

Making It Happen

**Operational
Framework
for the Delivery
of Mental Health
Services
and Supports**

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Introduction

1.1 Purpose

Mental health services in Ontario are engaged in a process of reform that is guided by *Making It Happen: Implementation Plan for the Reformed Mental Health System*. This Framework for the Delivery of Mental Health Services and Supports is the companion document to the Ministry of Health Implementation Plan for the Reformed Mental Health System which provides more detailed directions regarding how the delivery of services and supports will be improved through the reform process. These details ensure that core services are consistent with the implementation directions. While the Implementation Plan provides the context for the overall reform of the mental health system, the Framework focuses on how core services will be organized and delivered within the reformed mental health system. Guidelines are outlined to ensure that services are comprehensive, coordinated and provided based on consumer needs and best practices.

This document is intended for mental health service providers and planners. From the outset, newly funded mental health services should be planned, organized and delivered in a manner that is consistent with the continuum of care

requirements and the service guidelines. Over time, existing mental health services should, in partnership with the community and Ministry representatives, review their current operations and adapt their services to be consistent with the service delivery expectations outlined here. Other related Ministry policy directives should be applied where necessary.

The priorities and approaches to reinvestment will reflect system requirements as identified by the Ministry, District Health Councils, the Health Services Restructuring Commission and community stakeholders. Ministry staff, as system managers, will lead the strategic reinvestment, which may emphasize particular services and supports at different points in time.

As implementation proceeds, accountability mechanisms will be developed to ensure that consumers are receiving care based on their level of need.

In the year 2002, the Ministry will review the service and support framework and revise implementation strategies and program funding priorities as necessary. This framework will guide service delivery at the local, regional and provincial levels. It is expected that change will be ongoing as the system continues to evolve and as clear directions are established in relation to housing, shared service delivery mechanisms, and other essential mental health services.

1.2 Principles

1.2.1 Principles for a Reformed Mental Health System

The reformed mental health system will recognize the inter-relationship between the needs of the consumer, the organization of the service delivery system, and the performance and mandate of each Ministry-funded mental health program. These inter-relationships are a fundamental basis upon which the service delivery principles listed below are built.

The following principles will guide both system and policy development as strategies are implemented to support system restructuring and reform:

- 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 will be improved while access to services will be streamlined;



- Services will be linked and coordinated so the consumer is able to 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;
- 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.


The principles and service/support expectations outlined in this framework have been compiled from a number of sources including: Ministry of Health documents, best practices documents and working papers which have been prepared for mental health reform by planning work groups in Ontario. The source documents have been referenced in each section. The contributions of all outside sources to this framework are acknowledged and appreciated.

1.2.2 Principles for the Delivery of Services and Supports

The following principles will guide the provision of the services and supports outlined in this section of the document:

- The interests and rights of the consumer/survivor are to be respected in accordance with existing legislation. The principles of consent and confidentiality will be upheld;
- Consumers and mental health workers are expected to share the common values of mutual respect, dignity and understanding;
- People with serious mental illness will achieve greater independence; that is, the ability to live in the community with the least intervention from formal services and, to the greatest extent possible, make their own decisions;
- It must be acknowledged that gender, culture, language, creed, economic standing, education, age, sexual orientation and race play active dynamic parts in the lives of all people;
- The needs of consumers which pertain to age, gender, sexual orientation, limitations and/or challenges (physical, developmental disabilities, medical issues), language, culture, race, economic standing, creed, education, past or present experiences (substance abuse, sexual abuse, violence, homelessness, involvement with the forensic system, etc.) will be incorporated into service delivery;
- Informed choice, within the context of the individual's capacity and consistent with mental health and other legislation, should be maximized. Supports should be consistent with, and supportive of, the individual's needs and abilities. Services should respond rapidly to changing client needs;
- Barriers or exclusionary criteria which can prevent easy, flexible access to services will be removed;
- Proactive outreach is an important element in reaching people with serious mental illness who may require a period of time to engage in a working relationship. Proactive outreach is also important in ensuring early access to services;
- The contractual, mutually respectful partnership between the consumer and the service provider is key to success. Services are provided with the belief that human relationships are complex; all people have strengths, limitations and challenges;
- Services should build on individual strengths and work with the individual to provide and/or link them to formal and other community resources. A broad range of resources is considered, including mental health resources, other community resources and informal support networks;

- The least restrictive and the least intrusive interventions, which still provide safety for the person, will be used;
- Consumers will be active and valued participants in the planning, evaluation and governance of mental health services;
- Families will be active and valued participants in the planning, evaluation and governance of mental health services;
- Consumers have the right to define who they consider their 'family' and those individuals should have support services available to them;
- There are no obvious distinctions in the quality of services based on location. Hospital and community programs jointly share responsibility to respond to the consumer's health care needs and to promote skills and develop resources.



**Consumers
will be active
and valued participants
in the planning, evaluation
and governance
of mental health
services.**

1.3 Goals

Mental health services need to be organized and delivered in a manner that supports the goals of mental health reform. As stated in the Implementation Plan, the reform goals are intended to ensure that mental health services and supports:

- Are provided within a comprehensive service continuum developed to meet consumer needs and based on best practices;
- 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 a geographic area;
- Are part of the broader health and social service continuum;
- Facilitate a shared service approach to serving the needs of individuals with serious mental illness and the populations who have multiple service needs;
- Achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators;

- Are simplified and streamlined according to the consumer's needs.

1.4 Characteristics of the Reformed Mental Health System

The following table presents the characteristics of the reformed mental health system that will be achieved as a result of the implementation of mental health reform as outlined in this document.

The characteristics of the developing system provide a vision of the reformed system that will be achieved through the collaborative work of people and organizations at the local, regional and provincial levels.



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: <ul style="list-style-type: none"> • best practice models/levels of need; • strategic reinvestment; and • service agreements among agencies. Services and supports respond to individual needs through: <ul style="list-style-type: none"> • individualized service/treatment plans based on client needs; • common intake, assessment and discharge tools/protocols. 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • centralized information and referral functions; • lead agencies/hospitals, networks, amalgamations; • service agreements; and • common assessment tools/protocols. 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • cross sector planning; • service agreements among sectors; and • continued implementation of existing policy guidelines (dual diagnosis, long term care, etc.). 	<ul style="list-style-type: none"> • 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 : <ul style="list-style-type: none"> • best practices; and • system design and local/regional planning. 	<ul style="list-style-type: none"> • Implementation Plan for the Reformed Mental Health System
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: <ul style="list-style-type: none"> • Minimum Data Set; • operating plans; • Psycho Social Rehabilitation Tool Kit; • service agreements; • ACTT Standards; and • monitoring and evaluation of reinvestments. 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • implementation of Futureshape; and • implementation of Mental Health Reform within the decentralized structure. 	

*Assumes updated regional/local plans are required
TBD = to be developed

Comprehensive Continuum of Supports and Services

2.1 Introduction

A comprehensive continuum of supports and services that responds to all aspects of a person's life is required. Some supports and services cut across all levels of need, as outlined in the next section, and are a vital part of this continuum. Individuals can enter the support and services system at a number of points within the comprehensive range and will be able to move with ease within the system. Linkages will need to be established within the system and with other health and social service systems.

2.1.1 Comprehensive Continuum of Supports and Services

The following list is intended to highlight the range of supports and services in a comprehensive system.

- Health Promotion/Education
- Housing
- Income Supports and Services
- Peer Supports
- Self-Help and Alternative Supports

- Drop-Ins
- Vocational and Employment Programs
- Consumer-Run Businesses
- Family Supports
- Social/Recreational Programs
- Primary Care Physicians
- Health Service Organizations
- Community Health Centres
- 24 Hour Crisis Telephone Lines
- Mobile Crisis Teams
- Safe Beds
- Schedule 1 Emergency Services
- Inpatient Services
- Outpatient Services
- Intensive Case Management
- Assertive Community Treatment Teams
- Mobile Outreach Teams
- Residential Treatment Facilities
- Specialized Forensic Services

2.2 Levels of Need

2.2.1 Direction for Reform

Best practices literature identifies the types of services and supports which 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 Provincial Psychiatric Hospitals (PPHs) 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 enhance the effectiveness and efficiency of the overall system and to guide future strategic reinvestments in priority areas. Most importantly, this will ensure that the appropriate services and supports are available to serve the needs of people with a mental illness.

Specific to treatment, rehabilitation and support service functions, a conceptual framework based on consumer levels of need has been adopted which provides a basis for realigning and clarifying the roles and responsibilities of providers.

