community living and system-level functioning. Therefore, system integration and the implementation of recovery supports in the following areas must remain a priority for mental health reform and reinvestment funding:

- safe, affordable, and stable housing that can be maintained over periods of hospitalization;
- income benefits that provide incentives for working taking the episodic nature of many illnesses into consideration;
- employment opportunities (including supported employment where appropriate);
- better drug benefits; and
- transportation supports for those living in rural areas who feel particularly isolated.

Given that the first time many consumers had heard about mental health reform was during this interview, it is imperative that community consultation efforts focus on consumers who are receiving treatment, as well as consumer advocacy groups in order to address reform issues. In particular, it will be important to provide information on the view held by many that mental health reform is synonymous with bed reductions and reduced access to hospital services.

Secondly, clients must know what avenues of accountability are available to them if they have any kind of problem with mental health including access problems. District-wide accountability mechanisms, once developed, need to be widely communicated to clients and their families. Local area and district-wide information resources concerning system functioning and access to clinical and rehabilitation services also deserve high priority.

Routinely conducted consumer preference surveys should be used on an ongoing basis (e.g. every 2-3 years) as one form of accountability at both the program and the system levels and to ensure that representative cross-sections of consumers views are incorporated into mental health planning. Each time the survey is given, additional questions can be added to the core to delve deeper into a particular issue.

Finally, stigma and discrimination were common experiences of mental health consumers in this survey. Consumers often lower their expectations and settle for second best, and in so doing stigmatize themselves. Thus, in addition to efforts that are directed toward

the community, there should also be anti-stigma efforts that are directed toward consumers that teach self-management of stigma through empowerment, affirmation, education, and self-worth.

**Matching Community Mental
Health Services to Need**
Comprehensive Community Assessment Project

SOUTHEASTERN ONTARIO COMMUNITY COMPREHENSIVE
ASSESSMENT PROJECT

Matching Community Mental Health Services to Need

Submitted for consideration to
The Southeastern Ontario Mental Health Implementation Task Force

On Behalf Of:
The Research Committee

March 2002

Prepared By:

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Executive Summary

This study was part of a multi-centre needs-based planning initiative focusing on community mental health programs. It follows a long and growing legacy of Comprehensive Assessment Projects (CAPS) completed in all of the Provincial Psychiatric Hospitals across the province, and now in the community sector in all of the mental health implementation planning regions.

The Southeastern Ontario Community Comprehensive Assessment Project (C-CAP) was funded by the Southeastern Ontario Mental Health Implementation Task Force to assist them in making recommendations to the Ministry of Health and Long Term Care in support of mental health restructuring and reform. This report has assessed the extent to which current community mental health services match clients' needs.

The results of this study must be interpreted in light of the specific group of clients that were targeted—current users of community-based mental health treatment programs in the Southeastern Ontario mental health planning district. Programs addressing the needs of specialty populations, such as geriatric, forensic, concurrent disorder, or dual diagnosis were excluded, as were agencies and services outside of the formal mental health system. Thirteen agencies met the inclusion criteria for the study. Given that all thirteen participated and staff completed assessments on 525 clients—86% of all clients eligible to be sampled—decision makers can have considerable confidence in these results.

A second consideration in using these results for planning is that the levels of need assessments have been based on structured assessments provided by clinical staff. Although they knew the client well and could access additional information from clinical records or other clinical care providers, they could have under-estimated the range of services used outside of their specific program. This could inflate estimates of unmet need among multiple-service users—some 13% of the sample. To help mitigate this, only the most knowledgeable staff were chosen to complete the structured assessment.

The methods used in this study to collect staff assessments of need were standardized and have been used for this purpose throughout the Province in both hospital and community based assessment projects. By now, considerable experience with the

study instruments has been amassed, and a standardized training program has been developed to maximize reliability and validity.

As one of the goals of the Southeastern Ontario C-CAP was to build local capacity, staff members were trained in the use of the needs assessment instrument, and two individuals became sufficiently proficient in its use to be able to train others. The resulting cadre of trainers and trained assessors will remain an important legacy for future needs-based planning projects.

The essence of the CAP method is to systematically link clients' level of care needs to the particular levels of care they have received and, in this way, identify any mismatch that may have occurred. The Level of Care Template developed for this purpose makes use of information from a variety of functional domains widely considered to be important in determining needs for care. Staff ratings on these domains are combined using a standardized algorithm to yield five levels of care ranging from least intensive to most intensive. A second standard algorithm is applied to current service use to arrive at the same levels of care. A comparison of the levels of care required and those received provides an assessment of the degree to which services match needs.

Key Findings:

The sampling frame consisted of 3,618 clients. Thirteen percent of these had received services at more than one agency during the three-month study window. When multiple agency contacts were eliminated from the database, 3,163 unique individuals remained. Although desirable for planning, it proved impossible to derive county based estimates because several of the programs included in this study reported catchment areas that spanned county boundaries. This was particularly true of programs that provided outreach services over large rural and outlying areas. Future needs assessments could develop county based estimates if client postal code information were collected, making it possible to assign clients to a county based on their postal code designation.

The socio-demographic profile was typical of community-based mental health clients. They were largely unmarried, poorly educated, and unemployed. One percent had no fixed address. Just under one half lived outside of the major urban areas. Approximately one in five had moved in the year prior to the study and residential instability was highest among youth.

Half of the clients surveyed were receiving counselling and treatment services. Approximately one third were enrolled in intensive community services such as an assertive community treatment team or intensive case management. The majority had not had a recent psychiatric hospitalization. A third were using clinical treatment services (such as from a psychiatrist or family physician) two or more times per month. Virtually all of the clients surveyed (97%) had been diagnosed by a mental health professional, often with serious disorders such as mood, anxiety, or schizophrenia, and the majority (72%) were being treated with psychotropic medications. Substance abuse disorders, which often go undiagnosed, were identified in only 14% of this sample.

Few clients were rated by staff to have severe problems in any of the rated domains. Approximately half of those assessed were considered to have moderate problems with mood and affect; less among the elderly. Three percent had severe problems with thought and some forty percent, moderate problems. Thought disorders were less frequently reported among youth.

Four percent of the sample had severe social and role performance problems. This was highest amongst youth (5%) and lowest among the elderly (2%). Moderate problems in social and role performance were reported for approximately half of the youth and elderly, and close to sixty percent of adults. Problems with self-care were concentrated in the elderly group where over a third were reported to have moderate problems and three percent were reported to have severe problems.

Antisociality was relatively uncommon in the sample, particularly among the elderly. Youth were reported to have the highest prevalence of moderate problems; 16% compared to 12% among adults and 7% among elderly. Severe antisociality was reported in only one percent of youth and adults and not at all among the elderly.

Approximately one in five clients were capable of self-managed care, meaning they require intermittent access to care and are capable of managing their own care process. This proportion was the lowest among the young and the highest among the elderly. Community treatment (Level 2) was required for approximately half of the sample with a slight age gradient that favored higher levels of community treatment among youth.

Intensive community treatment (Level 3) was recommended for just under one third of the sample and less indicated amongst the elderly. Finally, residential treatment (Level 4) was identified for a small minority of clients, increasing slightly with age. No

one was rated in need of inpatient treatment. This is consistent with a community-based client population.

With respect to current level of care, just over half of the sample were receiving the lowest intensity care indicative of self-management. A further third received community treatment. Less than one in ten were accessing intensive community treatment programs and 4% were receiving residential or inpatient care. Elderly clients in this sample were more likely to receive less intensive community treatment. Self-managed care was the predominant mode for both youth and adults.

Concerning the match between recommended care and care received, slightly less than a third of the clients received an intensity of care that matched their need. Over half were being under-served. Fourteen percent of clients received services that exceeded their level of need. The distribution of care differed by age group. Youth were least likely to be over-served and, along with elderly, had the highest match (36%). The elderly were most likely to be over-served.

In every instance, youth were more likely to be under serviced with respect to mental health treatment services (such as medication management, assessment, diagnosis). Approximately one in five youth required more mental health services than they had received and this was fairly consistently noted across the full range of mental health treatment and crisis services. Elderly clients were more likely to have their needs for mental health treatment and crisis services adequately met. It is important to note that no age group was considered to be over-served with respect to substance abuse programming.

Compared to mental health treatment services, there was more unmet need for rehabilitation and other support services. The largest unmet needs were for meaningful activities (such as cultural activities or hobbies) and social/recreational supports. About a third of clients were under serviced in these areas. There was also significant unmet need for vocational and educational services particularly among youth. Services and supports for activities of daily living and self-care were unavailable to approximately one in ten.

The largest discrepancies occurred for caregiver supports, income supports, and housing supports. Both income and housing supports showed an age gradient with higher unmet needs among the youth. Rights protection and advocacy, justice/correctional services, and programming for the developmentally disabled all

appeared to be fairly well matched to needs in this non-specialized community-based sample.

In general, over-servicing was generally small, under five percent. The only area where significant over-servicing appeared was for psychotherapy and counselling for youth (13%) and to a lesser extent, adults (7%). The top three under serviced areas were:

For youth age 16-24 years:

- Meaningful activity (35% with unmet need)
- Social and recreational supports (34% with unmet need)
- Vocational supports (33% with unmet need)

For adults aged 25-64 years:

- Meaningful activity (35% with unmet needs)
- Social and recreational supports (30% with unmet needs)
- Vocational supports (25% with unmet need)

For elderly aged 65 and higher:

- Meaningful activity (29% with unmet need)
- Social and recreational supports (28% with unmet need)
- Caregiver supports (13% with unmet need)

The table below compares the results of the Southeastern Ontario C-CAP to those of three other regions that have completed similar C-CAP projects. What is striking about this table is that the level of care recommended based on the standardized needs assessment is relatively consistent across the four regions, whereas the levels of care actually received by clients varies much more widely. This local variation means that

MATCHING SERVICES TO NEEDS

the extent of gaps in the mental health service system will also vary by region. Thus, there is a need for ongoing monitoring within each region.

