2012

# Review of Crisis Services and Programs for the 'Common Client' in Times of Crisis:

## Findings and Recommendations

The review focuses on the common client's trajectory via the health care system in times of crisis. The purpose of the review is to identify systemic changes within the Cochrane District that, if implemented, would facilitate and improve the client's treatment journey in times of crisis.

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## Executive Summary

The Cochrane District Human Services Justice Coordination Committee was established in response to a recognized need to coordinate resources and services, and plan more effectively for people with clinical needs who are in, or have the potential to be, in conflict with the law.

In response to this mandate the Cochrane District Human Services Justice Coordination Committee has identified a number of priority activities to be undertaken in the 2011/12 fiscal year. Among this listing of priority activities is the need to:

- Understand and review the common client's trajectory via the crisis system;
- Establish a baseline for crisis utilization to inform the identification of needs and gaps;
- Identify structural and procedural changes that could improve the client's journey within this crisis system; and,
- Make systemic recommendations that could improve the effectiveness and efficiency of the crisis system as it pertains to the common client in times of crisis.

This document details the findings of the review of crisis-related supports for the common client within the Cochrane District and outlines a series of recommendations that collectively would transform the crisis system. The recommendations provide a framework to help guide decisions pertaining to how to realign key crisis services and programs around the needs of the client drawing heavily upon the context and resources in place at the community level.

To inform the review of the common client's trajectory via the crisis system with the goal of identifying systemic changes that could improve the effectiveness and efficiency of the referral process a planning approach was designed and implemented. The comprehensive process included a mapping exercise that allowed information on each crisis support to be gathered in a systematic and consistent manner, and included a series of focus groups across the district with common clients to gather their perception of the crisis system.

A total of 17 recommendations were developed by:

- Analyzing existing services and programs available in times of crisis;
- Consolidating opportunities and barriers/challenges identified in the mapping process;
- Integrating feedback from common clients;
- Grouping issues according to common themes from a systemic (and not programming) perspective; and,
- Discussing preliminary suggestions with key stakeholders and refining the suggestions based on their feedback.

The recommendations are as follows:

1. Establish one crisis line for the entire system; line should be modeled after, and linked to, the regional peer support warm line; facilities that operate 24/7 should be called upon to staff the crisis line on a rotational basis; staffing patterns must ensure that callers have access to attendants who speak French and English, and can provide culturally appropriate supports to Aboriginal people.

2. Establish client friendly crisis centre(s) across the district staffed by a crisis team; build upon existing 24/7 bedded facilities located in Hearst, Smooth Rock Falls, and Timmins or organize around major population centres such as Hearst/Kapuskasing, Iroquois Falls/Cochrane, and Timmins; crisis teams could be located (deployed) in crisis centres instead of in (to) emergency departments; system navigation function could also be integrated within the responsibilities of a crisis centre.
3. Ensure that crisis centres engage (not replace) case managers from various agencies in crisis assessment, planning, and follow-up; establish consistent protocols and processes with other agencies when dealing with client's in crisis.
4. Develop a primary care service delivery model geared to the needs of the common client; improved access and linkages are needed between the crisis system/crisis centres and primary care providers (physicians and nurse practitioners) and specialists; OTN technology and nursing resources should be integrated within a primary care service delivery model.
5. Expand the role of peer volunteers and paid peer support workers within crisis centres/system; enhance the crisis system's capacity by integrating peer support into the care model; ensure that peer support is in place to support clients during 'shut-down' periods.
6. Implement a simplified screening tool to enable non-health service providers (i.e., police, shelters, social services, etc.) the ability to complete an initial screen of individuals in crisis and refer appropriately within the system.
7. Create points of access to information and services that can prevent or stabilize a crisis (pre or post crisis); integrate more mobile outreach capacity to help ensure that basic necessities of life are being addressed as this will prevent the escalation of a crisis; draw upon those with 'lived experience' as part of the crisis response model; direct non-health service providers to crisis centres for information and education.
8. Support the adoption by all health service providers of the GAIN-SS to ensure that all common clients are being assessed using standardized tools (specifically Aboriginal organization and hospitals). Alternatively a protocol for referring to a crisis centre(s) or having mobile crisis assessments completed by a community agency should be put into place if hospitals do not adopt the GAIN-SS.
9. Achieve seamless integration by the crisis system via the adoption of integrated assessment record (IAR) by all addiction and mental health agencies.
10. Enhance system's ability to respond to, and address the needs of, Aboriginal people (whole person not just the illness) by adopting a cultural safety framework.
11. Address the lack of knowledge regarding financial supports among common clients who are in or are seeking out treatment. There is an opportunity to co-locate or integrate social services (i.e., DSSAB) within crisis centres, and/or link with crisis health service providers.

12. Ensure that employers and Employer Assistance Programs are aware of the range of crisis and treatment supports in place. Ensure that employees are aware of their rights to benefits if they seek treatment.
13. Develop and implement a housing strategy to address the acute and chronic housing needs of common clients. Many crisis situations are the result of a lack of safe and adequate housing.
14. Ensure that case managers with responsibilities for securing housing for common clients are working collaboratively to address their housing needs.
15. Make provisions for a district/sub-district transportation service to ensure that the common client has timely access to a centralized crisis centre or to strategically located crisis centres (access to a safe place).
16. Leverage systemic realignment efforts and integration opportunities taking place. Take advantage of the opportunity to redesign crisis resources in a more innovative and client-centered and client-friendly manner drawing upon all available community resources.
17. Establish a unified and simplified marketing or communication strategy that is more client-centered. Focus on issues (or client needs) in addition to the services or programs available. .

The recommendations detailed in this review provide a comprehensive framework that can be used to make significant crisis related systemic improvements for the benefit of the common client. The recommendations were endorsed by the members of the Cochrane District Human Services Justice Coordination Committee in May of 2012.

The recommendations are but a starting point as they will need to be further refined if they are to move from the conceptual stage into an actionable plan that can be implemented. With this goal in mind, it is important for the Cochrane District Human Services Justice Coordination Committee to ensure that key stakeholders who are contemplating or engaged in realignment discussions have access to this report to inform their own parallel and complementary health system initiatives.

As a final note, it is also crucial that the resources required to successfully implement the recommendations not be underestimated. Ideally, the redesign of the crisis system would be implemented using a 'service collaborative approach', which is being used by CAMH across the province. This approach directs very specific resources to a change management initiative, over an 18-month timeframe, greatly increasing the initiative's likelihood of acceptance, support and ultimately success.

## 1.0 Introduction

The Cochrane District Human Services Justice Coordination Committee (CDHSJCC)[1] was established in response to a recognized need to coordinate resources and services, and plan more effectively for people with clinical needs who are in, or have the potential to be, in conflict with the law.

In response to this mandate the CDHSJCC has identified a number of priority activities to be undertaken in the 2011/12 fiscal year. Among this listing of priority activities is the need to:

- Understand and review the common client's trajectory via the crisis system;
- Establish a baseline for crisis utilization to inform the identification of needs and gaps;
- Identify structural and procedural changes that could improve the client's journey within this crisis system; and,
- Make systemic recommendations that could improve the effectiveness and efficiency of the crisis system as it pertains to the common client in times of crisis.

This document details the findings of the review of crisis-related supports for the common client within the Cochrane District and outlines a series of recommendations that collectively would transform the crisis system. The recommendations were endorsed by the CDHSJCC on May 31st, 2012 and provide a framework to help guide decisions pertaining to how to realign key crisis services and programs around the needs of the client drawing heavily upon the context and resources in place at the community level.

The reader is cautioned that while the recommendations are firmly grounded in information gathered from service providers, common clients and key stakeholders, the recommendations are but a starting point, as they will need to be further refined if they are to move from the conceptual stage into an actionable plan that can be implemented.

## 2.0 Backgrounder

In the winter of 2011, the CDHSJCC completed a 'refresh' of its *CDHSJCC Strategic Directional Work Plan (October 2009)*. The CDHSJCC wanted to review the progress made since the creation of the that work plan and determine if the release of recent policy documents and the current operating environment warranted any additions or changes to the priority activities identified.

A series of meetings with the CDHSJCC co-chairs and the co-leads for each strategic direction were organized with the support of a planning consultant. Discussions were focused on any environmental, policy or operational changes at the district or provincial level that would warrant modifications, deletions, or additions to the activities detailed in the 2009 strategic directional work plan.

This review resulted in the creation of a revised document, the *CDHSJCC Strategic Directional Work Plan: Priority Activities for 2011 and 2012*, which was endorsed in the winter of 2011. The work

[1] For a listing of all acronyms used in the document refer to Appendix A.

plan grouped a total of 18 activities to be undertaken over a 2 year period under four strategic directions, namely:

- Communication and engagement;
- Crisis-related services and supports;
- System coordination; and
- Housing framework.

The CDHSJCC then completed a prioritization exercise. As part of this exercise each CDHSJCC member was asked to select two activities that, in their opinion, should be the focus of CDHSJCC efforts in 2011/12. Each member was asked to justify their priority selection. The number of votes received was then used to identify and build consensus for the top priorities for action.

