Erie St. Clair **LHIN**
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Mental Health Multi-Year Implementation Framework

June 2013 Report

Erie St. Clair Local Health Integration Network

Chatham-Kent, Ontario
Photo by Julie McKinlay

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Agenda Item 11.2

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Executive Summary:

On May 28, 2013, the Erie St. Clair Local Health Integration Network (LHIN) Board of Directors approved the Phase One, Mental Health Multi-Year Implementation Report. Approved deliverables included:

- An Erie St. Clair LHIN Mental Health Vision Statement.
- Ranking of the Mental Health Strategic Plan 67 opportunities into three phases with each phase having a time line of 12 to 18 months. The first phase commences in the summer of 2013, whereas, phase three concludes in 2017.
- A restructured Erie St. Clair LHIN Mental Health and Addictions Network as an overarching body overseeing five leadership tables. The five leadership tables were charged with action orientated tactical aims aligned with the nine strategic directions.
- Proposed promising practices to reduce, a) repeat (within 30 days) emergency department (ED) visits for mental health, b) suicide attempts, and c) wait times for community based mental health services.

The June 2013, Phase Two, Mental Health Multi-Year Implementation Report addresses the remaining deliverables:

- Analysis and recommendations for the cost, benefit, risks, and options business cases as they pertain to proposed hospital based programs divesting to the community.
- Mental health engagement summaries.
- Recommendations pertaining to promising practices business cases. Specifically, the Inner City Model, Suicide Prevention and Coordination Project, Next Day Bookings LHIN-wide Coordinator, and the Chatham-Kent / Sarnia/Lambton and Leamington area Rapid Assessment, Intervention and Treatment Program.
- Synopsis of the task force recommendations regarding mental health housing and the accessibility needs of minority population groups.
- Critical next steps.

The Erie St. Clair LHIN mental health engagement included a total of 11 psychiatrists, 26 consumers, and 47 family members. The engagement, coupled with seven cost benefit risk and options analysis, resulted in the following recommendations:

1. The 2011 Mental Health Strategic Plan proposed divesting of seven hospital based programs to one community mental health coordinating agency. This entity was envisioned as an integrated Canadian Mental Health Association (CMHA). To date, the integration has not occurred. Further, there is no evidence to suggest that divesting hospital based programs such as Assertive Community Treatment (ACT), Program of Assertive Community Treatment (PACT), Telephone Crisis, Early Intervention First Episode Psychosis, and Geriatric Mental Health Outreach Teams (GMHOT) operated by Chatham-Kent Health Alliance (CKHA), Windsor Regional Hospital (WRH), Bluewater Health (BWH), and Hôtel-Dieu Grace Hospital (HDGH), will result in higher quality care or more cost-efficient services. At this time, no service changes are recommended.

2. The access mechanisms for Intensive Case Management and ACT/PACT clients requires greater Erie St. Clair LHIN-wide standardization including ensuring that an appeals process is implemented, and communicated broadly to clients and family members. Similarly, transitional, client-centred, and flexible step up and step down models of care for Intensive Case Management and ACT/PACT clients is required.
3. Early Intervention First Episode Psychosis Programs in Windsor-Essex (Erie St. Clair LHIN funded and non-funded) requires a full Erie St. Clair LHIN investigation as it pertains to quality of services, wait times, client, and family satisfaction levels. The Erie St. Clair LHIN decision-making with respect to future service delivery sponsorship will be required.
4. Due to the changing demographics and complexity of care needs of the senior population, development of an Erie St. Clair LHIN Regional Geriatric Program is required.
5. The Wellness for Extended Psychosis Program warrants sustainable annualized base funding to enhance the delivery of services for greater numbers of clients and families.
6. Similar to the Erie St. Clair ED and Primary Care Physician Leadership roles, a dedicated psychiatrist lead is required to leverage and address the need for shared care models with primary care practitioners.
7. Leamington and area requires a full mental health engagement and analysis as it pertains to future service delivery needs, and alignment with either Windsor-Essex or Chatham-Kent providers. Analysis of utilization data and discussions are required with key stakeholders including psychiatrists, emergency department physicians, hospital leadership members of the community, mental health consumers, and their families.
8. Erie St. Clair LHIN staff will coordinate meetings with the Departments of Psychiatry and community mental health agencies to address concerns cited in this report.

The Erie St. Clair LHIN received five business cases representing four promising practices. Specific funding recommendations and critical next steps are outlined in the last section of this report.

Repeat Mental Health Emergency Department Visits Within 30 Days:

In May 2013, the Ministry of Health and Long-Term Care (MOHLTC) changed the methodology for the Ministry-LHIN Performance Accountability (MLPA) indicator for Mental Health and Substance Abuse (MH/SA) repeat ED visits within 30 days. The new methodology addresses the 14 LHINs concern regarding delayed reporting. The new methodology will shift the reporting period a month ahead, so that the look-up window for observing the repeat visits data will fall in the reporting quarter. Therefore, in Q3, data from Q1 would be reported, rather than data from Q4 of the previous year. Table 1 shows the LHINs MH/SA ranking for the current and new methodology for the fiscal year 2011/2012.

Table 1 Compare the Performance Ranking Using Two Methods, FY2011/12 Annual

Patient Residence LHIN	Mental Health				Substance Abuse			
	New		Old		New		Old	
	Repeat visit (%)	Ranking	Repeat visit (%)	Ranking	Repeat visit (%)	Ranking	Repeat visit (%)	Ranking
1 Erie St. Clair	**19.7**	**13**	**19.8**	**13**	24.2	9	23.6	8
2 South West	15.5	5	15.7	5	29.4	12	30.1	13
3 Waterloo Wellington	15.3	3	15.4	4	18.9	2	18.9	2
4 Hamilton Niagara Haldimand Brant	19.6	12	19.5	12	23.4	8	24.2	9
5 Central West	15.1	2	15.0	2	22.8	6	22.4	6
6 Mississauga Halton	15.4	4	15.3	3	21.3	5	21.0	5
7 Toronto Central	25.4	14	25.7	14	37.7	14	37.7	14
8 Central	17.4	9	17.5	9	19.8	4	20.2	4
9 Central East	18.8	10	18.8	10	22.9	7	22.5	7
10 South East	19.5	11	19.4	11	19.4	3	19.8	3
11 Champlain	17.2	8	17.2	8	24.4	10	24.6	10
12 North Simcoe Muskoka	14.7	1	14.8	1	16.8	1	17.7	1
13 North East	16.9	6	16.9	6	27.1	11	27.2	11
14 North West	17.0	7	16.9	6	29.5	13	29.5	12

Regardless of the new versus old methodology, the Erie St. Clair LHIN ranks as the second highest in Ontario for repeat MH ED visits within 30 days. High repeat MH ED visits are interpreted by the MOHLTC as patients not having access or not receiving adequate support in the community. Improving the Erie St. Clair LHIN's unacceptable and poor performance for this indicator is relevant to this report's proposed future direction, and promising practices designed to address access issues, repeat ED mental health visits, and ED diversion.

Mental Health Engagement:

In late April 2013, the Erie St. Clair LHIN staff conducted engagement activities with the Departments of Psychiatry in Windsor-Essex and Sarnia/Lambton. In total, seventeen psychiatrists provided feedback and suggestions for improving care. This section of the report summarizes key themes. The engagement sessions focused on what is working well, opportunities for improvements, and areas of concern. Please see Appendix 1 Department of Psychiatry Windsor Regional Hospital and Bluewater Health Consultation Summaries.

Department of Psychiatry Windsor-Essex

The Windsor-Essex engagement session included eleven psychiatrists, the mental health director, the ACT Team coordinator, and the Chief of Psychiatry for Windsor Regional Hospital (WRH) Specialized, Mental Health Tertiary Services. It is noteworthy, that the majority of psychiatrists are affiliated with HDGH Acute Care, Schedule One Facility as well as maintaining independent practices. In addition, one psychiatrist provides care for community mental health namely, Canadian Mental Health Association Windsor-Essex County Branch (CMHA WECB).