Comparison of C-CAP Results Across Districts					
District	Level of Care (Weighted %)				
	Self-Mgmt	Com Tx	Intensive Com Tx	Resid Tx	Inpt Tx
Recommended Care Level					
Ottawa/Champlain	23%	39%	27%	8%	4%
Northeast	23%	48%	25%	4%	0.4%
Grand River	19%	48%	27%	5%	1%
Southeast	19%	49	29%	3%	--
Level of Care Received					
Ottawa/Champlain	26%	52%	17%	6%	--
Northeast	64%	31%	2%	3%	--
Grand River	44%	43%	3%	11%	--
Southeast	55%	33%	8%	2%	2%

Also, it is important to note that despite wider variation, the general pattern is the same; an over-supply of lower and higher intensity services than is required and an undersupply of mid-range community-based services.

Conclusions:

This study revealed considerable un-met needs among clients accessing community based mental health programs for Community Treatment (Level 2) and Intensive

Community Treatment (Level 3). Unmet needs were evident across the full spectrum of mental health services, supporting the conclusion that the entire mental health delivery system must be reoriented to better meet consumer needs.

Approximately one third of the sample received services in excess to their needs. Unmet needs were highest with respect to social and vocational programming. In most instances, a clear age gradient emerged such that youth were the most likely to be disadvantaged.

Despite unmet needs in a variety of domains, few clients in this sample accessed multiple services suggesting the need for better program linkages. In addition, many staff did not know of their client's use of emergency room services in the six months prior to the study, suggesting poor continuity of information (and perhaps care) between these sectors.

Recommendations:

1. To insure that clients are appropriately diagnosed and their needs appropriately met, it is strongly recommended that standardized assessment protocols be used to evaluate service requirements for all new clients. Experience from the C-CAR indicates that staff can be easily trained in the use of standardized assessment protocols designed to match services to needs.
2. It is recommended that networks of care be created through formal inter-agency linkages and partnerships that are mandated to match services to client needs and provide comprehensive community-based care across a spectrum of supports and services.
3. To promote accountability and ensure consumer needs are met, the match between client needs and available services must be monitored on an ongoing basis. Service evaluations such as the C-CAP must become a routine part of mental health system delivery. Comparisons of future studies to the C-CAP baseline would provide an important means of evaluating system-level outcomes.
4. Given the gaps noted in this survey, it is recommended that reinvestment funding be used to develop the programs in the priority areas outlined in this study for youth, adults, and elderly as follows:

For youth age 16-24 years:

- Meaningful activity (35% with unmet need)
- Social and recreational supports (34% with unmet need)
- Vocational supports (33% with unmet need)

For adults aged 25-64 years:

- Meaningful activity (35% with unmet needs)
- Social and recreational supports (30% with unmet needs)
- Vocational supports (25% with unmet need)

For elderly aged 65 and higher:

- Meaningful activity (29% with unmet need)
- Social and recreational supports (28% with unmet need)
- Caregiver supports (13% with unmet need)



Chapter 1

Introduction & Purpose

This Community Comprehensive Assessment Project, or “C-CAP” was funded by the Southeastern Ontario Mental Health Implementation Task Force and undertaken in collaboration with the Ministry of Health and Long Term Care to support mental health planning for reform. Its purpose was to formulate recommendations concerning the community care needs of mental health clients in the Southeastern Ontario planning district by assessing the match between needs and services provided.

This project was part of a multi-centre, provincial initiative coordinated by the Health Services Research Unit of the Centre for Addictions and Mental Health in Toronto (the Coordinating Centre). To develop local evaluation capacity, the project was conducted by a research team led from Queen’s University. The Research Committee of the Southeastern Ontario Mental Health Implementation Task Force steered the project and defined the local study parameters.

The specific objectives of the Southeastern Ontario C-CAP were to:

- Survey consumers for their perspectives on mental health service use and needs;
- Survey staff about the care needs and current service use of a representative sample of recipients of intensive-level community mental health services; and
- Develop a standardized service profile of participating C-CAP agencies.

This Report:

This report is submitted to the Mental Health Implementation Task Force on behalf of the Research Committee. It describes the results of the staff assessments of levels of need for services among current users. The results of other two C-CAP components—the consumer survey and the program inventory—are described in separate reports.

**Chapter
2**

Background & Methods:

Background

In preparation for psychiatric hospital downsizing and mental health reform, the Ministry of Health and Long Term Care has previously funded six hospital-based Comprehensive Assessment Projects (H-CAPs) across the Province. These studies identified the community service needs and preferences of provincial psychiatric hospital populations. To promote province-wide comparisons, a common method was used across the six regions. In addition, regions made certain additions and refinements to address local planning questions and priorities. The H-CAPs were consistent in finding an under-capacity in the community system, as well as certain mismatch between consumers' level of need and the level of care available. They have recommended that existing community services, especially case management and assertive community treatment, be enhanced, and new residential treatment facilities be developed.

Since the spring of 2000, there has been growing interest in the further evaluation of the care needs and preferences of clients of community mental health programs and services. The Community Comprehensive Assessment Projects (C-CAPs) are the response. Using the standardized methods developed for the hospital studies, the C-CAP projects have been undertaken in almost every planning region to make recommendations regarding the fit between community client needs and available services. All of the C-CAPs have involved three components: the consumer preference survey, the program profile survey, and the level of need assessment. With the completion of the community CAPs, Mental Health Implementation Task Forces will have a more comprehensive overview of the needs of consumers in their regions, and the extent to which the existing system is capable of meeting those needs. As

reinvestment dollars become available, results from these studies will help guide resource allocation decisions.

Target Population for Level of Need Assessments

The target population for the C-CAPs was broadly defined by the Coordinating Centre to be current clients of community mental health programs who were 16 years of age or older. This was further delimited by our local Steering Committee to exclude:

- Clients who received services from programs targeting specialty populations—forensic, dual diagnosis, concurrent disorders, and psycho-geriatric—as separate planning efforts were underway for these groups. Also, little was known about the validity of the study questionnaire in specialty populations.
- Clients who received services outside of the formal mental health programs in Community Access Centres, Community Health Centres, Ministry of Health and Social Service agencies for children and youth, family practice settings, non-program based psychiatrists, and private mental health providers.
- Programs providing crisis services were excluded, as the staff considered they would have insufficient knowledge of the client to complete the study questionnaire. Since crisis services are the main portal of entry into mental health treatment programs, these clients were likely not lost to the study but captured through other program affiliations.

Creating the Sampling Frame:

The Steering Committee identified thirteen agencies across the district that provided community-based treatment and support services, all of which participated in this study. Therefore, results are representative of community-based treatment and support programs in the Southeastern Ontario mental health planning district. Programs that participated were:

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- Brockville Psychiatric Hospital Elmgrove Facility – Royal Ottawa Health Care Group
- Canadian Mental Health Association of Hastings and Prince Edward
- Canadian Mental Health Association of Leeds and Grenville
- Community Mental Health Program of Hastings and Prince Edward
- Frontenac Community Mental Health Services
- Lanark Community Mental Health Program
- Leeds Grenville Rehabilitation and Counselling Services
- Lennox and Addington Community Mental Health Services
- Quinte Healthcare
- Quinte and Region Community Homes
- Queen's University Affiliated Teaching Hospitals and Programs
 - Hotel Dieu Hospital
 - Providence Continuing Care Mental Health Program
- Youth Habilitation Quinte Incorporated

Agency staff provided researchers with a list of clients that had a program contact during the months of August to October 2001. Agency lists were amalgamated into a single database giving an initial sampling frame of 3,618 clients. Eighty-seven percent of the clients had contacted only one agency during the study months. However, thirteen percent had received services from two or more agencies so appeared in the database more than once. As they would have an unfair chance of being selected for the study, multiple agency contacts were omitted from the sampling frame. For each client, agency staff provided a unique identifier composed of the first three initials of the last name, the gender, and the date of birth. This was used to identify clients who received multiple services. Once identified, they were assigned to a single agency and all additional records were deleted. In order to maximize data quality, clients were

assigned to the program and agency most likely to have the greatest involvement with them. In this way, only the most knowledgeable staff would be completing assessments. In order of assignment, these were: (a) Assertive Community Treatment, (b) Case Management, (c) Counselling and Treatment, (d) Housing, and (e) any other program type.

Following this procedure, we created a sampling frame of **3,163** unique individuals from which our study sample was drawn (see **Table 1**).

Sample Selection:

The Southeastern Ontario Task Force adopted a population perspective in order to emphasize the needs of the seriously mentally ill across the life span. In order to insure that the unique needs of youth (16-24) and geriatric (65+) populations receiving community-based care were well represented in this study, these groups were oversampled. Over-sampling compensated for their lower prevalence in the community service population and ensured that there would be sufficient numbers in our sample to permit separate analyses (see **Table 1**). Those who were in the 16-24 year old age stratum were randomly sampled at approximately 50%. The sampling fraction for the 25-64 age stratum was 10% and for those 65 years of age or older it was 100%. Sample results have been appropriately weighted by age and gender to take these different sampling probabilities into consideration.

The age stratified sample diverges from other CCAP projects that stratified their samples according to program type. A minimum of 100 respondents per age group was considered to be sufficient for the planned analysis.

Once the sample was selected, a list of eligible study subjects was returned to each agency for data collection. A total of 609 people were eligible for study. Surveys were returned for 525, giving a response rate of 86%. The major reason for non-response was that clients were not followed by the program past a single contact. This meant that staff could not provide the detailed clinical information necessary to complete the study instrument. Therefore, the results of this study reflect the needs of the ongoing, or 'rostered' program clientele.