To inform the identification of priority activities each CDHSJCC member was asked to consider the following criteria:

- Quick win – can the activity be successfully undertaken with limited effort?
- What can be done in house what should be done with external help?
- Does this activity inform the work of other priority activities?
- Does the activity address a key link in the diversion pathway?
- Will activity positively impact a high number of common clients?
- Is there sufficient member interest to mobilize resources and undertake the activity?

It is through this priority setting exercise that the CDHSJCC decided to commit significant time and resources on the review of crisis-related services and programs in place to support the common client in times of crisis.

# 3.0 Defining Key Concepts

## 3.1 Who is the 'Common Client'?

For the purpose of this review, and all activities of the CDHSJCC, the common client (CC) is defined as: a*n individual who has a serious mental illness, intellectual disability, concurrent disorder, acquired brain injury, addiction, and/or fetal alcohol spectrum disorder and is (post charge), or has the potential to be (pre charge), in conflict with the law, as well as their significant others.*

## 3.2 What is the Review Catchment Area?

The geographical area for the review was the Cochrane District excluding the James Bay Coastal area. Some CCs from the James Bay Coastal Area were engaged in the review process as focus group participants. Furthermore their perspective was captured in discussions with health service providers (HSPs) who provide client care to all residents of the Cochrane District including CCs living in the more northern parts of the district.

## 3.3 How was 'Crisis' Defined?

For the purpose of the review, a definition of crisis was not provided. CDHSJCC members were asked to self-identify crisis services or programs available within their organization or community that could be accessed by CCs in times of need. This listing of crisis supports was then elaborated upon and refined with the assistance of CDHSJCC members and other key stakeholders.

When speaking with CCs, a similar approach was taken as the term crisis was not firmly defined. Focus group participants were asked to comment on 'crisis services or supports' that they have relied upon in the past, when in crisis. Framed in this manner 'crisis' took on a very different meaning to CCs as it evoked a much broader support network than was identified by service providers.

For the sake of defining the term, Wikipedia defines crisis as: *Any event that is, or is expected to lead to, an unstable and dangerous situation affecting an individual, group, community or whole society. Crises are deemed to be negative changes in the security, economic, political, societal or environmental affairs, especially when they occur abruptly, with little or no warning. More loosely, it is a term meaning 'a testing time' or an 'emergency event'.*

# 4.0 Methodology

## 4.1 The Planning Approach

To inform the review of the CC's trajectory via the crisis system with the goal of identifying systemic changes that could improve the effectiveness and efficiency of the referral process a planning approach was designed and implemented. The process included the following activities:

1. Identify a preliminary listing of crisis-related supports to be 'mapped';
2. Generate a series of standardized questions to gather, in a consistent manner, services/program information;
3. Conduct interviews with managers and front-line staff of each crisis service/program;
4. Generate a series of 'point-in-time' visual maps of each crisis service/program. Each visual map to provide an in-depth overview of:
    - Intake and Access (referral process)
    - Assessment (process and tools)
    - Eligibility Criteria (and non-eligibility criteria)
    - Wait Times
    - Discharge Practices
    - Collaborations and Partnerships
    - Opportunities, and Barriers/Challenges
5. Review and validate the information contained on the service/program crisis maps;

6. Analyze the crisis service/program mapping data and the information on barriers and opportunities to identify common themes and inform the development of a crisis framework;
7. Host a series of focus groups across the district with CCs to gather their perception of the crisis system targeting CCs who are Anglophones, Francophones, Aboriginals, and those who are incarcerated;
8. Analyze the focus group data and cross reference the information with service provider data (themes identified);
9. Generate preliminary recommendations on how to reconfigure a crisis response model that meets the needs of CCs living within the Cochrane District;
10. Discuss preliminary findings with key stakeholders who have a stake in the reforms or who rely on the crisis system;
11. Present the report and recommendations to the CDHSJCC for feedback and approval; and,
12. Work with the CDHSJCC to determine how to move forward with the implementation of the recommendations endorsed.

## 4.2 Process Related Limitations

There are a number of process-related limitations associated with the implementation of the planning process. They include the following:

- To contain the scope of the initiative it was deemed necessary to separate health related crisis services from justice related crisis services. The latter will be the focus of a subsequent review and mapping exercise. Consequently, the reader must keep in mind that the review is narrowly focused on health related crisis supports most of which are funded by the North East Local Health Integration Network;
- Information gathered was reflective of the perspective of individuals who participated (staff and CCs) and some comments may need to be validated for accuracy and/or quantified when assessing the level of need;
- Focus group participants were primarily individuals with a concurrent disorder. Focus groups did not include representation from individuals with an intellectual disability, acquired brain injury, and/or fetal alcohol spectrum disorder;
- Focus groups were organized and participants were recruited by addiction service providers. Consequently there was an overrepresentation of common clients whose primary presenting issue was addiction-related. While many participants had a concurrent disorder (self-identified during the discussion), discussions of crisis were often focused on an addiction issue which in turn brought on the crisis; and,

- CCs who participated in the focus groups were either in the system or had successfully completed treatment. They were considered 'stable' or not currently in crisis and consequently were very focused on the next steps along their healing journey.

# 5.0 Understanding the Current 'Crisis' System

## 5.1 Crisis Mapping Exercise

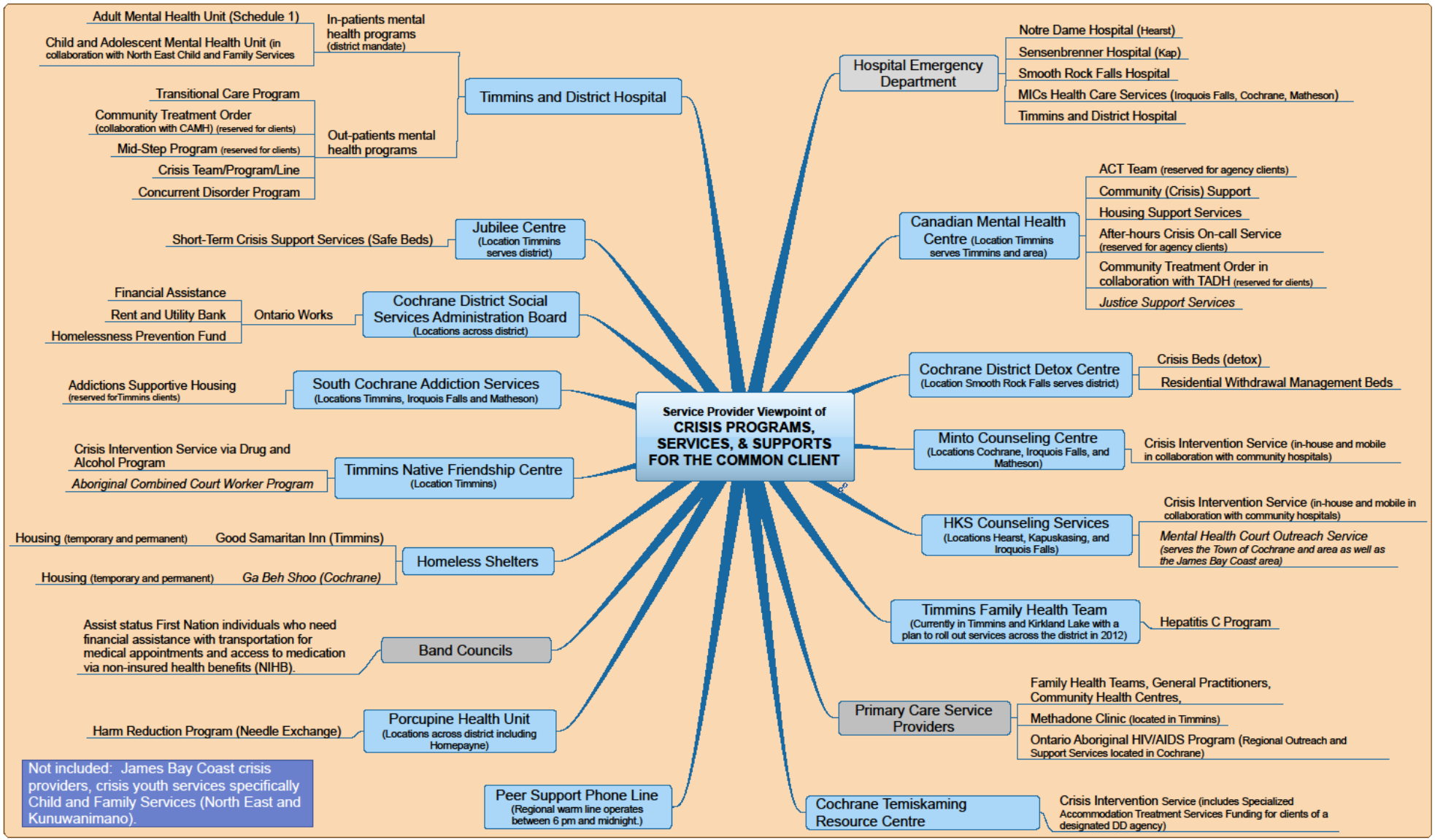
Over the course of a 9-month period an extensive mapping exercise, of crisis related services and programs, was undertaken. The process was very comprehensive and allowed for the gathering of in-depth information to inform the CDHSJCC's understanding of the crisis system in place for the CC. The process resulted in the creation of an extensive inventory or series of visual maps of each crisis service and program available within the Cochrane District.