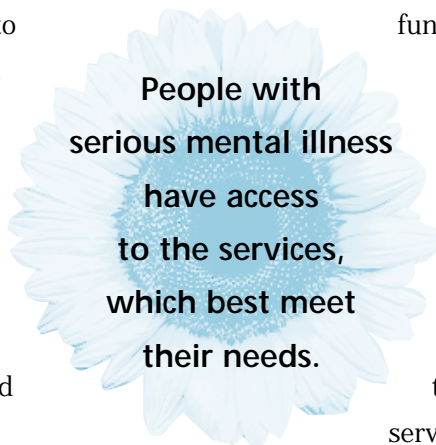
The service delivery system must be able to support consumers in identifying and achieving realistic goals. A realistic goal for individuals with serious mental illness

is to be able to adapt to the illness so as to allow life to go forward in a meaningful way.

Each person with serious mental illness should have access to the service functions outlined below

(Ontario Ministry of Health, *Draft Treatment and Rehabilitation Guidelines*, 1995; Coalition of Ontario Psychiatrists, 1998).

These functions are essential components of the services outlined in Chapter 3.



- **treatment** for the primary symptoms of the illness itself;
- **rehabilitation** to cope with the primary symptoms of the illness in activities of daily living e.g., employment and interpersonal relationships, and to maximize strengths; and
- **support** to sustain a good quality of life and to access social and health care services.

Treatment is generally thought of as those interventions directed toward assessing, alleviating, reducing or managing the symptoms of an illness or disorder, or symptoms resulting from the trauma of abuse. Treatment includes:

- Identification and assessment of signs and symptoms;

- Bio-psycho-social investigations;
- Diagnostic evaluation;
- Client-centered consultation i.e., with the client present, and case-centered consultation i.e., with provider;
- Development of working alliances among providers to ensure a collaborative treatment approach;
- Counseling and psychotherapy i.e., individual, family and group;
- Medication management i.e., provision and monitoring;
- Hospitalization; and
- Specific medical and psychiatric care i.e., physical health care, psychiatric monitoring, crisis assistance, medical/legal assessments and interventions, and other medical interventions.

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

Rehabilitation includes:

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

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

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

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 specific service functions that differ in terms of level of resource intensity, specialization, and/or service duration. An array of service intensities, combining crisis, supportive, clinical and environmental interventions is encompassed within each level.

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 based on client choice, and offered in accordance with the client's functional needs and clinical characteristics. Given that groups of clients share many common needs and will benefit from similar service approaches, people will receive most of their services from within a particular level but are not limited to accessing services only within one level.

The term "levels of need" has been chosen to focus on the range of consumer 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, consumer-centered approach to the delivery of mental health services as opposed to a perceived medical approach.

2.2.2 Definitions

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.

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 inpatient care, day hospital and home treatment, and ambulatory outpatient services).

Specialized:

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

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.

For the consumer, 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 examine the effectiveness of each program according to its contribution to a coordinated continuum of services, in addition to its individual program merits.



People with a serious mental illness are not a homogeneous group. 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 providing individualized and flexible treatment, rehabilitation, and support functions. Planning must include a broad spectrum of providers including general hospitals, physicians, community mental health professionals, family and friends. (Common intake assessment, discharge, referral and practice protocols need to be established 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.

2.2.3 Implementation Priorities

Over the next three years, the Ministry will:

- Ensure that all Ministry-funded 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.
- Provide for regular monitoring and feedback about program performance to determine how existing mental health services function within and across levels of need.

2.2.4 Populations to be Served

The populations to be served are defined according to the three levels of need – first line, intensive and specialized.

First Line:

While the priority population for mental health reform is people with serious mental illness (see below), first line emergency and crisis services must be accessible to all people with symptoms of mental illness. Upon assessment within this level, people will be directed to the service(s) which best meet their needs, i.e. brief crisis intervention, intensive and/or specialized services or generic supports in the broader social service/health care systems.

Intensive:

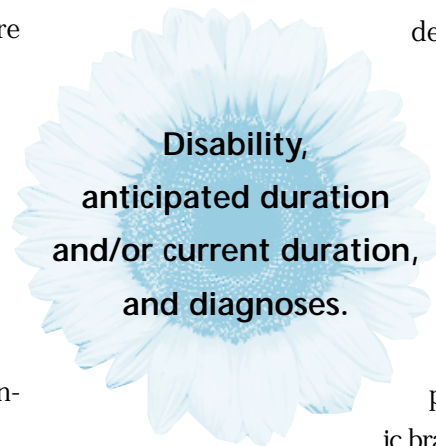
The target population for services within the intensive level of need is people with serious mental illness. Intensive services provide on-going and continuous contact to people whose condition is sufficiently stable to require weekly, monthly or less frequent interventions. In addition, a particular focus of services within the intensive level of need is the client with multiple and complex needs who is at risk for repeated or prolonged institutionalizations in health care or correctional facilities.

Fundamental to the understanding of the first priority population for mental health reform is the recognition that a

complexity of social, psychological, racial, cultural, political, spiritual and biological issues or forces may impact on the mental health of any individual. Accordingly, the first priority population is defined as follows (Ontario Ministry of Health, *Definition of Priority Population for Mental Health Reform*, 1994):

There are three dimensions used to identify individuals with a serious mental illness/severe mental health problem - **disability, anticipated duration and/or current duration, and diagnoses** (see glossary). 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 difficulties that interfere with or severely limit an individual's capacity to function in one or more major life activities i.e., eating, bathing or dressing; instrumental living skills i.e., 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 popu-



lation 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 on-going nature of the problems identified either through empirical evidence and objective experience suggesting persistence over time or through the subjective experience that the problems have persisted over time. It is important to note that this does not necessarily mean continuous, observable evidence of disorder but may include acute or intermittent episodes between which there are periods of full recovery. More recently, duration has been defined and measured in relation to amount of service utilization and so has become an indicator of severity as well as chronicity.
- **Diagnoses** of predominant concern are schizophrenia, mood disorders, organic brain disorders, paranoid psychosis or other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included. As previously noted, particular focus of services within the intensive level of need is the client with multiple and complex needs who is at risk for

repeated or prolonged institutionalizations in health care or correctional facilities. Based on research in other jurisdictions, an individual with multiple and complex needs is defined as 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, including:

- Psychotic symptoms that include feeling threatened, under control of outside forces, and increased hostility;
- Three or more psychiatric hospital admissions within the last two years or has been detained in an inpatient facility for 60 or more days within this period;
- Subject of two or more police complaints/interventions within 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.

Many people who have a serious mental

illness will have life long problems in coping and periodic episodes of acute illness that are characteristic of chronic illness or disorder. Other people with a severe illness or disorder will be very ill for a short period of time but totally recover with treatment. Sometimes people recover, or attain their desired level of stability, with informal supports or without any intervention at all.

Specialized:

There are a variety of needs within the group of people with serious mental illness. The care of many individuals cannot be managed within the existing array of first line and intensive services.

These are the people who comprise the target population for services within the specialized level of need. Because of their complex and rare service requirements, these individuals require on-going support, more structured and intensive treatment or a higher level of coordination, security and support. In addition, providers working with these individuals receiving services within the other levels of need may require consultation, and specialized back-up from providers in the specialized level of need.

Specific groups include:

- Elderly clients suffering from dementia, psychosis and medical illness i.e., psychogeriatric population;
- Clients who are developmentally disabled with psychiatric disorders, often with assaultive behaviour i.e., dual diagnosis population;

- Clients with schizophrenia who are chronically psychotic, assaultive or suicidal i.e., severe and persistent mental disorder population; and
- High risk forensic clients who are also part of one of the groups identified above, or who have complex overlapping needs relating to aggression, legal status, and clinical/risk management i.e., forensic sub-population.

required, with consultation from specialized service providers.

Within the population of clients with schizophrenia who are chronically psychotic, assaultive or suicidal, a large proportion suffer from concurrent substance abuse and require specialized services.