Table 1: Sampling Profile			
Characteristic	Sampling Frame Total (%)	Eligible Sample Total (%)	Surveys Received Total (%)
Gender:			
▪ Male	1240 (39.2%)	230 (37.8%)	194 (37.0%)
▪ Female	1923 (60.8%)	379 (62.2%)	331 (63.0%)
Age Group:			
▪ 16-24	276 (8.7%)	136 (22.3%)	109 (20.8%)
▪ 25-64	2688 (85.0%)	274 (45.0%)	239 (45.5%)
▪ 65+	199 (6.3)	199 (32.7%)	177 (33.7%)
Total	3,163	609	525

Data Collection:

Using a standardized questionnaire, clinical staff who knew the client well completed a detailed assessment of level of need and level of service use. Fifty-six percent (N=296) were university-trained and 41% (N=215) had received college or other training. Three percent (N=13) had no formal clinical training. Thirty-three percent had seen their client within the week prior to the survey, 31% had seen them within the last month, and 36% had seen them more than one month ago.

Two data collection tools were used.

1. Colorado Client Assessment Record (C-CAR)

The C-CAR is a comprehensive functional assessment measure first developed in Colorado in the 1970's. It has been used in a number of jurisdictions throughout the United States and Canada to make level of care decisions, and for assessing change over time in users of both hospital and community mental health services. The C-CAR was used with good success in all previous CAPs and has become the standard for comparability across these projects.

The C-CAR assesses functioning in twenty-two areas related to symptoms, behaviours, social functioning, community functioning, and health. Each of the domains is rated on a nine point scale ranging from high functioning with no special problems, to low functioning with extreme problems or difficulties. It is completed by a clinician who knows the client well and does not require a face-to-face interview. Staff may consult clinical records or other professionals to augment or verify their information.

The psychometric properties of the C-CAR have been assessed in Colorado, in several other states, and in Ontario through previous CAP projects. It has demonstrated good reliability and validity and takes approximately one hour to complete. Psychometric properties are described in more detail in prior C-CAP reports (see Bibliography).

2. Support/Service Needs Profile:

This scale records staff assessments of the client's support and service needs. It was originally constructed for use in the hospital CAPs. It captures clinician perceptions about the range of supports and services required by a client to facilitate their community integration and recovery. The profile serves as an independent measure of need to compare with the level of care assessments provided by the C-CAR.

The use of the C-CAR and the Support/Service Needs Profile in the context of the C-CAP projects is intended to provide an overall sense of the support and service needs of groups of individuals currently receiving community mental health services. By providing a brief snapshot of a group at one point in time, this approach facilitates a discussion of population (and sub-population) needs from a system planning perspective. It is not intended as a means of individual care planning as this requires a longitudinal view as well as input from various sources.

A copy of these study instruments can be obtained from the principal author upon request.

In order to insure that staff were using the rating instruments in comparable ways, they participated in a one-day training sessions. Two training sessions were held; the first in Kingston and the second in Brockville. Staff were provided with a manual of detailed definitions and instructions and successfully worked through scores for three test cases.

Data Management and Reporting:

Data were entered and analyzed by the local research team under the guidance of the Coordinating Centre. When percents are shown for the entire sample, they are appropriately weighted by age group and gender to take into account the stratified random sampling plan..

One copy of the electronic data files has been retained by the local Project Director. By agreement, one copy will be submitted to the Ministry of Health and Long Term Care through the Health Systems Research and Consulting Unit, Centre For Addictions and Mental Health, Toronto. The data will be pooled with that collected in the other sites for multi-site comparisons in support of provincial planning, and may be used by local Principal Investigators to support academic publications. Any other individuals wishing access to the electronic data for analysis purposes must submit a formal research proposal to the custodians of the data for their approval and receive an ethics clearance.

Ethics Clearance:

In order to ensure that data were collected and handled in ethically appropriate ways, clearance was obtained from the Queen's University Research Ethics Board. This study was considered to pose minimal risk. It used data provided by agency staff and did not require face-to-face interviews. No individual would be personally identified in the results, and data would be kept securely with access restricted to all but project staff.

Chapter
3

Results

This chapter reports the results of the C-CAR levels of need assessments made by staff on the sample of 525 current clients of community mental health programs.

Socio-demographic Information:

As mental illnesses often begin in childhood, they can seriously disrupt educational and social achievements and reduce subsequent employment opportunities. For those who cope daily with the symptoms and functional limitations of serious mental illnesses, the lack of supported employment opportunities may place competitive employment forever out of reach. The demographic profile shown in **Table 2**, is consistent with this familiar pattern.

Clients were largely unmarried, poorly educated, and unemployed. Approximately three quarters of the youth had not yet completed post-secondary education compared to about half of the other age groups. Virtually none of those of retirement age were working.

The proportion of those employed was similar across both youth and adults, although slightly higher among youth, confirming that employment prospects do not significantly improve over time. Of those who were working, the majority had gained independent employment. Supported or sheltered work situations were in the minority. Consequently, less than one in five clients of working age were primarily being supported by their employment earnings. The remainder received some form of financial assistance. Young people were more often supported by their families, adults by public assistance, and elders by a pension income.

Table 2: Demographic Information

Characteristic	Age Group			All Groups Total* (N=525)
	16-24 (N=109)	25-64 (N=239)	65+ (N=177)	
Marital Status				
▪ Married/Common-law	12%	34%	27%	31%
▪ Not married	88%	66%	73%	68%
▪ Missing	--	<1%	1%	<1%
Educational Status				
▪ High school or less	70%	55%	54%	56%
▪ Post-secondary	28%	34%	21%	32%
▪ Unknown	2%	12%	25%	12%
Job Status				
▪ Full time	9%	15%	<1%	13%
▪ Part time	15%	14%	2%	13%
▪ Not working	75%	70%	95%	72%
▪ Unknown	1%	1%	3%	1%
Job Support				
▪ Not working	75%	70%	95%	72%
▪ Independent employment	20%	20%	1%	19%
▪ Supported employment	3%	4%	2%	4%
▪ Unknown	2%	7%	2%	6%
Main Source of Income				
▪ Public assistance	30%	44%	14%	41%
▪ Employment earnings	15%	21%	1%	19%
▪ Family	40%	7%	2%	10%
▪ Pension	5%	19%	75%	22%
▪ Other	6%	3%	5%	4%
▪ Unknown	4%	6%	5%	6%
* Weighted by age group and gender.				

Residential Information:

Table 3 summarizes residential information. Just under one third of clients were living alone at the time of the study. This was less often the case for youth, who often still lived with their parents. Approximately one third of adult clients were living with a spouse or partner. Elders were more likely to live with an unrelated person in a supported housing or nursing home arrangement. Under one percent of clients in each age group had no fixed address when they received services. Either they were living on the street or lived in a homeless shelter.

Slightly less than half of the clients lived outside of major urban centres—about one in ten more than 50 kilometers away. Residential instability was an issue for one half to one third of clients, depending on age group. It was highest among the youth and lowest among the elderly. For example, almost half of youth had moved in the year prior to the survey compared to only 9% of the elderly.

Table 3: Residential Information

Characteristic	Age Group			All Groups Total* (N=525)
	16-24 (N=109)	25-64 (N=239)	65+ (N=177)	
Usually Lives With				
▪ Parents	45%	8%	1%	11%
▪ Spouse/partner	16%	33%	24%	31%
▪ Other relative	7%	11%	5%	10%
▪ Alone	13%	33%	27%	31%
▪ Unrelated person	19%	15%	41%	17%
▪ Unknown	2%	<1%	2%	<1%
Usual Residence				
▪ House/apartment/room	88%	92%	63%	89%
▪ Nursing Home or Long Term Care Facility	3%	1%	14%	2%
▪ Supported Housing	6%	6%	22%	7%
▪ No Fixed Address	1%	1%	1%	1%
▪ Unknown	2%	1%	2%	1%
Rural/Urban Residence				
▪ Urban	56%	56%	58%	58%
▪ 1-10 km to urban centre	5%	4%	5%	4%
▪ 11-50 km to urban centre	30%	25%	28%	26%
▪ > 50 km to urban centre	6%	9%	5%	9%
▪ rural distance not specified	2%	4%	1%	4%
Times Moved in Last Year				
▪ None	47%	70%	80%	68%
▪ 1	21%	12%	8%	12%
▪ 2	15%	3%	--	4%
▪ 3+	11%	3%	1%	3%
▪ Unknown	6%	13%	12%	12%
* Weighted by age group and gender.				

Illness Information:

Table 4 shows illness information. Risk factors for mental illness included physical and sexual abuse, neglect, a family history of mental illness and a family history of substance abuse. Almost two-thirds of the sample had experienced one or more of these. The most common in all groups was a family history of mental illness followed by a family history of substance abuse. One in five were reported to be victims of physical abuse and one in five were victims of sexual abuse. In all cases, the prevalence of risk factors was lowest among the elderly. This may be due to under-reporting of early childhood events due to a lack of recall, or because staff perceive distant events as less relevant to current psychiatric issues among the elderly and do not ask about them.

Staff were also asked to report on current disabilities. Sensory disabilities related to sight, hearing, and speech. These occurred in a minority of cases (less than 5% overall) and were highest among the young and the old. Developmental and learning disabilities were reported in one in five young people with decreasing proportions in the other age groups. Thirteen percent of elderly were also reported to be non-ambulatory.

Current psychiatric diagnosis referred to a diagnosis given by a licensed mental health professional. Virtually everyone was identified as having at least one diagnosis, although this was slightly lower among the youth. Over half of those sampled were reported to have a mood disorder and one in four had a diagnosis of schizophrenia or anxiety disorder. Substance abuse and personality disorders were reported in approximately fifteen percent of the sample overall. The reported prevalence of schizophrenia, organic disorders and developmental disorders increased with age. Reported use of psychotropic medication also increased with age. Approximately half of those under the age of 25 were reported to be taking psychotropic medications compared to approximately three quarters of adults and elders.