The mapping exercise also provided a unique opportunity to gather information on systemic opportunities and barriers as perceived by each service or program. This information was then collated and themed, along with the data from the focus groups, and used to generate a series of preliminary recommendations that were discussed and refined with the CDHSJCC members.

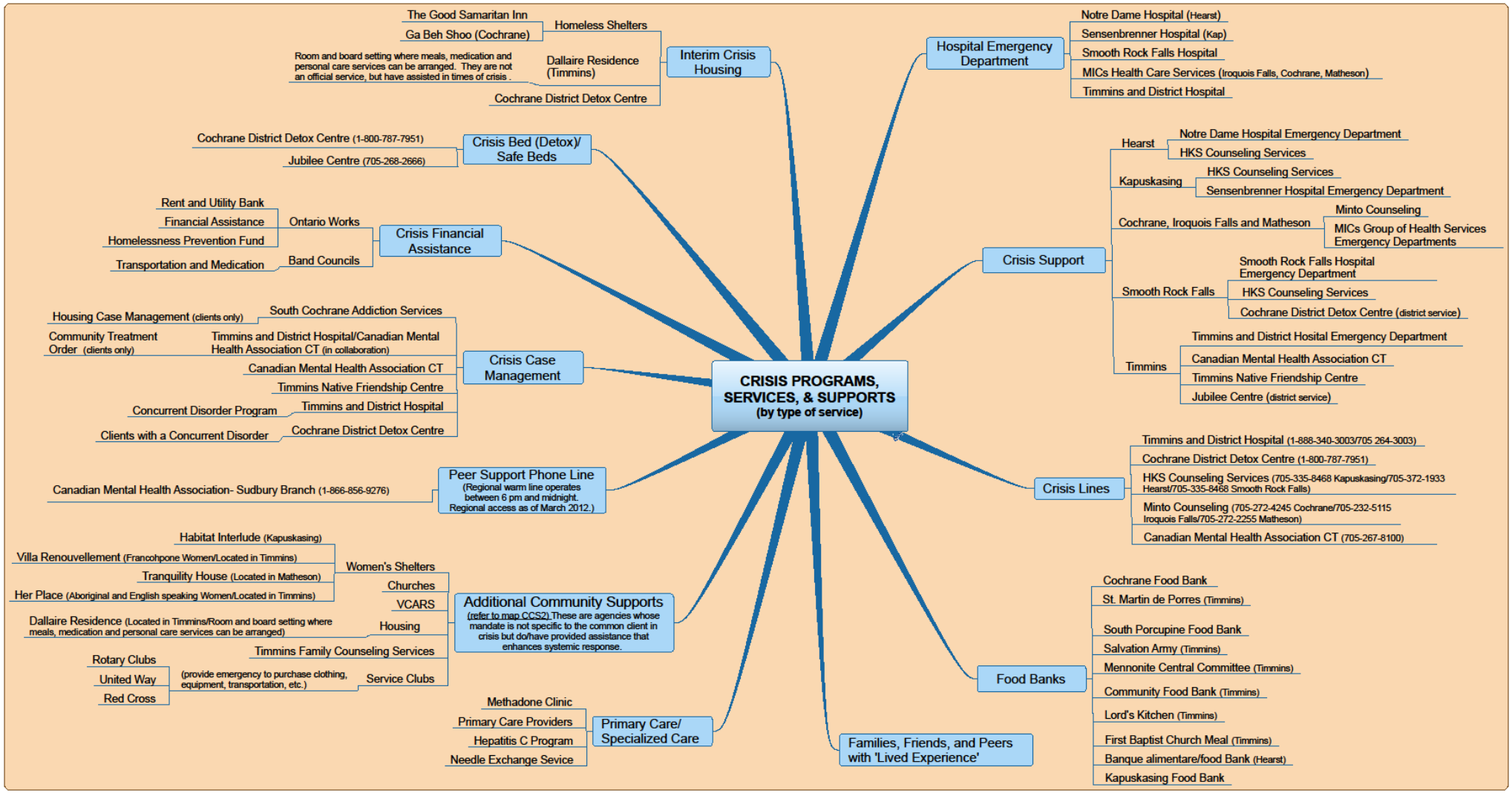
Figure 1 provides an overview of crisis services and programs included in the crisis mapping exercise. It provides an overview of the crisis system from an organizational or service provider viewpoint.

Figure 2 is an attempt to shift the focus from an organizational perspective or service provider perspective to the types of crisis supports in place. It was expected that this visual map would be used to inform the focus group discussion with CCs. However the map was quickly put aside, when focus group participants revealed a very different perception of the crisis system available to them in times of need.

**Figure 1: Overview of Crisis Supports for the Common Client in the Cochrane District, by Health Service Provider**



## Figure 2: Overview of Crisis Supports for the Common Client in the Cochrane District, by Service Type



## 5.2 Focus Groups

A series of focus groups were organized across the district with the assistance of addiction agencies. These agencies reached out to CCs whom they knew and encouraged them to participate in the focus group sessions. Individuals targeted were required to meet the definition of a CC and have experience using 2 or more crisis supports within the Cochrane District.

A total of 31 CCs participated in the five (5) focus group sessions and shared their experience as they moved through the crisis system. Table 1 provides an overview of where the focus groups were held, the number of participants and targeted population groups. Table 2 summarizes the age range of all focus group participants. It is worthy of mention that (self-identifying) Aboriginals made up 35% of all focus group participants, and that an unsuccessful attempt was made to host a female only focus group at Monteith Correctional Complex (MCC).

**Table 1: Focus Group Locations, Target Groups and Participation**

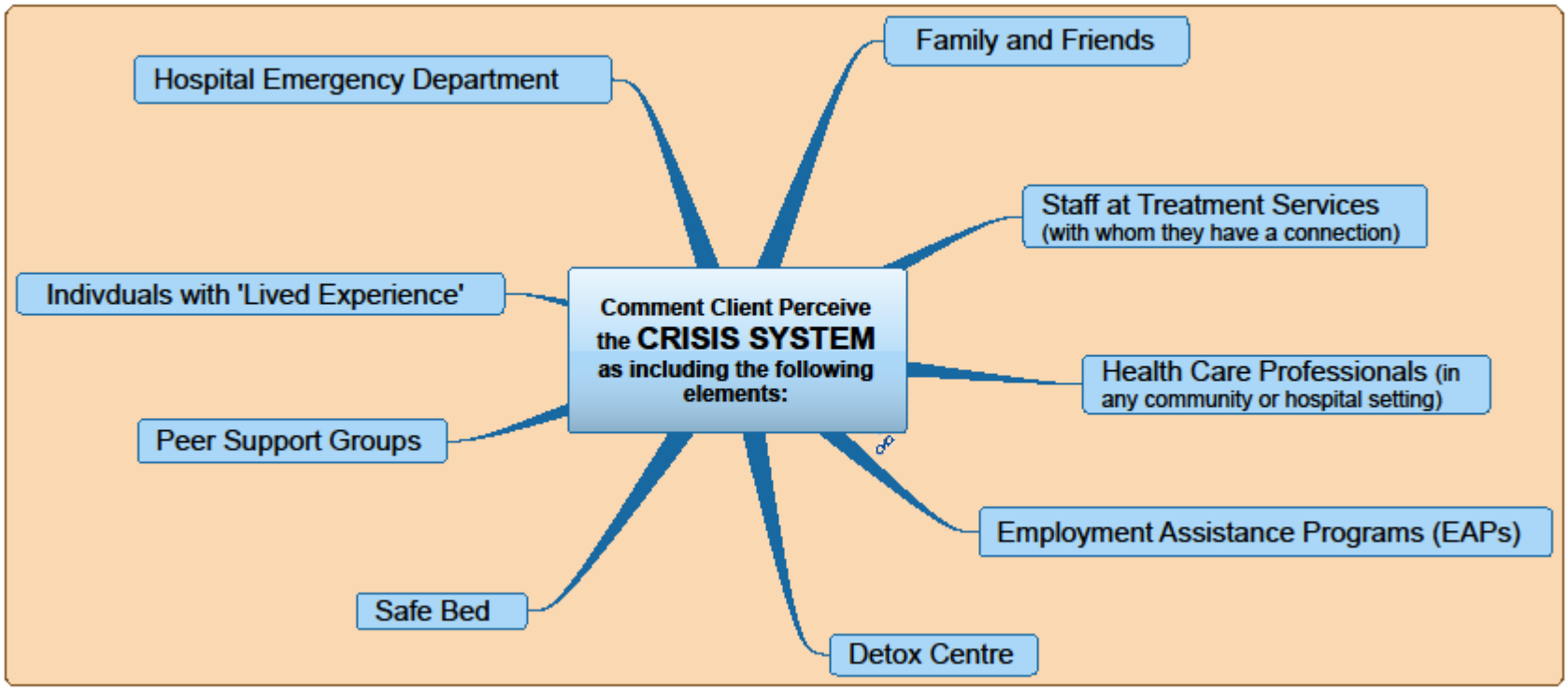
| Community | Target Group | # of Participants | # of Females | # of Males |
|---|---|---|---|---|
| Hearst | Francophones | 7 | 2 | 5 |
| Smooth Rock Falls | Open (English Session) | 6 | 1 | 5 |
| Timmins | Open (English Session) | 5 | 1 | 4 |
| Monteith | Aboriginals | 7 | 0 | 0 |
| Monteith | Open (English Session) | | | |
| | TOTALS | 31 | 4 | 27 |