Also appropriate for specialized services are individuals for whom there has been a poor response to psychiatric interventions, and behaviours are considered to be potentially dangerous and highly disruptive. Clients who receive direct service provision by specialized care providers will be part of one of these populations, and will require daily access to special, clinical resources that are available only within the specialized level of need programs. For other clients who are part of these populations but have more stable conditions, consistent outreach and support by either first line or intensive direct service providers is

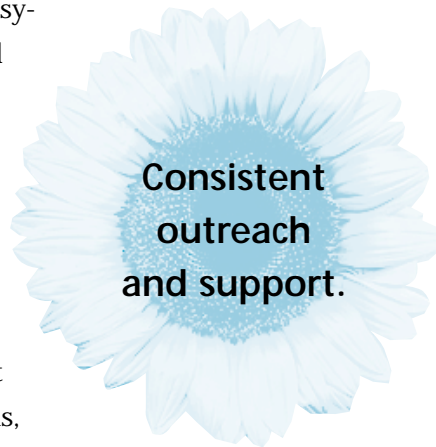


Table 2: Characteristics of the Levels of Need

Levels of Need	First Line	Intensive	Specialized
Definition	<ul style="list-style-type: none"> Refers to prevention, assessment and treatment by front line health care providers. This includes general practitioners, mental health services, social services, hospital emergency services and hospital primary care clinics. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 multidisciplinary team approach.
Populations to be served	<ul style="list-style-type: none"> The priority population for mental health reform is people with serious mental illness. First line emergency crisis services must be accessible to all people with symptoms of mental illness. 	<ul style="list-style-type: none"> Target population is people with serious mental illness who do not have an on-going need for services provided within the specialized level of need. Of particular focus is the client with multiple and complex needs who is at risk for repeated or prolonged institutionalizations in health care or correctional facilities. 	<ul style="list-style-type: none"> The target population is a sub-population within the group of people with serious mental illness that cannot be managed within the existing array of first line and intensive services. These people require on-going support, more structured and intensive treatment or a higher level of coordination, security and support.
Services	<ol style="list-style-type: none"> 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 Health service organizations 	<ol style="list-style-type: none"> Intensive case management/housing supports Skill development and psycho-social rehabilitation programs Medication clinics Schedule 1 psychiatric inpatient and outpatient services (including triage to inpatient care, day hospital and home treatment, and ambulatory outpatient services) 	<ol style="list-style-type: none"> Assertive community treatment teams Specialized mobile outreach teams Residential treatment facilities Specialized inpatient and outpatient services Regional forensic services

* Assumes updated regional/local plans are required
TBD = to be developed

2.3 *Strategic Reinvestment*

One of the key strategies of mental health reform is to establish a comprehensive service delivery system which is integrated and coordinated and places priority upon meeting the needs of individuals with serious mental illness. The focus of the system design and planning process led by the District Health Councils (DHCs) was to create such a system of care within each district and region in the province.

The district and regional plans contained an analysis of service and support needs of consumers/survivors with serious mental illness. Based on the provincial definitions, benchmarks and targets, an estimate of the key mental health services and alternative supports to meet the population-based needs of the district and region were established.

In addition, an estimate of the gap between district and regional resources and needs was provided. This gap has also been taken into consideration in the development of the strategic reinvestment strategy.

The strategic reinvestment is consistent with the following:

- In preparation for the transfer of services from the Provincial Psychiatric Hospitals (PPHs), Comprehensive Assessment Projects which look at

the service needs of inpatients and outpatients will be undertaken. The projects will assess the level of functioning and support/service needs of clients with serious mental illness who are served by PPHs. These assessments will identify areas requiring additional community services that need to be in place prior to the restructuring of PPHs;

- System designs completed by the DHCs based on Ministry expectations which included a range of recommendations regarding structural changes to the way in which community mental health services are delivered and evaluated;
- Health Services Restructuring Commission (HSRC) accepted advice and directives; also best practices have identified that a balanced and effective service and support system would include: assertive community treatment/case management; crisis response and emergency services; community and housing supports; inpatient and outpatient care; vocational and educational services; consumer self-help and economic development; and family self-help.

In addition, strategic reinvestment will support the development of an effective and coordinated system, based on a levels of need approach.

This reinvestment strategy will support the implementation plan and allow the Ministry to:

- Focus implementation planning activities on the delivery of essential services based on best practices;
- Prioritize funding to services identified as essential to build service capacity before inpatient reductions occur, in order to more effectively meet consumer needs and allow for the restructuring of the PPH system;
- Build upon prior system design planning initiatives and focus on reducing the number of access points into the system and streamlining service delivery;
- Immediately carry forward the mental health reform agenda in a multi-year phased approach while effectively managing and governing the system; and
- Maintain flexible approaches based on local requirements.



Ministry staff, as systems managers, will lead the strategic reinvestment, which may emphasize particular services and supports at different points in time. The priorities and approaches to reinvestment will reflect system requirements as identified by the Ministry, District Health Councils, the Health Services Restructuring Commission and community stakeholders.

The savings from restructuring within the PPHs will be utilized to build a comprehensive support and service system across Ontario.

Approaches to Support Effective Service Delivery

The Ministry will facilitate the implementation of a number of mechanisms to support effective service delivery. Three areas of focus will be service/system accountability, shared service models and improved access.

3.1 *Service/System 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 programs. In addition, current mental health programs and services 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, will identify system, program and client outcomes and will include input from consumers and families, in addition to including more qualitative/increased quality of life measurements;

- Further the development of evaluation tools to assist in the measurement of program and client outcomes; and
- Identify and provide the necessary additional resources (financial and expertise) required in order to fulfill these additional requirements.

3.2 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 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.

Participatory planning and service delivery are at the foundation of an effective response to clients with multiple and complex service needs. 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 within the context of their respective restructuring processes to ensure that their service organizations i.e., both transfer payment agencies and government operated services, understand the expectations to

jointly plan and share service delivery for people whose multiple needs require that they must access services from multiple systems.

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;
- Training and Education;
- Cooperative Treatment Planning;
- Individualized Treatment and Service Plans;
- Maintenance of Community Contacts through Periods of Institutionalization;
- Long-Term Resource Planning;
- Innovative Funding; and
- Primary/Specialty Care Partnerships.

[See Appendix 4I for full description]

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.

3.3 Improved 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 agencies which provide a wide range of mental health services and supports including: assertive community treatment teams, case management, crisis intervention, supports for housing, consumer and family self-help, and vocational and social rehabilitation. Many agencies provide several of these services and supports.

The degree to which mental health services are coordinated varies from area to area. In some areas, services are 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 better access to the mental health system. However, the choice of model used to achieve better access in a local area will depend on the current configuration and availability of local/regional community, hospital and physician resources. Local conditions e.g., rural, urban issues, will also be considered.

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 to services.

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

- Centralized information and referral functions;
- Fewer points of entry;

- Consultation services provided by psychiatrists will be facilitated; and
- Minimal assessments.

[See Appendix 4J for full description of Improved Access]

The changes and mechanisms outlined above will facilitate better 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 better access – a common assessment tool and a template for service agreements;
- A policy on housing and access to housing;
- An accountability framework; and
- Policy frameworks for Schedule 1 general hospitals and physician services.

Until the required research on common assessment tools 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 facilitate system and program mechanisms to improve access.

3.4 Ministry of Health as System Manager

The Ministry has the responsibility as system manager to provide leadership and policy direction, and to support the implementation and evaluation of mental health reform. The Ministry supports the need for local leadership regarding planning. The DHCs have been asked to take on this responsibility and they have been given the authority to plan at both district and regional levels.

The role of a system manager can be defined as one who:

- Articulates the direction of the health care system as directed by the Ministry of Health's strategic direction;

- Manages through clear policies and standards;
- Sets outcome measures;
- Facilitates public accountability and understanding;
- Enables and develops individual knowledge and expectations of the system;
- Provides funding through operating plans, service agreements or contracts;
- Ensures effective and efficient use of available resources;
 - Takes corrective measures when necessary; and
 - Focuses on population based needs versus individual needs.



The Ministry supports the need for local leadership regarding planning.

A key feature of the mental health reform policy is to develop a system which is integrated and coordinated. Any changes to the current mixed governance system i.e. both transfer payment and government-run services, will be part of changes in the greater health system.

Various system accountability mechanisms must be employed, such as service contracts and memoranda of understanding. There are two levels at which these mechanisms must be utilized:

- Service contracts and memoranda of understanding with the Ministry of Health as system manager; and
- Between or among supports and services in the mental health system.

It is expected that these types of mechanisms will be employed over the next few years of reform as the comprehensive mental health system is established. These types of mechanisms should be described as part of the district and regional mental health implementation strategies as tools to achieve the goals of integration and coordination.

The establishment of decentralized regional offices of the Health Services Management Division, Ministry of Health, has been initiated. These regional offices will have primary responsibility for health service management for a particular geographic area. The regional offices will work closely with local health services and planning bodies to ensure regional needs, priorities, issues and opportunities are identified and integrated into regionally focused programs aligned with provincial directions and priorities.

Until the decentralized structure is established the current regional teams, presently centrally located, will be responsible for the implementation of mental health reform. Although regional teams exist, the physical location of staff and decision making is centralized in the interim.

The ultimate goal of the regional office is to operate on a systems model where managers and program staff are grouped by specific geographical areas in the region. They all support the full range of programs in their part of the region, in a system management approach.

