COMMUNITY CAPACITY REFRESH:

A Progress Report on the Implementation of the South West LHIN's 2011 Community Capacity Report for Mental Health and Addiction Services

Final Report

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

Key Findings

- ✓ Implementing recommendations from the 2011 "*Time is Now*" report has represented a major investment of time and energy for affected health service providers (HSPs) and these significant change management efforts are praiseworthy because they are in addition to the HSP's full-time job of treating and supporting clients.
- ✓ The South West LHIN has made significant funding investments over the last 2 years to strengthen community-based mental health and addiction services ($7.8 million representing 90 new community-based staffing positions).
- ✓ These investments are not yet having the desired system impacts in terms of reducing hospital ER visits or wait times for certain services but are certainly having a significant impact with positive outcomes for individual clients that are benefiting from new or more coordinated services.
- ✓ No new system-wide service/staffing enhancements are recommended at this time but there are service pressure points in certain areas for certain services that should be considered by the LHIN as part of the 2014-15 MSAA and recommended service enhancements from the 2011 report that have not yet been implemented are still considered valid.
- ✓ For the next 24 months, there are a number of key areas for system improvement (Supportive Housing, Coordinated Access, Peer Support, Crisis Response, Primary Care), all of which will require facilitated processes. The LHIN should provide resources to support these planning and integration processes.
- ✓ Locally developed Supportive Housing strategies should be considered the top priority for all Mental Health & Addiction (MH&A) Networks and implementation of locally developed Coordinated Access models a top priority for the three MH&A Networks in the LHIN's south planning area (Oxford, Elgin, London-Middlesex).
- ✓ A comprehensive quality and performance framework for the mental health and addiction service system in the South West is recommended based on the following performance domains:
    - Client outcomes and experiences
    - Population health
    - Resource allocation
    - System integration

Recommendations

SUPPORTIVE HOUSING
THAT the South West LHIN, the South West Addiction and Mental Health (A&MH) Coalition and the five geographic Mental Health & Addiction (MH&A) Networks adopt a 'Housing First' philosophy to support individuals with mental health and substance abuse problems who are homeless or in inappropriate or unstable housing situations; THAT the South West LHIN support a facilitated process to work proactively with MH&A service providers, municipal social housing managers and the Ministries of Health and Municipal Affairs and Housing on regional and provincial strategies in support of 'Housing First'; THAT each MH&A Network expand its membership to include municipal social housing managers; THAT each MH&A Network work with their respective upper tier municipalities with a goal of developing a collaborative local plan for increasing the supply of housing with supports consistent with municipal Housing and Homelessness Plans; THAT the South West LHIN, RMHC (St. Joseph's) and the 5 MH&A Networks, work with the Ministry of Health and Long Term Care to better integrate Homes for Special Care (HSC) units with other supportive housing providers to ensure consistency with best practice supportive housing.
COORDINATED ACCESS
THAT the three MH&A Networks in Oxford, Elgin and London-Middlesex make the design and implementation of a local Coordinated Access (CA) model a top priority in 2014/15 with a designated lead agency for these initiatives; THAT the South West LHIN provider support for local CA processes including research, design, planning and implementation; THAT an expanded CA model in Oxford build on the successful components of the Oxford Addiction Treatment Strategy (OATS) and an expanded CA model in London-Middlesex build on the successful components of the CA approach shared by the London hospitals; THAT the Grey Bruce and Huron Perth Networks continue to review and refine their existing CA models based on emerging best practices and the results of recent external evaluations of their respective partnership/alliance models;

THAT Coordinated Access Models that have been and will continue to be developed by the five geographic MH&A Networks include:

- Single access phone number available in both official languages
- Screening and assessment tools that have been reviewed to ensure cultural appropriateness
- For Aboriginal clients, referrals options that include both mainstream services, as well as Traditional Healers and Aboriginal services

PEER SUPPORT

THAT The South West LHIN identify a Health Service Provider (HSP) to lead a Peer Support project in 2014/15 with a goal of strengthening peer support integration and infrastructure across the South West by looking at two key issues:

- A best practice model for a regional structure to drive practice standardization & training and the adoption of a full range of peer supports embedded in the continuum of mental health and addiction services; and

- A best practice model for local consumer support initiatives (CSIs) to augment the local service delivery system, maximize resources for direct peer supports and reduce the administrative requirements for existing CSIs;

THAT a thorough review of integration and partnership models be conducted as part of this project as well as national and international best practice peer support initiatives;

THAT the lead HSP work with South West Alliance Network (SWAN) and the South West A&MH Coalition to ensure all key stakeholders (both providers and individuals with lived experience) are fully engaged and regularly consulted over the course of this project.

CRISIS RESPONSE

THAT the South West LHIN review the capacity, function and utilization of all community-based crisis response services to determine if further standardization is required in terms of staffing, hours of service, service delivery model and outcomes;

THAT the South West LHIN provide ongoing support to the implementation of previous recommendations to improve crisis response services in the City of London (i.e. short term crisis beds and the development of a London Crisis Centre);

THAT the South West LHIN continue to work on improving urgent access to Schedule 1 psychiatric assessments through the work of the LHIN Lead for Emergency Departments.

PRIMARY CARE

THAT each MH&A Network create stronger working relationships with local primary care services through expanded Network membership and/or working groups to look at how the two sectors can more effectively collaborate;

THAT each MH&A Network in collaboration with local primary care services prepare an inventory of available mental health supports and services in the primary care system and assess what collaborative care models would be most effective, especially for non-SMI clients;

THAT the South West Primary Care Network in collaboration with the South West A&MH Coalition examine options for strengthening mental health and addiction service capacity in existing primary care structures;

THAT the South West LHIN, the South West Primary Care Network and the South West A&MH Health Coalition review the Collaborative Care Plan template that has been developed for Health Links to ensure that it will meet the needs of high-needs, complex care clients with mental health and/or substance abuse problems.

FRANCOPHONE

THAT the South West LHIN's French Language Coordinator, work with Identified HSPs to map existing French Language Service (FLS) capacity in the MH&A system in terms of gaps and opportunities;

THAT the program advisory committee structure being developed for Addiction Services of Thames Valley's new telemedicine system navigation service be evaluated for its potential to evolve into a regular forum of service providers, with French Language capacity, to provide ongoing input to the development of enhanced and integrated Francophone services for MH&A clients;

THAT all proposal submissions to the South West LHIN from Identified or Designated HSPs for new or expanded funding include an FLS component as per the French Language Services Toolkit;

THAT all MH&A service providers receive cultural/linguistic competency training including the importance of 'Active Offer' of French Language Services[1].

[1] See Section 2 of FLS Toolkit and "Practical Guide for the Active Offer of French Language Services in the Ontario Government", Office of Francophone Affairs (April 2008)

ABORIGINAL

THAT the South West LHIN support the ongoing re-design of Aboriginal health services across the Southwest based on a service delivery model that is holistic, client-centred and integrated using the principles of Experience-Based Co-Design and respectful Aboriginal/ First Nations participation;

THAT this re-design work be guided by the Aboriginal Health Committee with support from the LHIN's Aboriginal Health Lead and include a 'current state' baseline analysis of: service gaps, client experiences, current and emerging aboriginal community needs, the types of MH&A services that have and have not been funded from other levels of government, and linkages with non-Health funded services (e.g. MCYS Aboriginal MHA case managers);

THAT Aboriginal cultural competency training for South West LHIN health service providers be an MSAA requirement;

THAT the South West LHIN support capacity building for Aboriginal MH&A services through more formal linkages and partnerships with mainstream service providers that include:

- Better access to clinical supports and expertise for Aboriginal clients
- Support for Aboriginal /First Nations staff training (e.g. providing team-based care across the life cycle)

QUALITY AND PERFORMANCE FRAMEWORK

THAT the Ontario Perception of Care (OPOC) tool be adopted by the South West LHIN, the South West A&MH Health Coalition and the five geographic MH&A Networks as the preferred methodology for assessing the experience of clients with mental health and addiction issues; AND FURTHER THAT the South West LHIN, through the South West A&MH Coalition, work with Dr. Brian Rush and CAMH colleagues on an implementation strategy for standardized use of the OPOC tool among all mental health and addiction agencies;

THAT future performance measurement of MH&A services include client feedback on staff sensitivity to cultural/linguistic needs (as per OPOC tool above);

THAT South West A&MH Coalition work with the South West LHIN on implementing the necessary tools to support the development of a quality and performance scorecard for mental health and addiction services consistent with the Triple Aim framework and the LHIN's quality improvement enabling framework;

THAT the refinement and implementation of a performance scorecard for mental health and addiction services be the joint responsibility of the South West LHIN and the MH&A Networks in terms of collecting and tracking the required information.

SERVICE ENHANCEMENTS

THAT the following recommended service enhancements made in 2011 are still appropriate based on refreshed data analysis and stakeholder input:

- Additional ACT team for London-Middlesex (or other multi-disciplinary team model based on evaluation of the new Grey Bruce service);
- More supportive housing in all geographic areas (see Supportive Housing recommendations);

THAT there are service system components that would benefit from South West LHIN review of capacity, function and further standardization prior to additional service investments (e.g. crisis services, mental health counselling, residential addiction services). A review could include review of funding levels, performance targets, service delivery models and outcomes.

THAT if additional resources to support future service investments become available, the following should be considered as priority areas for new staffing/service enhancements:

- Quantifiable service pressure points for specific agencies based on lower per capita staffing levels and higher service wait times (e.g. case management services in Oxford, counseling services in rural Middlesex);
- For aboriginal clients, addictions treatment (incl. abuse of opiates), access and system navigation support and expanded traditional healing services;
- For MH&A clients involved in the justice system, better discharge, coordinated care and housing support plans for individuals released from correctional facilities who require ongoing community supports;
- Improved access for rural residents given the lack of rural transportation options;

THAT all MH&A service providers continue to pay attention to ensuring equitable access to service for rural residents including specialist outreach through telemedicine and access locations in more rural locations.

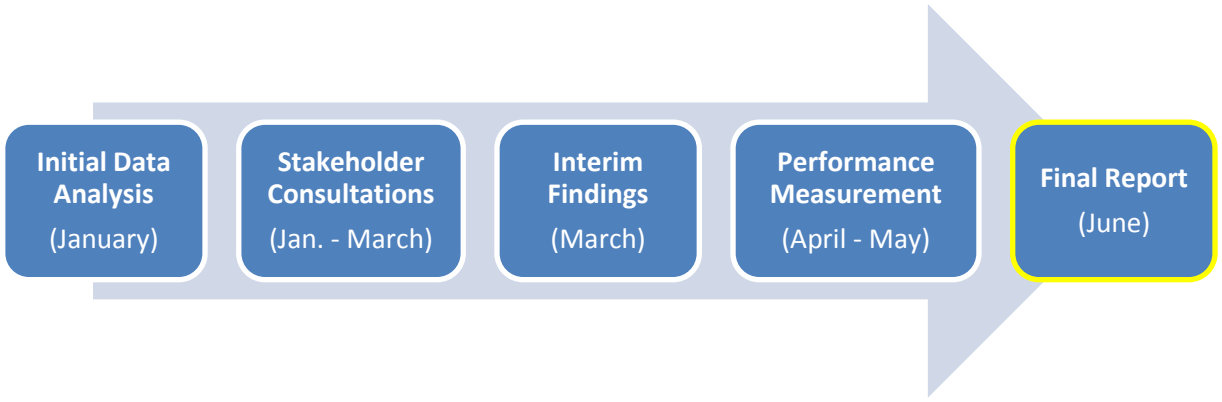
SECTION 1 - INTRODUCTION

In December 2011, the Board of the South West LHIN accepted ***"The Time is Now"*** report – a framework for action to strengthen community-based mental health and addiction services in the South West LHIN area. The 2011 report was prepared by Whaley & Company on behalf of the South West Addiction and Mental Health Coalition; the LHIN's regional planning table representing the 5 geographic mental health & addiction networks and other groups and organizations with a regional mandate[2].

The South West Addiction and Mental Health Coalition, with the support of the South West LHIN, recently re-engaged Whaley & Company to review implementation progress from the original report. More specifically, the terms of the reference for this 'refresh' project are:

- Phase 1: Determine system level outcomes achieved to-date based on 2011 recommendations;
- Phase 2: Update key data points from 2011 report;
- Phase 3: Engage stakeholders in dialogue about progress, success stories and current service pressures;
- Phase 4: Develop system level indicators and criteria to monitor performance and track transformation.

Project timelines are below:



An interim report was submitted March 31, 2014. This final report has been prepared based on the feedback to the interim report as well as further data analysis and stakeholder consultations.

[2] including Regional Mental Health Care (St. Joseph's Health Care, London), Centre for Addiction and Mental Health and the South Western Alliance Network (SWAN) which represents all mental health consumer/survivor initiatives.

SECTION 2 – WHAT'S CHANGED

2.1 Status of 2011 Recommendations

When the *"Time is Now"* report came forward for review and acceptance by the South West LHIN Board in December 2011, staff prepared a detailed briefing note about the report's 49 recommendations with a suggested implementation timetable (see Appendix A). A Community Capacity Coordinator was hired by the LHIN to support report implementation in 2012.

Two years later, there has been significant implementation progress on many of the report's recommendations in terms of integration, service enhancements and Tier 2 divestments (see Appendices B1, B2, C and D). The highlights from these implementation milestones as well as new investments in mental health and addiction services are described below.

<u>Tier 2 Recommendations</u>

The ongoing implementation of Tier 2 by Regional Mental Health Care is consistent with the original 2011 recommendations. Implementation milestones include:

- Tier 2 divestment has reduced/transferred 208 beds and related ambulatory services over 4 years; RMHC has worked very hard through a Tier 2 Partners Committee to negotiate with each of the 4 receiving hospitals and have successfully implemented the following:
    - Transfer of 50 beds and related ambulatory services transferred to Grand River Hospital (Kitchener) in 2010
    - Transfer of 59 beds and related ambulatory services to Windsor Regional Hospital in November 2011
    - Transfer of 14 beds and related ambulatory services transferred to St. Joseph's Health Care (Hamilton) in March 2013

- The business case and request for St Thomas Elgin General Hospital (STEGH) Schedule 1 designation was put forward at the end of August 2013.
- Due to unanticipated construction delays at STEGH, the Tier 2 transfer of 15 beds and related ambulatory services originally scheduled for May 2013 was delayed and opened in January 2014. During this time period, a contingency plan was put in place to ensure service continuity for Elgin clients.
- The completed transfer to STEGH completes the fourth and final transfer of planned beds and related ambulatory services from St. Joseph's Health Care, London to 4 partner hospitals.
- Each transfer has involved the transfer of staff, in-patients and out-patients who chose to transfer as well as financial resources. Formal processes have been completed with each transfer for staff and patients and transfer agreements have been signed between the receiving hospitals.

- Long stay patients[3] continue to be successfully placed in community settings through a community-based care planning process that over time will result in the permanent closure of 70 beds when complete.
- To-date, 85 former long-stay patients have been transferred and are living successfully in the community with appropriate housing and supports. Currently there are 35 long stay patients left – 12 have received special funding to facilitate discharge and 7 are under review for placement in long term care facilities.
- Final phase of bed reductions and placement of long-stay patient in the community is underway; closure of 27 beds to be completed by end of June 2014 will reduce bed numbers from 183 to 156.
- The new regional longer-term mental health care 156-bed facility is scheduled to open later this year on the Parkwood hospital site of St. Joseph's Health Care, London.