What is Working Well

Overwhelmingly, the psychiatrists stressed the importance of maintaining and enhancing the ACT Teams, Wellness for Extended Psychosis (W-PEP) and Schizophrenia, and First Episode Psychosis Programs (SEPP) as hospital based services. Presented evidence includes:

- Clients of the SEPP and W-PEP Programs have a reduced length of stay (LOS) of 3.75 days (10.39 total days) compared to the average LOS (14.4) for Windsor-Essex psychiatric clients who are not participants of the above programs. The reduced LOS is attributed to these programs providing continuity of care across the acute, tertiary and community sector (Cortese L, Geml J, Villella G, and Velehorschi C. "Evidence-based outcomes in an underserviced community's schizophrenia and first episode psychosis program." *Schizophrenia Research*. 102.1 Supplement 2. (2008): 212. Print).
- In the Fall of 2011, three ACT Teams divested from the Regional Mental Health Care (RMHC) London to WRH. Two ACT Teams serve Windsor-Essex and one team serves the residents of Chatham-Kent. Psychiatrists emphasized the efficiency of the current model in stabilizing clients and responding to crisis (e.g. ACT Team staff stays with clients while they wait at the ED.) Integrated care was repeatedly emphasized as an example; ACT Team clients access tertiary care beds by passing the acute care system.
- Research from clinical trials for SEPP and W-PEP showed a 65% improvement in positive symptoms including a 30% increase in quality of life measures in a one year time period (2008, International Schizophrenia Society Conference, Poster Presentation, Venice, Italy).
- The W-PEP Program recently received the Leading Practice Award by the Ontario Hospital Association.

Opportunities for Improvement

According to the MOHLTC Health Analytics Branch the Erie St. Clair region has the highest rate of admissions for mood disorders (53.4%) compared to Ontario (43.6%). This occurrence may be attributed to psychiatrists advanced diagnostic practices. Another contributing factor could be the severe economic impact over the past few years as it relates to individuals with moderate depression becoming more severe. This trend was distinguished by psychiatrists as an opportunity to build a new clinical model to serve persistent and complex mood disorder patients across the Erie St. Clair region. See Appendix 2 Mood Disorders an Integrated Model of Care. Additional opportunities for improvements include:

- The SEPP and W-PEP Programs are funded by pharmaceutical clinical trials and fundraising efforts. Sustainable funding and additional clinical staff is needed due to the current W-PEP client 1 to 31 to staff ratio. Psychiatrist stated best practices for high acuity staff to client ratio as 1 to 12. Two hundred clients are currently served by the SEPP and W-PEP Programs.
- Both Windsor-Essex ACT Teams currently has a wait list. An expansion of the ACT Program to include a third team was emphasized as a great need.
- Psychiatrists stressed that community mental health provides care for lower acuity clients. Better integration with community mental health could be achieved by case managers attending psychiatric sessions with their clients. In addition, psychiatrists suggested that the Erie St. Clair LHIN needs to better monitor clinical outcomes and follow up for community mental health programs.
- Need for more psycho-social rehabilitation and enhanced vocational services provided by the community sector.
- Shared care and shared responsibility between primary care physicians and psychiatrists would result in better continuity of care.

Concerns

The Windsor-Essex psychiatrists' strongly emphasized concerns with the current level of clinical competencies of community based mental health providers. A lack of confidence in the community sectors ability to manage clients with high acuity levels was noted with the following points:

- In the past year, seven ACT Team clients were referred as a step down to CMHA WECB Intensive Case Management services and subsequently returned to the ACT Teams. Of the 101 W-PEP clients, 25 or (24.7%) came from community mental health, Intensive Case Management services. Of the 25 clients, 14 are receiving medication management and 11 are receiving active case management by W-PEP. As of this date, 11 ACT Team clients are stabilized and could potentially step down to Intensive Case Management if flexible care was provided in meeting the transitional needs of these complex clients.
- Primary care physicians are bypassing community mental health services as it relates to clients experiencing a first episode psychosis by referring directly to the SEPP and W-PEP Programs. Family physicians cited as having concerns about community wait times.

- The Department of Psychiatry strongly expressed that current psychiatrists and Allied Health Professionals currently affiliated with the above programs will not shift employment to the community sector. This rationale pertains to the current concentration of resources and expertise being hospital based, as well as a significant difference in remuneration models. With this said, psychiatrists suggested that the current system provides an opportunity to build an integrated staged system, based on the level of client need, and expertise required in treatment.

Department of Psychiatry Bluewater Health

The Sarnia/Lambton Department of Psychiatry engagement session included six psychiatrists. There are a total of seven psychiatrists providing care for Bluewater Health Acute Care Schedule One facility and the PACT. Note: the term PACT is used in Sarnia/Lambton whereas ACT is used in Windsor-Essex and Chatham-Kent. There is no difference in the service model between PACT and ACT.

What is Working Well

- Bluewater Health psychiatrists stressed the high quality of care and continuity provided to PACT clients and their families. Adherence to the provincial ACT/ACT Standards of Care. The PACT clients are cared for by two Bluewater psychiatrists.
- The PACT Model at Bluewater Health focuses on a multi disciplinary team approach. With patients needs matched to psychiatrists area of expertise, there has been a notable increase in admitted patients being followed by the same psychiatrist upon discharge on an out-patient basis. Continuity is a hall mark of high quality care.

Opportunities for Improvements

- The PACT Program does not extend services to the County of Lambton. Psychiatrists stressed that additional resources are needed in order to expand service delivery.
- ED physicians utilize too many Form Ones resulting in some patients being admitted inappropriately. A Form 1 is an involuntary admission for psychiatric observation.
- Opportunities exist for greater education and collaboration with ED physicians. Clinical protocols leveraging the BWH Psychiatric Assessment Nurses decision making capabilities is also needed.
- Similar to Windsor-Essex, Bluewater Health psychiatrists cited the need for shared care responsibilities with primary care physicians. Currently, local Family Health Teams (FHT) are not accepting new patients.
- Clients with sub-acute care needs that are in between the levels of PACT and Intensive Case Management would benefit from a step up and step down program.
- Lack of housing resources with on-site support is a significant need.

Concerns

- Access to tertiary services to RMHC London is a persistent issue. In the 2012/13 fiscal year, 52 adults from Bluewater Health were referred to RMHC of which 15 or (28.8%) were denied access or discharged early to community. The wait time for BWH mental health adults ranged from 8 to 77 days. The most common tertiary referral includes mood disorders, psychosis, electroconvulsive therapy (ECT), concurrent disorders and Developmental Behavioral Unit (DBU).
- Recruitment of more psychiatrists, particularly child and adolescent psychiatry is greatly needed. In the last fiscal year, 230 or (26.6%) of all admissions were children and youth with suicidal ideation. Over the past three years, the Sarnia/Lambton community has been in crisis with high rates of suicide attempts and completed suicides. Overall, the Erie St. Clair region has a higher rate of mental health acute care cases for those aged 15 to 19 (606.8) per 100,000 populations compared to Ontario (396.7). In 2012/13 BWH referred 18 children/adolescents to London for tertiary level services. The wait time ranged from 8 to 22 days with 30% of cases having a wait longer than eight days.
- Community mental health provides care for a lower acuity level; high staff turnover is noted as a continuity concern. Similarly, psychiatrists noted, having a lack of confidence in community mental health ability to manage medication compliance and clients placed on a Community Treatment Order (CTO). Community Treatment Order is a legal document initiated by psychiatrists for treatment compliance. In addition, it is a legal document monitored by Justice of the Peace or other legal resources.
- High proportion of substance abuse clients. Psychiatrists indicated that having a 24 hour observation room in the ED and a Withdrawal Management Service is greatly needed.
- Psychiatrists and PACT staff will not transfer with the program if it is divested to community.

Clients and Families

Four engagement sessions were facilitated by the Erie St. Clair LHIN staff with a total of 73 participants; 26 clients and 47 family members. Note: 24 clients are inclusive of PACT, ACT, SEPP, and W-PEP. The engagement sessions were powerful, highly emotional, passionate testimonials from clients, and families articulating their experiences with severe mental illness, and how the above programs changed their lives. While this section provides a summary of common themes the reader is encouraged to review Appendix 3: Clients and Families Consultation Summary, and a sample of Letters, and Testimonials. For the sake of brevity, the term program will be used for PACT, ACT, SEPP and W-PEP.

What is Working Well

- Repeatedly, Erie St. Clair LHIN staff heard that prior to being accepted by the program, the clients mental illness was poorly managed resulting in severe symptoms, countless admissions, long LOS, and repeated/revolving door use of the ED.
- Overwhelmingly, families attributed the program to keeping their son/daughter alive and off the streets. Mental illness is about life and death; historically, the health care system has not funded or recognized this fundamental fact.

