Making It Happen

Implementation

Plan for

Mental Health

Reform

Ontario

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Background and Purpose

1.1 *Background*

There have been a number of reports on the mental health system in Ontario - all aimed at developing a comprehensive long-range plan that would be flexible enough to meet unique needs and yet structured enough to ensure high standards for quality of care. Mental health policy has evolved through these efforts, and this document incorporates and builds on the previous initiatives. The significant milestones were:

Developing a comprehensive long-range plan flexible enough to meet unique needs and structured enough to ensure high standards for quality of care.

- 1983 - *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective.* Also known as the Heseltine Report, this document recommended "a balanced and comprehensive mental health care system" and "a separation of treatment and accommodation."

- 1988 - *Building Community Support for People.* Also known as the Graham Report, this paper offered a long-range plan for an organized, comprehensive, community-focused mental health system. People with serious mental illness or disability were identified as the priority for mental health services. Province-wide principles and objectives were established to guide the planning process and encourage consumers and families to be involved.

- 1993 - *Putting People First: The Reform of Mental Health Services in Ontario.* This document sets out a ten-year mental health reform strategy based on a common vision and values. Reform strategies also identified the seriously mentally ill as the priority population for service and established measurable targets and timelines for change. These included specific plans for shifting resources from institution to community, optimum bed ratios, hospitalization rates, and key service ratios.

In early 1998 the Honorable Elizabeth Witmer, Minister of Health, determined that it was time to review the progress to date. Mr. Dan Newman, Parliamentary Assistant to the Minister of Health, led a consultative review of progress on mental health reform in Ontario. The overwhelming response was that the principles and direction of mental health reform were sound, but the government

needed to take the next steps with a clearly designed implementation strategy.

Making It Happen is the next step - describing how we can make sure that the mental health system works for people, with services that are effectively integrated and coordinated, and based on best practices.

Mental health services in Ontario are delivered through a continuum of health care from highly specialized inpatient care and physician services, to home care and informal community supports. Some of the challenges in reforming such a complex system are:

- individuals with severe and complex mental health needs tend to require more than one mental health service provider to meet their treatment, service and support needs;

- treatment and support needs cannot be easily predicted and planned; and

- service users may move back and forth between community and inpatient care during alternating periods of clinical instability and wellness.

1.2 *Purpose of the Implementation Plan*

This implementation plan outlines the Ministry's strategy to increase the capacity of the system for comprehensive and integrated treatment, rehabilitative and support services, while focusing on community alternatives wherever possible. This plan will also guide strategic reinvestments to support the restructuring of the mental health system over the next three years to support much needed changes in the way services are delivered.

PRINCIPLES

The Ministry remains committed to the vision and principles outlined in previous reform documents. The specific principles which will guide this implementation plan are:

- *the consumer is at the centre of the mental health system;*

- *services will be tailored to consumer needs with a view to increased quality of life;*

- *consumer choice and access to services will be improved;*

- *services will be linked and coordinated so that consumers will move easily from one part of the system to another;*

- *services will be based on best practices;*

- *mental health funding will continue to be protected; and*

- *there will be continued investments/ reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.*

This implementation plan will guide planning and service delivery at the local, regional and provincial levels. Accountability methodologies, including performance indicators, for each service area will be developed. It is expected that change will be ongoing as the system continues to evolve and as clearer directions are established in relation to housing, shared-service delivery mechanisms, and other essential mental health services. In the year 2002, the Ministry will review the implementation plan and revise implementation strategies and program funding priorities as necessary.

GOALS

The goals for this implementation plan are to ensure that core mental health services and supports:

- *are provided within a comprehensive service continuum developed to meet client needs and based on best practices;*

- *are well integrated with the broader continuum of care provided by health and social services;*

- *are organized and coordinated based on a "levels of need" structure, to ensure that consumers have access to the services that best meet their needs;*

- *are appropriately linked to other services and supports within geographic areas;*

- *facilitate a shared service approach to meeting the needs of individuals with serious mental illness who have multiple service needs;*

- *achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and*

- *are simplified and readily accessible, according to the consumer's needs.*
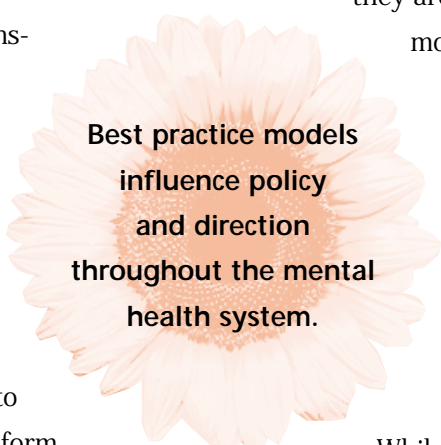
Driving Forces

There are a number of ongoing projects, processes and practice models that will influence the transformation of the mental health system at the provincial, regional and local levels over the next few years. These are key forces for change within the mental health system and will continue to provide direction as we reform the mental health system.

Best practice models influence policy and direction throughout the mental health system.

2.1 *Best Practices in Mental Health Service Delivery*

One of the central forces for change has been the increased focus on best practices. The document, *Review of Best Practices in Mental Health Reform*, defines best practices as those "activities and programs that are in keeping with the best possible evidence about what works." (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997).

For the purposes of this plan, the descriptions of best practice models are based on two documents; *Review of Best Practices in Mental Health Reform*, and *Best Practices in Mental Health Reform, Discussion Paper*, (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997).

According to these documents, "best practices define what one would expect to find in a reformed mental health system in terms of the types of services and supports and the infrastructure in which they are located." Best practice models influence policy and direction throughout the mental health system: from the local service delivery level to the broader province-wide management of the system.

While current best practices provide direction for the services and supports that should be available within a reformed mental health system, it is important to note that best practices evolve and will continue to be refined and added to based on new evidence and research. The Ministry of Health will continue to consider innovative approaches to service delivery based on emerging evidence of best practices. Existing and evolving best practices will also be considered at the regional and local level.

The intent of this implementation plan is to progress to a balanced, comprehensive and effective system of services and supports. The best practice literature has identified that at the service delivery level, a reformed mental health system should include:

- case management;
  - assertive community treatment teams;
  - crisis response and emergency services;
  - assessment;
  - community and housing supports;
  - inpatient and outpatient care;
  - treatment;
  - vocational and educational services;
  - consumer self-help and consumer initiatives; and
  - family self-help.

In every region, the mix and balance of these services will vary. Coordinating an effective flow of services and supports remains the key to developing a successful continuum of care.

Evidence suggests that effective services offered within each service area should be based on common principles and service standards but, at the same time, they should be adapted and individualized to meet specific client needs. Provincial benchmarks were established for case management and housing support in 1995 and are still widely accepted. The Ministry of Health regional offices will monitor progress towards the benchmarks on a region by region basis.

Current best practices confirm the need for a range of services to deliver balanced and comprehensive care to individuals with severe mental illness. In addition, effective linkages among services are needed so individuals have prompt access to the right services. The location for services is more focused on where the client lives than on institutions and offices.

An appropriate balance of inpatient and community mental health services is also required. The Ministry of Health will consider the mental health system balanced when the ratio of spending on community and inpatient services is 60/40. The target for inpatient beds identified in 1993 was a ratio of 30 beds per 100,000 people – to be reached by 2003. However, the Ministry has adopted the Health Services Restructuring Commission's recommended target of 35 beds per 100,000 people by 2003. Benchmarks should be viewed as a mechanism to promote system change, not an end in themselves.

Best practice literature indicates that a comprehensive, coordinated service system will occur if services are funded, managed, and accessed through efficient entry points rather than operating as autonomous and independent programs and services. Some of the best documented efforts to coordinate mental health services have emphasized the case manager as the service coordinator. The literature refers to the development of networks of services or strategic alliances among core mental health services to facilitate service integration. Networks and alliances can be bound together by a variety of mechanisms including the use of common practice protocols and procedures, and formal service partnership agreements. Best practice evidence also stresses the importance of client centred

performance measurement indicators and the creation of a client-centred information system to support planning, funding and evaluation of service delivery.