**Table 2: Age Range of Focus Group Participants**

| Age Range | # of Participants |
|---|---|
| 18 to 29 | 6 |
| 30 to 39 | 11 |
| 40 to 49 | 3 |
| 50 to 59 | 10 |
| 60 + | 1 |
| **TOTAL** | **31** |

As previously mentioned, focus group participants revealed a very different perception of the crisis system available to them in times of need. Figure 3 is a visual representation of the CCs perspective of the crisis system and it differs significantly from figures 1 or 2. It should also be noted that CC's view of the crisis system differs greatly based on whether they are new to the system, and whether they have experience with the system.

**Figure 3: Overview of Crisis Supports in the Cochrane District, According to the Common Client's Viewpoint**



## 5.3 Key Learnings and Observations

The review process, including both the crisis mapping exercise and the focus group sessions, revealed a number of 'key learnings' and interesting observations which worth noting before moving into the next section which discusses the recommendations. It should be noted that these key points were used to inform the development of the recommendations.

- What constitutes the crisis system differs greatly from a HSP perspective and from a CC perspective, as do points of entry into the system;
- HSPs define 'crisis' and 'crisis services and programs' more narrowly than the individual who relies on the crisis system; from a CC's viewpoint the definition of 'crisis' is having no transportation, no money to live, no rent, and no food;
- Entry or access into the system is complex; an individual's knowledge of the crisis system is acquired over a number of years; some individuals base their knowledge of the system on crisis offerings in other communities; some learn about crisis services from other addicts; some learn about the system through friends with 'lived experience'; some have family members who have researched options and provided suggestions; and others have been directed by a service provider (health or otherwise);
- Many CCs enter the system while accessing health care for a different issue (i.e., accident or illness); they are engaged in the health care system yet are not actively seeking out services;
- Crisis system resources and capacity is greatly enhanced by the activities of non-crisis services (i.e., police, health care professionals, probation and parole, court-related services, social services, shelters, etc.);
- All health professionals that come into contact with a CC play an important role in helping these individual access and navigate the crisis system;
- Individuals are being treated for their presenting issue but they need to be treated for more than their addiction; system is not addressing underlying issues which contribute to (or enhance) the addiction (i.e., anxiety, depression, bullying, marital breakdown, housing, unemployment etc.);
- Individuals who are new to the crisis system are lost; they do not know where to go as they do not understand the depth of their personal issues much less what type of service they require; they don't know the difference between a detox and a residential treatment program, nor do they care; they feel that it is the system that needs to assess and direct them appropriately;
- Once an individual has experience in the crisis system, they gain a lot of knowledge about where to go and who to call; their experience in the system is described very positively; and,
- One stop shop is needed to eliminate the need to move among services; this movement among agencies, with different peer groups is very difficult to navigate; model of care could also be a brokerage model which offers the whole range of services or just some of the

needed service; either way the important element is that CCs have a safe place to go to get their treatment journey started.

For additional information on the perceived systemic gaps and barriers to treatment from the perspective of the CC please refer to Appendix B.

# 6.0 Setting the Stage for a More Responsive Crisis System

## 6.1 Findings and Recommendations

The following 17 recommendations have emerged from the analysis of the information gathered from both the HSPs during the crisis mapping exercise and from the CCs during the focus group sessions. The recommendations are an important starting point for the work that needs to occur as the crisis system considers how to ensure that it is more client-centered and responsive to the needs of CCs in times of crisis.

Each recommendation is followed by a series of related bullet points that provide context for the recommendation. Context that has been taken directly from the discussions held with HSPs and CCs. They are provided as a means of supplementing the discussion regarding the recommendation.

**Recommendation: Establish one crisis line for the entire system; should be modeled after, and linked to, the regional peer support warm line; facilities that operate 24/7 should be called upon to staff the crisis line on a rotational basis; staffing patterns must ensure that callers have access to attendants who speak French and English, and can provide culturally appropriate supports to Aboriginal people.**

- The crisis line at Timmins and District Hospital (TADH) is a key feature of the crisis system and was designed to support a multi-agency systemic response; citing the unreliability of the call service, due to staff carrying other responsibilities, the number of referrals to the crisis service has decreased; service was to contact agencies affiliated with the client in crisis to ensure active follow-up yet this is not occurring consistently.
- Crisis line located at TADH was conceived as a means of enhancing the system's (and physicians') capacity to respond to presenting mental health crises; there is a need to reevaluate how the service is being provided and ensure that it meets the needs of clients.
- Many crisis calls are not being directed to the crisis line(s); calls are being made to the agency with which the client has developed a relationship; clients rely on staff who know them and who know their unique circumstances.
- Some clients noted that crisis lines/warm lines were utilized by their children; they note that when in crisis they are more likely to turn to a family member or friend.

- Clients were not aware of the district crisis lines; crisis lines were not seen as a useful resource in times of need; they were considered too impersonal; individuals were much more likely to turn to a peer who has 'been there' in times of crisis.
- Most well-known phone service was Telehealth; no focus group participants had heard of CONNEX, 211, or DART; a few individuals shared that they would use the internet when seeking out services; one individual was aware of the 1-800 # at TADH and had used it successfully; a few clients were aware that the detox had a 1-800 #.
- Minto Counselling advises clients who call in after-hours to contact Telehealth or present to the emergency department (ED) if in crisis; Telehealth did not have Minto in their database originally and it is suggested that all crisis services ensure that they are included in this provincial database to facilitate district referrals.
- Encouraging the use of a phone service or on-line service was not seen as a reasonable approach by some focus group participants, as many individuals do not have access to a phone much less the internet in times of crisis; need to ensure that the 211 service can be accessed via a pay phone for free.
- Clients were unclear at this early stage of the benefits of the peer support or 'warm line' recently put into place; clients were very receptive to the peer support/warm line concept and liked the idea of having someone who had 'been there to talk to and listen'.
- The need for a crisis line geared to Aboriginal people (based on a cultural safety model) was noted; children in the James Bay Area rarely use district crisis lines, they rely on telephone numbers found on cereal boxes (which were considered to be very helpful).

**Recommendation: Establish client-friendly crisis centres across the district staffed by crisis teams; build upon existing 24/7 bedded facilities located in Hearst, Smooth Rock Falls, and Timmins or organize around major population centres such as Hearst/Kapuskasing, Iroquois Falls/Cochrane, and Timmins; crisis team could be located (deployed) in crisis centres instead of in (to) emergency departments; system navigation function could also be integrated within the responsibilities of a crisis centre.**

Crisis Team/Centre

- Most individuals (at TADH) are triaged in the ED before being directed to the crisis team; there are instances where the individual can be referred directly to the crisis team thereby avoiding an ED visit.
- TADH strives to provide a private and secure area in the ED for individuals presenting with a mental health crisis if they need to wait before being seen by the ED physician and/or crisis team; this is not always possible due to the hospital's physical space limitations, which accentuates privacy concerns.

- Crisis services need to be expanded and include transitional brief solution focused services geared to working with people despite the level of 'readiness' for treatment.
- Client (from out of town) was released from jail in the middle of the night with nowhere to go in an unfamiliar community; a crisis center in Timmins, like those available in other communities, would have been helpful and reduced distress.
- Client resided in a homeless shelter and was asked to leave due to consumption of banned substances; shelter directed the individual to the local hospital, lacking any other local options.

