



THUNDER BAY DISTRICT
SOCIAL SERVICES ADMINISTRATION BOARD

Environmental Scan:

The Impact of Mental Health System Reform on
Social Services in Thunder Bay District

December 2007 (rev. Oct. 2008)

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EXECUTIVE SUMMARY

Health care and social services are naturally linked due to the shared goal of assisting people to maintain and improve their quality of life. Over the last half-century, and particularly within the last ten years, there have been continual efforts to reform the mental health system in Ontario which have impacted the social services system, social services clients, and social service providers.

Opinions and perceptions have been expressed to the Thunder Bay District Social Services Administration Board (TBDSSAB) by clients, social service providers and others that the availability and coordination of mental health services in Thunder Bay District may have declined over time in spite of the recent planning and reform efforts intended to improve the mental health system.

Results:

- Social service providers express significant concerns about the experiences of clients and social service programs with the mental health system.
- Many of the recommendations contained in the large number of recent mental health system reform plans and documents have not been fully implemented.

Recommendations:

- That the national, provincial, and local studies and reports on mental health system reform completed over the last ten years not be entirely repeated as a precursor to action;
- That the recommendations already made be acted upon by the provincial government or its designates to improve the mental health system in Thunder Bay District;
- That relevant outstanding recommendations contained in the 2002 Northwest Mental Health Implementation Task Force report *A Regional Mental Health System for Northwestern Ontario* be acted upon by the North West Local Health Integration Network as soon as possible;
- That to avoid gaps in and duplication of service, systems and procedures for greater information sharing and integrated planning between the health and social services systems be established at a provincial level; and
- That the North West LHIN examine the adequacy of crisis care services, inpatient beds, and supportive housing spaces available in Thunder Bay District for treatment of people with mental health problems.

1. Introduction

Purpose of This Report

Over the last half-century there have been continual efforts to reform the mental health system in Ontario. Many of these initiatives are incomplete or still underway. The purpose of this report is to make a preliminary assessment of the impact of the most recent of these reform efforts on the social service system and its clients in Thunder Bay District.

This Environmental Scan was prompted by opinions or perceptions expressed to the Thunder Bay District Social Services Administration Board (TBDSSAB) by clients, social service providers and others that the availability and coordination of mental health services in Thunder Bay District may have declined over time in spite of several recent planning and reform exercises intended to improve the system. These opinions or perceptions have been communicated to both staff and Board members of TBDSSAB, and are in part complemented by a lack of information readily available to the Board concerning the status of mental health system reform and ‘who does what’. The impact of a decline in accessibility or organization of the mental health system is potentially very serious for clients of TBDSSAB for a number of reasons; therefore the Board has requested this preliminary *Environmental Scan* with a view towards making whatever recommendations for system improvements and/or coordination with the social services sector are warranted at this time.

Except where noted, ‘social service system’ or ‘social services’ herein refers specifically to two social services funded and managed by TBDSSAB – *Ontario Works* and *Social Housing*.

TBDSSAB fully acknowledges that it is not the responsibility of the Board to plan, monitor, assess, or deliver health services, and furthermore that it was not possible to conduct a completely exhaustive review of the current status of mental health system reform due to the complexity of the task and time and resource considerations. There also exists a well-documented lack of concrete data upon which to base any examination of the mental health system. It is furthermore not the purpose of this report to affix credit or blame in any respect, or to provide substantive criticism or endorsement of mental health system reform efforts. It is also not within the scope or intention of this paper or of TBDSSAB to evaluate the quality of the mental health system or the quality of services provided.

This report is nonetheless intended to provide information concerning the possible impact of changes to the mental health system on social services clients and programs, and to spur productive discussion and renewed activity towards the creation of better integrated mental health and social service systems in Thunder Bay District.

The Thunder Bay District Social Services Administration Board (TBDSSAB)

The Thunder Bay District Social Services Administration Board (TBDSSAB) was established on April 1, 1999 by the District Social Services Administration Board Act. TBDSSAB is composed of 15 member municipalities and is responsible for the funding, management and delivery of Ontario Works, Licensed Child Care, and Social Housing in the Thunder Bay District. TBDSSAB Board members are elected members of the municipal level of government and territories without municipal organization.

Ontario Works

Ontario Works is Ontario's basic income security or social assistance program. The Ontario Works Program has two components:

- Short-term financial assistance to individuals and families in need, and
- Specific support and assistance to program participants in meeting their participation responsibilities under the *Ontario Works Act*.¹

Financial assistance provided through Ontario Works is limited to basic amounts for food, clothing, medication, and shelter in addition to a limited number of discretionary benefits.

As of September 30, 2008, Ontario Works served approximately 5,059 persons through 2563 'benefit units' (or individual and family clients) in Thunder Bay District.

Homeless shelters are also funded by the Ontario Works program through a per-diem system.

Social Housing

'Social Housing' is a broad term which describes programs that utilize public funding to construct, maintain, provide, or subsidize the cost of dwellings for low-income households. Social Housing is a social or economic program that solely provides assistance with housing and is not a health care or other type of support program in the sense that only physical accommodation is provided or subsidized based on economic need. Supportive services (such as nursing care, counseling, child care, education, recreation, etc.) may be available to social housing residents as they would be to residents

¹ *Participation responsibilities* are a central component of Ontario Works and include signed participation agreements between the client and provider outlining that the client will undertake negotiated activities such as seeking employment, completing basic education, undertaking volunteer work, or achieving self employment. Other participant responsibilities include complying with legislative, regulatory, or policy requirements to produce various types of documentation, attend appointments, etc.

of non-subsidized housing in the general population, i.e. through separately-funded third-party providers.

The Social Housing Division of TBDSSAB is responsible for the administration of approximately 4,300 social housing units, operated by twenty-seven (27) non-profit corporations with housing portfolios located throughout the District of Thunder Bay. All non-profit housing providers have a direct reporting relationship with TBDSSAB through the Social Housing Division.

Child Care

The impact of mental health reform activities on child and youth mental health services and therefore on Child Care was not assessed as part of this report.

2. Methodology

A variety of primarily qualitative methods were employed to assess the current status and effects of mental health system reform on TBDSSAB programs and clients. Due to time and resource considerations the methodology of the report focused on obtaining information from government as well as social service and mental health providers. Social service and/or mental health system clients were not interviewed or surveyed for the report and this is acknowledged as a potentially significant gap in information. It is to be noted that there are numerous documents incorporating client input which were reviewed for this report.²

There is a distinct and problematic lack of concrete data upon which to base any study or evaluation of the mental health system. The North West LHIN in its *Integrated Health Services Plan/Environmental Scan* dated October 2006 states: “The current unavailability of client-specific service data and comprehensive financial and statistical data has limited opportunities to ensure financial accountability and to compare clinical outcomes across providers. It has also hindered province-wide research for the sector.” (p. 135).