2.2 *Health Services Restructuring Initiatives*

2.2.1 System Design

Putting People First (1993) identified the need to develop local/district and regional implementation plans for mental health reform. In 1994, the Ministry issued *Implementation Planning Guidelines for Mental Health Reform*. This document outlined the expectations for the planning process and the role of District Health Councils (DHCs) in this planning process. By the fall of 1996, DHCs had completed their system designs. These included recommendations for structural changes to the delivery and evaluation of community mental health services, such as:

- unified, single provider i.e. amalgamated agencies, lead agencies, service networks, partnerships, service agreements, joint protocols, common assessment tools and tracking systems,
- common standards and outcome measures, and
- central access and intake mechanisms.

The plans reflect each community's unique mental health services and the readiness of each community to create change. The most comprehensive designs had three important characteristics in common, which were:
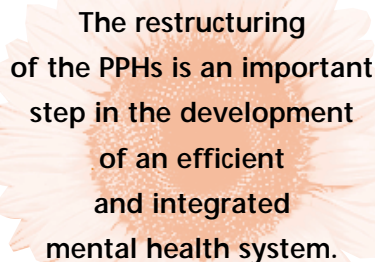
- models of service delivery based on best practices, i.e. addressing the continuum of services and supports, including community treatment teams and intensive case management;

- clear points of access to the system; and

- clearly defined roles and responsibilities for providers within the system.

These characteristics are the critical components that lay the groundwork for the developing mental health service system at the local and regional levels. Communities will continue to incorporate these characteristics as they continue to reform their mental health service system.

2.2.2 Health Services Restructuring Commission

Psychiatric facilities are a part of the overall restructuring of hospital-based services. The Health Services Restructuring Commission (HSRC) is an

> The restructuring of the PPHs is an important step in the development of an efficient and integrated mental health system.

independent body that has been guided by three principles: enhancing or maintaining the quality of health care, accessibility of health care, and affordability of health care. The HSRC has provided advice to the Minister regarding the future status of the Provincial Psychiatric Hospitals (PPHs) in Thunder Bay, Toronto, London, Ottawa, Brockville, Hamilton, Kingston, North Bay, and the Greater Toronto Area.

In all communities to date, the HSRC has recommended either the divestment or closure of the PPH and shifting programs to the public hospital sector.

- In Thunder Bay, London and St. Thomas the Ministry is supporting the recommendations to close the PPH sites and transfer programs to existing public hospitals.
- The Ministry has received recommendations for the closure of the Brockville and Hamilton sites with the transfer of programs to existing public hospitals.
- In Toronto a number of entities have been amalgamated to form a new public hospital corporation that includes the present Queen Street site.
- The HSRC has also recommended that the Whitby and Kingston sites remain open, but that operations be divested from the Ministry to public hospital boards.

The restructuring of the PPHs is an important step in the continued development of an efficient and integrated mental health system. The Ministry recognizes that significant investment in community mental health services is required before bed transfers and reductions can effectively take place. In addition, accountability structures and mechanisms must be established to accommodate the shift of program delivery.

Community mental health reinvestments are tied to a rollout of further reinvestments based on the closure dates proposed by the HSRC. Community reinvestment will come from savings derived from PPH bed transfers and new funding commitments, and will flow to the communities targeted for bed reductions before the reductions actually take place.

In 1998/99, the Thunder Bay, London/St. Thomas and Toronto PPH catchment areas will be the first to receive reinvestment dollars to address community service developments. Savings from bed reductions and administrative efficiencies due to PPH divestment will be realized in Thunder Bay and London in the following fiscal years.

Community reinvestments will be used to expand the capacity of services and supports within community settings, to serve people with a mental illness and will fund community treatment teams, case management, and crisis response

services. In some instances, an expansion of inpatient programs for children and adolescents, forensic clients and acute general hospital beds will take place.

2.2.3 Ministry Implementation Management

The HSRC provides recommendations to the Minister of Health regarding the closure and/or divestment of the PPHs. When those recommendations are accepted by the Ministry, the implementation process begins by establishing two Ministry led teams:

- **Ministry Implementation Team - Governance**

  This team is comprised of the Ministry Regional Director for mental health, Administrator of the PPH, other Ministry staff and representatives from the public hospital that will be receiving the transferred services. The purpose of this team is to develop the legal transfer agreement designed to support the transfer of governance and management of the PPH to the public hospital. The team is also responsible for developing the human resources agreement between Government and the public hospital.

- **Ministry Implementation Team - System**

  This team has broader membership because it is dealing with program design and linkages with other parts of the system. Membership includes representatives from the affected hospitals, District Health Councils, community providers and local citizens. The purpose of this team is to develop, following the transfer of governance, the best approach to restructuring the PPH services, and the subsequent closure of the PPH if appropriate.

2.2.4 Comprehensive Assessment Projects

Comprehensive Assessment Projects for inpatients and outpatients will be completed in preparation for the transfer of services from PPHs. The projects will assess the level of functioning and support/service needs of individuals with serious mental illness who are served by PPH inpatient and outpatient programs. These assessments will identify the need for additional community capacity and resources that are consistent with the priorities of mental health reform.

2.3 *Definition of First Priority Population for Mental Health Reform*

People with a serious mental illness (as defined in *Definition of Priority Population for Mental Health Reform*) are the priority for mental health services. Fundamental to the understanding of this population is the recognition that complex social, psychological, racial, cultural, political, spiritual and biological issues or forces impact on the mental health of any individual.

There are three dimensions used to identify individuals with serious mental illness/serious mental health problems: disability, anticipated duration and/or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

People with a serious mental illness are the priority for mental health services.

- **Disability** refers to the fact that difficulties interfere with or severely limit an individual's capacity to function in one or more major life activities. These activities include: basic living skills such as eating, bathing, or dressing; instrumental living skills such as maintaining a household, managing money, getting around the community, appropriate use of medication; and functioning in social, family and vocational-educational contexts. Increasingly, disability has been seen as the most important defining characteristic of this population and instruments have been developed to quantify the extent of disability and measure change over time.

- **Anticipated Duration/Current Duration** refers to the acute and ongoing nature of the problems identified which can be determined by empirical evidence and objective experience or through the subjective experience of the individual. It is important to note that this does not necessarily mean continuous, observable evidence of disorder but may include acute or intermittent episodes with periods of full recovery. More recently, duration has been defined and measured in relation to the amount of services being used, which also helps to assess the severity and chronic nature of the problem.

- **Diagnoses** of predominant concern are schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included.

Characteristics of the Reformed System

The Ministry will continue to guide the reform of the mental health system, building on the existing system and incorporating current directions in best practices. As the necessary strategies are implemented over the next few years, the system will evolve to become more accessible and accountability measures will be extended and refined.

The following table presents the characteristics of the reformed mental health system that can be achieved by implementing the changes described in this document. This vision can be realized through the collaborative work of people and organizations at the local, regional and provincial levels.

The following sections present further information on each of the six characteristics listed on the previous page.

