



SEIZING THE OPPORTUNITY

Final Report

Central East (Whitby) Mental Health Implementation Task Force

For submission to the Minister of Health and Long-Term Care

December 2002

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of the Task Force process

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ACKNOWLEDGEMENTS

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The Task Force wishes to acknowledge the dedication and contribution of the following groups whose efforts have enabled the Task Force to *Seize the Opportunity*, and take mental health reform one step further towards *Making It Happen*.

- Consumer/Survivor Advisory Committee members;
- Subcommittee, Steering Committee and Working Group members;
- Public Information Session attendees;
- Focus Group participants;
- Voluntary services of Mr. John Wilkinson of WeirFoulds LLP Barristers and Solicitors
- District Health Council staff; and,
- Ministry of Health and Long-Term Care staff.

PREFACE

Mental illness can be debilitating and costly to individuals, their families, businesses and society. **Individuals with a mental illness need and deserve a continuum of care that is timely, accessible, appropriate, integrated, accountable and comprehensive** (*Making It Happen, 1999*).

 *The Executive Summary can be found in Section 1 of the Task Force binder*

The Central East (Whitby) Mental Health Implementation Task Force (the Task Force) is pleased to present its recommendations and Implementation Strategy to build a mental health system that achieves these service system goals throughout the Central East (Whitby) catchment area (the Region).

SEIZING THE OPPORTUNITY

In February of 2001 the Task Force was created by the Ministry of Health and Long-Term Care and given two years to complete its work. The Task Force has worked tirelessly to *seize the opportunity* it was given to submit its report in concert with the other eight Mental Health Implementation Task Forces in Ontario. The Task Force looked to the future, beyond existing comfort zones to develop an implementation plan for change.

Within a relatively short timeframe, the Task Force developed a comprehensive implementation plan through a quality planning process that included extensive primary and secondary research, and community-based consultation.

KEY ELEMENTS OF CHANGE

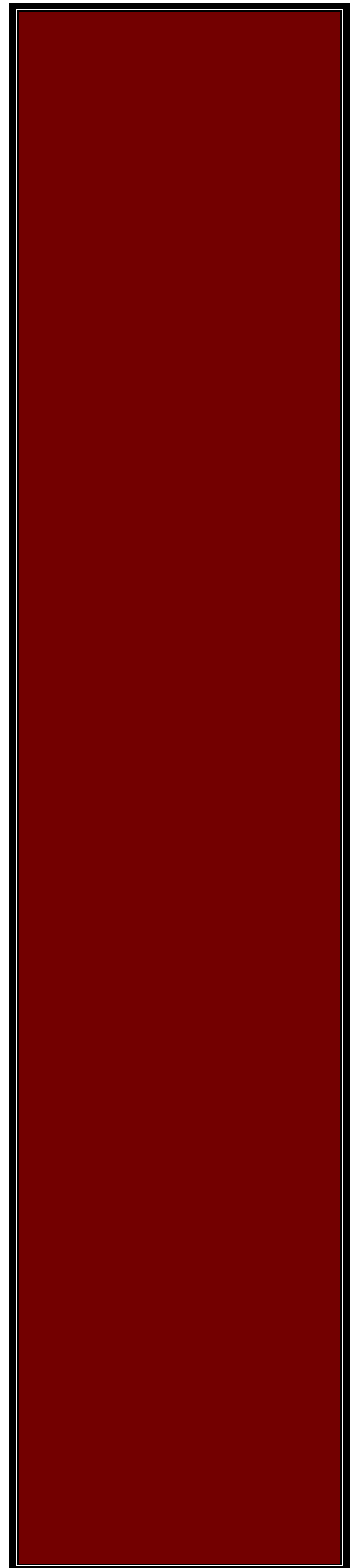
The planning process for mental health system reform in Ontario has been ongoing for many years. The Task Force has brought mental health reform one step closer to *making it happen*. Therefore the effort must continue after the mandate of this Task Force is completed. To this end, the **Task Force has made a set of mental health reform recommendations that address:**

- **Service Delivery;**
- **Transition; and,**
- **Governance.**

The Task Force is confident that the recommendations will serve the people in Central East (Whitby) well, and that reform partners throughout the Region will *seize the opportunities* that will be given to them to continue working towards excellence in the reformed mental health system.

SECTION 1

Context and Issues



Direction Documents

The work of the Task Force is based on direction provided by previous planning documents:

Towards a Blueprint for Change, 1983 recommended a balanced and comprehensive mental health system.

Building Community Support for People - Graham Report, 1988 recommended a long-range plan for an organized community-focused mental health system.

Putting People First, 1993 stated that “the mental health system is not a system”. The report outlines the need to develop a comprehensive service delivery model in which all the components are integrated and co-ordinated.

Local System Design, 1996 conducted by the District Health Councils. The Councils produced system designs for all the districts in Ontario. These system designs were reviewed by many Councils in 2001 and updated as necessary.

2000 and Beyond - Newman Report, 1998 led by MPP Dan Newman, Parliamentary Assistant to the Minister of Health and Long-Term Care. This consultative review of progress on mental health reform in Ontario revealed that the principles and direction of mental health reform were sound, but that the government needed to take the next steps with a clearly defined implementation strategy.

Making It Happen, 1999 described how to ensure that the mental health service system works for people, with services that are effectively integrated and co-ordinated, and based on best practices. This report places consumer/survivors at the centre of the system.

CHAPTER 1

Background

The Health Services Restructuring Commission was appointed in April 1996 to provide advice to the Minister of Health on hospital restructuring. In response to the Commission’s recommendations, then **Minister of Health, Elizabeth Witmer, appointed the first of nine task forces** in North Eastern Ontario in 1999. The Central East (Whitby) Mental Health Implementation Task Force was appointed in February 2001.

The mandate of the Task Force is to advise the Minister of Health and Long-Term Care on Provincial Psychiatric Hospital restructuring, community reinvestments, and other associated requirements for the implementation of a reformed mental health system in Ontario, as defined in *Making It Happen*.

The work of the Task Force is a culmination of decades of planning and building towards mental health reform.

PRINCIPLES AND GOALS OF MENTAL HEALTH REFORM

The principles and goals that directed the work of the Task Force were set out in *Making It Happen*. The specific principles upon which the Task Force recommendations are based include the following:

- the consumer is at the centre 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 co-ordinated so that consumers will move easily from one part of the system to another;
- services will be based on best practices;
- mental health funding will continue to be protected; and,
- there will be continued investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.

Source: Making It Happen, 1999.

.....

The goals of mental health reform are to ensure that core mental health services and supports:

““
*There needs to be
 respect within the system
 for people with invisible
 disabilities to nurture the
 human spirit.*””

York Region
 Consumer/Survivor

.....

- are provided within a comprehensive service continuum that is developed to meet client needs and is based on best practices;
- are well integrated with the broader continuum for care that is provided by other health and social services;
- are organized and co-ordinated based on a “levels-of-need” structure to ensure that consumers have access to the services that best meet their needs;
- are appropriately linked to other services and supports within geographic areas;
- facilitate a shared service approach to meeting the needs of individuals with serious mental illness who have multiple service needs;
- achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and,
- are simplified and readily accessible according to the consumer’s needs.


Source: Making It Happen, 1999.

COMPOSITION OF THE TASK FORCE

The Task Force membership represents a variety of stakeholder groups throughout the catchment area:

- consumer/survivors;
- family members;
- psychiatrists and community physicians;
- Community Mental Health Agencies;
- Community Care Access Centres;
- General Hospitals;
- a Provincial Psychiatric Hospital;
- local/regional business, education and social services;
- District Health Councils; and,
- ex-officio members from the provincial ministries of Health and Long-Term Care; Community, Family and Children’s Services; and Public Safety and Security.

The Task Force is accountable to the Minister of Health and Long-Term Care and to the public to provide sound and impartial advice on mental health reform. This responsibility requires that members:

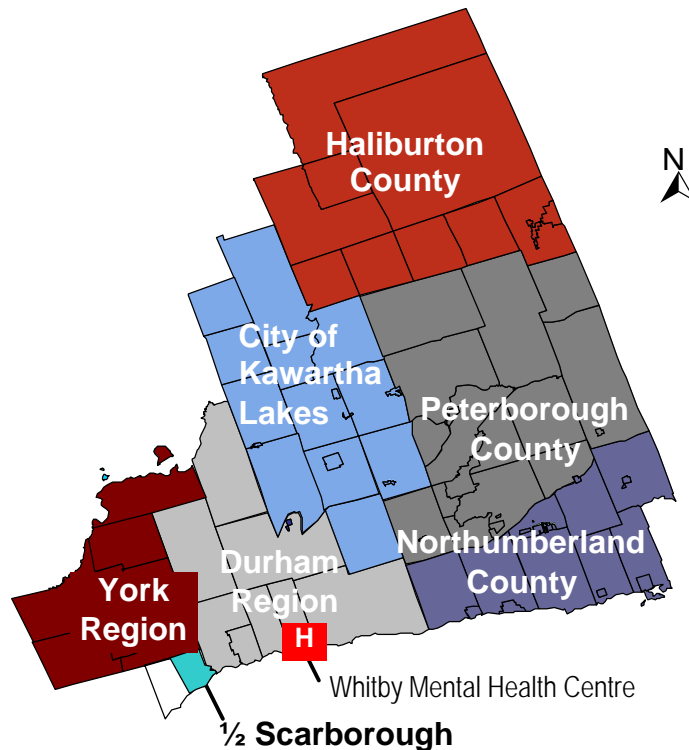
- participate in the decision-making process with the best interest of the community in mind, and;
- adhere to the confidentiality guidelines required by the Ministry of Health and Long-Term Care with respect to the planning process.  Refer to Appendix A – Confidentiality Guidelines.

THE CENTRAL EAST (WHITBY) CATCHMENT AREA

The Central East (Whitby) catchment area (the Region) is the same as the planned catchment area of the Whitby Mental Health Centre upon its divestment.¹ As depicted in Diagram 1.1, the Region’s catchment area includes Durham and York regions, the City of Kawartha Lakes, and the counties of Haliburton, Northumberland and Peterborough. These last four areas are often referred to as HKPR (Haliburton, Kawartha and Pine Ridge), or the “four counties”.

¹ Two task forces were created in Central East. The catchment area of each Task Force was defined by the catchment area of the two Provincial Psychiatric Hospitals serving this area, (Whitby Mental Health Centre and Mental Health Centre Penetanguishene). Each Task Force adopted part of the name of the respective Provincial Psychiatric Hospital in its catchment area.

Diagram 1.1 - Central East (Whitby) Mental Health Implementation Task Force Catchment Area



Half of the Scarborough population is also part of the Whitby Mental Health Centre catchment area. Consequently, the Task Force is to provide recommendations for Specialized Services for half of the Scarborough population.²

The geographic area for which the Task Force is responsible, spans the planning districts of three District Health Councils³. Therefore, linkages with all three of these planning partners were maintained either through direct Task Force membership or Subcommittee work.

The following chapter reviews the Task Force process, including: planning assumptions, structure and planning process.

² Additional information on the Scarborough population issue can be found in Chapter 6 – Service Delivery Model.

³ The three District Health Councils are: Durham, Haliburton, Kawartha and Pine Ridge; Simcoe York; and Toronto District Health Council, which are responsible to provide advice to the Minister of Health and Long-Term Care and to plan for health systems.

CHAPTER 2

Task Force Process

The Task Force based its implementation planning process on six key planning assumptions along with the principles and goals provided in *Making It Happen* and further defined by best practices.

PLANNING ASSUMPTIONS

1. **The goal of system planning in Central East (Whitby)** has been to design a system that will meet the needs of people who require mental health supports and services, not to meet specific financial targets⁴. Clearly, the implementation of the recommendations of the Task Force will require a substantial increase in mental health funding in the Central East (Whitby) catchment area.
2. **Local implementation plans** will need to be developed throughout the Region following the approval of the Task Force recommendations by the Minister. These local plans are necessary to achieve local accountability and to have service delivery models that reflect the diverse nature of communities in the Region.
3. **The Implementation Strategy** will be flexible since services will be delivered and utilized differently throughout the various districts and local areas that contain a diverse mix of urban and rural populations. **The proposed service functions will build on existing services and not duplicate them.** *The Implementation Strategy is discussed in Chapter 9.*
4. **The Recovery Model** will be adopted and the **Diversity Strategy** implemented in the new system. Reforming the system provides a unique opportunity to ensure that it reflects the theoretical frameworks that are most likely to lead to success. *These overarching themes are discussed in Chapter 5.*

.....

“ It will be important to not dismantle our present system, but rather increase the amount of service that is available. ”

City of Kawartha Lakes
Family Member

.....

⁴ The Ministry of Health and Long-Term Care did not provide financial guidelines for the reformed mental health system.

5. The Task Force structure and planning processes were designed to **collaborate and consult** with the many mental health stakeholders to develop a comprehensive Service Delivery Model that will work across the Region. It is particularly important to include the expertise in the Region and to involve people who will be most affected by mental health reforms.
6. Half of all people receiving psychiatric treatment have a **substance abuse problem**, and about half the clients in treatment for substance abuse have some mental or emotional problems⁵. Therefore, people with concurrent disorders (i.e., with a mental illness and a substance abuse problem) would benefit most from a system that offers co-ordination and flexible access to both addiction and mental health services.

The Task Force believes that:

- This co-ordination and flexible access to both addiction and mental health services would be best achieved if the Corporation also funded addiction services; and,
- the addictions sector needs to be engaged to determine how mental health and addiction services can best be co-ordinated and integrated. Representatives of the addictions sector have participated at the Task Force table in a limited way.

TASK FORCE STRUCTURE

The Task Force determined the need for several structural mechanisms to achieve an optimal level of effectiveness and community accountability by:

- reaching beyond Central East (Whitby) and developing close - liaisons with other Task Forces in Ontario;
- involving the maximum number of stakeholders in the Region through Subcommittees; and,
- maintaining ongoing communication with the community.

⁵ *Making It Happen*, 1999:33,34.

Beyond Central East (Whitby)

The Provincial Forum was comprised of the nine Mental Health Implementation Task Forces in Ontario. It was formed by the Minister of Health and Long-Term Care to:

- allow for sharing of planning information among the task forces and identification of common themes;
- build consensus for implementation of mental health reform;
- plan a province-wide public education campaign;
- hear from government and experts in the field; and,
- review the latest findings and best practices in mental health.

The Core Group was created to establish a link between the two Mental Health Implementation Task Forces in Central East (Whitby and Penetanguishene). The Chairs and Co-ordinators of the two Task Forces met on a monthly basis with the Regional Director of Central East (Newmarket) Region, Program Manager of Mental Health Services and two Mental Health and Addictions Consultants.

Task Force Subcommittees and Working Groups

The overall purpose of the Subcommittees was to provide advice to the Task Force in their respective areas of expertise. The first Task Force Subcommittees were established in the spring of 2001. All Task Force Subcommittees were chaired by a Task Force member.

Recruitment

The recruitment goal for the Subcommittees was to have representation from across the Region and from all stakeholder groups. *Refer to Appendix B – Membership Lists.* Task Force members first defined the required number of Subcommittees and then proceeded to recruit individuals to participate.

Task Force members were asked to volunteer for at least one Subcommittee to provide effective linkages between the Task Force and its Subcommittees. Based on the names of individuals who were identified by Task Force members, a personal letter from the Task Force Chair was mailed to all “key people in the Region” to request volunteers for the Subcommittees. Recruitment was also advertised in the Task Force newsletter.

Task Force

Subcommittees

- Children's Mental Health
- Consumer/Survivor Advisory Committee
- Communications
- Cross-Level Needs
- Design Team
- First-Line Needs
- Human Resources
- Implementation
- Intensive Needs
- Scarborough Populations
- Specialized Needs


Steering Committee

- Comprehensive Assessment Project

Working Groups


- Information Systems

Direction

 The Terms of Reference for each Subcommittee and the Subcommittee Report can be found in Section 3 of the Task Force binder.

The key objectives and deliverables of the Subcommittees were developed by the Task Force. Each Subcommittee's Terms of Reference addressed the overall goal, objectives, deliverables, timeframe, meeting schedule, membership composition, chair, and staff/ministry linkages. The Task Force defined the nature of the task of each Subcommittee and its expected products. Most Subcommittees started their work in the spring and summer of 2001.

The confidentiality guidelines for the Subcommittees were the same as those of the Task Force. All Task Force and Subcommittee members were asked to sign a copy of the Confidentiality Guidelines.

 Refer to Appendix A – Confidentiality Guidelines.

Outcomes

The mandate of the Subcommittees required that they:

- approve the Terms of Reference;
- be oriented to the Task Force mandate and purpose;
- review the availability of services and the need for mental health services by consulting the *Comprehensive Assessment Project* data, service inventories conducted by the District Health Councils, and information presented to the Task Force and Subcommittees by stakeholder groups;
- review best practices and benchmarks compiled by researchers in various jurisdictions; and,
- develop recommendations to the Task Force for mental health reform, based on the goals and principles listed in *Making It Happen*.

Subcommittees were given the opportunity to revise their recommendations once all the recommendations were integrated into a unified plan for a single Service Delivery Model.

Design Team

In spring 2002, the Subcommittee Chairs were asked to join the Design Team in its final deliberations. The task was to bring all Subcommittee recommendations into one Service Delivery Model.

The Design Team was given the following **additional responsibilities**:

- create a draft Service Delivery Model based on the recommendations of the Subcommittees that were approved in principle by the Task Force;
- review the draft Service Delivery Model in light of the feedback received from the twenty-one focus groups and the Consumer/Survivor Advisory Committee;
- develop a governance and management model for the reformed mental health system in keeping with best practices, the goals and principles of *Making It Happen*, and the draft Service Delivery Model; and,
- begin costing the Task Force recommendations.

Implementation Subcommittee

The Implementation Subcommittee was created in summer 2002. Its membership was comprised of all the Chairs of the past and present Subcommittees.


The specific responsibilities of the Implementation Subcommittee were to:


- review the recommendations put forth by the Human Resources, Children’s Mental Health, and Scarborough Populations Subcommittees and Information Systems Working Group in fall 2002;
- develop a multi-year implementation plan for all principal Task Force recommendations; and,
- review the costing of the new system.

Communication and Accountability

Excellent communication was deemed essential, therefore a Communications Subcommittee was created to advise and assist the Task Force with its communication strategy.

Six newsletters were created and circulated to over 500 stakeholders with mental health interests throughout Central East (Whitby). The newsletter informed members of the public when the Task Force was seeking Subcommittee members, updated them on Task Force progress and notified them of upcoming events.

 The six newsletters can be found in Section 4 of the Task Force binder.

 A summary of the Phase I Public Information Sessions can be found in Section 4 of the Task Force binder.

Seven public information sessions were held in April 2002 as part of Phase I consultations. These sessions, as listed in Table 2.1, were advertised through: a broad mailout to over 500 stakeholders, the newsletter, and a press release to all community newspapers, radio and television stations. The Task Force Chair and Co-ordinator travelled to seven communities (Ajax, Cobourg, Lindsay, Minden, Newmarket, Peterborough, and Richmond Hill).

Table 2.1 – Phase I Public Information Session Participation

Location	No. of Participants
Ajax, Durham Region	18
Cobourg, Northumberland County	23
Lindsay, City of Kawartha Lakes	23
Minden, Haliburton County	24
Newmarket, York Region	16
Peterborough, Peterborough County	29
Richmond Hill, York Region	13
Total	146

The purpose of the information sessions was to:

- inform the public about the work and process of the Task Force;
- explain the Task Force’s understanding of the challenges facing various parts of the Region; and,
- invite participation in focus groups to be held in May 2002.


Participants were also asked to answer three broad questions:

- What are your primary concerns that were not discussed today?
- What else do we need to know?
- If you had one piece of advice for us, what would it be?

Major themes reflected at the presentations were:

- access and funding adequacy of the Ontario Disability Support Program needs to be re-examined and re-assessed very carefully;
- confidentiality of the Task Force process created anxiety and fear in some information session attendees;
- some consumer/survivors felt excluded from the Task Force process;

- community desperately needs reinvestment to provide adequate service; and,
- service equity needs to be addressed across the province and within the Region.

 A summary of the Phase III Public Information Sessions can be found in Section 4 of the Task Force binder.

Phase III public information sessions were held in November and December 2002. These sessions, as listed in Table 2.2, were advertised using a flyer and newsletter that were mailed to over 500 stakeholders. The Task Force Chair travelled to seven communities (Cobourg, Lindsay, Minden, Newmarket, Peterborough, Richmond Hill and Whitby).

Table 2.2 - Phase III Public Information Session Participation

Location	No. of Participants
Cobourg, Northumberland County	27
Lindsay, City of Kawartha Lakes	18
Minden, Haliburton County	14
Newmarket, York Region	30
Peterborough, Peterborough County	10
Richmond Hill, York Region	15
Whitby, Durham Region	52
Total	166

The purpose of the public information sessions was to:

- update the public on the work of the Task Force; and,
- share the local Service Delivery Model, Implementation Strategy and the Governance Model for the reformed system.

Major themes reflected at the information sessions were:

- beds recommended by the Health Services Restructuring Commission are not yet available. This means that there is currently a shortage of inpatient mental health beds throughout the Region;
- implications of the District Mental Health Agency model for existing community-based staff and agencies were explored. Most meetings addressed the strengths that exist in the current local mental health systems and the need to build on these strengths;
- adequate funding is necessary for the new system and the transition process;

- the role and composition of the Regional Corporation needs to be such that local needs are respected, and consumer/survivors' needs drive decision making processes; and,
- integration is needed with other services and the community.

PLANNING PROCESS

Three Planning Phases

The Task Force employed a three-phase process to achieve its mandate.

Phase I took place from April 2001 to April 2002. During this time the Task Force:


- established seven Subcommittees, one working group, and a steering committee;
- completed an inventory of Mental Health Services funded by the Ministry of Health and Long-Term Care;
- reviewed the inventory of needs as defined by the *Comprehensive Assessment Project* results and the local planning documents produced by the District Health Councils and stakeholder groups;
- reviewed best practices and benchmarks compiled by researchers in various jurisdictions;
- listened to various presentations made to the Task Force and Subcommittees by stakeholders;
- received preliminary recommendations from each Subcommittee and approved them in principle;
- created a draft Service Delivery Model based on the preliminary recommendations, and final revisions were made by all Subcommittees;
- held seven community presentations to inform the public on the Task Force process and to recruit participants for the focus groups in Phase II; and,
- briefed all twelve local MPPs on the Task Force process and challenges facing the mental health system in the Region through personal meetings with the Task Force Chair.