Literature Review

A plethora of local, provincial, and national documents relevant to reform of the mental health system in Thunder Bay District are available.² Many of these documents were reviewed in order to place the current status of reform efforts in historical context and in some respects to gauge progress, or to attempt to predict the future direction of reform efforts. The literature review also included extensive examination of various Government of Ontario and other websites containing information relevant to mental health reform.

Key Informant Interviews

Several interviews were conducted with key informants to obtain both concrete information concerning the current status of mental health system reform initiatives as well as to attain qualitative information such as interviewees’ perception of the accessibility or coordination of mental health services. The opinions expressed by interviewees represent their experiences and opinions, or the experiences of their clients as reported to them, and are not necessarily the opinions of TBDSSAB.

Analysis of TBDSSAB Financial and Statistical Data

Review of internal TBDSSAB financial and service data was conducted with respect to expenditures for mental health services purchased for social service clients by TBDSSAB, homeless shelter occupancy and per diem expenses, and other relevant data.

² See References section.

Survey of Ontario Works Caseworkers

A survey of Ontario Works Caseworkers was conducted to assess the level of information concerning the mental health system and its reform available to Caseworkers, to gauge the Caseworkers' perception of the impact of mental health issues on Ontario Works clients, and to assess trends and/or difficulties Caseworkers perceive in assisting clients to access the mental health system.

3. Impact of the Mental Health System on Social Services

Health care and social services are naturally linked due to the shared goal of assisting people to maintain and improve their quality of life. Ideally, health and social services are planned in an integrated fashion in order to avoid gaps in, and duplication of, service. The report *Out of the Shadows at Last: Highlights and Recommendations*, published in May 2006 also notes the outstanding need for (greater) integration:

Within the health sector, on the one hand, mental health services must be integrated with physical health care services. On the other, the variety of mental health treatments and services funded by ministries of health must also be integrated with the broader range of services required by people living with mental illness that are the responsibility of the several governmental departments and agencies that deal with income support, housing, employment, etc.³

The basic relevance of Ontario's mental health system to social service providers and clients is perhaps intuitively obvious. The health care and social services systems are intended to fulfill different societal functions, however. A conceptual distinction between the basic premises of social services programs and health programs is necessary in order to more clearly illustrate integration problems, or the difficulties which may arise when problems or changes in one system overlap into the other.

The Functional Intent of Ontario Works and Social Housing

Ontario Works and Social Housing are essentially economic support programs for low income individuals and families, and are not 'treatment' programs in a clinical sense. Ontario Works and Social Housing are intended to provide a minimum level of personal or individual economic security and societal stability by assisting people to meet their most basic financial needs on a temporary basis when they need help to do so. Social services are in this respect often referred to as the 'social safety net', from which people are expected to spring back to independence after a temporary fall.

There are many straightforward social and economic reasons why an individual or family may not be able to independently meet their needs for food, clothing, and shelter, such as being laid off work and subsequently unable to find a new job. The assumption of social services programs like Ontario Works is that the reasons affecting *eligible clients* are temporary and/or remediable through a limited range of economic or social interventions⁴. The time period required to achieve economic independence for eligible clients may vary from days to years, but is nonetheless assumed to be finite. Social service eligibility and service provision are therefore primarily based upon what may be defined as purely social or economic need rather than medical or clinical need. Clients of

³ *Out of the Shadows at Last: Highlights and Recommendations - Final Report of The Standing Senate Committee On Social Affairs, Science And Technology*, The Honourable Michael J.L. Kirby, Chair, The Honourable Wilbert Joseph Keon, Deputy Chair, May 2006, p.7.

⁴ Non-clinical interventions such as job training, basic life skills, job search training, educational upgrading (high school or GED), etc.

Ontario Works and Social Housing are not required to have any degree of identifiable medical pathology or functional physical or mental disability as the reason for requiring assistance. The assumption of these programs is in fact the opposite - that clients are capable of achieving independence *with or without* supports from third party providers such as home care or other community health teams and in most cases ‘getting off’ the program. This is not to say that social service clients do not have the same temporary or chronic medical or health problems as would be encountered in the general population. When these problems are properly managed and supported they do not present a barrier to independence for Ontario Works or Social Housing clients any more than they would for the general population. The same accommodations and supports that allow persons with physical disabilities, for example, to achieve employment and financial independence are expected for social services clients with physical disabilities.

Severe, unmanaged, unsupported, or undiagnosed health problems, and particularly mental health problems, can make it much more difficult (and at times impossible) for social service clients to both attain independence and even to maintain eligibility for social service programs. Participation in Ontario Works in particular requires a basic level of ‘health’ or functional ability to complete mandatory program activities as outlined by legislation and clients’ participation agreements. There is an implicit assumption that health problems and/or disabilities should have been or will be addressed by the health care system, and either ‘cured’, adequately managed, or certified as a barrier to achieving financial independence therefore removing the client from eligibility for Ontario Works and into eligibility for long-term health or disability services and financial supports⁵. Similarly, clients of social housing are assumed to be medically able to live independently in the community with or without in-home supports from third-party, community based health care or disability agencies or organizations. To maintain eligibility for social housing, a client must be able to live independently in the community without further assistance *from the social housing provider* beyond building maintenance and financial subsidy for occupancy costs.

In this sense, the social service system relies upon the health care system to address medical conditions which may present a functional barrier to independence, and by extension, participation in social service programs geared towards achieving or maintaining independence. TBDSSAB understands that it is the mandate of the health care system to identify persons with non-remediable medical conditions which prevent independent living with or without supports, and to make arrangements for long-term care and treatment. When the health care system does not function in this expected sense, the difficulties created for social service clients and systems are significant.

⁵ The Ontario Disability Support Program provides long-term income security for persons ineligible for Ontario Works due to medically certified disabilities which present a barrier to achieving economic independence (employment). Hospitals, long-term care facilities, and many supportive housing programs are health care- oriented or disability system- funded programs which provide accommodation for persons who are unable to live independently in the community with available community or ‘home-care’ supports.

