

Integrated Health Service Plan

Integration Priority & Action Plans:

Integrating Mental Health and Addictions Services

Mississauga Halton Local Health Integration Network

Section Appendix G.5

Appendix
G.5

Integrating Mental Health and Addictions Services

Description

This priority addresses the challenges facing people living with mental illness and/or addictions, and their families, within the Mississauga Halton LHIN through a multi-faceted approach addressing the broad determinants of health.

The Toronto-Peel Mental Health Implementation Task Force (“MHITF”), Central South MHITF, Centre for Addiction and Mental Health (“CAMH”) and the Ontario Mental Health Implementation Task Force have formulated best practices, service delivery and policy in the development of a Mental Health and Addictions Recovery Model. Specifically, these committees believe that “recovery – as defined by the individual, not by service providers – is possible for all people living with mental illness.” Recovery does not mean complete cure – it is a process which individuals work through over time, which can be achieved through many different paths and approaches¹. The primary goal of a recovery-oriented mental health system is to promote maximum independence. Individuals living with mental illness have the right to make informed choices based on the opportunities available allowing them to assume increasing personal responsibility for their actions. Currently, there are no defined “recovery” models in practice. However, a recovery-based model would be driven by the principles outlined below²:

- **Placing individuals with mental illness and their families at the centre of the system³**
 - Tailoring a comprehensive range of services and supports to consumer needs to increase quality of life⁴
- **Focusing on streamlining access⁵**
 - Improving consumer choice and access to services⁶
 - Linking and coordinating services so that consumers will move easily from one part of the system to another⁷

¹ [The Time Has Come: Make It Happen](#). Toronto-Peel Mental Health Implementation Task Force. 2002.

² Ibid

³ [The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario](#). Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.

⁴ [Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports](#). Ontario Ministry of Health. 1999.

⁵ [The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario](#). Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.

⁶ Ibid

⁷ [Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports](#). Ontario Ministry of Health. 1999.

- **Creating greater accountability⁸**
 - Basing services on best practices⁹
 - Continue to protect mental health funding¹⁰

There will be continued investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system¹¹

Stigma associated with individuals with mental illness and addictions causes many patients to be labeled as 'hard to serve' or 'uncooperative'. Stigma refers to discrimination, verbal or emotional abuse and isolation from family and friends that result from misconstrued views about this condition, such as the belief that individuals with mental illness are dangerous or violent, lack intelligence, cannot recover and that they are unpredictable in their interactions with others. Stigma and discrimination create barriers to recovery.¹²

Individuals with mental illness and/or addictions, who do not receive the appropriate treatment and supports, face the risk of falling into a vicious cycle of economic downturn resulting in a loss of financial independence and having insufficient resources to seek the necessary support to improve their condition. An appropriate network of support in health, housing, vocation and social-recreation is necessary to help maximize their health conditions and welfare.

It is now well-documented in literature that coexistence of severe mental health and substance misuse problems are common¹³ and often correlated with a number of adverse outcomes.¹⁴ To address the needs of this population it has been recognized, "That a more integrated, consistent and efficient system is needed to ensure the proper identification and timely delivery of evidence-based treatment services to clients challenged by mental illness and addictions."¹⁵ Perron goes on to say that closer collaboration between mental health and addictions offers clear benefits, however it must be noted that the each field is unique and that neither can be subsumed within the other even though there is overlap and commonality

⁸ The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario. Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.

⁹ Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.

¹⁰ Ibid

¹¹ Ibid

¹² The World Health Organization's World Health Report 2001

¹³ REGIER, D. A., FARMER, M. E., RAE, D. S., *et al* (1990) Co-morbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, **264**, 2511-2518

GRAHAM, H. L., MASLIN, J., COPELLO, C., *et al* (2001) Drug and alcohol problems amongst individuals with severe mental health problems in an inner city area of the UK. *Journal of Social Psychiatry and Psychiatric Epidemiology*, **36**, 448-455

¹⁴ JOHNSON, S. (1997) Dual diagnosis of severe mental illness and substance misuse: a case for specialist services? *British Journal of Psychiatry*, **171**, 205-208

¹⁵ Perron, Michael, (2005) 'Canadian Centre on Substance Abuse Presentation to the Standing Senate Committee on Social Affairs, Science and Technology.

in some methods and approaches.¹⁶

Pockets of exemplary service exist across the LHIN, but this is not the norm. The current system is fragmented. Individuals living with mental illness and/or addictions, their families and support networks have difficulty gaining access to a range of services tailored to their needs. This is especially true for individuals with concurrent disorders or dual diagnoses. Improving accessibility to services will help to foster choice, allow individuals to reside in their own homes and enable an individual's independence in making life decisions.