Phase II took place from May 2002 to July 2002. During this time, the Task Force:

- held focus groups to obtain feedback on the draft Service Delivery Model;
- refined the recommendations and Service Delivery Model based on comments from the community throughout the Region; and,
- submitted the Interim Task Force Report to the Minister of Health and Long-Term Care.

Phase III took place from July 2002 to November 2002. During this time the Task Force:

- finalized the Information Systems and Human Resources Subcommittee recommendations;
- developed the Children’s Mental Health and Scarborough Populations Subcommittee recommendations;
- developed a Public Education/Dialogue Strategy with the Consumer/Survivor Advisory Committee;
- developed an implementation plan for Task Force recommendations;
- held MPP and community information sessions to share the Service Delivery Model, Implementation Strategy and Governance Model; and,
- completed *Seizing the Opportunity – Final Report* of the Task Force.


 A summary of the Public Education/Dialogue Strategy is included in Section 3 of the Task Force binder under the Consumer/Survivor Advisory Committee tab.

 A List of Presentations to the Task Force can be found in Section 4 of the Task Force binder.

Stakeholder Presentations

The Task Force scheduled a comprehensive array of presentations to learn more about the planning area and options. Twenty-four groups of experts made presentations to Task Force members. Presenters were instrumental in identifying the strengths and challenges of the existing mental health system and in influencing the Task Force directions.

Comprehensive Assessment Project

 A copy of the "Comprehensive Assessment Project" Report can be found in Section 5 of the Task Force binder.

The MOHLTC funded the *Comprehensive Assessment Project*. This project was led by researchers from the Centre for Addiction and Mental Health who undertook similar hospital and community comprehensive assessment projects in other jurisdictions across Ontario. This project's primary purpose was to identify the spectrum of needs of clients served by community and hospital mental health programs located in Central East (Whitby) and determine the level of "match" or "fit" with the services that clients were actually receiving. It made recommendations about:

- system capacity;
- system organization;
- client support services;
- services for specific populations, namely dual diagnosis, concurrent disorder and psychogeriatric disorders; and,
- forensic services.

Its recommendations were a key element in the development of the Region's Service Delivery Model.

Community-Based Consultation

Twenty-one focus groups were held in May 2002. As shown in Table 2.3, nearly 200 people and over 50 organizations participated. The purpose of the focus groups was to:

- evaluate how well the draft Service Delivery Model would achieve the consumer-centred principles and goals identified in *Making It Happen*; and,
- identify implementation priorities.


Table 2.3 - Number and Distribution of Focus Group Participants

Key Stakeholder Type	No. of Focus Groups	No. of Attendees	Locations
Consumer/survivors	5	56	Richmond Hill, Oshawa, Peterborough, Cobourg, Lindsay
Family members	4	38	Lindsay, Whitby, Newmarket, Minden
Front-line providers	4	43	Markham, Whitby, Cobourg, Minden
Physicians	5	20 psychiatrists 3 GPs or Chief of Staff	Oshawa, Ajax, Peterborough, Markham, Newmarket, Cobourg
Intake linkages/workers	1	5	Markham
Diversity planners	2	17	Pickering, Richmond Hill
Consumer/survivors and family members		94	
All stakeholder types		182	
Per cent consumer/survivors and family members		46%	
Total Organizations*		55	

* Each CMHA branch was counted as one separate organization, and each organization was counted only once.

Source: Hume McKenna Associates, *Phase II Consultation Final Report*, June 2002.

The Phase II focus group discussions resulted in:

 *The Phase II Consultation report can be found in Section 4 of the Task Force binder.*

- a thorough analysis of the draft Service Delivery Model that included specific service delivery recommendations, and clear endorsement of many elements of the model;
- identification of a clear need for the development of an implementation/transition strategy to ensure that the momentum of this planning process is not lost, and to begin to make the changes that people are ready for, and have waited a long time to see; and,
- identification of issues that will need to be addressed in the next step in the implementation planning process, or that need to be addressed on a broader scale.

The Task Force was diligent in developing a thorough process. One of the responsibilities of the Task Force was to become familiar with the planning area. The Context is reviewed in the following chapter.

CHAPTER 3

Context

The catchment for Central East (Whitby) is approximately 17,350 square kilometres and encompasses two regions: Durham and York as well as four counties: The City of Kawartha Lakes, Haliburton, Northumberland and Peterborough. Durham Region is approximately 2,300 square kilometres, York Region is approximately 1,750 square kilometres and the four counties, (also referred to as HKPR), are approximately 13,300 square kilometres. Most of the HKPR and the northern portions of Durham and York Regions are rural.

.....

“ There are large differences in the cost of living between rural and urban areas. Groceries cost more in small places because there is no competition.”

Peterborough County
Consumer/Survivor

.....

On average, 34 per cent of individuals with mental illness surveyed in the *Comprehensive Assessment Project* reside in rural areas. Access to services is a significant issue for people in rural areas, because of:

- greater distances to travel to access services with few public transportation options;
- fewer human resources in rural areas; and,
- increased resource pressures when delivering outreach services.

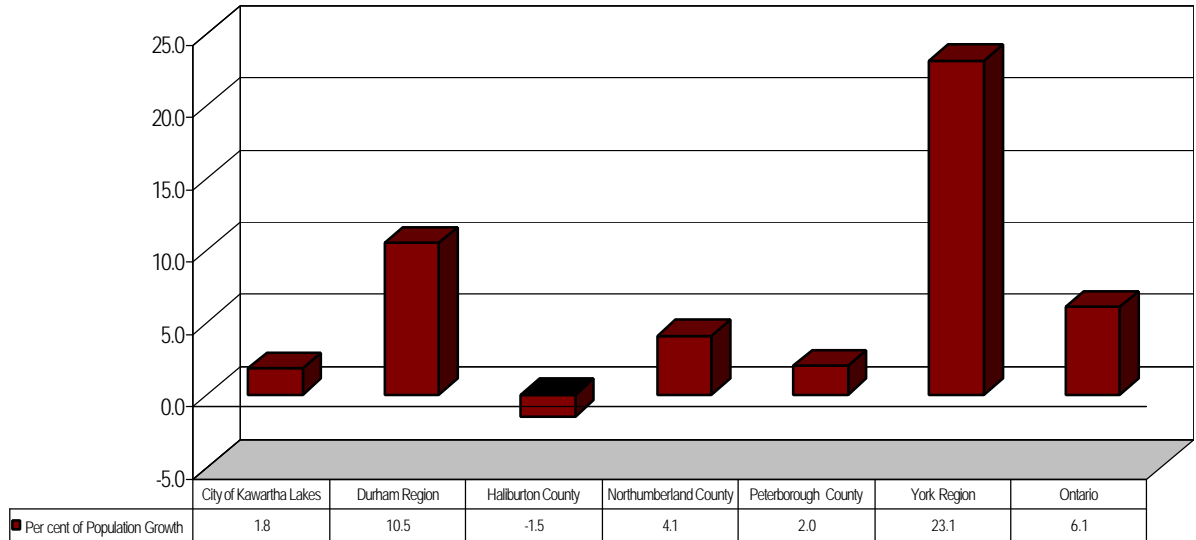
Access to Specialized supports for mental health professionals who practice in these areas also presents a serious challenge.

POPULATION

The population estimates, growth and density vary throughout the Region. As shown in Graph 3.1, York Region is the most populated with the largest population growth and density, followed by Durham Region, Northumberland County, Peterborough County and City of Kawartha Lakes. Haliburton County decreased in size between 1996 and 2001 by 1.5 per cent.

Between 1996 and 2001, York Region’s growth rate was almost four times that of Ontario, and Durham Region’s growth rate was close to twice the rate of Ontario. Mental Health Services are not growing at the same rate as the population, thereby creating severe service shortages.

Graph 3.1 - 2001 Census Population Growth Between 1996 and 2001 by Region/County



Source: Ministry of Finance 2001 Projections.

Population Estimates

The Task Force is planning for a reformed mental health system that will serve the population today and in the future. Therefore, the Task Force looked at population estimates for 2003, 2006, and 2011. As shown in Table 3.2, it is estimated that the greatest population growth between 1996 and 2011 will occur in York Region (59 per cent), followed by Durham Region (34 per cent), City of Kawartha Lakes (16 per cent), and the counties of Northumberland (11 per cent), Peterborough (8 per cent) and Haliburton (6 per cent). York and Durham regions will experience greater growth rates than Ontario (19 per cent).

Table 3.2 - Projected Population and Projections on a Percentage Basis from 1996 for 2003, 2006, 2011 by Region/County

Region/County		2003	2006	2011
City of Kawartha Lakes	1996 Basis	72,820	75,690	81,093
	Per Cent Growth	4%	9%	16%
Durham Region		543,578	575,699	632,798
		15 %	22 %	34 %
Haliburton County		15,862	16,199	16,597
		1 %	3 %	6 %
Northumberland County		89,197	90,784	93,019
		6 %	8 %	11 %
Peterborough County		131,448	133,825	137,391
		4 %	6 %	8 %
York Region		796,793	861,351	973,267
		30 %	41 %	59 %
Ontario		12,073,590	12,486,334	13,156,975
		9 %	12 %	19 %

Source: The Ministry of Finance projections for each year was altered by the percentage difference between the 2001 counts and the adjusted 2001 census.

Socio-Demographic Characteristics of the Population

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“*Transportation is a significant problem for many new immigrants, particularly if they are experiencing mental health problems. Some new immigrants from China may rely on bicycles for transportation and it may take hours for them to get where they need to be.*”

Richmond Hill
Diversity Planners

.....

There are a number of socio-demographic characteristics that any good planning process needs to consider. These population characteristics are important because they contribute to the prevalence of mental illness; they have implications when developing mental health services; or both. As shown in Table 3.3, these socio-demographic characteristics include age, income, education, language, immigration and ethnicity.

Table 3.3 indicates, among other findings that:

- York Region needs to develop its mental health services with a strong outreach component for immigrants (both established immigrants and recent immigrants), and individuals who speak neither French nor English;
- KPR needs to pay special attention to the lower socio-economic status and employment of its population since these factors are known to contribute⁶ to mental illness; and,

⁶ *World Health Report 2001: Mental Health, New Understanding, New Hope.* World Health Organization, 2001; and *A Report on Mental Illness in Canada.* Health Canada, Ottawa, Canada, 2002.

- Durham Region needs to ensure the development of mental health services that is suitable to the immigrant population that is nearly one fifth of its total population. Durham Region also needs to ensure the availability of French language services for its relatively large French speaking population.


Table 3.3 - Income, Education, Language, Immigration, and Ethnicity by Region

	Durham Region	HKPR	York Region	Ontario
Average total income of married or common-law families	\$ 69,441	\$ 52,516	\$ 77,816	\$ 64,434
Average total income of lone-parent families	\$ 35,027	\$ 28,118	\$ 40,866	\$32,417
1996 Unemployment Rate	8.1 %	10.5 %	6.8 %	9.1 %
1996 Labour Force Participation Rate	70.9 %	59.8 %	70.3 %	66.3 %
Per cent of population 25 years of age and over with less than grade nine education	7.3 %	11.0 %	10.6 %	11.7 %
Total recent immigrants (within 5 years)	1.8 %	0.5 %	7.1 %	-
Total immigrants	18.7 %	9.5 %	36.4 %	-
Knowledge of neither English or French language	0.4 %	0.1 %	3.3 %	-
French is the first language learned and still understood*	1.5%			


Source: Statistics Canada, 1996 Census.

* Note: Durham Public Health Unit catchment area.

CURRENT MENTAL HEALTH SERVICES

A brief overview of the current mental health services in the Region is provided in the following section.  An inventory of Ministry of Health and Long-Term Care mental health services is included in Appendix C.

Community Mental Health Programs

There are 30 community mental health programs funded by the MOHTLC.  Refer to Appendix D - Community Mental Health Programs.

As shown in Table 3.4, these programs include: two sexual assault programs, five child and youth mental health programs, one family support program, three consumer/survivor support programs, and one Assertive Community Treatment Team (ACTT).

Table 3.4 - Overview of Mental Health Services in Central East (Whitby)

Region/County	No. of Community Mental Health Programs	No. of Schedule 1 Facilities (2003)	No. of Children's Community Mental Health Programs
City of Kawartha Lakes	3	-	-
Durham Region	7	2	2
Haliburton County	1	-	-
Northumberland County	2	-	-
Peterborough County	3	1 (serves HKPR)	1
York Region	8	2 (+ 1 Schedule 3)	2

Note: There are two ACT Teams, one serving Durham Region and HKPR and another serving the Township of Georgina that are not included in these numbers. The programs included above are funded by the Community Mental Health Transfer Payment Programs, MOHLTC.

.....

“ More time is required for patient contact by the nursing staff. I know of someone who wasn't able to find 'their nurse' all day, so they couldn't get a blanket.”

York Region
Consumer/Survivor

.....

Mental Health Beds

As shown in Table 3.4, **there are currently six hospitals in the Region operating mental health beds:** three in York Region, two in Durham Region and one in HKPR. Of these, five are Schedule 1 facilities. One hospital in York Region is a Schedule 3 facility slated to become a Schedule 1 facility by 2003. **There is one Provincial Psychiatric Hospital** in the Region that provides Specialized Tertiary Services - Whitby Mental Health Centre.

Average Length of Stay and Discharges in Schedule 1 Facilities

The average length of stay for patients of Schedule 1 beds has declined from 1994/95 to 1999/00. This is true regardless of the area of residence. The decline in length of stay is consistent with the general trend toward reduced lengths of stay in Ontario hospitals over that a time period. It is not clear what implications this trend has for the community-based mental health services. It could be argued that reduced length of hospital stay, shifts the need for immediate access to community-based services for relatively more intense follow-up. In contrast, the reductions of medical/surgical lengths of stay have been supported by increases in home care resources through the Community Care Access Centres. The resources shift to support shorter mental health lengths of stay has not been as evident.

As shown in Table 3.5, the discharges for Schedule 1 beds do not seem to follow a general trend from 1994/95 to 1999/00. However, two populations seem to have experienced dramatic changes in the number of discharges. Durham Region residents had 590 more discharges, a 40 per cent increase from 1999/00 to 1994/95. Similarly, Victoria County residents had 55 more discharges, a 60 per cent increase, over the same period. The reasons for this increase would need to be researched further. For example, this could reflect changes in admission/discharge practices or could reflect increased difficulty accessing community-based services.

It is interesting to note that the trend for Ontario was for a decrease in discharges over this time period. The decrease in the discharges for Haliburton County residents may reflect this larger provincial trend or may indicate some increasing difficulty accessing beds.

Table 3.5 – Schedule 1 Hospitals

Home Region of Patients Discharged	Number of Discharges		Average Length of Stay ** (Days)	
	1994/95	1999/00	1994/95	1999/00
York Region	2,005	1,995	13	11
Durham Region	1,525	2,115	13	10
Haliburton County	55	40	18	14
Northumberland County	140	190	15	11
Peterborough County	595	610	17	16
Victoria County	90	145	16	13
Ontario	47,115	44,700	15	13

Source: Provincial Health Planning Database.

** This is calculated from the number of discharges shown and the total discharge days for the same time period. (Total Discharge Days ÷ Number of Discharges = Average Length of Stay).

Average Length of Stay and Discharges in Provincial Psychiatric Hospitals

As shown in Table 3.6, the average length of stay for those admitted to Provincial Psychiatric Hospitals is less useful as an indicator because of the sensitivity of the average to the small numbers in the denominator and the very large numbers in the numerator with untrimmed lengths of stay (year maximum). In other words, the average can be easily distorted by single admissions with extraordinarily extended lengths of stay (beyond one year). Despite

this caution, it can be noted that the more distant parts of the catchment area have longer lengths of stay, with the exception of Victoria County (now City of Kawartha Lakes).

As shown in Table 3.6, the number of discharges from Provincial Psychiatric Hospital beds for residents of all the catchment areas declined (or remained unchanged) from 1997/98 to 2000/01. This decline was particularly notable in Victoria County, at 25 fewer discharges (or a 42 per cent decline). Durham Region residents had 65 fewer discharges (or an 18 per cent decline).

This pattern of declining Provincial Psychiatric Hospital discharges but increased Schedule 1 discharges (in Victoria and Durham counties) may indicate a shift in inpatient utilization of Specialized Provincial Psychiatric Hospital beds to General Hospital beds. The reason for this shift may be that beds are not available at the Provincial Psychiatric Hospital, as anecdotal evidence/reports would suggest. Further investigation of this trend is needed to uncover the reasons.

Table 3.6 – Provincial Psychiatric Hospital Discharges and Average Length of Stay


Home Region/ County of Patients Discharged	Number of Discharges		Average Length of Stay (Days)	
	1997/98	2000/01	1997/98	2000/01
York Region	90	80	270	195
Durham Region	355	290	150	155
Haliburton County	5	5	95	690*
Northumberland County	30	20	685	235
Peterborough County	80	70	130	615
Victoria County	60	35	155	60
Ontario	7,525	6,000	170	170

Source: Provincial Psychiatric Hospitals

* This appears to be an anomaly based on the trends in the intervening years. It may reflect the discharge of a very long-stay patient.

The Health Services Restructuring Commission (the Commission) recommended:

- **increasing mental health beds** in the Region by 2003. (Refer to Table 3.7 – Health Services Restructuring Commission-Directed Mental Health Beds by 2003);
- **that York Central Hospital (Richmond Hill, York Region), becomes a Schedule 1 facility.** This hospital is currently a Schedule 3 facility with 15 beds;
- **creating a new Schedule 1 facility in HKPR** at Ross Memorial Hospital in Lindsay, City of Kawartha Lakes. This hospital does not currently have mental health beds, but it is scheduled to have 15 mental health beds by 2003;
- **that Whitby Mental Health Centre catchment area be changed** to include Haliburton, Peterborough and Northumberland counties and that the Whitby Mental Health Centre serve half of Scarborough. The Commission recommended that 40 beds be set aside to provide services to HKPR residents;
- **that Whitby Mental Health Centre becomes** a public hospital with new governance and that beds decrease from 325 to 258 beds. The 258 beds would include 40 beds for HKPR residents, 56 beds for Durham Region residents, 15 child and adolescent beds, and 40 forensic beds; and,
- **the creation of three child and adolescent mental health units** across the Region. These new units will be located at Lakeridge Health Corporation, Peterborough Regional Health Centre and Southlake Regional Health Centre. **The acute mental health beds scheduled to be in operation by 2003 are in various stages of development.** Five of the 24 recommended acute child and adolescent mental health beds are in operation at Southlake Regional Health Centre, where another 5 beds have yet to be opened. Some hospitals have had to develop interim plans until hospital expansions are completed.

 A complete description of the role of the Whitby Mental Health Centre and the Scarborough population can be found in the Scarborough Populations Subcommittee Report in Section 3 of the Task Force binder.


 A complete overview of the Region's child and adolescent mental health services can be found in the Children's Mental Health Subcommittee Report in Section 3 of the Task Force binder.

Table 3.7 – Health Services Restructuring Commission-Directed Mental Health Beds by 2003

	Mental Health Beds in Operation	Schedule 1 Beds Recommended by the Commission for 2003	New Child and Adolescent Mental Health Units for 2003 (beds)
Durham Region			
Lakeridge Health Corporation	39	48	10
Rouge Valley Health Centre, Ajax-Pickering	20	29	-
HKPR			
Peterborough Regional Health Centre	26	43	4
Ross Memorial Hospital	-	15	-
York Region			
Markham Stouffville Hospital	25	27	-
Southlake Regional Health Centre	23	24	10 (5 beds were opened in Nov/02)
York Central Hospital	15	19	-
Central East (Whitby)			
Whitby Mental Health Centre	325	258	-

Sources: Health Services Restructuring Commission, *GTA/905 Health Services Restructuring Report*, November 1997. Health Services Restructuring Commission, *Haliburton, Kawartha and Pine Ridge Health Services Restructuring Report*, June 1998.

Progress on the Health Services Restructuring Commission Recommendations

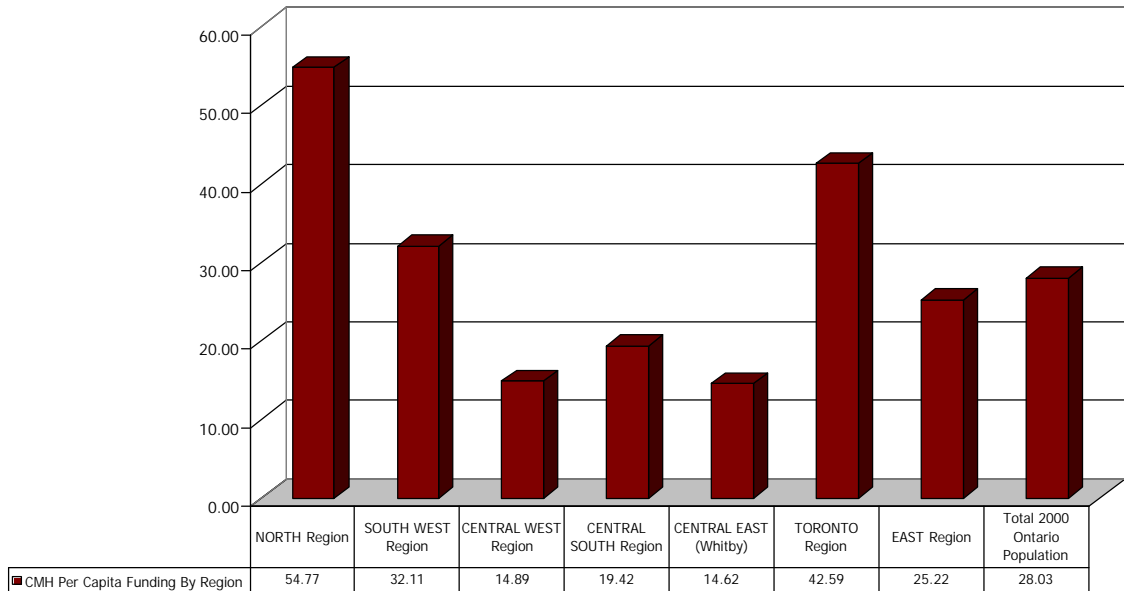
Most of the recommendations of the Commission have not been implemented. Specifically:

- Whitby Mental Health Centre is not divested;
- York Central Hospital is still a Schedule 3 facility; and,
- only five of the 81 new acute adult, child and adolescent mental health beds are in operation.