Problems in the Social Service System Related to Mental Health System Reform

It must be acknowledged that TBDSSAB is aware that it is difficult and/or potentially impossible to prove a direct causal link, or even a clear correlation, between mental health system reform activity or inactivity and possibly increased difficulties experienced by social service clients with mental health issues. These difficulties are compounded by the lack of available data from the health care system upon which to base any analysis or evaluation. It is also not the purpose of this paper to fix blame for difficulties experienced by TBDSSAB clients, programs, or contracted service providers upon the mental health system or upon those responsible for its funding, planning, administration, or delivery.

Ontario Works

Interviews with Ontario Works staff reveal a clear and consistent pattern of difficulties encountered by clients attempting to access the mental health system. Workers and supervisors report that many clients present with the symptoms of mental illness and substance abuse/misuse.⁶ Caseworkers report that many of the apparent issues are untreated and/or undiagnosed, and that it is not clear where in the mental health system to refer clients with suspected mental health problems. The majority of Ontario Works clients do not have family physicians.

TBDSSAB has found it necessary to implement an Intensive Caseworker function to assist clients in the most extreme circumstances to navigate the health and mental health systems, and has contracted with a family physician to provide basic assessment and referral services in order to gain some access for clients to the mental health system.⁷

Ontario Works has been unable to obtain necessary mental health assessments from the mental health system for clients unable to participate in the program due to mental health problems. These assessments are necessary to help demonstrate that clients have a disability and are therefore not able to independently meet the requirements of Ontario Works participation agreements, and therefore maintain their benefits. Clients with such a disability inevitably fail to provide required documents or undertake required activities, and are therefore placed on hold or terminated (cut off) from the Ontario Works program due to legislative and regulatory requirements. Many clients have been found to be

⁶ TBDSSAB Ontario Works has implemented the Addiction Services Initiative (ASI) in response to the persistent need of OW clients for addiction treatment. Addiction treatment or system issues were not extensively reviewed for this report.

⁷ MPP Deb Matthews notes in her *Report to The Honourable Sandra Pupatello, Minister of Community & Social Services - Review of Employment Assistance Programs in Ontario Works & Ontario Disability Support Program* that “Concerns were repeatedly expressed that the application process for ODSP is extremely cumbersome for people with intellectual or mental disabilities. It prevents eligible people from applying; they stay on OW when they belong on ODSP. I heard many concerns that lack of access to a family doctor limits a client’s ability to apply for ODSP. Walk-in clinics will not participate in the application process.” p.10.

eligible for the Ontario Disability Support Program rather than Ontario Works, where there is no ongoing participation requirement to maintain eligibility and the clients may experience a stable income, prescription drug coverage, etc.

Beginning in 2003, TBDSSAB Ontario Works Division has found it necessary to pay for psychological assessments for harder-to-serve clients struggling to participate in the program due to suspected mental health and/or developmental or neurological problems. These assessments have not been readily obtainable in the publicly-funded mental health/health care system. In 2004, Ontario works paid for 46 clients to have Preliminary Intake with or without Brief Formal Assessments, Psychological Assessments, Neuropsychological Assessments, Learning Disability Assessments, Full Scale Intelligence Assessments, Psychovocational Assessments, and additional tests for a total expenditure of \$38,852. The need for assessments has grown consistently year-over-year. In 2007, 174 clients had been provided with psychological assessment services for a total cost of \$119,198, and so far 154 clients for a total of \$94,554 up to September 30, 2008.

Ontario Works staff completed 25 surveys concerning client mental health issues and mental health system accessibility. Highlights of the survey include:

- **100%** of respondents answered “no” when asked, “Do you feel that you have adequate information about the mental health system? (i.e. Are you aware of and do you understand recent and proposed restructuring? Do you know “who does what”?)”
- An average response of **50%** when asked “Please estimate what proportion of your clients has either diagnosed or undiagnosed mental health problems (such as symptoms of depression or anxiety lasting longer than two weeks, personality disorders, post-traumatic stress disorder, social dysfunction, evictions, substance misuse, anger, anxiety, lethargy, poor hygiene, strange behaviour, rambling speech, difficulty concentrating, self-harm, etc.)”
- An average response of **36%** when asked “Please estimate what proportion of your case management time *overall* is spent on mental health issues”
 - **100%** of respondents reported that the proportion of time spent on mental health issues is increasing.
- **92%** of respondents answered “no” when asked “Do you feel that the mental health system is adequately meeting the needs of OW clients?”
 - Many listed waiting lists or difficulties accessing service as problems.
- An average response of **23%** when asked “What proportion of your clients with mental health problems is receiving some form of professional help for those problems?”⁸
- When asked “Please describe the problematic symptoms that clients display or report most often”, respondents reported social dysfunction, evictions, substance misuse, anger, anxiety, lethargy, poor hygiene, strange behaviour, rambling

⁸ Caseworkers may not be aware of all treatment and community supports which clients participate in or which are available.

- speech, difficulty concentrating, self-harm, poor memory, isolation, slurred speech, sexual dysfunction, inappropriate emotional responses.
- When asked “What improvements or deterioration have you noticed in the mental health system over the last few years? (Please consider wait lists, housing options, inpatient treatment availability, community supports, etc.)” respondents reported lack of housing options, lack of family physicians, many clients should be on ODSP but aren’t accepted, long waiting lists, lack of inpatient treatment, need for better referral arrangements to access the system, lack of access to psychiatrists, difficulty getting/maintaining medications due to lack of physicians, lack of community supports, some improved community supports, lack of awareness of community supports available, some improvements in housing, lack of supportive housing, lack of follow up from community agencies.

Mental Health System Issues Affecting Shelters

Shelter House is a facility providing primarily overnight shelter and some meals to homeless persons. They report that more and more people seeking shelter seem to have mental health and addictions problems. They would classify some of their clients in the ‘hard to serve’ category due to in many cases a lifetime of experience with or exposure to substance abuse, untreated or unsuccessfully treated mental illness, physical violence, social isolation, and poverty. Many of these clients’ behaviours are unmanageable by Shelter House and pose a risk to other clients or staff, making it necessary to deny these clients access to the most basic necessities of food and overnight shelter.

Over the years 2006-07, Shelter House has been able to identify at least 59 individuals in this ‘hard to serve’ category, all of them with known or suspected mental health and addiction problems. These clients are fearful of others, lonely, hungry, and regular victims of emotional and physical abuse. In many cases they are known to have been evicted from their homes (in some cases social housing programs) due to their behaviours.