The Tier 2 Divestment process led by Regional Mental Health Care (St. Joseph's) has been unfolding over a number of years. More recent investments include:

- October 2013: $425,400 in annual base funding (prorated for $159,635 for fiscal 2013/14) and $4,500 one-time funding to support mental health capacity enhancements to provide safe and secure placement of 3 clients with needs specific to dual diagnosis (developmental delay and mental illness) care from Regional Mental Health Care (St. Joseph's) will serve as paymaster to direct funding to three non-LHIN funded agencies: Community Living London, South East Grey Support Services and Community Living Elgin.

- October 2011: $1,347,498 annual base funding (prorated to $693,720 for fiscal 2011/12) to support mental health capacity enhancements for CMHA Elgin, WOTCH and Crest Support Services to provide safe and secure placement of 17 clients from Regional Mental Health Care (St. Joseph's).

- Vocational Services transitioned to community through partnership with CMHA Elgin and Goodwill Industries
    - Phase 1 (May 2013): Closure of the Alternatives to Competitive Employment (ACE) Program in St. Thomas-Elgin; CMHA Elgin, Goodwill and Habitat for Humanity have launched new Transitional Employment Program. Up to $300,000 in funding from unallocated Tier 2 base taken from this fund to support one-time start-up costs associated with this initiative
    - Phase 2 (Fall 2013): Closure of the Andrews Resource Centre (ARC) Program in London; CMHA Elgin flow through for Goodwill to expand program to London. $378,410 in one-time was provided by South West LHIN from Community Investments (not from Tier 2 reserves) to support start-up costs associated with this initiative.

[3] Patient length of stay greater than 365 days

Integration Recommendations

The current status of each of the 13 recommendations from the original report is listed in Appendix B1. Formal integrations approved by the South West LHIN Board in the past two years are listed in Appendix B2 and include the following:

- ✓ Huron Perth Addiction and Mental Health Alliance Agreement: June 2012
- ✓ Oxford Addiction Treatment Strategy: July 2012
- ✓ Elgin Transitional Employment Program: May 2013
- ✓ London Crisis Services: July 2013
- ✓ London-Middlesex Mental Health Amalgamation (CMHA London-Middlesex, Search, WOTCH): October 2013

The development of the Huron Perth Alliance is noteworthy because the core members of the Huron Perth Addiction and Mental Health Network voluntarily pursued a new legal agreement in order for them to more effectively work together to 'collectively manage' adult mental health and addiction services in Huron Perth. MH&A networks functioning as 'system managers' was the intent behind the Network recommendations in the 2011 report.

The voluntary integration of CMHA London-Middlesex, Search and WOTCH is significant because the 2011 report did not recommend agency mergers. However, in accepting the report, the South West LHIN added the following implementation strategy:

To engage consultants to work with core Thames Valley Mental Health Service Providers including the Oxford, Elgin and London Middlesex Canadian Mental Health Associations (CMHAs), and WOTCH to explore advantages and disadvantages associated with integration including: (i) governance models, (ii) leadership models, (iii) operational policies, (iv) service type and delivery models; and (v) outcomes measures

Initial meetings between these four organizations took place in January 2012 and in February 2012, the boards of 3 organizations: (CMHA London-Middlesex, Search Community Mental Health Services and WOTCH) announced their intent to pursue a formal integration. Two years later, the 3 organizations have now formally amalgamated into a single legal entity (CMHA Middlesex) under one Board and one CEO. The South West LHIN provided one-time funding to support this integration process and is now conducting an evaluation of 'lessons learned'.

The other more recent integration initiative that is noteworthy is London Health Science Centre's (LHSC) clinical renewal strategy for mental health which has the following overall goal and vision statements:

- **Overall Goal:** *To deliver a fully integrated, collaborative and accessible system of Mental Health care, in partnership with peer hospitals and community partners.*

- **Future Vision:** *The integration of all Mental Health services with a single hospital organization.*

This is a collaborative initiative with RMHC (St. Joseph's) and community partners that has the following strategies:

- Strengthen the integration between LHSC and St. Joseph's Mental Health Care Services to ensure the right care in the right place
- Work in an enhanced collaborative model with community mental health and primary care providers
- Improve access to hospital-based Mental Health Services
- Become an innovative model mental health program for advancing the quality of care and safety of patients, family and staff

Special Priority Populations

The current status of each of the recommendations from the original report is listed in Appendix D. The original recommendations covered the following special priority populations:

- Aboriginal individuals with mental health and/or substance abuse problems
- Francophone individuals with mental health and/or substance abuse problems
- Individuals with a moderate mental illness (MMI)
- Children and adolescents with mental health and/or substance abuse problems

For the first two groups, the LHIN has designated staff 'Leads' for French Language and Aboriginal Health services. Their 'lead' responsibilities include all health services of which mental health and addiction services are a part.

In terms of Aboriginal services, as part of the implementation of the 2011 *"Time is Now*" report, the Erie St. Clair and South West LHINs agreed to develop a Joint Aboriginal MH&A Strategy. In July 2012, a consultant was hired and the Strategy was finalized and approved by the South West LHIN Board in Spring 2013. It is embedded in the IHSP: 2013-2016 through the Aboriginal Logic model. Since approval of the Strategy, the South West LHIN was without an Aboriginal Health Lead for 6 months but a new Lead staff person has been recently hired.

Consistent with the report recommendations, the South West LHIN has made investments in case management services and addiction treatment services through funding (4 FTEs) to the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). SOAHAC services now include a Transitional Case Manager which helps individuals to navigate services (both mainstream and Traditional Healing) and also has system benefits including reduced wait times for access to some MH&A services. SOAHAC is currently in the process of integrating a family approach to

recovery for MH&A clients by incorporating the Ministry of Children and Youth Services (MCYS) funded services into their newer MH&A services.

In terms of Francophone services, one of the significant accomplishments over the last 2 years has been the development and distribution of a new French Language Services Toolkit for health service providers. The LHIN's French Language Services Lead continues to work with health service providers on implementation of recommendations from the 2011 report. A current progress report is found in Appendix E. The LHIN has also made some investments to support the provision of French Language Services in the addictions services sector; specifically through new staffing at Addiction Services Thames Valley.

Lack of services for children and adolescents with mental health and/or substance abuse problems continues to be a significant issue throughout the Southwest. Although it was not part of the scope of the original 2011 report, the Ministries of Health and Long Term Care, Community and Social Services and Children and Youth Services (MCYS) continue to pursue strategies for enhancing services for this priority population through the government's 10-year strategy for Mental Health and Addictions.

These provincial strategies include:

- Establishment of 18 *Service Collaboratives*, through the Centre for Addiction and Mental Health (CAMH), to improve support and continuity of care for youth with mental health and addiction needs (www.servicecollaboratives.ca)
- MCYS designation of lead agencies for children's mental health for different parts of the province

With respect to local service initiatives, the London Service Collaborative was established in March 2012 and has recently developed:

- the *Be Safe* toolkit including a mobile app and pocket guide based on a robust youth engagement strategy
- a transition protocol between London's Pediatric Emergency Department and the Crisis Intake Team.

2.2 Service Enhancements and New Investments

The investments resulting from the *"Time is Now"* recommendations plus other South West LHIN investments in mental health and addiction services are summarized below.

Table 1 summarizes the new investments (funding and approved staffing positions) for new and enhanced community-based mental health and addiction services that are aligned with original report recommendations. These staffing positions are intended to be permanent positions resulting in base budget adjustments for the sponsoring agency:

TABLE 1 - New Funding & Staffing (2012-13 and 2013-14)

	2012-13 Funding	2013-14 Funding	2012-13 Positions (FTEs)	2013-14 Positions (FTEs)
NORTH				
Addictions	$252,000	$168,000	3	2
Crisis Response	$630,000	0	7	0
MH Case Management	$97,000	$840,000	1	10[4]
Supportive Housing	0	$84,000		1
Telemedicine	$201,720	0	2	
TOTALS:	**$1,180,720**	**$1,092,000**	**13**	**13**
CENTRAL				
Addictions	$252,000	$336,000	3	4
Crisis Response	$90,000	$84,000	1	1
MH Case Management	0	0	0	0
Supportive Housing	0	$84,000	0	1
Telemedicine	$403,400	0	4	
TOTALS:	**$745,400**	**$504,000**	**8**	**6**
SOUTH				
Addictions	$420,000	$588,000	5	7
Crisis Response	$540,000	$354,000[5]	6	4
MH Case Management	$935,000	0	12	0
Supportive Housing	0	$336,000	0	4
Telemedicine	$573,482	0	6	0
TOTALS:	**$2,468,482**	**$1,278,000**	**29**	**15**

[4] New intensive case management team that is being piloted in Grey Bruce, co-sponsored by CMHA Grey Bruce and Grey Bruce Health Services

[5] Funds flowed in 2014-15

Table 1 (cont'd)

Aboriginal and Francophone				
Addictions	0	$168,000 (Aboriginal)	0	2
Crisis Response	0	0	0	0
MH Case Management	$265,000 (Aboriginal)	0	3	0
Supportive Housing	0	0	0	0
Telemedicine	0	$84,000 (Francophone)	0	1
TOTALS:	**$265,000**	**$252,000**	**3**	**3**
GRAND TOTALS				
Addictions	$924,000	$1,260,000	11	14
Crisis Response	$1,260,000	$438,000	14	5
MH Case Management	$1,032,000	$840,000	15	10
Supportive Housing	0	$504,000	0	6
Telemedicine	$1,178,602	$84,000	12	1
TOTALS:	**$4,659,602**	**$3,126,000**	**53**	**37**

Over the past two years, 90 new staffing positions have been added to community-based mental health and addiction services across the South West LHIN representing a base budget increase of approximately $7.8 million. Some of the new programs/services approved in 2012-13 did not become operational until 2013-14. These new investments are generally consistent with the recommendations in the 2011 report and in some cases, were greater than what was originally recommended.

2.3 Other LHIN Investments

Table 2 - Addiction Supportive Housing (ASH) Units & Funding

Location (Year of Approval)	***Agency Sponsor***	***Housing Units***	***FTEs***	***Funding(*)***
South (2010-11)	Addiction Services of Thames Valley(*)	32	4.0	$336,000
Central (2011-12)	Choices for Change	8	1.0	$84,000
North (2011-12)	HOPE Grey Bruce	8	1.0	$84,000

(*) funding based on 1.0 FTE staff person for every 8 units

(**)The 32 supportive housing units implemented in the south planning area are being managed by the following supportive housing providers in partnership with Addiction Services of Thames Valley:

- CMHA Middlesex – 24 units
- CMHA Oxford – 4 units
- CMHA Elgin – 4 units

To illustrate the benefit of the new ASH units, here is Stephanie's story[6]:

Stephanie age 29 applied to the ASH program while she was staying in a Women's Shelter. Stephanie has a long history of substance abuse, she was abused physically and sexually starting when she was 10, she was removed from the abusive situation and spent the next 6 years in foster care. There she began experimenting with drugs at the age of 12, she progressed from using marijuana weekly to daily and then onto harder drugs like cocaine, ecstasy and methamphetamine (meth). By the age of 18 Stephanie was using meth on a daily basis. She had started using it to help her keep her weight under control but it quickly took over her life.

Stephanie has been involved with many different agencies over the years and has received counselling for addiction issues, trauma and anger management. Stephanie has been arrested on various drug possession charges over the years as well as a number of theft charges. Sporadically, Stephanie would attend Narcotics Anonymous (NA) meetings, usually shortly after being arrested and at the urging of her probation officer. Stephanie had arrived at the women's shelter fresh off of a 6 month stint in prison. While in prison Stephanie became involved in NA and became motivated to change her life for good this time.

While staying in the shelter, Stephanie was accepted to a 21 day program at a residential treatment facility and when she completed her treatment she moved into ASH housing. Stephanie had never been able to keep her own apartment for very long, alternating between couch surfing for long periods, trying to share apartments with other using friends or living in various women's shelters. Having her own apartment that she was responsible for was a big change for her, one of many that took place during her year in ASH. Stephanie stayed in the ASH program for one year; with support from her ASH worker she achieved many of her goals. Stephanie finally had people in her corner helping her to stay on task. She became involved with the Centre for Learning and Employment and through some determination and a lot of hard work she completed her GED. In addition to getting her GED, Stephanie developed a resume and received training that prepared her to get back into the work force.

Stephanie continued to attend NA throughout her time in ASH. She received her 1 year key tag and was very proud to chair several meetings. Stephanie is hopeful that in the future she will be able to offer her support as a NA sponsor. Stephanie now has valid forms of ID which had always been an issue for her as she would constantly lose them prior to ASH. Stephanie is very proud of the budgeting and scheduling skills she learned during her time in ASH, she now not only has a bank account but a savings account that she adds to each month. By working with her Ontario Works counselor, Stephanie was able to secure social housing that will allow her to continue working towards her own apartment at market rent. By the end of her year in ASH Stephanie had secured part time employment and was following her dream of becoming a baker. She will begin an apprenticeship in the summer. Currently Stephanie is still

[6] Stephanie is a fictitious client but her story is based on the experiences of real life clients that have been supported through the Addiction Supportive Housing (ASH) program

receiving assistance from Ontario Works (OW) but her goal is to be off OW by the end of next year. She is taking part in the ASH alumni group where successful ASH graduates can share their experiences about their year in ASH with newer clients that are just starting their journey.

2.4 New LHIN Priorities

Probably the most significant new priority for all LHINs in the last 24 months is the introduction of Health Links. The Huron Perth Health Link (sponsored by the North Perth Family Health Team) was approved as one of the 19 'early adopter' Health Link projects when the Ministry's Health Link strategy was announced in December 2012. Readiness assessments followed by business plan development for additional Health Links are now underway for the South West LHIN's south and north planning areas:

- London Health Link (Sponsor: Thames Valley Family Health Team)
- Elgin Health Link (Sponsor: East Elgin Family Health Team)
- Oxford Health Link (Co-Sponsors: CMHA Oxford and Woodstock Community Health Centre)
- Southern Grey Bruce Health Link (Co-sponsors: South Bruce Grey Health Centre and Brockton and Area Family Health Team)
- Northern Grey Bruce Health Link (Co-sponsors: Grey Bruce Health Services and Owen Sound Family Health Team)

Because the Health Link strategy is focused on supporting "high-needs, high-use" clients, it will be important for the mental health and addictions agencies because a number of their clients have complex co-morbidities and are already 'high-users' in terms of ER visits, hospital re-admissions and longer lengths of inpatient stay.

Over the past two years, ongoing efforts at improving coordinated access and strengthening system integration have focused on partnerships <u>within</u> the mental health and addiction service sector. As the Health Links strategy and the development of coordinated care plans for 'high-need' patient/clients continues to unfold, the system conversations will need to shift to partnerships <u>between</u> the mental health and addiction sector <u>and</u> other health and social services.

SUMMARY OBSERVATIONS:

Overall, the South West LHIN, the South West Addiction and Mental Health Coalition, the five geographic mental health and addiction (MH&A) networks and individual service providers have made good progress on implementing many of the recommendations in the 2011 *Time is Now* report.

Over the last 2 years, approximately $8 million has been invested in adult community-based mental health and addiction services representing 90 new staff across the South West LHIN.

The recruitment of new staff, the successful transitioning of long stay clients out of Regional Mental Health Care (St. Joseph's) and the implementation of many integration and coordination initiatives represents a significant investment of time and energy for mental health and addiction service providers outside of their full time job of caring for and supporting clients.