It should be noted that certain diagnoses, such as substance abuse among those with a serious mental illness, or depression among the elderly, may be significantly under-identified. Therefore, staff-reported prevalence estimates should be considered to reflect a conservative estimate of illness occurrence.

A quarter of the sample was known to have previously attempted suicide, although this was significantly less among the elderly. Since any survey necessarily deals with the surviving members of a population, the lower history of suicide attempts in the elderly could be a function of their higher mortality, both from suicide and from other causes.

Table 4: Illness Information				
Prevalence	Age Group			All Groups Total* (N=525)
	16-24 (N=109)	25-64 (N=239)	65+ (N=177)	
Risk Factors:				
▪ Victim of physical abuse	26%	20%	13%	20%
▪ Victim of sexual abuse	21%	25%	6%	23%
▪ Victim of neglect	16%	13%	7%	13%
▪ Family substance abuse	22%	24%	13%	23%
▪ Family mental illness	41%	36%	24%	35%
Any Risk Factor	69%	66%	38%	64%
Disability:				
▪ Sensory/Perceptual	6%	3%	9%	4%
▪ Developmental/Learning	19%	13%	10%	14%
▪ Non-ambulatory	1%	3%	13%	4%
Psychiatric Diagnosis:				
▪ Mood	45%	57%	50%	55%
▪ Anxiety	23%	25%	12%	24%
▪ Schizophrenia	14%	25%	33%	25%
▪ Substance	13%	15%	2%	14%
▪ Personality Disorder	15%	14%	6%	14%
▪ Eating Disorder	17%	4%	1%	5%
▪ Organic Disorder	1%	3%	10%	3%
▪ Developmental	6%	7%	10%	7%
▪ Childhood Disorder	15%	5%	1%	5%
▪ Other	9%	8%	4%	8%
Any psychiatric diagnosis	91%	98%	98%	97%
Psychotropic medication use	47%	74%	78%	72%
History of suicide attempts	21%	26%	10%	25%
Unstable employment	21%	24%	11%	23%
Legal problems**	18%	10%	2%	11%
* Weighted by age group and gender. ** Missing values for this item were 45. Note: Individuals may fit in to more than one category so percentages shown in this table do not add to 100%.				

Unstable employment was a problem for a quarter of these clients, again with significantly fewer among the elderly. Finally, the proportion identified with legal problems (on probation, unfit to stand trial, not criminally responsible, on probation, charges pending, etc.) was eleven percent overall. Legal problems were highest among youth (almost one in five) and lowest among the elderly.

Health Service Profile:

Table 5 summarizes clients' health care utilization profile. With respect to mental health programs, the study method required that each client be identified with one main program, even though 13% used services from multiple agencies. Clients were assigned to programs in order of program intensity, beginning with assertive community treatment and case management. Table 5 shows these in their assignment order.

Approximately a third of clients overall used intensive services (ACT and case management). About half as many youth as adults or elderly were assigned to intensive services as their main service contact. Counselling and treatment services were assigned to over half of youth and adults but only a third of the elderly. Housing services were assigned to approximately one in five youth and elderly but virtually no adults. This means that their only mental health program contact was through a housing program.

Approximately fifteen percent of clients were known to have had a psychiatric hospitalization within the six months prior to the study, and this was lowest among the elderly and highest among the youth. Although the data are not shown in the table, approximately three quarters of those having hospitalizations accumulated less than 30 hospital days.

Program informants had considerable difficulty reporting on their client's past emergency room use. Often they did not know, particularly if the client was under 25 years of age.

With respect to current service use, few clients were hospitalized at the time data were collected and this is consistent with a community-based population. The bulk of residential services were used by the elderly.

Table 5: Service Profile

Characteristic	Age Group			All Groups Total* (N=525)
	16-24 (N=109)	25-64 (N=239)	65+ (N=177)	
Main Program Type :				
▪ ACT	3%	11%	10%	10%
▪ Case management	13%	24%	29%	24%
▪ Counselling & Treatment	58%	54%	33%	52%
▪ Housing	24%	5%	19%	8%
▪ Other	3%	6%	9%	6%
Psych Inpatient t in past 6 months:				
▪ None	73%	77%	90%	77%
▪ 1	18%	13%	6%	13%
▪ 2	5%	1%	2%	1%
▪ 3+	1%	2%	1%	2%
▪ Unknown	3%	8%	2%	7%
Emergency Room Use in past 6 months				
▪ No	39%	63%	76%	62%
▪ Yes	17%	13%	11%	14%
▪ Unknown	44%	24%	14%	25%
Current Psych Inpatient	3%	3%	1%	2%
Current Residential Service	8%	9%	37%	10%
Current Individualized Management & Support Services	53%	54%	67%	55%
Current Clinical Services				
▪ None	28%	15%	18%	16%
▪ Psychiatrist	35%	52%	58%	51%
▪ General Practitioner	31%	40%	54%	40%
▪ Nurse	19%	18%	28%	19%
▪ Other	35%	41%	26%	39%
Frequency of Treatment Contact for Clinical Services				
▪ None	28%	15%	18%	16%
▪ Intermittently	26%	24%	29%	25%
▪ Once a month	17%	23%	22%	23%
▪ Every 1-2 weeks	20%	26%	18%	25%
▪ Several times a week	7%	10%	10%	10%
▪ Unknown	2%	3%	3%	3%
* Weighted by age group and gender.				

Half or more of those surveyed were using individual management and support services at the time of the study and this was higher among the elderly. The majority of clients were receiving clinical services. Receipt of services from a psychiatrist increased with age from a third among youth, to a half among adults, to sixty percent for elderly. Overall, forty percent of the sample was receiving services from a general practitioner at the time of the survey. However, this increased with age as well. Nursing services were received by one in five and approximately a third received services from other professionals, although this was lower among the elderly. These findings highlight the importance of shared care models, particularly with general practitioners.

Problem Severity:

The C-CAR instrument has the staff member rate each client according to a number of psycho-social problem areas on a nine-point scale. The rating reflects the extent to which the staff member considers the problem to be of current or ongoing concern. The overall degree of problem severity is a global rating that is made by the staff member taking all other problems into consideration. The psycho-social problem areas and indicators used in the C-CAR are summarized in **Table 6** below.

Table 6: Colorado Client Assessment Record Problem Severity Items	
Mood and Affect	
Emotional withdrawal	Under-active, distant, passive, subdued, doesn't verbalize feelings, blunted affect
Depression	Depressed, lonely, hopeless, worthless, sad, dejected
Anxiety	Anxious, fearful, flashbacks, panic, tense, nervous, nightmares or terrors, phobic
Hyper-affect	Overactive, pressured speech, elevated mood, mood swings, accelerated speech, mania

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Suicide, danger to self	Suicide ideation, suicide attempt, danger to self, suicide plan, self injury/mutilation, recklessness/self-endangerment
Thought Processes	
Attention problems	Agitated, distractible, attention span, restless, impulsive, poor concentration
Thought processes	Bizarre, hallucinations, paranoid, obsessive, delusions, suspiciousness, repeated thoughts
Cognitive problems	Confused, loose associations, lacks self-awareness, disoriented, disorganized, impaired judgment
Social and Role Performance	
Family issues	No family or no contact, separation/custody, parenting, unstable home/family, out of home placement, family legal, domestic violence
Family problems	Parent, partner, relative, sibling, child
Interpersonal problems	With friend, establishing relationships, social skills, maintaining relationships
Role performance	Absenteeism, performance, behaviour, suspensions/probation, termination, limited employability
Self Care and Management Needs	
Self care and basic needs	Hygiene, gravely disabled, doesn't use resources, self care problems, doesn't manage money, doesn't provide food, doesn't provide housing
Medical Illnesses	Acute illness, medical care needed, physical handicap, chronic illness, injury by abuse/assault, permanent disability
Security/management issues	Seclusion/time out, medication compliance, security, behaviour management, close supervision, walkaway/escape, inadequate adult supervision, suicide watch

Antisociality	
Resistiveness	Resistive, evasive, wary, uncooperative, guarded, denies problems
Aggressiveness	Acting out, defiant, threatening, aggressive, hostile, intimidating
Antisocial	Disrespect, disregards rules, uses/cons others, disobedient, dishonest
Legal problems	Legal problems, probation/parole, offenses, charges pending
Violence	Violent, assaultive, physical/sexual abuser, homicidal ideation, homicidal threat or attempt, danger to others.
Substance Abuse	Problems with alcohol or drugs, dependent or addicted, substance abuse interferes with responsibility, or in recovery.

Table 7 analyzes the items from the C-CAR according to the broad domains of mood, thought, social role performance, self-care, and antisociality. Scores for each nine-point scale were summed across the items in each domain, then categorized into low, moderate, and high severity groupings based on scale tertiles. Clients who were rated as having a “slight” problem had a persistent, low level problem or one that was intermittent. The problem would not be considered to require immediate attention, would be unrelated to problems in other domains, and would not require therapeutic intervention but might in the future. Clients who were rated in the “moderate” category would have had a persistent problem of moderate intensity that could become severe on occasion. Problems at this level would be more complex and interrelated, and would require therapeutic interventions. If a client were rated as having a “severe” problem, it would be acute and severe or sub-acute or chronic. Almost always it would extend to other domains and involve other persons and social contexts. It is likely that hospitalization or some other form of external control would be needed in addition to other therapeutic interventions.