Shelter House staff report enormous difficulty in acquiring appropriate and timely treatment and support for these clients either through mental health crisis response services, the acute care (hospital) system, or ultimately from the police. In many cases the mental status and behaviour of these clients represents a clear and immediate danger either to themselves or others in the judgment of Shelter House staff, but this assessment is not shared by agencies to which they are referred for help.

“What exactly constitutes a danger to yourself? Does being completely disoriented, dressed in rags, and sleeping on the sidewalk represent a danger to yourself? Or is it just a danger for certain segments of society, but fine for others to endure?”

Staff at The Salvation Army Booth Centre report concerns also, noting four to eight week waits for clients to see a crisis counselor, then up to an additional 6 months before clients can see a physician, and up to three weeks more to see a psychiatrist.

Reported Problems for Social Housing Related to the Mental Health System

The Social Housing providers which were interviewed universally reported an increase in the perceived number of tenants with apparently inadequately managed mental health disorders and associated disruptive behaviours. Disruptive or bizarre behaviours such as shouting/screaming, hoarding, aggression, or hygiene/public health issues have at times led to evictions as a last resort when the tenant is unable to comply with housing program rules, fire regulations, other legal building requirements, judicial orders, and lease agreements. Statistics are not kept on the number of evictions for mental health or behavioural issues; however it is the impression of providers that the number has recently increased.

Social Housing providers report that they are not informed when a tenant with a mental health problem is admitted to social housing. It is understood that this is for reasons of privacy and confidentiality, and that for the majority of tenants with stable or adequately supported or managed mental illness, these illnesses are not relevant to maintaining their housing arrangements. Many tenants may be in receipt of community mental health support services, and this is also largely unknown to housing providers.

The housing providers interviewed report universally that they would be willing to assist clients with mental illness to function independently in the community to the best of their ability by aiding in the selection of appropriate buildings for placement, or otherwise contacting community mental health support services on behalf of clients to obtain services or to aid in managing or averting crises where possible, as such crises may lead to eviction if repeated and not properly addressed. Housing providers request to be consulted on the selection of buildings or programs in particular, as each location may have its own culture or character that may serve as either an aid or a detriment to successful independent living for tenants with particular needs.

Housing providers point out that many Ontario Works and Social Housing clients do not have telephones and may find it difficult to avail themselves of telephone-based community support or crisis services.

Thunder Bay Police Department

The Thunder Bay Police Department receives and responds to many calls concerning disruptive persons, altercations, noise complaints, etc. but does not have the current technology required to separately track which of those calls are specifically mental health-related, or which calls result in police assisting a client to seek specifically mental health treatment. They do report a perceived increase in the number of mental health-related calls and the number of persons living independently in the community with apparently inadequately treated or managed mental illness and/or substance abuse problems. These remarks are made with caution, as it is difficult for protective services workers to accurately assess and/or clinically diagnose the precise nature of an apparent emotional or health crisis requiring police intervention.

The police do report difficulty obtaining mental health services for clients in crisis, however. The police cite long wait times often of several hours at the emergency room, sometimes resulting in no treatment for a client, and relate the story of one individual who was brought to the emergency department on five separate occasions by police, never admitted, and who subsequently committed suicide. The police also note the impression that the public safety and corrections systems often are the last resort to address the mental health needs of some individuals, and ideally these problems should be addressed by other systems prior to this necessity.

The Thunder Bay police also concur with the opinions and experience of police departments in other jurisdictions in Canada, such as those reflected in a recent report of the Vancouver Police Department (*Lost in Transition*, 2008) which is critical of the results of mental health system reform activities and has included recommendations for a mental healthcare facility that can accommodate moderate to long-term stays for individuals who are chronically mentally ill, and what has been termed an “Urgent Response Center” by Vancouver Coastal Health, where individuals can be assessed and “sorted” according to their needs.

Summary of Problems Possibly Related to Mental Health System Reform

It is not ‘scientifically’ possible to establish a proven or direct causal link between changes to the mental health system such as the closure of beds in a provincial psychiatric hospital and perceived increases in difficulties experienced by social services clients. Qualitative or anecdotal reports of improvements or deterioration in mental health services must also be weighed with caution, as many factors may contribute to changes in perception. Greater public awareness of mental health issues may lead to increased identification of apparent mental health problems; this does not mean the prevalence of problems has increased but rather that the problems are more frequently noticed or more frequently ascribed to mental health issues.

It is possible nonetheless to state that social service providers and clients report frequent and persistent difficulties related to client mental health issues and that these difficulties seem to be getting worse. These difficulties range from simple practical difficulties in accessing the mental health system (lack of family physicians, getting a psychological assessment, getting admitted to a community mental health program, seeing a psychiatrist) to more general and troubling concerns, such as the apparent lack of access to services for ‘hard to serve’ clients.

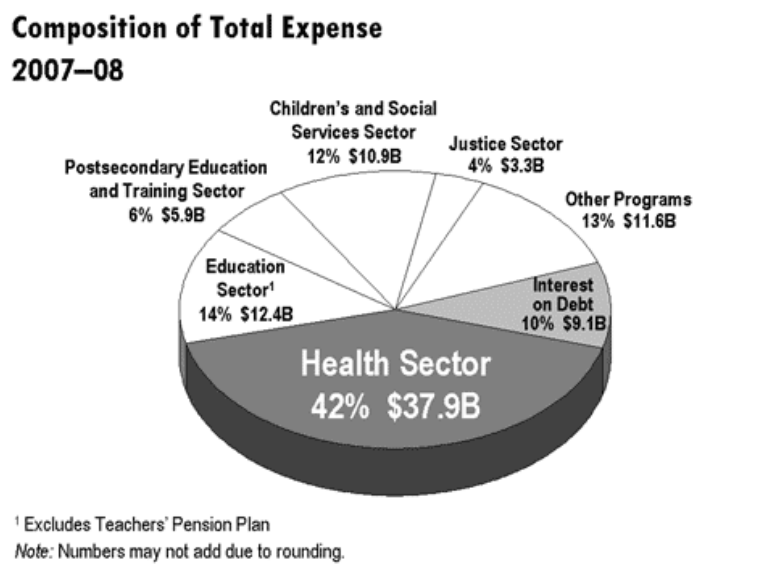
As one indicator of potential causes of perceived difficulties experienced by social services clients, it is also possible to briefly review and assess the current status of mental health system reform activities in Thunder Bay District.