FUNDING

There is an obvious direct relationship between the availability of mental health services and mental health dollars. When examining the community mental health per capita funding by region in 2000 (that includes: community mental health programs, outpatient medical salaries, children’s mental health, Homes for Special Care and supportive housing), **Central East (Whitby) has the lowest funding at \$14.62 per capita.** As shown in Graph 3.8, the North Region has the highest per capita funding at \$54.77. Central East (Whitby) receives \$40.15 less per capita funding than the North Region or one quarter of the North Region. Central East (Whitby) receives only half of the provincial average per capita funding.

Graph 3.8 – Community Mental Health Per Capita Funding by Region 2000/01 (excluding Simcoe County Funding of \$6.36M)

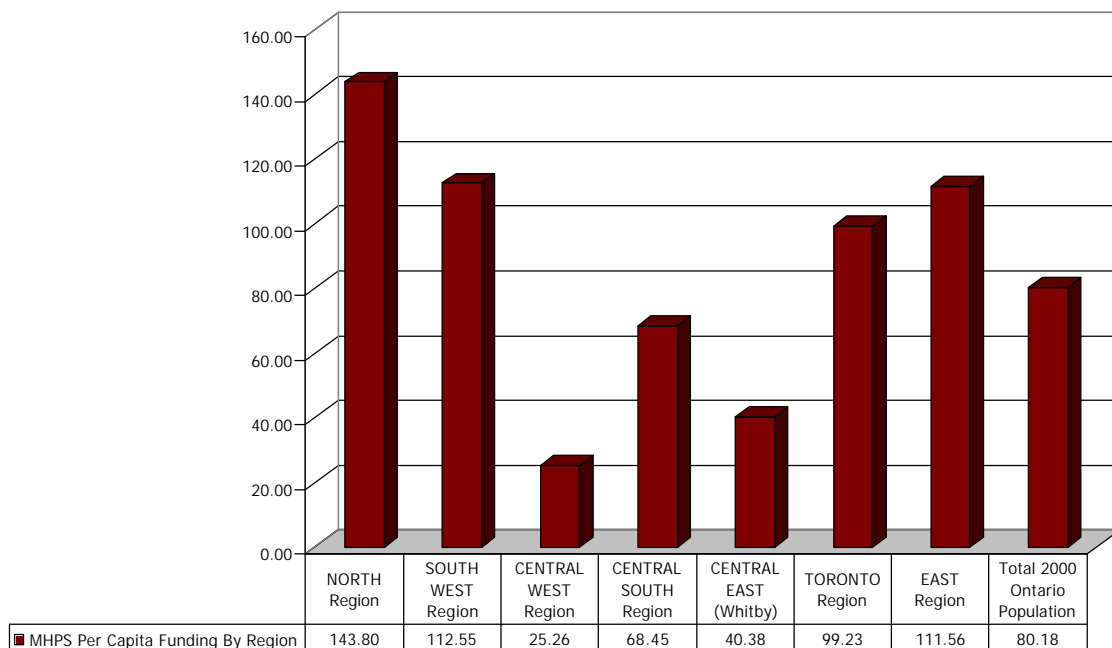


Source: *Mental Health Implementation Task Force Web Site*, January 2002.

Note: Community Mental Health funding includes: community mental health programs, outpatient medical salaries, children’s mental health, Homes for Special Care and supportive housing.

The same trend is found when examining the Mental Health Program Services per capita funding by region, in 2000 (that includes funding for community mental health as described above, specialty psychiatry, municipal tax⁷, Provincial Psychiatric Hospitals, and total hospital-based services). As shown in Graph 3.9, **the Region has the second lowest funding at \$40.38 per capita**. Central East (Whitby) received less than one quarter of the per capita funding for the North Region and half the provincial average per capita funding.

Graph 3.9 – Mental Health Program Services Per Capita Funding by Region 2000/01 (excluding Simcoe County Funding of \$39.5M)



Source: *Mental Health Implementation Task Force Web Site*, January 2002.

Note: Mental Health Program funding includes: Community Mental Health (see Graph 3.8), specialty psychiatry, municipal tax, Provincial Psychiatric Hospitals, and total hospital-based services.

There are also inequities within Central East (Whitby), whereby York, Durham, and Northumberland have fewer community mental health dollars per capita than the other three HKPR counties.

⁷ Municipal taxes are paid on behalf of Provincial Psychiatric Hospitals and Speciality Psychiatric Hospitals by MOHLTC.

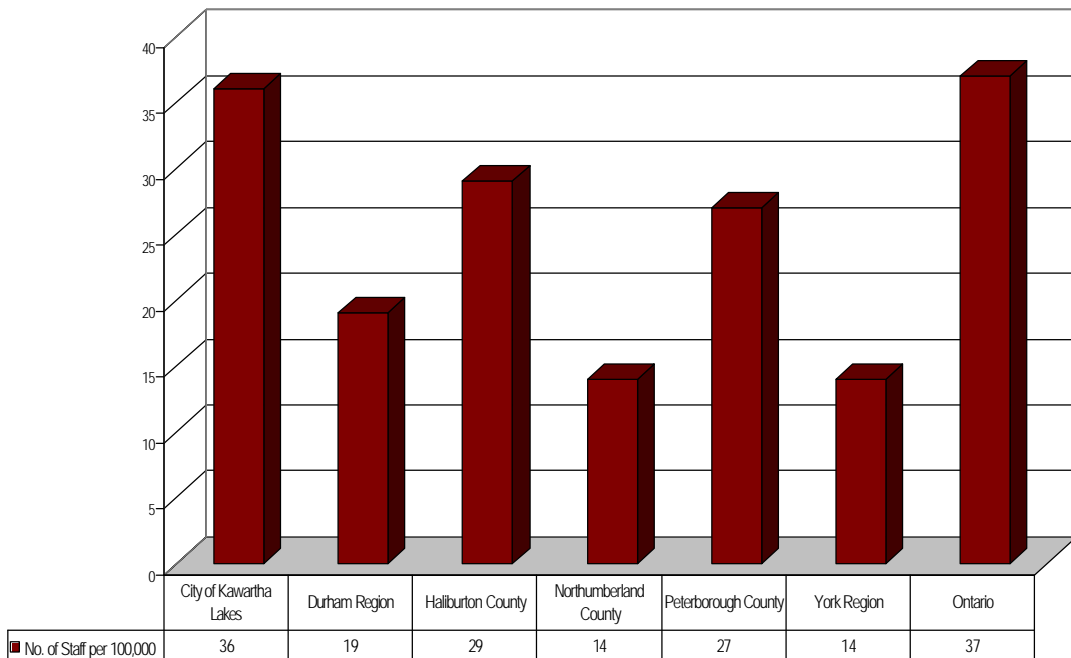
Human Resources

A complete discussion of the Region's human resources is found in the Human Resources Subcommittee Report in Section 3 of the Task Force binder.

The number of community mental health program staff per 100,000 population varies by region/county. York Region and Northumberland County have 14 community mental health staff per 100,000. Durham Region has the second lowest staff-to-population ratio with 19 community mental health staff per 100,000 in the Region.

York Region and Northumberland County have only one-third of community mental health staff per capita when compared to the provincial average, while Durham Region is staffed at only half the provincial average. As shown in Graph 3.10, both regions and the four counties in Central East (Whitby) have fewer funded staff per 100,000 than the provincial average.

Graph 3.10 - Community Mental Health Programs Full Time Equivalents – 2000/01 by Region/County



Source: Community Mental Health Program Year-End Report, *Community Mental Health Programs Inventory and Budget*.

Note: Age is standardized to Ontario 2000; the ACCT is not included in this number; and numbers are rounded to the nearest full time equivalent.

These inequities are primarily affecting the regions with the highest growth rate. These inequities can be explained by the lack of increase to the base funding of community mental health programs to keep pace with inflation and growth. Therefore, the inequities within the Region and the Province need to be addressed when the distribution of community mental health dollars is equalized across Ontario. It is imperative that the existing workforce be stabilized as soon as possible to ensure that sufficient human resources remain in the system when mental health reforms are implemented.

ASSESSMENT OF NEEDS

Planning for mental health reform requires an awareness of service need. This section discusses the need for services by: applying the prevalence rate of mental illness to the total population and examining the unique⁸ number of clients served in the system at a given time. The latter figure under estimates the total need for services; however, it shows the absolute minimum number of individuals who require services. These individuals currently require and qualify for mental health services.

.....
“ An issue that needs to be addressed is how to meet the needs of seniors who are caring for another senior with a mental illness. These people need education and they need to know how to make linkages with ongoing supports in the system. They worry about who will care for their loved one after they are gone and who can manage the information about this person that they have managed on their own for years.”

Haliburton County
Family Member
.....

Also, individuals receiving services are not always getting the appropriate level-of-care to match their needs. Planners need to examine which services are insufficiently available or do not exist to service consumer/survivors.

Prevalence Rates and Incidence of Mental Illness

Youth and Seniors

In reforming mental health services, it is important to plan the appropriate amount of services for specific age groups since **the prevalence rate of mental illness varies among the age groups.** For example, in Haliburton County there are more seniors who require mental health services than children and teens. However, there are more than three times as many children and teens that require mental health services than seniors in York and Durham regions. (Refer to Table 3.11 – Incidence of Mental Illness in Youth and Seniors by Region/County, 2001 where the top figure represents the number of

⁸ The *Comprehensive Assessment Project* cross-referenced the names from the various lists to ensure that clients were only counted once; hence the term “unique clients”.

people and bottom figure represents the number of people with mental illness).

The relatively high incidence rate of mental health disorders in the 15 to 24 year age group reflects the risks, challenges, struggles and developmental tasks of this age group. The availability of timely mental health supports and public education for people of this age group may be instrumental in avoiding a serious mental health crisis, thus modifying the long-term impact of a chronic mental illness at an early stage.

The high incidence of mental illness in the elderly highlights the need to provide adequate services for seniors and their families and to design services that span different parts of the health care system (e.g., long-term care).

Table 3.11 - Incidence of Mental Illness in Youth and Seniors by Region/County, 2001 (based on generally accepted prevalence rates)

Region/County		Incidence of Mental Illness Age 15 to 24 ¹	Incidence of Mental Illness Age 65+ ²
City of	No. of Youths and Seniors	13,170	13,810
Kawartha Lakes	No. with Mental Illness	3,293	2,072
Durham Region		114,610	49,960
		28,653	7,494
Haliburton County		2,390	4,050
		598	608
Northumberland County		154,00	14,960
		3,870	2,244
Peterborough County		22,640	23,290
		5,660	3,494
York Region		145,680	67,960
		36,420	10,194
Total No. of Youth and Seniors		313,970	174,030
Total No. with Mental Illness		78,493	26,105

Source: Ministry of Finance, *Ontario Population Projections, 1999-2028*.

¹ According to *Ontario Health Survey, 1990*, 25 per cent of individuals between the ages of 15 and 24 have one or more disorders.

² According to *Elderly Service Benchmarks of the Province of British Columbia, 1994*, 15 per cent of the elderly population will need mental health services at a given point in time.

Adult Population

The mandate of the Task Force is to plan for individuals with serious mental illness. Three dimensions are employed to define serious mental illness in *Making It Happen*: disability, anticipated duration and/or current duration and diagnosis. According to the MOHLTC⁹, the prevalence rate of serious mental illness in Ontario is 2.5 per cent for people between the ages of 15 and 64.

Applying the prevalence rate of serious mental health illness (2.5 per cent) to the Region indicates that there were approximately 26,940 individuals with serious mental illness between the ages of 15 and 64 years in 2001. (Refer to Table 3.12 – Incidence of Mental Illness in Individuals Between Ages 15-64 by Region/County, where the top figure represents the population and the bottom figure represents the number of individuals with serious mental illness based on the 2.5 per cent prevalence rate).

It is difficult to determine if 2.5 per cent of the population with a serious mental illness requires mental health services at the same time. This prevalence rate does however, provide planners with the maximum number of individuals requiring services.

Table 3.12 - Incidence of Mental Illness in Individuals Between Ages 15 and 64 by Region/County, (based on generally accepted prevalence rates)

Region/County		2001	2003	2006	2011
City of	No. of People	45,750	48,670	51,840	56,450
Kawartha Lakes	No. with SMI*	1,143	1,217	1,296	1,411
Durham Region		358,430	377,360	407,840	454,650
		8,961	9,434	10,196	11,366
Haliburton County		9,950	10,280	10,680	11,080
		249	257	267	277
Northumberland County		57,170	59,190	61,380	63,630
		1,429	1,480	1,535	1,591
Peterborough County		84,520	87,210	90,270	93,310
		2,113	2,180	2,257	2,333
York Region		521,800	556,520	606,140	683,040
		13,045	13,913	15,154	17,076
Total No. of People		1,077,600	1,139,230	1,228,150	1,362,160
Total No. with SMI		26,940	28,481	30,704	34,054

Source: Ministry of Finance, Ontario Population Projections, 1999-2028.

* SMI: Serious Mental Illness.

⁹ MOHLTC, Implementation Policy and Planning Branch, December 11, 2001 memorandum to Task Forces.

Unique Clients Currently Served

When comparing the total incidence (26,940) to the number of individuals found to be receiving mental health services in the *Comprehensive Assessment Project* (6,295)¹⁰, it appears that less than one quarter of the total population (between ages 15 and 64) with serious mental illness in the Region is currently being served by the MOHLTC-funded mental health system, exclusively acute mental health beds. (Refer to the pie charts and Table 3.13 - Number of Unique Clients Served between April 1 and June 30, 2001 in the Community System by Region/County).

In the case of York Region, 16 per cent of the target population is receiving mental health services. **This percentage of clients served significantly decreases when adding the ‘over 65’ age group that may require mental health services (26,105 individuals).**¹¹ It also appears that less than one eighth of the total population (ages 15 and up) with serious mental illness is currently being served by Community Mental Health Programs, Homes for Special Care, Approved Homes and the Whitby Mental Health Centre in York Region. These figures support the information received from stakeholders that there are long wait lists and a lack of availability of mental health services throughout the Region.

Table 3.13 - Number of Unique Clients Served Between April 1 and June 30, 2001 in the Community System by Region/County

Region/County	No. of Unique* Clients Served	Per Cent of Target Population Receiving Services, 2001
Durham Region	2,498	29%
HKPR	1,729	35%
York Region	2,068	16%
Total	6,295	23%

Source: *Comprehensive Assessment Project, 2002.*

* Note: The *Comprehensive Assessment Project* cross-referenced the names from the various lists to ensure that clients were only counted once; hence the term “unique clients”.

¹⁰ *Comprehensive Assessment Project, 2002:* iv – excludes Scarborough populations.

¹¹ (Refer back to Table 3.11 – Incidence of Mental Illness in Youth and Seniors by Region/County, 2001).

LEVEL-OF-NEED ASSESSMENT

The *Comprehensive Assessment Project* was led by researchers at the Centre for Addiction and Mental Health. A random sample of consumer/survivors receiving services from MOHLTC-funded community mental health programs was included in this study: Durham Region 264, York Region 289, and HKPR 184. All 295 inpatients at the Whitby Mental Health Centre were included as well as a random sample of outpatients (89) and Homes for Special Care and Approved Homes residents (66).

Researchers trained staff to administer the *Colorado Client Assessment Record*. The use of this instrument enabled researchers to compare the level-of-care provided to the level-of-care that is needed. There are five levels-of-care that are described in Table 3.14, and they compare to the levels-of-need described in *Making It Happen*.

Table 3.14 – Levels-of-Care

Levels-of-Care	Criteria	Levels-of-Need
Level 1	Intermittent up to monthly contact with mental health providers	First-line / Intensive
Level 2	Weekly contact with case manager or at least weekly contact with clinical treatment or rehabilitation program	Intensive
Level 3	Up to daily contact with case manager (e.g., ACT)	Specialized
Level 4	Use of a residential program with 24-hour professional staffing and medical staff available on call or more often. (e.g., Residential Treatment facilities)	Specialized
Level 5	Inpatient	Specialized

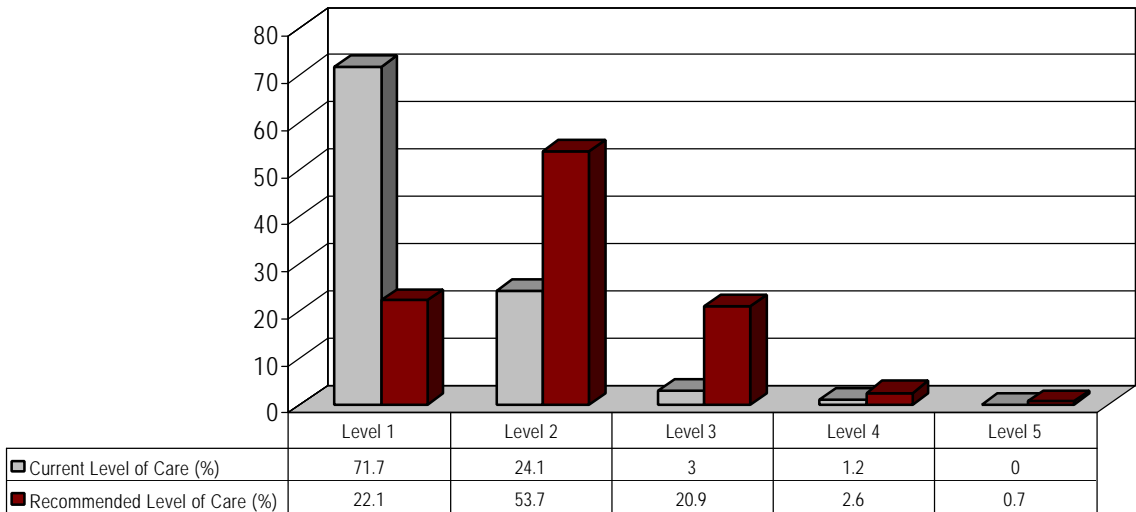
Source: *Comprehensive Assessment Project, 2002*.

Community Mental Health Services

According to the *Comprehensive Assessment Project* data, **many consumer/survivors receiving community mental health services are receiving a lower level-of-care than is recommended.** When the level-of-care received is compared to the recommended level-of-care for each individual, 63 per cent of individuals receiving services from community mental health programs are receiving a lower level-of-care than is recommended. For example, 72 per cent are receiving Level 1 care and 24 per cent are receiving Level 2 care, when 22 per cent require Level 1 and 54 per cent require Level 2. Furthermore, three per cent are receiving Level 3 care, when 21 per cent require this level-of-care.

As shown in Graph 3.15, six per cent of consumer/survivors receiving community mental health services are receiving a higher level-of-care than is recommended.

Graph 3.15 - Community: Current Level-of-Care Provided and Recommended (per cent)



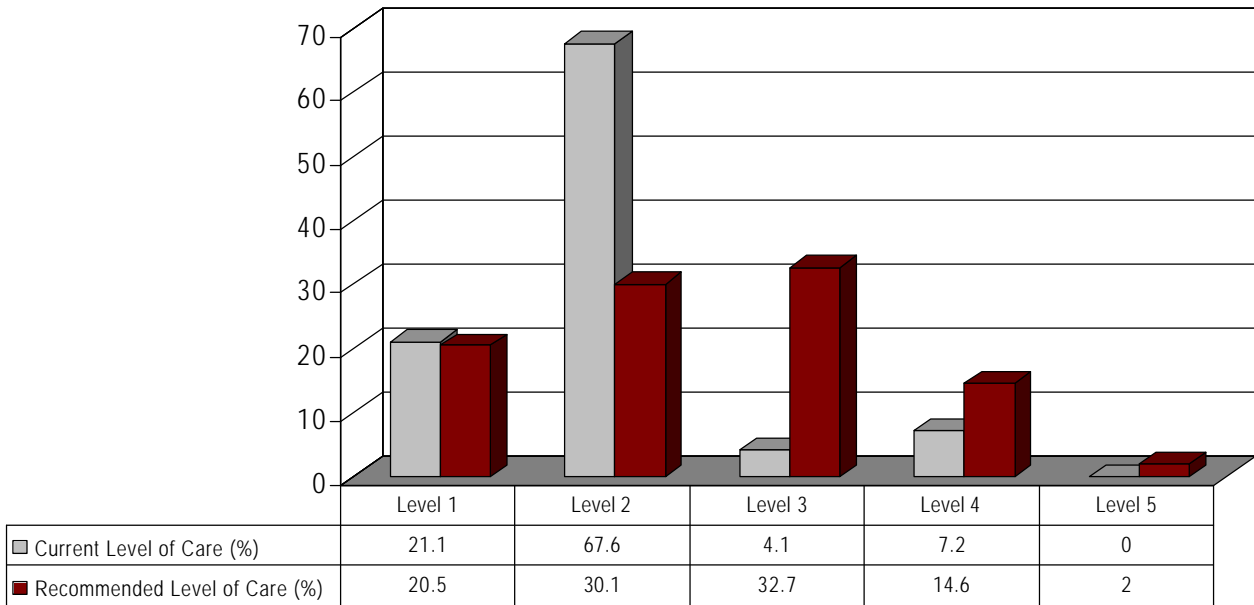
Source: *Comprehensive Assessment Project, 2002.*

Whitby Mental Health Centre Outpatient Programs, Homes for Special Care, Approved Homes

In comparison to the number of individuals receiving services from community mental health programs, a smaller number of individuals who received their mental health services from the Whitby Mental Health Centre’s Outpatient Programs, Homes for Special Care and Approved Homes, were receiving a lower level-of-care than is recommended and a greater number were receiving a higher level-of-care than is recommended.

When comparing the level-of-care each individual is receiving to the recommended level-of-care, 41 per cent of individuals receiving mental health services from Whitby Mental Health Centre’s outpatient programs, Homes for Special Care and Approved Homes are receiving a lower level-of-care than is recommended and 23 per cent are receiving a higher level-of-care than is recommended. Also, as shown in Graph 3.16, a smaller number of consumer/survivors in this group required Level 2 care and more required Level 3 care.