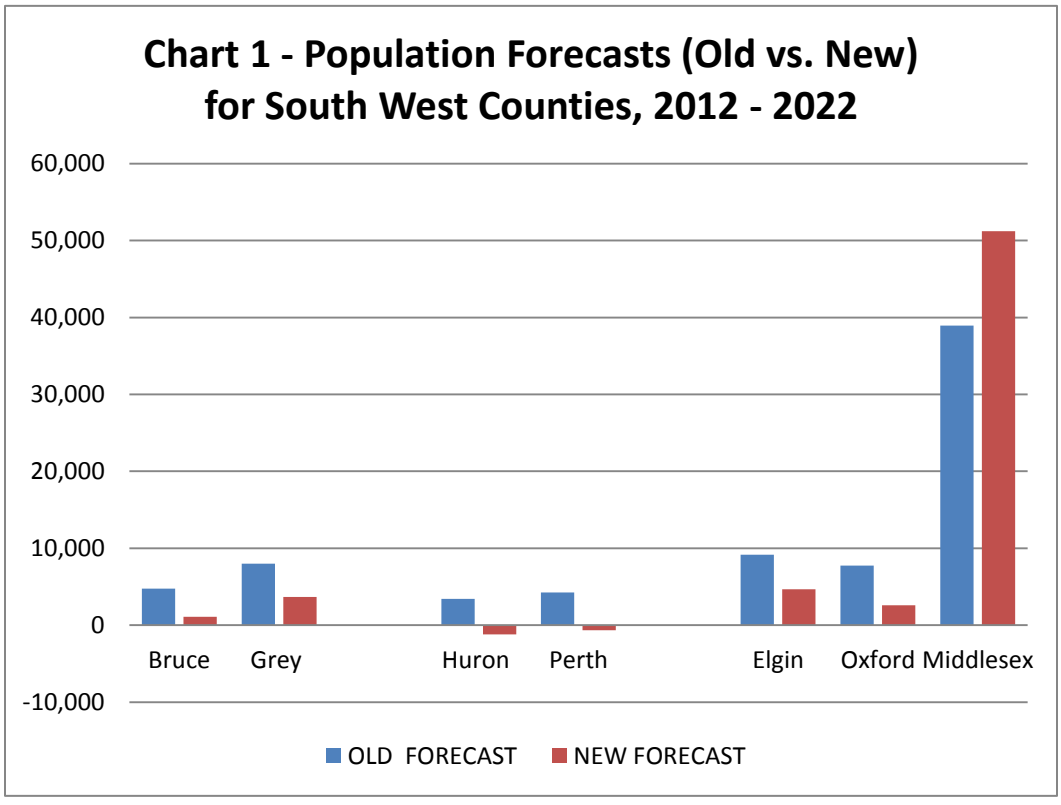
All of these system improvements also represent a major change management exercise, which is still unfolding.

SECTION 3 – REFRESHED DATA

3.1 Population Growth

Demographic data used in the original 2011 report was based on 2006 Census results so more recent population growth estimates are now available from the Ministry of Finance based on 2011 Census results. Chart 1 below compares the original (old) population forecasts for each South West county with the new forecasts based on the more recent Census data. Overall, there is not significant change to total estimated population growth in the South West LHIN over the next ten years but there are noteworthy variations within the LHIN's south, central and north planning areas. The highlights are as follows:

- Total forecasted population for the seven Southwest counties is 1,026,588 (13,500 fewer people than originally predicted - a variation of 1.2% over ten years)
- Huron and Perth counties are predicted to decline in population by 2022;
- Bruce, Grey, Elgin and Oxford counties are expected to grow more slowly than originally predicted;
- The London-Middlesex area is forecast to grow more quickly than originally predicted and by 2022 can expect 19,500 more residents.



Prevalence rates, staffing ratios and other per capita calculations used in this report are based on the following 2012 population figures:

Bruce	67,500
Grey	96,522
North	**164,022**
Huron	60,496
Perth	77,032
Central	**137,528**
Elgin	91,113
Oxford	108,784
London-Middlesex	463,710
South	**663,607**

SOURCE: South West LHIN

The total South West LHIN population for 2012 is estimated at **977,573** which includes 13,829 population from Haldimand-Norfolk.

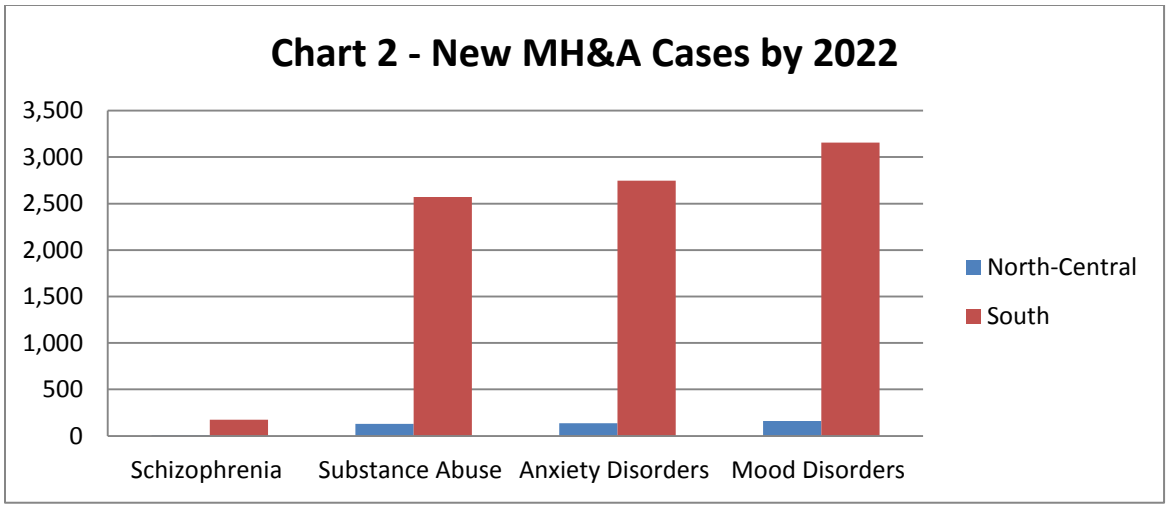
The original report did not provide separate population estimates for London vs. Middlesex. Stakeholder consultations (see Section 5) confirmed that there are ongoing access challenges for rural residents of Middlesex County. Future reporting should distinguish between urban and rural populations whenever possible:

City of London	366,151[7]
Middlesex County	75,618[8]

3.2 Disease Prevalence Estimates

Based on the revised population forecasts for the South West LHIN and published disease prevalence rates[9], the forecast number of new mental health and addiction cases over the next ten years is described below in Chart 2. The higher the prevalence rate, the higher the number of projected new cases. Consistent with forecast population growth, the large majority of new cases of mental health and substance abuse disorders will occur in the LHIN's south planning area.

[7] 2011 Census population
[8] 2013 population estimate from Middlesex County (www.middlesex.ca)
[9] Prevalence rates from 2012 Canadian Community Health Survey (CCHS): Substance Abuse Disorders (4.4%) and Mood Disorders (5.4%) as published in Statistics Canada Bulletin, "Mental and substance abuse disorders in Canada" (2013) and prevalence rates from 2002 CCHS: Schizophrenia (0.3%) and Anxiety Disorders (4.7%) as published in "The Human Face of Mental Health and Mental Illness in Canada" (2006)



Many diagnosable mental health problems have a range of symptoms and acuity making it difficult to forecast the number of serious mental illness (SMI) cases based on disease categories. A more recent U.S. study estimates the national SMI prevalence rate at approximately 4%.[10] The Centre for Mental Health and Addiction reports that in any given year, one in five Canadians (20%) will experience a mental health or addiction problem[11]. This suggests a significant number of individuals who would benefit from treatment and support even if their symptoms do not qualify as a SMI diagnosis.

In fact, many service providers in the South West are reporting anecdotally that they are seeing an increase in the number of clients who do not fit the SMI definition but are suffering from an episode of mental illness that requires urgent, transitional support. Some have referred to this group of patients as having "moderate mental illness (MMI)" (see Section 5 – Stakeholder Consultation).

These non-SMI clients may be growing in number but It is difficult to get a handle on exact numbers because:

- Many mental health diagnoses (e.g. depression) have a broad range of symptoms and severity (e.g. mild to moderate to severe);
- There is not a standardized methodology or assessment protocol for capturing client acuity;
- There are lots of people with undiagnosed problems that cope with mild to moderate symptoms, sometimes with the help of family, friends and other informal supports like clergy;
- Some of these individuals will seek help, often during a crisis, when life events conspire against them and they are no longer able to cope;

[10] National Institute of Mental Health: www.nimh.nih.gov
[11] Centre for Addiction and Mental Health website:

- Some of these individuals are coming forward as mental health becomes de-stigmatized thanks to education and promotion strategies like Bell's "Let's Talk" campaign.

Tim's story[12] helps to illustrate:

Tim, a 40 year old male has been experiencing a lot of stress at home and work. He shared that he hates his boss and describes having no ability to make a difference at work. He has become aware of having symptoms of depression and anxiety, but does not think anyone will care, including his family. To manage his emotions he starts to drink more heavily. Today at work he is drunk. He gets into a verbal altercation with his supervisor, smashes his hand into the wall at work and storms out saying 'I might as well kill myself'. As this suicide threat was not the first time that Tim's boss, co-workers or family have heard him utter these words they respond by calling the police. Tim is shaking when the police escort him to hospital. Tim is terrified that he will be perceived as 'crazy' and that people at work and at home will treat him differently. When the mental health crisis worker arrives, he is shaking uncontrollably. His fears are normalized and this helps to de-escalate his fear.

During his time in the Hospital emergency department, Tim describes being beaten as a child. He reported that he witnessed his mother being abused and could not do anything to stop it. He describes a sense of his boss being like his father and described feeling powerless at work. He reported that his boss bullies a colleague and he does not know how to intervene without putting himself at risk. At the time, Tim was not consciously connected to how his present fears about his boss were connected to his childhood fears. Suicide and drinking were described as his only reference point for ending his emotional pain. He reported that if he was to leave the hospital, he was going to lock himself in his car in his garage and ingest the fumes. Tim was already actively planning a time when his wife and children were away from the house. He had been contemplating this silently for weeks—and it was this thought of suicide that helped him go to work every day. Together, the ER physician and mental health crisis worker determined that Tim needed to be in hospital for 24 hours of stabilization and support. While in hospital, contact was made with Tim to help establish follow-up. Tim was diagnosed with an anxiety disorder and prescribed anti-depressant medication.

In crisis follow-up, Tim was supported to talk about his past abuse. He was connected to addictions services for support around his drinking and began to learn strategies like Cognitive Behaviour Therapy to examine how his thoughts were impacting on his emotions. Tim felt less alone and more supported. He was able to speak with his supervisor directly about his concerns and arranged a meeting with the Human Resources department. Tim expressed that this was the first time that he had support to directly confront injustice. He started to become aware of the options that were available to him now that were not available to him as a child. He and his family started family counselling to address other underlying concerns. Tim is presently on a wait-list for the traumatic stress therapy program.

Service providers have noted that many of these individuals are 'new' to the system and require considerable work-up by staff because they have not been previously assessed.

[12] Tim is not a real client but was submitted by Search Community Mental Health Services (now CMHA Middlesex) as an example of the non-SMI clients in Middlesex County that they are seeing in increasing numbers

3.3 Staffing Changes

The 2011 *Time is Now* report provided numbers of approved mental health and addictions staffing (FTEs) throughout the South West. Those staffing levels were compared to 2013-14 approved staffing levels and summarized in two tables below.

Table 3 – Changes in Mental Health Staffing

Geographic MH&A Network	2011-12 FTEs	2013-14 FTEs	FTE Increase
Grey Bruce	103.2	121.7	18.5
Huron Perth	69.5	70.6	1.1
Elgin	60.4	75	14.6
Oxford	57.2	65.5	8.3
London-Middlesex[13]	173.7	220.4	46.7

Table 4 – Changes in Addiction Staffing

LHIN Planning Area	2011-12 FTEs	2013-14 FTEs	FTE Increase
North	32.0	36.8	4.8
Central	10.7	20.0	9.3
South	43.9	64.7	20.8

In terms of mental health staffing, Huron Perth and Oxford saw the most modest staffing increases. For addictions staffing, Grey Bruce saw the most modest staffing increases. Some of these differential staffing increases are appropriate given the original 2011 report noted that there were geographic inequities in per capita distribution of MH&A staff across the South West LHIN.

SUMMARY OBSERVATIONS:

Refreshed population estimates indicate that the large majority of population growth in the South West over the next decade will take place in London-Middlesex; and this forecasted growth is greater than was originally predicted. This also means that by 2022 the large majority of new mental health and addiction cases will occur in the London-Middlesex area.

Service providers are reporting an increase in the number of episodic, urgent, non-SMI cases who would benefit from some type of transitional support and treatment.

In terms of staffing levels, numbers of community-based mental health and addictions staff have increased 20% and 40% respectively across the South West LHIN over the last two years.

[13] Does not include ambulatory/outpatient MH staff from London hospitals

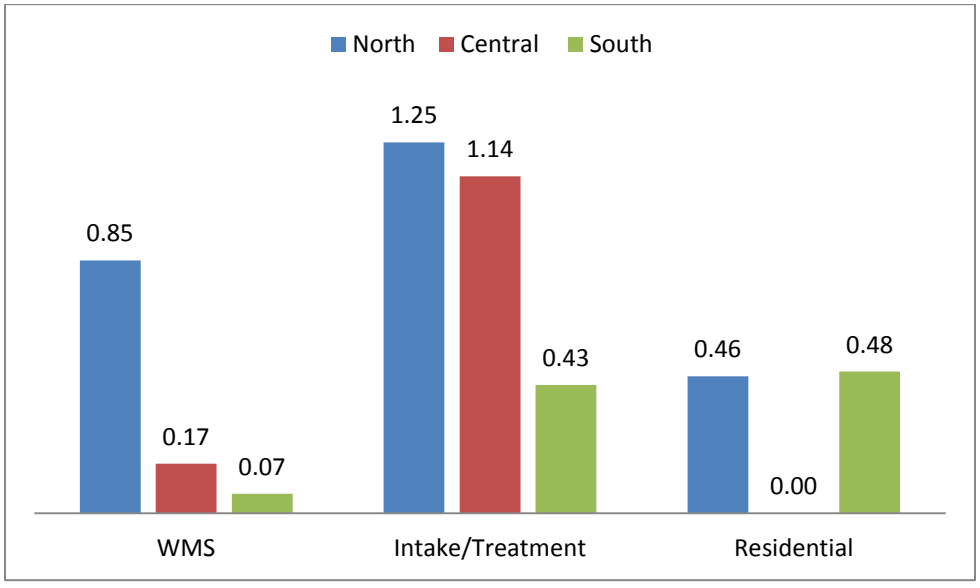
SECTION 4 - System Impacts

4.1 Staffing Availability Per Capita

Based on approved staffing levels for 2013-14 and 2012 population estimates for adults (15+), per capita staffing ratios in each of the LHIN's three planning areas are found in Chart 3. For intake/treatment and withdrawal management services, the South West LHIN's North planning area (Grey Bruce) has the highest staffing ratios and the South planning area (London-Middlesex, Oxford, Elgin) has the lowest. There are no residential addiction treatment facilities in the Central planning area (Huron Perth).