<u>Active Outreach, Follow-Up, Discharge Planning (System Navigation), System Education</u>

- Delays in being seen by the crisis team (at TADH) of even a few hours may result in the individual leaving the hospital while still in crisis; if the client leaves after having been triaged it may be possible to do active outreach with those who are suicidal or homicidal.
- More active community follow-up post crisis is needed as there is no way of ensuring that the individual is accessing needed services; on-site follow-up visits at TADH with clients who presented in crisis can and do occur; this service could be more widely offered to ensure that individuals who are struggling but have a long wait for services have access to supports.
- There is a need for more involvement of community-based agencies (i.e., schools, cultural services, etc.) that can support youth in crisis upon discharge; their involvement would ensure better follow-up and result in a 'wrapping' of services around the youth post crisis; implementing this approach is challenged by the fact that TADH's in-patient unit is a short stay program, which makes it difficult to gather community and supportive services quickly prior to discharge; community involvement would however help with the discharge planning process, enhance the system's knowledge of services and supports available in the various district communities, and ensure that youth are better connected to local community services.
- Client reported being cleared medically by the hospital and being released despite the fact that health care worker knew that he had an addiction and was in need of help; CC then called the detox and was told to keep calling back until a bed became available; no one followed up with this individual during this difficult time; once a bed became available the detox paid for the bus ticket to the centre; client noted that this was their first time seeking help for an addiction.
- Client shared that when released from custody (jail) found himself with no ID and homeless; system should have provided a thorough discharge plan, where all services were set up prior to discharge from custody.
- Client appreciated the fact that a social worker at MCC helped him make arrangements as part of his program plan/release plan; client was concerned about the 1 week gap between his release from custody and the start of residential treatment; client believes that he would have benefited from a halfway house program or a shelter during that week; client was informed about the safe beds at Jubilee and also knew about the detox.

- Wait times for services are a problem; a person's courage to seek treatment is fleeting and if services and supports are not easy to access and timely then the individual will likely abandon the idea of seeking treatment; individuals that want to enter treatment need supports until they are treatment ready and can enter a treatment program.
- System places too much responsibility on the individual who is in need; onus is on the individual to make calls and organize their own trajectory through the system in times of crisis; need more professional support to direct clients to needed services; more 'hand holding'.
- Review of program and process for admission to Schedule 1 with district hospitals and police services would be beneficial; a review of how a patient on a Form 1 is transferred between hospitals is also needed; a contingency plan is also needed if the Schedule 1 facility is not accepting patients.

Safe Environment

- Client was challenged to find a safe environment where they could receive medical/clinical care; individual is connected to many of the crisis services identified (i.e., Hep C team, needle exchange program) yet continues to struggle and needs support along their journey.
- Issue of 'safe' transfers and safe places to stay while waiting for treatment services is one of the biggest concerns facing clients; for them the ideal set up would be a 'hub' were they show up and despite the type of service needed or wait time for treatment the system helps them 'then and there'.
- Police recognize the need for a safe place and have allowed some individuals to stay in their lobby when there are no other options in the community.
- Having no family support upon release from custody makes it difficult to 'stay clean'; many individuals cited the detox as the only viable option; the detox provides temporary shelter, facilitates access to an assessment and helps with referrals to treatment programs.
- Detox personnel is helpful, very friendly, offers counseling 1 on 1; offers an anger management program; helps to guide clients from point A to point B; prepares lunches for clients to ensure that they have food while traveling to treatment; detox wraps supports around the client and facilitates the transition from jail to detox to treatment.

**Recommendation: Ensure that crisis centres engage (not replace) case managers from various agencies in crisis assessment, planning, and follow-up; establish consistent protocols and processes with other agencies when dealing with client's in crisis.**

- District hospitals and mental health providers have a protocol in place for mobile crisis mental health outreach at community hospitals upon request; in Timmins clients who present to TADH and are affiliated with Canadian Mental Health Association (CMHA) are asked if their worker should be paged; it has been suggested that a protocol should be in

place to ensure that the client's worker is called in and involved in the (TADH) crisis team's assessment and planning (as done for youth).

- Mobile crisis outreach is provided at the ED and can be provided to local shelters, area reserves, among others sites upon request (within Minto's catchment area); it is estimated that almost 3/4 of crisis cases who present to the ED are clients of the agency, and of the remaining 1/4 served 15% become clients of the agency.
- TADH protocol with Child and Family Services specifies that youth in crisis should be jointly assessed; there are times when it is impractical to wait for the worker to attend the hospital and consequently it is completed by the hospital only.
- Establishment of a protocol with police services, shelters, and district hospitals to facilitate and streamline access to detox/safe beds would be beneficial to the system.
- Hearst has a mobile assessment service – Northern Corridor Assessment & Resource Service – that is called upon when needed to do on-site assessments.

**Recommendation: Develop a primary care service delivery model geared to the needs of the common client; improved access and linkages are needed between the crisis system/crisis centres and primary care providers (physicians and nurse practitioners) and specialists; OTN technology and nursing resources should be integrated within a primary care service delivery model.**

Medical Clearance Prior to Treatment

- Individuals with a mental health problem who are 'off their meds' must be cleared medically before being admitted to a safe bed/residential treatment; since many clients are transients and do not have a primary care provider, the system must rely on the ED for primary care.

Continuity of Primary Care

- When in need of medical care, clients who do not have access to a physician rely on the ED; personnel at the hospital (Hearst) treat First Nation people very well and fairly.
- Access to, and continuity of, primary care in Kapuskasing (particularly) is a challenge; Sensenbrenner Hospital operates a regional clinic where orphaned clients were previously referred but the clinic is no longer accepting referrals given its significant caseload.
- Primary care services are lacking; some rely on walk-in-clinics; some individuals rely on the health unit to access information on where to go for help.
- Addiction caused by a need for pain relief; physicians are not helping individuals manage their pain and avoid becoming 'addicted'.
- Community Treatment Orders (CTOs) could be more widely used throughout the district; criteria are restrictive and limit eligibility; engagement of a local physician to monitor compliance is a challenge for communities with limited access to primary care physicians.

- TADH's Mid-Step Program will accept patients who are without a primary care provider if they are patients of the program's psychiatrists.
- The wait time before being seen by a doctor at MCC can be lengthy. Also it is difficult to access medication at the MCC.
- CCs commented that public health or primary care providers need to let them know of the outcomes of tests; even if all is good; the 'if you don't hear from us all is good' approach is very stressful.
- Hepatitis C Team (Timmins FHT) should be contacted to explore the potential for providing on-site outreach services in various locations.

Access to Specialists

- Timely access to forensic assessments is a challenge within the Northeast. Clients can wait up to a month at MCC before a bed can be secured at North Bay Regional Health Centre.
- Access to psychiatrists who specialize in concurrent disorders is an ongoing challenge.
- TADH Mental Health Programs – individual can wait up to 6 month before they can be seen by a therapist/counselor; there is a 6 to 8 month wait for an English speaking psychiatrist; 1 to 2 month wait for a French speaking psychiatrist (locums from Ottawa); and up to 1 year wait to obtain a psychometric assessment.
- Access to a psychiatrist in Timmins is challenging as an individual may be on a wait list for 9 to 12 months before being seen.

Expand Access to Primary Care and Specialist via OTN

- Video conferencing should be used more for initial screens and assessments; need to identify OTN resources and capacity within the crisis system; increased usage of OTN would address issues relating to the lack of travel grants.
- The system should take a more client-focused approach and work as a system using OTN resources to reduce excessive wait times for assessments within the district.
- More Aboriginals are seeking services from 'mainstream' health service providers; some HSPs have used OTN to respond to requests for assessment and treatment services from the James Bay Coastal Area.

System Capacity

- Individuals can be referred to Transitional Care Program at TADH while they wait to be seen by a therapist/counselor (which can take up to 6 months).
- District hospitals, community agencies, families, clients and other community providers need more education and information regarding CTOs; CTOs are underused by HSPs in the district; CTOs benefit clients by providing them with access to case management services which may help avert future crises.

**Recommendation: Expand the role of peer volunteers and paid peer support workers within crisis centres/system; enhance the crisis system's capacity by integrating peer support into the care model; ensure that peer support is in place to support clients during 'shut-down' periods.**

- AA/NA groups are not well attended in some areas, yet peer support is crucial; AA/NA meetings need to be in a consistent location and regularly scheduled; ideally meetings should be held at an addiction agency as individuals are comfortable going to these locations.
- Detox has moved from having AA/NA meetings from 1x/week to 4x/week which has been very helpful; once per week is just not enough support; suggested that meetings not be chaired by a peer as there is not enough structure and consistency; ideally a paid worker should chair meetings.
- AA/NA meetings are not offered 10 weeks per year (treatment facility shut-down period) which is very hard on those who need continuous support.
- Peer support has been extremely beneficial; need individuals with 'lived experience' working in the system.
- Need more mobile outreach by either staff or volunteers; clients need someone telling them 'to hang-on that dark days will pass'; clients feel very isolated; system should not expect that clients will reach out for services; many clients need someone to come to them to see if they are OK; some clients will never reach out for help 'they will shut out the world as they don't want to be judged by others'; clients need someone to help them understand that there is hope, remind them that they need to get help.
- Client commented that the Public Health Unit makes calls for those on the smoking cessation program but no one calls an individual who is struggling with an addiction when they are awaiting access to treatment.