4. Background - Mental Health System Reform

Overview of Ontario's Mental Health System and Funding

By national and international standards Ontario has a relatively well-funded health system. Canada's annual per capita spending on health in 2003 was variously ranked at around 4th in the world at approximately \$3839 (2003 CDN dollars) (The USA is consistently ranked first in the world at ~\$5711USD in 2003).⁹ Ontario's per capita spending ranked third among Canadian provinces at \$3945, behind Manitoba (\$4220) and Alberta (\$4010).

Ontario's health spending continues to increase in terms of both the per capita amount and amount as a proportion of the total provincial budget. The following chart represents Ontario's health spending as a proportion of the provincial budget in 2007-08:¹⁰



Current information on provincial spending specifically related to mental health is not readily available without further research, however spending on a range of services including Cancer Care Ontario, mental health, emergency health services and other programs in Ontario has increased from 2003-04 to 2007-08 by \$600 million.

⁹ Canadian Institute for Health Information, Organisation for Economic Co-operation and Development. *OECD Health Data 2006*, from the OECD Internet subscription database updated October 10, 2006. Copyright OECD 2006, <http://www.oecd.org/health/healthdata>. Note definitions of health spending can vary internationally and from organization to organization.

¹⁰ Ontario Ministry of Finance figures and chart.

Components of Ontario's Publicly-Funded Mental Health System

The provincial health care system is funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC).

Local Health Integration Networks

Local Health Integration Networks (LHINs) were created by the Ontario government in March 2006. There are 14 LHINs in the province; one for Northwestern Ontario which includes the Thunder Bay, Kenora, and Rainy River Districts. LHINs are not-for-profit corporations which are mandated to work with local health providers and community members to determine the health service priorities of their regions and to plan, integrate, and fund local health services.

LHINS control and allocate two-thirds of the provincial health care budget (\$37.9 billion) for hospitals, Community Care Access Centres, Community Support Services, Long-Term Care, Mental Health and Addictions Services, and Community Health Centres.

The North West LHIN has listed access to mental health and addiction services as a top priority in its *Integrated Health Service Plan* (2006) approved by the North West LHIN Board of Directors on October 23, 2006, where mental health services are identified as a priority that is “pervasive” and “impacts all other priorities” (p. 76). The *IHSP* goes on to state that, “Although numerous local and organizational integration strategies are in place, there is a general consensus that broader, enhanced coordination and integration is still needed in the Northwest.” (p.77).

The LHIN also states in its *Community Engagement Report* (2005):

“Accessing mental health and addiction services was identified as a particular challenge in the North West. It was reported that these services are not well coordinated across the region and that patients have difficulty accessing services across the continuum of care from crisis care to chronic community support. An inadequate supply and rationing of services to meet the demand, and poor coordination of services were identified as factors contributing to the insufficient delivery of mental health and addiction services in the region...Crisis care services were identified as a particular challenge in many communities” (pp. 11-12)

Mental Health Services Available

According to the Ministry of Health and Long-Term care website, Ontarians may receive publicly-funded mental health services from a broad range of sources including:

- psychiatric hospitals
- specialty hospitals

- general hospital psychiatric units
- community mental health programs
- homes for people discharged from psychiatric hospitals
- self-help groups run by consumer/survivors
- psychiatrists and family physicians.

Recent History of Mental Health Reform in Ontario

Between 1959 and 1979, the province of Ontario closed 7,000 of its 11,000 provincial psychiatric hospital (PPH) beds. Since that time policy debate has occurred around what to do with the remaining provincial hospital beds and the hospitals themselves, general hospital psychiatric programs and community mental health programs.¹¹

The Government of Ontario has produced several policy frameworks or program initiatives intended to improve the provincial mental health system over the last 25 years, including;¹²

- 1983 - *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective* (the Heseltine Report);
- 1988 - *Building Community Support for People* (the Graham Report);
- 1993 - *Putting People First: The Reform of Mental Health Services in Ontario*;
- 1998 - *2000 and Beyond: Strengthening Ontario's Mental Health System*;
- 1998 - *Making It Happen: Implementation Plan for the Reformed Mental Health System*;
- 1999 - *Advice to the Minister of Health on Building A Community Mental Health System in Ontario* – Health Services Restructuring Commission.
- 1999 - *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Support*;
- (undated) - *Making it Work - Operational Framework for the Delivery of Mental Health Services and Supports*;
- 2000 - *The Next Steps : Strengthening Ontario's Mental Health System*;

¹¹ *Comparative Mental Health Policy: Are there lessons to be learned?* Steve Lurie, BA, MSW, MMgt, CMHA Toronto Branch, 2004.

¹² This list does not include specific program reform-related guidelines or legislative and regulatory change descriptions, and is not exhaustive.

- 2002 - *The Time Is Now: Themes And Recommendations For Mental Health Reform In Ontario - Final Report Of The Provincial Forum Of Mental Health Implementation Task Force Chairs;*
- 2003 - *Mental Health Accountability Framework.*

In spite of these significant and repeated policy development efforts, the Romanow Commission on the Future of Health Care (2002) still identified mental health as the 'orphan child' of health care. As noted previously, as recently as 2006 the report *Out of the Shadows at Last: Highlights and Recommendations* notes that in spite of these many policy initiatives, better integration is still required for the mental health system.

Of the above, arguably of most relevance to the recent history of mental health reform in Thunder Bay District is the process begun in 1998 which led to the *Making It Happen* policy documents. In January 1998 Dan Newman, Parliamentary Assistant to the provincial Minister of Health, was tasked with conducting a review of mental health reform. The main target of this review was to evaluate the progress of the 1993 policy document *Putting People First*.¹³

Mr. Newman noted in June of 1998 in his report entitled *2000 and Beyond: Strengthening Ontario's Mental Health System* that:

The first asylum (in Ontario) was opened in 1850 at what is now the Addiction and Mental Health Services Corporation (formerly the Queen Street Mental Health Centre). For the next century, the provincial public mental hospitals provided treatment, shelter, asylum and custody for the seriously mentally ill, criminals, the homeless and other marginalized members of society.

The catalyst for the de-institutionalization of Ontario hospitals began in the early 1960s with the introduction of psychotropic drugs for treating mental illness. While these drugs could not affect a cure in most patients suffering from a mental illness, they were often capable of reducing or controlling symptoms. This allowed patients to be discharged into the community and find acceptance within society. Patients began to be discharged into settings like Homes for Special Care, community hospital psychiatric units, private hospitals and other community settings.

The therapeutic advances, which allowed earlier discharge and de-institutionalization, however, were not matched by a development of appropriate community services. As discharges from provincial hospitals increased so too did the number of readmissions. This was referred to as the "revolving door syndrome". This syndrome has been attributed to a failure by past governments to design a strong mental health system capable of providing a continuum of care which follows the patient, wherever the patient may be, as that patient moves from one place to another.