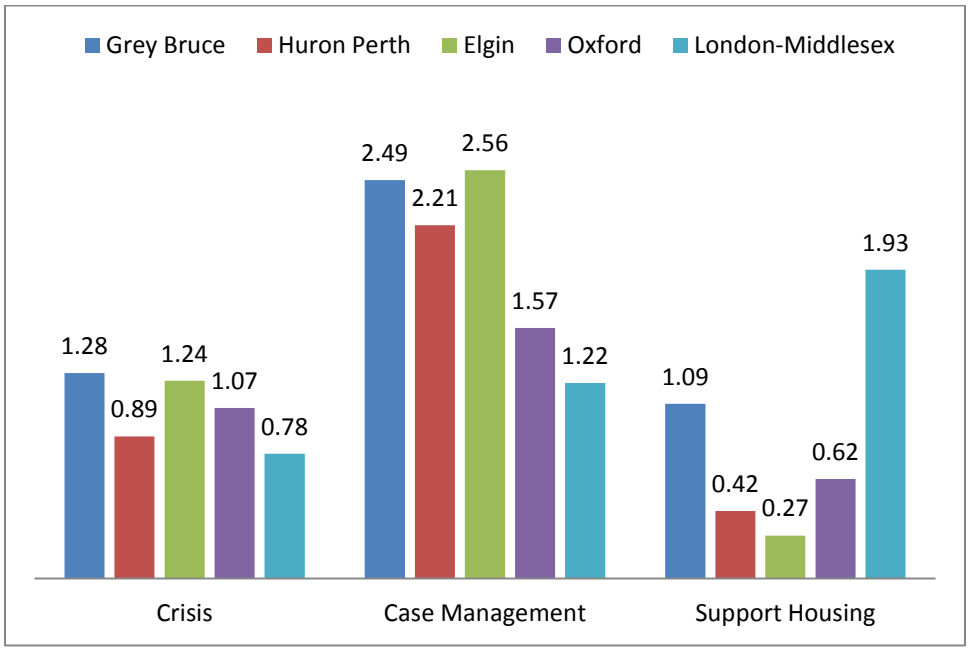
The geographic variations in the per capita availability of addictions staff were similar in 2011. The higher population estimates for London-Middlesex may have exacerbated the differences between the three LHIN planning areas.

Chart 3 – Staffing Levels Per Capita for Addiction Services (FTEs per 10,000 pop.)



Per capita staffing levels for community mental health services are listed in Chart 4. For crisis response services, Huron Perth and London-Middlesex have the lowest staffing levels. Crisis staffing has improved in Grey Bruce as a result of new investments. For case management services, Oxford and London-Middlesex have the lowest staffing levels. Since 2011-12, staffing ratios have declined in Oxford relative to the other four areas. In terms of staffing for supportive housing, Elgin, Oxford and Huron Perth have the lowest staffing levels.

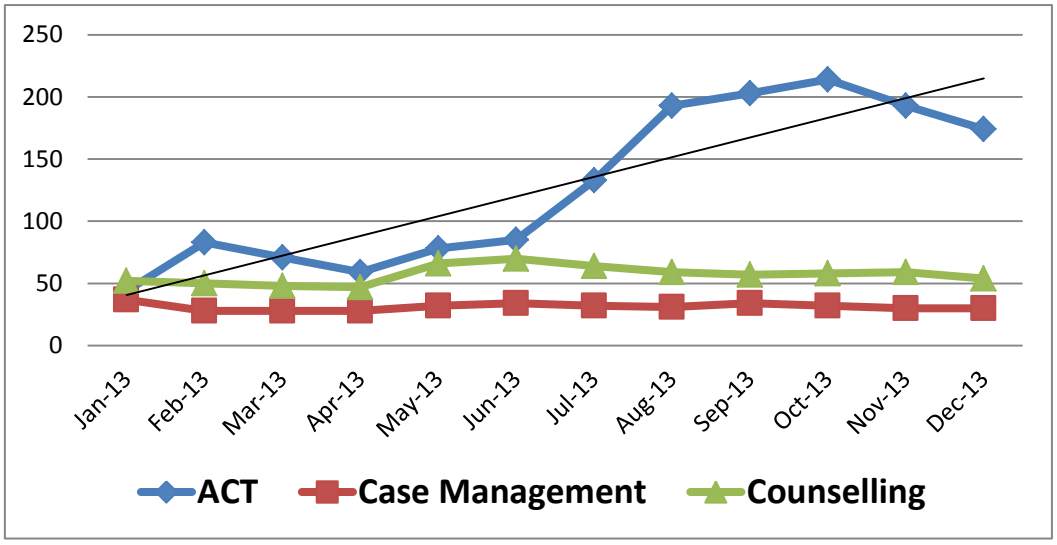
Chart 4 – Staffing Levels Per Capita for Mental Health Services (FTEs per 10,000 pop.)



4.2 Wait Times

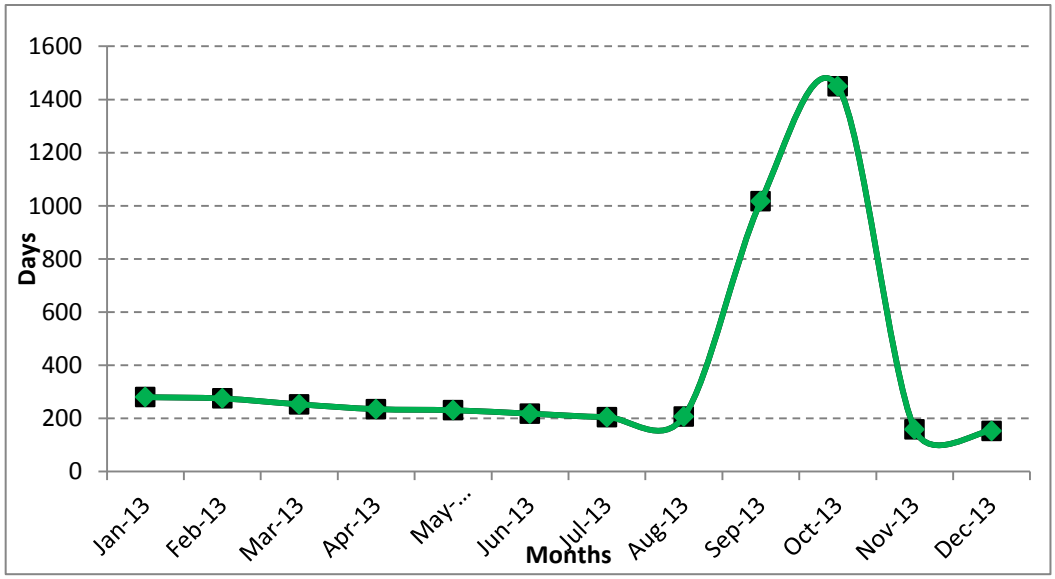
2013 wait time information provided by Connex is displayed below for certain mental health and addiction services. At a South West systems level, wait times for certain mental health services (Chart 5) have stablized (e.g. case management, counselling) but appear to be worsening for others (e.g. ACT teams). The ACT team wait times are much higher than the provincal average.

Chart 5 – 2013 Wait Times for Select Mental Health Services



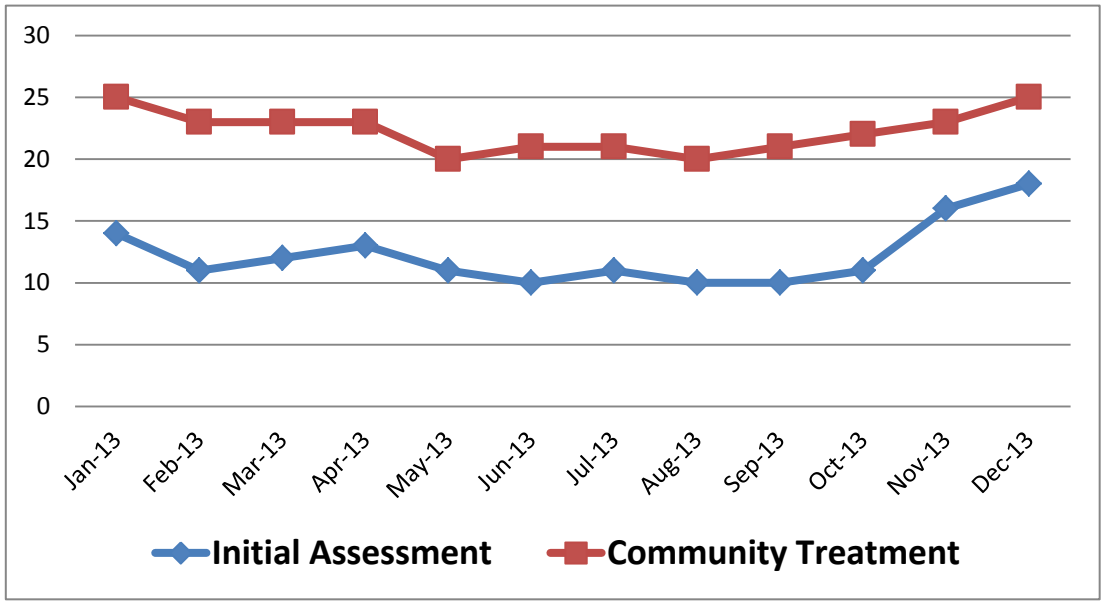
Supportive housing wait times (Chart 6) are high and the reason for the 'spike' in the fall of 2013 remains unclear.

Chart 6 – 2013 Wait Times for Mental Health Supportive Housing



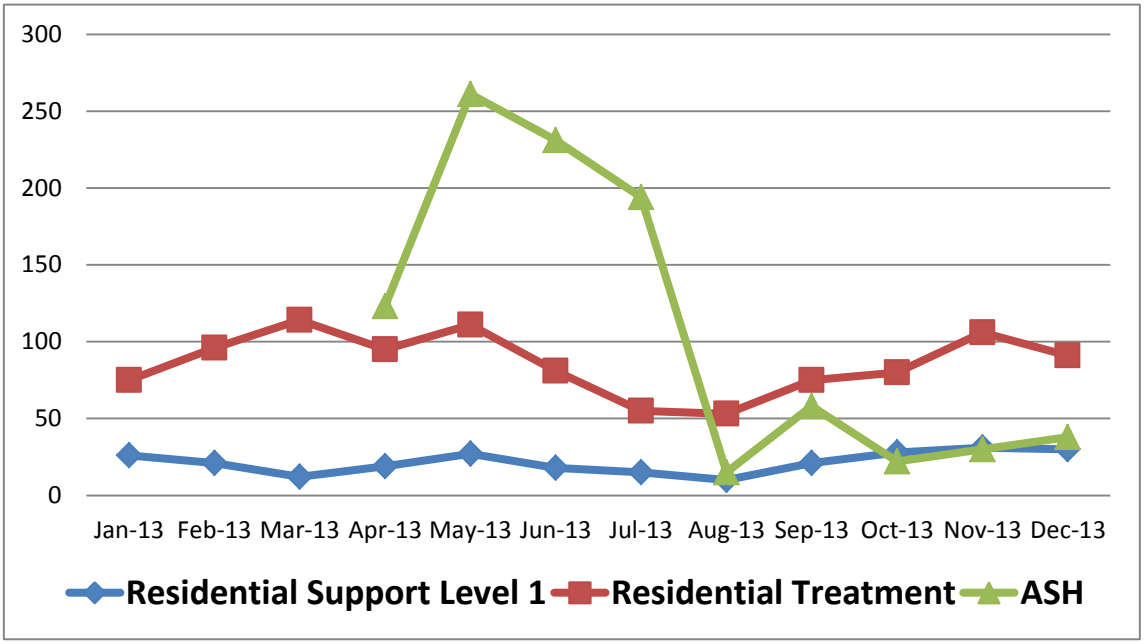
Wait times for addiction services are moving upwards in the last quarter of 2013 for community-based assessment and treatment services (Chart 7) and at a South West LHIN aggregate level are higher than the provincial average.

Chart 7 – 2013 Wait Times for Addiction Services – Assessment & Treatment



The relatively new addiction supportive housing (ASH) units initially started with very high wait times but these have come down substantially in the latter part of 2013 and are now lower than the provincial average. There are still much longer wait times for residential addiction treatment services.

Chart 8 – 2013 Wait Times for Addiction Services – Supportive Housing & Residential Treatment



4.3 ER Visits

The most current data for ER visits covers the 15-month period October 2012 to December 2013. The total number of annual ER visits to all South West hospitals for mental health and addiction issues (regardless of patient residence) has fluctuated between 4,000 - 4,400. Non-SWLHIN residents contribute between 6 – 10% to that visit total. Charts 9 – 11 (below) highlight Mental Health visits to the ER for the South West LHIN's three planning areas.

In Grey Bruce (Chart 9), visit volumes are stable over time at the Hanover and South Bruce Grey Health Centre hospital sites and may be declining at the Grey Bruce Health Services sites as a result of the new crisis response team. Further trend data would be required to confirm this.

In Huron Perth (Chart 10), ER visit volumes have been fluctuating over time with declines in the third quarter (Q3) at the Huron Perth Healthcare Alliance and South Huron hospital sites. Again further trend data would be required to confirm if these are normal fluctuations in volumes or a downward trend.

Chart 9 – Mental Health ER Visits at Grey Bruce Hospitals (Oct. 2012 – Dec. 2013)