**Recommendation: Implement a simplified screening tool to enable non-HSPs (i.e., police, shelters, social services, etc.) the ability to complete an initial screen of individuals in crisis and refer appropriately within the system.**

- There is an opportunity for cross training police officers and staff of the addiction/mental health agencies; objective is to expand the community's understanding of crises and help them direct clients in times of crisis; enhanced knowledge and experience will open the door to direct referrals to services by non-clinical providers using a simplified screening tool.
- About 40 individuals are screened annually by Jubilee Centre but don't present to treatment for a variety of reasons (i.e., passive referrals, no safe-bed vacancy, and facility shut-down due to operational deficit); more outreach and active referrals are needed.

- Once the (Jubilee Centre) residential program workers have received further training, gained experience with the screening process and are comfortable with the demands of clients who occupy the safe beds, they will complete the screen in-house after hours and on weekends (currently being done by the crisis team at TADH).

**Recommendation: Create points of access to information and services that can prevent or stabilize a crisis (pre or post crisis); integrate more mobile outreach capacity to help ensure that basic necessities of life are being addressed as this will prevent the escalation of a crisis; draw upon those with 'lived experience' as part of the crisis response model; direct non-HSPs to crisis centres for information and education.**

First Step Program/One Stop Centre

- Access to information on community resources is a challenge for homeless shelters (i.e., safe beds, employment opportunities, affordable housing options, etc.).
- Need a central point of contact for individuals who are looking for work but who may not know who to contact; employment resources need to have a 'live' person on line to assist individuals who are not comfortable with the automated attendant; noted that 211 Ontario North (with live attendants) will be a benefit to residents.
- Suggested the need to create a one stop service where a counselor could help individuals address their immediate needs, be readily accessible, offer follow-up support as needed.
- Indicated the need for one stop organization in the Cochrane District that could address all the basic necessities like shelter, clothing, money, counselors, outreach workers, court, and bail; CCs referred to the Elizabeth Fry Centre in Sudbury as a potential model.
- CCs noted that there is a program called the "first step program" in Sudbury which is open to anyone in the justice system; this program gets the ball rolling in regards to counseling; program helps clients access a psychiatrist and any needed services, before and after being in custody.

Friendship Centres/Aboriginal First Step Program

- Wrap around model of care in place at Timmins Native Friendship Centre (TNFC), as all workers have case management functions; the needs of the client determine programming, as opposed to fitting clients with individualistic needs into an existing program's mandate.
- TNFC works closely with Timmins Police Services to empower clients struggling with addictions by helping them move forward, further their education, obtain work, and improve their quality of life; the initiative provides Aboriginals with information and tools that help them live healthier and successful lives and serves as a point of connection.
- Native Friendship Centre accessed in Hamilton had been helpful; within a 3-month period they helped individual find a furnished home, and funding to purchase a fridge, stove and other basic necessities.

- Native Friendship Centre helped find individual a job; were very efficient; type of service is lacking in areas such as Hearst, and in the far northern parts of the Cochrane District (i.e., Peawanuck, Moosonee, and Moose Factory); client indicated that there is a lack of training for people caring for First Nations off reserve.
- Band Office also helps access transportation, shelter, personal items and other necessities.

HSP Outreach/Setting the Stage for Treatment

- Hepatitis C Team (Timmins FHT) should be contacted to explore the potential of providing on-site outreach services (i.e., detox).
- Mobile outreach could be provided by CMHA to local shelters and other housing units, upon request, as a means of reducing the likelihood that a situation escalates into a crisis.
- On-site assessment at homeless shelters for residents with an addiction or mental health issue would be welcomed.
- Individual would benefit from outreach services once they are in treatment or in the detox (i.e., financial support or housing support); cannot do this on own; need support and structure.
- Many referrals to treatment programs are premature; system needs to spend more time helping clients get ready for treatment.
- While some judges force individuals into treatment before they are ready; this is seen as a win-win situation; clients learn about treatment whether they are ready or not and they are kept out of the judicial system which is not where they should be in the first place.

Community Policing

- More pro-active community-based outreach is needed to support community policing in the district; development of a protocol and approach like the one in place with Timmins Policy Services, CMHA and South Cochrane Addiction Services (SCAS) would facilitate the sharing of information and provision of outreach support for individuals who have a mental health issue who come into contact with police.
- Further sharing of information about detox services and supports could be provided to police services, physicians, and the justice system; also, detox should be monitoring trends to determine if more sharing of information with remote mining companies is warranted.
- (Some) police officers do not bother with Aboriginals they call the Nishnawbe-Aski Police Service (NAPS) when help is needed; Aboriginals feel comfortable calling upon NAPS when in crisis; they are very kind and supportive; NAPS also follows up the next day to see how everybody is doing.
- Individual had been in police custody previously due to public intoxication but was never referred or advised that detox was an option available to them.

- Police was not helpful during stay in jail; advised that the individual could make arrangements to attend a detox once released from jail (on their own time); wanted to be admitted to a detox; felt that they were being discriminated against.
- It was noted that while in jail if a person had done a crime they would have the right to call their lawyer but for intoxication individual does not have the right to call a detox centre.
- If sentencing was longer then individuals incarcerated would be able to access needed programs while in custody.

Policing Issues

- 'Oxis' are taking over Timmins; access to drugs is easier and easier.
- Mining communities are being 'pried on' by drug dealers; access to drugs increases where there is a lot of disposable income; need to engage mining companies in the process of helping clients.

**Recommendation: Support the adoption by all HSPs of the GAIN-SS to ensure that all CCs are being assessed using standardized tools (specifically Aboriginal organization and hospitals); alternatively a protocol for referring to a crisis centre or having a mobile crisis assessment completed by a community agency should be put into place if hospitals do not adopt the GAIN-SS.**

- All addictions and mental health service providers are using the GAIN-SS; implementation of the GAIN-SS tool in community hospitals would help with the triage and referral of common clients; GAIN-SS is being considered by TADH but has not been implemented.
- Detox and North Cochrane Addiction Service (NCAS) staff works collaboratively to administer the GAIN-SS; not all staff of the detox has been trained to administer the GAIN-SS due in part to budgetary constraints; annual operational budget shortfall is an ongoing challenge.
- (TNFC) Drug and Alcohol Worker has been trained to administer ADAT with adult clients; GAIN-SS training is complete; tools are being implemented; GAIN-SS has been reviewed by Aboriginal agency and takes into consideration cultural need.

**Recommendation: Achieve seamless integration by the crisis system via the adoption of an Integrated Assessment Record by all addiction and mental health agencies.**

- Regional implementation of Integrated Assessment Record (IAR) is targeted for November 30th, 2011; IAR is an application that allows assessment information to be accessed by various health service providers who have signed a data sharing agreement; IAR will allow health service providers to view client assessment information completed by various HSPs electronically, securely and accurately.

**Recommendation: Enhance system's ability to respond to, and address the needs of, Aboriginal people (whole person not just the illness) by adopting a cultural safety framework.**

Historical Context and Education

- (TNFC) Drug and Alcohol Worker provides education and information services to schools, community groups, other Friendship Centres, and mainstream health service providers; goal is to enhance cultural awareness by educating the community about the impacts of historical traumas and ultimately provide cultural safety (and advocacy) for Aboriginals.
- Community and health service providers are not sufficiently aware of the Aboriginal historical context and how the past impedes the effectiveness of mainstream treatment approaches; the system needs to move beyond cultural awareness and adopt a cultural safety framework; this approach requires more advocacy on behalf of the Aboriginal common client until such time that they are sufficiently empowered and find their own voice.

Assessment and Treatment

- TFNC is working towards being recognized as a designated health service provider; they have plans to expand their referral, assessment, intervention, prevention abilities, and increase their community training and education service.
- More Aboriginals are seeking services from 'mainstream' health service providers; some HSPs have responded to assessment and treatment service requests from the James Bay Coastal area using OTN.
- TNFC and Jubilee Centre are working with CAMH-Toronto (Aboriginal Treatment Program) and other Aboriginal service providers to implement Aboriginal cultural programming enhancements at Jubilee Centre (residential treatment).

Culturally Appropriate Spaces/Infrastructure

- If the child and adolescent inpatient unit at TADH (or any other service) is redesigned, consideration could be given to the integration of 'cultural' aspects within the redesign.
- Plan for and respond to changing demographic needs due to a growing Aboriginal population; Aboriginal culture needs to be integrated in realignment efforts and infrastructure changes.

**Recommendation: Address the lack of knowledge regarding financial supports among common clients who are in or are seeking out treatment. There is an opportunity to co-locate or integrate social services (i.e., DSSAB) within crisis centres, and/or link with crisis health service providers.**

Financial Resources/Emergency Funding

- Clients in crisis eligible for Ontario Works have access to a range of crisis and other related supports; referrals should be made to determine eligibility; low unemployment rate/high demand for labour locally has resulted in a significant caseload reduction to Ontario Works (~250 less recipients compared to last year).
- (CDSSAB) Homelessness Prevention Fund can be accessed by the general public including OW and ODSP recipients who have exhausted program benefits.
- (CDSSAB) Rent and Utility Bank Fund can be accessed by OW and ODSP recipients (and are over and above their social assistance allocation), as well as qualifying members of the general public; funds under this program are not entirely allocated annually.
- There are provisions to provide emergency dental (adults), basic dental (children) and prescription coverage for individuals who no longer receive financial assistance (OW); additionally, extended health related coverage for a period of 6 months can also be obtained and includes: dental services, eye glasses, prosthetic appliances, and other authorized health-related benefits; an arrangement for payment of the Trillium deductible may be considered for an additional 6 months (excluding drug card). Note: must have been eligible for financial assistance the previous month to quality for extended benefits.