Table 7: Problem Profile

Problem Severity	Age Group			Total*
	16-24	25-64	65+	
Mood :				
▪ Slight	56%	51%	70%	53%
▪ Moderate	43%	48%	29%	46%
▪ Severe	1%	0.4%	1%	1%
▪ Total Available	(105)	(226)	(169)	(498)
Thought:				
▪ Slight	66%	57%	58%	58%
▪ Moderate	32%	40%	39%	39%
▪ Severe	2%	3%	3%	3%
▪ Total Available	(108)	(232)	(176)	(511)
Social & Role Performance				
▪ Slight	45%	39%	49%	40%
▪ Moderate	50%	57%	48%	56%
▪ Severe	5%	4%	2%	4%
▪ Total Available	(104)	(230)	(170)	(505)
Self-care				
▪ Slight	88%	82%	61%	81%
▪ Moderate	11%	17%	36%	18%
▪ Severe	1%	1%	3%	1%
▪ Total Available	(107)	(231)	(167)	(508)
Antisociality				
▪ Slight	83%	88%	93%	87%
▪ Moderate	16%	12%	7%	12%
▪ Severe	1%	1%	--	1%
▪ Total Available	(107)	(227)	(173)	(501)
Overall Problem Severity				
▪ Slight	70%	66%	76%	67%
▪ Moderate	30%	34%	24%	34%
▪ Severe	--	--	--	--
▪ Total Available	(99)	(207)	(153)	(456)
*Weighted by age group and gender. Overall problem severity ratings were constructed by summing C-CAR ratings, then dividing the ratings into tertiles to reflect low, medium, and high problem severity groups.				

The profile presented in Table 7 is consistent with a community-based sample. Few clients were rated by staff to have severe problems in any of the domains. Approximately half of those assessed were considered to have moderate problems with mood and affect; less among the elderly. Three percent of the sample were reported to have severe problems with thought and some forty percent, moderate problems. Thought disorders were less frequently reported among youth.

Social and role performance was a severe problem for four percent of the sample. This was highest amongst youth (5%) and lowest among the elderly (2%). Moderate problems in social and role performance were reported for approximately half of the youth and elderly, and close to sixty percent of adults.

Problems with self-care were concentrated in the elderly group where over a third were reported to have moderate problems and three percent were reported to have severe problems.

Antisociality was relatively uncommon in the sample, particularly among the elderly. Youth were reported to have the highest prevalence of moderate problems; 16% compared to 12% among adults and 7% among elderly. Severe antisociality was reported in only one percent of youth and adults and not at all among the elderly.

Summing scores across all of the domains, a third of the sample were considered to have a moderate rating signifying that they require ongoing therapeutic intervention. None received a rating that would place them in the severe category. The majority (67%) were rated to have problems that may not require immediate or ongoing therapeutic intervention and would be amenable to lower intensity or intermittent service and self-care.

Strengths and Resources:

A client's strengths and resources can play an important mitigating role in their social and role performance so must be considered in the context of level of care needs assessments. Clients without resources may have difficulty coping with even minor problems, whereas those with considerable resources may be able to successfully manage in the face of significant impairments. Using the C-CAR, staff also rated each client's strengths and resources in a key social, economic, and inter-personal spheres. Using a nine-point scale and the same cut-points as in the previous analysis, scores

were categorized into three groups reflecting low, moderate, and high resources. These results are presented in **Table 8**.

Table 8: Strengths and Resources				
Strengths	Age Group			Total*
	16-24	25-64	65+	
Economic				
▪ Low	30%	30%	17%	30%
▪ Moderate	41%	42%	48%	43%
▪ High	29%	27%	35%	28%
▪ Total Available	(107)	(234)	(176)	(515)
Education & Social				
▪ Low	39%	35%	32%	36%
▪ Moderate	33%	41%	43%	40%
▪ High	28%	24%	25%	24%
▪ Total Available	(106)	(235)	(169)	(515)
Personal Resources				
▪ Low	29%	39%	36%	38%
▪ Moderate	42%	37%	45%	38%
▪ High	30%	24%	19%	24%
▪ Total Available	(108)	(234)	(177)	(515)
Personal Strengths				
▪ Low	27%	26%	25%	26%
▪ Moderate	52%	49%	50%	50%
▪ High	21%	25%	25%	25%
▪ Total	(106)	(231)	(176)	(508)
* Weighted by age group and gender.				

Overall, slightly less than a third of clients were reported as having poor economic resources, including financial resources, employment, housing, and access to transportation. Fewer elderly clients were considered to have poor economic resources compared to the other two age groups.

Education and social skills included language skills, education, intelligence, job skills, and basic interpersonal skills. Just over one third of clients were considered to have poor resources.

Personal resources refers to access to supportive people including parents, relatives, siblings, children, partners, or friends. Overall, two thirds were considered to have

moderate or high personal resources. High personal resources differed by age group with youth being reported to have the most (30%) and elderly the least (19%).

Personal strengths included rated whether the person was likeable, their overall appearance, confidence, judgment, empathy, tolerance, health, hopefulness, responsibility, insight, adaptability, thought clarity, resourcefulness, and emotional stability. One quarter of the clients were considered to rate highly on this dimension, slightly fewer amongst youth. Half in each age group were rated as having moderate personal strengths.

Levels of Care:

The main aim of the C-CAP was to link levels of need to levels of care so that service planning could become needs-based. Using the problem profile data, a standardized template was developed to quantify five recommended levels of care. This template has been used consistently in all of the CAP projects to date to define five levels of care as follows:

Level 1: Self-Management:

This level of care is characterized by intermittent access to psychiatric care from a general practitioner or psychiatrist. The individual will have the capacity to access a care manager as needed and will use community supports and services as desired.

Level 2: Community Treatment & Support:

This level of care is characterized by regular (such as monthly) contact with a general practitioner or psychiatrist with more frequent visits if required. The individual will have the capacity to access a case manager on a regular basis and will receive rehabilitation services as needed. They may also need assistance to access community supports and services.

Level 3: Intensive Community Treatment & Support:

Intensive community treatment and support is characterized by contact with a psychiatrists every one or two weeks, sometimes more if required. There must be round-the-clock access to a case manager with up to daily visits if required.

There will be a strong rehabilitation component at this level and regular assistance to access community supports and services.

Level 4: Residential Treatment

Residential treatment will include up to daily access to psychiatric and nursing staff for clinical treatment to reduce symptoms and improve functioning. There will be 24 hour on site support and supervision and a strong rehabilitation component. The setting will be lockable and will use behavioural and other risk management strategies.

A peculiarity of the scoring algorithm for this item for determining current level of care is that it included any support provided in a residential setting in this level. This included nursing homes, long term care facilities, and some independent but supported housing. To correct for this, we have operationalized Level 4 care to be synonymous with residential treatment facilities which provide a lockable environment, 24-hour on-site supervision, and intensive rehabilitative programming and have excluded clients from this level if their usual living arrangements were nursing homes/long term care facilities.

Level 5: Inpatient Treatment:

At the highest intensity of care, specialized diagnostic and treatment services are offered in the context of an inpatient setting. This may include daily access to a multi-disciplinary team of professionals with high levels of psychiatric expertise. There will be 24-hour on site support and supervision with a strong rehabilitation component. The setting will be lockable and will use behavioural and other risk management strategies.

Individuals will move up and down the continuum of care depending on their needs. In an ideal system, linkages would be in place to insure that this would happen seamlessly. In rural areas the divisions between basic and intensive community treatment services may not be so pronounced and these services may be combined.

The standardized algorithm used to assign each client to a level of care based on their C-CAR results is contained in **Appendix A**. The algorithm is complex, and includes a number of factors considered to reflect needs for care. Clients were assigned to levels based on a staged approach that considered the following factors:

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- Security and management issues,
- Overall problem severity,
- Risk of violence or suicide,
- Ability for self care, and
- Strengths and resources.

Table 9 shows the levels of care requirements based on the C-CAR results.

Table 9: Level of Care Requirements				
Level of Care	Age Group			Total*
	16-24	25-64	65+	
Self-management	14%	19%	30%	19%
Community Tx	56%	49%	45%	49%
Intensive Community Tx	29%	29%	21%	29%
Residential Tx	2%	3%	5%	3%
Inpatient Tx	--	--	--	--
Total Available	(108)	(230)	(168)	(498)
*Weighted by age group and gender.				

Approximately one in five clients were rated as capable of self-managed care, meaning they require intermittent access to care and are capable of self-managing their care process. This proportion was the lowest among the young and the highest among the elderly. Community treatment was required for approximately half of the sample with a slight age gradient that favored higher levels of community treatment among youth.

Intensive community treatment was recommended for just under one third of the sample and less indicated amongst the elderly. Finally, residential treatment was identified for a small minority of clients, increasing slightly with age. No one was rated in need of inpatient treatment. This is consistent with a community-based client population.

Current Levels of Care:

The crux of needs-based planning is to match levels of need to the current levels of care actually being received. Once recommended levels of care have been identified, the next step in the process is to assess current levels of care, recognizing that program staff may not have been entirely familiar with the client's use of services outside of their particular program and actual service use may have been under-estimated. With this limitation in mind, staff were asked to estimate each client's use of inpatient hospitalization, residential care, case management and individualized support and clinical services. **Table 10** summarizes the standardized criteria that have been used throughout the CAP projects to estimate the level of care each client was receiving at the time of the survey.

Table 10: Criteria for Assigning Current Levels of Care	
Level of Care	Assignment Criteria
1. Self-management	▪ contact with a case manager as needed OR ▪ monthly contact or more with a provider for clinical services, OR ▪ up to monthly contact elsewhere in the system
2. Community Tx	▪ weekly contact with a case manager, OR ▪ at least weekly contact for clinical services (medication management, assessment & diagnosis, psychotherapy & counselling) ▪ at least weekly contact for support services (selfcare, other activities of daily living, vocational supports, educational supports, housing supports)
3. Intensive Community Tx	▪ up to daily contact with a case manager
4. Residential Tx	▪ use of a residential facility that was lockable or locked, had 24-hour staffing, and offered rehabilitative programming ▪ excluded persons living in nursing homes or long term care facilities as their usual place of residence
5. Inpatient Tx	▪ use of inpatient psychiatric hospital care

Table 11 shows that 2% clients had received inpatient psychiatric care at the time this survey was completed and this proportion decreased with age. This is consistent with the fact that many mental health services for children and youth are provided through

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the Ministry of Community and Social Services. Youth who received services in the formal mental health system may be more seriously impaired and more likely to use inpatient psychiatric services. Slightly less than one in ten youth and adults, and over one third of the elderly were in a program that provided them with residential services or supports. Similarly, elderly were more likely to receive individualized support services these were often of low (41%) or moderate (46%) intensity.