Graph 3.16 – Whitby Mental Health Centre Outpatient Programs, Homes For Special Care and Approved Homes: Current Level-of-Care Provided and Recommended (per cent)



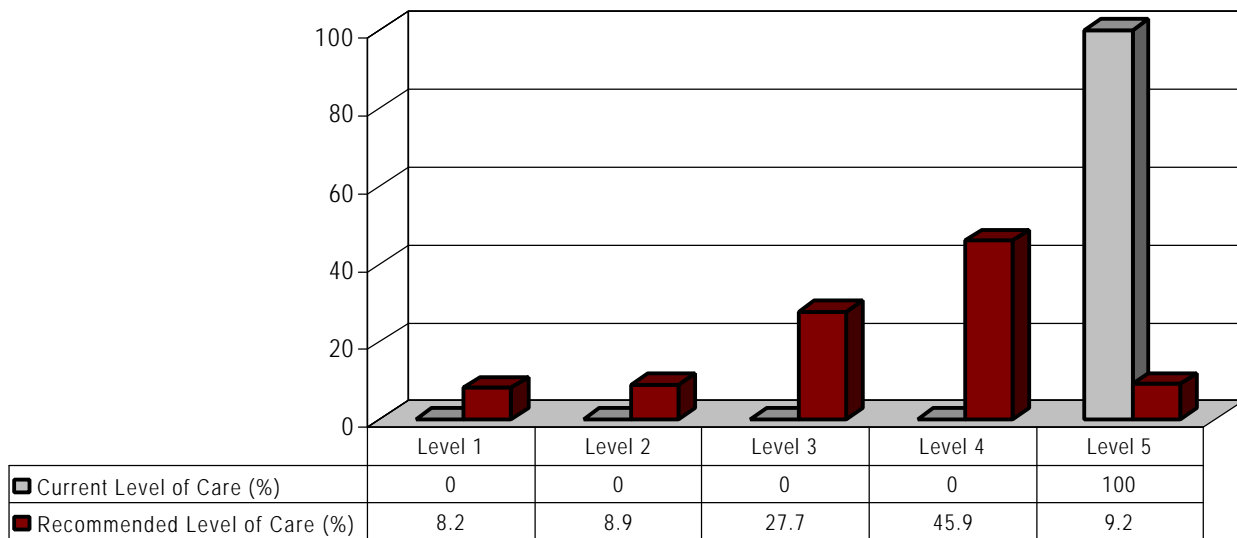
Source: *Comprehensive Assessment Project, 2002*

Whitby Mental Health Centre

The *Comprehensive Assessment Project* data indicate that by increasing community-based Level 3 services and creating Level 4-type residential facilities in the community, pressure on the Specialized Services at Whitby Mental Health Centre would be relieved. This would allow individuals requiring Specialized mental health services who are “blocking” mental health beds at Schedule 1 facilities, to receive the specialized care they need from the Whitby Mental Health Centre.

According to the *Comprehensive Assessment Project*, the majority of inpatients at The Whitby Mental Health Centre are receiving a higher level-of-care, than is recommended. When considering this information it is worth noting that many inpatients (130 out of 292, or 45 per cent) were reported as having a forensic designation¹². This means that a Review Board Order requires these consumer/survivors to be in a hospital setting. As well, as shown in Graph 3.17 and Graph 3.18, Level 4 services (e.g., Residential Treatment facilities) do not currently exist in the Region, and Level 3 services (e.g., ACT Teams) are extremely limited.

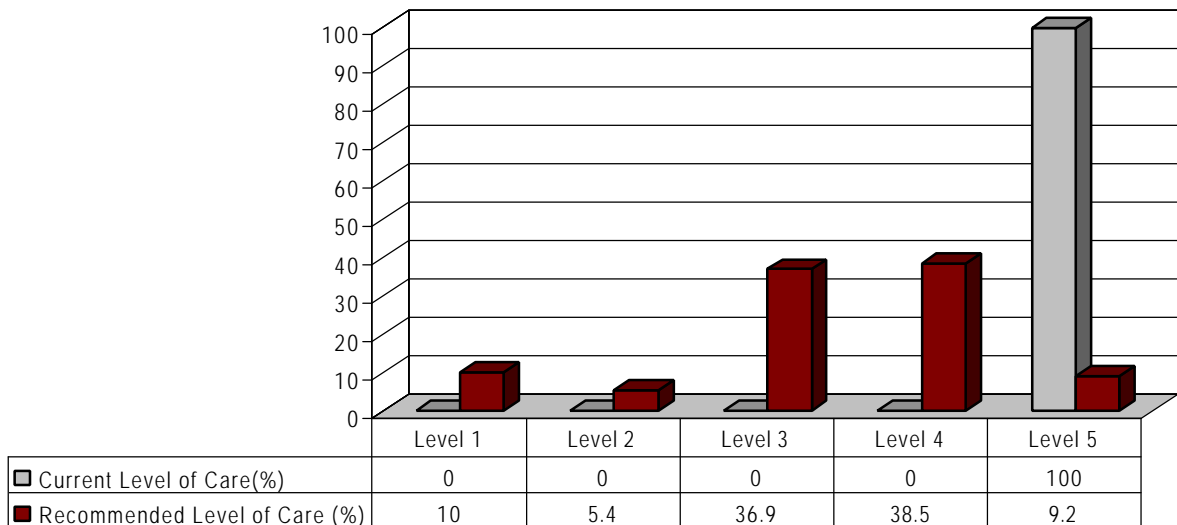
Graph 3.17 – Whitby Mental Health Centre Inpatients: Current Level-of-Care Provided and Recommended for Total Inpatients (per cent)



Source: *Comprehensive Assessment Project, 2002.*

¹² Forensic Designation is a patient who is deemed not criminally responsible, unfit to stand trial or undergoing a forensic assessment.

Table 3.18 – Whitby Mental Health Centre Inpatients: Current Level-of-Care Provided and Recommended for Total Clients with a Forensic Designation* (per cent).



Source: *Comprehensive Assessment Project, 2002.*

Note: * *Forensic Designation means not criminally responsible, unfit to stand trial or undergoing a forensic assessment.*

It should be noted that inpatients in Schedule 1 facilities were not included in the *Comprehensive Assessment Project*, therefore it is **impossible to confirm with these data the level-of-need of individuals in Schedule 1 facilities.**

The *Comprehensive Assessment Project* data emphasized the consistency across the Region in both the level-of-need for services and the differences between the level-of-need and recommended level-of-need¹³.

¹³ It should be noted that results were not compared within HKPR due to the sample size since it would lead to unstable estimates due to the small cell sizes and could lead to a breach in confidentiality.

CHAPTER 4

Challenges in Central East (Whitby)

The preceding discussion identified a number of challenges to providing appropriate and timely mental health services to people in need in the Region. These challenges are summarized as follows:

Funding

There are challenges directly related to the low per capita funding in the Region. **Central East (Whitby) receives half of the provincial average per capita funding for Community Mental Health and Mental Health Program Services.** Lower per capita funding has been an historic problem throughout the Region. It can only be corrected if the MOHLTC allocates future mental health dollars to favour the three regions of the province that are significantly below the provincial average – Central East, Central West and Central South.

Human Resources

There are a number of human resource challenges. Some are related to the **general shortage** of family physicians, psychiatrists and all other mental health professionals experienced across the province. Other human resource challenges are related to **discrepancies in wages and benefits** between the community mental health and institutional sectors, and between the Provincial Psychiatric Hospitals and Schedule 1 facilities. Professionals of equal qualification doing comparable work, earn on average 30 per cent more in the Schedule 1 facilities than in the community mental health programs.

Whitby Mental Health Centre Divestment

The Health Services Restructuring Commission recommended that the Whitby Mental Health Centre be divested in 1998. Since 1999, five of the nine Provincial Psychiatric Hospitals have been divested¹⁴.

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“ There is too much turnover in staff within single agencies. This means repeating histories, getting to know people and learning to trust new people so often that environments are destabilized because of this continuous change. ”

Haliburton County
Family Member

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¹⁴ Three Provincial Psychiatric Hospitals are awaiting divestment. The Commission made no recommendation for divestment of the Provincial Psychiatric Hospital in Penetanguishene.

The Whitby Mental Health Centre divestment has been repeatedly deferred. The delays in divestment are having a serious impact on the hospital.

In early 2002, patients at Whitby Mental Health Centre experienced a 55-day strike that would have been avoided if divestment had occurred since General Hospital staff are not allowed to strike. Staff morale is low¹⁵ and the hospital has lost a large percentage of front line staff and psychiatrists.

Population Growth

High population growth has contributed to service shortages in the Region. Service delivery capacity has been unable to keep up with the high population growth. **Shortages will only increase if services are not expanded to meet the needs of growing population.**

Mental Health Beds

The increase in mental health beds directed by the Commission and slated to be operational by 2003 will, in the majority of cases, not be available at that time. The hospitals need to find ways to provide interim beds until such time as the capital expansions are completed. These beds are crucial to a reformed mental health system because they are important supports for community services.

Transportation and Geography

The other significant challenge to delivering mental health services in the Region is the **lack of adequate public transportation.** Consumer/survivors must rely on living in close proximity to all services or on the support and kindness of others to drive them to appointments. This is particularly onerous for consumer/survivors who require day treatment and reside one or more hours away from such services. The long distances inherent in the geography of the Region also pose challenges to outreach programs and to family members who must either drive family members to services or travel distances to visit loved ones.

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“ *If people do not have transportation to get back to the hospital on Sunday, they can't go out for their weekend passes.* ”

Durham Region
Consumer/Survivor
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¹⁵ Staff Survey 1998, 2001. Whitby Mental Health Centre.

Diverse Population

“ There needs to be fluidity in the application of service delivery so it makes sense in different communities and makes use of the human resources that are already ‘in town’. There needs to be different designs for cities, big towns and small towns.”

HKPR
Provider

The population composition of the Region requires special consideration when planning mental health services. In other words, identical services cannot be deployed with the same success rate due to the following unique features:

- large pockets of urban and rural areas;
- concentrations of immigrant and non-English speaking populations;
- concentration of seniors;
- large pockets of populations with lower economic status; and,
- First Nations populations.

Community Supports

The new system will only be successful if there is a complete range of mental health services to support consumer/survivors and their families. This means:

- strong support in the community, where people will live most of the time;
- adequate General Hospital mental health beds and services to support people when they need that level of support; and,
- the support of a Tertiary Care facility (e.g., the Whitby Mental Health Centre).

Currently, there is a lack of Level 3 and 4 services in communities. This results in:

- pressure on community-based services that are not designed to provide care at this high level;
- inappropriate use of acute care mental health and Specialized beds; and,
- inability to access hospital beds in a timely manner.

“ Need to think in terms of homes instead of beds. People need to have access to home-like environments that are safe if they do not want to be alone. It is important to have adequate numbers of beds so that one is always available in the system and also it is important to have alternate supports to help people who are in crisis and avoid the need for beds altogether.”

Northumberland County
Consumer/Survivor

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System Integration

“ *There needs to be a commitment to long-term changes that will improve the health care system as a whole.* ”

Durham Region
Family Member
.....

Historically, mental health services in the Region, as well as in the rest of Ontario, have not functioned as a system. Reports from District Health Councils, among others, tell us of a collection of different services that have developed in different ways with different funding sources and different management structures and processes. Although some change has occurred, there still appears to be little co-ordination between consumer/family groups, physicians, community mental health programs, General Hospitals and Psychiatric Hospitals.

Without a clearly defined system, the array of programs and services can be confusing for consumers, families and service providers. Services and supports can be difficult to access. Once an individual is in the system, care is often fragmented. Some people may receive similar services from different agencies, while others receive no services at all.

The lack of a common information system has often been linked to the lack of integration in the overall system. The Task Force created a Subcommittee to examine this issue and develop information systems recommendations.

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Housing Shortage

“ *A lack of affordable housing contributes to the need for shelter space and to homelessness. If people have a place to live, they have much less stress in their lives.* ”

City of Kawartha Lakes
Consumer/Survivor
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The critical housing shortage indicates that living in appropriate and affordable housing within walking distance of all services is a reality very few are fortunate to experience. District Health Councils across Ontario conducted extensive consultations on housing for individuals with mental illness in summer 2001. Their results attest to this housing shortage.

Access to affordable and appropriate housing for individuals with mental illness is not only required for recovery, but also a basic human right. The MOHLTC established housing benchmarks for 2003 of 207 units per 100,000 people. According to these benchmarks, a total of 2,358 units are required in the Region to house individuals with a mental illness between the ages of 15 and 64. The Corporation will be required to review the existing available housing and add to these units to ensure that there are a minimum of 2,358 units available in Central East (Whitby). The Corporation will also be in the position to review the Simcoe York and Durham HKPR District Health Council reports on housing. These reports summarize the housing needs of consumer/survivors in Central East (Whitby) (e.g., housing should be accessible, safe and near services). The Task Force believes that all housing units should be subsidized at \$500.00/per month.

Inadequate Financial Supports and Initiatives for Consumer/Survivors

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“ *Enough money needs to be available to people so that they can have: stable housing that is clean and near transit, a balanced diet, respectable clothing, heat, telephone, and reasonable ability to purchase transportation services, for example, to go to church on Sunday.* ”

York Region
Consumer/Survivor

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A dominant theme that emerged from the Phase II focus groups was inadequate financial support for people on the Ontario Disability Support Program (ODSP). **This impacts on the ability of consumer/survivors to access services, and to maintain appropriate housing and a proper diet.** Furthermore, financial disincentives (e.g., they will no longer have their medications reimbursed) discourage efforts to work. This system contradicts the Recovery Model, according to which it is crucial to a consumer/survivors’ recovery to have the opportunity to be independent if they so wish.

These issues affect 7,060 individuals in the Region who have a “mental health disability” and receive support from the Ontario Disability Support Program¹⁶. This means that the MOHLTC system will likely have to spend more money to support people with mental illness because of the circumstances created by inadequate financial support from other branches of government. This impacts on community-based services, as well as hospitals. For example, how can a person be discharged from a hospital if they cannot afford appropriate housing?

¹⁶ *Ontario Disability Support Program*, cases with mental health disabilities, disability codes (ICD9). March 2001. Source: CIMS, Ministry of Community and Social Services.

CHAPTER 5

Overarching Themes

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“ *The goal of treatment needs to be recovery. To move towards this, people need to have a home and meaningful activities to give some purpose to their lives.* ”

City of Kawartha Lakes
Consumer/Survivor

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“ *Support is necessary at all stages for people with mental illness recovery, not just during times of crisis. Support is necessary to reach full recovery, to maintain recovery status and at times of relapses. During relapses, easy access to services is important.* ”

York Region
Consumer/Survivor

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The Task Force has adopted two overarching themes that are fundamental to the new Service Delivery and Governance models. This chapter defines the Recovery Model and Diversity Strategy and the role of this model and strategy in the new mental health system.

THE RECOVERY MODEL

The adoption of the Recovery Model is fundamental to mental health reform for the Task Force. The Task Force has embraced this model and developed its recommendations with the underlying assumption that the Recovery Model will be adopted at each level of the reformed mental health system and by all stakeholders. This grassroots model requires a paradigm shift for all stakeholders, including consumer/survivors, family members and providers.

Recovery does not imply “cure”¹⁷. However, it implies that better times can and will come, that the existing despair will not always be present. There are several recovery models, each of which emphasizes the complexity of human nature. In order for wellness to be present, both the internal¹⁸ and external¹⁹ aspects must be functioning well. Furthermore, external influences (e.g., family, friends, community and the mental health system) must support and encourage recovery.

“Recovery is often a lifetime effort”²⁰. Above all else, family members, friends and providers should **offer hope** to assist in the recovery of consumer/survivors. That is not to say that consumer/survivors should be overwhelmed by optimistic plans about their own future, but rather that their support system should remain hopeful despite the odds. Other themes in the Recovery Model include the following:

¹⁷ Ralph, Ruth, 2001. Mental Health Services in the Recovery Context. *Recovery Conference*, Birmingham, United Kingdom, October 17, 2001.

¹⁸ Internal is what happens within oneself.

¹⁹ External includes the interactions with others.

²⁰ Ralph, Ruth, 2001. Mental Health Services in the Recovery Context. *Recovery Conference*, Birmingham, United Kingdom, October 17, 2001.

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“ Providers throughout the system need to have sensitivity training to build respect for, and equality of, peer providers who are working with them. Teams should have peer support workers who should be paid for the value of the work they are doing. ”

Durham Region
Consumer/Survivor

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- To assist in recovery, family members, friends and providers should **listen and believe in consumer/survivors**. Consumer/survivors know what they have tried and not tried, what works for them and what does not. Listening and giving credence to their beliefs will open the door to assist and contribute to their recovery.
- **Language should be given careful attention.** For example, it is not an issue of “compliance” but one of “choice” for consumer/survivors.
- Efforts should be made to **get to know consumer/survivors**, including their skills and interests, in order to assist them when their functioning improves again.
- Providers should understand the **important role of families** in the support system and honour the consumer/survivor choice regarding the level of involvement of the families in their treatment planning.
- People wishing to assist others in their recovery should read **literature written by consumer/survivors** to increase their level of understanding.
- **Consumer/survivors should be valued and respected.** They should be supported and encouraged in their participation on boards and committees. Accommodations should be made to permit them to participate with grace and dignity.
- Consumer/survivors should be hired for **real positions with competitive salaries** and reasonable accommodations in the workplace should be made to promote well being.

Recovery is attainable. The system should not focus all its energy on convincing people that “they will never get better or back to normal”²¹. They can and they will recover with time, effort and support.

Implications for a Service Delivery Model

Adoption of the Recovery Model means that the Service Delivery Model must:

- offer a range of supports and choices for consumer/survivors depending where they are on the road to recovery;
- support families;

²¹ Gottstein, Jim. 2001. The Mental Health System: Recovery Should be the Goal. *Alaska Mental Health Consumer Web*. <http://akmhcweb.org/recovery/sytem.htm>.

- provide education and resources to help the consumer/survivors, their families and friends, to help themselves;
- educate/dialogue with the general public; and,
- be based on respect for consumer/survivors and their families and friends.

THE DIVERSITY STRATEGY

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“ People from different cultures cannot fully understand the intrinsic characteristics of another. Respect for others is the most important characteristic to bridge the gap.”

Richmond Hill
Diversity Planners

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The Region is diverse²² in: age, educational level, income level, ethnicity, home language, urban or rural community, type of housing and community, traditions, affiliations, perspectives, philosophies and level of physical ability (e.g., individuals who are deaf and blind). These factors impact on the way people interpret the world around them and will impact on the way they view their health and mental health, specifically.

Any system reform strategy must recognize that the people who use the system are diverse. This means that individuals will use, or not use the system for different reasons. They will find different ways to access the system. Individuals will use different parts of the system or they will choose to have their needs met elsewhere entirely.

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“ Migration of people into a new culture and loss of their old culture may be a life crisis. They need to be able to connect to their cultural roots. Alternatively, the values that family members adopt in their new home, because of the need to survive financially, may lead to a loss of dignity based on the values of the home culture.”

Richmond Hill
Diversity Planners

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The current mental health system is focused on the notion that society is homogeneous. While there are several individual initiatives that recognize and attempt to embrace diversity, this does not happen on a systemic level.

In order for Central East (Whitby) to effectively reform its mental health system, it must, on a systemic level, embrace diversity. It must become a system in which cultural competence and inclusivity are the norm. ☞ *A complete description of the Diversity Strategy is included in Appendix E.*

The Diversity Strategy is based on these three broad-based sub-strategies:

- System Inclusiveness Strategy;
- Outreach and Linkages Strategy; and,
- Diverse Treatment Strategy.

²² The Task Force based its Diversity Strategy on two pieces of work: *Kaleidoscopic Organizations, Diversity and Inclusivity: A Framework*, Ajok Mukherjee and the United Way of York Region, 2001; and, *Mental Health and Addictions Diversity Strategy*, Simcoe York District Health Council, 2001.

System Inclusiveness Strategy

The System Inclusiveness Strategy focuses on operational policy, practices and composition that acknowledge, support and encourage diversity. The Strategy is intended to ensure that organizations are “diversity friendly”. Its implementation requires organizations (including the system management structure) to make decisions and develop policies and programs in a way that ensures perspectives from diverse points of view. Service providers will work in the context of a shared commitment to cultural competence²³. The system management structure will make a commitment and plan to align program policies and practices in a way that emphasizes cultural competence in the following areas:

- declaration of the importance of diversity;
- policies, procedures and practices;
- personnel practices; and,
- organization composition.

Outreach and Linkages Strategy

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“ It is important to recognize the importance of grassroots community networks in supporting people - not interfering with them, and for establishing effective linkages for when they are required.”

Richmond Hill
Diversity Planners

The Outreach and Linkages Strategy focuses on **effectively engaging diverse communities** in the planning, delivery and management of services that are culturally, linguistically, age and socio-economically appropriate. The diverse community should be engaged using accessible materials, mechanisms and vehicles. This strategy is based on the assumption that although organizations may become “diversity friendly” with the implementation of the System Inclusiveness Strategy, it does not mean that traditionally marginalized populations will begin using their services. There will need to be an effort to ensure that diverse population groups are informed of the available services, and that services are marketed in a way that invites participation. The Outreach and Linkages Strategy proposes a continuous and well-developed strategy for communication and linkages with diverse population groups.

²³ Cultural competence is the ability to serve and support individuals and families in our community from all cultural backgrounds.

Diverse Treatments Strategy

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““ Accommodate traditions as much as possible. Consider having cultural places where people can practice their rituals such as burning tobacco or lighting candles. There needs to be a safe place for native people’s medicine bundles.””

Richmond Hill
Diversity Planners
.....

The Diverse Treatments Strategy focuses on **approaches, services, programs and structures that are founded on evidence-based practice and regular community consultation**. It includes policies, procedures, training and education that enable services to be provided in a culturally and linguistically appropriate manner. Agencies may be “diversity friendly” and well linked with diverse population groups, but they will also need to adapt services or create new programs to address special needs and values. These approaches should be based on best practices. If they are innovative in nature they should include a strong evaluation component. These services should be developed and implemented in partnership with provider agencies in the broader community. A strong consultative element should be incorporated.

An example of when a Diversity Strategy comes into play:

First Nations

There are a number of First Nations Reserves and Off Reserve First Nations citizens in the Region. The Task Force had the opportunity to hear from community representatives who understand the high prevalence rate of mental illness and intergenerational trauma in First Nations citizens. The Task Force believes that the Corporation should:

- engage First Nations and ensure that the mental health services in Central East (Whitby) address cultural diversity and support First Nations initiatives; and,
- review the work of the other Task Forces who have a significant First Nations population and have dedicated entire Subcommittees to First Nations issues.