Supports and Services

This chapter outlines the features and functions of many mental health supports and services. The Ministry will continue to develop guidelines for the continuum of supports and services.

4.1 Supports

4.1.1 Consumer/Survivor Initiatives

FEATURES

The Ministry supports the key elements of best practice identified for Consumer Self-Help and Consumer Initiatives in *Review of Best Practices for Mental Health Reform* (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997):

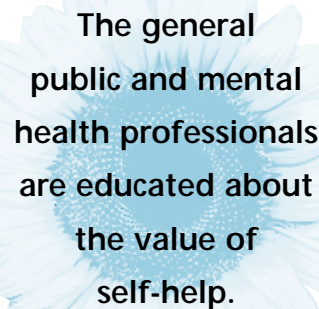
- There are a number of organizations that use non-service models to engage in: mutual support, advocacy, cultural activities, knowledge development and skills training, public education, education of professionals and economic development;

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

[See Appendix 4A for Functions of Consumer/Survivor Initiatives]

4.1.2 Family Initiatives

People define their families in a variety of ways: those related by birth, through choice and through traditions related to their cultures of origin. Consumers/survivors have the right to define who they consider their “family” and those individuals should have the support services available to them. In the event that a consumer/survivor rejects his/her biological family, members of that family would still be entitled to support.



The general public and mental health professionals are educated about the value of self-help.

FEATURES

The Ministry supports the key elements of best practice identified for Family Self-Help Initiatives in: *Review of Best Practices for Mental Health Reform* (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997):

- Family self-help groups (as individual or joint consumer-family initiatives) are resources in the planning, evaluation and governance of care delivery.
- Evaluation of the effectiveness of the groups that use appropriate alternative methods is encouraged and supported.

[See Appendix 4B for Functions of Family Initiatives]

4.2 Services

4.2.1 First Line

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

4.2.1 A: Comprehensive Crisis Response Services

The crisis response system needs to be universally accessible and take into account the age, gender, race, language, etc., of a person who is experiencing a psychiatric crisis. It must give priority to individuals with serious mental illness (see definition of this group in Section 2.2.4) and those who may be at risk of causing harm to themselves or others.



The crisis response system needs to be universally accessible.

It is recognized that individuals familiar with, and recipients of, mental health services who are in a state of crisis will tend to seek assistance from existing service providers such as case managers. Therefore, as noted above, a crisis response capacity will be needed, within the current system of services and supports, which is responsive on a 24-hour basis and which provides opportunity for individual choice. On the other hand, for individuals who are not currently part of the mental health system but who need to access crisis intervention services and supports, crisis services may be the point of entry into the mental health system. This would include referral from and involvement by generic crisis services such as the general practitioner, police or ambulance (Ontario Ministry of Health, *Draft Multi-Year Plan*, 1995).

A crisis is 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. There is a need to provide immediate relief from symptoms and rapid stabilization so that the condition does not worsen.

Crisis intervention also provides an opportunity to effect a longer-term treatment and rehabilitation plan if necessary. It holds the potential of mobilizing community resources and averting the need

for short and/or long term hospitalization. It is one of the points of access or entry to the mental health system for individuals in crisis, particularly those individuals who have not previously received mental health assistance.

SERVICE FEATURES

Each district will establish 24 hour capability to provide rapid assessment and intervention in an array of environments. In larger centers, a crisis intervention team is available which is flexible and mobile enough to carry out assessments and provide treatment and support in a variety of settings. These settings include clients' homes, shelters and other community environments. In some cases, it will make sense to have the team based in the Schedule 1 facility, operating in or near the hospitals' emergency area. More typically, the crisis intervention team is located elsewhere in the community but will require 24 hour back-up from the Schedule 1 facility.

- A collaboration among the existing services including hospitals, mental health centres, community programs (including consumer and family initiatives) is needed to balance, develop and implement local crisis response strategies. This could include collaboration between services to put in place a 24-hour crisis response capability, without each

service needing to be available for the full 24 hour period. The important role the police play in the crisis and emergency response should be acknowledged. Efforts need to be made to ensure the police are involved in the on-going development of mental health emergency and crisis systems.

In addition to the above, the following key elements as outlined in the *Review of Best Practices in Mental Health Reform* (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997) are supported by the Ministry:

- Services are established that resolve a crisis for persons with serious mental illness using minimally intrusive options;
- Crisis programs are in place to divert people from inpatient hospitalization; and
- Evaluation/research protocols are incorporated into crisis programs.

Examples of crisis programs are:

- Telephone crisis services;
- Mobile crisis units;

- Crisis residential services, e.g. supervised apartments/houses, foster homes; and
- Psychiatric emergency/medical crisis services in hospitals.



FUNCTIONS OF A CRISIS SERVICE

A range of services and supports are required by clients and their families which assist in crisis prevention and on-going support. The following should be included as specific functions of a crisis service:

- Assessment and Planning
- Crisis Support/Counseling
- Medical Intervention
- Environmental Interventions and Crisis Stabilization
- Review/Follow-Up/Referral
- Information, Liaison, Advocacy and Consultation/Collaboration

[See Appendix 4C for full description of Crisis Service]

4.2.1 B: Emergency Services Provided by Schedule 1 Facilities

Schedule 1 facilities will be expected to provide the following first line services (Ontario Ministry of Health, *General Hospital Psychiatric Services: Role*

Statement, 1995; Clarke Consulting Group, 1997; The Eiger Consortium/ Dreezer & Dreezer Inc. and the Clarke Consulting Group, 1998.)

Emergency Services, Including Crisis Response Services

- 24 hour/7 days a week access to emergency services including the availability of a psychiatrist for assessment;
- The hospital's emergency department must provide a 24 hour back-up to the crisis teams;
- The hospital **may** be the service provider for the integrated community-focused crisis response system which each local area is required to have in place. These services could alternatively be provided by a community agency working with the hospital. Crisis services should include: telephone crisis and warm lines, and a crisis team.

4.2.2 Intensive

Individuals with an intensive level of need will access following service components:

- Schedule 1 facilities;
- Intensive case management services;
- Programs for clients with multiple and complex needs; and
- Supportive housing and other community support programs.

4.2.2. A: Intensive Services at Schedule 1 Facilities

These intensive services are comprised of the inpatient and outpatient services provided by hospitals which fall under Schedule 1 of the *Mental Health Act*: the mental health services at general hospitals and specialty psychiatric hospitals. To date, they have been referred to as acute care services.

SERVICE FEATURES:

The Ministry supports the directions of the elements of best practice identified for inpatient and outpatient services in Review of Best Practices for Mental Health Reform (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997):

- Long stay clients in Provincial Psychiatric Hospitals are moved into the community with carefully planned transitions to alternative care models;
- Inpatient stays are kept as short as possible without harmful effects on client outcomes and partial hospitalization programs are available as an alternative for inpatient admission. Day treatment is an option for those with non-psychotic diagnoses; and
- Home treatment programs (that are either assertive community treatment teams or adjuncts to intensive case management) are available as an alternative for inpatient admission. New service delivery models, that link family physicians with mental health specialists, need to be developed.

The needs within each local district with respect to these directions will be reviewed. The implementation of these directions will be dependent on local needs and available resources.



FUNCTIONS OF INPATIENT AND OUTPATIENT SERVICES IN SCHEDULE 1 HOSPITALS:

[See Appendix 4D for full description]

- Emergency Services, Including Crisis Response Services
- Short Term Inpatient Assessment/Holding Beds
- Assessment, Stabilization and Short-Term Inpatient Treatment
- Discharge Planning
- Day Hospital
- Outpatient Services
- Consultation, Education, Coordination and Integration

4.2.2 B: Intensive Case Management Services

SERVICE FEATURES

The Ministry supports the key features of case management practice as outlined in the *Review of Best Practices for Mental Health Reform* (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997):

- the development of a caring, supportive relationship between the practitioner and the individual;
- an emphasis on continuity of care, i.e. supports are provided as long as they are needed and across service and program settings;
- flexibility in provision of supports to meet a person's perceived and changing needs over time; and
- the provision of supports to coordinate a fragmented system of care.

In addition, the following features of case management continue to be expectations.

- Case management is a service which is provided on the basis of individual choice and need. Referral sources should be broad and self-referrals are encouraged;
- Case management is not to be a prerequisite for access to their services and supports, nor is acceptance of other services to be a prerequisite for case management; and
- Clients have reasonable choice in selecting case managers.

FUNCTIONS OF INTENSIVE CASE MANAGEMENT SERVICES:

[See Appendix 4E for full description]

- Outreach and client identification;
- Comprehensive individualized assessment and planning;
- Direct service provision;
- Coordination and support;
- Monitoring and evaluation;
- Systemic advocacy and coordination; and
- Outreach functions.