- Prior to the program, families experienced "*sleeping with one eye open",* constantly being on guard, feeling abandoned and helpless by an unresponsive health care system. The emotional toil experienced by families cannot be emphasized strongly enough.
- Clients expressed a lack of trust, fear, and anxiety with respect to having their care transferred to community based mental health providers.
- A summary of the benefits of the programs include:
    - Family relationships have been restored e.g. *"I can be a mom now and not a case manager".*
    - Daily supports provided by a multi-disciplinary team allow the clients to live independently e.g. medications are dispensed and monitored.
    - Peer support was noted as being invaluable, nonjudgmental, and filling a void.
    - Program staff readily available for clients and family members.
    - Consistent psychiatry support, quick access, and strong trusting relationships were repeatedly cited as the foundation, enabling client wellness.
    - Family members expressed great fear if the program is divested e.g. *who will look after my loved one?*
    - Clients are at ease with themselves now, no longer frightened, feel safe and accept their mental health needs, and treatment.
    - Family members receive education and ongoing support from the program.

Opportunities to Improve Services

- Clients and families consistently expressed the need for more program staff/resources.
- Develop linkages with community mental health services but, "*don't change the current programs simply for the sake of change!"* The community can help with housing, psycho-social rehabilitation, vocational skills, and system level advocacy addressing mental health stigma. Build upon current positive relationships between the program and community resources.
- Leverage technology when clients are in a well stage, be mindful of privacy.
- Access to primary care remains a long-standing barrier.

Engagement Conclusions

The voices of clients and family members passionately defended the current programs as being the "*right service to meet the level of need".* Change for the sake of change was repeatedly questioned "*don't fix something that isn't broken".* The level of fear and anxiety associated with potential divestment of current services from hospital to community was indisputable. The above synopsis while accurate; does not reflect the intensity or passion of clients and their families. The reader is advised to review. See Appendix 3 Clients and Families Consultation Summary, Letters, and Testimonials.

Cost, Benefit, Risks, and Options Analysis:

The 2011 Erie St. Clair LHIN Adult Mental Health Strategic Plan proposed the divestment of seven hospital based programs to an integrated Community Mental Health Coordinating Agency. The Community Mental Health Coordinating entity was an envisioned integration between Canadian Mental Health Association Lambton-Kent Branch and Canadian Mental Health Association Windsor-Essex. To date, a formal integration has not been achieved. As directed by the Erie St. Clair LHIN Board of Directors, a cost, benefit, risks, and options (CBRO) analysis was conducted for the following programs:

- Windsor Regional Hospital ACT Teams
- Bluewater Health PACT Team
- Chatham-Kent Health Alliance Early Intervention, First Episode Psychosis Program
- Windsor Regional Hospital, Geriatric Mental Health Outreach Team
- Chatham-Kent Health Alliance, Geriatric Mental Health Outreach Team
- Windsor Regional Hospital, Wellness for Extended Psychosis Program
- Hotel Dieu Grace Hospital Crisis Program

The Mental Health Task Force members responsible for the above programs completed the CBRO Template and as a group in depth discussions occurred including achieving consensus with respect to recommendation themes. See Appendix 4: Cost, Benefit Risks, and Options Analysis. This section of the report focuses on key findings from the CBRO analysis. For the purpose of this report, programs of a similar nature will be discussed collectively, e.g. ACT and PACT; Geriatric Mental Health Outreach Teams.

ACT and PACT Analysis

The 2012 ACT Team Directory shows a total of 59 ACT Teams in Ontario of which 24 or (41%) are sponsored by a community agency. A deeper analysis of the community ACT Teams show that 11 or (46%) are through a Canadian Mental Health Association. From the 24 community based ACT Teams, four are identified as an integrated mental health and housing agency. The remaining 35 or (59.3%) ACT Teams are through tertiary hospitals or Schedule One Facilities. It is noteworthy that two ACT Teams are dedicated for the dual diagnosis population, one team is specific to psycho-geriatrics and one team is sponsored by a Community Health Centre, in the Champlain LHIN, providing care for the seriously mentally ill (SMI) Francophone population.

In Erie St. Clair LHIN, there are a total of four ACT Teams, with three transferring from RMHC London to Windsor Regional Hospital in the Fall of 2011. The inception of ACT is longest in Windsor-Essex with 15 years, followed by Chatham-Kent 14 years and Sarnia/Lambton at 13 years. Historically, the provincial standards defined ACT Teams as either urban or rural. The original premise was rural teams would have a lower number of clients and staffing. Over the years the urban versus rural distinction has proved to be a poor benchmark for estimating the number of clients in need. All four of the Erie St. Clair ACT Teams are sponsored by hospitals. Tables two and three show ACT Team utilization, resources, and costs respectively, for the 2012/2103 fiscal year. Note: the ACT psychiatrists are salaried positions as per MOHLTC standards.

Table 2: ACT Team Utilization 2012/2013 Fiscal Year

ACT Program	Total # of Clients	Total # of New Clients	Total # of Discharges	Current Wait Time
WRH ACT 1	94	6	5	6 – 8 months
WRH ACT 2	102	6	2	6 – 8 months
WRH – CK ACT	84	6	5	No wait time
BWH PACT	78	11	6	No additional capacity at this time
ESC LHIN Total	**358**	**29**	**18**	-

Table 3: ACT Resources and Cost 2012 – 2013 Fiscal Year

ACT Program	Total # of FTEs	Cost per Client	Units of Service	Expenditures	Psychiatry expenditures
WRH ACT 1	13.3	$16,110	25,669	$1,678,043	$202,602
WRH ACT 2	12.8	$13,054	38,060	$1,602,148	$202,601
WRH CK ACT	13.8	$16,999	29,668	$1,539,374	$281,880
BWH PACT	7.8	$17,770	14,669 face to face + 2,962 telephone	$1,381,426	$365,800
ESC LHIN Total	**47.7**	**$17,321**	**111,028**	**$6,200,991**	**$1,052,883**

A total of 358 ACT Team clients were served in Erie St. Clair in 2012/2013, with a cost per client of $17,321. As a conservative analysis using one admission to an acute care, Schedule One Facility for 14 days (LOS) the system cost is $14,000. If each ACT Team client in Erie St. Clair avoided one admission, using the above LOS as a proxy, the health care savings is $5,012,000. From a resource perspective, the Provincial ACT Standards recommends a 1–10 staff to client ratio due to the high acuity level. As illustrated above, the four ACT Teams are operating at lower resource levels than the standards recommend. In other words, the current ACT staff resources are being stretched beyond recommended ratios.

In 2012/2013 fiscal year, a total of 18 ACT Team clients were discharged. In Ontario, similar to the United States the philosophy of care for ACT Team clients is for life. This philosophy is shifting across Ontario and in Erie St. Clair to a more integrated step up and step down model of care. In May 2013, the Erie St. Clair Mental Health Multi-Year Implementation Report focused on the access mechanism, standardized tools for measuring client acuity levels and step up and step down up model for ACT Teams and Intensive Case Management clients. Further information pertaining to access and step up and step down models is discussed in the recommendations and next steps section of this report.

Table 4 shows a summary of the benefits of the ACT/PACT Programs alongside of the risks associated with transferring to community based mental health.

Table 4

Benefits of ACT/PACT Program	Risks Associated with Divestment
Ease of access and consistency in psychiatrist and multi-disciplinary team. Education and on-going support for families.	Compromise therapeutic relationships. Some clients may not transfer with the program leaving them at risk as a danger to themselves or others (lack of medication compliance).
Decreased hospital admission and LOS/ED visits.	Potential risk of relapse, increased use of the system, ED visits, hospitalizations.
	Loss of psychiatrist and existing staff not transferring with the program.
Partnerships with both CMHA LK and W-E for supportive housing. In Windsor, ACT clients have access to the WRH Residential Treatment Facility.	Severance packages. Numerous ACT/PACT staff are long standing employees. By not transferring with the program, internal bumping will occur as per Union Collective Agreements.
ACT/PACT are now using the same assessment tool as Intensive Case Management (Ontario Common Assessment of Need).	Political risks associated with system change, psychiatrists, staff, and patients/families complaints.
Erie St. Clair LHIN-wide, ACT/PACT partnerships with CMHAs are stronger now than in the past. Willingness to develop, implement, and standardize a step up and step down model including accepting the client back if decline occurs. Significant shift in treatment philosophy.	Linkages between ACT/PACT and in-patient care, grand rounds and out-patient mental health and addiction programs would be lost or significantly severed.