Table 1: Characteristics of the Current and Reformed Mental Health Systems

Characteristics of The Current System		Characteristics of the Reformed System	How we will get there*	Processes/Tools
1. Service system is not comprehensive resulting in clients not receiving the services they need where and when they need them.	⇨	A comprehensive continuum of services ensures that clients receive the services they need when and where they need them.	Comprehensive continuum of services developed through: • best practice models/levels of need; • strategic reinvestments; and • service agreements among agencies. Services and supports respond to individual needs through: • individualized service/treatment plans based on client needs; • common intake, assessment and discharge tools/protocols.	• Ministry will issue implementation strategies and requirements • Operational Framework for the Delivery of Mental Health Services and Supports • Ministry Implementation Teams/PPH Restructuring • Comprehensive Assessment Projects in PPHs • Policy frameworks for Schedule 1 general hospitals and physician services (TBD)
2. Service system is fragmented with many separate agencies and many access points.	⇨	Streamlined access to the mental health system through fewer entry points and centralized information and referral mechanisms.	Streamlined access is achieved through: • centralized information and referral functions; • lead agencies/hospitals, networks, amalgamations; • service agreements; and • common assessment tools/protocols.	• Ministry will issue implementation strategies and requirements • Policy on housing and access to housing • Guidelines for common assessment tools • Template for service agreements
3. There are gaps in services for clients who have multiple service needs and must access separate service systems (e.g., forensic, dual diagnosis, elderly).	⇨	Clients with multiple service needs served better through shared service models of care.	Shared service model of care is developed through: • cross sector planning; • service agreements among sectors; and • continued implementation of existing policy guidelines (dual diagnosis, long term care, etc.).	• Ministries will issue shared service requirements
4. Decisions to reinvest in services are made on a program by program basis.	⇨	Mental health service capacity will be enhanced based on reinvestments reflecting best practices and meeting system needs.	Reinvestments are determined by : • best practices; and • system design and local/regional planning.	• Implementation Plan for Mental Health Reform
5. Limited system/service accountability is not driven by consumer needs.	⇨	Clear system/service responsibility and accountability achieved based on consumer need.	Systems/service accountability is achieved through: • Minimum Data Set; • operating plans; • Psycho Social Rehabilitation Tool Kit; • service agreements; • ACTT Standards; and • monitoring and evaluation of reinvestments.	• Accountability Framework (TBD) • Operational Framework for the Delivery of Mental Health Services and Supports
6. Centralized ministry structures are not responsive to local and regional needs.	⇨	Decentralized regional structures responsive to local and regional needs.	Decentralized responsive regional structures are established through: • implementation of Futureshape; and • implementation of Mental Health Reform within the decentralized structure.	

*Assumes updated regional/local plans are required

TBD = to be developed

3.1 *Comprehensive Continuum of Services: Levels of Need*

Best practices literature identifies the types of services and supports that will be available in a reformed, comprehensive mental health system, how they will be delivered and the infrastructure in which they will be located (*Review of Best Practices in Mental Health Reform*, Health Systems Research Unit, Clarke Institute of Psychiatry, 1997). In Ontario, mental health reform and PPH restructuring will bring about fundamental changes in the roles, responsibilities and relationships within the mental health service system. These changes are necessary to ensure that people with serious mental illness have access to the services, which best meet their needs. Having well defined and articulated roles and responsibilities for each type of service i.e. who is served, what services need to be linked, and required coordination mechanisms, is necessary to ensure that the system works, and to guide future strategic reinvestments in priority areas. Most importantly, this will ensure the most appropriate services and supports are available to serve the needs of people with a mental illness.

It is critical to ensure a comprehensive and holistic continuum of services – one that will respond to all aspects of a person's life. Many services and supports cut across all levels and are a vital part of this continuum.

These services/supports include:

- housing,
- self-help and alternative supports,
- income support and sources,
- vocational and employment programs,
- consumer-run businesses,
- family supports, and
- social/recreational programs.

LEVELS OF NEED

Consistent with the literature, (Goering, P. et al. 1998), three levels of need have been identified for the reformed mental health system. The term "level" is used for simplicity, and does not imply that the service arrays are static or linear. Each level describes a flexible or variable combination of services that differ in terms of resource intensity, specialization, and/or service duration. Each level includes an array of services such as: crisis, supportive, clinical and environmental interventions. Levels of need serve as a guide to resource utilization, which must be applied in conjunction with sound clinical thinking. The services a client receives will usually be

The services a client receives will usually be based on client choice

based on client choice, and offered in accordance with the client's functional needs and clinical characteristics. People will usually receive most of their services from within a particular level but are not limited to only the services within that level.

The term "levels of need" has been chosen to focus on the range of client needs, which then determine the types of services required. The levels: First Line, Intensive and Specialized, reflects a shift from the terms used in earlier documents, (primary care, secondary care and tertiary care) and emphasizes a multi-disciplinary, client-centred approach to the delivery of mental health services as opposed to a perceived medical approach.

The three levels of need are:

- **First-line:** refers to prevention, assessment and treatment provided by frontline health care providers including general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics.

  Examples of first line services include:
  - information and referral,
  - crisis telephone lines,
  - mobile crisis teams,
  - Schedule 1 hospital emergency services,
  - holding/safe beds,
  - primary care physicians,
  - mental health counseling,

- community health centres, and
- health service organizations.

For most people with mental health problems, the first-line level will be their first contact with mental health services. Individuals who are identified as having serious and on-going mental illness will usually be referred to intensive or specialized services for further assistance. Where the illness is less serious or of short duration, the provision of first-line services will usually be enough to respond to the person's needs.

- **Intensive:** refers to mental health assessment, treatment and support services which are provided in community or hospital settings and are focused on people with serious mental illness.

Examples of intensive services include:
- intensive case management/housing supports,
- skill development and psycho-social rehabilitation programs,
- medication clinics, and
- Schedule 1 psychiatric inpatient and outpatient services (including triage to in-patient care, day hospital and home treatment, and ambulatory outpatient services).

People who need intensive services meet the definition for serious mental illness, often requiring on-going and long-term support from service providers, but not daily contact. Within this level, services will be provided for people with serious

and complex mental disorders that are common among the general population (including concurrent and dependence disorders; individuals with eating disorders; first episode schizophrenia; and personality disorders). Treatment, rehabilitation and support services may be offered through a number of separate programs that must be coordinated and linked to each other. Service integration will be facilitated through intensive case management.

- **Specialized:** refers to highly specialized mental health programs provided in community or hospital settings and which focus on serving people with serious mental illness who have complex, rare, and unstable mental disorders. Long term care is not synonymous with specialized care. Treatment, rehabilitation and support services are integrated within each program/service type and provided through a multi-disciplinary team approach.

  Examples of specialized services include:
  - assertive community treatment teams,
  - specialized mobile outreach teams,
  - residential treatment facilities,
  - specialized inpatient and outpatient services, and

- regional forensic services.

People who need specialized services are a small subset of individuals with serious mental illness who require on-going, daily contact with service providers. Usually their illnesses have not been successfully treated with routine community care or brief inpatient care. These individuals might have the following problems:

- elderly clients suffering from dementia, psychosis and medical illness,
- clients who are developmentally disabled with psychiatric disorders often with aggressive behaviours,
- clients with schizophrenia who are chronically psychotic, aggressive or suicidal, and
- high risk forensic clients who are also included in one of the sub-groups identified above, or who have complex overlapping needs relating to aggression, legal status and clinical/risk management.

Being part of one of these groups does not always indicate a need for specialized services.

Consistent use of the levels of need will help to realign service delivery so that consumer needs are met, while maintaining the highest level of independence possible. The companion document to this plan, the "*Operational Framework*

Consumer needs are met, while maintaining the highest level of independence possible.

for the Delivery of Mental Health Services and Supports" provides more details about the core services that apply to each level of need.

CLIENT AT THE CENTRE

For the client, access to services within and across the levels of need must be seamless and integrated. Programs across the service continuum will share responsibility for responding to all aspects of the client's needs. Services will be linked together through service agreements and other mechanisms as needed. Evaluation and outcome measurement mechanisms will assess the effectiveness of each program based on individual program merits and how well the program fits with other programs.

People with a mental illness are not a homogeneous group and the needs of any individual will fluctuate over time. The delivery of mental health services will be tailored to meet individual needs. A coordinated care/treatment plan, based on a comprehensive assessment of need, is the starting point for individualized and flexible treatment, rehabilitation, and support functions. Planning must include a broad spectrum of providers including general hospitals, physicians, community mental health professionals, and others. Common intake assessment, discharge, referral and practice protocols need to be estab-

lished within the system. The client will be at the centre of service provision.

When appropriate, the individualized treatment/care plan will incorporate specialized knowledge and expertise from mental health professionals and physicians familiar with the specific needs of the individual. In this way, treatment and care will be provided in the most comprehensive and effective manner possible, based on the client's level of need.