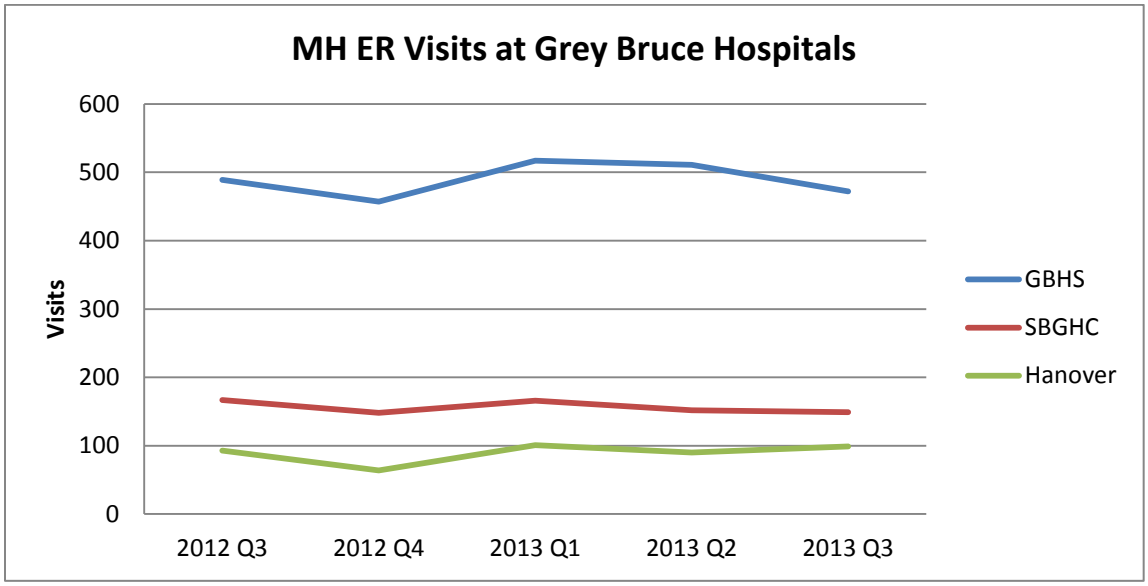
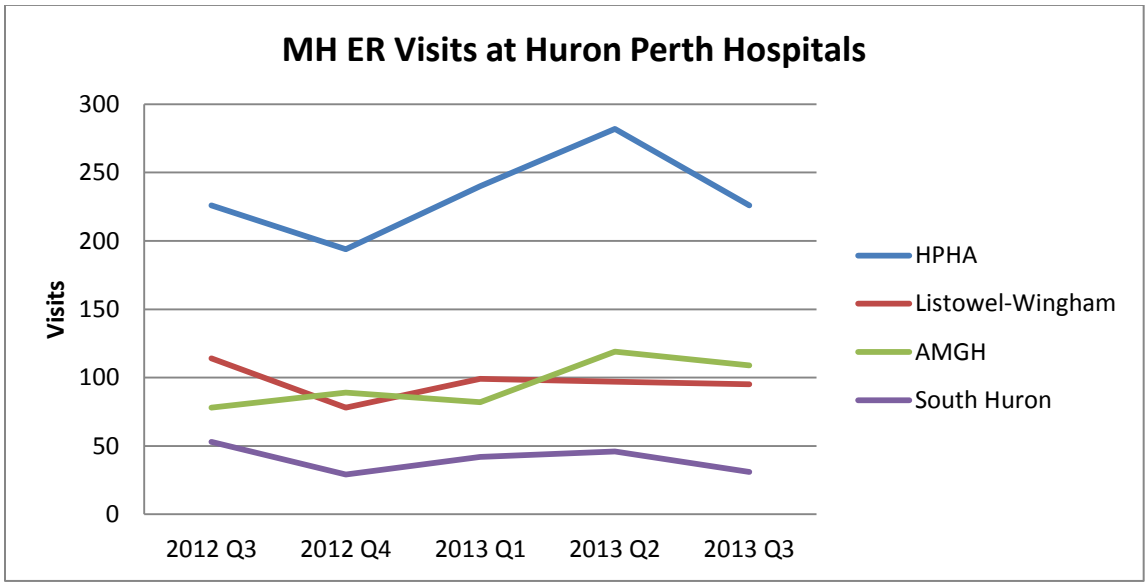
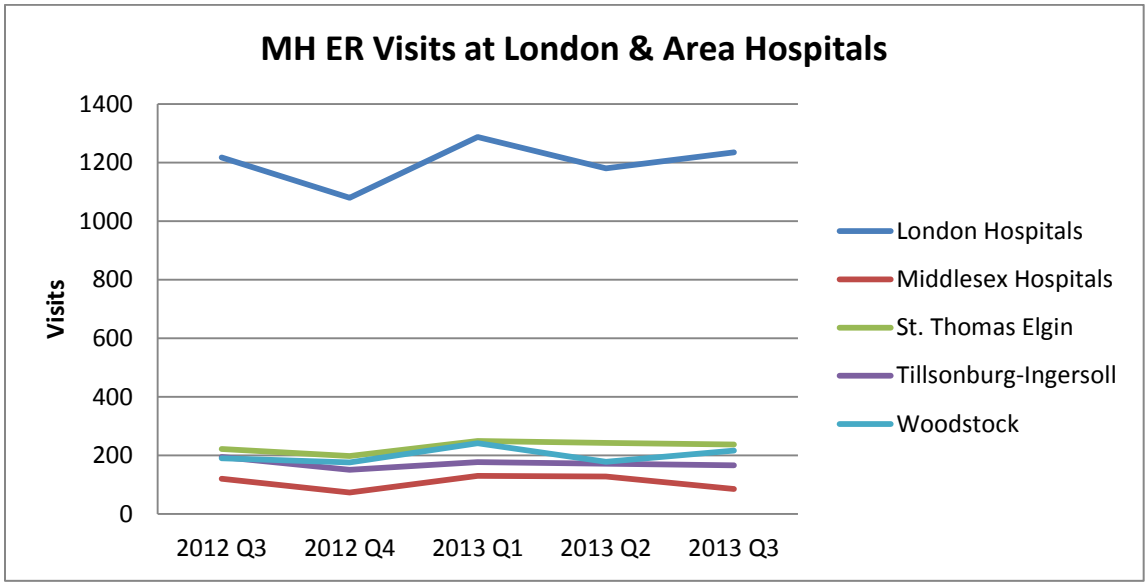


Chart 10 – Mental Health ER Visits at Huron Perth Hospitals (Oct. 2012 – Dec. 2013)



In the LHIN's south planning area (Chart 11), the pattern is similar in terms of what appear to be normal fluctuations in ER visit volumes over time for mental health clients. At the London hospital sites, Mental Health ER visits per quarter (every 3 months) fluctuate between 1,100 and 1,300.

Chart 11 – Mental Health ER Visits at London and Area Hospitals (Oct. 2012 – Dec. 2013)



The working hypothesis underlying community-based investments in mental health and addiction services is that over time additional investments should reduce wait times and the reliance on hospital-based services as measured by system performance indicators such as ER visits and hospital re-admissions. Based on the information analyzed to-date, it's not clear yet that the investments in community-based services are having a discernible impact on some of these system performance indicators.

The lack of discernible impact of recent community investments on hospital utilization for clients with mental health and addiction issues is likely attributable to a range of factors:

- Not all new investments will reduce reliance on hospital-based care (e.g. case management still largely provides 9:00 – 5:00 supports for clients so problems that can arise after-hours or on week-ends sometimes result in an unplanned hospital visit);
- Some SMI clients still need to return periodically to hospital for stabilization and access to certain clinical services as part of their care plan;
- For some new services, there have been challenges in hiring new staff and this delayed start creates a lag time between investment and measurable system improvement outcomes;
- Some hospital utilization trend data is slightly dated and fourth quarter results for 2013-14 may reveal additional insights.

4.4 Inpatient Capacity

As Tier 2 divestment nears completion, one of the issues that may need further attention and analysis is specialized mental health inpatient capacity. While one of the longstanding goals of mental health reform has been increasing capacity of community-based services, this needs to be balanced with sufficient inpatient capacity. There is no conclusive evidence about the right mix of hospital and community-based resources for mental health and addictions treatment. The reality is that the both have to be adequately resourced to ensure a balanced and comprehensive system.

It is has been almost 15 years since the Health Services Restructuring Commission provided its Tier 2 divestment recommendations about bed sizing and siting. The Tier 2 divestment process has taken much longer than anyone originally anticipated and much has changed in the intervening period of time. Recent figures provided by RMHC (St. Joseph's) indicate that occupancy rates are increasing despite the discharge of many long stay clients. The actual occupancy levels are higher than reported because 11 of remaining 27 beds to be reduced are not in use but occupancy rate is calculated on full 27-bed complement.

RMHC Inpatient Programs (excl. Forensics)	Occupancy Rate (%) 2012-13	Occupancy Rate (%) 2013-14 (10 mos.)
Adolescent (T1)	65.43	73.12
Assessment Unit (AA G2, AU H2, AU EN2S)	74.47	87.69
Dual Diagnosis Program (S1)	96.93	90.22
Geriatric (G1, L1)	84.20	91.09
Moods and Anxiety (K2)	93.12	93.70
Psychosis (P1, R1, EN2)	89.14	95.27
	84.66	**90.69**

SECTION 5 – STAKEHOLDER CONSULTATION

5.1 Consultation Process

The schedule of stakeholder consultations for this project is described in the chart below:

Group	***Meeting Type***	***Date***
Elgin Mental Health & Addictions Network	Face-to-face	Jan. 15
South West Addiction Services Network (SWASN)	Telecon	Feb. 4
Huron Perth Addiction & Mental Health Alliance	Face-to-face	Feb. 10
London-Middlesex Addiction & Mental Health CORE	Face-to-face	Feb. 13
Justice and Police	Face-to-face	Feb. 19
Municipal Housing	Telecon	Feb. 19
RMHC/LHSC Leadership	Face-to-face	Feb. 19
Oxford Mental Health & Addictions Network	Face-to-face	Feb. 24
Grey Bruce Mental Health & Addictions Network	Face-to-face	Feb. 24
Francophone	Face-to-face	Feb. 25
Aboriginal	Face-to-face	March 10
South West Alliance Network (SWAN)	Face-to-face	April 24[14]

Following from these sessions, there were also a number of requests for brief telephone interviews (in March) and some stakeholders submitted written responses to the questions that were circulated.

The discussions with stakeholder focused on the following questions:

- From your perspective, what has changed in the MH&A services system since the 2011 *Time is Now* report? (i.e. What has improved? Is there anything that's gotten worse? What hasn't changed?).

- Is there evidence that investments in MH&A services over last 2 years have reduced ER visits or re-admissions to hospitals?

- What are the most pressing current pressures and service gaps in the MH&A services system today?

- What more can be done to improve access for current and future clients?

- What more can be done to improve service coordination for current and future clients?

[14] SWAN did submit written response to stakeholder consultation questions in March

- In terms of ongoing South West LHIN monitoring of how the Mental Health & Addiction system is doing, what system performance indicators do you think should be tracked over time for addiction services?

For the consultation sessions with Francophone and Aboriginal reps, the questions were modified and customized based on input from the South West LHIN's Francophone and Aboriginal Health Leads.

5.2 Consultation Highlights

Key Themes

The new investments in mental health and addiction services, over the last 24 months, have been most welcome especially since funding for this sector has largely been 'frozen' for many years prior to the 2011 report. Because the recommended investments were targeted for specific functions, not all agencies received new funding and as a result wait lists are growing for some services in some organizations. The new funding has predominantly been approved for the creation of new staff positions and stakeholders noted that as we continue to 'grow' community-based services, there is a need to pay attention to the administrative and infrastructure costs that are required to support additional staff.

In terms of ongoing system pressures, the most common service gap across the South West appears to be supportive, affordable housing based on feedback received. For most rural areas, lack of transportation options also continues to be an ongoing challenge in terms of client access to services. In terms of newer service pressures, increasing demand for services from moderately mentally ill (MMI) clients was raised at a number of network tables. Many of these individuals are 'first-time' clients who 'present' to the system during a crisis. This also raises the issue of the role of primary care in supporting individuals with mild to moderate mental health and addiction problems.

Over the last 24 months, South West LHIN staff has been working with the Oxford, Elgin and London-Middlesex network tables on strategies to improve coordinated access including common assessments tools. Stakeholder feedback suggests that the system still remains difficult to access and navigate for many clients.

Highlights from individual consultation sessions are described below; specifically a combination of key service pressures balanced with local success stories.

Elgin Network

- LHIN-supported Coordinated Access process is ongoing
- Wait lists for housing and other services are growing
- Gaps in criminal justice system incl. drug treatment court
- Partnership 'success stories':
    - CMHA partnership with Goodwill re: vocational services
    - CMHA & Community Health Centre are looking at back-office efficiencies
    - Mental health counsellors funded in primary care

Oxford Network

- LHIN-supported Coordinated Access process is ongoing
- Increasing wait times for case management and other services
- MH Crisis Team has made service changes (i.e. hours, locations)
- Under-utilization at Woodstock General Hospital Schedule 1 beds (12 of 19 beds) plus readmissions have been low
- Partnership 'success stories':
    - CMHA-Hospital working relationship has improved
    - Oxford Addictions Treatment Strategy
    - Co-location of Oxford Self-Help Network with CMHA

London-Middlesex Network

- Service gaps, access issues for Middlesex county residents; need to look at geographic distribution of staff in London vs. Middlesex
- Repeat ER visits at LHSC for addictions are down recently but ER wait times are up
- Gaps in service to Justice system

- Lack of access to Psychiatry is a pervasive problem and acuity is increasing
- Still no meaningful clinical supports outside of hospital
- Navigating the current system is still a problem for clients
- Mobile crisis team has been well-received but need to coordinate with other crisis services (e.g. CAReS)
- Need to move forward with Crisis Services Centre

Huron Perth Alliance

- New investments have been well-received, and have led to reduced wait times and improved staff:client ratios
- Increasing client acuity – SMI clients are more complex with more co-morbidity
- Partnership 'success stories':
    - Creation of formal Alliance between core Network members has led to many system benefits including enhanced Coordinated Access system (one number and common screening)
    - Six Alliance organizations are collectively managing MH&A services for Huron Perth and monitoring system performance metrics (incl. ER visits) on a regular basis
    - A modest base funding increase allowed Phoenix Survivors to start a youth mental health program

Grey Bruce Network

- Lack of housing and increasing MMI cases are top priorities
- Seeing patients with a lot of chronic pain which affects mental health
- Need more support for transitional age youth (16-17 yrs)
- Partnership 'success stories':
    - External evaluation of Mental Health Grey Bruce has been completed
    - Mental Health & Addictions Court Support is a good collaboration

- South Grey Team has good partnership with South Grey Community Health Centre (but elsewhere role of primary care in serving low to moderate mental illness needs more clarification)

RMHC/LHSC Leadership

- Tier 2 divestment has been a huge change management exercise involving complex negotiations with a variety of different receiving facilities
- Need to re-visit bed calculations – current beds are full and there is no 'overflow' capacity in Schedule 1 facilities
- Other Hospitals have successfully implemented Mental Health Short-Stay Units so need to look at this model
- Lack of supportive housing remains a major obstacle to community-based care
- Partnership 'success stories':
    - Closing of Andrews Resource Centre and ACE in St. Thomas has resulted in a great new partnership with CMHA Elgin, WOTCH and Goodwill to support vocational services
    - Creation of CMHA Middlesex from amalgamation of WOTCH, Search and CMHA London is very important to hospitals from a discharge planning perspective

South West Addiction Services Network (SWASN)

- Need to do a better job of embracing addictions crisis model – it is a different approach than dealing with mental health crises
- Addiction Services of Thames Valley has been trying to find a way to coordinate crisis response across 3 counties (Elgin, Oxford, Middlesex), especially for walk-ins
- Providers need more input on Ministry/LHIN targets which are focused solely on quantity of service, not outcomes
- Improved access has led to blurring of MH&A roles – *is the system becoming more complicated for clients?*

Municipal Housing

- Need to create a better relationship with South West LHIN re: working collaboratively on an overall housing strategy

- Need more personal support workers in residential care homes and support staff in social housing units (e.g. hoarding has become a huge issue)
- Housing providers need to be involved in hospital discharge planning and coordinated care plans
- Key indicators for MH&A scorecard:
    - Stability of housing (based on *Housing First* philosophy)
    - Diversion from all Emergency Services (not just hospital visits)

Justice System (incl. Police, Courts, Jails and Detention Centres)

- In London, seeing positive outcomes and benefits from new mobile crisis team and drug treatment court
- Crisis team has definitely improved police response and follow-up strategies
- Increasing client acuity in jails and detention centres
- Need better discharge planning and follow-up supports (including housing with supports) for individuals that are released from correctional facilities

South West Alliance Network (SWAN)

- There are still problems with stigma and shaming when people with mental health problems seek out services
- Still an ongoing need for better police training to deal with mental health crises
- Need a coordinated access strategy to help people find the services they need, preferably one phone number to call
- No base funding increases for independent CSI groups and costs are increasing
- Need to look at expanding peer support strategies including Peer Support workers in the ER and Peer System Navigators
- Need a coordinated strategy for Warm Line as number of calls is increasing
- Partnership 'success stories':
    - Phoenix Survivors Perth County is a full partner in a legal agreement that created Huron Perth Addiction and Mental Health Alliance
    - Mobile crisis team in London

Aboriginal Consultation

- Systemic racism is an ongoing challenge for aboriginal clients
- There is often poor communication between aboriginal and mainstream services
- Need more social workers to support clients and their families
- Investments in SWOAHAC were welcome and have created much needed additional capacity; too early to tell if these investments are having system-wide benefits
- Staff of aboriginal services need training and more clinical supports in order to build capacity
- Cultural competency needs to be seen as a professional requirement (instead of 'add-on' training)

Francophone Consultation

- French Language Services (FLS) toolkit is an important new resource which needs to be utilized by all health service providers
- Need an inventory of current MH&A services with French-speaking/translation capacity
- Need to promote/support the concept of 'Active Offer' of French Language Services[15]
- Education system needs more training funding for providers who are willing to upgrade their French and others who want to learn French as a second language
- Current Francophone service providers need to create an organized forum to discuss collaborative strategies
- Need to create awareness of mental health services for recent French-speaking immigrants, especially ethno-cultural groups that have experienced trauma in war-torn countries
- New staff resources through Addiction Services of Thames Valley (FLS telemedicine navigator) will be able to identify gaps in service and support/coordinate a more effective approach to delivery of services for Francophone clients

[15] See "Practical Guide for the Active Offer of French Language Services in the Ontario Government", Office of Francophone Affairs, 2008

SECTION 6 – QUALITY AND PERFORMANCE FRAMEWORK

The development of a quality and performance framework for mental health and addiction services is driven by three related health system trends:

- A much stronger focus on quality improvement
- Increasing emphasis on patient/client experience to inform system transformation
- Ministry/LHIN accountability requirements including tracking and reporting of performance metrics

6.1 High Quality Health Systems

Over 10 years ago, the Institute of Medicine (IOM) in its ground breaking report on quality in health care[16], defined the following six aims of high quality health care:

- ✓ **Safe**—avoiding injuries to patients from the care that is intended to help them.
- ✓ **Timely**—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- ✓ **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- ✓ **Effective**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- ✓ **Efficient**—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- ✓ **Equitable**—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

More recently Health Quality Ontario (HQO) has built on these six quality dimensions by changing ***Timely*** to ***Accessible*** and adding the following three dimensions to define nine attributes of a high-performing health system:

- ✓ **Integrated** – all parts of the health system should be organized, connected and work with one another to provide high quality care

[16] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century", 2001

- ✓ **Appropriately Resourced** – the health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs
- ✓ **Focused on Population Health** – the health system should work to prevent sickness and improve the health of the people of Ontario

The other related quality framework that is gaining momentum in both the United States and Canada is the Triple Aim Framework developed by the U.S. Institute for Healthcare Improvement (www.ihi.org) – see Figure 1. Ongoing research by IHI confirms that it is possible to simultaneously achieve the 3 Triple Aim goals of:

- ➢ Improve the patient/client experience
- ➢ Improve the health of the population
- ➢ Reduce health system costs

The Canadian Foundation for Healthcare Improvement (www.chfi-fcass.ca) is supporting the implementation of the Triple Aim framework through a number of projects across Canada. The framework is also being used by a number of LHINs and is part of the South West LHIN's Quality Improvement Enabling Framework.