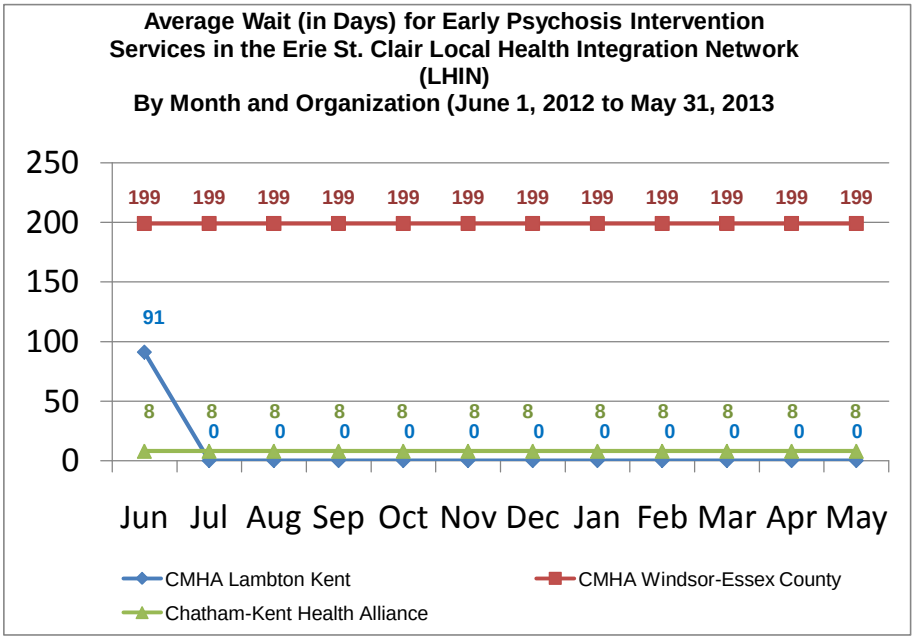
Early Intervention, First Episode Psychosis Analysis

Prior to the inception of the LHIN, three existing Early Intervention First Episode Psychosis Program (EI) providers were determined by the MOHLTC. The EI Programs received funding by the MOHLTC in 2004 to address the need for immediate psychiatric intervention and support for families. The importance of timely, comprehensive intervention for individuals experiencing their first psychosis is critical for maintaining functional abilities of clients. Each year, 12 out of every 100,000 people in Ontario will experience psychosis with the overwhelming majority being adolescents and young adults between the ages of 14 and 35. Psychosis is a debilitating condition characterized by delusions, hallucinations, disorganized thinking and/or bizarre behaviour. Symptoms may emerge gradually or abruptly impacting all aspect of life including education, relationships, social functioning, employment, physical, and mental well-being. Long standing evidence shows that the duration of untreated psychosis (DUP) is extremely stressful for families and results in poor clinical outcomes for clients. The first few years are associated with the highest risk for serious physical, social, legal, and functional decline. One in ten people with psychosis commit suicide, two-thirds of these deaths occur within the first five years of illness. Finally, the economic and societal impact of untreated psychosis includes premature death, years of disability, homelessness, incarceration, and reduced potential for long-term stabilization (Ministry of Health and Long-Term Care, 2011, Early Psychosis Intervention Program Standards).

In Erie St. Clair, the EI providers are CMHA Lambton Kent, CMHA WECB and CKHA. In the fiscal year 2011/2012, the Erie St. Clair LHIN enhanced annualized base funding for EI providers with a total investment of $606,042. This investment utilized CMHA Lambton Kent as a lead agency. The CKHA EI Program has been operational for the past seven years. Additional funding support is provided by the Chatham Rotary Club. In the 2012/13 fiscal year, CKHA EI Program served 74 clients, with 54 new clients and 40 discharged to CMHA Lambton Kent and local primary care providers. The CKHA program operates with 2.65 FTEs with one staff shared with CMHA Lambton Kent. It is noteworthy that the CKHA and CMHA Lambton Kent have recently implemented a horizontal integration model for mental health services. Horizontal integration refers to an integration of services that are similar in nature or at the same stage of service delivery. The current integrated relationship between CKHA and CMHA Lambton Kent allows patients to flow easily from in-patient to community Intensive Case Management. Risks associated with divesting the CKHA EI Program are as follows:

1. Financial/severance packages for staff
2. Resources may not transfer with the program. The loss of experienced and well trained staff has implications for client care.
3. Risk to the existing horizontal integrated relationship between hospital and community mental health.

Figure 1 Shows the Connex Ontario Wait Time for Erie St. Clair LHIN Early Intervention First Episode Psychosis Programs from June 2012 until May 31 2013.



In Windsor-Essex there are two programs providing support for the EI population, namely CMHA WECB and WRH Schizophrenia and First Episode Psychosis Program (SEPP). The WRH SEPP inception predates the LHIN. At that time, the MOHLTC allocated EI funding to CMHA WECB. The WRH SEPP receives funding through pharmaceutical clinical trials and fund raising. The majority of SEPP clients transition to the WRH Wellness for Extended Psychosis Program. Both EI Programs in Windsor-Essex adhere to the 2011 MOHLTC standards for Early Psychosis Intervention by using dedicated psychiatrists, providing education and ongoing supports for families. It is noteworthy that the WRH SEPP psychiatrists stressed during the Erie St. Clair LHIN engagement, that due to community EI wait times they continue to receive and accept referrals from family physicians, families, and other mental health providers.

The EI Program's sole mandate is early intervention; no wait times should occur for vulnerable, young individuals experiencing their first psychosis. The Erie St. Clair LHIN recognized this significant need through 2011 funding enhancements and took further action in 2013 by embedding a no wait time stipulation in each EI Provider's Multi-Sectorial Accountability Agreements (M-SAA). Further investigation on the part of Erie St. Clair LHIN is required, including examining Erie St. Clair LHIN funded and non-funded EI programs, utilization rates, referral patterns/sources, clinical outcomes such as relapse rate leading to hospital admission, client, and family satisfaction levels, and wait times.

Geriatric Mental Health Outreach Teams Analysis

Prior to the Aging at Home (AAH) initiative the Erie St. Clair LHIN geriatric mental health services were fragmented, stretched, and not well coordinated. Through AAH the Erie St. Clair LHIN invested $1.1 Million to develop three mobile, multi-disciplinary GMHOT. The Erie St. Clair LHIN's investment built upon small existing resources (.5 FTE) CKHA and (one FTE) at WRH. In Sarnia-Lambton a new team was developed based at CMHA Lambton Kent. The GMHOT multi-disciplinary resources are comprised of registered nurses, social workers, dedicated psychiatrists, and occupational therapist.

In 2011 through the Behavioral Supports Ontario (BSO) initiative the Erie St. Clair LHIN invested an additional $255,000 which provided dedicated funding for one FTE Psycho-Geriatric Resource Consultant (PRC) Lead for each GMHOT. The GMHOT serve older adults with mental health, addictions, cognitive impairments, and dementia related conditions resulting in difficult to manage behaviors such as, aggression, severe exit seeking/wandering, relentless calling out, and resistance to receiving care. The GMHOT provide assessment, treatment recommendations, and follow up older adults residing in the community, LTC and Rest and Retirement Homes. This section of the report addresses the 2011 Mental Health Strategic Plan proposed divestment of the CKHA and WRH GMHOT to community mental health. Table 5 shows the number of years the GMHOT programs have been in operation, total number of clients served in 2012/13, units of service, cost per client and staffing resources for CKHA and WRH GMHOT. Note: Table 5 FTEs is not inclusive of psychiatrists.

Table 5

Program	# of years in Operation	Total # of Clients served	Total # of Units of Service	Total # of FTEs	Cost per Client
CKHA GMHOT	9	355	2375	4.8	$1,243
WRH GMHOT Note: Data does not reflect WRH Mental Health Older Adults Program	24	358	6,356	4.97	$1,050

The average wait time for CKHA GMHOT is 17 days comparable to WRH 2.5 weeks. The benefits of the programs include:

- Integrated with inpatient care, ED, Complex Continuing Care and Tertiary Psychiatric Services – Grand Rounds. Consistent psychiatrist for in and out-patient care.
- Multi-disciplinary approach mobile on-site assessment and treatment recommendations with psychiatrist for LTC and Rest and Retirement Homes.

Risks associated with divesting the programs are similar to those previously cited:

- Severance/financial impact with allied health professionals bumping other hospital employees as per union collective agreements. Psychiatry and allied health professionals not transferring with the program.
- Loss of clinical expertise and established relationships with clients and families.
- Disrupting the current BSO clinical collaborative progress. The clinical collaborative provide wrap-around, client consultation with additional providers such as acute care, Community Care Access Centre (CCAC) BSO Alternative Level of Care (ALC) Coordinator and Alzheimer's Societies System Navigators. Over the past year, the BSO Clinical Collaborative facilitated rapid, real-time change resulting in improved clinical outcomes, and a reduction in ALC patient LOS.