.....
““ People with specific challenges are often greeted by people at agencies who are not sensitive to people with special needs and therefore become impatient with them when there are communication problems. This results in frustration and anger for the ‘client’ at the point of contact.””

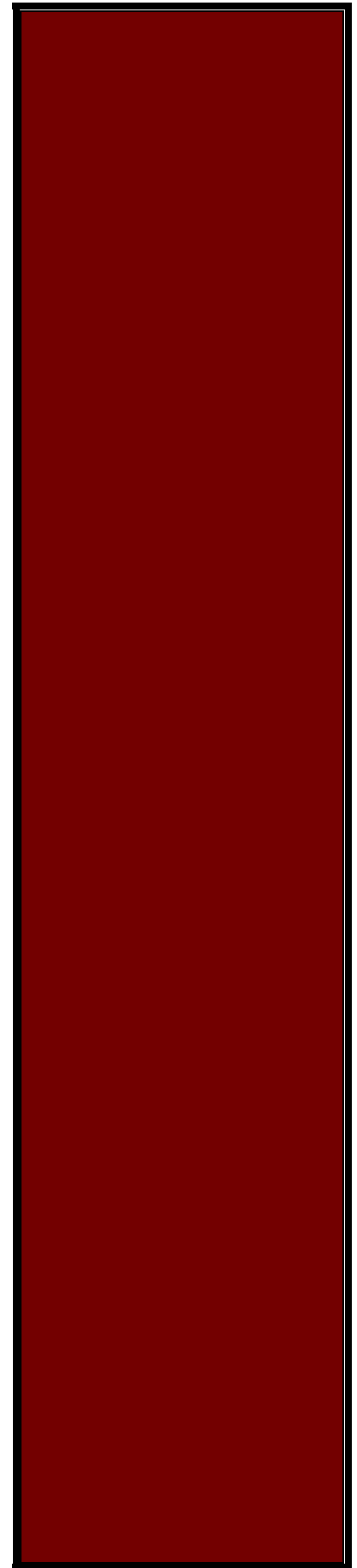
Pickering
Diversity Planners
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A UNIQUE OPPORTUNITY

Reforming a system provides a unique opportunity to address the issue of diversity and the adoption of the Recovery Model from a systems perspective. It is imperative that the Region *seizes this opportunity* and ensures that the system it develops reflects the diversity of people within its communities and promotes the recovery of consumer/survivors.

SECTION 2

Recommendations and Implementation



CHAPTER 6

Service Delivery Model

The Service Delivery Model emerged from the Subcommittee recommendations and was adapted based on the feedback from the focus groups. This model builds on and maximizes the strengths of the current system. At the same time, **this model introduces several new service concepts that are designed to:**

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“ There needs to be choice in the system about whether to get professional supports or mutual aid.”

Northumberland County
Consumer/Survivor

.....

- improve timely access to services, including crisis response mechanisms;
- alleviate pressure on hospital beds and emergency rooms by providing alternative sites for support, comprehensive discharge planning and a community-based support system;
- provide services to fill the existing gaps at Levels 4 and 5 (Intensive and Specialized Services); and,
- promote recovery by providing housing, employment, social recreational and educational supports.

The Service Delivery Model is composed of five main services:

- The Regional Call and Information Resource;
- Schedule 1 facilities;
- Self-Help Supports;
- Community Integrated Mental Health Teams (the Teams); and,
- Specialized Services.

Some of the new services are:

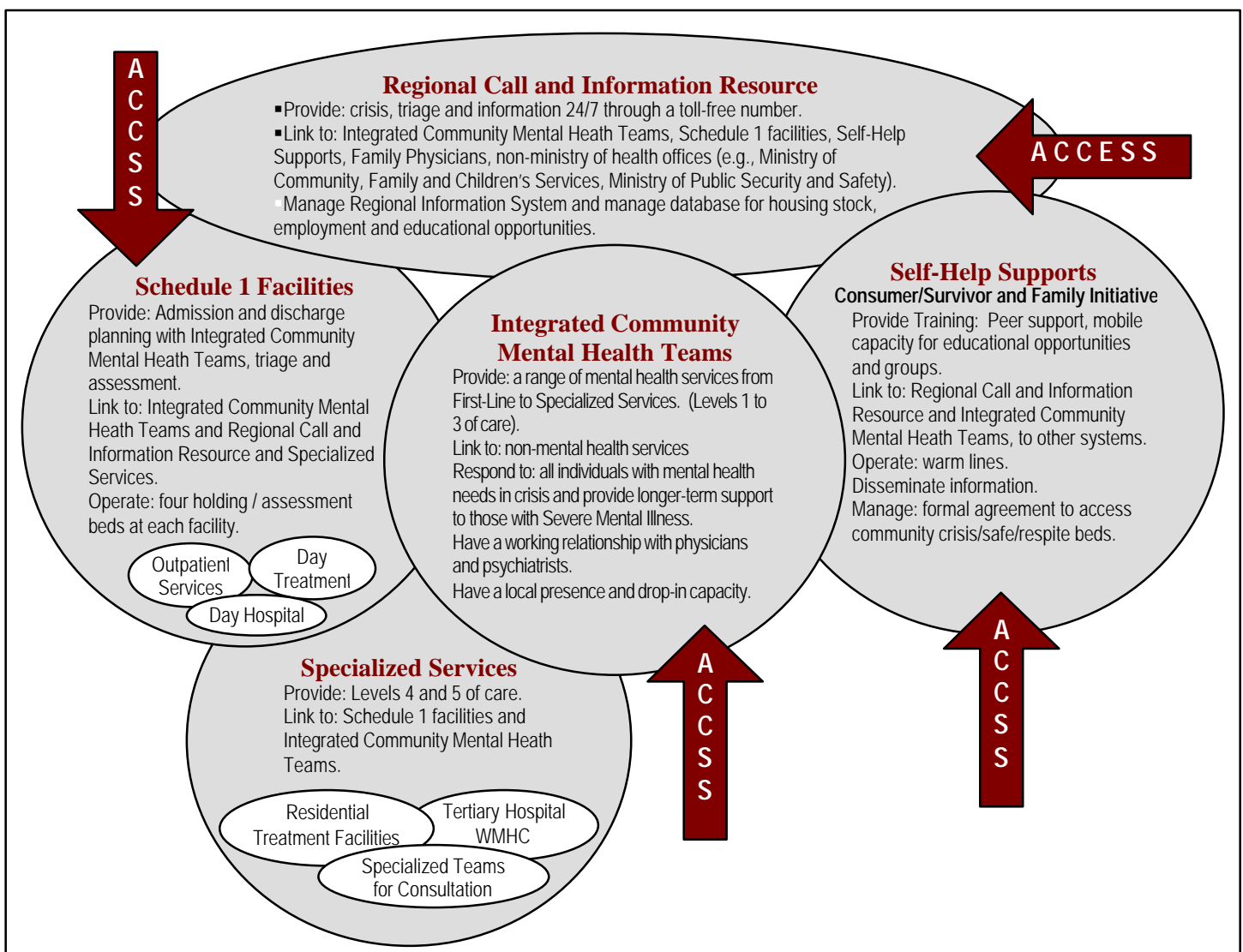
- introduction of a Regional Call and Information Resource;
- transformation of the existing array of community-based services to the Teams;
- augmentation of community-based crisis/safe/respite beds;
- creation of beds in each Schedule 1 facility; and,
- creation of Residential Treatment facilities and Specialized Consultation Teams that will be part of the Specialized Services.

These new services will be integrated with the other services that already exist, namely:

- Schedule 1 facilities;
- Self-Help Supports (not currently in all communities); and,
- the Whitby Mental Health Centre.

The relationships between the five main services in the Service Delivery Model are depicted in Diagram 6.1.

Diagram 6.1 – Service Delivery Model



DESCRIPTION OF THE MODEL

Access

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“ Signs on storefronts may be the thing that triggers someone to come in and get help.”

York Region
Consumer/Survivor

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There will be five ways in which to access the mental health system for the first time. In addition to contacting their local family physicians, individuals requiring services may access the mental health services by:

- contacting the Regional Call and Information Resource through a toll-free number or via the Internet;
- contacting the Self-Help Supports through a toll-free number or drop-in locations;
- contacting the Teams through a local phone number or drop-in location; or,
- presenting themselves at the emergency room of their local hospital.

.....

“ Put the phone number across the front of the telephone book. Make the phone number a three-digit number that is easy to remember.”

Durham Region
Family Member

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Emergency rooms will only be used in cases of emergency. Most individuals will be triaged by the Regional Call and Information Resource and directed to the Team(s) in their local area. The Self-Help Supports will also be linked to the Teams and be able to refer consumer/survivors. The Teams will be, in essence, the points of primary access to the mental health system.

All individuals with a severe mental illness requiring mental health services will be affiliated with a local Team if they so wish. Access to Specialized/Tertiary Care beds will be through Intensive-Level Services, that is, either through the Schedule 1 facility or the Teams.

All services will have **open and transparent admission processes with written admission criteria.** This will allow providers to refer consumer/survivors to the most appropriate level-of-care.

An **appeal process** will be in place if individuals are denied access to services. This appeal process will be either through the ombudsperson’s function or the Corporation in the case where two providers are repeatedly disagreeing on the application of admission inclusion/exclusion criteria (e.g., if a local Team is repeatedly unable to access Schedule 1 Services or vice-versa).

.....

“ We accept that the motivation behind the information system is to provide useful information to service providers that will enhance the quality of services they provide and we agree that this is good. However, after many years of feeling oppressed by the mental health system, we find it difficult to take the leap of faith required. We do not trust all service providers. We are concerned about who will have access to the information system and what their purpose will be and we are aware that supposedly secure data files are regularly exposed to hackers.”

York Region
Consumer/Survivor

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“ The qualities required of the person answering the phone are helpful; patient; empathetic; good listener; respectful; warm; welcoming; able to problem-solve; creative; appropriately assertive; believe in the credibility of the caller; and, able to initiate crisis management.”

York Region
Consumer/Survivor

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Regional Information System

A Regional Information System holding client information that is to be shared between providers for the benefit of individuals with mental illness will be in place. Consumer/survivors will be asked to consent to allowing their information to be on the common database. This database will:

- decrease the number of assessments consumer/survivors need to complete. The assessment will be built from the first point of contact, while respecting consumer/survivor confidentiality;
- assist the emergency room and hospital staff to respond quickly in times of crisis; and,
- allow the Regional Call and Information Resource to redirect calls in a timely manner to the appropriate Team.

Five Services in the Service Delivery Model

The following section provides a brief overview of the functions of the five services/providers in the Service Delivery Model.

Regional Call and Information Resource

The Regional Call and Information Resource will offer **a regional number for any individual wishing information on mental health services**. It will be staffed by experienced mental health workers 24 hours a day, seven days a week. The Regional Call and Information Resource will provide information regarding mental health services and other required services (e.g., housing, employment, and recreational services). It will also be in the position to triage callers. Some consumer/survivors may need to be connected to their local Team.

Staff will be able to answer crisis calls. The Regional Call and Information Resource will be able to either dispatch 911, contact the Mobile Crisis Unit at the Teams, or direct consumer/survivors to the nearest Schedule 1 facility or General Hospital Emergency Room. Peer support workers will also be part of the Regional Call and Information Resource.

Integrated Community Mental Health Teams

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“ ACT: This function should be built into the integrated Teams as a high end of the services they provide. This would make for less fragmentation in the system, easier access, and better continuity of care for the clients. ”

Durham Region
Provider

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The most important guiding principle for the Task Force is keeping the consumer/survivor at the centre of the system. The Service Delivery Model is designed to keep the consumer/survivor at the centre of the system by ensuring easier access and service integration and co-ordination. Creating Integrated Community Mental Health Teams will ensure that consumer/survivors are surrounded by a multi-disciplinary team and will not have to go from one program to the next for their services (e.g., case management and housing support). The team approach will also ensure that providers will be supported in their work by the inter-disciplinary team members and therefore consumer/survivors will be better served.

There will be a minimum of forty Teams throughout the Region to serve clients currently receiving mental health services. The number of Teams may increase as resources are increased to provide services to consumer/survivors waiting for services. These Teams will provide the full range of core mental health services (Levels 1 to 3) including, but not limited to: crisis treatment and support, walk-in services, mobile outreach, counselling, case management and employment, housing and recreational supports.

Most consumer/survivors wishing and requiring mental health services will receive their services from a Team. The Teams will be composed of 10 to 12 staff from various disciplines and a peer support worker. The Teams will have a working relationship with a physician and/or psychiatrists. Most of the services will be delivered on an outreach basis and not be office-based. Each Team will have a local presence and a drop-in capacity.

The Teams will be flexible and adaptable to the changing level-of-need of consumer/ survivors. Teams will be in the position to support consumer/survivors who require Level 1 care and up to Level 3 care. During times of greater need, the Teams will refer consumer/survivors to the Schedule 1 facility or Specialized beds. Discharge planning will begin on admission and include the Team, hospital staff, consumer/survivor and primary care giver/family member.

Self-Help Supports

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“ Fund Self-Help Supports as a real service with salaries equal to other parts of the mental health system.”

York Region
Consumer/Survivor
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The Self-Help Supports are consumer/survivor and family initiatives. Among other services, the supports provide training for peer support, operate warm lines, disseminate information, educate/dialogue with consumer/survivors and family members and provide a drop-in function.

The Self-Help Supports will be connected to the Regional Call and Information Resource. This will allow individuals calling the Regional phone number to be connected to the Self-Help Supports, and for the Self-Help Supports to be able to access the housing and recreational database managed by the Regional Call and Information Resource in order to assist consumer/survivors and family members.

.....
“ There needs to be an alternate site for crisis management, rather than hospitals and jails.”

Northumberland County
Consumer/Survivor
.....

The Self-Help Supports will also be linked to the Teams so that consumer/survivors wishing to receive support from Self-Help Supports and mental health services from Teams can do so in a co-ordinated system. This relationship will also enable Self-Help Supports to access community crisis/safe/respite beds.

Schedule 1 Facilities

There will be seven Schedule 1 facilities, one per district. The Schedule 1 facilities will operate Schedule 1 beds, deliver outpatient services, as well as offer day treatment and day hospital services.

.....
“ There should be a specific waiting/triage area where people with mental health issues can access hospital services directly. Waiting in a crowded Emergency Department with no specific mental health triage is very stressful for some people. There needs to be nurturing staff for both the consumer/survivor and the family member.”

City of Kawartha Lakes
Family Member
.....

Schedule 1 facilities will be in a position to accept clients referred by the Teams and in turn discharge clients to the Teams. Schedule 1 facilities will also be linked to the Specialized Services, where they can either refer a client for admission at the Whitby Mental Health Centre or one of the new Residential Treatment facilities, or call on the Specialized Teams for consultation when there are difficulties in serving clients with complex needs. Schedule 1 facilities will also be linked through the Corporation to ensure some co-ordination and consistency in acute mental health services throughout the Region.

The Schedule 1 facilities will implement a 24-hour hospital crisis Team with psychiatric backup and emergency room backup, and develop crisis response in collaboration with community mental health providers. Schedule 1 facilities will also develop a minimum of four assessment/holding beds at each Schedule 1 facility in the Region. The assessment/holding beds will be made available for up to 72 hours and include a strong assessment component. These beds will be located in or near an Emergency Department or in or near a Psychiatric

Unit where observation can occur and where skilled personnel are nearby.


Specialized Services

There will be three types of Specialized Services: Specialized inpatient beds at Whitby Mental Health Centre, Residential Treatment facilities and Specialized Teams for consultation.

The **Residential Treatment facilities** will have onsite staff 24 hours a day, seven days a week. They will offer a strong rehabilitation component. They will be geared to consumer/survivors requiring Level 4 care (i.e., constant supervision). The purpose of the rehabilitation program will be to assist consumer/survivors make the transition to more independent community living.

Specialized Teams for consultation will be developed to assist providers of Intensive-Level Care (i.e., Schedule 1 facilities and Teams). These Specialized Teams will consist of specialists in sub-disciplines (e.g., concurrent disorders, dual-diagnosis, and seniors with mental illness (psychogeriatrics).

Specialized Services for the Scarborough Population

 The Scarborough Populations Subcommittee Report can be found in Section 3 of the Task Force binder.

A Subcommittee was created to address the cross-border issue for the Scarborough Population. The Toronto-Peel Task Force has been mandated to develop recommendations for all of Toronto, including Scarborough. Meanwhile, the Commission recommended that Whitby Mental Health Centre provide Specialized Services to half of the Scarborough population. Therefore, the members of the Toronto-Peel and Central East (Whitby) Task Forces formed a Subcommittee and developed recommendations regarding Specialized Services to be provided by Whitby Mental Health Centre to half of the Scarborough population.

The **Subcommittee recommendations** are as follows:

- The Toronto Regional Mental Health Board funding envelope will include that portion of the Whitby Mental Health Centre global budget that supports delivery of services to half of the Scarborough population as mandated by the Commission.
- Specialized Services at Whitby Mental Health Centre will continue to be available to Scarborough residents. A representative of the Whitby Mental Health Centre will sit on the Toronto-Peel Board's

East Quadrant Local Care Delivery Network, and will participate in the development of plans regarding the use of resources for and delivery of Specialized Services to Scarborough. The Toronto Regional Mental Health Board would review and fund this plan.

- The Toronto Regional Board will develop a funding/performance contract with the Whitby Mental Health Centre.
- A memorandum of understanding will exist between the Central East (Whitby) Mental Health Corporation and the Toronto Regional Mental Health Board to formalize the Health Services Restructuring Commission recommendations.
- The Central East (Whitby) Mental Health Corporation and the Toronto Regional Mental Health Board should consider the cross appointment of one member who is familiar with the Specialized Tertiary needs of the Scarborough population.

ADVANTAGES OF THE NEW SERVICE DELIVERY MODEL

In the current mental health system, there is a lack of co-ordination and linkages between various types of services. There are also some services that are missing in parts of the catchment area creating inequities in the Region. The new system addresses these major concerns as depicted in Diagram 6.2 and 6.3.

Diagram 6.2 - Current Service Delivery System

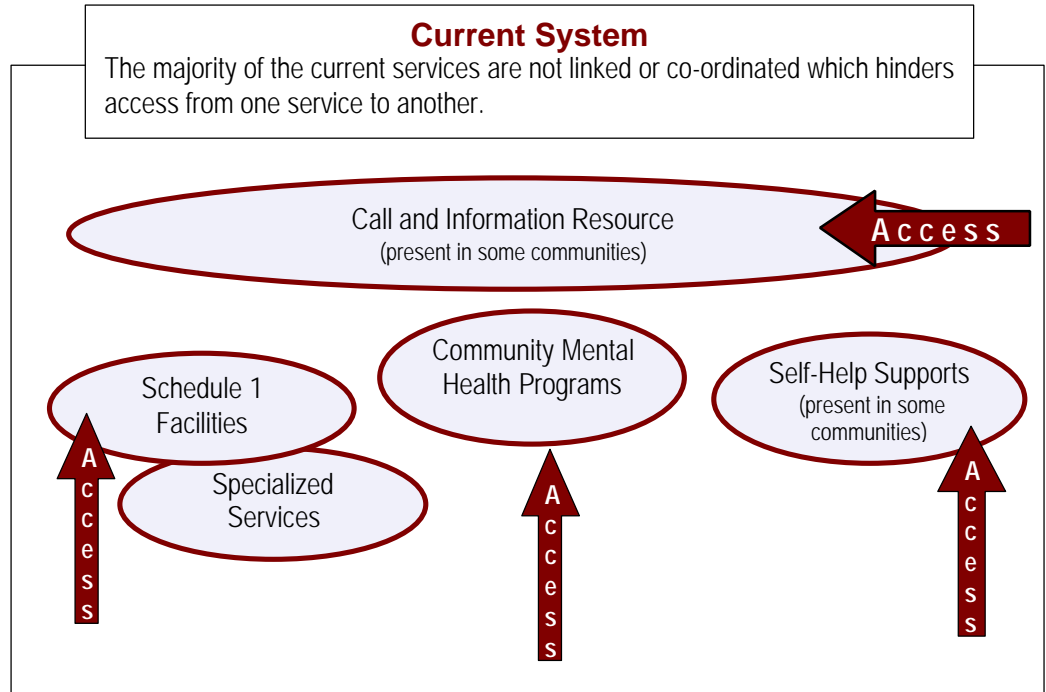
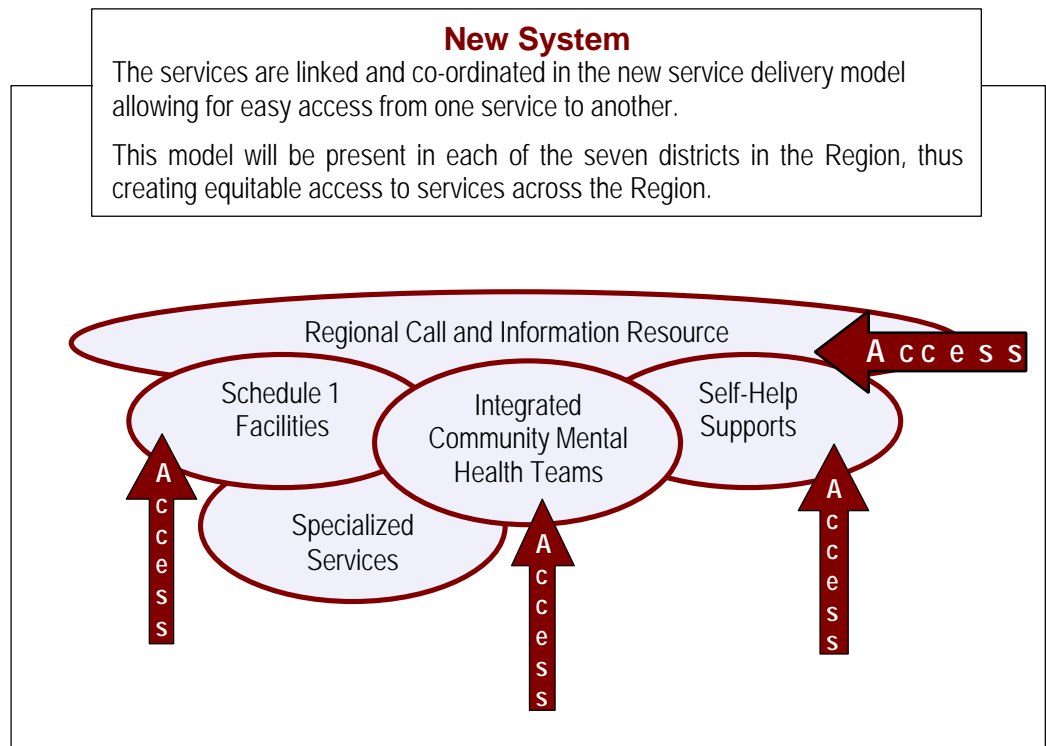


Diagram 6.3 - New Service Delivery System



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““ *The discharge planning process needs to be able to offer comprehensive planning by linking with the mental health system to which the consumer/survivor will be discharged. This may be different from the region where they are hospitalized depending upon where their family support system is located.*””

City of Kawartha Lakes
Family Member

.....