¹³ Ontario Federation of Indian Friendship Centres *Issues Paper on the Mental Health Reform Process in Ontario*, October 2001.

Given these fundamental observations, along with other information collected, *2000 and Beyond: Strengthening Ontario's Mental Health System* made several recommendations concerning mental health reform. These included:

- A commitment from the government to implement reform
- A focus on quality of life issues for the seriously mentally ill
- The creation of a coordinated and integrated system of mental health service delivery that provides a continuum of care
- A holistic approach to mental health reform that addresses the broader determinants of health¹⁴

Health Services Restructuring Commission

At roughly the same time as Mr. Newman's review, and also of direct relevance to mental health system reform, the Health Services Restructuring Commission (HSRC) was established by the MOHLTC in 1996 with a four-year mandate to make recommendations regarding hospital restructuring. The HSRC was also to advise the Minister on changes required in other parts of the health care system as the result of, or in concert with, hospital restructuring in order to facilitate an integrated and coordinated broader health care system. The HSRC was dissolved in March 2000.

In February 1999, HSRC published the report *Advice to the Minister of Health on Building A Community Mental Health System in Ontario*. The report proposed a *Core Services* system model:

Based on the literature and consultations with mental health stakeholders, including providers and consumers, there is general agreement that the core services¹⁵ outlined (below) need to be in place at the community level to support individuals with mental illness.

Core Services:

- Case management
- Assertive community treatment teams
- Crisis response and emergency services
- Community & housing supports
- Inpatient and outpatient care
- Vocational & educational services
- Consumer self-help and consumer initiatives
- Family self-help
- Advocacy

¹⁴ OFIFC, 2001.

¹⁵ Certain essential, core services must be available in all communities to meet the needs of individuals with mental health illnesses/disorders. Establishing a range of core services helps to ensure that a continuum of care, treatment and support will be available to meet the needs of individuals and their families/caregivers.

- Income support
- Recreation
- Links with GP/general health care system

The HSRC plan for restructuring in Thunder Bay therefore depended upon the timely development of the complete range of these services.

The HSRC report further notes:

The slow progress in implementing the necessary restructuring of provincial psychiatric hospitals (PPHs) in Ontario has been identified as a key barrier prohibiting progress of hospitals, as well as broader health system reform. There are concerns that the problems resulting from the de-institutionalization of individuals with mental illnesses/disorders in the early 1970s will be repeated. In addition, there is a need to ensure that monies saved from bed reductions are actually redirected to the development of essential community programs.

...The proposed closures and/or transfer of services from PPHs will have an enormous impact on the delivery of mental health care in communities and in their immediate catchment areas where PPHs are currently located.

...In 1995/96 there were 2,900 mental health beds in PPHs¹⁶. The number of beds that will be available post -restructuring [2003] is estimated at 1,767 beds, resulting in a decrease of 1,133 beds (39 per cent decrease).¹⁷

Advice to the Minister of Health on Building A Community Mental Health System in Ontario goes on to note that:

In Ontario, the down-sizing of mental health beds and the commensurate shift in the locus of care to the community has been hampered by three key issues:

- Lack of local leadership to implement restructuring of PPHs,
- Uncertainty regarding the reinvestment/service strategy and the level and timing of 'up front' investment that will be available to facilitate restructuring of PPHs, and
- Difficulties in reaching agreement concerning labour mobility and adjustment plans [including related governance transfer agreements] at the local/regional level.

...Much of the HSRC's advice regarding restructuring of Ontario's mental health system has been grounded in the assumption that the Ministry of Health would move quickly to establish local 'Mental Health Agencies' as a vehicle for beginning to build

¹⁶ Source: Ministry of Health, Mental Health Branch.

¹⁷ See Appendix 1 for Thunder Bay Bed numbers and targets. The HSRC supported an original planning rate of 30 beds/100,000 (adult) population as the ultimate planning target. However, to ensure that the pace of change is appropriate to achieve an orderly restructuring of mental health services, the HSRC proposed interim planning guidelines to the years 2000 and 2003 as follows: by 2000: 37 beds/100,000 (21 beds/100,000 acute; 16 beds/100,000 longer term); by 2003: 35 beds/100,000 (21 beds/100,000 acute; 14 beds/100,000 longer term). The targets resulted in an overall planned reduction in inpatient mental health beds in Thunder Bay of between 61 and 82 beds by 2003.

the necessary community service infrastructure and capacity through a process of reallocation of 'savings' achieved from PPH closures/program transfers.

The concept of developing a local agency was first recommended in the HSRC's *Thunder Bay Restructuring Report* (June 1996). Although the Ministry initially agreed to set up a 'pilot agency' in Thunder Bay, the initiative was worked on with very little conviction by the Ministry in the early days. Over the past year, the Ministry has insisted that it will set-up an infrastructure -- based on the concept of establishing Regional Ministry of Health offices -- that will provide the necessary coordination to make the transfer of services and resources from the Lakehead Psychiatric Hospital (and other PPHs) to the community a reality.

The fact that 'very little' has happened over the last two and a half years to move the proposed PPH changes forward, has not only stalled the progress of mental health reform in all regions of the province, but has contributed greatly to the increased skepticism about mental health reform in general. In particular, there is a lack of confidence (among providers, individuals with mental illnesses/disorders and their families) that a Ministry-led process will be able to respond expeditiously to local circumstances.

The lack of a local structure with clear responsibility and accountability to effect and monitor the shift from inpatient to community-based services, and coordinate reinvestments continues to be a major barrier to reform. The HSRC is convinced that identification of a 'local leader' is essential.¹⁸

These observations on the part of the HSRC, along with further policy direction as described in the next section, led to the formation of local Mental Health Implementation Task Forces to guide mental health reform.

Making It Happen

Making it Happen: Implementation Plan for Mental Health Reform; and, *Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports* were issued by the province in 1999 to further direct mental health reform.

Three levels of need were identified in the reformed mental health system, which reflect the types of services required:

1. *First-line services* - These refer to prevention, assessment and treatment services by frontline health care providers. This will be the first contact of clients with the mental health system. The service population will include all people with symptoms of mental illness. Individuals with less serious mental illness or illness of short duration will stay within first-line services. Individuals with more serious or ongoing mental illness will be referred to intensive or specialized services.
2. *Intensive services* - These are services both in the community and hospital setting for clients with a serious mental illness. These clients need ongoing and long-term

¹⁸ Pages 6-7. These recommendations were identified in a round table discussion hosted by the HSRC on November 13, 1998.

support but not daily contact with the system. These services will also cater to clients who are at risk for repeated or prolonged institutionalizations in health care or correctional facilities.