In the Erie St. Clair LHIN there is a dichotomy between the client's mental health needs and their physical condition. The 2012 Provincial Seniors Strategy indicates the most common mental illness amongst older adults are mood (depression) anxiety disorders, cognitive, and mental disorders due to medical conditions including dementia, delirium, and psychotic disorders. Older adults are at risk of developing a serious mental illness during critical life transitions including disablement, loss of a spouse, caring for a spouse with dementia, or moving to a LTC Home. The Rising Tide Provincial Report estimates that by 2014, almost 11,000 Erie St. Clair residents will have Alzheimer's disease or a related dementia. This long standing separation of mind-body in treating mental health clients is not unique to Erie St. LHIN. As it pertains to the Erie St. Clair geriatric population, this dichotomy is being addressed differently in Chatham-Kent and Windsor-Essex.

During the past year, CKHA hired a physician's assistant (PA) to work alongside of the Chatham-Kent GMHOT. This invaluable resource acts as an extender to the psychiatrist by identifying medical co-morbidities that often-time are the root cause behind responsive behavior.

In Windsor-Essex, the GMHOT is inclusive of two teams, the Psycho-Geriatric Resource Consultants and the long-standing Mental Health Older Adults Program (MHPOA). In 2011/12 WRH voluntarily integrated the two programs creating one GMHOT with 10 FTEs in total. During this same time period, WRH hired a geriatrician. It is noteworthy, that this geriatrician is the only one in the Erie St. Clair region. As a specialized, tertiary site, WRH further identified the need to address the dichotomy of care for older adults by bringing together key stakeholders. The engagement results include:

- Creating a vision and mission statement as a prelude to becoming a Regional Geriatric Program (RGP). This endeavour includes an environmental/SWOT analysis. See Appendix 4: Cost, Benefit Risk, and Option Template.
- Identification of service gaps impeding a RGP designation
- Inclusion of the School of Medicine and community providers as key partners in the delivery of RGP services.

Implementation strategies and early development of an action plan using measurable objectives and accountability measures (known as SMART – specific, measurable, attainable, realistic and time bound).

The WRH strategic goal for developing a RGP builds upon their existing infrastructure, programs, resources, and tertiary level status. This direction is also consistent with recommendations from the 2012 Provincial Seniors Strategy. Specifically, there are five RPG in Ontario the common denominator is linkage to Academic Health Sciences Centres. The current RGP is not standardized and access to services is inequitable for many LHINs. As noted by the Provincial Seniors Lead, Dr. Sinha "*RGPs were established to leverage the expertise of geriatricians to help improve the quality of geriatric services provided by acute and chronic hospitals and to enhance local geriatric education and capacity building. Some LHINs have raised concerns that the historical RPG funding allocations have inadvertently created service delivery inequities which have made it difficult for them to attract, retain and support geriatricians and therefore provide specialized geriatric services without a dedicated funding model. The Ministry of Health and Long-Term Care and its LHINs should expedite their review of the Provincial Regional Geriatric Programs to determine if they are being utilized to their greatest strengths and how well they align with current government priorities. They should then develop recommendations on a future model for Regional Geriatric Programs in Ontario.*"

The Erie St. Clair region is dependent upon RGP services from Parkwood Hospital in the South West LHIN. Over the years, access to RGP resources has been inconsistent and inequitable amongst the Erie St. Clair three counties. The MOHLTC Health Analytics 2011 data for community-dwelling seniors shows a total of 135,818 Erie St. Clair seniors aged 65 and older. Erie St Clair has the sixth highest rate of seniors in Ontario. As our senior population grows and care needs become more complex, specialized geriatric services, and elder friendly hospitals will be demanded as a rite of passage from the baby boom generation.

Wellness for Extended Psychosis Analysis

The W-PEP was created in 2003 in advance of the transfer of the long stay, specialized mental health beds from RMHC London to Windsor Regional Hospital. The program was designed to provide treatment for individuals with severe and persistent psychotic illness, primarily schizophrenia. In the last fiscal year the W-PEP served 101 clients, with seven new clients and two discharges. Discharges occurred when the client moved to a new community. The program is managed by 3.3 FTE registered nurses and three psychiatrists.

The 2012/2013 cost per client is $2,024, with a total of 4,496 units of service and a total annual expenditure of $371,000. Benefits and risks associated with divesting the program to community mental health are summarized in Table 6.

Table 6

W-PEP Benefits	Risks Associated with Divestment
Continuity of care. Psychiatrists follow the clients from in patient (acute) to tertiary and in the community. Includes: medication monitoring and support for families.	Psychiatrist and Registered Nurse Case Managers will not transfer with the program if divested. High cost of severance packages as staff are senior level.
W-PEP and SEPP are one of two host programs for the Faculty of Medicine (University of Western/Windsor Campus). Enables research to allow patients to be introduced to new medications under the auspice of regular monitoring by RNs and psychiatrists.	Non-compliance with medications. Many clients may not transfer to community therefore, at risk to themselves and others, e.g. homelessness, incarceration etc. Risk to family/client relationships nurtured by W-PEP staff and psychiatrist through education and peer support.
W-PEP does not have a wait list.	Impact on clients could result in relapse, ED visits, admissions, and caregiver burden/stress.
Strong relationship between W-PEP and Iris House (65 bed Domiciliary Hostel).	Political risk clients, families, staff and psychiatrist complaints.
W-PEP recognized nationally and internationally as a “Gold Standard” best practice program. Presented at Schizophrenia Conferences in Italy, Norway, Argentina, Egypt, Lebanon, and Saudi Arabia.	25% of the W-PEP clients originally referred by CMHA WECB due non-compliance with medication/treatment, high acuity levels, and difficulties formulating client goals.

The Erie St. Clair LHIN engagement with W-PEP clients, families, and psychiatrists identified the following needs:

1. Psycho-social rehabilitation, vocational skill development, and housing needs.
2. W-PEP partnership and affiliation with local housing agencies would benefit from having a specialized outreach team for support.
3. Annualized base funding from the Erie St. Clair LHIN. Sustainable funding would enable the program to reach a greater number of clients and facilitate more groups.

The Erie St. Clair Mental Health Strategic Plan states *“the LHIN should fund the W-PEP program in Windsor and similar programs in Sarnia and Chatham”.* Through the cost, benefit, risk, and options discussion, task force members from Sarnia/Lambton and Chatham-Kent expressed a lack of awareness and understanding of the W-PEP program, and questioned the W-PEP client’s acuity level. Task force members wondered if the W-PEP clients’ clinical needs were in between the ACT/PACT Team clients, but, higher than Intensive Case Management. This hypothesis has significant ramifications for the Erie St. Clair mentally ill population and current treatment modalities. Clinical evaluation of a sample of ACT/PACT/W-PEP and Intensive Case Management clients could provide evidence to demonstrate if there are indeed three different population groups with varying levels of clinical needs, and subsequently if there is merit in expanding the W-PEP to the Sarnia/Lambton and Chatham-Kent community.

Community Crisis Program Analysis

The 2011 Erie St. Clair Mental Health Strategic Plan recommended "*the creation of an equitably funded and geographically distributed mental health crisis service system. The Strategic Plan further recommends that the crisis telephone lines operated by Family Counseling Centre in Sarnia Lambton, CMHA Lambton Kent (Chatham) and Hôtel Dieu Grace Hospital (HDGH) should be consolidated into a single 1-800 crisis line for the Erie St. Clair LHIN to be operated by the Community Mental Health Coordinating Agency".* This section of the report focuses on the crisis services provided by HDGH.

The Community Crisis Service of Windsor-Essex County has been operated by HDGH for the past 14 years. This service and resources are now intertwined with other crisis related programs. To illustrate, HDGH operates a 24/7 crisis line, a mobile crisis team, a police mental health mobile response unit known as COAST and a walk in crisis counseling service. Crisis resources are utilized interchangeably to maximize efficiency, e.g. crisis staff who are not engaged with a caller may be deployed with the mobile crisis team or walk in crisis counseling program. The HDGH CBRO template shows that in 2012/13 fiscal year 4.5 telephone crisis staff responded to 13,242 calls. The cost per client is $33, whereas the annual expenditures are $441,766. Benefits and risk associated with divesting the program are illustrated in Table 7.