The new Service Delivery Model will improve services to consumer/survivors and their families by:

- improving service co-ordination, integration, delivery and quality;
- increasing the amount of consumer/survivor choice in services and supports that are available to them;
- bringing services and supports to people, so that travel is not a barrier to service;
- increasing the ease of access to mental health services;
- making access to services timely and seamless;
- broadening the admission criteria to Specialized inpatient hospital beds so that people can be admitted directly from the community without previous hospitalization;
- providing community-based alternatives to using hospital emergency rooms for mental health crises;
- increasing crisis response capability on a 24-hour basis;
- ensuring that the level-of-care fits the level-of-need; and,
- making the discharge planning process an essential element of the service system so that no one will be discharged from a hospital without the appropriate community-based supports in place.

Satisfaction with the Model

When the draft Service Delivery Model was taken to the community for evaluation, there was overall agreement with its intentions and spirit. There was also a great deal of discussion about the specifics of the model that will be invaluable in the next phase of implementation.

The aspects of the new Service Delivery Model that were most appreciated by the people who participated in the Phase II focus groups, are summarized in Table 6.4.

Table 6.4 - Perceived System Improvements

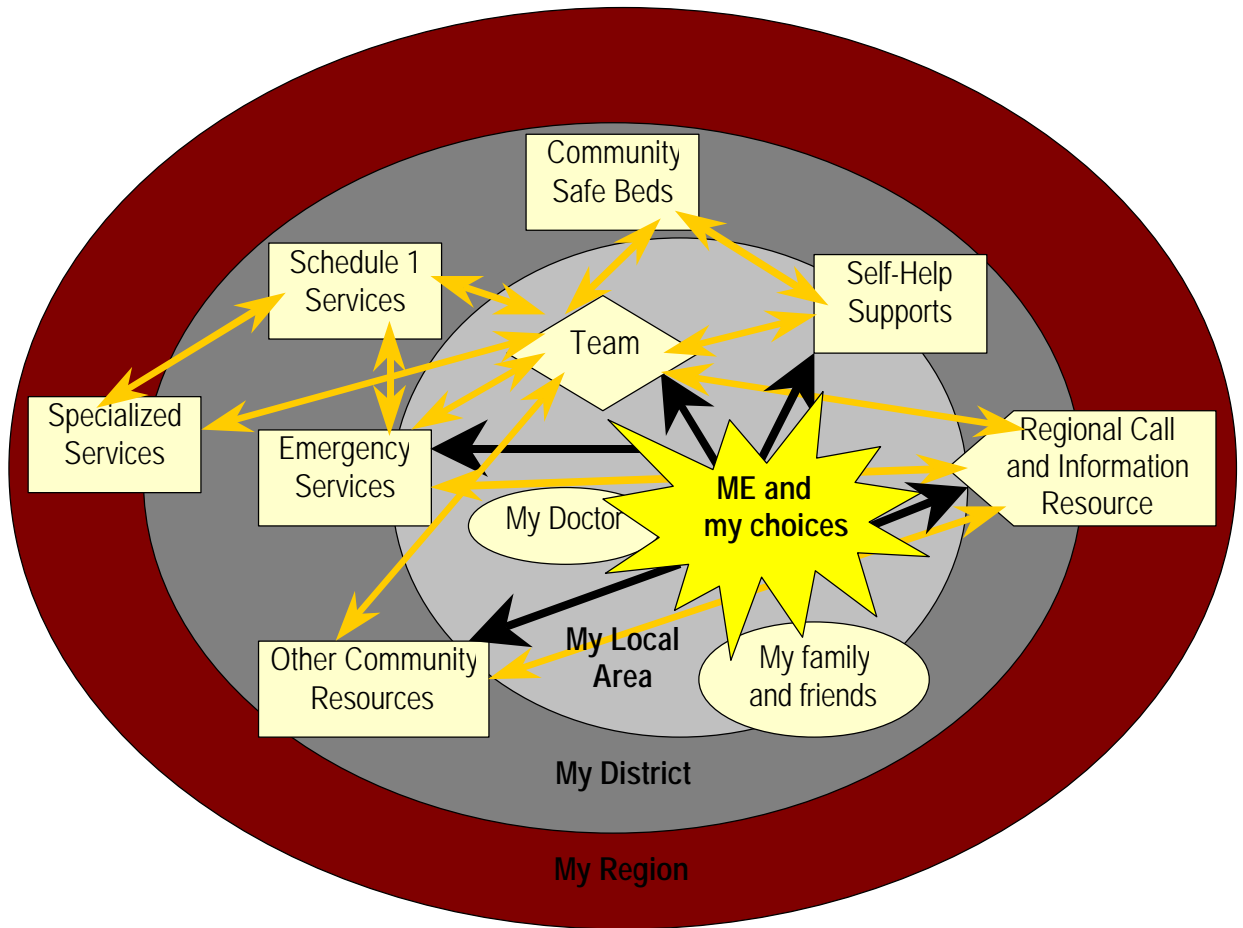
Focus Group Participants	Perceived Improvements
Consumer/Survivors	<ul style="list-style-type: none"> ■ simplified access ■ improved crisis intervention ■ walk-in access points ■ community-based and mobile services ■ safe beds in the community ■ discharge planning ■ employment and housing focus ■ increased emphasis on peer support ■ independent advocate
Family Members	<ul style="list-style-type: none"> ■ same as above, and ■ Public Awareness and Education Campaigns ■ increased range of treatment options closer to home ■ more family support through Self-Help Centres
Physicians	<ul style="list-style-type: none"> ■ community-based bed options ■ ability to admit to specialty services from the community ■ options to divert patients from hospital beds ■ supports to address non-medical paperwork
Front Line Providers	<ul style="list-style-type: none"> ■ more resources to provide a wider range of community support services ■ more community-based beds and locations ■ increased crisis support capability ■ Residential Treatment facilities for people with special needs
Diversity and Crisis Linkages	<ul style="list-style-type: none"> ■ increased access to crisis services ■ Integrated Community-Based Teams ■ maintenance of acute care beds in the system

Consumer/Survivor-Centred Model

The Service Delivery and Governance models described in the previous section were designed to keep the consumer/survivor at the centre of the system while maximizing consumer/survivor choice. Diagram 4 illustrates how individuals requiring services can choose the type of service they wish/need (black arrows) and how the services are linked and co-ordinated to allow consumer/survivors easier access to all services (yellow arrows). The idea is to adapt the services to the needs of consumer/survivors and not oblige consumer/survivors to adapt to the available services.

From the perspective of the consumer/survivor, navigating the system and accessing services will be much easier. The following diagram shows the consumer at the centre in the new system.

Diagram 6.5 - Consumer/Survivor-Centred Model



Leadership for Integration

The importance of integration in the mental health system was emphasized repeatedly in the focus groups. Although Phase II consultation was not intended to seek advice about the system leadership, it was stressed many times that the system as a whole needed strong leadership to:

- achieve true integration and effective communication between the parts of the system;
- obtain adequate funding and human resource levels and to use these resources in a way that would make the most efficient use of them;
- provide consistent access to high quality services throughout the Region; and,
- implement a common information system to increase the co-ordination and integration of services.

☞ The next chapter outlines the Governance Model for the Region that was based on goals and principles discussed in Making it Happen, and the planning assumptions discussed in Chapter 2.

CHAPTER 7

Governance Model


INTRODUCTION TO THE GOVERNANCE MODEL

.....

“ *In order for the model to work, there needs to be a strong administrative structure that can act effectively to resolve problems in the system.* ”

Durham Region
Physician

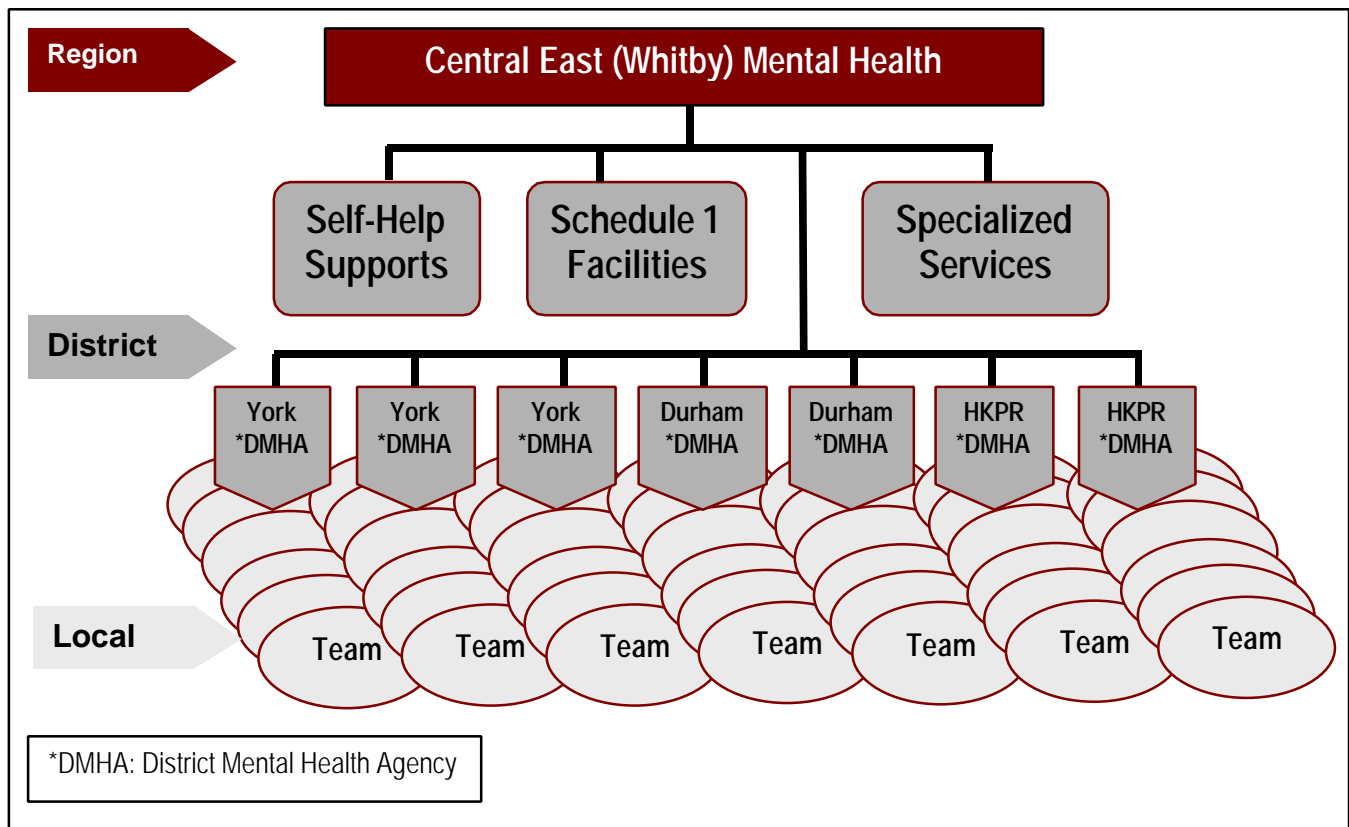
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The Task Force is recommending a new Governance Model to provide the operating infrastructure for Central East (Whitby)’s reformed mental health system.  Refer to additional background information in Appendix F – Mental Health System.

The Governance Model will consist of a new **Central East (Whitby) Mental Health Corporation** (the Corporation) that will govern, fund and manage all mental health services in the Region.

The Governance Model will **encompass the Whitby Mental Health Centre, Self-Help Supports, the seven Schedule 1 facilities and seven District Mental Health Agencies.** The Agencies will provide integrated community-based services in their defined districts in close collaboration with the other district mental health services. The relationship between the system components in the Governance Model is depicted in Diagram 7.1.

Diagram 7.1 – Governance Model



As an integral part of this model, it is imperative that the **Whitby Mental Health Centre be divested** from the Ministry of Health and Long-Term Care, and incorporated as its own entity, as was recommended by the Commission.

The creation of the Corporation will mean that the **responsibility of the Ministry of Health and Long-Term Care** in the system will be to act:

- at a policy level;
- to integrate mental health planning within the broader health and public sectors;
- as a system funder; and,
- to ensure accountability of the system.

It also means that there will be only one Board accountable for the MOHLTC mental health services, instead of the existing 22 in Central East (Whitby)²⁴.

ROLES AND RESPONSIBILITIES OF PROVIDERS/SERVICES

The following section describes the system providers/services in the Governance Model. As shown in Table 7.2, particular emphasis is placed on accountability, responsibility and governance.

Table 7.2 – Accountability and Governance of Mental Health System Providers in Central East (Whitby)

	Funding	Accountability	Governance
The Corporation	Funded by the Ministry of Health and Long-Term Care	Accountable for funding allocation and outcomes across all mental health to the MOHLTC	Independent board that represents the Region
District Agencies	Funded by the Corporation	Accountable to the Corporation for funding, outcomes, and compliance with standards	Governed by independent boards of directors representative of the Districts
Self-Help Supports	Funded by the Corporation	Accountable to the Corporation for funding, outcomes, and compliance with standards	Governed by independent boards of directors representative of catchment area.
Schedule 1 Facilities	Funded by the Corporation	Accountable to the Corporation for funding, outcomes, and compliance with standards	Governed by hospital boards
Whitby Mental Health Centre	Funded by the Corporation	Accountable to the Corporation for funding, outcomes, and compliance with standards	Governed by new hospital board
Other Specialized Services	Funded by the Corporation	Accountable to the Corporation for funding, outcomes, and compliance with standards	Governance dependent on where supports are located/sponsored
Integrated Community Mental Health Teams	Funded by the District Agencies	Accountable to the District Agencies for service provision in accordance with established policies and procedures	Governed by boards of the District Agencies, and managed by District Agency staff

²⁴ This number excludes boards and programs in Simcoe County, children's mental health programs, and consumer/survivor and family initiatives.

The Central East (Whitby) Mental Health Corporation

The Corporation will be governed by a 12 to 15 member Board. The Board will have representation from stakeholders throughout the catchment area. **The Transition Team, which is recommended in the Implementation Strategy²⁵,** will conduct a thorough and fair recruitment process to select the first Board members of the Corporation. The first Board of the Corporation will be approved by the Ministry of Health and Long-Term Care.

The Corporation Board will adopt the rules and guidelines of corporations, and therefore will:

- be a new legal entity;
- have directors who owe their primary duty to the Corporation;
- formalize internal and external relationships with policies and contractual agreements;
- protect its directors from personal liability with insurance; and,
- implement Board operations that reflect all legal, fiduciary and governance accountability requirements outlined in relevant provincial and federal legislation.

The Corporation will have a Consumer/Survivor Advisory Board chaired by a consumer/survivor.

The Corporation will govern:

- mental health services in Durham and York regions, Haliburton, Northumberland and Peterborough counties and the City of Kawartha Lakes; and,
- Specialized Services for half of the Scarborough population as directed by the Health Services Restructuring Commission.

²⁵ A description of the composition and function of the Transition Team is in Chapter 9 – Implementation Strategy.

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“ *Funding of service providers should be linked with real consumer/survivor involvement at the policy, management and program levels.* ”

York Region
Consumer/Survivor

.....

The Corporation will be accountable to, and receive an envelope of funding from the Ministry of Health and Long-Term Care. It will in turn manage the envelope within prescribed parameters and agreed upon components. **The envelope of funding will include dollars for:**

- existing community mental health;
- future mental health reinvestment;
- Whitby Mental Health Centre global budget (post-divestment);
- Homes for Special Care and Approved Homes;
- Schedule 1 facility mental health and “separate vote funding”²⁶ dollars;
- sessional fees for physicians; and ,
- some child and adolescent mental health services (i.e., acute child and adolescent mental health beds, a community mental health program in each District, extra resources to the Teams to serve transitional youth).

The Corporation will distribute funds to the Whitby Mental Health Centre, seven District Agencies, seven Schedule 1 facilities and other Specialized Services²⁷ on the basis of population size and growth, immigration, density and age. The Corporation’s funding envelope should include alternate payment mechanisms for the mental health specialty, to encourage physician participation²⁸.

The **responsibilities of the Corporation** are outlined in Table 7.3.

²⁶ Separate vote funding is transfer payment funding.

²⁷ Other Specialized Services are equivalent to future dollars designated to Tertiary/Specialized Services (e.g., new Residential Treatment facilities) that may or may not be managed by the Whitby Mental Health Centre.

²⁸ This would not be sought until all other dollars are flowing with ease through the Corporation.

Table 7.3 – Summary of the Responsibilities of the Central East (Whitby) Mental Health Corporation

Responsibilities	Example(s):
Working with the MOHLTC to develop mental health policies	<ul style="list-style-type: none"> ■ housing reform.
Setting priorities across the Region	<ul style="list-style-type: none"> ■ determining the top funding priorities.
Implementing MOHLTC's policy directions	<ul style="list-style-type: none"> ■ implementing the directions to best suit the local context.
Managing the mental health funding envelope by: <ul style="list-style-type: none"> ■ ensuring that funding is linked to outcomes; and, ■ conducting evaluations of outcome and adherence to the prescribed standards for District Agencies, Schedule 1 facilities, Self-Help Supports, Whitby Mental Health Centre, and other Specialized Services. 	<ul style="list-style-type: none"> ■ community mental health dollars to the seven District Agencies that will be accountable to the Corporation; ■ funds for inpatient mental health services and programs to 7 Schedule 1 facilities that will be accountable to the Corporation; ■ funds to Self-Help Supports that will be accountable to the Corporation; ■ funds to Homes for Special Care and Approved Homes that will be accountable to the Corporation; and, ■ funds to Whitby Mental Health Centre and other Specialized Services that will be accountable to the Corporation.
Supervising and co-ordinating service delivery	<ul style="list-style-type: none"> ■ Specialized Services such as Residential Treatment facilities; and, ■ The Regional Call and Information Centre.
Setting standards for all mental health providers (community, Schedule 1, and Specialized Services)	<ul style="list-style-type: none"> ■ intake and discharge criteria for all levels of mental health services; ■ quality of care; and , ■ amount of mental health services available.
Developing common tools	<ul style="list-style-type: none"> ■ intake; ■ triage assessment/access; ■ minimum data sets; and, ■ evaluation.
Providing infrastructure support	<ul style="list-style-type: none"> ■ information systems/technology; ■ database management (e.g., housing and employment) for the Region; and, ■ client electronic charting system.
Planning and co-ordinating	<ul style="list-style-type: none"> ■ public education/dialogue; ■ on-going staff development; and, ■ staff recruitment and retention.
Co-ordinating relationships	<ul style="list-style-type: none"> ■ MOHLTC; ■ other government ministries (e.g., Community, Family and Children's Services; Public Security and Safety; Human Resources Development Canada); and, ■ District Agencies, Specialized Services, Self-Help Supports, Regional Call and Information Resource, Schedule 1 facilities.
Resolving grievances	<ul style="list-style-type: none"> ■ developing and implementing a comprehensive grievance procedure, (e.g., ombudsperson/office).
Advocating on behalf of the Region	<ul style="list-style-type: none"> ■ specifically for consumer/survivors; family members and caregivers; and, providers of mental health services.

Seven District Mental Health Agencies

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“ For linkages between service providers to be effective, there needs to be trust between people working in the system. Providers need to know each other for the required linkages to actually work. The mental health system has to build partnerships with other points of entry in the community such as jails, churches and social services.”

Regional Intake Linkages

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Each District Agency will be governed by an independent Board. The Board membership will have a broad representation of stakeholders, including consumer/survivors and family members.

The creation of District Agencies will be the responsibility of the Corporation. The seven District Agencies can initially be created by:

- creating new agencies; or
- amalgamating existing community mental health agencies.

District Agencies will receive their funds from the Corporation, and they will be accountable to the Corporation. The District Agencies will be responsible for:

- co-ordinating and integrating the Service Delivery Model in their district;
- developing strong relationships with Self-Help Supports;
- developing “working agreements” with the Schedule 1 facility in their respective district;
- managing the local Teams; and,
- providing the core professional community-based mental health services that are funded by the MOHLTC through the Corporation.

District Agencies will be responsible for all aspects of service provision by the Teams including:

- determining the sitting, number and composition of teams;
- providing equipment, physical space and transportation; and
- planning, implementing and evaluating services.

Self-Help Supports

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“ Older children and teenagers need support and education to help them understand what is happening in their homes. Storefronts need to be child-friendly and they need to have a service to look after children while the parents access the services they need. Services have to focus on the whole family unit, not just the person who has been diagnosed.”

Haliburton County
Family Member

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The Self-Help Supports will be governed by independent board(s) of directors.

The Self-Help Supports will receive their funding directly from the Corporation. These Supports will be self-governed and managed on equal terms with the District Agencies. As with the District Agencies, the Self-Help Supports will be evaluated and their funding will be related to outcomes. These evaluations will be especially designed for Self-Help initiatives and not medically-based programs.

The Self-Help Supports will have a strong relationship with the District Agencies and the Regional Call and Information Resource. This could be achieved by seconding peer support workers from the Self-Help Supports to the Teams and the Regional Call and Information Resource.

The Self-Help Supports will be accountable to the Corporation for outcomes and compliance with standards and working agreements.