Figure 1 – Triple Aim Framework

6.2 Measuring Quality in Mental Health & Addiction Services

There have been a number of international reports defining quality indicators for mental health and addiction services over the last decade.

The World Health Organization[17] definition of quality is focused first and foremost on the client experience & quality of life, and secondly on effective and efficient use of resources. They define quality in mental health services to include:

- preserving the dignity of people with mental disorders;
- providing accepted and relevant clinical and non-clinical care aimed at reducing the impact of the disorder and improving the quality of life of people with mental disorders;
- using interventions which help people with mental disorders to cope by themselves with their mental health disabilities; and
- making more efficient and effective use of scarce mental health resources.

Using an expert consensus panel, the Organization for Economic Cooperation and Development (OECD) has defined a variety of indicators for the international benchmarking of mental health and addictions care based on the following three dimensions of quality (see Appendix J) which align with two of the nine HQO performance domains:

- Clinical Treatment/Support (Effective)
- Continuity (Integrated)
- Outcomes (Effective)

In Ontario, with the passage of the *Excellent Care for All* Act (2010), all health care providers have developed or are in the process of developing Quality Improvement Plans (QIPs). Many of the key QIP performance areas build on the IOM/HQO domains of high performing health systems. For providers that have already developed QIPs, key performance areas and indicators include the following:

QIP Performance Areas	***Hospital Indicators***	***Primary Care Indicators***
Access	ER wait times	Same or next day appointments; Patient visits to ER for conditions best managed elsewhere
Patient Safety	Hand hygiene compliance;	

[17] WHO, "Quality Improvement for Mental Health", 2003

	Surgical safety checklist	
Patient Centred	Patient rating of hospital care	
Integrated	Unnecessary hospital readmissions; ALC days	Unnecessary hospital readmissions; Timely access to primary care following hospital discharge
Financial Health	Total margin	
Population Health		Influenza vaccination rates; Cancer screening rates

Not all of these QIP indicators are relevant to mental health and addiction providers but there are several additional quality improvement initiatives that can inform the development of a performance scorecard for mental health and addiction services in the South West LHIN:

- Mental Health and Addictions Quality Initiative (MHAQI) for Hospitals
- CMHA Ontario Template for Mental Health Quality Improvement Plans (QIP)

Key performance domains and key indicators from these two scorecards are listed below. Detailed indicators from each scorecard can be found in Appendix K.

Performance Areas	***MHAQI Indicators***	***CMHA QIP Indicators***
Client Access	ALC days	Wait times (referral to assessment, assessment to service initiation)
Client Safety	Use of medical and physical restraints; Unauthorized leave of absence (ULOA) days	Medication errors; Incidents of client violence or aggression
Client Centred		Client complaints; Clients recommending service to others
Client Complexity	Number of psychiatric diagnoses; Number of reasons for admission	
Client Outcomes	GAF scores; Readmissions; Self-Care Index	

Integrated		Transferred clients receiving follow-up; Partner satisfaction with agency relationship; Use of integrated client record
Effective		Change in unmet needs following 1-year of service; Reduction in use/frequency of substance abuse; Reduced involvement in the criminal justice system
Financial Health	Balanced budget	
Workplace Health	Staff Safety – loss time injury index; Absenteeism rate	Staff satisfaction levels; Staff reporting 'burn-out'

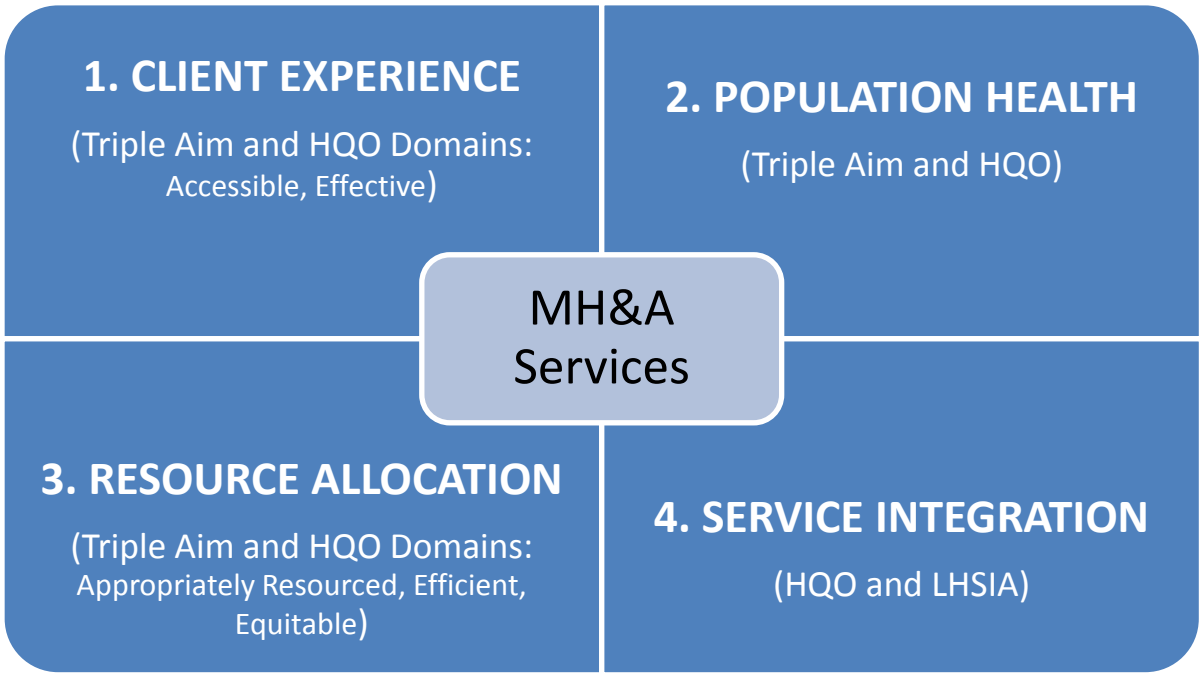
6.3 Recommended Quality and Performance Framework for MH&A Services

Based on quality performance frameworks being used provincially, nationally and internationally and the South West LHIN's Quality Improvement Enabling Framework, there are four performance domains recommended for assessing mental health and addiction services:

- ✓ Client Experience
- ✓ Population Health
- ✓ Resource Allocation
- ✓ Service Integration

The first three align with the Triple Aim framework as well as key dimensions from Health Quality Ontario (HQO) that are being incorporated into Quality Improvement Plans. The fourth (Integration) is part of HQO's performance framework and is also key requirement for all service providers consistent with the *Local Health System Integration* Act. These four performance domains form the basis for a Balanced Scorecard for the Mental Health and Addiction (MH&A) Services System – See Figure 2.

Figure 2 – Balanced Scorecard Framework for the MH&A Service System



For each quadrant, key performance questions are suggested below as well as current indicators that can be used and future indicators that need to be developed.

Green	Indicator available and in use
Yellow	Indicator developed but data not yet collected
Red	Indicator requires further development

QUADRANT #1: Client Experience
Key Performance Questions: ✓ How long did I have to wait for assessment & treatment? ✓ Was I well supported by the health professionals that looked after me? ✓ Do I have safe and affordable housing with supports? ✓ Did I get better? (recovery); Was I better able to manage my symptoms over time?
Suggested Indicators:
• Wait Times by service functions by geographic area (Connex)

Key Questions from the Ontario Perception of Care (OPOC) tool:

- Q1: The wait time for services was reasonable for me.
- Q8: Staff and I agreed on my treatment services and support plan.
- Q9: Responses to my crises or urgent needs were provided when needed.
- Q12: I was involved as much as I wanted to be in decisions about my treatment and supports.
- Q19: Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background etc.)
- Q30: The services I have received have helped me deal more effectively with my life's challenges.
- Q32: If a friend were in need of similar help I would recommend this service.

Housing Stability

- % of people under care who are in stable housing situations (i.e. safe, affordable housing with supports)
- # of individuals with mental health & addiction problems living in social housing without adequate support

*This could initially be assessed by service providers (indicator #1) and social housing providers (indicator #2) and then eventually added to future client surveys to better understand the client's housing experience.

QUADRANT #2: Population Health

Key Performance Questions:

- ✓ Is the burden of illness in the population being reduced over time (disease prevalence)?
- ✓ Is the system intervening soon enough in the progression of mental health and addiction problems?

Suggested Indicators:

- # of SMI and non-SMI individuals under care by geographic area
- Wait Times for Child & Adolescent MH&A services by geographic area

QUADRANT #3: Resource Allocation

Key Performance Questions:

- ✓ Are there sufficient resources to treat mental health and addiction problems?
- ✓ Are these resources being used cost-effectively?
- ✓ Do priority populations have equitable access to available services?

Suggested Indicators:

- Staffing levels (per capita) by geographic area for key service functions
- Cost per unit of service (adjusted for client acuity)
- Equity Analysis for Priority Populations (e.g. aboriginal, francophone, rural residents, individuals in the criminal justice system)

QUADRANT #4: Service Integration

Key Performance Questions:

- ✓ Do the different parts of the system work well together?
- ✓ As a client, was the transition ("hand-off") between service providers a positive experience?

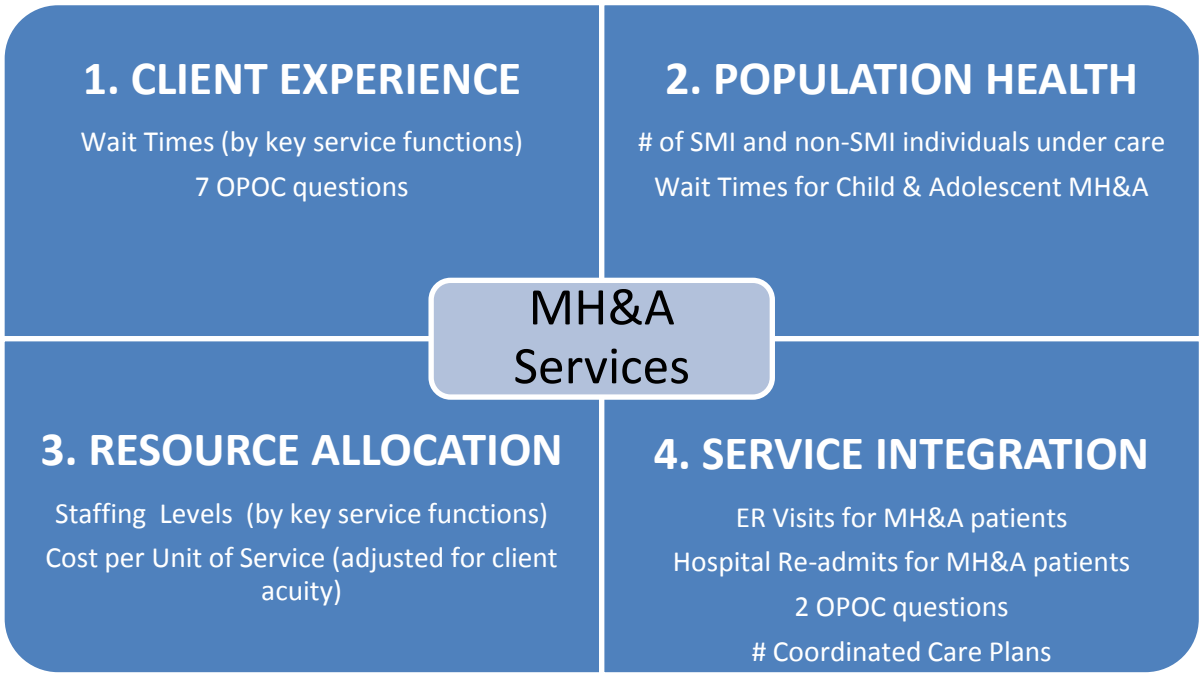
Suggested Indicators:

- ER Visits for MH&A patients by geographic area
- Hospital Re-admits for MH&A patients by geographic area
- # of Coordinated Care plans for high-needs, complex care clients

Key OPOC questions:

- Q28: I have a plan that will meet my needs after I leave the program.
- Q29: Staff helped me identify where to get support after I leave the program.

Summary of MH&A Performance Scorecard Indicators



RECOMMENDATIONS:

THAT the Ontario Perception of Care (OPOC) tool be adopted by the South West LHIN, the South West A&MH Health Coalition and the five geographic MH&A Networks as the preferred methodology for assessing the experience of clients with mental health and addiction issues; AND FURTHER THAT the South West LHIN, through the South West A&MH Coalition, work with Dr. Brian Rush and CAMH colleagues on an implementation strategy for standardized use of the OPOC tool among all mental health and addiction agencies;

THAT future performance measurement of MH&A services include client feedback on staff sensitivity to cultural/linguistic needs (as per OPOC tool above);

THAT South West A&MH Coalition work with the South West LHIN on implementing the necessary tools to support the development of a quality and performance scorecard for mental health and addiction services consistent with the Triple Aim framework and the LHIN's Quality Improvement Enabling framework;

THAT the refinement and implementation of a performance scorecard for mental health and addiction services be the joint responsibility of the South West LHIN and the five MH&A Networks in terms of collecting and tracking the required information.

SECTION 7 – PRIORITIES FOR ACTION

Based on the stakeholder consultations, further data analysis and original recommendations where there has been insufficient progress, the following are the top system-wide priorities for action for the South West LHIN and its mental health and addiction service providers.

- ✓ Safe, Affordable and Supportive Housing
- ✓ Coordinated Access
- ✓ Peer Support
- ✓ Crisis Response Services
- ✓ Collaboration with Primary Care
- ✓ Special Priority Populations

7.1 Safe, Affordable and Supportive Housing

This was the number one issue identified during consultation with stakeholders. Without proper housing with supports, there can be no recovery for individuals with persistent and serious mental health and addiction problems. One of the recommendations from the original 2011 report still requiring attention is:

THAT the South West Addiction and Mental Health Coalition conduct further research into the numbers of individuals who are homeless or at risk of homelessness and their needs in terms of mental health and addiction services.