Table 11: Level of Current Care Received

Current Service Use	Age Group			Total*
	16-24	25-64	65+	
Psychiatric inpatient Total Available	3% (109)	3% (239)	1% (177)	2% (525)
Residential supports/services Total Available	8% (109)	8% (239)	37% (177)	10% (525)
Individualized Support Total Available	53% (109)	54% (239)	66% (177)	55% (525)
Intensity of Individualized Supports				
▪ Low: contact as needed	48%	38%	41%	39%
▪ Moderate: about weekly	43%	43%	46%	43%
▪ High: up to daily	7%	18%	13%	17%
▪ Unknown	2%	2%	1%	2%
▪ Total Available	(58)	(128)	(117)	(286)
Clinical Services Total Available	71% (109)	85% (239)	82% (177)	84% (525)
Frequency of clinical treatment contacts				
▪ Intermittently as needed	36%	28%	36%	29%
▪ About once a month	23%	27%	26%	27%
▪ About every 1-2 weeks	28%	31%	22%	30%
▪ Several times per week	10%	12%	12%	12%
▪ Unknown	3%	3%	5%	3%
▪ Total Available	(78)	(203)	(145)	(440)
Current level of care assignment				
▪ Self-management	60%	57%	31%	55%
▪ Community tx	34%	31%	59%	33%
▪ Intensive community tx	1%	8%	8%	8%
▪ Residential care	3%	1%	2%	2%
▪ Inpatient care	3%	3%	1%	2%
	(109)	(239)	(182)	(525)
* Weighted by age group and gender.				

Clinical services such as those provided by a psychiatrist, general practitioner or nurse were accessed by the majority of clients. Over half of the time, these were accessed once a month or less. Over one in ten clients used clinical services several times a week.

The current level of care was assigned following the criteria described earlier, hierarchically, beginning with the most intensive. Just over half of the sample were receiving the lowest intensity care indicative of self-management. A further third received community treatment. Less than one in ten were accessing intensive community treatment programs and 4% were receiving residential or inpatient care.

Elderly clients in this sample were more likely to receive less intensive community treatment. Self-managed care was the predominant mode for both youth and adults.

Matching Levels of Care to Levels of Need:

The main aim of the C-CAP was to assess the match between service need and service use. **Table 12** summarizes the extent to which levels of care received by clients matched their level of care needs as they were assessed from the problem based inventory in the C-CAR.

Table 12: Match Between Need and Care Received				
Degree of Match	Age Group			Total* (N=525)
	16-24 (N=109)	25-64 (N=239)	65+ (N=177)	
Under serviced	56%	57%	38%	56%
Matched	36%	29%	36%	30%
Over serviced	8%	14%	26%	14%
* Weighted by age group and gender.				

Overall, slightly less than a third of the clients received an intensity of care that matched their need. Over half were being under-served. Fourteen percent of clients received services that exceeded their level of need. The distribution of care differed by age group. Youth were least likely to be over-served and, along with elderly, had the highest match (36%). The elderly were most likely to be over-served.

Figure 1 uses bars to compare these differences by level of care type. The bars reflect the percentage difference between the care that was received and the care that was needed. A positive bar difference reflects care received that is in excess to requirements. A negative bar shows a level of care that is under-used relative to need.

This figure shows that the mental health system significantly over-uses self-managed care and under uses community treatment options for youth and adults. In the elderly, self-managed care needs appear to be well matched. However, less intensive community treatment is substituted for intensive community treatment. Inpatient care is over-used in youth and adults and residential treatment is under-used in adults and the elderly.

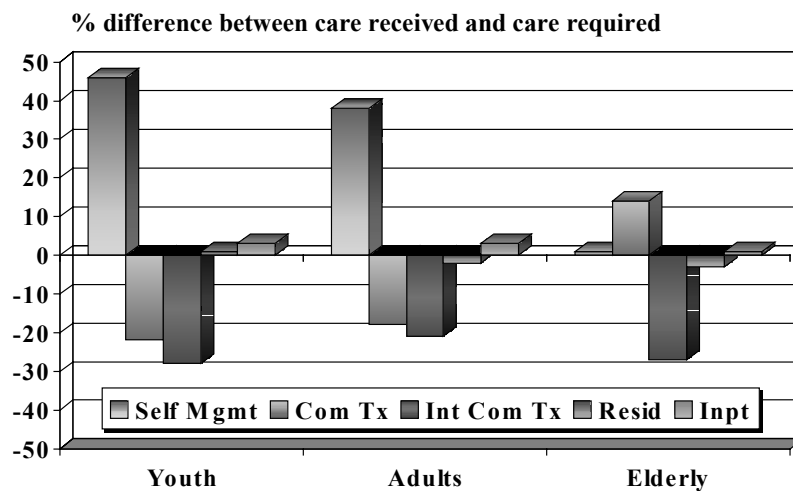


Figure 1: Difference Between Care Received and Care Required

Specific Areas of Under-met and Over-met Need:

The final section of the C-CAR instrument required staff to identify current use and estimated need for a series of specific services and supports relating to four broad domains:

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- mental health services and supports such as medication management, assessment and diagnosis services, psychotherapy and counselling, substance abuse programming, and crisis intervention,
- other health treatments such as those provided for physical or dental health care,
- rehabilitation services such as supports for self care, activities of dialing living, vocational and educational activities, social and recreational activities, and
- other supports and services, such as housing, income, rights protection, advocacy, supports to family, correctional and justice services, and developmental disability programming.

Keeping the problem of under-reporting of service use in mind, these results are summarized in **Tables 13-15**. Missing data varied by service and, in some cases, was large. This could mean that staff were either unsure of current needs in these areas, or did not know of their client's current service use.

In every instance, youth were more likely than adults to be under serviced. Approximately one in five youth required more mental health services than they had received and this was fairly consistently noted across the full range of mental health treatment and crisis services. Elderly clients were more likely to have their needs for mental health treatment and crisis services adequately met. It is important to note that no age group was considered to be over-serviced with respect to substance abuse programming.

Physical and dental health care were often difficult for staff to assess. The greatest amount of missing information occurred with respect to physical and dental health care making these estimates the least reliable of all presented. In addition, the levels of care template used was reported by the Coordinating Centre to be less sensitive to physical health needs, particularly among the elderly. With these caveats in mind, staff considered that most of these needs were adequately met. There was a clear age gradient with respect to physical health care, with the youth being most disadvantaged and the elderly the least. No age differences were noted with respect to dental care.

Table 13: Match Between Need and Care Received for Mental Health Treatment and Crisis, and Physical Health Services

Service and Degree of Match	Age Group			Total* (N) %
	16-24 (N) %	25-64 (N) %	65+ (N) %	
Mental Health Treatment and Crisis Services				
Medication Management	(99)	(205)	(158)	(454)
▪ Under serviced	20%	10%	8%	11%
▪ Matched	77%	88%	91%	87%
▪ Over serviced	3%	3%	1%	2%
Assessment and Diagnosis	(100)	(206)	(156)	(456)
▪ Under serviced	17%	10%	9%	11%
▪ Matched	80%	86%	89%	86%
▪ Over serviced	3%	3%	2%	3%
Psychotherapy & Counselling	(104)	(216)	(163)	(477)
▪ Under serviced	24%	15%	8%	15%
▪ Matched	64%	71%	80%	78%
▪ Over serviced	13%	7%	4%	7%
Substance Abuse Programs	(101)	(207)	(153)	(458)
▪ Under serviced	20%	16%	6%	16%
▪ Matched	80%	84%	94%	84%
▪ Over serviced	--	--	--	--
Crisis Interventions	(99)	(204)	(157)	(452)
▪ Under serviced	22%	10%	10%	11%
▪ Matched	72%	84%	88%	84%
▪ Over serviced	6%	5%	2%	5%
Physical and Dental Health Care				
Physical Health Care	(88)	(188)	(152)	(417)
▪ Under serviced	20%	11%	7%	12%
▪ Matched	76%	82%	85%	82%
▪ Over serviced	3%	7%	8%	7%
Dental Health Care	(51)	(150)	(132)	(327)
▪ Under serviced	12%	10%	7%	10%
▪ Matched	87%	89%	92%	89%
▪ Over serviced	2%	1%	1%	1%
*Weighted by age group and gender.				

Table 14 summarizes the match between need for services and care received for social and recreational services and supports.

Table 14: Match Between Need and Care Received for Social and Recreational Services				
Service and Degree of Match	Age Group			Total* (N) %
	16-24 (N) %	25-64 (N) %	65+ (N) %	
Rehabilitation Services				
Selfcare	(97)	(209)	(159)	(461)
▪ Under serviced	6%	8%	8%	8%
▪ Matched	93%	90%	89%	90%
▪ Over serviced	1%	2%	3%	2%
Other ADL	(97)	(209)	(160)	(461)
▪ Under serviced	7%	11%	12%	10%
▪ Matched	92%	88%	83%	88%
▪ Over serviced	1%	1%	5%	2%
Vocational	(101)	(211)	(156)	(465)
▪ Under serviced	33%	25%	2%	24%
▪ Matched	65%	74%	97%	75%
▪ Over serviced	2%	1%	1%	1%
Meaningful Activity	(96)	(205)	(164)	(454)
▪ Under serviced	35%	35%	29%	34%
▪ Matched	64%	63%	68%	63%
▪ Over serviced	1%	2%	3%	2%
Educational	(99)	(210)	(154)	(462)
▪ Under serviced	32%	20%	5%	20%
▪ Matched	63%	78%	94%	78%
▪ Over serviced	5%	2%	1%	2%
Social/recreational	(98)	(208)	(164)	(460)
▪ Under serviced	34%	30%	28%	31%
▪ Matched	64%	65%	70%	65%
▪ Over serviced	2%	5%	3%	4%
* Weighted by age group and gender.				