Implementation Priorities

Over the next three years, the Ministry will:

- ensure that all mental health programs have service agreements in place and are linked with other programs within and across the three levels of need, to facilitate access to the best available continuum of services;

- develop mechanisms to coordinate access across and within levels of need to ensure that services are responsive to the needs of the client. Such mechanisms would include:
  - a common assessment protocol; and/or
  - a triage protocol based upon service agreements and established referral relationships among services;
  - regular monitoring and feedback about program performance to determine how existing mental health services function within and across levels of need.
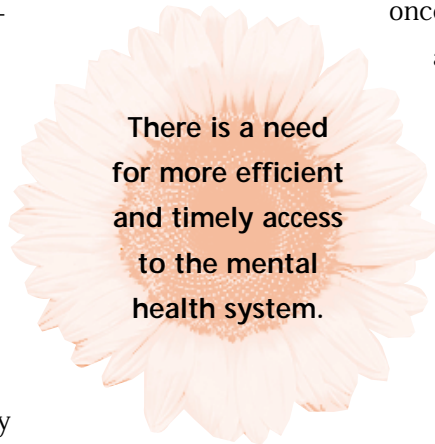
3.2 *Streamlined Access*

Direction of Reform

The points of entry into the mental health system play a vital role in ensuring prompt access to the services that will best meet the needs of clients and their families/key supports. At present, access to mental health services in Ontario can be confusing and time-consuming for clients and their families/key supports. There are approximately 60 general hospital psychiatry departments, nine PPHs and five specialty psychiatry hospitals in the province. There are approximately 350 community programs which provide a wide range of mental health services and supports including: assertive community treatment teams; case management; crisis intervention; supports for housing/supportive housing spaces; consumer and family self-help; and vocational and social rehabilitation. Many agencies provide several of these services and supports. Both initial entry into and repeated contacts with the various mental health services are complex and do not necessarily get easier with time.

The degree to which mental health services are coordinated varies from area to area. In some areas, services are effectively coordinated and linked. In other areas, there are several agencies that provide similar or identical services with minimal coordination. Clients and families/key supports are often unclear as to which services are suitable to their needs and how to access them. As a result, they may seek several services at once (undergoing separate assessments for each service) and they may be on several waiting lists at the same time. There is a need for more efficient and timely access to the mental health system.

Improving access will ensure that there is clear responsibility at both the hospital and community level to make information available, to facilitate access to a comprehensive continuum of services responsive to the client's needs, and to coordinate the availability and selection of possible services. It is intended to enhance client choice and access.

The choice of model used to achieve better access will depend on the current range and availability of local and regional resources. Local conditions e.g., rural, urban issues will also be considered.

> There is a need for more efficient and timely access to the mental health system.

In order to improve access to mental health services, the Ministry of Health will require each local system of mental health services to develop:

1. Centralized information and referral functions.

Clients, families/key supports and service providers will be able to contact a central source to get information about mental health services and how to access them. The following information about ministry funded services must be available: the purpose of the service; the intended client group i.e., including criteria, such as age, that will define access; how to access the service and whom to contact to get more information about the service. In addition, information about and referral to other non mental health services and supports must also be available e.g., relevant provincial health and social services, municipal services and supports funded by the voluntary sector.

2. Fewer points of entry to mental health services leading eventually to single access points.

Within each level of need, the number of points of entry to all mental health services will be streamlined through a variety of mechanisms that may be utilized depending on community infrastructure and local/regional capacity. These mechanisms include:

- the development of a formalized collaborative process among a group or network of agencies/hospitals through which access is coordinated. Service agreements among the participating organizations will be required to formalize the collaborative arrangement;

- the establishment of lead agencies (including hospitals) mandated to coordinate access to a specific service type e.g., case management. Service agreements among the lead organizations and the other organization(s) will be required; and

- amalgamating agencies to reduce the number of agencies providing similar or complementary services.

3. Access to consultation services provided by psychiatrists will be facilitated.

4. A minimal number of assessments – so that people are asked to provide necessary information only once. A coordinated care/treatment plan, based upon a comprehensive assessment of need, is the starting point for providing individualized and flexible services.

The changes and mechanisms outlined above will help to improve access to mental health services to ensure that clients are promptly linked to the services they need.

Implementation Priorities

Over the next three years, a number of policies and guidelines will be developed by the Ministry of Health to guide these changes, including:

- tools to facilitate access:
  - ◆ a common assessment tool; and
  - ◆ a template for service agreements;

- a policy on housing and access to housing;

- accountability framework; and

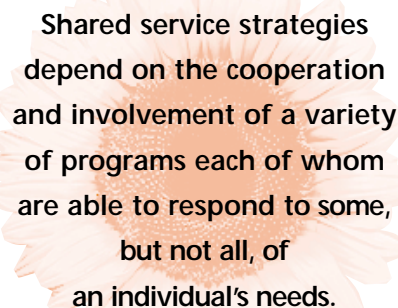- policy frameworks for Schedule 1 general hospitals and physician services.

Research on common assessment tools is underway. Until it is completed, communities and service providers are encouraged to move to common assessment tools and protocols, as they already have in some areas, using the best research available.

The local Ministry Implementation Teams, that have been or will be established to guide the implementation of PPH restructuring, will help communities to implement these plans for improved access to care.

3.3 *Shared Service Models of Care*

Direction of Reform

Many consumers of mental health services have multiple problems that cross a variety of service jurisdictions. Examples include individuals with the following kinds of problems: substance abuse, developmental disabilities, legal issues, long-term care needs, and age-related issues i.e., children and elderly. There are currently no consistent mechanisms to ensure that the person receives not only integrated and comprehensive mental health services, but that the services and expertise required from other jurisdictions or sectors are also integrated into the person's overall treatment plan. In fact, the presence of multiple needs can result in the person being ignored by all sectors with the expectation that someone else is responsible to serve him/her.

Shared service strategies depend on the cooperation and involvement of a variety of programs each of whom are able to respond to some, but not all, of an individual's needs.

To make sure that the system works for clients with multiple and complex service needs, the people who are planning and delivering those services need to work together. Participatory planning and service delivery is at the foundation of effective service delivery. Shared service strategies depend on the cooperation

and involvement of a variety of programs and service providers, including physicians, each of whom are able to respond to some, but not all, of an individual's needs.

Each ministry, or branches within each ministry, must take appropriate steps to ensure joint planning and shared service delivery. Within the context of their respective restructuring processes, both transfer payment agencies and government operated services need to understand these expectations to jointly plan and share service delivery. Policies and guidelines dealing with special populations will be developed or enhanced to reinforce the government's commitment to shared service models of care.

The sharing of and access to client information, within consent and confidentiality requirements is key to the development of effective shared service models and must be reflected in the development of protocols.

Each local system of mental health services will contribute to shared service processes for clients with multiple needs through the following strategies:

- **Identification of consistent mental health support** Service providers will follow the client as he or she moves through different settings, including long term care facilities, programs for the developmentally disabled and jails. Intensive case management/outreach

programs focused on clients with multiple and complex needs may be identified as the primary mental health support where no other appropriate alternative exists. This approach also assists in the establishment of a better network of community supports so that high risk but reluctant clients are not overlooked.

- **Training and Education** A model of shared responsibility for clients will extend to treatment/placement planning, ongoing education and training of staff in cross-sectoral disciplines and techniques, as well as having access to best practice information about service delivery to specific populations. Training and continuing education programs will be provided by psychiatrists specializing in specific disorders, as well as other health professionals within the academic health science centres and other experts. This training will be available to providers in a variety of settings including community health centres, general hospitals and group practices.