One of the key priorities from the government's 10-Year Plan for Mental Health and Addictions (*Open Minds, Healthy Minds*) is: '**Create healthy, resilient, inclusive communities'** and one of the key strategies for achieving this goal is: '**Harmonizing policies to improve housing and employment supports'.** Specifically the 10-Year Plan states:

Safe housing and stable employment are crucial for the mental health and well-being of all Ontarians. If we have means of supporting ourselves and a place to call home, we are more likely to be able to cope. While Ontario has come a long way in improving its housing and employment programs, we need to do more to ensure programs work together and benefit those who need them the most.

Measurable success should be defined as:

More people living in safe, stable homes and fewer living in shelters or hospitals.

Since the approval of the original 2011 report, all upper tier municipalities have been required to develop Housing and Homeless Prevention Strategies in accordance with the Ontario Housing Services Act, 2011 (see Appendix I for a summary of these plans developed in 2013).

As an example, the City of London's Homeless Prevention & Housing Plan identifies two strategic priorities:

1. *Individuals and families experiencing homelessness obtain and retain housing and individuals and families at risk of homelessness remain housed;*
2. *We provide an integrated mixture of affordable and adequate housing options for the greatest number of people in need*

With respect to the homelessness prevention priority, the City's key strategic objectives are:

- Securing housing
- Housing with support
- Housing stability
- Shelter diversion
- Based on the philosophy of '**Housing First' or "Housing with Support".**

Housing First Principles:

- ✓ Immediate access to housing with no housing readiness conditions
- ✓ Consumer choice and self-determination
- ✓ Recovery orientation
- ✓ Individualized and person-driven supports
- ✓ Social and community integration

The Mental Health Commission of Canada has recently released its final report on a 2-year study of 2,000 homeless individuals in 5 Canadian cities. The research results strongly reinforce the tangible client and system benefits that can be achieved by adopting a 'Housing First' strategy:

In Canada, our current response relies heavily upon shelters for emergency housing and emergency and crisis services for health care. Typically, individuals who are homeless must first participate in treatment and attain a period of sobriety before they are offered housing. This is a costly and ineffective way of responding to the problem. Alternatively, Housing First (HF) is an evidence-based intervention model… that involves the immediate provision of permanent housing and wrap-around supports to individuals who are homeless and living with serious mental illness, rather than traditional "treatment then housing" approaches. HF has been shown to improve residential stability and other outcomes[18]*.*

[18] Mental Health Commission of Canada, "National Final Report: Cross-Site At Home/Chez Soi Project", 2014

For individuals with mental health and substance abuse problems experiencing homelessness or housing instability or living in substandard or unaffordable housing, a Housing First strategy can only be accomplished through strong working relationships between housing and health and human service providers and their respective funding bodies including LHINs.

Recommendations from a recent report by the Ontario Non-Profit Housing Association[19] are instructive in this regard:

- *There is a general and pressing need for LHINs to enhance their housing policy capacity. LHINs should have designated staff to "hold the housing file" and actively liaise with supportive and social housing providers, service managers, and the Province.*
- *Supportive housing providers will continue to enhance coordination with the health system, but the health system should acknowledge that supportive housing differs legally and philosophically from sites of medical care.*
- *Integration should focus on coordination between funders, in addition to between funded agencies*
- *Development of new supportive housing is challenged by the division of responsibility for limited available funding between service managers (capital) and LHINs (support services). Funding streams should be coordinated and enhanced to smooth the path to new development of much-needed supportive housing.*
- *LHIN-funded services delivered in social housing can help stabilize unsupported tenants and improve social housing communities, while reducing unnecessary use of resource-intensive components of the health care system. Such building-based services in social housing and collaboration between LHINs and social housing providers should be expanded on a province-wide basis, with Provincial financial support.*
- *LHIN-service manager collaboration will be required to reach province-wide goals for the housing and health systems, including ending and preventing homelessness and reducing costs associated with the top one per cent of health system users. Collaboration should be enhanced with Provincial financial support to build necessary linkages.*

One of the recommendations from the original 2011 was more narrowly focused on outreach/on-site support to municipal social housing units but should now be considered part of a more comprehensive local housing strategy based upon on a 'Housing First' philosophy

THAT The 5 Mental Health and Addiction Networks, in partnership with municipal social housing managers, should develop collaborative strategies to provide on-site and outreach services to those social housing units (buildings) where the need for intervention and support is greatest.

[19] ONPHA, "FOCUS ON: LHINS and the Housing System", Volume 4, Dec. 2013

Another supportive housing recommendation from the 2011 report that stakeholders agree requires further action is:

THAT the South West LHIN, RMHC and the 5 Mental Health and Addiction Networks, work with the Ministry of Health and Long Term Care to better integrate Homes for Special Care (HSC) units with other supportive housing providers to ensure consistency with best practice supportive housing.

SUPPORTIVE HOUSING RECOMMENDATIONS:

THAT the South West LHIN, the South West Addiction and Mental Health (A&MH) Coalition and the five geographic Mental Health & Addiction (MH&A) Networks adopt a 'Housing First' philosophy to support individuals with mental health and substance abuse problems who are homeless or in inappropriate or unstable housing situations;

THAT the South West LHIN support a facilitated process to work proactively with MH&A service providers, municipal social housing managers and the Ministries of Health and Municipal Affairs and Housing on regional and provincial strategies in support of 'Housing First';

THAT each MH&A Network expand its membership to include municipal social housing managers;

THAT each MH&A Network work with their respective upper tier municipalities with a goal of developing a collaborative local plan for increasing the supply of housing with supports consistent with municipal Housing and Homelessness Plans;

THAT the South West LHIN, RMHC (St. Joseph's) and the 5 MH&A Networks, work with the Ministry of Health and Long Term Care to better integrate Homes for Special Care (HSC) units with other supportive housing providers to ensure consistency with best practice supportive housing.

7.2 Coordinated Access

Since the 2011 report, there has been ongoing progress in creating more coordinated access strategies in the LHIN's five geographic planning areas:

North (Grey Bruce)
For many years, Mental Health Grey Bruce (MHGB) has been providing coordinated local access to some but not all mental health and addiction services through its innovative rural model of five multi-disciplinary, geographic teams. More recently, there has been an external evaluation of MHGB which may have implications for coordinated access.
Central (Huron Perth)
In December 2012, the core members of the Huron Perth Network launched the Huron Perth Addiction and Mental Health Alliance through a legal agreement between six partner organizations. The agreement supports an integrated management approach for coordinating mental and addiction services and improved access through a single new Helpline phone number. A qualitative review of the Alliance was recently conducted.
South (Oxford)
Coordinated Access has been a LHIN-facilitated process with the following accomplishments to-date: • Shared calendar in development between CMHA Oxford and Oxford Elgin Child and Youth Centre, using the Connex platform. • Consensus reached on use of two screening tools (GAIN Short Screener and a second screener for woman abuse) with staff training planned for April 2014
South (Elgin)
Coordinated Access has been a LHIN-facilitated process with the following accomplishments to-date: • Shared calendar in development between CMHA Elgin and Oxford Elgin Child and Youth Centre, using the Connex platform. • System wide training provided in January 2014 on GAIN Short Screener and woman abuse screener followed by implementation into practice
South (London-Middlesex)
Coordinated Access has been a LHIN-facilitated process with the following accomplishments to-date: • Shared calendar between CMHA London and WOTCH using the Connex platform, has been operational since June 2012. • A common intake referral form was implemented between CMHA and WOTCH. • Coordination of intake teams took place in May 2013. Teams share space, coordinate referrals, services and intake processes. • As a result of the amalgamation to create CMHA Middlesex, a single telephone number

has now been established for coordinated intake.

Outside of the LHIN-facilitated process, the two London Hospitals had previously implemented a successful Coordinated Access Program (CAP) to improve the transfer of patients from LHSC to RMHC (St. Joseph's). CAP has been facilitated by a nurse manager who coordinates activities related to admissions and discharge within and between the two facilities including maintaining close linkages with the emergency/inpatient continuum, monitoring available beds, evaluating the potential for discharge and communicating with various health care providers regarding transfers. Over time, CAP has expanded to include all referrals to bedded care at RMHC. A 2012 review recommended:

RMHC and LHSC continue in the partnership of Access and Intake recognizing that the Coordinated Access Teams extension into LHSC, their largest referring partner, streamlines both the process and patient experience. Likewise, recommend the continuation of the existing coordinated intake which creates a single point of entry for Ambulatory care in London Middlesex creating the foundation for the community to consider further development of shared access with a view to a virtual single point of entry for all Mental Health in London Middlesex.

RMHC and LHSC have more recently implemented a coordinated approach for access to their acute and specialized ambulatory programs. RMHC (St. Joseph's) and LHSC share a single point of entry (Monday to Friday, 8-4) with each hospital contributing a nurse case manager. It is currently a physician-driven service but can be expanded to include community referrals.

While these Coordinated Access accomplishments have been important, consumer and provider feedback suggests that the system remains difficult to access and navigate, particularly in the LHIN's South planning area. A summary of Coordinated Access models from across the Province is contained in Appendix G. Based on these and other examples, there is more progress to be made in improving access and system navigation for patients and clients in the South West LHIN with mental health and addiction problems.

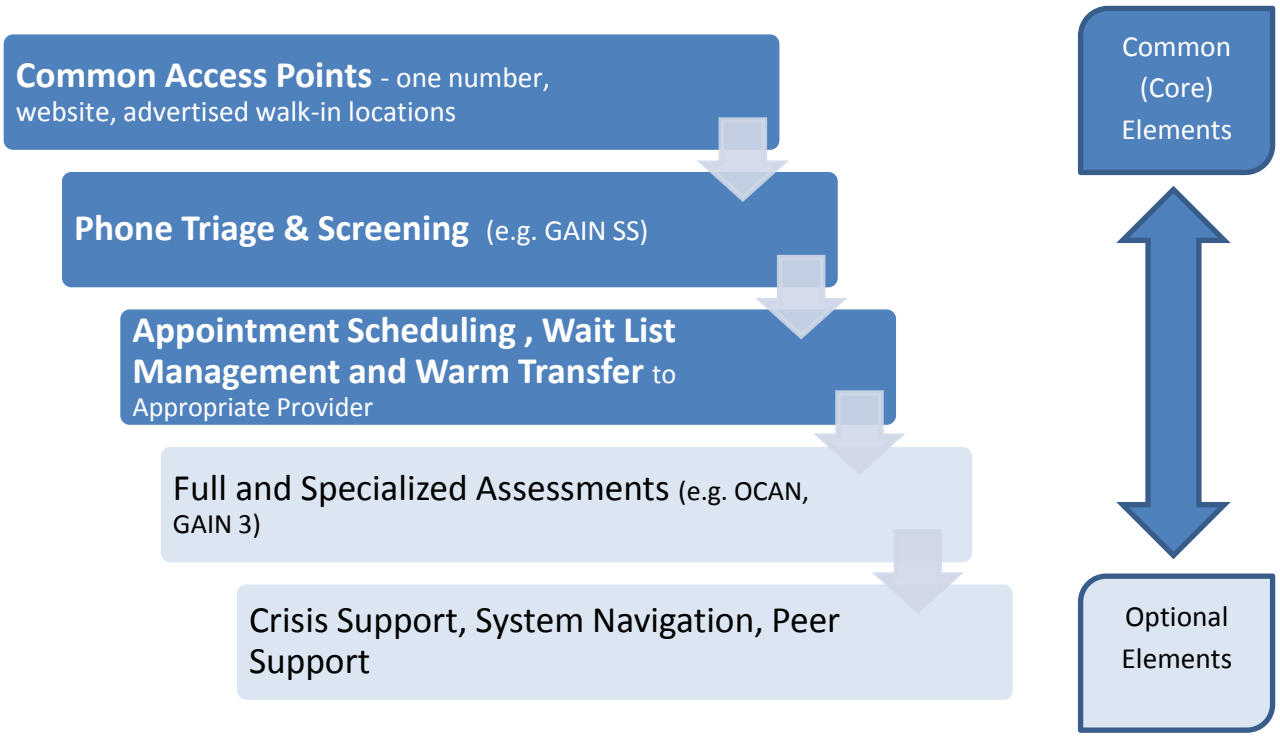
Figure 3 highlights the common components of many of these Coordinated Access (CA) models. There is no single best practice model so each jurisdiction needs to determine what the key components should be and how comprehensive the access model should be in terms of coordinated access to which services.

Design parameters for planning and implementing a local Coordinated Access model should include:

- All services or some (mental health vs addictions, hospital vs community)?
- All types of calls or some (urgent vs non-urgent)?
- Just screening and referral or fuller assessments?
- Access to urgent psychiatric consults?

- Redeploy existing staff vs hiring new staff?
- Governance/management agreement required to support the CA model?

Figure 3 - Core Components of a Coordinated Access Model (Non-Urgent Calls/Visits)



COORDINATED ACCESS RECOMMENDATIONS:

THAT the three MH&A Networks in Oxford, Elgin and London-Middlesex make the design and implementation of a local Coordinated Access (CA) model a top priority in 2014/15 with a designated lead agency for these initiatives;

THAT the South West LHIN provider support for local CA processes including research, design, planning and implementation;

THAT an expanded CA model in Oxford build on the successful components of the Oxford Addiction Treatment Strategy (OATS) and an expanded CA model in London-Middlesex build on the successful components of the CA approach shared by the London hospitals;

THAT the Grey Bruce and Huron Perth networks continue to review and refine their existing CA models based on emerging best practices and the results of recent external evaluations of their respective partnership/alliance models.