Key Components of Intensive Case Management Services

- Proactive outreach;
- Caseloads of 15-20 or fewer. This represents the range for mature programs. It is recognized that caseloads for newly established case management services, rural areas and some populations, such as the homeless, may need to be lower;
- At least 20% of clients are seen more than once a week;

- More than 50% of case manager contacts with clients take place out of the office; and
- 24 hour access to services within the system.



The mental health case management system will often serve as the first point of contact to service providers and individuals associated with other service systems e.g., criminal justice, developmental services, addictions, etc. Case management services will be accessible and responsive to clients with multiple needs, and case managers will play a pivotal role in coordinating shared service delivery arrangements.

4.2.2 C: Programs for Clients with Multiple and Complex Needs

- Each local or regional area must have programs that are especially targeted to high-risk, individuals with multiple and complex needs who are at risk for repeated or prolonged institutionalizations in health care or correctional facilities. (Human Services and Justice Coordination Project, 1996). These programs will function as a fail-safe community safety net, characterized by continuous monitoring, need and risk interventions, and follow-up.

Services provided should include intensive psychoeducational programs; support and training for families; the provision of, and training in, the use of psychotropic drugs; and assistance in obtaining and maintaining housing.

Effective programs will have the following elements:

- Highly structured and behavioural or cognitive-behavioural;
- Run in the community rather than in an institution;
- Target higher rather than lower risk clients;
- Assertive delivery of services in the least restrictive environment possible; and
- Intensive in terms of number of hours and overall length of program.

The traditional psychotherapy or case work, reliance on the mere prescription of drugs, and custodial care in institutions or in the community may be less effective with high-risk clients than the intensive services noted above.

Crisis intervention, and relapse and risk management for high-risk clients, requires the availability of immediate access to bed-based services, service agreements to ensure psychiatric assessment and, if necessary, access to beds through civil committal mechanisms. Resource utilization will be enhanced through coordinated admissions/discharges from psychiatric facilities; and

- Where clients are reluctant they will be followed through an assertive outreach model until the risk to themselves or to the public is reduced i.e., the person no longer meets the criteria for an individual with multiple and complex needs. Assertive outreach and a no-turn down policy will be the central focus of continuous case management and will be offered to individuals with serious mental illness who are located in non-traditional settings.

4.2.3 Specialized

Individuals with a specialized level of need will access the following service components:

- Assertive community treatment teams;
- Specialized sub-population outreach teams;
- Tertiary care inpatient facilities;
- Residential treatment;

- Supportive housing and other core community support programs; and
- Specialized forensic services.

Specialized level of need functions can include:

- Special, intensive, acute care assessment and short term treatment programs;
- Both short term i.e., episodic, and long term rehabilitative care for severe chronic cases; and
- Outpatient, outreach and consultative services.

Delivery of specialized care should not be tied to a particular model, location of care, or time frame. Flexible strategies for providing specialized support should be employed in order to maximize the amount of time individuals remain in the least restrictive setting. Inpatient specialized care requires a team that may not be possible except at a centralized, regional location.

The specialized level of need consists of highly specialized services for those people with serious mental illness who have multiple and complex needs that are more difficult to treat and are not manageable at another level. Services are provided by multi-disciplinary teams, mostly in hospital settings, but also includes for-

mal linkages with providers at other levels to support the provision of service at the first line and intensive levels.

While many providers serve individuals with complex conditions, specialist providers are those having both extensive advanced training and commitment to service individuals who are temporarily in need of specialized supports.

Staff are expected to work in a variety of settings, integrate with staff from other organizations, maintain expertise that meets the needs of defined client groups, and provide training and consultation to a range of caregivers.



4.2.3 A: Assertive Community Treatment Teams (ACTT)

Assertive Community Treatment Teams:

- Are a self-contained clinical team.
- Assume responsibility for directly providing needed treatment, rehabilitation, and support services to identified clients with severe and persistent mental illnesses (in rural/remote areas service contracts may be required with existing case management and crisis response services).
- Minimally refer clients to outside service providers.
- Provide services on a long-term care basis with continuity of caregivers over time.
- Deliver 75 percent or more of the services outside program offices.
- Emphasize outreach, relationship building, individualization of services, and client choice.

The clients to be served are individuals who have severe symptoms and impairments not effectively remedied by available treatments or who, because of reasons related to their mental illnesses, resist or avoid involvement with services.

The team coordinator, program psychiatrist, program assistant, and multidisciplinary staff are to ensure service excellence and courteous, helpful, and respectful services to program clients. On average, there should be no more than 10 clients to one staff member (excluding the psychiatrist and the program assistant).

SERVICE FEATURES

Review of Best Practices in Mental Health Reform (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997)

- Assertive outreach;
- Continuous, round the clock, time unlimited, individual support to people with serious mental illness;
- Services are predominantly provided in the community as opposed to office-based;
- Provision of flexible support specifically tailored to meet the needs of each individual; and
- Involvement of clients and their families/key supports in all aspects of service delivery, including design, implementation, monitoring and evaluation.

FUNCTIONS OF AN ACT TEAM

[See Appendix 4F for full description]

- Case management
- Crisis assessment and intervention
- Symptom assessment, management and individual supportive therapy
- Medication prescription, administration, monitoring and documentation
- Provision of substance abuse services
- Work related services
- Activities of daily living
- Social, interpersonal relationship and leisure-time skill training
- Support service
- Education, support and consultation to clients' families and other major supports

Operating as a continuous treatment service, the ACT Team will have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

(Please refer to the Ontario Ministry of Health Standards for Assertive Community Treatment Teams (1998) for full functional descriptions)

4.2.3 B: Mobile Outreach Teams

- Outreach teams will be specific to particular client populations e.g., psychogeriatrics; concurrent disorders; dual diagnosis; and forensic, in areas where the need can be demonstrated;

- Multidisciplinary, 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;

- Offer training to providers, and identify opportunities for increased coordination and collaboration between two or more care systems. This approach assists individuals to maintain their current placement, can expand the capacity of services within the intensive level to serve individuals with high needs, lead to efficient use of limited specialized level

expertise, and is particularly useful where more than one treatment system is needed to participate in an individual's care; and

- Functions include, assessment, clinical consultation, crisis intervention, case management, education (in service training) client advocacy, developing linkages with other services. These services are accessible to individuals with complex and rare mental disorders who are temporarily in need of enhanced specialized supports in a variety of settings,

including the individual's home, long-term care facility, developmental services, and other community settings.



4.2.3 C: Specialized Services in Hospitals

Specialized services in hospitals involve the provision of diagnostic and therapeutic health care by specialized professionals. In addition to compliance with mental health legislation, this level of service is usually associated with techniques or procedures which need to be centralized within a regional area due to limited volume, limited specialized skills or extraordinary cost of services. Access to specialized services in psychiatric facilities require referrals from hospital inpatient/outpatient resources.

Specialized services in mental health 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 excludes long term care that does not require daily access to the clinical resources that are available only within the specialized/tertiary programs. It includes outpatient, outreach and consultative services. These specialized programs are almost always affiliated with a university health science centre.

SERVICE FEATURES

- Specialized care facilities providing long term services for specialized populations. Because of the costs involved considerable attention must be paid to making sure that the individual meets the criteria for this level of care;
- A subset of specialized care beds could be located in specially designed residential treatment facilities instead of the more traditional hospital location;
- More intense staff and program resources;
- Advanced, specialized, multidisciplinary staff expertise; and
- A higher level of management and security.

FUNCTIONS OF SPECIALIZED SERVICES IN HOSPITALS

Services and supports include the following key elements:

- Detailed assessment and treatment specification/refinement;
- Medication management;
- Behavioural approaches; and
- Back-up to other care providers.

4.2.3 D: Residential Treatment Facilities

Evidence suggests that most people with serious mental illness can function effectively with the support of community-based services and periodic access to general hospital psychiatric services for episodic stabilization. However, a small number of people with serious mental illness may also require more specialized services in residential facilities (Goering et al., 1998). Including these non-hospital beds as a component of specialized services will ease community integration of those with special needs.

- Residential treatment facilities should be considered as an alternative to inpatient beds for individuals who would otherwise be placed in hospitals and need a highly structured, staffed residence with some room for independence;
- These facilities may provide 24 hour staffing and the capacity to handle difficult to place clients and are in fact intended exclusively for people with a history of non-compliance and long-standing maladjustment to community living. Their function is to facilitate transitions to independent housing for the more complex and disabled provincial psychiatric hospital residents.