Table 7

Crisis Program Benefits	Risk Associated with Divesting
Current structure has procedures in place to manage multiple calls and maximize resources for mobile/walk in services. Unique procedures include keeping the caller on the line while 911 staff is contacted and deployed.	Confusion to clients, families, and providers throughout the city and county. Many providers after-hours voice mail direct clients to the HDGH 24/ crisis telephone services.
Crisis calls are given the option to speak with a Distress Centre volunteer until a crisis staff is available. The Distress Centre in Windsor-Essex receives United Way funding support. Volunteers provide "warm call support".	HDGH crisis telephone services provide after-hours support for two Windsor-Essex ACT Team clients. In Chatham-Kent after hour support is provided by CMHA Lambton Kent (Chatham crisis line).
Continuity for COAST clients who are instructed to call the crisis line after hours for support.	Loss of experienced staff/severance/financial risks with staff bumping rights as per union collective agreements.
HDGH crisis resources participate in case conferences with other providers as it relates to complex clients.	Changes to the program could result in the termination of the Memorandum of Understanding between HDGH and the Windsor Police Services for the COAST Program.
HDGH has formal agreements in place as per crisis after-hour services for: ACT One and Two, CMHA WECB, OPP, Windsor Police Services and Distress Centre.	HDGH Crisis Program long standing relationship with the ED. Changes to the program would fracture this relationship.

There are five telephone crisis services in Erie St. Clair.

1. **HDGH 24/7 crisis telephone services** managed by professional staff (Erie St. Clair LHIN funded).
2. **CMHA Lambton Kent (Chatham office) 24/7 crisis telephone services** managed by professional staff for Sarnia/Lambton and Chatham-Kent residents (Erie St. Clair LHIN funded).
3. **Family Counseling Centre (FCC) 24/7 telephone services** managed by volunteers available for Sarnia/Lambton residents (Erie St. Clair LHIN funded).
4. **Distress Centre of Windsor-Essex 24/7 telephone services** managed by volunteers (United Way funded).
5. **Connex Ontario Mental Health Information and Service Repository** 24/7 telephone information services managed by professional staff (funded by MOHLTC provincial).

The Erie St. Clair Mental Health Task Force members discussed the array of crisis services as they relate to the proposed promising practices. In theory, the promising practices should make an impact on crisis contacts, however, as noted by task force members:

- There is no way of tracking and cross referencing crisis versus warm calls managed by professional staff versus volunteers.
- Crisis calls are received and served by CKHA Psychiatric Assessment Nurses in the ED.
- Crisis calls are not always “in crisis”.
- Crisis services including “safe beds and housing” needs to be coordinated.
- Connex Ontario primary caller population seeks information about mental health and addiction resources. Therefore as it pertains to next day bookings, this population may not be the same population calling crisis lines.
- Crisis calls should maintain linkages to police-mental health teams in the Erie St. Clair LHIN specifically, COAST in Windsor-Essex and HELP in Chatham-Kent.
- Increased public awareness for suicide prevention may increase crisis calls.

In response to this feedback, coupled with the priority need of implementing the Inner City Model, HDGH re-evaluated crisis resources and suggest a re-deployment of crisis functions. See Appendix 5: Inner City Business Case.

Promising Practices Business Cases:

The Erie St. Clair LHIN May 2013 Mental Health Multi-Year Implementation Framework described four promising practices as critical drivers to decrease:

- Emergency Department repeat mental health visits (within 30 days)
- Emergency Department diversion
- Community mental health wait times and crisis volumes
- Suicide attempts

This section of the report provides a high level summary of each promising practice including funding needs and projected client volumes. See Appendix 5: Business Cases.

Inner City Model

The proposed Inner City Model will provide short-term (3-5 weeks) shelter and transitional, wrap-around supports for individuals with mental health and addiction issues residing in the City of Windsor. The targeted population includes males and females who are known repeat users of the ED and frequent low intensity users of police services. As a proxy measure in the first quarter of 2012/2013 HDGH had 1,077 repeat (within 30 days) mental health ED visits this represents 22.4% of the total HDGH ED visits. Similarly, in 2012, Windsor Police on average had 2.8 mental health and addiction contacts per day. Approximately, 19% did not require a visit to the hospital. The average ED wait time for police is two to three hours; however, it is not unusual for waits to extend upward to 10 hours. Using the 2012 police services data the annual cost related to police waiting in the ED is $246,633.

In addition to shelter and transitional support a proposed outreach team is envisioned as a critical arm by providing on-going client follow-up for 18 months at a minimum. The outreach team functions as a “safety net” for a population group with a proven history of being difficult to engage and maintain using traditional mental health and addiction service delivery models.

Inner City service delivery is inclusive of in-kind resources and programs from a number of Erie St. Clair LHIN funded providers. Inner City core partners include, City of Windsor Housing Department, Victorian Order of Nurses (VON), CMHA WECB, Windsor-Essex Community Health Centre, WRH, and Windsor Police Services. In-kind contributions as a redeployment of HDGH crisis resources include three FTEs at a cost range from $255,000 to $300,000. The total in-kind resources from VON, HDGH and CMHA WECB are seven FTE with a cost range from $580,000 to $705,000.

The first phase of the Inner City operations includes 25 beds with a conservative projected client volume of 50 to 75 individuals from November 2013 until March 31, 2013. At start up approximately 15 to 22 clients per month are anticipated to be served. From a cost avoidance perspective, if 50 individuals avoided one ED visit each, approximately $15,750 system savings will occur. If these same 50 individuals avoided one schedule one admission approximately $35,000 to $50,000 in hospital savings would result.

The first year of Inner City is projected to have a per diem of $136 and a total budget request of $1.8 Million. As a comparator, the Windsor Regional Hospital Withdrawal Management Services operates 27 beds, 24/7 with a budget of $1.2 Million. Additional Inner City expenditures are associated with the needed outreach team. During phase two of operations the outreach team will extend supports to W-PEP clients many of whom reside at domiciliary hostels including Iris House.

Windsor Hospitals Transformation

As it pertains to this report, it is vital to acknowledge the future transformational changes to the Windsor-Essex hospital sector. In February 2013, Windsor Regional and Hôtel-Dieu Grace Hospitals' Board of Directors unanimously agreed on a new vision for service delivery. This vision includes:

- A new governance model,
- A single site for acute care,
- A shifting of responsibilities with WRH responsible for all acute care services and HDGH responsible for specialized mental health, addiction services, complex continuing care and rehabilitation.

The driving force behind this significant announcement is the overriding vision of creating a new state-of-the art acute care hospital to better serve the needs of the citizens of Windsor-Essex. Hospital leaders and both Board of Directors believe that in addition to a new acute care facility significant benefits will be realized through this realignment including:

- Optimizing capacity for both sites,
- Improved economies of scale,
- A more consistent and coordinated approach to health care delivery and the consolidation of management for clinical acute care.

While still in the early planning stages the Windsor hospital transformation has the added potential of maximizing the School of Medicine and attracting much needed future physician resources, such as, geriatricians. Ideally, the transformation will lead to a consolidated Department of Psychiatry with one over aching Chief.

Sucide Prevention and Coordination

The Erie St. Clair LHIN May 2013 Mental Health Multi-Year Implementation Framework identified as a phase one need the creation of suicide prevention and awareness strategies. Identified deliverables include:

- Suicide risk screening and assessment tools for hospitals, community and primary care providers.
- Suicide care paths for youths and adults for each county.
- Implementing or aligning existing resources to raise awareness, promotion, and prevention strategies that address stigma associated with suicide.

The Mental Health Task Force members achieved consensus that the above deliverables are a time-limited, project-orientated endeavour. To this end, task force members were invited to submit a business case for one-time funding. Two business cases were received. See Appendix 5: Business Cases.

Rapid Assessment Intervention and Treatment Model

The Chatham-Kent and Sarnia/Lambton providers designed an innovative new model for serving large geographical areas composed of cities, towns, villages and rural pockets. The proposed model aligns in-kind and proposed new mental health resources with existing primary care providers, the ED, and utilizes the Erie St. Clair electronic next day bookings as a resource. The Rapid Assessment Intervention and Treatment (RAIT) model will provide mobile, real-time intervention for the Chatham Health Links, primary care providers and/or patients perceived need for mental health services. The population expands past the traditional seriously mentally ill (SMI) to include individuals with moderate mental health issues.

The RAIT proposal identified that rapid intervention (within 24 hours) will address delays in care and/or perceived barriers in care on the part of clients and families by being physically available on a pro-active basis, therefore, diverting crisis repeat ED mental health visits and or crisis calls. Further, the RAIT links to existing Psychiatric Assessment Nurses (PANs) based at CKHA and BWH ED as a fast tracking mechanism. The projected client volumes (assuming a start time of September 2013) is 3,900 client visits. The two lead agencies are CKHA and CMHA Lambton Kent.