- **Co-operative Treatment Planning** A shared treatment/placement planning process will be initiated when a mentally ill client is receiving, or should receive services from a variety of service agencies e.g., long-term care, addictions, correctional services, and developmental services and/or when a client with specialized mental health service needs is receiving care and treatment through the primary care sector. Cooperative treat-
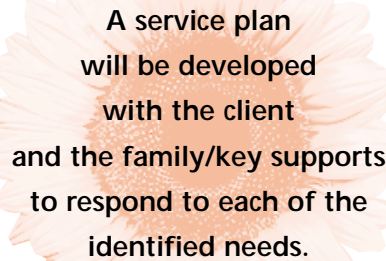
ment planning will have the following characteristics:

- the program area that already has some service responsibilities for the client will initiate shared treatment/placement planning. However, this may vary depending on individual circumstances;

- service providers from each of the involved service sectors will participate in planning discussions. People with knowledge about the needs of particular clients and best practices to address such needs, as well as those familiar with the requirements of building sustainable community service plans, will be included, as well as actual and potential service-providers; and

- shared planning forums will be organized at the earliest opportunity e.g., when the client is first admitted to a general hospital or facility, not simply one or two weeks prior to discharge or release. Anticipation is the key. Long-term community plans may be difficult to organize, and there must be sufficient time to address unforeseen contingencies or setbacks.

- **Individualized Treatment and Service Plans** A service plan will be developed with the client and the family/key

supports to respond to each of the identified needs and will have the following characteristics:

- service intensity will match level of need and degree of risk;

- suitable service providers will be identified from the most appropriate service sector;

- responsibility for the coordination of services across different sectors will be identified;

A service plan will be developed with the client and the family/key supports to respond to each of the identified needs.

- service providers will be informed of the range of service providers who are involved in the person's care; and

- information exchange practices will be identified up front, with the client's involvement and consent.

- **Maintenance of community contacts through periods of institutionalization** Depending on the assessed needs of the individual, community service providers will be in contact with clients in general hospitals and facilities, and may supplement services available to the client by offering additional therapeutic supports during their regular visits. General hospitals and facilities will have open door policies for permitting service providers

from other systems to continue to provide care and support services to the client, as developed through the shared planning forum. The involvement of the client's psychiatrist as part of the shared delivery team is important to the success of shared service delivery. Just as clients will need access to community providers when they are in hospital, hospital providers will need to reach out to clients in the community.
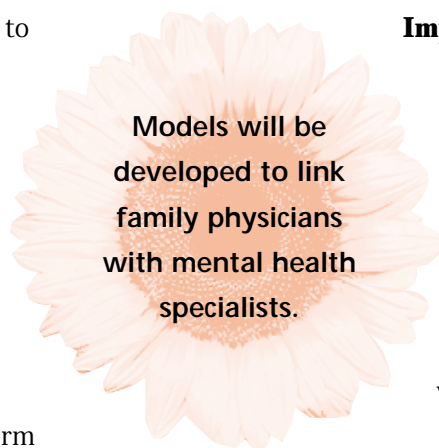
- **Long-Term Resource Planning** If no suitable services are readily available because the client has more intensive needs than current programs are equipped to handle, or acceptable programs have long waiting lists, a primary sector lead e.g. mental health or MCSS, must be identified to ensure that an interim treatment plan that adequately responds to the client's need and risk issues is developed. The appropriate sector lead will initiate a process to develop resources in the longer-term that are better suited to respond to the complete range of client needs.

- **Innovative Funding** Flexible arrangements for financing individual service plans are encouraged. At the local level, managers and service providers will examine existing resources to establish a contingency fund where necessary

to create suitable alternative placements. This is particularly important where the costs of the existing placements are unfairly borne by one sector and exceed the costs of alternative settings, or where the benefit to the client would be greatly enhanced through such alternate arrangements.

- **Primary/Specialty Care Partnerships** Primary care/specialty care partnerships and service delivery models will be developed to link family physicians with mental health specialists. There will be enrichment training in psychiatry for general practitioners, and mentoring arrangements between GPs and psychiatrists.

Implementation Priorities

Over the next three years, the Ministry will facilitate:

- the development of formalized shared service agreements;

- the cooperative development of cross-sector policies that outline shared service responsibilities of the respective service jurisdictions; and

- the development of a solid conceptual framework, based on best practices, for the work with special populations.

Models will be developed to link family physicians with mental health specialists.

3.4 *Strategic Reinvestments*

Direction of Reform

In the past, reinvestments were made on a program by program basis, often following the existing types of programs with the result that strategic opportunities for new investments were missed.
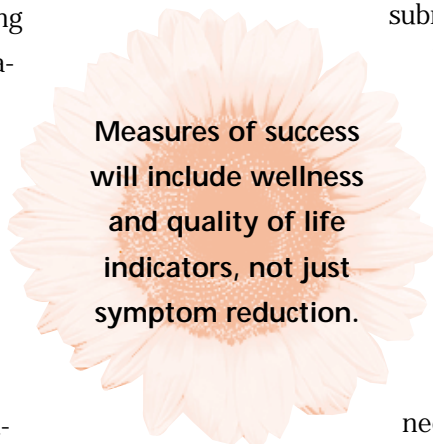
In the long term, the mental health system will be rebalanced through further strategic reinvestments that tie funding to program performance. The plan is to reduce the reliance on inpatient services and fund the continuum of community and inpatient services sufficiently to meet the diverse range of client needs. The goal is to ensure an appropriate service continuum incorporating all core components of a reformed mental health system i.e. treatment, rehabilitation and support programs including consumer and family initiatives that are balanced between community and hospital settings.

Implementation Priorities

Initially, strategic reinvestments will focus on communities affected by PPH restructuring to expand community based service capacity and inpatient capacity for children/adolescents, acute care and forensic programs within general hospitals.

Measures of success will include wellness and quality of life indicators, not just symptom reduction.

Specific actions related to the strategic reinvestment approach include:

- planning for the restructuring of PPHs and expanded community capacity to meet the needs of individuals currently being served through PPH inpatient services;

- ensuring, through project management and careful monitoring, that reinvestments are made before proposed bed reductions take place;

- based on current information about clients and community service needs, strengthening priority services in communities where PPHs are being restructured. As a requirement for new funding, programs will develop services based upon best practices, adhere to new service guidelines and submit required data that will be used to monitor performance more effectively;

- proceeding with the Comprehensive Assessment Projects designed to ascertain the support and service needs of inpatients impacted by PPH restructuring. A comprehensive assessment of the consumers' support and service needs will further inform the reinvestment plan and determine how first line, intensive and specialized services

will be better linked to provide integrated services to people discharged from PPHs in those affected communities;

- improving discharge planning effectiveness; and

- determining how new services that have received reinvestment funding are to be integrated with existing community services.

3.5 *System Management/Service Delivery Responsibility and Accountability*

Direction of Reform

There are many accountability limitations within the current mental health system. Service accountability is often not driven by consumer needs and reporting requirements are not always clear to the program providers. In addition, current mental health program and service providers are not required by the Ministry to evaluate their programs/services against documented best practices research. However, the Ministry is committed to the principle of greater accountability in the reformed mental health system. The mental health system will be measured against the accountability framework that is to be developed. Measures of success will include wellness and quality of life indicators, not just symptom reduction. Linking

funding to system and program performance is a critical element of system change.

Implementation Priorities

To support the development of system accountability, the Ministry of Health will:

- identify performance expectations, program standards, and service benchmarks to inform regional/local implementation planning, including identifying the mix of services required in particular communities to ensure an effective, balanced, and consumer-focused mental health service delivery system;

- review current data collection tools/instruments against developed performance measures to ensure all components are fully covered. The planned Minimum Data Set is intended to document the critical outcomes of the continuum of care and addresses the system objectives to support system planning and development;

- develop key indicators that measure performance at the program/service and system levels. Performance measures will be simple and easy to apply, identify system, program and client outcomes and include input from consumers and families, in addition to including more qualitative increased quality of life measurements;

- further the development of evalua-
tion tools to assist in the measure-
ment of program and client out-
comes; and

- identify and provide the necessary
additional resources (financial and
expertise) required in order to fulfill
these additional requirements.

3.6 *Decentralized and Responsive Regional System*

Direction of Reform

The mental health system operates
under a centralized structure that often
lacks responsiveness to local and region-
al needs. As the Ministry decentralizes
responsibilities to regional offices, there
is a need to develop or update the region-
al/local implementation plans to build
service accountability and strong service
integration mechanisms with clearly des-
ignated responsibility for the continuum
of care. The regional offices of the Min-
istry will have primary responsibility for
the development of these implementa-
tion plans.