What will success look like?

To meet the needs of this population a truly integrated approach to service delivery across the continuum of care – promotive, preventive, curative, rehabilitative and supportive – and a new level of coordination and connectivity is required.

An integrated continuum of care for mental health and addictions services will be designed on best practices currently in existence within the Mississauga Halton LHIN and best practices from other jurisdictions. A broad based cross-sectoral group is needed to support the development of this integrated model.

Mission, Vision, Principles, Goals

- The *Vision* is a description of the desired future state. The *Mission* reflects the mandate of the integrated service delivery continuum. The *Principles* will guide the thinking, design and decision making for the development of the integrated service delivery model. *Goals* reflect the specific objectives the LHIN would like to achieve.

Population Definition

- This specifies the characteristics of the model's target population(s).

Size of Population

- This provides estimates of the number of people that will be utilizing the model. It can be determined based on catchment or residence.

Points of Access or Entry

- To describe how an individual will gain initial access to the service delivery model.

Scope of Services

- This defines the basket of services and supports that will be available to the target population and the timeliness of such services.

¹⁶ Ibid.

Coordination

- Describes how services will be accessed and coordinated by the patients and their families, as well as how providers will work with one another to ensure smooth interfaces and transitions for patients/clients/families. It also addresses the requirements of the role of care coordination.

Approach to Assessment

- The method used to determine the appropriate level of care and services for the individual.

Consistency of Care Classification

- This refers to how the terminology and classifications of care is defined among different service providers and whether agreed upon definitions exist.

Linkages and Fit within the Continuum

- Refers to how different service providers interact, communicate, share information with one another in order to create a seamless integration model.

Information Requirements and Flow

- This describes how the client's health information is coordinated and communicated with various service providers, the patient and the family.

Accountability

- Given our cross-provider, multi-sectoral integration requirements the definition for accountability is critical. Identification of who is responsible for the specific outcomes, joint outcomes, maintenance of the system, and for managing risk is required.

Performance Management

- Provides for a description of the indicators that are used to track performance and the process by which the system is monitored to determine overall effectiveness of the model in relation to the objectives stated and the targets set.

Rationale

Environmental Scan:

Key messages extracted from the full environmental scan and pertinent to this priority include:

Both acute and chronic mental health and addiction services should be provided in the community to the greatest extent possible and that access to

services should be coordinated through local integrated service delivery systems operating within the LHIN. The specific categories of acute and chronic mental health and addictions care generally used in the health system are described below:

Adult Acute Care: Generally affiliated with acute general hospitals. Inpatient services include crisis & emergency intervention, assessment & short-term admission, treatment and referral services.

Child and Adolescent Services: Largely ambulatory-based except for specialized programs which could be inpatient.

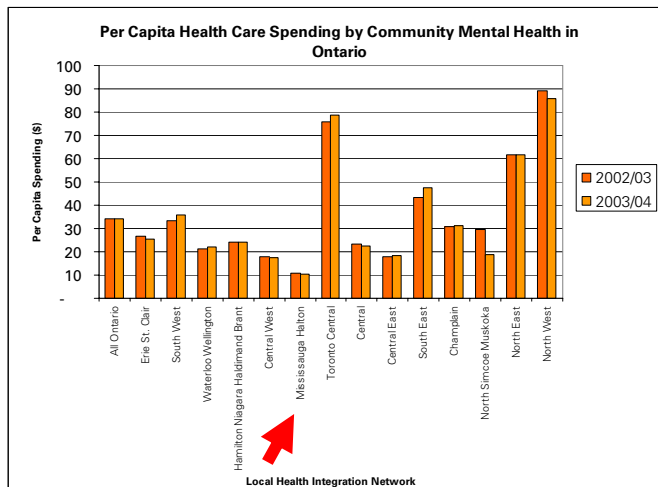
Forensic Mental Health Services: Services for offenders who are mentally ill.

Chronic Care: Psychiatric Rehabilitation, Specialized Programs, Psycho-geriatric Services.

Community-Based Care: Includes case management, housing support and social/family support.