Compared to mental health treatment services, there was more unmet need for rehabilitation and other support services. The largest unmet needs were for meaningful activities (such as cultural activities or hobbies) and social/recreational supports. About a third of clients were under serviced in these areas.

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There was also significant unmet need for vocational and educational services particularly among youth. Services and supports for activities of daily living and self-care were unavailable to approximately one in ten.

Table 15 summarizes the perceived match between need for other supports and their availability.

Table 15: Match Between Need and Care Received for Other Supports and Services				
Service and Degree of Match	Age Group			Total* (N) %
	16-24 (N) %	25-64 (N) %	65+ (N) %	
Other Supports and Services				
Housing	(95)	(211)	(156)	(463)
▪ Under serviced	17%	10%	6%	11%
▪ Matched	79%	87%	91%	86%
▪ Over serviced	4%	3%	3%	3%
Income Support	(98)	(214)	(157)	(470)
▪ Under serviced	25%	15%	6%	15%
▪ Matched	74%	84%	91%	83%
▪ Over serviced	2%	2%	4%	2%
Rights & Advocacy	(101)	(212)	(158)	(468)
▪ Under serviced	13%	9%	10%	9%
▪ Matched	85%	90%	89%	90%
▪ Over serviced	2%	1%	1%	2%
Caregiver Supports	(104)	(213)	(177)	(471)
▪ Under serviced	20%	15%	13%	16%
▪ Matched	80%	85%	86%	84%
▪ Over serviced	--	1%	1%	1%
Corrections/Justice Services	(104)	(213)	(157)	(471)
▪ Under serviced	4%	1%	1%	2%
▪ Matched	94%	98%	99%	97%
▪ Over serviced	3%	1%	--	1%
Developmental Disability Programming	(95)	(212)	(158)	(469)
▪ Under serviced	4%	2%	2%	2%
▪ Matched	96%	98%	98%	98%
▪ Over serviced	--	--	1%	--
* Weighted results.				

The largest discrepancies occurred for caregiver supports, income supports, and housing supports. Both income and housing supports showed an age gradient with

higher unmet needs among the youth. Rights protection and advocacy, justice/correctional services, and programming for the developmentally disabled all appeared to be fairly well matched to needs in this sample.

In general, over-servicing was generally small, under five percent. The only area where significant over-servicing appeared was for psychotherapy and counselling for youth (13%) and to a lesser extent, adults (7%). Otherwise, significant over-servicing was not apparent in this sample.

Finally, based on the foregoing analyses, the top three un-met needs by age group are as follows:

For youth age 16-24 years:

1. Meaningful activity (35% with unmet need)
2. Social and recreational supports (34% with unmet need)
3. Vocational supports (33% with unmet need)

For adults aged 25-64 years:

1. Meaningful activity (35% with unmet needs)
2. Social and recreational supports (30% with unmet needs)
3. Vocational supports (25% with unmet need)

For elderly aged 65 and higher:

1. Meaningful activity (29% with unmet need)
2. Social and recreational supports (28% with unmet need)
3. Caregiver supports (13% with unmet need)

Discussion & Recommendations

Summary

This study was part of a multi-centre needs-based planning initiative focusing on community mental health programs. It follows a long and growing legacy of such projects completed in all of the Provincial Psychiatric Hospitals across the province, and now in the community sector in all of the mental health implementation planning regions.

The Southeastern Ontario Community Comprehensive Assessment Project (C-CAP) was funded by the Southeastern Ontario Mental Health Implementation Task Force to assist them in making recommendations to the Ministry of Health and Long Term Care in support of mental health restructuring and reform. This report has assessed the extent to which current community mental health services match clients' needs.

These results must be interpreted in light of the specific group of clients that were targeted for this study—current users of community-based mental health treatment programs in the Southeastern Ontario mental health planning district. Programs addressing the needs of specialty populations, such as geriatrics, forensic, concurrent disorder, or dual diagnosis were excluded, as were agencies and services outside of the formal mental health system. Thirteen agencies met the inclusion criteria for the study. Given that all thirteen participated and staff completed assessments on 525 clients—

86% of all clients eligible to be sampled—decision makers can have considerable confidence in these results.

A second consideration in using these results for planning is that the levels of need assessments have been based on structured assessments provided by clinical staff. Although they knew the client well, and could access additional information from clinical records or other clinical care providers, they could have under-estimated the range of services used outside of their specific program. This could inflate estimates of unmet need among multiple-service users—some 13% of the sample. To help mitigate this, only the most knowledgeable staff were chosen to complete the structured assessment.

The methods used to collect staff assessments of need were standardized and have been used for this purpose throughout the Province in both provincial hospital and community based assessment projects. By now, considerable experience with the study instruments has been amassed, and a standardized training program has been developed to maximize reliability and validity.

As one of the goals of the Southeastern Ontario C-CAP was to build local capacity, staff members were trained in the use of the needs assessment instrument, and two individuals became sufficiently proficient in its use to be able to train others. The resulting cadre of trainers and trained assessors will remain an important legacy for future needs-based planning projects.

The essence of the CAP method is to systematically link clients' level of care needs to the particular levels of care they have received and, in this way, identify any mismatch that may have occurred. The Level of Care Template developed for this purpose makes use of information from a variety of functional domains widely considered to be important in determining needs for care. Staff ratings on these domains are combined using a standardized algorithm to yield five levels of care ranging from least intensive to most intensive. A second standard algorithm is applied to current service use to arrive at the same levels of care. A comparison of the levels of care required and those received provides an assessment of the degree to which services match needs.

We experienced difficulties in correctly classifying elderly clients into Level 4 care reflecting their current needs. The key questionnaire item used in the algorithm to identify Level 4 support asked staff members to indicate whether their client was currently living in a residential program which had on site supervision and staff.

Responses to this item included individuals in nursing homes and long term care facilities, as well as individuals living in independent housing with supports.

Level 4 care is intended to reflect individuals who are in residential treatment facilities that are lockable and have intensive rehabilitation programming. To correct this difficulty, we used individuals who were in a locked/lockable facility with 24-hour staffing and rehabilitation programming, and excluded any individuals from the Level 4 designation if they were residents of a nursing home or long term care facility. Using the uncorrected algorithm, we identified over-use of residential treatment facilities, particularly among the elderly. Using the corrected algorithm, we identified an under-use of residential treatment facilities among the elderly which was more in keeping with the experiences of local experts.

Key Findings:

The sampling frame consisted of 3,618 clients. Thirteen percent of these had received services at more than one agency during the three-month study window. When multiple agency contacts were eliminated from the database, 3,163 unique individuals remained. Although desirable for planning, it proved impossible to derive county based estimates because several of the programs included in this study reported catchment areas that spanned county boundaries. This was particularly true of programs that provided outreach services over large rural and outlying areas. Future needs assessments could develop county based estimates if client postal code information were collected, making it possible to assign clients to a county based on their postal code designation.

The socio-demographic profile was typical of community-based mental health clients. They were largely unmarried, poorly educated, and unemployed. One percent had no fixed address. Just under one half lived outside of the major urban areas. Approximately one in five had moved in the year prior to the study and residential instability was highest among youth.

Half of the clients surveyed were receiving counselling and treatment services. Approximately one third were enrolled in intensive community services such as an assertive community treatment team or intensive case management. The majority had not had a recent psychiatric hospitalization. A third were using clinical treatment services (such as from a psychiatrist or family physician) two or more times per

month. Virtually all of the clients surveyed (97%) had been diagnosed by a mental health professional, often with serious disorders such as mood, anxiety, or schizophrenia, and the majority (72%) were being treated with psychotropic medications. Substance abuse disorders, which often go undiagnosed, were identified in only 14% of this sample.

Few clients were rated by staff to have severe problems in any of the rated domains. Approximately half of those assessed were considered to have moderate problems with mood and affect; less among the elderly. Three percent had severe problems with thought and some forty percent, moderate problems. Thought disorders were less frequently reported among youth.

Four percent of the sample had severe social and role performance problems. This was highest amongst youth (5%) and lowest among the elderly (2%). Moderate problems in social and role performance were reported for approximately half of the youth and elderly, and close to sixty percent of adults. Problems with self-care were concentrated in the elderly group where over a third were reported to have moderate problems and three percent were reported to have severe problems.

Antisociality was relatively uncommon in the sample, particularly among the elderly. Youth were reported to have the highest prevalence of moderate problems; 16% compared to 12% among adults and 7% among elderly. Severe antisociality was reported in only one percent of youth and adults and not at all among the elderly.

Approximately one in five clients were capable of self-managed care, meaning they require intermittent access to care and are capable of managing their own care process. This proportion was the lowest among the young and the highest among the elderly. Community treatment (Level 2) was required for approximately half of the sample with a slight age gradient that favored higher levels of community treatment among youth.

Intensive community treatment (Level 3) was recommended for just under one third of the sample and less indicated amongst the elderly. Finally, residential treatment (Level 4) was identified for a small minority of clients, increasing slightly with age. No one was rated in need of inpatient treatment. This is consistent with a community-based client population.

With respect to current level of care, just over half of the sample were receiving the lowest intensity care indicative of self-management. A further third received community treatment. Less than one in ten were accessing intensive community

treatment programs and 4% were receiving residential or inpatient care. Elderly clients in this sample were more likely to receive less intensive community treatment. Self-managed care was the predominant mode for both youth and adults.