Combined, in-kind provisions include four FTEs (intake and therapists) and a .2 management from each lead agency respectively. The total annualized funding request is $1,572,020, inclusive of administration, mileage expenditures, and psychiatry support.

In addition to the Chatham-Kent and Sarnia/Lambton communities, the RAIT business case proposes to service Leamington and area. Leamington and area by definition includes, the Town of Essex, Kingsville, Wheatley, and Harrow. The 1998 Health Services Restructuring Commission (HSRC) determined that patients from Leamington and area would access mental health services from Windsor-Essex providers. Over the past eight years, Leamington District Memorial Hospital (LDMH) informally aligned their mental health service needs to CKHA. Complicating the situation is the fact that patients do not seek health care based on imaginary boundaries, HSRC directive or even the advice of the nearest hospital. To illustrate, the 2011/12 NACRS data showed that 511 individuals residing in Leamington and area presented at HDGH ED, of which, 108 or 21.1% received HDGH mental health, follow up services. The data showed a very small proportion (<5) of the 511 patients were referred from LDMH ED. Prior discussions with LDMH senior leadership team verified great concern with respect to access for mental health and addiction services either on-site of the hospital or in the community.

There is a significant evidence for the Erie St. Clair LHIN to conduct an investigation into the mental health and addictions needs for the Leamington and area community that represents approximately 50,000 citizens. The Erie St. Clair LHIN engagement will be inclusive of:

- LDMH senior leadership team,
- LDMH ED physicians and telemedicine mental health and addictions nurses,
- HDGH, WRH, CKHA Psychiatrists, Mental Health Directors and ED Directors,
- WE and CK CMHAs, and most importantly,
- Leamington and area mental health and addiction clients and their families.

An updated review of utilization data from LDMH, CKHA and W-E mental health providers is required coupled with engagement activities before any service delivery changes are implemented.

Next Day Bookings Coordination

The Erie St. Clair LHIN is poised to implement a Next Day Electronic Booking model as a provincial pilot. The Next Day Bookings will align individuals with the Erie St. Clair LHIN mental health and addiction providers (known as early adopters), telemedicine mental health and addiction nurses for initial intakes (face-to-face or via OTN) including follow-up support until the client is accepted by a permanent provider. The software to enable this important initiative was a one-time purchase ($20,000) by the Erie St. Clair LHIN at the end of the 2012/13 fiscal year. The software will be leveraged to allow psychiatric assessment nurses based in the ED (CKHA, HDGH, and BWH) to book repeat ED mental health clients into a local providers calendar. The overarching need associated with this business case is a one FTE to act as the air traffic controller. See Appendix 5: next day bookings coordinator business case, flow charts, coordinator role and phases one, two, and three providers, and respective location map. This initiative has implications for enabling better access and integrated care for Erie St. Clair as well as other LHINs who may choose to adopt the model.

Mental Health Housing and Accessibility Needs

The 2011 Mental Health Strategic Plan suggests a number of minority population groups experience access issues with the mental health system. Population groups identified were quite diverse ranging from the physically disabled, intellectually disabled with a mental illness (known as dual diagnosis), individuals who are deaf, deafened or hard of hearing, visible minorities, Francophone and First Nations, new immigrants, refugees, and the lesbian, gay, bisexual, transgendered, and two-spirited population groups. The task force members deliberated and recommended that the Erie St. Clair LHIN establish an Accessibility Mental Health Committee as a phase three initiative.

Similarly, the Mental Health Strategic Plan raised a number of issues associated with mental health and addiction housing resources. The Mental Health Task Force recommended that given the complexity and the need for a broader range of stakeholder representation including housing departments funded through the municipalities, that a Specialized Mental Health and Addictions Housing Committee should be formed by the Erie St. Clair LHIN as a phase two initiative.

Recommendations:

The Mental Health Task Force completed the deliverables outlined by the Erie St. Clair Board of Directors as per the December 2011 Directives. In summary, the following recommendations are provided to the Erie St. Clair LHIN Board of Directors for consideration subject to potential future funding availability. For brevity purposes, the recommendations are presented by key themes:

ACT/PACT Recommendations

Across the province and in Erie St. Clair LHIN, ACT/PACT Programs are operated by both hospitals and community agencies. There is no research or evidence to suggest that one model is better than the other. The 2011 Mental Health Strategic Plan proposed divesting ACT/PACT to a non-existent community mental health coordinating agency (an integrated CMHA). The engagement and CBRO templates provided overwhelming validation that the current ACT/PACT services are high quality, client-centred and efficient by avoiding excessive system cost. With this said, there are opportunities to improve coordination and service capacity by addressing the need for evidence-based, equitable, and standardized access mechanism Erie St. Clair LHIN-wide. As well as implementation of a flexible, client-centred, and well-monitored step up and step down. Recommendations include:

1. The ACT and PACT Teams operated by WRH and BWH remain intact with no changes.
2. Redesign the current ACCESS mechanisms in each county to incorporate the Ontario Common Assessment of Need and the Assertive Community Treatment Transition Readiness Scale along with clinical judgment for each proposed client stepping down or up from ACT to Intensive Case Management. It is noteworthy that the ACCESS mechanisms in each of the three Erie St. Clair communities are different. Therefore, a standardized approach including ensuring an appeals process is in place and communicated broadly to clients, providers, and families.
3. A retrospective analysis of ACT clients who have successfully transitioned to Intensive Case Management services and those who have returned to ACT needs to occur to ensure positive clinical outcomes are replicated and those clients/families are satisfied with services.
4. As one of the five new leadership tables the Erie St. Clair Data, Performance and Quality Group will develop a an Erie St. Clair LHIN-wide mental health scorecard focusing on wait times that includes ACT/PACT and Intensive Case Management. The Erie St. Clair LHIN will design an annual county level ACCESS reporting template including clinical indicators such as, disposition/diagnosis, referral destination; time of referral until time of acceptance, notable trends, and gaps in services. Future funding enhancements for ACT/PACT or Intensive Case Management will be contingent upon evidence of quality care, volumes, acuity levels, client and family satisfaction levels.

Early Intervention First Episode Psychosis Program Recommendations

Individuals experiencing their first psychosis are at the greatest risk for long-term physical, social, legal, and functional consequences if left untreated. The Erie St. Clair LHIN has proactively responded to this population with increased funding and by enacting a zero wait time in provider M-SAA. Given the evidence presented in this report it is recommended:

1. The Erie St. Clair LHIN conducts an in-depth review of Early Intervention Programs operated by CMHA WECB and Windsor Regional Hospital. Alongside of the Windsor-Essex investigation, Early Intervention First Episode Psychosis providers in Chatham-Kent and Sarnia/Lambton will actively participate in discussions and data request made by the Erie St. Clair LHIN. This investigation will commence in the summer of 2013. Recommendations with respect to potential service changes will be formulated in the early fall for the Erie St. Clair LHIN Board of Directors consideration.

Geriatric Mental Health Outreach Teams Recommendations

At this point in time, there is no evidence to suggest that transferring the CKHA and WRH long-standing Geriatric Mental Health Outreach Teams to CMHA Lambton Kent would promote better service quality or system cost savings. Recommendations include:

1. The Geriatric Mental Health Outreach Teams operated by CKHA and WRH remain intact with no changes.
2. Given the changing demographics and complexity of need, Windsor Regional Hospital should be encouraged to continue the development of a Regional Geriatric Program that would act as a tertiary service for the Erie St. Clair senior population.

Wellness for Extended Psychosis Program Recommendations

In the past, the Erie St. Clair LHIN provided one-time funding support for the WRH Wellness for Extended Psychosis Program. Given the longevity of the program, operations, and high volume of clients and families served the recommendations are as follows:

1. The Erie St. Clair LHIN provide annual base funding in the initial amount of $200,000 for the expansion of WRH Wellness for Extended Psychosis Program. This funding will permit the expansion of resources and an increase of clients served. Performance metrics and regular reporting is a requirement of the funding.
2. Under the leadership of the WRH Chief of Psychiatry, a sample of W-PEP clients, ACT/PACT and Intensive Case Management clients from CMHA WECB and CMHA Lambton Kent will be reviewed and assessed with a standardized instrument for the purpose of determining if there are three different population groups with varying levels of clinical need, e.g. sub-acute/ in-between ACT/PACT and Intensive Case Management. Depending upon the results of this research, the Wellness for Extended Psychosis Program may need to be implemented in Chatham-Kent and the Sarnia/Lambton Community.