The community mental health and addictions sectors have seen little or no change in terms of investment and restructuring despite major reform initiatives in both sectors. As a result, these sectors remain fragmented, undersized and difficult to access.¹⁷

Per Capita Spending for Community Mental Health Services, LHIN and Ontario, 2002/03 and 2003/04



Mississauga Halton LHIN Hospitals

- Mississauga Halton LHIN hospitals currently operate 101 psychiatry beds – 26 at Credit Valley Hospital; 43 at Trillium – Mississauga Site; and 32 at Halton Healthcare Services – Oakville Site.
- Acute mental health separations represented 4.9% of total separations and 10.0% of total days for Mississauga Halton LHIN hospitals. This is lower than the proportion for all Ontario hospitals (5.8% and 10.9%)

¹⁷ Halton-Peel District Health Council Operating Plan – September 15, 2004

respectively). This also represented 5.2% of all mental health separations and days for the province.

- The average length of stay for Mississauga Halton hospital mental health separations was approximately one day longer than the acute portion. For Halton Healthcare Services – Georgetown site this was significantly longer (i.e., four days), but very few separations were reported and this site has no dedicated psychiatric beds. Nonetheless, there appear to be opportunities to reduce alternative level of care days in this patient population. The total length of stay was similar to that of Ontario hospitals.
- South Etobicoke residents tended to have almost two days longer total length of stay than other areas for the acute portion suggesting, that among other factors that require further analysis, this community may have fewer post-acute community support services available locally.
- Few residents of this LHIN receive acute inpatient mental health care outside of the local area. The age-standardized acute mental health separation rate for Mississauga Halton residents was significantly lower than the rate for Ontario residents (2.9 vs 4.5). The crude total mental health day rate was almost one third lower than the rate for Ontario residents (37.6 vs 55.9).
- Readmission rates over the last three years for psychiatry are comparable or lower than the provincial average.
- Facts from the Data regarding Mental Health and Addictions:
 - Mental Health & Addictions receives 0.5% of the base funding for the Mississauga Halton LHIN in comparison to the provincial average of 0.6% for mental health and addictions.
 - Conversely Mental Health Supportive Housing funding within the LHIN is at 0.0% in comparison to the provincial average of 0.2%.
 - Furthermore mental health program funding for the LHIN is 1.4% in comparison to the average for the province at 2.6%.
 - Peel-Halton children experienced relatively short wait times for mental health (5.4 weeks – lowest among the DHCs) and rehabilitation services (24.0 weeks – 6th ranked among the DHCs) for children reported by non-hospital organizations compared to other districts.
 - Within the DHC report it was found that only about half of the organizations surveyed in the study indicated any collaborative relationships existed between providers and those that existed were most often between “like” services (e.g., hospital to hospital; mental health agency to mental health agency). This suggests there is a need and opportunity to develop a more integrated service delivery model for children and youth for the residents of the Mississauga Halton LHIN.
 - Compared to Ontario, the Mississauga Halton LHIN has a significantly higher proportion of problem gambling and substance abuse clients that are:

- Male
- In the 35-54 age group
- Live in the Regional Municipality of Peel
- Employed full-time
- Users of crack cocaine
- The LHIN has a significantly lower proportion of problem gambling and substance abuse clients that are presenting with alcohol, cannabis or tobacco related problems. (DATIS)
- Data from the 2005 Ontario Student Drug Use Survey which surveyed students in grades 7 through 12, shows a relatively higher use of solvents (5.3% vs. 3.2%) and significantly lower use of hallucinogens (6.3% vs 9.2%) in comparison to the province as a whole.
- The rates of selected mental health problems often associated with substance abuse for Mississauga Halton LHIN students in grades 7 to 12 in 2005 include:
 - Physical injury
 - Fire setting
 - Suicide ideation; and
 - Co-existing problems
 - It should be noted that each of the problems identified above indicate a significantly higher rate of occurrence than is seen in the province overall.

Community Engagement:Phase 1 Engagement:

The comments received during the provider and public forums indicated the need to develop an integrated approach to service delivery that spans the life cycle.

Children

There is a general lack of services and resources for children with mental illness, particularly for children with multiple issues. This gap in the service continuum needs to be filled. Early intervention and accurate diagnosis will help to ensure the child's health is maximized.

Youth/Adolescents

One of the greatest challenges faced by youth with mental illness is difficulty in transitioning from child/youth services to adult services. This is particularly evident in dual diagnosis/developmentally handicapped adolescent transitioning to the "adult" system.