Concerning the match between recommended care and care received, slightly less than a third of the clients received an intensity of care that matched their need. Over half were being under-served. Fourteen percent of clients received services that exceeded their level of need. The distribution of care differed by age group. Youth were least likely to be over-served and, along with elderly, had the highest match (36%). The elderly were most likely to be over-served.

In every instance, youth were more likely to be under serviced with respect to mental health treatment services (such as medication management, assessment, diagnosis). Approximately one in five youth required more mental health services than they had received and this was fairly consistently noted across the full range of mental health treatment and crisis services. Elderly clients were more likely to have their needs for mental health treatment and crisis services adequately met. It is important to note that no age group was considered to be over-served with respect to substance abuse programming.

Compared to mental health treatment services, there was more unmet need for rehabilitation and other support services. The largest unmet needs were for meaningful activities (such as cultural activities or hobbies) and social/recreational supports. About a third of clients were under serviced in these areas. There was also significant unmet need for vocational and educational services particularly among youth. Services and supports for activities of daily living and self-care were unavailable to approximately one in ten.

The largest discrepancies occurred for caregiver supports, income supports, and housing supports. Both income and housing supports showed an age gradient with higher unmet needs among the youth. Rights protection and advocacy, justice/correctional services, and programming for the developmentally disabled all appeared to be fairly well matched to needs in this non-specialized community-based sample.

In general, over-servicing was generally small, under five percent. The only area where significant over-servicing appeared was for psychotherapy and counselling for youth (13%) and to a lesser extent, adults (7%). The top three under serviced areas were:

For youth age 16-24 years:

- Meaningful activity (35% with unmet need)
- Social and recreational supports (34% with unmet need)
- Vocational supports (33% with unmet need)

For adults aged 25-64 years:

- Meaningful activity (35% with unmet needs)
- Social and recreational supports (30% with unmet needs)
- Vocational supports (25% with unmet need)

For elderly aged 65 and higher:

- Meaningful activity (29% with unmet need)
- Social and recreational supports (28% with unmet need)
- Caregiver supports (13% with unmet need)

Table 16 compares the results of the Southeastern Ontario C-CAP to those of three other regions that have completed similar C-CAP projects. What is striking about this table is that the level of care recommended based on the standardized needs assessment is relatively consistent across the four regions, whereas the levels of care actually received by clients varies much more widely. This local variation means that the extent of gaps in the mental health service system will also vary by region. Thus, there is a need for ongoing monitoring within each region.

Table 16: Comparison of C-CAP Results Across Districts					
District	Level of Care (Weighted %)				
	Self-Mgmt	Com Tx	Intensive Com Tx	Resid Tx	Inpt Tx
Recommended Care Level					
Ottawa/Champlain	23%	39%	27%	8%	4%
Northeast	23%	48%	25%	4%	0.4%
Grand River	19%	48%	27%	5%	1%
Southeast	19%	49	29%	3%	--
Level of Care Received					
Ottawa/Champlain	26%	52%	17%	6%	--
Northeast	64%	31%	2%	3%	--
Grand River	44%	43%	3%	11%	--
Southeast	55%	33%	8%	2%	2%

Also, it is important to note that despite wider variation, the general pattern is the same; an over-supply of lower and higher intensity services than is required and an undersupply of mid-range community-based services.

Conclusions:

This study revealed considerable un-met needs among clients accessing community based mental health programs for Community Treatment (Level 2) and Intensive Community Treatment (Level 3). Unmet needs were evident across the full spectrum of mental health services, supporting the conclusion that the entire mental health delivery system must be reoriented to better meet consumer needs.

Approximately one third of the sample received services in excess to their needs. Unmet needs were highest with respect to social and vocational programming. In most instances, a clear age gradient emerged such that youth were the most likely to be disadvantaged.

Despite unmet needs in a variety of domains, few clients in this sample accessed multiple services suggesting the need for better program linkages. In addition, many staff did not know of their client's use of emergency room services in the six months prior to the study, suggesting poor continuity of information (and perhaps care) between these sectors.

Recommendations:

1. To insure that clients are appropriately diagnosed and their needs appropriately met, it is strongly recommended that standardized assessment protocols be used to evaluate service requirements for all new clients. Experience from the C-CAR indicates that staff can be easily trained in the use of standardized assessment protocols designed to match services to needs.
2. It is recommended that networks of care be created through formal inter-agency linkages and partnerships that are mandated to match services to client needs and provide comprehensive community-based care across a spectrum of supports and services.
3. To promote accountability and ensure consumer needs are met, the match between client needs and available services must be monitored on an ongoing basis. Service evaluations such as the C-CAP must become a routine part of mental health system delivery. Comparisons of future studies to the C-CAP baseline would provide an important means of evaluating system-level outcomes.
4. Given the gaps noted in this survey, it is recommended that reinvestment funding be used to develop the programs in the priority areas outlined in this study for youth, adults, and elderly as follows:

For youth age 16-24 years:

- Meaningful activity (35% with unmet need)

MATCHING SERVICES TO NEEDS

- Social and recreational supports (34% with unmet need)
- Vocational supports (33% with unmet need)

For adults aged 25-64 years:

- Meaningful activity (35% with unmet needs)
- Social and recreational supports (30% with unmet needs)
- Vocational supports (25% with unmet need)

For elderly aged 65 and higher:

- Meaningful activity (29% with unmet need)
- Social and recreational supports (28% with unmet need)
- Caregiver supports (13% with unmet need)

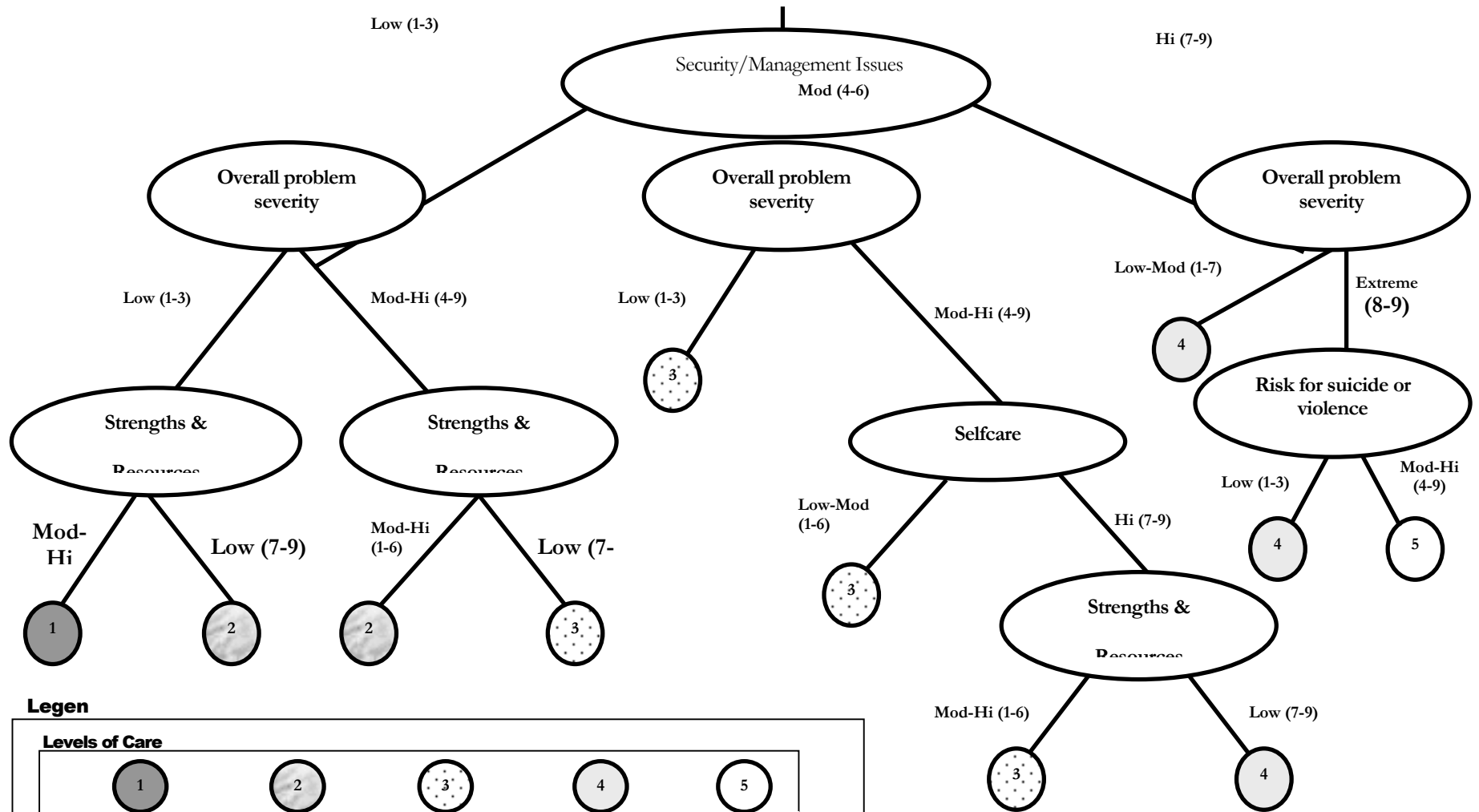
Bibliography

Durbin J, Koegl C, Macfarlane D, Sheldon T, Goering P. (2001) Grand River District Community Assessment Pilot Project. Toronto: Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

Durbin J, Koegl C, Macfarlane D, Sheldon T, Aitchison-Drake C, Goering P. (2002) Champlain District Community Assessment Pilot Project. Toronto: Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

Durbin J, Macfarlane D, Sheldon T, Koegl C, Goering P. (2001) Northeast District Community Assessment Pilot Project. Toronto: Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health.

Template for Assigning Clients to RECOMMENDED Level of Care



Legen

Levels of Care



Rating categories:

All domains except resources

Low = none-mild problem
Mod = moderate problem

Resources

Hi = high to very high
Mod = moderate
Low = some to low