Rent Subsidies

- Increasing knowledge of available rent subsidies (across organizations for example CMHA and CDSSAB) will ensure that this clientele and the system can maximize available resources and coordinate efforts to ensure that the client has access to the right intensity of case management services.

Financial Planning Information and Support

- While on sick leave seeking treatment CCs are off without pay; bills are backing up; unaware of CDSSAB programs that may be available; lack of information about employee rights and benefits while in treatment; can one get sick leave for an addiction; can one collect EI or long-term benefits for an addictions if long-term treatment is needed?

**Recommendation: Ensure that employers and Employee Assistance Programs (EAPs) are aware of the range of crisis and treatment supports in place. Ensure that employees are aware of their rights to benefits if they seek treatment.**

- Human resource departments pressure individuals to return to work before they are ready; they do not understand how difficult it is to deal with stress when dealing with a mental illness.
- Client worked in Timmins; advise his employer of his addiction with the hope of getting help and was let go.

- Individual was employed remotely; did not consume while on work rotation but would consume heavily during two weeks off; was let go from employment after a 'bender'.
- A number of focus group participants in treatment have supportive work environments; jobs are waiting for them when they complete their treatment; these same individuals had employers who suspected their addiction but the employer was waiting for the employees to self-identify their need for treatment.
- One individual went to human resources for help and did not receive needed support despite being a large company with extensive employee benefits – decided to leave employment because of a lack of support.
- Some employers are not providing 'addicts' with the support needed; clients are fearful of going to human resources with concerns or to ask for help; focus group participants questioned if an employer can legally fire a person who seeks help from their workplace; noted that individuals on ODSP receive supports needed to help them access treatment.

**Recommendation: Develop and implement a housing strategy to address the acute and chronic housing needs of common clients. Many crisis situations are the result of a lack of safe and adequate housing.**

Demand Exceeds Supply

- There is a very limited supply of rental housing in the City of Timmins; high demand challenges the ability of case managers to secure housing for clients; treatment needs of the client cannot be addressed unless they are adequately housed, yet the chronic addiction is in itself (at times) an impediment to maintaining/securing housing.

Safe Housing Pending Treatment

- Detox provides a safe place pending treatment; a safe place to stay for individuals being released from custody; no housing options for many once released from custody; some stay on the couch of a family member or friend; others do not have access to any family support and call police for assistance; others go directly to a detox centre if they have nowhere to stay.
- Some clients like that the detox is in a remote location; encourages people to stay – not just walk out; others feel that it should be easier to access, and closer to home where supports are located.
- Client appreciated that a social worker at MCC helped him make arrangements for his release plan; he is concerned about the 1 week gap between his release from custody and start of treatment at Jubilee Centre; believes that he could benefit from a halfway house program or a shelter during that week.
- There are no shelters in Kapuskasing and in Hearst and this has been flagged as a concern by clients; the Shelter in Cochrane is nice and clean, has good food, and good resources; the shelter in Timmins has moved to a new location and is not as nice; it is an older building.

Affordable/Social Housing

- Timely access to housing is a significant concern district wide; demand for social housing units in Timmins (either via CDSSAB or Timmins Native Housing Authority) is high and wait times can be 5 to 6 years in the district; individuals, who are homeless, are victims of domestic violence, or meet the definition of 'medical urgent' are prioritized, yet wait times are still 3 to 4 months long; given the long wait time for priority populations, this option cannot be considered 'urgent housing'.
- In regards to housing the rent is too high and client cannot afford rent on welfare; must either share the apartment with someone else to cover the costs or sell drugs; when people do not have a place to stay they turn to crime, no choice as there are limited options available; should have more geared to income housing in Timmins as wait list is 2-3 years long.

Transitional Housing/Recovery Homes

- Lack of transitional housing for clients who have completed treatment but still require support, and interim housing for pregnant women who are in crisis and awaiting residential treatment services.
- HSPs have secured 'dedicated' housing units in Timmins and Kapuskasing; Timmins in particular is in need of more housing for clients with mental health/addiction issues; housing options must take into consideration the needs of this population group and be geared towards 'helping them succeed in the community'; for example, a half-way house for individuals who are engaged in the justice system and have been recently released from jail or transitional housing for those who have completed treatment but are in need of further support.
- Recovery homes are needed in Timmins; those in need of long-term treatment and support cannot be expected to go to another community to access a recovery home (like Sault Ste. Marie); CCs have jobs and family responsibilities; they need long-term treatment while they are working and in their home communities.
- No housing option for 'addicts' they are on banned list at shelters; need for some type of recovery home or extended treatment option; long-term housing not just short term options.
- Existing physical infrastructure at Jubilee Centre could be re-designed to create more residential bed space and innovatively designed living units in which individuals could be stepped up or down through different intensities/levels of care and support.

Homelessness Prevention

- Annually, if the (CDSSAB) Homelessness Prevention Fund is not entirely allocated by the end of December, budget surplus can be directed to a local initiative geared to preventing homelessness; for example, in the past a room was secured from a local landlord/establishment for one year; the guaranteed room provided timely access to

housing for homeless client's in crisis; annual cost of the arrangement was $5,000; in the future, if a unit could be identified a similar arrangement could be considered.

- Community has a lack of affordable housing. The Good Samaritan Inn houses the working poor (room and board arrangement ~$450/month) until affordable housing can be secured.
- Good Samaritan Inn is aware of funding programs that they could leverage (Homelessness Initiative) but without access to individuals who can assist with the development of a proposal, they cannot access more stable sources of funding to help house the homeless.
- Client was homeless, after being released from custody; called the police and they allowed him to stay at the police station until he found a place to stay.

Rent/Financial Concern noted by Common Clients

- Very dangerous to have money; addicts will spend money on their addictions; money needs to go to housing or transportation directly.

**Recommendation: Ensure that case managers with responsibilities for securing housing for common clients are working collaboratively to address the housing needs of the CC.**

Housing Case Management

- Housing case management is offered by SCAS, CMHA, and TNFC; case managers' from these agencies will help clients secure housing upon discharge from a crisis service; they will review and discuss housing options with clients and provide transportation (if needed) to allow the client to view different housing options; staff from all three agencies should be working together to minimize duplication of efforts and develop linkages with shelters.
- Housing case management program is a new provincial initiative with limited access to best practices and procedural guidelines; no consistency in definitions, eligibility criteria, and standards among the province (yet this does allow for local uniqueness to be incorporated); assessment of the housing case management program revealed the need for more stringent criteria to reduce the current caseload and wait list which will then allow the program to provide more intensive case management.
- A second phase of funding is anticipated to result in an additional 0.5 FTE Housing Case Manager for SCAS and 4 additional rent supplements (administered by CMHA).
- Many communities in the northeast have access to dedicated housing units for common clients which greatly facilitates their ability to provide timely crisis housing and allows staff to concentrate on other pressing case management functions.
- Given the vast geography of the district and the limited resources associated with the Addictions Supportive Housing clients must (or be willing to) reside in the City of Timmins; this however was not identified as a problem but it raises a question of equity.

- Housing Case Management Program at SCAS needs an emergency reserve for one time unexpected expenses such as damages to a unit, moving expenses, furniture acquisition, etc.

**Recommendation: Make provisions for a district/sub-district transportation service to ensure that the CC has timely access to a centralized crisis centre or to strategically located crisis centres (access to a safe place).**

- To access a detox bed, arrangements are in place to facilitate the transfer of clients via bus; clients are encouraged to approach ODSP, Ontario Works, or their Band Council to cover the cost of a bus ticket to Smooth Rock Falls; in addition there is an informal arrangement with Ontario Northland which facilitates the ability of clients to travel, with the cost of the bus ticket being reimbursed by the detox if no alternate financial arrangement can be secured.
- The Ontario Northland bus schedule can be an impediment to getting an individual to the detox; the bus goes through Smooth Rock Falls twice per day, 7 days per week; it leaves Hearst at 5 am and arrives at 7 am; it leaves Timmins at 10:30 pm and arrives at 11:45 pm.
- Transportation funding is needed to ensure that individuals can access the safe-bed unit once deemed eligible; hospital will cover the cost of some transfers, and ODSP and Ontario Works cover the cost of transportation for their clients; no funding is available for the 'working poor'; also, clients occupying a safe bed who are being treated by the methadone clinic do not have access to transportation to attend the clinic on a daily/weekly basis.
- The system would be better served if there was access to a medical transportation system to transport clients in need of services (as opposed to the use of buses or taxis).
- Movement between services (transport) is a challenge if one does not have friends and family to rely upon.
- Review of program and process for admission (criteria for a Form 1) with district hospitals and police services would be beneficial. As would a review of how patients on a Form 1 are transferred between hospitals.
- Physicians determine if an escort is needed for the safe transfer of a patient on a Form 1 via ambulance; if there are behavioural concerns then a security guard or police escort may be warranted for safety reasons.
- Since an addiction is a disease, clients questioned why there is no travel grant to help people access a detox or treatment services; or is there if they meet the 100k distance requirement?
- First Nation people have access the medical van if they do not have access to own transportations (from Calstock to Hearst and back); medical van will stop at pharmacy as needed.