Adults

Adults aged 45 – 60 are often excluded from the services they require, simply as a result of inflexible eligibility criteria services. Often times, services they seek are provided only to seniors, who is often defined by individuals aged 65 and over.

Seniors

Please note psycho-geriatrics will be addressed in Integration Priority #3 on Seniors.

From Phase 1, there was general consensus surrounding a “no wrong door” policy, where only one door would have to be entered from the “womb to tomb” to ensure individuals do not have to line up every time they change services or lifecycle categories. This is especially important for individuals with mental illness or addictions because they may go through intermittent phases of where they require minimal services and periods when they require more medical attention. Also, the needs of mothers postpartum were highlighted as a gap within the system. This is not the current situation, as there were many comments noting that the mental health system is not linked well to the rest of the health care system. There are many small Mental Health providers, with different and unclear mandates, and a lack of clarity of services provided. The result is a fragmented system that is confusing and difficult to navigate for the individual with mental illness, the families and providers. It might also suggest opportunities to enhance efficiencies and reinvest cost savings in direct care.

A number of very positive examples were shared at the forums demonstrating how service providers have taken significant steps to coordinate services for the good of their share clients. The message was clear, that care for individuals with mental illness can be greatly improved by leveraging what is working and by forming additional partnerships to further enhance coordination and integration.

Phase 2 Engagement:

This phase has included dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from the LHIN and the provider conference. From these conversations it has been suggested that:

- Central access to services would be beneficial to support ‘no wrong door’ concept.
- Integrated approach across services is needed.
- Providing ease of access to services for family doctors would be most helpful.
- Wait times for MH&A should be tracked.
- Case management is a critical issue and funding for these services is required.
- Client/family/friends/community is first ingredient and provider is secondary.
- Lack of understanding of services available across MH LHIN for both providers and the public.
- Patients need more time with their health care providers to talk and interact and this is being continually shortened.

- Emergency rooms are not friendly, nor supportive of the individual suffering with addictions or mental illness.
- Attending professionals do not have access to a person's current data and this is a significant problem which frequently causes patients to wait until morning to get appropriate care when accessing through emergency departments.
- Hospital emergency department does another assessment after both the police and crisis team have assessed the patient – no communication between hospital and external providers and thus duplication of treatment.
- Cohorts are not available for all MH&A patients.
- Current system does not work well.
- Not sure about how MH&A will be managed across the LHIN and across LHIN boundaries.
- Public awareness of MH&A and the negative stigma associated with the disease.
- Major concern that the LHIN will not support organizations that are delivering good care today and will not build on what is working well.
- Transportation of patients north and south is an issue – transportation overall is an issue.
- Those providers in the north do NOT want to amalgamate with those in the south as it will dilute the effectiveness of the programs in the north.
- Not enough psychiatrists in the area.
- Community outreach is critical for rural communities and it has not been identified in the priority.
- Hospitals have a 'revolving door' policy for MH&A patients as they appear to recycle the patients through the hospital and discharge them before they are ready due to the demand for beds.
- There is no post discharge follow-up and discharge planning is extremely limited as one person relayed his experience when he was told he was being discharged 10 minutes before he was released.
- There is a shortage of MH&A services for children and youth.
- Harm reduction model needs to be part of the service delivery model.
- Peers need to be part of the process.
- Sexual orientation needs to be included in service provision.
- Need to bridge both the youth and seniors transition gaps by providing learning/training activities.
- Concern that addictions services are limited.
- Concurrent disorder supports need to be expanded.

Other relevant evidence

- A sizable portion of individuals with a substance abuse problem also suffer from some form of serious mental illness such as schizophrenia or major depression.¹⁸
- One third of individuals who are dependent on alcohol also have a psychiatric diagnosis, while about half of those who abuse illicit drugs also have a mental illness.¹⁹
- There is another stratum of individuals whose substance abuse is related to a less severe mental health issue and who often go unnoticed in discussions around concurrent or co-occurring problems.²⁰
- Canadians filled more than 30 million prescriptions for antidepressants in a year, an increase of 40 per cent since 1997, with young people and seniors increasingly using the drugs.²¹
- The impact on the use of the mental health system is significant. Mental illness is the longest length of stay in hospitals, which is 37% higher than the next diagnostic group. Approximately one quarter of all hospital days used in Canada is used to treat individuals with mental illness.²²
- Mental health problems is one of the most expensive health problems in Canada, in 2001, the total fiscal impact on mental health problems was \$16 billion²³.
- Alcohol, tobacco and illicit drugs account for 20% of all acute-care hospital beds in Canada today.²⁴
- Health-care costs related to alcohol, tobacco and illicit drugs account for \$8.8 billion annually.²⁵
- Four out of every 10 people in Ontario have or have had a family member or a friend who suffers from a substance abuse problem.²⁶
- In 1991, one third of all deaths in Ontario were linked to alcohol or drugs.²⁷
- 2/3 of people with known mental illness never seek help from a health professional, fearing that they will be shunned by society.
- Statistics Canada research indicates that most Canadians with mental illness do recover and are able to lead fulfilling lives with the appropriate treatment and support.