The Ministry's role is that of system
manager. As system manager, the Min-
istry will set policy direction, allocate
mental health funding, and ensure ongo-
ing monitoring and evaluation of perfor-
mance measures, targets, and outcomes.
The regional offices will serve as a clear
point of responsibility for allocating

funds, and organizing and monitoring
services and supports. Regional offices
will be supported by integrated and
comprehensive mental health policies
that ensure consistent high quality ser-
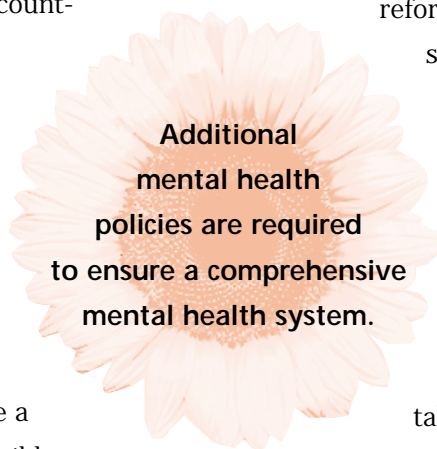vice standards and performance across
the province.

The roles and responsibilities of the Min-
istry's regional offices, in partnership
with District Health Councils and other
mental health stakeholders, will include:

- strategic reinvestment which is in
accordance with the directions set
out in this Implementation Plan and
the Operational Framework for the
Delivery of Mental Health Services
and Supports;

- development/update of local imple-
mentation strategies that are consis-
tent with the implementation plan,
taking into account community
readiness and meeting community
needs;

- evaluation and monitoring of pro-
grams so that they are organized and
provided according to the Ministry's
implementation plan, service guide-
lines, and minimum requirements;

- ensuring the adoption, by existing
programs, of the Ministry's require-
ments so that they are able to meet
the Ministry's expectations for funded
services; and

- monitoring program performance to guide future implementation planning and system development.

The roles and responsibilities of the Ministry's corporate offices will include:

- development of provincial standards and guidelines, including service guidelines, performance measures and indicators, and service benchmarks;
- ensuring that reinvestments are consistent with the implementation plan;
- development of an accountability framework for mental health that includes a client-focused information system;
- development of additional mental health policies that are required to ensure a comprehensive, accessible and balanced mental health system;
- monitoring of system performance in partnership with the regional offices; and
- continued liaison with the Minister's Provincial Advisory Committee (PAC) on Mental Health.

Additional mental health policies are required to ensure a comprehensive mental health system.

Implementation Priorities

During the next year the Ministry of Health will:

- decentralize mental health operational system management;
- integrate mental health service delivery into broader health reform activities; and
- assume a greater system management role.

A number of policy initiatives will be required to support the continued reform of the mental health system. The work which is underway on policy initiatives in the areas of housing, shared service requirements, concurrent disorders (substance abuse and mental illness), and mental health legislation, is outlined below. In addition, policy initiatives in the areas of Schedule 1 general hospitals and physician services (including sessional fees) will be developed.

Next Policy Development Steps

4.1 *Policy Initiative: Expanded Housing Alternatives and Options*

A stable and supported living environment is essential for consumers of mental health services. Historically, the predominant form of housing available for people with a mental illness tended to be in institutional settings. However, during the last twenty years there has been widespread support regarding the approach to housing that is based on the understanding that most people can live in an independent situation in the community when appropriate support is provided. This has resulted in the development of a broad range of community based housing options for persons who cannot live independently without some form of support and/or supervision.

The following is a list of the current supportive and supervised housing options available for people with a mental illness:

- Homes for Special Care – these are mainly for-profit, private residential homes monitored by the PPHs.
  - **Total capacity 1775 beds**

- Approved Homes – these are for-profit, private residential homes that are funded and monitored by several PPHs, and are separate from the Homes for Special Care Program.
  - **Total capacity 133 beds**

- Domiciliary Hostels – these are mainly for-profit, private residences administered through municipal agreements, and cost shared between the province (80%) and municipality (20%).
  - **Total capacity for psychiatrically disabled, as estimated using municipal data, is 2249 beds**

- Habitat Services – these are Toronto boarding homes that are monitored and administered by a mental health transfer payment agency. Almost 95% of the boarding homes are private, for-profit accommodation. Costs are subsidized by the province (80%) and the city of Toronto (20%).
  - **Total capacity 707 beds**

- Dedicated Supportive Housing – previously funded by the Ministry of Municipal Affairs and Housing and will now be funded by the Ministry of Health. These are non-profit subsidized housing spaces which include:
  - communal living accommodations with varying levels of supports, including "group homes"; and
  - independent apartment units with varying levels of support.
  - **Total capacity 2422 units/beds**

- Social Housing operated by munici-palities – which may have varying levels of wholly de-linked supports. This housing is integrated non-profit housing for a variety of other mixed tenant groups, such as low income, single parents, and refugees.
  - ◆ **Total capacity unknown**

A further housing option is supportive non-profit housing. This is a combination of support services coupled with non-profit or subsidized housing. The provision of supportive non-profit housing is currently an interministerial initiative involving the Ministry of Municipal Affairs and Housing (MMAH) and the Ministry of Health (MOH). Recently, the government decided to transfer all dedicated supportive non-profit housing for the psychiatrically disabled population to the MOH. The entire program and financial transfer will occur by April 1, 1999.

The concept of delinking is fundamental to an understanding of the approach to supportive housing. Delinking means that the support service component and the housing component of supportive housing are distinct and separate such that a person's eligibility for accommodation is not affected by his/her support service needs.
The old thinking was that accommoda-tion should be supplied by regular providers of community housing via MMAH funded transfer payment agencies, with the support service component being provided by community-based service organizations funded through MOH transfer payment agencies.

Now that the MOH has the mandate to provide rent subsidies to housing providers, and is now in the business of providing housing, this way of thinking has changed. There is a renewed acceptance of the necessary coordination between support services and accommodation, especially given that MOH will now be the sole provincial funder for both the support service and accommodation components of supportive housing. The old approach will be replaced with a system of flexible supports to match individuals' needs and preferences where ever they may choose to live.

There is a renewed acceptance of the necessary coordination between support services and accommodation.

As the concept of supportive housing has evolved, the notion of moving a resident through a series of residential settings has changed. Supports evolved as "portable" and accommodation as "fixed". The term "housing support services" will be used to describe these delinked services which may also include case management, social rehabilitation, assertive community treatment teams,

and to some extent, crisis intervention services.

In total, there are currently approximately 7286 beds/units to house the psychiatrically disabled across Ontario as previously described. Additional housing units, and the associated support services, are needed as the reduction of psychiatric beds proceeds according to mental health reform.

In June 1998, the province announced funding for the domiciliary hostel program at the 80%/20% rate i.e., provincial/municipal. Current estimates indicate that about two thirds of the clients residing in the domiciliary hostels are psychiatrically disabled.

In 1996, the Ministry developed and distributed its policy guideline: *"The Provision of Community Mental Health Services to People who are Homeless or Socially Isolated"* (Ontario Ministry of Health). This guideline, for the first time, addressed the systemic barriers to serving the homeless/socially isolated population and offered suggestions to overcoming these barriers. However, the guideline addressed primarily the service needs of the homeless/socially-isolated population and offered little substantive solutions to housing these individuals. Specifically, the lack of affordable housing spaces (with or without supports) had not been addressed.

The definition for the homeless/socially isolated population that was adopted in 1996, was: "A person is considered homeless or socially isolated if s/he lacks adequate shelter, resources and community ties or whose accommodation is at risk given a lack of resources and community ties." (Levine, 1983).

In order to be consistent with current provincial initiatives, the Ministry will need to review the housing needs of this population, who, as defined above, are also mentally ill.