TYPES OF RESIDENTIAL TREATMENT FACILITIES

[See Appendix 4G for full description]

4.2.3 E: Specialized Forensic Services

MOH is committed to a hybrid system, with specialized forensic programs dedicated to the treatment and management of high risk/high need clients. Integrated mental health services assume greater responsibility for low risk clients.

Regional forensic services will be fully integrated with the broader mental health system. This will encourage efficient use of available resources and eliminate/reduce the additional degree of stigmatization associated with forensic status. The broader mental health system will support the regional forensic service by:

- Establishing a preventative focus that reduces conflict with the legal system;
- Providing avenues for early diversion of low-risk, minor offenders; and
- Providing access to the general mental health services, including assertive community treatment programs, generic treatment and rehabilitation, as well as essential community supports and services.

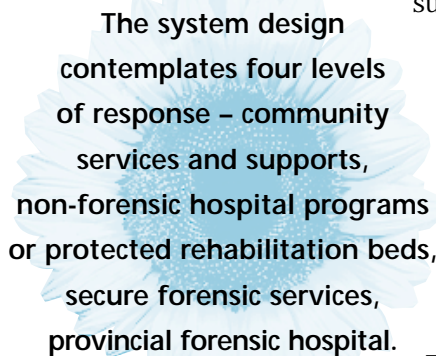
The regional forensic service will support the general system by ensuring the predictable, expedient access to all the specialized forensic functions. These include the assessment, treatment and clinical management of mentally ill people who may be accused of or may have committed violent, dangerous or criminal acts.

Clinical programs are directed at treating mental illness and reducing risk of re-offence.

The system design contemplates four levels of response – community services and supports, non-forensic hospital programs or protected rehabilitation beds, secure forensic services, provincial forensic hospital. The least restrictive alternative is always preferred and clients would proceed to the next highest level only where it is clear that less intrusive options are not capable of responding to the client's complex needs, or able to protect public safety. Regional forensic services will have a step down capacity where clients who are no longer high risk/high need can be transferred to other non-forensic mental health programs.

Appropriate community services and supports are essential for both forensic and non-forensic clients. Many (although not all) forensic clients present the same

needs and risk levels as people with mental illness generally. Community services will play a preventative role, supporting people in the community to minimize the likelihood of their coming in conflict with the law, or experiencing other symptoms of dysfunction. Some clients will require very intensive supports, the type of support that an assertive community treatment team (ACTT) can provide. Chronic, relapsing schizophrenics are a population at risk for becoming forensic. The development of program models which have proven success in working with this population will also serve to reduce pressures on the forensic system.



The system design contemplates four levels of response – community services and supports, non-forensic hospital programs or protected rehabilitation beds, secure forensic services, provincial forensic hospital.

Effectively treated clients are less likely to become involved with the criminal justice system or to engage in aggressive behaviour.

Treatment however must address all known risk factors, including substance abuse problems. For the reluctant client, not wanting help must be viewed as part of the symptoms and the staff must work respectfully and assertively to engage the client in treatment.

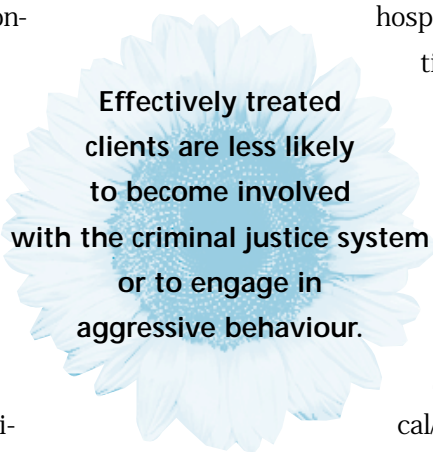
When clients are in trouble, this should be viewed as an opportunity for staff to offer the client supports. For example, the service system needs to respond quickly to police requests for assistance.

Where conflict with the law cannot be avoided, community services must provide assistance for early diversion of low-risk, minor offenders. Repeat offending will be reduced by treatment of the mental disorder. Case management/brokerage programs such as court diversion are beginning to demonstrate success.

Mental health staff will be connected to the formal criminal justice process and will help develop treatment/intervention plans at any stage of the criminal justice process i.e., diversion, bail, conditional sentence, probation. Depending on the seriousness of the crime, these plans represent the least criminalizing alternative to incarceration. Services will also follow clients into jail settings to assist in meeting the person's treatment and rehabilitation needs and to plan for that person's discharge back into community settings.

To enable the early discharge of an individual from hospital following a forensic stay and at the same time assure community safety, forensic clients must have access to effective treatment and rehabilitation services in the community. These must be linked with supervised and supportive living accommodations, as well as access to other key community supports.

Specialized and secure forensic services are a component of the services needed through regional mental health systems, and represent a logical progression in terms of specialization and capacity for secure containment. Specialized forensic services include the regional forensic service and the provincial forensic hospital. The target population is different from other psychiatric programs i.e. clients who represent a very high risk of violence, or who have complex overlapping needs relating to aggression, legal status, and clinical/risk management.



SERVICE FEATURES

A service continuum will provide step-down capacity for forensic clients to progressively lower levels of security within the regional forensic service including double-locked, locked, and open hospital beds, plus community supervision.

Opportunities to integrate clients within broader mental health services will be actively explored at every level.

Programs will be aimed at facilitating client readiness for this transition. As clients move through levels of security, the number receiving direct services from the specialized forensic programs will be reduced. The size of the program will be proportionate to the service population.

FUNCTIONS OF SPECIALIZED FORENSIC SERVICES

[See Appendix 4H]

A regional forensic service is comprised of the following core functions:

- The regional secure program;
- The protected/integrated bed program; and
- The mobile forensic outreach program.


Provincial Forensic Hospital

The provincial forensic hospital will offer the following services:

- A high security service;
- A long-term treatment service;
- Court-ordered assessments where the client requires a high security service;
- A crisis service; and
- Consultation and support to regional forensic services.

Coordination

Forensic services in Ontario require strong coordination and leadership at the provincial level. Forensic services will not come together simply through local and/or regional coordinating efforts. Strong government leadership is essential to shaping both service demands and service responses to better match service intensity to the client's level of need and risk. Such leadership is needed as well to respond to legitimate unmet treatment issues within correctional populations. This leadership can only be effective if it is supported by a comprehensive platform of research, program standards and utilization reviews, and outcome evaluations.



Provincial coordination, standards, and program consistency are critical.

Provincial coordination, standards, and program consistency are critical. Services should offer reasonably comparable treatment programs, using the same assessment instruments, and based on the same lexicon of client

needs. Risk management and treatment methodologies should be similar within each region. Program planning should be a system function, with knowledge disseminated to each of the forensic services. Each of these elements should be specifically developed as a program standard for provincial and regional forensic services. Through the provincial coordinating structure, standards will be established for programs and services offered across the provincial forensic system.

The regional forensic service will participate in various coordinating mechanisms/activities at several different levels:

- **Provincial Coordination.** Each Regional Forensic Service will have representation on, and work in coordination with, a provincial forensic planning/coordinating structure;
- **Regional Health Services Coordination.** Each region will have a planning/coordinating structure to ensure the coordination of services between multiple sites and amongst the affiliated Academic Health Services groups in the one forensic service region. Coordination mechanisms include: direct affiliation through a common management structure; co-location of programs in one centre; or clear memoranda of understanding/service agreements to ensure effective linkages e.g. referrals; and

- **Regional and/or Local Inter-ministry Coordination.** Each Regional Forensic Service will participate on an active Human Services and Justice Coordination Committee. This committee will be comprised of representatives from agencies providing services to the forensic client population and should include police, crown attorneys, community mental health agencies, local detention facilities, defence bar, probation and parole, judiciary, etc. The purpose of the committee is to coordinate the provision of services to the benefit of the forensic client and the community in such a manner as to make the most efficient use of available resources.

Accountability Management

The provision of forensic services under the **Criminal Code** is a core government function and the promotion of public safety is a state responsibility. The ministry will maintain a significant interest and presence in the forensic psychiatry field within Ontario through the development of specific accountability management mechanisms.

Given the overlapping populations found in health and correctional programs, and to some extent developmental services, it makes sense for government to provide consistent direction to address strategic concerns across broader government systems, and move away from the silo mentality of rigid and unrealistic sector barriers.

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Appendices

Appendix 4A

FUNCTIONS OF CONSUMER/ SURVIVOR INITIATIVES (and joint consumer/survivor and family initiatives):

- Consumer/survivor initiatives offer unique opportunities to consumers/survivors to find support from others who have direct experience of what it means to be a consumer/survivor;
- Provide opportunities for consumers/survivors to become involved as members and take on leadership and decision-making roles in the planning and operations of our own organizations; and
- Operate based on the needs and interests of consumers/survivors in local areas.