3. *Specialized services* - These services focus on clients with serious mental illness who have complex, rare, and unstable disorders. These clients form a sub-population within the group of people with serious mental illness. These individuals require ongoing, daily contact with service providers. They require more structured and intensive treatment or a higher level of coordination, security and support.¹⁹

Features of the reformed mental health system were to include:

- a consumer-focused mental health system;
- an increased focus on best practices for mental health;
- access for clients to a comprehensive continuum of services through the development of service agreements within and across the three levels of need;
- streamlined access to the system for clients through fewer entry points to the system, centralized information and referral mechanisms, and an emphasis on fewer assessments;
- improved quality of care for clients with multiple service needs through the development of shared service agreements and cross-sector policies that clearly outline the responsibilities of different service jurisdictions;
- linking funding to the system with established performance measures;
- clearly defined roles, responsibilities and relationships for providers within the system; and,
- decentralized regional structures that are responsive to local and regional needs and manage the operations of services.¹⁹

Features of the operational framework included:

- the development of common intake assessment, discharge, referral and practice protocols as part of a coordinated treatment plan;
- a focus on the 'seriously mentally ill' population;
- a focus on the development of system accountability through performance measures, indicators, and evaluation tools;
- development of shared service agreements and cross-sector policies outlining shared service responsibilities;
- development of tools to facilitate access to services, such as, a common assessment tool;
- development of system accountability mechanisms such as service contracts and memoranda of understanding;
- decentralization of services management to regional offices; and,

¹⁹ OFIFC, 2001.

- the development of guidelines for a continuum of supports and services for clients.¹⁹

Creation of Mental Health Implementation Task Forces

Mental Health Implementation Task Forces (MHITFs) were established in 1999 by the Minister of Health and Long-Term Care to implement mental health system reform as outlined in the *Making it Happen* policy documents.²⁰

Nine MHITFs were established across the province (one for Northwestern Ontario, including Thunder Bay, Kenora, and Rainy River Districts) as a mechanism for providing specific recommendations to the Minister on:

- provincial psychiatric hospital restructuring;
- reinvestment in community-based mental health services of resources saved through hospital divestment; and,
- the implementation of mental health reform in their designated region based on level of need, evidence-based research, and in accordance with government policy (*Making It Happen* documents).²⁰

Membership in the Task Forces was by MOHLTC appointment, and included representation from the following sectors:

- hospital representatives
- family representatives
- community mental health agencies
- community care access centre
- community physician/psychiatrist
- district health council representatives
- local/regional business community
- local/regional education system
- MOH rep (ex-officio)
- MCSS rep (ex-officio)²⁰

A Provincial Forum of MHITFs was set up to provide a mechanism for identifying commonalities in issues across regions, and make recommendations regarding provincial operational and policy issues to the Ministry of Health and Long-Term Care. MHITFs were given an 18-month period to provide recommendations to the Minister of Health and Long-Term Care. Various sub-committees were created under each Task Force to address specific issues under reform such as consumer and family initiatives, specialized services, integration and system management. The sub-committees reported to their respective Task Forces. As part of their terms of reference, MHITFs were required to form linkages and relationships with “relevant community stakeholders”. This could be

²⁰ OFIFC, 2001.

accomplished through various mechanisms such as community consultations, focus groups with service providers, family members and consumers. It was left up to the regional MHITF to determine the most effective way to meet this requirement.²¹

Northwest Region Mental Health Implementation Task Force Report

The Northwest Mental Health Implementation Task Force (responsible for Thunder Bay District) completed its report *A Regional Mental Health System for Northwestern Ontario* in 2002. The Task Force made numerous recommendations to the Minister of Health.

Brief Summary of MHITF Recommendations and Progress to Date

It must be noted that there is a lack of available data to completely assess the current status of many of the MHITF recommendations, and that the North West LHIN is compiling a complete report scheduled for completion in spring 2009.

To promote regional governance:

1. Establish the Northwest Region Mental Health Board and the Consumer and Family Supports Board to co-ordinate and integrate the mental health system in Northwestern Ontario.
 - Responsibility for local mental health system planning, funding and integration has been transferred to the North West LHIN.
 - There is currently a Northwestern Ontario Mental Health and Addictions 'Entity', and the North West LHIN has recently formed the Mental Health and Addictions Advisory Team in early 2008.
 - The MHITF recommendations included formulation of a strategic plan, an accountability framework, an evaluation component, an operational plan, a community consultation process for the planning and delivery of regional mental health services. It is not clear what progress has been made in this regard specifically in the area of mental health, although a report is expected in spring 2009.
 - The LHIN has completed an *Integrated Health Services Plan* (2006) which outlines the intention to further investigate, develop plans, and work with providers to reduce barriers to, expand the capacity of, and improve the effectiveness of, mental health services.
 - It is not clear if there is a formal Consumer and Family Support board or committee component to current activities.
 - The timelines for establishment of the Board and related recommendations were 1-3 years (i.e. by 2005).

²¹ OFIFC, 2001.

To facilitate closure of the provincial psychiatric hospital (Lakehead Psychiatric Hospital) and to provide coordinated community-based services through a Centre of Excellence to people with a serious mental illness in Thunder Bay:

2. Establish a community mental health centre in the city of Thunder Bay, Ontario.
 - The creation of a Community Mental Health Centre in Thunder Bay was intended to facilitate the “Transfer (of) outpatient and community-based programs from the Lakehead Psychiatric Hospital to the Community Mental Health Centre or other appropriate organizations” as well as to “...provide local first-line services for Thunder Bay and regional specialized services for Northwestern Ontario as well as providing regional support and consultation services as required”²².
 - All ACT Teams and forensic services were to be centrally located in the Centre.
 - The Centre was to have a shared-care primary care component.
 - Officially opening in December 2007, the outpatient programs of the LPH have been transferred to an outpatient clinic in Victoriaville Mall in Thunder Bay, however the facility does not fully meet the stated requirements or vision of a “community mental health centre” or Centre of Excellence as outlined in the MHITF report. Further details are expected in spring 2009 concerning the clinic’s role in primary care and as a regional support and consultation resource.