The Ministry has assumed responsibility for supportive housing and has begun the process of developing a comprehensive housing framework for the planning and provision of a continuum of housing and related support services for people with serious mental illness. Support services will be individualized and flexible, with respect to type, amount and continuity of service, to meet the unique and changing wants and needs of the client to assist him/her in developing and maintaining independence. Independence can be defined as living in the community, requiring the least intervention from formal services and, to the greatest extent possible, making one's own decisions. The Ministry will establish a Mental Health Housing Steering Committee to oversee the housing policy development and implementation, which will include:

- developing better housing definitions, utilizing the expertise of current supportive/supervised housing providers, to cover the housing continuum; and

- surveying, analyzing and reforming the supportive and supervised housing sectors.

The purposes of establishing a comprehensive mental health housing framework are:

- to provide policy direction to the planning and provision of housing for people with serious mental illness;

- to ensure that clients have opportunities to live as independently as possible as members of their communities. It is noted that many clients live with families/key supports or in private accommodations, and should be supported in these choices as well;

- to ensure that clients have access to, and can maintain, residence in safe, affordable and secure accommodation that is in keeping with their choice, accessible to people with physical, visual and hearing impairments and that supports are sensitive to race, language, gender, age and sexual orientation; and

- to increase, over a period of time, the availability and use of accommodation that is within the range of choices desired by consumers, provides a physical environment that fosters independence, enables the client to be a tenant, and provides support services tailored to the wants and needs of the client.

4.2 *Policy Initiative: Shared Service Requirements*

This implementation plan acknowledges in several sections that the priority population, those with serious mental illness, is made up of several important sub-populations. These client populations, consisting of people with complex and multiple needs, often fall through the cracks of service delivery. The specialized level of care, as outlined earlier in this document, focuses exclusively on providing specialized services in various modalities to special populations. However, special population clients should be more broadly integrated into mainstream service delivery wherever possible. Planning efforts will concentrate on building an integrated community treatment foundation that is also able to meet specific population needs.

Previous attempts to develop strong direction and policies for mental health special population groups have had limited success. The Ministry has made some progress in developing joint strate-

gies in cooperation with other concerned service sectors for mentally ill clients who are elderly, dually diagnosed, or involved with the criminal justice sectors. Cross-sector policies that reinforce this implementation plan and clearly outline the shared service responsibilities of the respective service jurisdictions need to be developed further. Additional population groups including children, Aboriginal and ethno-racial clients also need to be considered.

Specific activities that will be undertaken to develop shared service requirements include:

- developing a solid conceptual foundation for the work with special populations. Special populations, at the moment, include a long, and rather fragmented, list of groups defined by social, linguistic, legal, clinical, and demographic characteristics. A framework would assist with identifying priority populations for funding, taking into account the funding implications of developing specialized service delivery systems for these populations; and

- consulting with other program areas and ministries as to the implications of the implementation plan for specific

populations, and the development of additional supporting policies.

4.3 *Joint Approach to Concurrent Disorders (Substance Abuse and Mental Illness)*

The vision for reform of Ontario's addiction treatment services is similar to that of mental health reform. Specifically, the addiction services' view of access to an integrated, client-focused system of evidence-based, cost effective services designed to meet diverse needs as well as the needs of family members/key supports and others affected by their addiction is also a cornerstone of mental health reform. The addiction treatment services system exists to meet the needs of people with addictions. The system will continually evolve and adapt, to reflect new knowledge, changing client needs, and changes in the broader health and social services system.

The document *Setting the Course A Framework for Integrating Addiction Treatment Services in Ontario* (Ontario Ministry of Health, 1999) lays out how Ontario will use a combination of best practices, monitoring and evaluation, and restructuring to improve the quality of addiction services, increase the

Special populations, at the moment, include a long, and rather fragmented, list of groups defined by social, linguistic, legal, clinical, and demographic characteristics.

capacity of the system, coordinate services and make more effective use of addiction resources. The framework also describes the strategies that government, District Health Councils, addiction agencies and others involved in the field will use over the next three years to create a client-centred approach to addiction treatment.

The main components of the framework are:
- improve how services are delivered;
- improve how services are monitored and evaluated; and
- improve how services are structured, planned and organized.

The overall goal is to provide a more coordinated, efficient system of treatment services through a variety of implementation strategies such as:
- using evidence-based practice;
- streamlining the assessment process;
- helping clients move easily through the system by developing standard admission and discharge criteria;
- clarifying roles and responsibilities;
- reshaping residential treatment services;
- sizing the system;
- making services more flexible;
- giving clients more choices;
- responding to changing client needs; and
- meeting the needs of special populations including those with concurrent disorders.

One of the major directions in both the substance abuse and mental health implementation documents is to shift the emphasis from institutional to community based services. Some linkages currently exist between the two systems: at the provincial level, through the Ontario Federation of Community Mental Health and Addiction Programs; and at the regional and local levels through agencies working together to provide coordinated client services. In Toronto, four existing addictions and mental health facilities were recently merged to create the Centre for Addictions and Mental Health.

However, while there are many similarities between the mental health system and the substance abuse system, both operate under two separate, parallel systems and have different philosophies and service approaches. It can be extremely difficult, therefore, for a client with a severe mental illness and an addiction problem, to receive coordinated care for both problems.

It has been documented that about half of all people receiving psychiatric treatment have a substance abuse problem, and about half the clients in treatment for substance abuse have some mental or emotional problems. Therefore, in order to optimize opportunities for integration and coordination between the two systems, it is best to focus on where the two systems clearly intersect. People with concurrent disorders i.e., those

individuals with both a mental illness and a substance abuse problem, could benefit from more coordinated and flexible access to services in both systems.

As both implementation strategies move forward over the next few years, the Ministry will ensure that common policy direction is developed in relation to concurrent disorders. Such direction will be vital to ensuring there is a coordinated and effective use of resources between the mental health and substance abuse programs/services for these individuals.

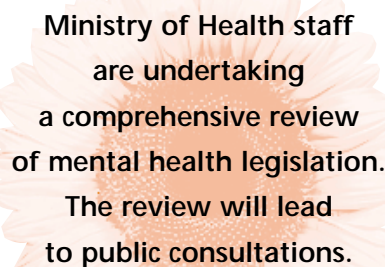### 4.4 *Policy Initiative: Legislative Review*

Following the recommendations in Mr. Newman's report; *2000 and Beyond: Strengthening Ontario's Mental Health System* (1998), and in response to numerous calls for legislative action, the Ministry has embarked on several initiatives to improve Ontario's mental health legislation. The need for a strong legislative foundation to move mental health reform forward is acknowledged.

Ministry of Health staff are undertaking a comprehensive review of mental health legislation. The review will lead to public consultations.

The Ministry has begun an extensive education and awareness campaign aimed at clarifying the intent and application of the Mental Health Act and related legislation as well as to obtain feedback on areas which require further clarification. The campaign includes professionals, providers, consumers/survivors and their families/key supports, and criminal justice officials. The education strategy complements the legislative review and is viewed as a vehicle to ensure legislative changes support the fundamental principles of the legislation.

Ministry of Health staff are undertaking a comprehensive review of mental health legislation. The review will lead to public consultations to ensure that legislation fulfills the following fundamental principles:

- that legislation supports the creation of an integrated and coordinated mental health system capable of providing a continuum of care from prevention to in-hospital and community based treatment;

- that legislation allows those who need mental health services to access those services where and when they need them; and

- that legislation ensures public safety.

The review will look at all aspects of mental health legislation to ensure the most comprehensive legislation possible. This

will include an analysis of the Mental Health Act, and related legislation such as the Ontario Health Care Consent Act and the Substitute Decisions Act, their current use and perceived deficiencies. The need for legislation to address all aspects of mental health treatment and services including community mental health services will be considered. A review of mental health legislation in other jurisdictions will also be undertaken. The review, as well as the feedback from a public consultation process, will provide the government with the necessary information to determine if legislation needs revising.

Conclusion

This implementation plan identifies next steps in the reform process which are required to ensure that Ontario's mental health system best meets the needs of people with serious mental illness. With the continued commitment and involvement of consumers, families, service providers and others we will create a system which provides Ontarians with the best possible mental health services into the year 2000 and beyond.