¹⁸ Perron, Michael, (2005) 'Canadian Centre on Substance Abuse Presentation to the Standing Senate Committee on Social Affairs, Science and Technology.

¹⁹ *ibid*

²⁰ *Ibid*.

²¹ National Post, Nov 2, 2002, page A1 (Use of Antidepressants up 40% in 'very anxious nation,' report shows: Young, old taking more, A time to change article)

²² Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.

²³ Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports. Ontario Ministry of Health. 1999.

²⁴ Canadian Centre on Substance Abuse, 2006

²⁵ *Ibid*.

²⁶ Setting the Course: A Framework for Integrating Addiction Treatment Services In Ontario. Ontario Substance Abuse Bureau, 1999

²⁷ *Ibid*.

There are three levels of care that have been defined to guide the services offered, the levels differ in resource intensity, specialization and service duration. Each level provides different services such as crisis, support, clinical and environmental intervention. These levels serve only as a guide and are not linear, nor does being in one level exclude an individual from using services in a different level. The levels are:

First Level

This level refers to prevention, assessment and treatment provided by frontline health care providers. It relates to services such as, information and referrals, crisis telephone lines, mobile crisis teams, holding/safe beds, primary care, physicians, mental health counseling, community health centres.²⁸ The Toronto-Peel MHITF noted that the first level care is lacking in its triage role, where there is no central source for consistent and reliable information about mental health services and supports. There is also a lack of coordination between primary care providers and mental health.²⁹

For example:

- To enhance first level care for addictions and mental health within Halton, the recently expanded Concurrent Disorders Program will provide integrated support across Halton by way of knowledge exchange, improved service linkage and an inter-professional crisis team.
- CMHA Peel and PAARC are partners in the CHC satellite in Mississauga, and within Peel and Etobicoke the homelessness initiative through SHIP has seven community partners including addictions and diversity

Intensive

This second level refers to mental health assessments, treatment and support services which are provided in the community or hospital settings for patients with serious mental illness and addiction problems who require ongoing and long term support from service providers. It has been noted that there is inappropriate use of Schedule 1 emergency rooms, where individuals with mental illness and substance abuse problems are automatically taken during non-business hours. There is also insufficient coordination between Schedule 1s which results in inefficient operations.³⁰

For example:

- The Halton inter-professional team in cooperation with other providers, community and hospital will provide assessments, treatment and ongoing support services.
- Trillium Health Centre has established a mental health intake for all intensive case management clients.

Specialized

This refers to highly specialized mental health programs provided in community or hospital settings and which focus on serving people with

²⁸ [Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports](#). Ontario Ministry of Health. 1999.

²⁹ [The Time Has Come: Make It Happen](#). Toronto-Peel Mental Health Implementation Task Force. 2002.

³⁰ IBID

serious mental illness who have complex, rare and unstable mental disorders. There are many gaps in services for individuals with concurrent disorders, there are services to treat the disorders, but an integrated system to treat multiple needs simultaneously is not well coordinated. The range of services available is insufficient to meet multiple needs, especially in Peel (e.g. Prevention/diversion, in custody/jail).³¹

For example:

- The recently expanded Concurrent Disorders Program of Halton will fill a critical gap in service in supporting the hospitals in the provision of a range of highly specialized services.
- CMHA Peel has a concurrent disorders specialist working through PAARC in the Mental Health and Justice Program.

Overview of Action Plans

The overall implementation plan will require two action plans:

- 1) Develop an integrated approach to service delivery across the continuum and life cycle which builds on current initiatives and previous studies.
- 2) Focus on an early win approach which leverages current partnerships and concentrates on the development of new ones to enhance coordination.