Appendix 4B

FUNCTIONS OF FAMILY INITIA- TIVES (and joint consumer/survivor and family initiatives):

- Provide support and training to enable families to adequately fulfill their roles in relationship to their family member and within the mental health system;
- Will be open to and encourage participation of all families;
- Serve as access and coordination points;
- Strengthen and maximize natural supports and existing community networking systems that are relevant to the consumer/family;
- Reflect community needs and diversity and address locally relevant ethnora-
cial issues;
- May provide or involve the following activities: networking with existing family organizations, education, information sharing, advocacy, system access, support, outreach to families who are involved with other service sectors, research, coordination and community development;

- Seek to help meet family needs for system access, diagnostic information, treatment information, family support (i.e., including the needs of children, siblings, spouses, significant others), and respite and advocacy;
- Work cooperatively with all other sectors in the mental health and related systems; and
- Work cooperatively and collaboratively with existing family organizations (e.g., Schizophrenia Society of Ontario and Mood Disorders Association of Ontario) to maximize a network of family support, and to maximize family members' ability to participate in all their roles (e.g., planning, evaluation, governance) within the mental health system.

Appendix 4C

Functions of a Crisis Service

I ASSESSMENT AND PLANNING

Crisis assessment and planning include the gathering of pertinent data and history from the client(s) and others (e.g., family, physician, case manager, etc.). The assessment also includes a clear understanding of the recent events, psychosocial and biological factors as they contribute to the presenting crisis, and a plan for how to intervene in the crisis. The need for immediate and follow-up intervention(s) is assessed in collaboration with the client(s), taking into account the client's most immediate needs, strengths and weaknesses, and his/her social support system.

II CRISIS SUPPORT/COUNSELING

Provides the individual and /or family with emotional support, practical assistance and a range of appropriate resources available to assist in resolving the immediate crisis. This can sometimes be accomplished through telephone crisis lines or mobile outreach teams.

III MEDICAL INTERVENTION

Medical intervention, which can be provided by nurses and/or physicians, should be an integral part of mobile crisis outreach.

Effective collaborative links between medical and non-medical service providers are essential. Examples of situations in which such links are important include: collaboration among a crisis worker, a physician and a pharmacist to assist a client to obtain a repeat prescription as a way of minimizing the severity of a crisis, collaboration between a crisis worker, a physician and/ or other hospital personnel to facilitate emergency medical attention for a client, etc. It is expected that the crisis worker will follow through to ensure client access to such resources.

The crisis worker should be proactive in developing good working relationships with all aspects of the mental health, health and broader community support system.

IV ENVIRONMENTAL INTERVENTIONS & CRISIS STABILIZATION

Crisis response often involves direct action within the individual's community and supports, such as arranging for money/income support, dealing with employers, schedule changes, housing issues and family issues.

Crisis response provides for access to a range of safe, short-term (and appropriate linkage with longer term) accommodation, including inpatient stay as well as a crisis centre or other form of emergency shelter, if needed. This may include brief respite as well as creative, less conventional, informal accommodation, which may be identified by the client.

V REVIEW/FOLLOW-UP REFERRAL

Once the crisis has dissipated, crisis services should facilitate appropriate referral to any ongoing services and supports that have been mutually determined by the client and the service provider as follows:

A. INFORMATION

To provide information to client, families/key supports and service providers regarding types, availability and access to a full range of services and supports that include prevention, early intervention and full crisis intervention.

B. LIAISON

To establish a partnership/relationship with the police in the development of a local crisis plan.

To provide liaison services among service providers, clients and families.

C. CLIENT-CENTERED ADVOCACY

To advocate on behalf of and with clients and families.

D. CONSULTATION AND COLLABORATION

To consult with and on behalf of clients within the service network.

Appendix 4D

FUNCTIONS OF INPATIENT AND OUTPATIENT SERVICES IN SCHEDULE 1 HOSPITALS:

In addition to compliance with the **Mental Health Act**, the following treatment functions will continue to be provided by Schedule 1 facilities (Ontario Ministry of Health, *General Hospital Psychiatric Services: Role Statement, 1995*; Clarke Consulting Group, 1997; The Eiger Consortium/Dreezer & Dreezer and the Clarke Consulting Group, 1998):

Emergency Services, Including

Crisis Response Services: (Refer to Section 4.2.1 “Emergency Services Provided By Schedule 1 Facilities.”)

Short Term Inpatient Assessment/Holding Beds

- Holding beds should be provided in addition to inpatient beds;
- The holding beds provide crisis access to a bed for up to 72 hours, including assessment services;
- Depending on demand, holding beds could be used for detoxification; and
- The beds should preferably be located in or near the emergency department or adjacent to or just inside the psychiatric unit.

Assessment, Stabilization and Short-Term Inpatient Treatment

- the short term unit provides:
 - ◆ Brief stay (e.g. <16 days) treatment for diagnosis and stabilization;
 - ◆ Intensive care beds to confine, closely observe and treat people whose behaviour is disruptive/difficult to manage; and
 - ◆ Secure beds for clients who are experiencing periods of acute disturbance.

Discharge Planning

- Discharge planning must begin on admission and involve the individual, his/her personal supports, key community-based providers and the Schedule 1 treatment team;
- Discharge planning can include: regular teleconferencing; regular visits from community providers, family, other key supports; exploring use of new distance technology for those living far away; inclusion of referrers in assessments, care and discharge planning; arranging for home visits to assess living conditions where indicated; and back-up support and consultation to community agencies which are/will be involved during the transition and after discharge.

Day Hospital

- Should operate with the objective of preventing inpatient admissions, supporting early discharge, allowing for phased stages of recovery, supporting crisis response services, and facilitating movement between various Schedule 1 programs;
- Optimal length of stay would be similar or slightly longer than inpatient units (e.g. 14-28 days); and
- In areas where there are adequate alternatives available, e.g. assertive community treatment teams, this component may not be necessary.

Outpatient Services

- Services must be targeted to people with serious mental illness;
- Should include an urgent clinic which is linked to crisis intervention/emergency services for immediate, short-term ambulatory psychiatric assessments or support;
- Should be integrated with community services without duplicating them. Focus should be on individuals who have more complex service needs than people who can be adequately served by community services;
- Require a multidisciplinary staff with expertise in medication management and personal support for individuals and groups;

- Must have a capacity for outreach and/or strong links with case management programs in order to prevent service gaps, ensure continuity of care and maintain links with people in difficulty and who miss medication appointments; and
- Must provide community programs with access to a psychiatrist for administering medications and monitoring clinical status.

Consultation, Education, Coordination and Integration

- Extend beyond the medical consultation-liaison activities typically carried out by psychiatrists;
- Are carried out by both medical and non-medical staff;
- Include client-centered case consultation and program-centered consultation to community groups, agencies and family physicians;
- Should include educational and skills training activities for community based providers and volunteers and psychoeducational programs for families/key supports;
- Schedule 1 facilities should develop clear linkages and coordination mechanisms between all providers in the intensive and specialized levels of need;
- Schedule 1 facilities should have ongoing input into programming for the specialized level of need in the region and should participate in decisions about which clients are most appropriate for referral to specialized services and how referrals are made; and
- Schedule 1 facilities must build linkages with community mental health and other health and social service programs in the community by having staff participate in region-wide and local planning coordination activities.

Depending on a number of locally varying conditions and what is negotiated through the local implementation process for mental health reform, general hospital psychiatric units may provide additional inpatient and outpatient services including (Ontario Ministry of Health, *General Hospital Psychiatric Services: Role Statement*, 1995):

- Outpatient services for clients whose care would be fragmented by the involvement of an additional service provider;
- Day treatment programs providing diagnostic, treatment and rehabilitative services and social rehabilitative programs offering life skills teaching;
- Case management services;
- Mental health prevention and promotion programs; and
- In the case of teaching hospitals: education, research and consultation.

Appendix 4E

FUNCTIONS OF INTENSIVE CASE MANAGEMENT SERVICES

Outreach and Client Identification

- Outreach and client identification must reach out to clients who may identify or appear to have a service need, assuring sufficient time and flexibility to initiate a working relationship;
- It must inform family members, including significant others, and other service providers about the availability of and access to case management.

Comprehensive Individualized Assessment and Planning

- A comprehensive, individualized assessment that takes into account all his/her immediate, on-going needs and values and that aids each client to identify personal strengths and establish personal goals must be undertaken with each client;
- With client consent, include participation from members of the client's social network in assessment and planning; and
- Develop with each client a comprehensive individualized plan which incorporates his/her goals and values (such as housing, social, vocational, treatment, etc.) and identifies all skills, resources and service requirements.