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Glossary of Terms

Assertive Community Treatment Team (ACTT) is a self-contained multi-disciplinary clinical team which: provides treatment, rehabilitation, and support services to clients with severe and persistent mental illness. This service can be provided on a ongoing basis. Seventy-five percent or more of the services are delivered outside program offices. The team emphasizes outreach, relationship building, individualization of services and client choice.

Best Practices: The document, *Review of Best Practices in Mental Health Reform*, defines best practices as those "activities and programs that are in keeping with the best possible evidence about what works." (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997). Best practice models influence policy and direction at both the service system level and the service delivery level.

Crisis: The onset of an emotional disturbance or situational distress (which may be cumulative), involving a sudden breakdown of an individual's ability to cope.

Crisis Intervention: Refers to active treatment and support offered as soon as possible after an individual has been identified as in acute distress.

Decentralized and Responsive Regional System: The Ministry will be moving system management responsibilities to regional offices in order to respond to regional needs. This change creates a need to develop or update the regional/local implementation plans to build service accountability and strong service integration mechanisms.

- **Regional:** Seven Ministry of Health Regions as defined by FutureShape: Toronto, Central West, Central South, Central East, Southwest, North and East.
- **Local:** The seven Ministry of Health regions that may be subdivided into local, smaller entities.
- **Community:** Stakeholders within a given geographic area, which can be regional, local or by another community (such as the consumer/survivor community).

Delinking: The concept is used in relation to supportive housing. Delinking means a person's eligibility for accommodation is not affected by his/her support service needs.

District Health Councils (DHCs): DHCs are established by Order-in-Council under the Ministry of Health Act, to advise the Minister of Health on health needs. DHCs are Schedule III Agencies and non-profit corporations with limited liability.

The mandate of a DHC is: to advise the Minister on health matters and needs in the council's geographic area; to make recommendations on the allocation of resources to meet health needs in the council's geographic area; to make plans for the development of a balanced and integrated health care system in the council's geographic area; and to perform any other duties assigned to it under this or any other Act or by the Minister.

There are 16 DHCs in Ontario. Each DHC has about 20 volunteer members. Each DHC office has about 10 staff.

First Priority Population: The primary target population for mental health reform remains those individuals with a serious mental illness. The three categories to identify these individuals are: disability, anticipated duration and/or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

• Disability: Refers to the fact that some individuals lack the ability to perform basic living skills such as eating, bathing, or dressing; maintaining a household, managing money, getting around the community and appropriate use of medication; and functioning in social, family and vocational-educational contexts.

• Anticipated Duration/Current Duration: Evidence may indicate that the client's problem may be ongoing in nature. This does not mean that the problems are continuous. There may be intermittent periods of full recovery.

• Diagnoses: For example, schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included.

Frontline Health Care Providers: These include general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics.

Health Services Restructuring Commission (HSRC): The Health Services Restructuring Commission was established in April 1996 as an organization at arm's length from the Ontario Government. The Commission's mandate is to make decisions about hospital restructuring and to recommend changes to other aspects of the health care system. The HSRC is guided by three principles: enhancing or maintaining the quality of health care, accessibility of health care and affordability of health care.

Homeless/Socially Isolated: A definition of this population that was adopted in 1996, is: "A person is considered homeless or socially isolated if s/he lacks adequate shelter, resources and community ties or whose accommodation is at risk given a lack of resources and community ties." (Levine, 1983).

Housing Support Services is used to describe the delinked services which may also include case management, social rehabilitation, assertive community treatment teams, and to some extent, crisis intervention services.

Independence can be defined as living in the community, requiring the least intervention from formal services and, to the greatest extent possible, making one's own decisions.

Individual with multiple or complex needs: A person who meets the criteria for serious mental illness, has had past episodes of aggressive or violent behaviour and has one or more of the following characteristics: three or more psychiatric hospital admissions within the last two years; has been detained in an inpatient facility for 60 or more days within this period; subject to two or more police complaints/interventions within the last 12 months or has been incarcerated in a correctional facility for 30 or more days within this period; recently evicted from housing, or is homeless, or living in shelters; current problems with drugs and/or alcohol; and/or problems following-up with recommended treatment plans.

Levels of Need: These levels focus on the range of clients needs, which then determine the types of services required. The levels: First Line, Intensive and Specialized emphasizes a multi-disciplinary, client-centred approach to the delivery of mental health services.

• First Line: Refers to prevention, assessment and treatment provided by frontline health care providers including general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics.

• Intensive: Refers to mental health assessment, treatment and support services which are provided in community or hospital settings and are focused on people with serious mental illness.

• Specialized: Refers to highly specialized mental health programs provided in community or hospital settings and which focus on serving people with serious mental illness who have complex, rare, and unstable mental disorders. Long term care is not synonymous with specialized care. Treatment, rehabilitation, and support services are integrated within each program/service type and provided through a multi-disciplinary team approach.

Ministry Implementation Team – Governance: This team is comprised of the Ministry Regional Director for mental health, Administrator of the PPH, other Ministry staff and representatives from the public hospital that will be receiving the transferred services. The purpose of this team is to facilitate the development of the legal transfer agreement designed to support the transfer of governance and management of the PPH to the public hospital. The team is also responsible for ensuring that steps are taken towards the development of the human resources agreement between Government and the public hospital.

Ministry Implementation Team – System: This team has broader membership because it is dealing with program design and linkages with other parts of the system. Membership includes representatives from the affected hospitals, District Health Councils, community providers and local citizens. The purpose of this team is to develop, following the transfer of governance, the best approach to restructuring the PPH services and the subsequent closure of the PPH, if appropriate.

Mobile Outreach Teams: Multi-disciplinary, accountable, mobile outreach teams will offer consultation, assessment and treatment planning services to both first line and intensive service providers and to families. Wherever possible, an emphasis will be placed on averting hospitalization and allowing the client to remain in an integrated setting in the local community. Where necessary, however, mobile outreach teams will facilitate immediate access to specialized services. The functions provided include assessment, clinical consultation, crisis intervention, case management, education (in-service training), client advocacy and developing linkages with other services.

Provincial Psychiatric Hospitals (PPH): PPHs are operated by the Government of Ontario and provide inpatient and outpatient treatment and rehabilitation for people with serious mental illness.

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

Residential Treatment Facilities: These facilities provide specialized services in a residential setting for people who require a higher level of support in order to be discharged from long term hospitalization. The function of the residential treatment facility is to facilitate transition to independent housing for the more complex and disabled provincial hospital residents.

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

Shared Service Models of Care: This model ensures that clients with multiple problems that cross a variety of service jurisdictions receive coordinated services.

Specialized Forensic Services: One of the specialized clinical programs available in regional hospitals. Functions of the specialized forensic services include the assessment, treatment and clinical management of people with a mental illness who may be accused of or committed violent, dangerous or criminal acts. Clinical programs are directed at treating mental illness and reducing risk of re-offence. The target population is different from other psychiatric programs i.e. patients who represent a very high risk of violence, or who have complex overlapping needs relating to aggression, legal status, and clinical/risk management.

Specialized Services in Hospitals: Specialized services in hospitals involve the provision of health care by specialized professionals. Specialized services are provided to persons with serious, complex, and/or rare mental disorders whose service requirements cannot be met in the first line or intensive levels of service. Specialized services include special intensive programs and both

episodic and long-term rehabilitative care for people with severe and chronic symptoms. It includes outpatient, outreach and consultative services. These specialized hospital programs are almost always affiliated with a university health science centre.

Strategic Reinvestments: The reformed mental health system will make reinvestment decisions strategically instead of on a program by program basis. Program funding will be directly tied to program performance so that reliance on inpatient services is decreased and the continuum of community and inpatient services is sufficiently funded to meet a diverse range of client needs.

System Management/Service Delivery Responsibility and Accountability: These approaches will allow greater accountability in the reformed mental health system. The mental health system will be measured against the accountability framework that is to be developed. Measures of success will include wellness and quality of life indicators, not just symptom reduction. Linking funding to system and program performance is a critical element of system change.