To create a Streamlined Access framework/mechanism:

3. Establish the ‘Call/Go Framework’ for streamlined access to mental health services throughout Northwestern Ontario.
 - The Call/Go framework has been modified, improved, streamlined and implemented according to the North West LHIN.
 - The operational implementation of this framework has not been apparent to Ontario Works or social housing providers.
 - The North West LHIN states that it is possible for Ontario Works clients to call a mental health program and go for intake assessment or services without a physician referral or other preliminary requirements.
 - The time frame for establishment of supportive housing programs was 4-6 years (i.e. by 2008).

In order to co-ordinate and integrate services to prevent duplication:

4. Establish the Service Agreement and Memorandum of Understanding process for coordinated service delivery and consumer and family supports throughout Northwestern Ontario.

²² MHITF Final report financial projections, p.4-5.

- This function is understood by TBDSSAB to be the responsibility of the North West Local Health Integration Network.
- The North West LHIN has listed access to mental health and addiction services as a top priority in its *Integrated Health Service Plan* approved by the North West LHIN Board of Directors on October 23, 2006.

To create a comprehensive continuum of services and supports:

5. a) Ensure that mental health services and supports are delivered by the most appropriate provider in an efficient and effective manner that is responsive to individual and family needs as close to home as possible.
5. b) Ensure that client rights advice and advocacy are available for clients and their families and are an integrated part of the mental health system in Northwestern Ontario.
5. c) Establish economic initiatives in Northwestern Ontario that support employment opportunities for people with a serious mental illness.

To ensure/create Standards of Practice and Best Practices:

6. Initiate, monitor and maintain the process for ensuring appropriate standards of practice and best practices in the delivery of mental health services in Northwestern Ontario.

To promote Public Education, Education and Training:

7. a) Implement the Public Education Plan (developed by the Public Education Work Group) to increase awareness of mental health reform, to identify problems and solutions, to change public attitudes, and to promote system change.
7. b) Establish and implement an education and training plan that encompasses all levels of mental health services including consumers, families, mental health workers, and the broader public.

With respect to housing needs:

8. Establish appropriate, safe and affordable housing for individuals with a serious mental illness that is tailored for these specialized populations in Northwestern Ontario.
 - Relative completion or incompleteness of recommendations five to eight is extremely difficult to evaluate without concrete data, some of which may be forthcoming from the LHIN in spring 2009. Qualitative evidence acquired through key informant interviews strongly suggests that further work is needed in these areas, particularly in communications and public

education concerning mental health system access, coordination, and structure (i.e. who does what). Some of the recommendations are also qualitative in nature, and again, subjective information acquired through key informant interviews suggests that further work is required.

Summary

It is apparent that the recommendations made by the Northwest Mental Health Implementation Task Force, Health Services Restructuring Commission, and other policy and planning initiatives and reports are, and were intended to be, interdependent or *integrated*. This interdependence exists not only within the individual reports, but between them to a considerable extent as well, as the recommendations were drafted with awareness of parallel and historical activities for the most part.

As the most basic example of this interdependence, the recommendation to close provincial psychiatric hospitals (and Lakehead Psychiatric Hospital in Thunder Bay) was contingent upon the enhancement of community services and inpatient or residential care options sufficient to meet clearly identified needs.

The Northwest Mental Health Implementation Task Force recommendations in particular hinged in many important aspects upon the creation of a body to oversee the planning of the mental health system in Northwestern Ontario (the Northwest Region Mental Health Board). This Board was not created, however the responsibility for local mental health system planning, funding and integration has been transferred to the North West LHIN.

At this point, the status of many past recommendations, directives, planning and policy documents, studies, and plans is not clear. The North West LHIN plans to produce a report in conjunction with the local Mental Health and Addictions Entity that examines the degree of progress in implementation of the MHITF recommendations. The report is scheduled for completion in spring 2009.

5. Recommendations

There are numerous international, federal, provincial, municipal, non-profit, academic, voluntary, and private-sector reports and studies outlining best practices in mental health service provision, system design, and system reform.

The reports, plans and studies already completed for Thunder Bay District appear to TBDSSAB Administration as sufficient to guide system reform. There is a high degree of consistency in the work completed to date. The 2002 Northwest Mental Health Implementation Task Force report *A Regional Mental Health System for Northwestern Ontario* represents an extremely comprehensive summary of current research, needs, trends, and issues in the Thunder Bay District mental health system and makes concise recommendations for creation of an integrated system.

While it is not possible in this brief *Environmental Scan* to conclusively analyze the direction and progress of mental health system reform subsequent to the MHITF report and recommendations, it is possible to conclude that:

- Social service providers express significant concerns about the experiences of clients and social service programs with the mental health system.
- Many of the recommendations contained in the large number of recent mental health system reform plans and documents have not been fully implemented.

Recommendations:

- That the national, provincial, and local studies and reports on mental health system reform completed over the last ten years not be entirely repeated as a precursor to action;
- That the recommendations already made be acted upon by the provincial government or its designates to improve the mental health system in Thunder Bay District;
- That relevant outstanding recommendations contained in the 2002 Northwest Mental Health Implementation Task Force report *A Regional Mental Health System for Northwestern Ontario* be acted upon by the North West Local Health Integration Network as soon as possible;
- That to avoid gaps in and duplication of service, systems and procedures for greater information sharing and integrated planning between the health and social services systems be established at a provincial level; and
- That the North West LHIN examine the adequacy of crisis care services, inpatient beds, and supportive housing spaces available in Thunder Bay District for treatment of people with mental health problems.

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Appendix 1 – Planned Changes in Provincial Psychiatric Hospitals and Bed Redistribution

Bed and Place Chart, Before and After Restructuring								
March 1999*	Adult Acute MH		Long Term MH		Forensic MH		Child/Adol MH	
	95/96	2003	95/96	2003	95/96	2003	95/96	2003
Thunder Bay	24	30	118	38	20	20	-	13

Source: Health Services Restructuring Commission
 *Planned or projected as of March 1999.

MH – Mental Health
 CCC – Complex Continuing Care
 LTC – Long Term Care

PPH	Beds 95/96*	Beds Post Restructuring 2003	Redistributed Beds	Decrease in Beds 2003
Brockville	295	0	173	122
North Bay	307	87	31	189
Lakehead	138	56	0	82
Whitby	287	163	0	124
Queen St.	442	404	0	38
London/ St. Thomas	633	203	109	321
Hamilton	211	136	53	22
Penetanguishene	291	208	0	83
Kingston	296	104	40	152
Total	2900	1361	406	1133

Source: HSRC 1999