THAT Coordinated Access Models that have been and will continue to be developed by the five geographic MH&A Networks include:

- ***Single access phone number available in both official languages***
- ***Screening and assessment tools that have been reviewed to ensure cultural appropriateness***
- ***For Aboriginal clients, referrals options that include both mainstream services, as well as Traditional Healers and Aboriginal services***

7.3 Peer Support

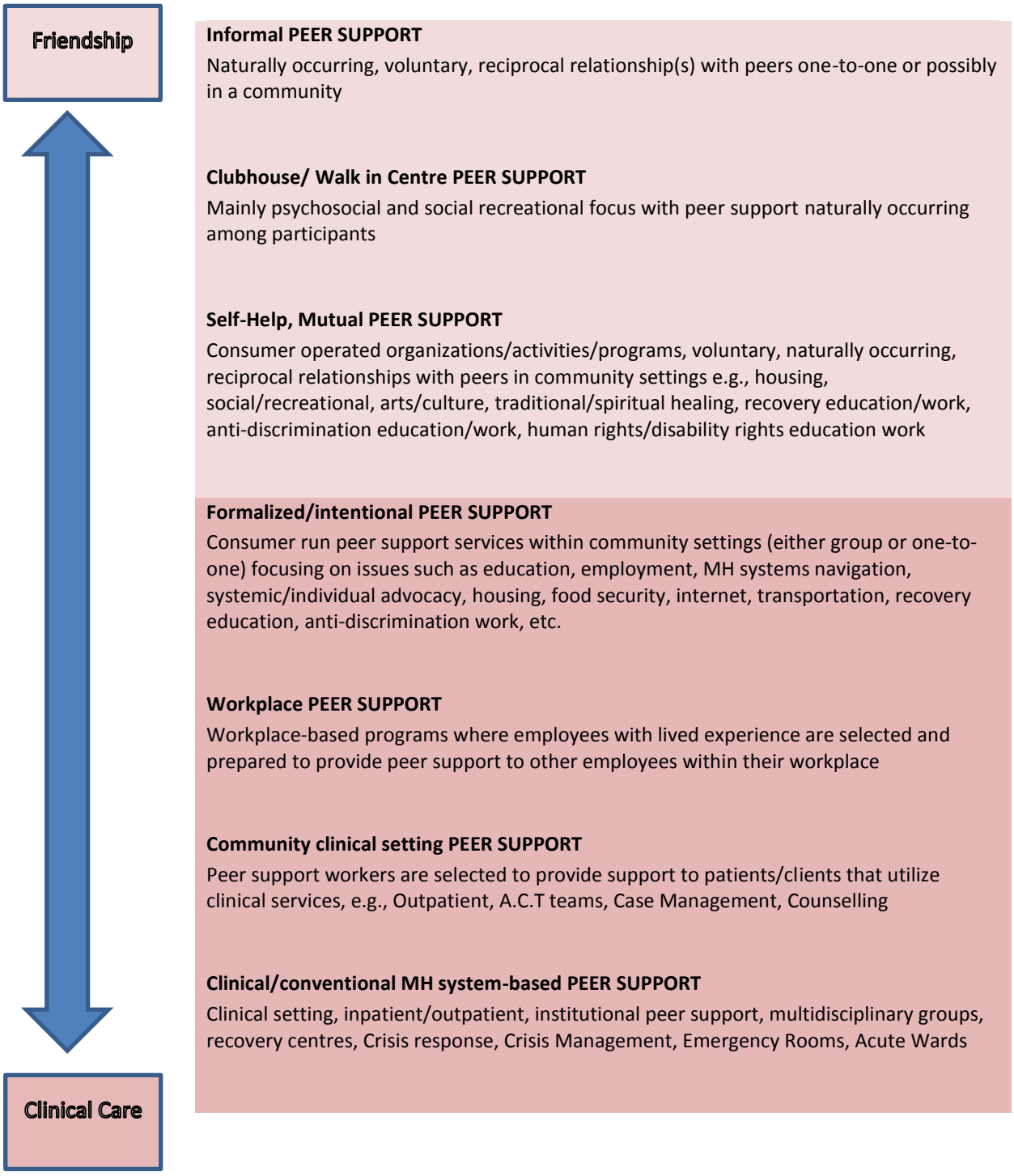
There is no better way to create a mental health and addiction service system that is more cost-effective and more client-centred than by strengthening peer supports.

Peer support services are effective in encouraging people to move from "patienthood to personhood". Benefits include: decreasing hospitalization and mental health service usage, reduction of symptoms of mental distress, increases in quality of life, improvements in social support and accommodation/housing, increased rate of volunteering and employment, less reliance on benefits, improvements in physical health (when this was targeted) and increases in use of recreational and community agencies; in addition as peer support workers cost less than clinicians – suggesting that they are cost-effective. Peer workers have also been used successfully in education, evaluation and training roles. All roles may lead to the decrease of stigma as people in services and communities see consumers contributing to services in a positive way[20].

The Mental Health Commission of Canada (MHCC) has recently released its guidelines for the practice and training of peer support. Based on their research regarding best practices, the new guidelines recommend that a full spectrum of peer supports should be in place – see Figure 4 below. In the South West, most of the Consumer Survivor Initiatives (CSIs) have focused on informal peer support options (e.g. one-to-one friendship support, clubhouse drop-in models etc.) because of limited operating budgets. To take full advantage of the power of peer support in terms of both client experience and system improvements, the MHCC recommends that in addition to these important informal supports, more formalized and intentional peer support options should be available especially in various clinical settings.

[20] Janet Peters, "Walk the Walk and Talk the Talk: A summary of peer support activities in *International Initiative for Mental Health Leaders* (IIMHL) countries", Nov. 2010

Figure 4 - Spectrum of Peer Supports (Mental Health Commission of Canada)



The LHIN did make some modest investments in peer support and consumer/survivor initiatives in 2011-12 and did earmark funds in 2013-14 for the following 2011 recommendation:

THAT the South Western Alliance Network and the South West Addiction and Mental Health Coalition should develop a proposal for a new regional peer support organization which can provide consultation, education, training, system advocacy and peer support accreditation. The new organization will need to align new investments in peer support and any future allocations to ensure there are sufficient resources to provide peer support to the new Coordinated Access model, in particular for individuals on the centralized wait list, and to all multi-disciplinary professional teams supporting individuals with SMI. Existing CSIs and the RMHC Patient Council will need to be formally linked to the new organization through multi-agency accountability agreements.

There is now a more urgent need to move forward with a strategy to strengthen peer support as an essential part of the mental health & addictions continuum of care in the South West based on best practice models. The original report envisioned a stronger regional peer support structure that could provide leadership and support for a range of functions such as:

- System planning
- System and policy advocacy
- Training & certification
- Mutual aid
- Coordinate back-office functions (e.g. shared service agreements)
- Performance measurement to demonstrate value (e.g. reduced hospitalization, ER visits)

There is also a pressing need to stabilize existing independent Peer Support/CSI organizations which are challenged by increasing costs and no base budget increases. As noted in the original report, these are very small organizations with the same LHIN reporting requirements as much larger health service providers. Peer support initiatives need to maximize the skill and ability of those providing peer supports through a strengthened and sustainable peer support infrastructure.

Given the need to create stronger peer support infrastructures at both a local and regional level, revised recommendations for a comprehensive Peer Support project are as follows:

PEER SUPPORT RECOMMENDATIONS:

THAT The South West LHIN identify a Health Service Provider (HSP) to lead a Peer Support project in 2014/15 with a goal of strengthening peer support integration and infrastructure across the South West by looking at two key issues:

- ***A best practice model for a regional structure to drive practice standardization & training and the adoption of a full range of peer supports embedded in the continuum of mental health and addiction services; and***

- ***A best practice model for local consumer support initiatives to augment the local service delivery system, maximize resources for direct peer supports and reduce the administrative requirements for existing CSIs;***

THAT a thorough review of integration and partnership models be conducted as part of this project as well as national and international best practice peer support initiatives;

THAT the lead HSP work with the South West Alliance Network (SWAN) and the South West A&MH Coalition to ensure all key stakeholders (both providers and individuals with lived experience) are fully engaged and regularly consulted over the course of this project.

7.4 Crisis Response Services

As part of the implementation of the 2011 report, the LHIN produced a follow-up report on "Remodeling the London Mental Health Crisis Response System" (April 2012). The recommendations from this report were as follows:

- ✓ Enhancement of the capacity and skill of the Mobile Outreach Team to respond around the clock every day of the year to mental health crises whenever and wherever they occur in the City of London;

- ✓ Implementation of six short term (up to 72 hours) non-medical crisis/relief beds at an existing staffed facility as a means of providing stabilization to people in crisis who have no current medical/psychiatric needs;

- ✓ Establishment of a Crisis Services Centre in close proximity (but not in the hospital) and functionally coordinated with the Emergency Department of LHSC for people experiencing a mental health crisis who require assessment and follow-up, but who do not have current medical/psychiatric needs.

With respect to the mobile crisis response team, feedback from a number of stakeholders (including London police) is that the introduction of the London team has been an important addition to the crisis response system. However, as community-based crisis response services continue to develop across the South West LHIN, there are still lingering questions about appropriate staffing levels, skill mix, hours of service and capacity of existing services in each of the LHIN's three planning areas as well as appropriate rural response capacity at the many small hospital sites across the South West LHIN. This is a key component of a community-based

service system and would benefit from further LHIN review of capacity, function and (if necessary) further standardization.

The two remaining recommendations from the 2012 London crisis report are still a 'work-in-progress' with funding proposals under development.

CRISIS RESPONSE RECOMMENDATIONS:

THAT the South West LHIN review the capacity, function and utilization of all community-based crisis response services to determine if further standardization is required in terms of staffing, hours of service, service delivery model and outcomes;

THAT the South West LHIN provide ongoing support to the implementation of previous recommendations to improve crisis response services in the City of London (i.e. short term crisis beds and the development of a London Crisis Centre);

THAT the South West LHIN continue to work on improving urgent access to Schedule 1 psychiatric assessments through the work of the LHIN Lead for Emergency Departments.

7.5 Collaboration with Primary Care

Over the last 5 years, there have been significant investments in primary care and specifically the implementation of Family Health Teams (FHTs) throughout the South West LHIN. While strengthening and improving access to comprehensive primary care has had many benefits for rostered patients, it has led to increasing confusion about the role of primary care in the continuum of mental health and addiction services. Many of the Family Health Teams have social workers and mental health counsellors on staff but there appears to be considerable variability among FHTs about the types of mental health and/or addiction clients they could or should be seeing.

Developing a more collaborative partnership between the primary care sector and the mental health and addictions sector has been difficult for several reasons:

1. There has not been a consensus among providers and funders about the types of collaborative arrangements that would work best depending on client needs;
2. FHTs have a wide range of governance and management structures most of them focused on single communities and it has been challenging for other service providers to interact with them as a 'system' of providers.
3. Timely access to psychiatric assessments has been an ongoing challenge.

Collaboration success stories, where they do exist, have all been based on local relationships between either clinicians, administrators or front-line staff.

There has been some more recent work to engage primary care and psychiatry through sessional fees with community mental health providers. A London-based project proposal has been developed, based on a collaborative care model, with the intention to maximize existing resources by ensuring that psychiatry is present in the community and supported through sessional fees some of which to-date have been returned unspent.

The terms of reference for this Psychiatry Sessionals project are as follows:

1. Address current barriers to the uptake of psychiatry sessionals
2. Coordinate the recruitment of psychiatrists across agencies
3. Describe an economical method for providing administrative support for the sessional positions
4. Describe how patients will transition between primary care and mental health / addiction community agencies (in either direction) and how care will be shared when patients are followed by both types of agencies at the same time

A recent report from the British Columbia Ministry of Health based on a best-practice literature review[21] is instructive and could form the basis for a collaborative planning framework for the primary care and mental health and addiction sectors in the South West:

Community models of integrated care	Severity of client needs	Setting / provider / type of care
I – Communication Approach		
1. Communication between practices	mild to moderate	Separate practices, care/case management, psychiatric consultation
2. Medical-provided MH&A care	mild to moderate	Consultation-liaison; care is physician-provided with specialized support
II – Co-Location and Collaboration Approach		
3. Co-location	mild to moderate	Shared space - separate service; collaborative care; provision of education & self-management; independent treatment plans which may include references to the other.
4. Shared care	mild to moderate	Services generally provided **at primary care (PC) site**, care manager provides follow-up care by monitoring individual's responses and adherence to treatment; MH&A service outreach to GP; provision of education & self-management; treatment plan is primary care of which MH&A is a component.

[21] BC Ministry of Health, "Integrated models of primary care and mental health & substance use care in the community: Literature review and guiding document", (August 2012)

II – Integrated Team Approach		
5. Reverse shared care	moderate to severe & persistent	Services provided **at the MH&A site**, shared space where the general/nurse practitioner (full or part time) is in a psychiatric/MH&A setting; treatment plan is primarily MH&A of which primary care is a component.
6. Specialized 'hub & spoke' outreach teams	severe and/or persistent/ complex	Building upon shared care, specialized multi-disciplinary teams provide the GP, family and other care providers with specialized assessment, consultation, education & support, and time-limited direct treatment to the individual **in the community setting**.
7. Unified care	severe & persistent	Full-service primary care & full-service MH&A/psychiatric care in one place; organization-wide integration of clinical services, financing, administration and integrated medical record/treatment plan.
8. Primary Care MH&A team	moderate to severe	Fully-integrated – MH&A staff part of PC Team and co-manage care; focus on brief interventions for a large number of client/patients; one-stop concept at intake.
9. Fully-integrated system of care	severe & persistent/ complex	Wrap-around teams, seamless continuum of outpatient and supported housing; inter-disciplinary (outpatient and residential); Individualized care plans for high-risk individuals across multiple service agencies/ disciplines.

It is worth noting that the 'fully-integrated system of care' model (#9) is consistent with the ACT team model and the individualized coordinated care planning that is being recommended for Health Link patients/clients. In the BC framework, they use the term' integrated' to mean:

Those models of care where one care plan and a multi-disciplinary team is responsible for the overall care of an individual and often goes beyond the particular area of specialization to address numerous health and social needs. Individuals who require integrated care models would likely have complex health and social needs that require specialists, various health providers and support workers to work as a team to address and improve the determinants of health for these individual.

A fuller description of these collaborative models is found in Appendix H.

With the advent of Health Links, the need for service providers to share in the development of coordinated care plans for complex patients is growing in importance. The Ministry of Health has developed a Coordinated Care Plan (CCP) template for use by Health Links projects (see Appendix L). It will be important that this CCP template meet the needs of complex patients with serious and persistent mental health and addictions problems.

PRIMARY CARE RECOMMENDATIONS:

THAT each MH&A Network create stronger working relationships with local primary care services through expanded Network membership and/or working groups to look at how the two sectors can more effectively collaborate;

THAT each MH&A Network in collaboration with local primary care services prepare an inventory of available mental health supports and services in the primary care system and assess what collaborative care models would be most effective, especially for non-SMI clients;

THAT the South West Primary Care Network in collaboration with the South West A&MH Coalition examine options for strengthening mental health and addiction service capacity in existing primary care structures;

THAT the South West LHIN, the South West Primary Care Network and the South West A&MH Health Coalition review the Collaborative Care Plan template that has been developed for Health Links to ensure that it will meet the needs of high-needs, complex care clients with mental health and/or substance abuse problems.

7.6 Special Priority Populations

Consultations with Francophone and Aboriginal representatives highlighted a number of ongoing systemic challenges for providing services to these two important groups. The following recommendations were developed in consultation with the respective LHIN Leads based on the input received during stakeholder consultation sessions.

FRANCOPHONE RECOMMENDATIONS:

- ***THAT the South West LHIN's French Language Coordinator, work with Identified Health Service Providers (HSPs) to map existing French Language Service (FLS) capacity in the MH&A system in terms of gaps and opportunities;***

- ***THAT the program advisory committee structure being developed for Addiction Services of Thames Valley's new telemedicine system navigation service be evaluated for its potential to evolve into a regular forum of service providers, with French Language capacity, to provide ongoing input to the development of enhanced and integrated Francophone services for MH&A clients;***

- ***THAT all proposal submissions to the South West LHIN from Identified or Designated HSPs for new or expanded funding include an FLS component as per the French Language Services Toolkit;***

- ***THAT all MH&A service providers receive cultural/linguistic competency training including the importance of 'Active Offer' of French Language Services[22]***

ABORIGINAL RECOMMENDATIONS:

- ***THAT the South West LHIN support the ongoing re-design of Aboriginal health services across the Southwest based on a service delivery model of that is holistic, client-centred and integrated using the principles of Experience-Based Co-Design and respectful Aboriginal/ First Nations participation;***

- ***THAT this re-design work be guided by the Aboriginal Health Committee with support from the LHIN's Aboriginal Health Lead and include a 'current state' baseline analysis of: service gaps, client experiences, current and emerging aboriginal community needs, the types of MH&A services that have and have not been funded from other levels of government, and linkages with non-Health funded services (e.g. MCYS Aboriginal case managers);***

- ***THAT Aboriginal cultural competency training for South West LHIN health service providers be an MSAA requirement;***

- ***THAT the South West LHIN support capacity building for Aboriginal MH&A services through more formal linkages and partnerships with mainstream service providers that include:***

    - ***Better access to clinical supports and expertise for Aboriginal clients***
    - ***Support for Aboriginal /First Nations staff training (e.g. providing team-based care across the life cycle)***

[22] See Section 2 of FLS Toolkit and "Practical Guide for the Active Offer of French Language Services in the Ontario Government", Office of Francophone Affairs (April 2008)