The Self-Help Supports will be responsible for:

- training for peer support;
- linking to other systems;
- providing mobile capacity for educational opportunities and groups;
- managing formal agreements to access crisis/safe beds staffed by the Teams;
- operating warm lines;
- disseminating information/education;
- co-ordinating community volunteer support; and,
- providing storefront access and drop-in centres.

Schedule 1 Facilities

Seven Schedule 1 facilities will receive mental health funding from the Corporation. **The Schedule 1 facilities will continue to be governed by** the existing hospital boards. The Schedule 1 boards will be accountable to the Corporation for only the mental health funds provided by the Corporation.

The Schedule 1 facilities will be responsible for managing Schedule 1 mental health services and developing working agreements with the District Agencies and local Teams in their respective districts.

The Schedule 1 facilities will negotiate service agreements with the Corporation for the delivery of mental health services and will be accountable to the Corporation for meeting the requirements of those service agreements.

Whitby Mental Health Centre

The Whitby Mental Health Centre must be divested and be governed by an independent board. The new Board has been selected and endorsed by MOHLTC. The Board “in-waiting” is representative of the various stakeholders (e.g., consumer/survivors, family members, and providers), and the different regions/counties in the Region.

The Whitby Mental Health Centre Board will be accountable to the Corporation for the funding it receives from the Corporation. The Whitby Mental Health Centre will also be responsible for delivering Specialized mental health services to all parts of the Region. Other Specialized mental health services (e.g., Residential Treatment facilities) may or may not be the responsibility of Whitby Mental Health Centre.

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“ Co-ordination and integration of existing services is the most important thing. There needs to be a real-time communication mechanism to show where there are available beds in the system. There also needs to be an ongoing forum for communication so that people in different parts of the system understand what the pressures are in other parts of the systems and to work toward problem resolution with the best interest of the patients as the focus for discussion and problem-solving.”

Durham Region
Physician

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RATIONALE FOR THE MODEL

A Regional Mental Health Service System

The creation of the Corporation is a similar approach to that which is being recommended by eight of the nine Task Forces in Ontario.

The Task Force has recommended the creation of the Corporation in response to challenges in the current system, namely to improve:

- service integration;
- system planning;
- accountability;
- consistency in service access and quality throughout the Region; and,
- ultimately to improve mental health outcomes.

Service Integration

According to Goering et al. 2001²⁹, two of the essential elements of an integrated mental health system in Ontario are: “a system manager is needed to serve as a single point of accountability for provision of care to a defined population. This manager should be arms length to decentralize decision making and facilitate local responsiveness and sense of ownership.” (p.42). “The system manager needs to have control over an envelope of funding. Minimally, this envelope needs to include community mental health funding, with other mechanisms available to the system manager (such as influence over approval of organizational operating plans) to gain influence over inpatient and other relevant resources” (p.42-43).

There should also be a provincial body to plan and co-ordinate the provincial mental health services with the regional bodies (e.g., the Corporation).

²⁹ Goering, Paula, Janet Durbin, Joy Rogers, Dianne MacFarlane and Pat Baranek, August 2001, *Strategies for Mental Health System Integration: A Review*.

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“ *The Implementation process needs to be continually evaluated to assess how well changes are working and to make adjustments where necessary.* ”

York Region
Physician

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Improved System Planning

District Health Councils provide planning advice to the Minister of Health and Long-Term Care on local health system planning. Their role does not include the allocation of resources. Once the Corporation is given responsibility for a funding envelope for mental health services, it will have the capacity to link mental health system planning directly to funding allocations.

Accountability

The Corporation, along with a Provincial Change Team, will be in the position to develop monitoring and evaluation tools for the entire mental health system.

The Corporation will offer a single point of accountability for consumer/survivors, family members and the MOHLTC.

Consistency in Service Access and Quality

There is currently a lack of consistency in the type and availability of mental health services throughout the Central East (Whitby) Region. This is demonstrated in particular, by the variation in the number of human resources per capita in each of the local planning areas. There is also considerable variation in the number and type of community-based mental health programs in each area. There is a lack of affordable (or any) transportation. This is a significant issue particularly when comparing rural to urban municipalities. An integrated mental health planning, management and funding system is the means by which service equity can be achieved throughout the Region.

Outcomes

In order to make this transition towards regionalization of mental health services a success, it is crucial to be realistic about the outcomes of such a process. The cost of delivering health care will not be reduced. Physician, allied health professional and overhead costs are still required. Salaries, rent and utilities, as well as the size and age of the population are increasing. Therefore, the success of regionalization cannot be measured with a reduction in the cost of delivering mental health services.

One cannot assume that regionalization of mental health services will place a greater emphasis on population health and wellness. This can only be achieved if it becomes a priority of the government and if

funds are set aside, above and beyond the delivery of essential health services for this purpose. For a time, the mental health budget would need to grow until the effect on the goals and initiatives of population health and wellness are felt by a decrease in the need for essential services. The Corporation and MOHLTC will set realistic goals to evaluate mental health reforms.

A Corporate Model

The Task Force reviewed a number of governance models. **The Task Force is recommending the Corporate Model as the Governance Model for Central East (Whitby) for a number of important reasons.**

First, the Corporate Model best accommodates regional and district structures. It offers the most protection for Board members and allows more control over risks.

Secondly, the Corporation is a new legal entity. Given that some of the players in the system may change (e.g., the creation of new District Mental Health Agencies), and that many will have formal relationships for the first time, the Corporation places everyone on a level playing field. That is, one group is not more liable than another (as in a contractual arrangement governing structure).

Third, Corporate directors owe their primary duty to the Corporation. This is not the case for all governing models. For example, in a contractual arrangement, representatives may owe their primary duty to their “home” company/organization.

Fourth, the Ministry of Health and Long-Term Care will only be required to deal with one entity, the Corporation, and accountability will rest with that one body.

A Golden Opportunity

By regionalizing mental health services through the creation of a Corporation in Central East (Whitby), the Ontario Government has a golden opportunity to improve system planning, service integration and consistency, accountability, and ultimately the mental health outcomes of the people in this Region.

CHAPTER 8

Recommendations

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“ Don't change what's
working now.”

City of Kawartha Lakes
Consumer/Survivor

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The Service Delivery Model and the Governance Model were described in Chapters 6 and 7. **This chapter presents the Task Force's key recommendations and sixteen supporting recommendations** for the reformed mental health system in Central East (Whitby).

The following key principles guided the development of the Task Force's recommendations:


- the goals and principles of *Making It Happen*;
- best practices;
- local autonomy in service delivery and utilization across the seven district and local areas; and,
- service functions will build on, and not duplicate existing services (e.g., existing databases and call centres, such as 211 information lines and Telehealth).

KEY RECOMMENDATION

The Central East (Whitby) Mental Health Implementation Task Force recommends that the Ministry of Health and Long-Term Care endorse and mandate the new:

- Implementation and Transition Strategy (☞ see Chapter 9);
- Integrated Service Delivery Model (☞ see Chapter 6) and,
- Governance Model (☞ see Chapter 7).

CORNERSTONE ACTIONS

Prior to reviewing these sixteen supporting recommendations it is imperative to note that there are essential “cornerstone actions” that need to take place in order for the “key recommendation” of the Task Force to be implemented.  *These “cornerstone actions” are discussed in greater detail in Chapter 9 - Implementation Strategy.*

To ensure success, the Task Force recommends that the Ministry of Health and Long-Term Care:

- appoint an Assistant Deputy Minister to lead the implementation of Task Force recommendations in the MOHLTC in collaboration with the Provincial Change Team;
- establish the Transition Team;
- develop a fair and equitable provincial funding³⁰ formula for mental health;
- allocate new mental health funds to disadvantaged areas until an equitable provincial funding formula is developed and implemented;
- inject funds to stabilize human resources;
- delineate the funding envelope for Central East for Mental Health Services, including; Community Mental Health Programs, Schedule 1 facilities, Provincial Psychiatric Hospitals and new dollars; and,
- divest Whitby Mental Health Centre.

The Task Force also recommends that the Transition Team and the Ministry of Health and Long-Term Care:

- promote the integration of current services within the Region; and,
- establish the Central East (Whitby) Mental Health Corporation and in turn establish the District Mental Health Agencies.

³⁰ A fair and equitable provincial funding formula is required to distribute funds equitably across the province-based on need. This formula should take into account such factors as: ageing population, density, socio-economic status, level-of-need, current available resources, and diversity of population.

Sixteen supporting recommendations were formulated by the Subcommittees that represented the range of stakeholders throughout the Region. The Design Team and the Implementation Subcommittee then refined the supporting recommendations for consistency, maximum clarity and cost-effectiveness. They appear in the following charts grouped according to the *Guidelines for the Mental Health Implementation Task Force Final Reports* (i.e., Sections A to E, and sub-sections identified by roman numerals). **The Implementation Strategy of these sixteen supporting recommendations is discussed in the next chapter, Chapter 9.**

SUPPORTING RECOMMENDATIONS

A - Comprehensive Continuum of Services and Supports (Levels-of-Need)

The reformed mental health system should provide a comprehensive and holistic continuum of care. Best Practices have identified a number of key services/supports required by individuals with serious mental illness. Three required “levels-of-need” have been identified, these “focus on the range of client needs which then determine the types of services required” (*Making It Happen*, 1999, 15).

SUPPORTING RECOMMENDATION #1

The Regional Call and Information Resource, Integrated Community Mental Health Teams, and Schedule 1 facilities will deliver First-Line Services.

FIRST - LINE SERVICES

“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*, 1999, 15)

Ensure that there is a Regional Call and Information Resource that provides 24/7 information and referral, crisis response and triage by enhancing and building upon existing call-in services in the Region to reach the goal of a 24/7 regional toll-free number staffed by mental health professionals.

Develop Teams that provide the full range of core community mental health services (Levels 1 to 3) including, but not limited to: treatment and support, walk-in services, and Mobile Crisis Services.

The Teams will:

- provide a range of mental health services from First-Line to Specialized needs;
- have a working relationship with physicians and psychiatrists; and
- have a local presence and drop-in capacity.

The Teams will increase:

- the number of Intensive case managers dedicated to sub-populations; workers will “follow” clients and maintain liaison throughout the system and across sectors; and,
- the capacity of Mobile Crisis Services including police, in response to situations where an arrest can be diverted.

A - Comprehensive Continuum of Services and Supports (Levels-of-Need)

SUPPORTING RECOMMENDATION #2

The Integrated Community Mental Health Teams and Schedule 1 facilities will deliver Intensive Services.

FIRST-LINE SERVICES (continued)

Develop a minimum of ten community crisis/safe/respice bed capacity in each district, provided through a range of options.

Implement 24-hour Hospital Crisis Teams with psychiatric backup and emergency room backup. Each Schedule 1 facility will develop crisis response in collaboration with community mental health providers.

Develop a minimum of four assessment/holding beds at each Schedule 1 facility in the Region. Make available assessment/holding beds for up to 72 hours and include a strong assessment component. Locate assessment/holding beds in or near an Emergency Department or in or near a Psychiatric Unit where observation can occur.

Create a co-ordinated 24/7 crisis response capacity that integrates the Regional Call and Information Resource, Integrated Community Mental Health Team mobile crisis, community crisis/safe/respice beds, 24-hour Hospital Crisis Team, and the hospital assessment and holding beds.

INTENSIVE SERVICES

“Intensive 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.” (*Making It Happen*, 1999, 15)

Develop Schedule 1 beds by:

- designating all General Hospitals with mental health beds as Schedule 1 facilities, as directed by the Health Services Restructuring Commission;
- implementing all Health Services Restructuring Commission recommended inpatient mental health beds by the target year 2003. Ministry of Health and Long-Term Care to support any reasonable ideas to operationalize the beds temporarily until hospital redevelopments are complete; and,
- reviewing and implementing Health Services Restructuring Commission recommendations for the ratio of inpatient beds in the Region with appropriate adjustments for the latest Statistics Canada population figures.

Implement a discharge planning process that begins on admission, reflects both clinical considerations and individual choice, is outcome focused, and attempts to discharge the client to the best possible situation.

Vary application of length of stay benchmarks according to given conditions. Consumer/ Survivor, his/her personal supports, and key community-based support providers, and Schedule 1 or Whitby Mental Health Centre staff should take part in determining the length of stay.

Implement a follow-up plan after discharge if consumer/survivors are not discharged to a Team (participation in a Team will be a consumer/survivor choice).

A - Comprehensive Continuum of Services and Supports (Levels-of-Need)

SUPPORTING RECOMMENDATION #3

Assertive community treatment will be incorporated into the Integrated Community Mental Health Teams. Specialized Services will include Specialized Regional Tertiary Inpatient Services, Residential Treatment facilities, and Specialized Consultation Teams with mobile outreach.

SPECIALIZED SERVICES

“Specialized 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.” (*Making It Happen*, 1999, 16).

Create Specialized Mobile Outreach Teams³¹ for specific sub-populations³² to act as a resource in early detection and assessment and to provide backup to Intensive-Level services (including Intensive case management services, hospitals, long-term care facilities, developmental services).

Streamline the use of tertiary hospital inpatient stays for assessment and stabilization (various lengths of stay for different sub-populations) but these stays would be kept as short as clinically helpful and would include carefully planned transitions back to Intensive-level community supports.

Develop Residential Treatment facilities as an alternative to longer stays in hospital.

Increase the number of Assertive Community Treatment resources (Level 3) within each district so that the Teams have the resources to provide Levels 1 to 3 of care.

Plan Specialized Services for specific sub-populations at the regional level. The Corporation will establish central vision/benchmarks and standards for specific sub-populations throughout the Region building on provincial policy and direction and will assess the need for additional services.

31 Specialized Mobile Outreach Teams are comprised of highly trained staff with particular expertise in relation to specific sub-populations; the Teams provide consultation to Intensive-Level services in highly complex cases; and, also provide training and support to staff in hospitals and in communities.

32 Sub-populations include adolescents, seniors, dual diagnosis, concurrent disorder, eating disorders, neuropsychiatry and forensic.

A - Comprehensive Continuum of Services and Supports (Levels-of-Need)

SUPPORTING RECOMMENDATION #4

The Corporation will increase employment opportunities and benefits for individuals with mental illness, who are able and willing to work. The Integrated Community Mental Health Teams will provide employment support.

EMPLOYMENT SUPPORTS

“Programs aimed at placing individuals more quickly into actual jobs and providing flexible levels of support for longer periods of time are the most promising new developments in the field.” (Goering et al., (1997) *Best Practices*, p.95)

Implement program elements in *Making It Work*.

The Corporation will:

- Develop incentives for employers to facilitate the hiring of consumer/survivors.
- Develop linkages and affiliations with mental health service providers, business associations, government agencies and departments, economic development authorities, Human Resources Development Canada, unions, colleges and universities, adult education, service clubs and media.
- Develop strategic and operational linkages with educational institutions and facilitate training.
- House an inventory of employment opportunities.
- Develop standards, evaluation, planning, co-ordination, employer relations, communication, and public education.
- Implement a placement function that includes staffing by consumer/survivors and includes flexible staffing plans that will support employer needs therefore protecting jobs.

Incorporate benefit management strategies into any program or system development that would include extended health benefits for consumer/survivors.

Incorporate employment expertise in each Team.

Develop employment strategies that are accessible to people receiving assistance from the Ontario Disability Support Program.

A - Comprehensive Continuum of Services and Supports (Levels-of-Need)

SUPPORTING RECOMMENDATION #5

The Corporation will co-ordinate and enhance the development of housing stock. The Integrated Community Mental Health Teams will provide housing support. A Mental Health Housing Advisory Committee will ensure that all housing stock is co-ordinated.

SUPPORTING RECOMMENDATION #6

The Self-Help Support will develop consumer/survivor and family initiatives and participate in a regional and provincial mentoring program to link these initiatives.

HOUSING AND RELATED SUPPORTS

Home is a place you feel you belong and where your basic needs are met. It is stable, decent, and affordable and it maintains a healthy environment. Consumer/survivors are accepted by the community and are part of the community in which they live.

The Corporation will:

- Assess the need on a regular basis.
- Develop a full range of appropriate housing options to meet diverse needs of residents (e.g., subsidized housing, supported housing, residential or supportive housing and emergency housing/shelter support) facilitate the development of co-operatives and enhance existing Alternative Community Living housing options.
- Co-ordinate vacancy management by maintaining a current regional inventory of housing stock, including accommodation standards (affordability, cleanliness, safety, access, acceptance of the landlord).

Maintain a continuum of housing supports, from high support to independent living with a focus on suitable one bedroom supported apartments in mainstream neighbourhoods (e.g., near transportation, with full-bathrooms and storage).

Develop a Mental Health Housing Advisory Committee that includes a broad representation of stakeholders to ensure that all housing stock is co-ordinated (e.g., Regional Municipalities and Housing Authorities).

CONSUMER/SURVIVOR AND FAMILY INITIATIVES/SUPPORTS

“Self-Help is an attempt by people with a problem to take control over the circumstances of their lives. [...] Self-Help is founded upon the principle that people who share a disability have something to offer each other which cannot be provided by professionals. Self-Help groups have been recognized for the enormous benefits they provide to members, their families and society.” (Goering et al., (1997) *Best Practices*, p.73)

Self-Help Supports will:

- Develop mutual peer support programs and family support programs to help prevent relapse and provide ongoing support.
- Generate and support consumer business initiatives.
- Offer transportation and accompaniment to address transportation barriers.

Develop a mentoring capacity provincially that would allow consumer/survivor and family initiatives to network regionally and provincially to share skills and ideas.

B – Streamlined Access

“The points of entry into the mental health system play a vital role in ensuring prompt access to the services that will best meet the needs of clients and their families/key supports.” (*Best Practices*, 1999, p.18)

SUPPORTING RECOMMENDATION #7

The Regional Call and Information Resource will streamline access to mental health services by implementing a common intake and discharge process, and clarifying access to mental health services.

Ensure the services of a single toll free regional telephone number (function is defined under Supporting Recommendation 1).

Implement a common intake and discharge process between providers.

- Co-ordinate the intake and discharge to Schedule 1 and Specialized Needs through the Teams.
- The Corporation should work with the other Regions in Ontario, the Teams, Schedule 1 facilities, Regional Call and Information Resource, and Specialized Services to develop a common assessment tool that will be implemented on a provincial basis (e.g., RAI, PRS Toll-kit).

Implement a Regional Information System (e.g., Regional Call and Information Resource) to hold client information to be shared between providers for the benefit of individuals with mental illness. Ask consumer/survivors to consent to allowing their information to be on the common database. Build the assessment from the first point-of-contact, which often involves the General Hospital Emergency Department and/or police, or the Regional Call and Information Resource, while respecting confidentiality.

- **Provide funding and support to ensure that all mental health providers have hardware and software that will ensure timely access to the proposed database management system and internet access.** Build into annual budget funds for the maintenance and regular upgrade of computer hardware and software and to provide ongoing computer training.
- **Create a common patient data repository** using the *Electronic Child Health Network* (ECHN) data repository model and the *Smart Systems for Health* infrastructure.
- **Connect all mental health providers** (i.e., Schedule 1 facilities, physician offices, Teams, Self-Help Supports and Specialized Services) to one another through *Smart Systems for Health*.

Develop access to a “seamless” mental health service system with flexible entry and exit points.

- Access to the Teams can be through the Regional Call and Information Resource, Schedule 1 facilities, Self-Help Supports, and a number of other services, including self-referral.
- All individuals in the mental health system will be affiliated with a local Team, if it is their wish.
- All services will have clearly written admission processes and inclusion/exclusion criteria that are open and transparent.
- Access to Specialized Services will be through Intensive-Level Services (e.g., Schedule 1 and Integrated Community Mental Health Teams).
- An appeal process (if denied access to services) will be made available to all individuals.

C – Shared Service Models

"Many consumers of mental health services have multiple problems that cross a variety of service jurisdictions. Examples include individuals with the following kinds of problems: substance abuse, developmental disabilities, legal issues, long-term care needs, and age-related issues i.e., children and elderly." (Goering, et al., (1997) *Best Practices*, p.20)

SUPPORTING RECOMMENDATION #8

The Corporation will embrace, develop and implement the Shared Care Model across Central East (Whitby).

Shared Care Model and Best Practices

Provide additional mental health training to primary care nurse practitioners and extended class nurses and hire these professionals throughout Central East (Whitby).

Provide funding (e.g., for sessional fees and co-ordination) to establish the Shared Care Model throughout Central East (Whitby). Here a psychiatrist works directly with family physicians and/or senior mental health workers in primary care settings.

Extend funding to psychologists and other mental health professionals to cover psychotherapy.

D – System Management / Service Delivery Responsibility and Accountability

"Measures of success will include wellness and quality of life indicators, not just symptom reduction. Linking funding to system and program performance is a critical element of system change." (*Making It Happen*, 1997, 25)

SUPPORTING RECOMMENDATION #9

The Corporation will develop a Regional Data Management System to manage, evaluate, and be accountable for the mental health services.

The Corporation will be responsible for:

Establishing a data management system that is accessible to all providers with live updates, by creating a web-based service for providers which offers a comprehensive content repository of mental health and behavioural care information and provides information on making mental health care more efficient.

Developing standards and an approach to evaluation in order to improve accountability for outcomes.

E - Any Other Areas Addressed by the Task Force

SUPPORTING RECOMMENDATION #10

The Corporation will ensure an independent ombudsperson function so that advocacy functions are distinct from any direct service function.

GRIEVANCES

Develop a grievance process for consumer/survivors and other stakeholders. The ombudsperson or grievance advocacy office should be independent from the Corporation (e.g., Psychiatric Patient Advocacy Office (PPAO)).

SUPPORTING RECOMMENDATION #11

The Corporation will increase social and recreational opportunities. The Self-Help Support and the Integrated Community Mental Health Teams will provide social recreational supports.

SOCIAL/ RECREATIONAL SUPPORTS AND SERVICES

Social and recreational opportunities are those things that a person chooses to do in order to make their leisure time more interesting and satisfying. They include sport, cultural, physical, artistic, creative, cultural, social and intellectual activities that are essential to a person's psychological, social and physical well being. (Adapted from the *Benefits Catalogue*, 1997 – Canadian Parks and Recreation Association).

Develop local and regional services that promote integration into general community supports and services and new services designed for consumer/survivors. Plan supports and services that are accessible in terms of financial obligations and transportation, and accessible to individuals from a broad range of cultural and linguistic backgrounds and that reflects diverse needs.

Incorporate social/recreational expertise into Teams.