Direct Service Provision

- Provides information and strategies for health promotion and prevention;
- Assists clients in identifying and advocating for their civil and legal rights;
- Facilitates access to, and supports the provision and use of, wanted and needed services in areas such as assistance with daily living, crisis intervention and treatment. Where necessary, these services will be provided by case managers;
- Provides assistance in obtaining and maintaining housing;
- Provides support in independent housing settings;
- Provides support, encouragement, counseling and feedback to enable clients to realize their goals;
- Provides counseling and information to reduce the incidence, duration and intensity of a crisis;
- Provides family support and education, as appropriate, to support the interests of the client; and
- Works collaboratively and in partnerships with ethno-racial communities and organizations to facilitate appropriateness of services for the members of these communities.

Coordination and Support

- Facilitate linkages to needed and wanted services, supports and resources, including those in the broader community;
- Client-centered advocacy to facilitate access to and modification of existing resources to meet individual needs;
- Collaborate with resources to facilitate the provision of services as arranged;
- Assist clients to identify, build and maintain a natural support system (such as family and friends); and
- Facilitate access to and work collaboratively with specialized services for clients who are traditionally served by separate service sectors (such as youth, the elderly, francophones, women, ethno-racial groups, persons with substance abuse issues, persons with developmental disabilities, mentally disordered offenders, etc.).

Monitoring and Evaluation

- Evaluate the achievement of goals (from the perspective of both the client and the case manager) and client satisfaction;
- Monitor, regularly review and, if appropriate, revise service plans with clients to facilitate the provision of services that are appropriate and relevant.

Systemic Advocacy and Coordination

- Focus on the interests of the client;
- Identify and advocate for services that are accessible, relevant and coordinated;
- Participate in evaluating services;
- Identify gaps and needed modifications in services and advocate for the funding of needed services; and
- Initiate system change which addresses society power imbalances that jeopardize the clients' interests.

Outreach functions are an essential feature of case management supports. The following are important features of outreach services (Canadian Mental Health Association, Ontario Division, 1998).

Outreach Functions of Intensive Case Management Services

- Include identification, engagement, crisis intervention, intensive/short-term support, and linkages to appropriate levels of service;
- Outreach is targeted to persons with serious mental health problems who, due to social or individual factors, would not seek services on their own and who, without some intervention, would be seriously at risk;

- The person is often homeless or socially/geographically isolated. Staff are available in settings and situations in which socially isolated people may be found (e.g., coffee shops, shelters, courthouses). The person can be linked to an outreach worker by generic service providers, police, concerned citizens, etc; and
- Staff identify and offer supports and services to people in a non-intrusive way. Basic needs are addressed prior to the exploration of more complex problems.

Appendix 4F

FUNCTIONS OF AN ACT TEAM

A. Case Management

Each client will be assigned a primary case manager. The case manager will coordinate and monitor the activities of the treatment team and has primary responsibility to write the treatment plan, to provide individual supportive therapy, to ensure immediate changes are made in treatment plans as clients' needs change, and to advocate for client rights and preferences. The primary case manager is also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's treatment team share these tasks with the case manager and are responsible to perform the tasks when the case manager is not working.

B. Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health systems emergency services program as appropriate.

C. Symptom Assessment, Management, and Individual Supportive Therapy

Symptom assessment, management, and individual supportive therapy help clients cope with and gain mastery over symptoms and impairments in the context of adult role functioning.

D. Medication Prescription, Administration, Monitoring, and Documentation

The ACT Team program shall establish medication policies and procedures which identify operational processes.

E. Provision of Substance Abuse Services

As needed, provision of substance abuse service shall include but not be limited to individual and group interventions to assist clients.

F. Work Related Services

Work-related services to help clients find and maintain employment in community-based jobs.

G. Activities of Daily Living

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, on-going supervision (e.g. prompts, assignments, monitoring, encouragement) and environmental adaptations to assist clients to gain or use the skills required for an independent/interdependent lifestyle.

H. Social, Interpersonal Relationship, and Leisure-Time Skill Training

Services to support social, interpersonal relationship, and leisure-time skill training include supportive individual therapy (e.g. problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase their social experiences and provide them with opportunities to practice social skills and receive feedback and support.

I. Support Services

Support services or direct assistance to ensure that clients minimally obtain the basic necessities of daily life (e.g. income support, housing, etc).

J. Education, Support and Consultation to Clients' Families and Other Major Supports

Services provided under this category to clients' families and other major supports, with client consent, include:

- Education about the client's illness and the role of the family in the therapeutic process;
- Intervention to enhance relationships; and
- On-going communication and collaboration, face-to-face and by telephone, between the ACT Team and the family.

Appendix 4G

TYPES OF RESIDENTIAL TREATMENT FACILITIES

- Long-term structured residences are for those individuals who do not require nursing care, but do require treatment and rehabilitation in a secure setting;
- These settings have the capacity to be locked, if necessary, to protect a resident from harm. They are of a maximum size of 16 and some have been designed to deal with particular behaviour problems (e.g. fire setting);
- The other type of residential facility is designed for clients with serious mental illness and will work with 6-18 residents to develop the skills necessary to move to independent housing; and
- Residents are expected to be involved in meaningful activity outside of the setting in the day and share in the maintenance of the residence. They may also be clients of an assertive community treatment team, so that the level of treatment and support is quite intensive, but the environment is home-like.

Appendix 4H

FUNCTIONS OF SPECIALIZED FORENSIC SERVICES

Each regional secure bed program will offer the following services: assessment; short-term crisis management; medium term rehabilitation and community reintegration; outpatient case management; as well as indirect services such as consultation, education, and research. In addition, the regional secure program may operate specialty clinics, as negotiated between the ministry and the service provider.

The Protected/Integrated Bed Program is an administrative device to achieve greater integration of forensic clients in broader mental health programs. It also serves to operationalize the ministry's policy of integrating lower-risk forensic clients into broader mental health services.

Integration means that protected beds must be considered on the same level as any other hospital-based mental health program, and based on similar goals, outcomes, psycho-social rehabilitation principles, and clinical best practices.

To ensure access and to accommodate greater than average lengths of stay associated with Ontario Review Board (ORB) status, a defined number of beds in rehabilitation and other specialty psychiatric programs (where these pro-

grams are delivered as a bed-based service) will be reserved for use by ORB clients. An ORB client will have first access to a protected bed over and above any other psychiatric clients on the waiting list, up to the maximum protected bed capacity for that program.

On a request or referral basis, a portable outreach team will deliver community-based consultation, assessment, treatment planning, and risk management advice with a goal of averting hospitalization and allowing the client to remain in the local community. The forensic mobile outreach team will be involved in the screening of clients referred for hospital admission, with a mandate to explore and develop alternative community placements if possible.

Indirect services include consultation, training, and support to family or service providers in the community or other service jurisdiction (shelters, homeless, jails, etc.) where a client has a serious mental illness and a history of violence, and identifying opportunities for increased coordination and collaboration between two or more care systems. Outreach staff are organized as a multidisciplinary, accountable, mobile mental health team.

Appendix 4I

MUTUAL STRATEGIES FOR SHARED SERVICE CLIENTS WITH MULTIPLE NEEDS

- **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, on-going 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 sub-populations. Training and continuing education programs provided by psychiatrists specialized in specific disorders, as well as other health professionals within the academic health science centres and other experts, to providers in a variety of settings including community health centres, general hospitals and group practices are critical;

- **Cooperative 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 treatment 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 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 involvement of the client and the family/key supports to respond to each of the identified need areas 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;
- ◆ 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 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 (i.e. mental health, 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, systems managers and service providers will examine existing resources with a view to establishing 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; and

• **Primary/Specialty Care Partnerships.** Primary care/secondary 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.

Appendix 4J

IMPROVED ACCESS

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 and 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. Information about and referral to other services and supports (e.g., relevant provincial health and social services, municipal and supports funded by the voluntary sector) must also be available.

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 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. In order to facilitate this process, service agreements among the participating organizations will be required to formalize the collaborative arrangement;
 - The designation of lead agencies (including hospitals) mandated to coordinate access to services. Service agreements between the lead organizations and the other organization(s) will be required;
 - The reduction of the number of agencies through amalgamations in areas where a number of agencies are providing similar or complementary services.
3. A system whereby access to consultation services provided by psychiatrists will be facilitated.
4. An approach which ensures that clients receive a minimal number of assessments and will be 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.

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 an on-going 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; and

- **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 developed 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 emphasize 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; and
- 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 multidisciplinary 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 hos-

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

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.

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