Challenges that Could Impact Successful

Phase 2 Community Engagement consisted of dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from across the LHIN and the provider conference. From these conversations the following challenges have been suggested:

- Acceptance of the recovery model by all providers across both mental health and addictions.
- Lack of educational programs for: Individuals; Families; Providers; Other ministries; Police; and local politicians.
- Language barriers increase the challenges and complexities of service delivery.
- Detox facilities are not available.
- Lack of psychiatrists across the LHIN.
- Criteria for access is an issue – do not understand and too restrictive thus creating barriers to access.
- There are 22 crisis lines in the LHIN.
- Current funding would not support raising awareness of MH&A services.
- Most children's Mental Health is funded by MCSS

³¹ IBID

- There is a significant disparity across Mental Health and Addictions today.
- There are significant disconnects across providers/institutions/agencies/sectors today.
- Family Health Teams lack linkages to the community social determinants of health.
- Provision of a full range of specialized services in the LHIN without an academic medical institution.
- Stigma associated with MH&A.
- Youth transition to adult services is very difficult.
- Structures of accountability/liability to support collaborative relationships.

Networks and Current Best Practices Identified to Support Success Implementation

The following networks or opportunities for leverage have been identified through the Phase 2 Community Engagement with the networks and providers.

- Mental Health & Addictions Leaders Forum for Mississauga – Halton
- Peel Crisis Capacity Network

The following initiatives or opportunities were identified through the Phase 2 Community Engagement with the providers as strengths that the Detailed Planning and Action Teams could use as a basis for further development:

- Trillium centralized in-take system
- Addictions common intake and discharge assessment tool
- Leverage existing memorandums of understanding (MOU)
- Broaden community support agreement with addictions
- Leverage COAST
- ADAPT Concurrent Disorders Treatment Group
- Leverage experience of development of the nurse practitioner role
- Use of video conferencing to work with clients
- Acton Community Support and Treatment Team in north Halton could be leveraged across the LHIN

Action Plan #1

Develop an integrated approach to service delivery across the continuum and life cycle which builds on current initiatives and previous studies.

Description

Local care delivery systems focus on providing services within the community and are built upon current and new partnerships to enhance coordination across the full continuum, including:

- A local care delivery system, which focuses on providing a comprehensive service continuum, is based on client needs and best practices. Mental health services levels of care (first-line, intensive and specialized) and supports (e.g. housing, vocational, social-recreational supports) will be coordinated and integrated.
- Many opportunities to create system improvements in the first Level.
- Creating linkages within the different levels of care.
- Sharing responsibility and accountability among service providers is required to ensure the roles and responsibilities of providers is clear so that services delivered are effective, efficient, seamless, responsive and accountable.³²
- Addressing recommendations for specific populations, including age specific and cultural needs. (concurrent disorders, providers who are sensitive to cultural needs)
- Referencing 'Out of the Shadows' report by Senator Kirby to focus on health promotion within Mental Health and Addictions to further de-stigmatize these conditions within our communities.

Integration needs to embrace a multi-faceted approach by incorporating greater coordination in the following areas:

- Within and across mental health services and providers;
- Within and across addiction services and providers;
- Across mental health and addiction services and providers;
- Across mental health and addition services and the health care system; and
- Across mental health and addition services and key partners of the health care system.

³² [The Time Has Come: Make It Happen](#). Toronto-Peel Mental Health Implementation Task Force. 2002.

Deliverables – Years one to three

Year 1 Deliverables:

Establish a mental health and addictions services Detailed Planning and Action Team

- Conduct detailed environmental scan to understand the population needs and secure a current inventory of available services across all providers at the local, geographic, LHIN-wide levels, as well as those that are available at the inter-LHIN and provincial levels.
- Deliver community engagement events with patients, survivors, and their families to understand fully the challenges within the system.
- Leverage learnings and approach from the best practices and initiatives that exist currently.
- Run a cross-sectoral visioning day to launch the development of the initial building.
- Research of best practices on each of the building blocks in order to begin designing the integrated service delivery for mental health and addictions.
- Incorporate a holistic approach to effectively address the needs of the individual and their families by including a focus on integration with the medical community across the continuum.
- Recognize the commonalities across mental health and addictions and the points of uniqueness that will need to be managed within the integrated service delivery model.
- Develop the necessary sub-service delivery requirements to address the special needs of those with concurrent disorders and those with dual diagnosis.
- Make recommendation on a fully integrated service delivery model across the continuum and the appropriate basket of services at the primary, secondary and tertiary levels.