The Regional Call and Information Resource will develop a regional clearinghouse of information about social/ recreational services with local information about the availability of social and recreational services.

SUPPORTING RECOMMENDATION #12

The Corporation will develop a human resources plan to address the recruitment, retention and education of staff.

SUPPORTING RECOMMENDATION #13

The Corporation will facilitate the co-ordination and integration of mental health services across service levels, specialties and ministries.

HUMAN RESOURCES

Inject funds immediately into mental health budgets to eliminate salary discrepancies between the community, Provincial Psychiatric Hospitals, and General Hospital sectors to stabilize the workforce.

The Ministry of Health and Long-Term Care undertake:

- a provincial analysis of billing data for mental health visits to physicians (including psychiatrists) and other mental health professionals to determine the use of mental health resources to improve planning.
- a human resources analysis, similar to the *Comprehensive Assessment Project*, to measure the existing resources, the specialties, credentials, and educational needs of existing staff.

The Ministry of Health and Long-Term Care to standardize job expectations and salary ranges. This would assist in planning, recruitment and training, and stabilize the workforce. Flexibility should be built into the team composition in rural areas.

Develop linkages with area universities and colleges to ensure that the curricula are designed to teach applicable and required skills. The required credentials for the Integrated Community Treatment Teams need to be determined and university and college courses developed to fill these credentials. Furthermore, that work with high school guidance counsellors and career teachers is undertaken to recruit new college and university students in the field of mental health.

Apply Best Practice strategies for recruitment and retention of mental health workers in Central East (Whitby).

Develop the Implementation Strategy for the new Service Delivery and Governance models bearing in mind the current human resources challenges, and demographic trends. For example, the ageing population will require additional psychogeriatricians, and as the workforce is approaching retirement additional recruitment strategies will be required to replace retiring workers.

Enhance televideo and teleconferencing capacity for psychiatric consultation throughout the Region, especially in rural areas.

INTEGRATION

There are a number of cross-ministry and cross-sector issues when addressing the needs of people with a serious mental illness and multiple, complex needs. There are also some existing provincial level and district level standing committees working on behalf of various Specialized sub-populations.

Ensure linkages between Self-Help Supports, Teams, generic community recreational services, employment initiatives, provincial and inter-ministry initiatives.

SUPPORTING RECOMMENDATION #14

The Corporation will develop a broad-based ongoing public education/dialogue strategy.

SUPPORTING RECOMMENDATION #15

The Corporation will ensure that the child and adolescent mental health services it funds are accessible and integrated with the broader children's mental health service system funded by the Ministry of Community, Family and Children's Services and by other stakeholder ministries.

Ensure systemic needs and advocacy issues are identified and policy influenced to address social environmental determinants of health that are central to the consumer/survivor's quality of life (e.g., adequate income and housing).

PUBLIC EDUCATION/DIALOGUE

One of the first tasks of the Transition Team should be the development of a broad-based public education/dialogue strategy to coincide with the provincial public education/dialogue strategy.

CHILDREN'S MENTAL HEALTH SERVICES

General Recommendation:

- **Provide adequate funding to support mental health prevention, assessment, and support for children and adolescents in publicly funded schools.**

Child and Adolescent Mental Health Services

- **Allocate new funds to underfunded areas in the Province**, including Central East (Whitby). Currently, both the MOHLTC and MCFCS funding for Child and Adolescent Services is significantly below the provincial average.
- **Distribute new funds to all programs on a regular basis to keep up with population growth and inflation.** The combination of population growth, inflation, no budget increases in 20 years, and in some cases budget reductions, has meant a decrease in services. The decrease in services has not meant a decrease in staff, but also the hiring of less qualified staff. This is problematic when we compare the trend of increased complexity of mental health diagnosis and symptoms. Prevention is also cut when budgets are funded below the need.

Family Supports

- **Fund family support programs to care for parents and their children's mental health.** Parents may not be able to access services if they do not have a serious mental illness. This may affect the mental health of the children at home; hence, the need for family support services.
- **Establish a continuum of appropriate, flexible and accessible family supports that recognize the interdependence of parent and child mental health.** Services should be available for, among other groups, the child who has a parent who does not meet the criteria to receive mental health services in the adult system and the child with a parent with a severe mental illness.

Governance Recommendations

Include the MOHLTC funding for child and adolescent mental health beds and children's community mental health in the Corporation's envelope of funding. **The Corporation will be responsible for planning children's mental health services it funds in partnership with MCFCS and other ministries and stakeholders.**

Management Recommendations

- **Manage child and adolescent acute mental health beds through sponsoring Schedule 1 facilities.** The Schedule 1 facility will be accountable to the Corporation for the funding provided by the Corporation.
- **Consider Whitby Mental Health Centre's adolescent mental health program a specialized provincial resource to be co-ordinated by the Corporation and managed by Whitby Mental Health Centre Board.** The Whitby Mental Health Centre will be accountable to the Corporation for the funding they provide.
- **Manage child and adolescent community mental health services currently funded by MOHLTC and sponsored by hospitals, through the District Mental Health Agencies.** The District Mental Health Agencies will be responsible for managing both adult, and child and adolescent community mental health services.

Service Delivery Recommendations

- **Ensure there is at least one comprehensive child and adolescent mental health program funded by the Corporation in each of the seven Districts in Central East (Whitby).**
- **Ensure that in each district, the Teams provide mental health services to transitional youth (15 to 24 years of age).** Where there is sufficient demand, Teams dedicated to transitional youth should be implemented to assist youth to make the transition from a system that assumes total dependence to one that assumes total independence. Each Team will have some skills to serve transitional youth. The Teams will also have a higher staff to client ratio when they are serving transitional youth.

SUPPORTING RECOMMENDATION #16

Whitby Mental Health Centre will work with the Toronto Mental Health Board and the Central East (Whitby) Mental Health Corporation to provide Tertiary Care Services to half of the Scarborough population.

SCARBOROUGH POPULATION - SPECIALIZED SERVICES

The Toronto Regional Mental Health Board funding envelope will include that portion of the Whitby Mental Health Centre global budget that supports delivery of the Health Services Restructuring Commission-directed Specialized Services to half of the Scarborough population.

Specialized Services at Whitby Mental Health Centre will continue to be available to Scarborough residents. A representative of the Whitby Mental Health Centre will sit on the Toronto-Peel's East Quadrant local care delivery network, and will participate in the development of plans regarding the use of resources for and delivery of Specialized Services to Scarborough. The Toronto Regional Mental Health Board will review and fund this plan.

The Toronto Regional Board will develop a funding/performance contract with the Whitby Mental Health.

A memorandum of understanding will exist between the Central East (Whitby) Mental Health Corporation and the Toronto Regional Mental Health Board to formalize the Health Services Restructuring Commission recommendations.

The Central East (Whitby) Mental Health Corporation and the Toronto Regional Mental Health Board should consider the **cross appointment** of one member who is familiar with the Specialized Tertiary needs of the Scarborough population.

CHAPTER 9

Implementation Strategy

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“ Communities need to become involved so that there is an increase in the numbers of safe and appropriate community settings.”

Northumberland County
Consumer/Survivor

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A great deal of momentum has been gathered within the mental health community through the work of the Task Force. Stakeholders throughout the Region have invested a great deal of time and energy in the process and are ready for change. At the same time, many are sceptical that any meaningful change will actually take place. It is imperative to counteract this scepticism and sustain the momentum by immediately:

- implementing the cornerstone actions outlined below; and,
- creating a mandated Transition Team in Central East (Whitby).

CORNERSTONE ACTIONS

As noted in Chapter 8, the Task Force has essential “cornerstone actions” that need to take place to successfully implement the Task Force recommendations.

The Task Force asks that the Ministry of Health and Long-Term Care immediately move to:

- **Appoint an Assistant Deputy Minister to lead the implementation of Task Force recommendations in the MOHLTC in collaboration with a Provincial Change Team.**
 - The Task Force believes that the appointment of an Assistant Deputy Minister of mental health will ensure that it is a government priority and that the recommendations of the Task Forces are implemented in a timely manner. The Task Force recommendations need to be implemented without delay.
- **Establish the Transition Team³³.**
 - The Task Force believes that the momentum for mental health reform created by the Mental Health Implementation Task Force must continue. A Transition Team would have this responsibility along with other tasks identified later in this chapter.

³³ The composition and mandate of the Transition Team is described later in this chapter.

Divestment of the Whitby Mental Health Centre

Opportunities Gained by Divestment:

- university affiliation, (e.g., no teaching hospital in Central East funding for new and innovative programs);
- fundraising for research and innovation through establishment of a Whitby Mental Health Centre Foundation;
- leadership in mental health reform through Mental Health Implementation Task Force and regional governance; and,
- 'state of the art' facility and cutting edge organization.

Divestment of the Whitby Mental Health Centre

Chronology:

In July 1998, the Health Services Restructuring Commission (the Commission) advises divestment of the Whitby Mental Health Centre. In May 1999, the Commission's advice was accepted by the MOHLTC. In March 2001, the Whitby Governance Steering Committee was formed and a Board recruitment approval was requested in May 2001. The Board recruitment approval was granted October 2001. In December 2001, the Board nominees were forwarded to the MOHLTC. In March 2002, the OPSEU strike took place for 55 days. In June 2002, the divestment was postponed again.

- **Stabilize the workforce by equalizing mental health salaries between General Hospitals, Provincial Psychiatric Hospitals and community mental health sectors to start mental health reform.**
- **Develop a fair and equitable provincial funding formula for mental health.**
 - Central East (Whitby) and at least two other regions in Ontario are severely under funded for mental health services. All regions must reach benchmarks prior to reinvestment in regions that are below. Equitable distribution of resources needs to occur to ensure that Ontario residents have equal access to the same quality services regardless of where they reside.
 - A provincial funding formula should provide stable funding over a multi-year timeframe. A minimum three-year timeframe is suggested.
- **Delineate the funding envelope for Central East (Whitby) for Mental Health Services, including; community mental health programs, Schedule 1 facility mental health dollars, and the Provincial Psychiatric Hospital global budget (post divestment dollars and new community reinvestment).**
 - The Task Force believes that mental health dollars need to be protected and that the envelope of funding should be managed by the Corporation.
 - The funding envelope should be provided on a global funding basis to the Corporation. This will allow regional and local priorities to be addressed and maximize efficiencies across the system. For this reason, it is important to identify the resources available for mental health services.
- **Divest Whitby Mental Health Centre.**
 - In May 1999, the MOHLTC accepted the Commission's recommendation to divest the Whitby Mental Health Centre. In June 2002, the divestment was postponed despite a 55-day strike in spring 2002. Delays in divestment are impacting mental health planning, human resources, and more importantly, services to a vulnerable population. For example, some programs have remained closed following the departure of clinical staff during the strike in spring of 2002.

Divestment of the Whitby Mental Health Centre

“Meanwhile, in Toronto”.... In March 1997, the Health Services Restructuring Commission advised the amalgamation of the Clarke Institute of Psychiatry, the Donwood Institute, the Queen Street Mental Health Centre and the Addiction Research Foundation. In the spring of 1997, the Commission advice was accepted by the MOHLTC. A Joint Merger Steering Committee was formed in April 1997, and the governance model was developed in July 1997. In March 1998, the Centre for Addiction and Mental Health was incorporated.

Divestment of the Whitby Mental Health Centre

Implications of the Delay in Divestment:


- salary discrepancies versus public hospitals;
- recruitment/retention problems – morale/credibility;
- missed opportunities for new funding initiatives;
- impaired ability to participate in regional strategic planning / the Mental Health Implementation Task Force; and,
- vulnerable clients subjected to a 2-month strike.

The Task Force also recommends that the **Transition Team** and the Ministry of Health and Long-Term Care:


- **Promote the streamlining of services within the Central East Region.**
 - The Task Force believes that prior to implementing the Teams the existing community mental health providers should be encouraged to deliver their services using a team approach as opposed to the existing program approach.
- **Establish the Central East (Whitby) Mental Health Corporation.**
 - The Task Force believes that establishing the Central East (Whitby) Mental Health Corporation to allocate the mental health dollars and co-ordinate mental health services in Central East (Whitby) will ensure the implementation of the Service Delivery Model as proposed.

The Task Force also recommends that the Corporation:

- **Establish the District Mental Health Agencies.**
 - The Task Force believes that the Service Delivery Model will be best implemented, integrated and co-ordinated with the creation of a District Mental Health Agency in each of the seven Districts.

The Implementation Strategy Table that was requested in the *Task Force Guidelines*, outlines best practices, action leads, participants, enablers/risks and expected outcomes has been completed for the sixteen supporting recommendations.  *The Implementation Strategy Table is included in Appendix G.*

The Task Force has developed an Implementation Timeline for the major recommendations. Following this timeline will ensure that the mental health system is reformed by the end of 2006, however, ongoing work will always be required. The appointment of a Transition Team immediately following the devolution of the Task Force will ensure that the Implementation Strategy is a success.

 *Refer to Appendix H– Implementation Strategy Timeline.*

TRANSITION TEAM

The Task Force believes that in order for mental health reform to take place, a Transition Team is required to continue the work of the Task Force. The Task Force strongly recommends the implementation of a Transition Team in January 2003. The Transition Team should not be advisory. It must have a mandate from the Minister of Health and Long-Term Care to move forward with the implementation of the Task Force recommendations. It is recommended that the Transition Team mandate extend to six months following the appointment of the Central East (Whitby) Mental Health Corporation. The Task Force believes there should be a Transition Team in each Task Force area of responsibility.

A Provincial Change Team to co-ordinate the implementation of provincial level recommendations should also be created. The Provincial Change Team should be comprised of the Chairs of the Transition Teams throughout the province.

The Transition Team should have a Chair and will require staff and resources to complete the mandate.

The Task Force believes that to maintain the corporate memory of the Task Force, there should be some continuity in the membership. The Transition Team will be comprised of up to 12 members selected by the current Task Force Chair with input from the Ministry of Health and Long-Term Care. A majority of the Transition Team members should be current Task Force members to maintain the corporate memory.

The mandate of the Transition Team is crucial. While reviewing the most cost effective and efficient ways of implementing the Task Force recommendations and while maximizing existing resources to implement the recommendations, the Transition Team will:

- **start to establish the infrastructure for the new mental health system**
 - ensure that the funding envelope is brought closer to the Region. The envelope will contain: existing community mental health dollars; mental health dollars in Schedule 1 facilities; the Provincial Psychiatric Global Budget; and, new community reinvestment;
 - work with the Ministry of Health and Long-Term Care to maintain the Task Force momentum and implement Task Force recommendations;

- co-ordinate and assist the Ministry of Health and Long-Term Care with implementing the recommendations for which they have been designated the action lead;
- offer resources and expertise in “change management” to community groups;
- implement an independent ombudsperson or ombudsperson office;
- promote integration of existing mental health services in the Region;
- implement the data management system;
- establish the Central East (Whitby) Mental Health Corporation (the Corporation); and,
- conduct a thorough and detailed selection of the Central East (Whitby) Mental Health Corporation Board and submit these names to the Ministry of Health and Long-Term Care for approval and appointment.

■ **start to establish new mental health services³⁴**

- increase social and recreational opportunities by expanding and increasing access to existing recreational services;
- enhance Self-Help Supports;
- develop the Regional Call and Information Resource;
- implement Crisis Teams for Emergency Rooms;
- implement holding beds in Schedule 1 facilities;
- create a co-ordinated crisis response capacity that operates 24 hours a day, seven days a week;
- increase employment opportunities for consumer/survivors; and,
- co-ordinate and enhance housing stock, housing supports and create a Mental Health Housing Advisory Committee.

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“ Education needs to start in high schools so that people can recognize their own and other’s symptoms so that they can get early interventions. ”

Peterborough County
Consumer/Survivor

.....

■ **develop and implement public education/dialogue strategy**

- work closely with consumer/survivors, family members and the community to develop and implement a broad-based ongoing public education/dialogue strategy at all levels of the mental health system.

³⁴ This list of services is not in order of priority.

Funding Assumptions and Cost Estimates

Equal access to comparable mental health services across the province is a key principle in *Making It Happen*. This concept is also featured in the *Themes* document of the Provincial Forum, where a funding formula which considers age, density, growth and other factors, is being strongly recommended. The implementation of the new Service Delivery and Governance models will require significant reinvestment in mental health services in the Region.

However, it is estimated that if the Region's funding was brought up to the provincial average, the recommendations in this report would be adequately funded. Currently, mental health services are not distributed equally across the province. Significant reinvestment will be required in some of the Regions that are seriously under funded. For example, Central East (Whitby) only receives half of the provincial average of per capita dollars for community mental health and mental health program services.

Implementing Mental Health Reform

As work progresses to implement the local Service Delivery Model it will be important for the Transition Team and later the Corporation to:

- involve local stakeholders in establishing implementation priorities and local variations on the model through the formation of Local Planning and Implementation Teams. These Teams should be created with a bias toward action and incentives for timely decision-making;
- maintain and use the linkages established through the Phase II consultation process. Many good people with great ideas participated and will be the key to the success of the local reformed mental health system; and,
- make use of the specific information collected in the Phase II consultation process.

Successful implementation of the Service Delivery Model throughout Central East(Whitby) will require flexibility in its application. Furthermore, the local Service Delivery Model should be holistic, adaptable and have incentives for best practices and innovation.

CHAPTER 10

Seizing the Opportunity and Moving Forward

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“ People need to feel that they are safe where they are receiving care, and have peace of mind, spirit and body. ”

Richmond Hill
Diversity Planners

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The Central East (Whitby) Task Force, challenged by a short timeframe, has worked diligently to fulfil its mandate and design a reformed mental health system for the Region. Countless volunteer hours have been devoted to developing the Task Force recommendations. Guided by the principles and goals in *Making It Happen*, integrated **Service Delivery and Governance models have been designed that will put the consumer at the centre of the system.** These models will provide easy access to services and supports that will improve the quality of life for people with mental illness and the families who support them.

The Task Force focused on the Service Delivery Model. The Model was tested on focus groups of consumers, family members, providers, physicians, crisis workers and diverse populations with positive results. **The communities that make up Central East (Whitby) support the need for mental health reform.**

It is imperative that the MOHLTC continue to support the work of the Task Force and maintain the momentum created by the Task Force process. The Task Force has provided MOHLTC with a great opportunity to help reform the mental health system in Central East (Whitby) and it may be a long time before the opportunity arises again.

It is time for the MOHLTC to seize the opportunity and negate any scepticism of the government’s willingness to implement the recommendations and move forward with mental health reform.

Funding Priorities

There is no shortage of important issues to address throughout the mental health service system. These criteria have been developed to assist in the identification of more specific funding priorities. Specifically:

- gaps in existing services need to be filled;
- initial funding should support visible and meaningful initiatives to signal that real change is happening and will continue to happen;

- initiatives chosen for first round funding need to be implemented quickly, so that gains are evident as soon as possible; and
- local stakeholders should be involved as much as possible in planning to meet their local community's needs.

Implementation Priorities

This chapter outlines the implementation priorities and some quick wins for the MOHLTC to consider.

First and foremost, it cannot be overstated that the momentum engendered by the Task Force needs to continue and that some of the recommendations need to be implemented early in 2003/04. The Task Force has worked diligently to bring busy people to the table to make a commitment to our work and to participate in this important process.

Stakeholders have been kept at the table by promoting the belief that mental health reform, which will benefit consumer/survivors, family members and service providers, is indeed achievable.

Second, the Task Force recommends the appointment of a time-limited Transition Team following completion of the Task Force mandate at the end of the year, to continue the work started by the Task Force. This Team should be mandated and funded by the MOHLTC and should have the full support of the ministry. It is also recommended that there be some continuity between membership on the Task Force and the Transition Team.

Quick Wins

The community needs to see change in the mental health system early in 2003/04, as a result of the work of the Task Force. Some of the “Quick Win” recommendations that do not require legislative changes, the creation of new Boards, or the amalgamation of existing agencies, include:

Ministry of Health and Long-Term Care will:

- **appoint an Assistant Deputy Minister for mental health** to lead the implementation of Task Force recommendations in the Ministry of Health and Long-Term Care in collaboration with a Provincial Change Team;
- **establish a Transition Team for Central East (Whitby);** and,

- **provide funds to stabilize the workforce.**

The Transition Team will:

- create a centralized regional function to:
 - cultivate employment opportunities;
 - develop strategic and operational linkages with educational institutions, facilitate training;
 - house an inventory of employment opportunities; and,
 - develop a broad-based ongoing public education/dialogue strategy.
- enhance existing consumer/survivor and family member initiatives; and,
- maintain a current regional inventory of housing stock, including accommodation standards (affordability, cleanliness, safety and access).

The Transition Team and the Ministry of Health and Long-Term Care will:

- increase the technological capabilities of agencies and the regional group by:
 - providing capital to purchase equipment (i.e., hardware and software); and,
 - providing funds to train staff as required.
- develop the Assertive Community Treatment (Level 3) capabilities within each district so that the Teams will have the resources to provide Levels 1 to 3 services.

The Provincial Change Team and the Transition Team will:

- develop a common intake and discharge tool.

MOVING FORWARD, MOVING ON

The Central East (Whitby) Mental Health Task Force completed its mandate on December 31, 2002. Its leadership work as a community change agent was completed successfully with the involvement of hundreds of people from throughout the Central East (Whitby) Region.

The Task Force has repeatedly stressed the need to continue an uninterrupted change process and to begin implementing its recommendations as soon as possible.

The results of not proceeding quickly are that:

- thousands of people with serious mental illnesses will continue to be deprived of the quality and level-of-care they need because the services they need and the number of people they need to help and support them are, quite simply, not there; and,
- the crisis in human resources will worsen as compensation disparities and overwork continue to erode staff morale.

Despite the best efforts of those who work in the system, it is not working. The Task Force has confidence that the mental health system in Central East (Whitby) will become a world-class model with the timely implementation of Task Force recommendations. **Most important is that the people who need help from the system will receive it, so that they can *seize the opportunity* to recover.**

The Task Force was established to develop a detailed implementation plan based on *Making it Happen*. The work of the Task Force has involved a broad-range of stakeholders from all parts of the Region, and a number of public consultations have occurred. There is an expectation that the reforms recommended by the Task Force will produce tangible changes in the way mental health services are delivered – and also an expectation that the Minister and the Government will indeed ***seize the opportunity to make mental health reform happen in Central East (Whitby).***