Crisis Program Recommendations

There are multiple providers, some funded through other sources than the Erie St. Clair LHIN, providing telephone crisis and warm support services. The promising practices are designed to address rapid access to mental health services. Coupled with HDGH efforts to re-deploy and redesign crisis services the following actions are recommended:

1. The Erie St. Clair LHIN Performance Staff and Mental Health Lead, design an evaluation tracking mechanism, measuring the promising practices impact on current telephone crisis/warm service volumes, and wait times. No changes to the current crisis service system should occur until the promising practices have had an opportunity to be operational and evaluated for at least 8 to 12 month time frame.
2. Erie St. Clair LHIN staff will provide the Erie St. Clair LHIN Board of Directors with a statistical impact analysis and further recommendations for potential service changes including if implementing a 1-800 number is required. In addition, prior to the 2015 Tri-County United Way funding wave, the Erie St. Clair LHIN staff will share the statistical impact analysis for the purpose of developing, collaborative, and coordinated mental health strategies to address the telephone crisis needs Erie St. Clair LHIN-wide. This endeavour has the strategic potential for an Erie St. Clair LHIN/Tri-County United Way funding partnership.

Inner City Recommendations

Since the inception of the repeat mental health ED visits (within 30 days) indicator, HDGH consistently has the highest volumes in the Erie St. Clair region. Ample evidence suggests that a unique solution to meet this hard to serve population is required. Recommendations include:

1. The Erie St. Clair LHIN provide annualized base funding in the amount of $1.8 Million to implement the Inner City Model. With a pro-rate start date of November 2013, the funding request this fiscal year is $750,000.

2. Erie St. Clair LHIN Performance Staff and the Mental Health Lead will develop performance metrics associated with the funding as well as provide the Erie St. Clair LHIN Board of Directors with progress reports prior to the end of the 2013/14 fiscal year.

Suicide Prevention and Coordiantion Recommendations

The Erie St. Clair LHIN received two business cases to address the need for suicide prevention, awareness, and clinical tool-kit. While both business cases were comprehensive, one was determined as a better fit as it pertains to budget constraints and alignment with the deliverables cited in the May 2013 Mental Health Multi-Year Implementation Framework document.

1. It is recommended that under the auspice of HDGH, that one-time funding in the amount of $100,000 is allocated to Alive! Canada.
2. Project deliverables and milestones will be developed and monitored by Erie St. Clair LHIN staff.

Next Day Bookings Coordinator Recommendations

1. It is recommended that the Erie St. Clair LHIN Board of Directors support the request for annualized base funding in the amount of $90,000 for a one FTE Next Day Bookings Coordinator.
2. The funding for this important role will be allocated through an Erie St. Clair LHIN-wide Expression of Interest open to all Erie St. Clair LHIN funded mental health and addiction providers.
3. Erie St. Clair LHIN staff will develop performance metrics and tracking tools.

Rapid Assessment Intervention and Treatment Program Recommendations

The Chatham-Kent and Sarnia/Lambton Rapid Assessment Intervention and Treatment (RAIT) promising practice aligns well with Health Links, and the Erie St. Clair LHIN aim of greater access, minimal wait times, and partnerships with primary care. At this point in time, funding as it pertains to the Leamington and area are deemed out-of-scope. The RAIT business case also includes a funding request for personal support workers. Personal support workers while critical to the home care sector; do not provide direct mental health service. The recommendations for the Chatham-Kent and Sarnia/Lambton RAIT Promising Practice are as follows:

1. The Erie St. Clair LHIN Board of Directors approves the annualized funding request of $876,920. Assuming a start date of October 2013 pro-rated funding request is $438,460.
2. Similar to the Inner City Model, Erie St. Clair Performance and Mental Health Lead will develop performance metrics associated with the funding as well as provide the Erie St. Clair LHIN Board of Directors with progress reports prior to the end of the 2013/14 fiscal year.

Psychiatry Lead Recommendation

Throughout the development of the 2013 Mental Health Multi-Year Implementation Framework, it became very clear that in order to address many pressing and often long-standing systemic issues that there is a need for an Erie St. Clair Psychiatrist Lead. This position would be similar to the existing Erie St. Clair ED Physician Lead and Primary Care Lead. It is envisioned that in order to gain significant traction in the creation of shared care practices between psychiatrists and primary care family physicians that the two leads (psychiatrist/primary care) should co-chair a committee of their peers.

As discussed in the May 2013 Mental Health Multi-Year Implementation Framework an Erie St. Clair LHIN-wide Psychiatrist Leadership Table will be implemented. It is a well-known fact that physician tables must be physician-led if sustainable, realistic, and meaningful cultural change is to be achieved. Recommendations include:

1. The Erie St. Clair LHIN Board of Directors supports the establishment of a Psychiatrist Lead.
2. The Psychiatrist Lead selection process will occur by issuing an Erie St. Clair LHIN-wide Expression of Interest. A decision making criterion similar to the documents used for the Primary Care Lead will be utilized. Final recommendations with respect to a successful candidate will be vetted through the Erie St. Clair LHIN Board of Directors.

3. The Erie St. Clair LHIN Board of Directors approves the annualized funding amount of $60,000 to establish an Erie St. Clair LHIN Psychiatrist Lead position.

Mood Disorders

The Erie St. Clair LHIN has the highest rate of individuals admitted with a mood disorder in Ontario. A regional approach designed to address the most complex and persistent mood disorders patients is needed. Recommendations include:

1. Building upon the *draft* Integrated Mood Disorders Model developed by WRH the Psychiatry Leadership Table will review and agree upon a regional approach prior to formally submitting to the Erie St. Clair LHIN.

Department of Psychiatry Concerns

The Departments of Psychiatry in Windsor-Essex and Sarnia/Lambton cited a number of concerns with respect to community based mental health services. To facilitate greater understanding and communication between sectors the following action items are recommended:

1. The Erie St. Clair LHIN staff will facilitate meetings with the Department of Psychiatry and community mental health (CMHA) senior leaders concerns regarding, community mental health clinical competencies, follow-up, medication, and CTO monitoring role will be discussed.

Funding Summary

Table 8: Provides a Snap Shot Summary of the Funding Recommendations.

Program and Provider	Annualized Base Funding	2013 – 2014 Pro-Rated Funding	One Time Funds
Inner City Model-HDGH	$1,800,000	$750,000 (November 2013)	
Rapid Assessment Intervention and Treatment Program - CMHA LK	$876,920	$438,460 (October 2013)	
Suicide Prevention and Coordination – Alive! Canada-HDGH			$100,000
Psychiatrist Lead-Future Expression of Interest	$60,000		
Next Day Bookings Coordinator-Future Expression of Interest	$90,000		
Wellness for Extended Psychosis–WRH	$200,000		
Total	**$3,026,920**	**$1,188,460**	**$100,000**

Next Steps:

Critical Next Steps Include:

1. Restructure the Erie St. Clair LHIN Mental Health and Addiction Network establishing the five leadership tables. Action orientated, tactical terms of references, and work plans will be developed. The leadership tables and restructured Erie St. Clair LHIN Mental Health and Addiction Network will commence in September 2013.
2. Contingent upon the Erie St. Clair LHIN Board of Directors decision, develop and post an Expression of Interest for a Psychiatrist Lead.
3. Contingent upon the Erie St. Clair LHIN Board of Directors decision, develop and post an Expression of Interest for the Next Day Bookings Coordinator.
4. Develop an evaluation framework for the Early Intervention Psychosis Program with a start date of August 2013.
5. In the summer of 2013 implement engagement activities pertaining to the Leamington and area mental health and addiction needs, and geographic utilization of services.
6. The Erie St. Clair LHIN Data, Quality and Performance Leadership will develop a Mental Health Wait Time Scorecard by the fall of 2013.
7. Through the Inter-Hospital and Community Leadership Table create a sub-working group charged with restructuring and standardizing the ACCESS Mechanism including designing an evidence based process for determining ACT/PACT/Intensive Case Management step up and step down care model, including metrics.
8. The Erie St. Clair Performance and Mental Health Lead will develop new metrics for the promising practices designed to measure system and clinical outcome impacts.
9. In the summer of 2013 Erie St. Clair LHIN staff will coordinate meetings with the departments of psychiatry and community mental health agencies to address concerns cited in this report.
10. In the Fall of 2013, initiate an Erie St. Clair LHIN-wide addiction strategic planning process including engagement activities, utilization analysis, trends and service gaps. The Addiction Strategic Plan will be presented to the Erie St. Clair LHIN Board of Directors during the last quarter of 2013/2014 fiscal year.