Year 2 Deliverables:

Conduct a community engagement to test the integrated model

- Develop recommendations on integrated approach to service delivery and the appropriate basket of services at the primary, secondary and tertiary levels.

Develop the detailed project plan for successful implementation:

- Determine the strategic approach to phase-in the service delivery implementation across the continuum and the geographic levels.
- Create the detailed implementation project plan understanding interdependencies, resource requirements, timelines, milestones and critical success factors.

- Finalize the process and health system outcomes that support the phased implementation plan in accordance with the performance management framework.

Year 3 Deliverables:

Continue the detailed implementation plan for roll-out of the new service delivery model

Execute the performance measurement system for all process outcomes and service delivery outcomes as appropriate

Outcomes

- Quality
 - Improved client/family satisfaction
 - Reduced readmission rate as a result of better care pathways
 - Reduced emergency department visit rate as a result of providing better services in the community
- Access
 - Reduced wait times for community services
 - Reduced barriers to access acute services
- Efficiency
 - Care maps and clinical pathways based on best practices/evidence
 - Adoption of standardized approaches/processes and/or tool kit across mental health and addictions where appropriate and possible
 - Increased units of service provided within the same financial allocation
- System/Process
 - Care coordinators/managers to help with system navigation
 - Level of coordination with medical and mental health and addictions – the holistic approach

Performance Indicators

- Wait times for mental health and addictions services – identify the most acute services for monitoring purposes
- Average length of stay in hospital
- Consumer/survivor/family satisfaction
- Number of clients/patients
- Number of assessments regarding client health pre and post service
- Number of clinical problems presenting
- Consistent with known prevalence rates
- Discharge plans in place
- Number of service agreements:
 - Across providers

- Across sectors
- Across ministries
- Number of inter-agency linkages:
 - Co-location
 - Agreements
- Diversion rates from hospitals
- Number of referrals
- Number of referrals actioned with service within a specified time frame
- Others determined as appropriate by Detailed Planning and Action Team

Please note a comment from the forums: 'There isn't a measure of the cost of failing to treat mental health'.

Action Plan #2

Focus on an early win approach which leverages current partnerships and concentrates on the development of new ones to enhance coordination

Description

The ability to leverage existing examples of exemplary service must align with the vision, strategic goals and guiding principles for mental health and addiction services across the Mississauga Halton LHIN. Our mandate will focus on those areas that can leverage current capability across the Mississauga Halton LHIN and deliver improvements for both the public and providers in the short to mid-term. Thus any work on early wins must follow from the establishment of the foundational vision and strategy. The actions in the short term must be reviewed by the team supporting the long-term vision of the integrated approach to service delivery. The Mental Health and Addiction Rapid Action Teams will collaborate with the Mental Health and Addiction Detailed Planning and Action Team to ensure coordination with the long-term vision.

Deliverables – Years one to three

Year 1 Deliverables:

Establish a mental health and addictions Rapid Action Team to identify opportunities to enhance coordination

Early Wins:

- **Early Win** - Crisis intervention in hospital emergency rooms, providing direct linkage to 24/7 crisis response teams and use of EDP forms across all emergency departments in the LHIN.
- **Early Win** - Develop purposeful professional education and development programs that are focused across all providers, for example concurrent disorder training.

Develop performance monitoring for early wins

Year 2 Deliverables:

Early Wins:

- **Early Win** – Develop standardize assessment tools or tool kit for mental health and addictions where appropriate. For example Addictions common intake and discharge assessment tool.
- **Early Win** - Standardization of case management process as per MOHLTC case management standards.

Track performance from Year 1 and develop performance monitoring for Year 2 early wins**Year 3 Deliverables:****Early Wins:**

- Other Early Wins as defined by the Mental Health and Addiction Detailed Planning & Action Team.

Track performance from Year 1 and 2 indicators and develop performance monitoring for Year 3 Early Wins**Outcomes**

- Quality:
 - Improved client/family satisfaction
 - Reduced emergency department visit rate as a result of providing better services in the community
- Access:
 - Greater understanding of how to access services
 - Reduced wait times for community services
- Efficiency:
 - Adoption of standardized approaches/processes
- System/Process:
 - Care coordinators/managers to help with system navigation
 - Level of participation in education on Mental Health and Addictions

Performance Indicators

- Early Win initiatives will determine indicators in support of the longer term vision
- Others as appropriate to be determined by Detailed Planning and Action Team