**Recommendation: Leverage systemic realignment efforts and integration opportunities taking place. Take advantage of the opportunity to redesign crisis resources in a more innovative and client-centered and client-friendly manner drawing upon all available community resources.**

- Child and Adolescent Mental Health Unit operates only 1 of its 2 beds due to the lack of physical space at the hospital; renovations are pending and would allow the program to operate out of a locked unit (as opposed to a secure room); in the interim, youth in crisis are accommodated in a 'step-down' bed located on the pediatric floor, with 24/7 coverage by the hospital's security personnel; also being considered is a change in program mandate to youth who are less than 18 years of age (as opposed to 16).
- Bedded facilies have annual planned shut-downs due to budgetary shortfalls; while agencies/individuals are informed, the shutdown impacts referral practices beyond the closure period.
- There is a need to identify and streamline 'common clients' who receive mental health services from both TADH and CMHA to minimize unnecessary duplication.

**Establish a unified and simplified marketing or communication strategy that is more client-centered. Focus on issues (or client needs) in addition to the services or programs available.**

- Recommended that a full page add in the phone be placed describing all the services and supports available; need to explain what kind of services are available to individual who do not know the names of agencies or even the range of support and treatment options available; need to market services to families and friends in addition to clients.
- Some were just coming to the realization that they were in need; at that point they are not aware of what a detox was and how this differed from a treatment centre; marketing strategy needs to be simplified.
- Clients feel that it is difficult to understand the range of supports in place; in Sudbury pamphlets are placed in the newspaper once a week to inform the community about the services and programs available; this could be a good way of informing locals about services and program available in the Cochrane District.
- Focus groups participants liked the idea of the information cards to be given out by police officers or service providers (none had received any); these cards need to be easily available; great tool for wallet; located in public areas.

## 7.0 Next Steps

The recommendations detailed in this review provide a comprehensive framework that can be used to make significant crisis related systemic improvements for the benefit of the CC. The recommendations were endorsed by the members of the CDHSJCC in May of 2012.

Attention must now focus on opportunities to move these recommendations forward. With this goal in mind, it is important for the CDHSJCC to ensure that key stakeholders who are contemplating or engaged in realignment discussions have access to this report to inform their own parallel and complementary health system initiatives.

As a starting point, the report should be shared with the following organizations and groups:

- North East Local Health Integration Network;
- Hearst Initiative (recently formed collaboration among FHT and HSPs);
- Minto Counselling Services (only mental health provider who has not seen firsthand the recommendations);
- Mental Health and Addiction District Providers; and,
- Regional and provincial HSJCC.

As a final note, the recommendations provide a good starting point for moving ahead with the implementation of structural and system changes. It is however crucial that the resources required to implement successfully the recommendations not be underestimated. Ideally, the redesign of the crisis system would be implemented using a 'service collaborative approach', which is being used by CAMH across the province. This approach directs very specific resources to change management initiatives over an 18-month timeframe, greatly increasing the initiative's likelihood of success.

## Appendix A: Acronyms Used

| Acronym | Definition |
|---|---|
| **CAMH** | Centre for Addiction and Mental Health |
| **CC** | common client |
| **CDHSJCC** | Cochrane District Human Services Justice Coordination Committee |
| **CMHA** | Canadian Mental Health Association |
| **CTO** | Community Treatment Order |
| **EAP** | Employee Assistance Program |
| **ED** | Emergency Department |
| **HSP** | Health service provider |
| **IAR** | Integrated Assessment Record |
| **MCC** | Monteith Correctional Complex |
| **MH** | Mental health |
| **NAPS** | Nishnawbe-Aski Police Service |
| **NCAS** | North Cochrane Addiction Service |
| **SCAS** | South Cochrane Addiction Service |
| **TNFC** | Timmins Native Friendship Centre |

# Appendix B: Additional Information on Gaps and Barriers

## Gaps in Services

Aboriginals

- Aboriginal services and programs that integrate cultural safety; history, traditions and culture; look at the person as a whole (not focus only on the illness).
- Aboriginal services are needed in the north part of the district.
- TNFC is not recognized by the LHIN as a service provider. Consequently, they cannot access NE LHIN funds directly to enhance programming.
- TNFC and Jubilee Centre are working with CAMH-Toronto (Aboriginal Treatment Program) and other Aboriginal service providers with the goal of implementing Aboriginal cultural programming enhancements at Jubilee Centre (residential treatment).

Youth

- There is a significant gap in services for youth who need access to mental health supports but have not been 'formed'. These youth require/would benefit from in-patient mental health services for which they are not eligible locally.
- Crisis outreach gap for the assessment of youth under the age of 16 who present in crisis in the Cochrane/Iroquois Falls/Matheson area. Youth in crisis are redirected to Child and Family Services in Timmins, as Minto is mandated to serve the 16 and over age group. To serve youth Minto staff would require specialized training and would require access to validated tools, to address insurance liability requirements.

Youth/Housing

- A significant systemic gap surrounds services and supports for youth aged 16-18, as they no longer fall under the responsibility of child protection, yet are not entitled to benefits afforded to those 18+. From a housing viewpoint, to be eligible for services a trustee must be identified and a room and board arrangement secured as they cannot enter into a contractual housing arrangement.

Long-Stay Residential Program

- Longer stay program (i.e., Maison Fraternite) is needed; 3 weeks is not long enough; need a 6 week program like other parts of the province; flexible bed stock would allow for the needs of the client to determine their length of the stay.
- Continuous admissions would increase the timeframe to access treatment which would decrease the odds of a client losing their motivation for treatment; day program attracts a different clientele and often is not an appropriate alternative.

Medical Detoxification

- Cochrane District (the entire north) does not have a medical detoxification service; there are only a handful of these services provincially; community hospitals provide this services;

system needs to review educational needs and medical protocols to support the provision of this service within hospitals and ensure that the medical community is linked to the system and best practices.

Women's Services and Programs

- Limited number of services (and # of beds) for females (when compared to males).
- Support services for women in jail are lacking.

Housing

- Detox in Smooth Rock Falls is one of the few detoxes that provides a safe place to stay pending treatment; other detox 'push you out' regardless of whether you have anywhere to go.
- Interim crisis and transition housing while awaiting treatment is needed in all parts of the district.
- Recovery homes – supported housing environment for individuals who are back in the community (and some working) but require ongoing support and treatment is needed.

## Barriers to Treatment

Literacy Rates

- Literacy rate among Aboriginals can be an impediment to their participation in mainstream treatment programs.
- Individuals with developmental delays can be difficult to serve if they are not psychologically capable of working in a group setting. Eligibility is reviewing on a case by case basis.

Accessing Services Away From Home Community

- "Stereotypes" are a big thing on reserves like Calstock and Moosonee and the gossip, the drama, the talk about people going for treatment makes it uncomfortable and deters people from getting help.

Moderately Ill versus Seriously Mentally Ill

- Focus on the 'seriously' mentally ill as opposed to 'moderately' mentally ill is a systemic barrier, as it diverts resources away from prevention. This segment represents a significant number of individuals in need of services.

Wait Times

- The wait times for addiction treatment services are too long; SCAS (6 weeks) and this increases chance of a relapse.
- Given the nature of the safe bed service at Jubilee Centre, wait times/list are difficult to compile; since the service was implemented in 2008 demand for a safe-bed is on the increase; wait times can vary from 2 hours to 3 weeks (during shut down period); there are periods of low activity followed by demand that exceeds capacity; trends that are emerging

include an increase in demand following a weekend, and an increase in the number of self-referrals from repeat clients who are now familiar with the service; when access to a safe-bed is limited, staff will remain in close contact with the referring agency and attempt to secure an alternate setting until a bed becomes available.

HR Shortage

- Staff complements in the Child and Adolescent In-patient unit are not at full capacity. A 0.5 nurse position is vacant.

Others Points – not classified

- Privacy requirements restrict the sharing of personal information across CDSSAB departments. Province is reviewing means of integrating client data which would alleviate this barrier.
- By 2018, Ontario Works program will be 100% funded by Ministry of Community and Social Services; administration costs will remain an 80/20 cost sharing arrangement; changes to programming should be anticipated.
- Safe beds, crisis beds, and jails are in need of clothing donations; Good Samaritan Inn operates a Thrift Store and they will provide clothing to individuals in crisis for free; excess clothing is sent to an international destination after being offered to local community agencies.