

*Final Report on the  
Transfer of District and Local Mental Health &  
Addictions Program in Northeastern Ontario*

*Ken W. White,*

*Facilitator*

*August 4, 2005*

*Transfer of District Mental Health & Addictions Programs  
In Northeastern Ontario*

*Executive Summary*

**Process**

In November 2004, the Minister appointed me, Ken White, President & CEO of Trillium Health Centre in Mississauga to act as Facilitator to ensure the successful transfer of local and district community mental health and addictions programs in Sudbury and North Bay.

From the outset, I have been committed to an open and transparent process. To assist with this initiative, I established two Advisory Committees, one in North Bay and one in Sudbury, comprised of community leaders representing various health system perspectives. The Advisory Committees have provided me with valuable advice on the timely, efficient and effective transfer of community district mental health and addictions services and have brought forward their independent community perspectives into the process. Monthly progress reports have been provided to the Chief Executive Officers and Board Chairs of the four hospitals involved and to the Ministry. As Facilitator, I held press conferences immediately following the meetings of the Advisory Committees in North Bay and Sudbury.

In addition, a Communications Task Group was established to provide communication support and advice. This group ensured consistent and regular communication to interested stakeholders related to the transfer of community based mental health programs from Northeast Mental Health Centre/North Bay Psychiatric Hospital to North Bay General Hospital; and from Northeast Mental Health Centre to Hôpital Regional Sudbury Regional Hospital. Prior to beginning my work, there had been a high degree of community discontent expressed in the media and at council meetings concerning community mental health programs and acute and long-term psychiatric specialty bed transfers. As part of the process, I had asked the parties to agree that I would be the single point of communication to avoid the media chaos seen in the past. To date, all parties have honored this practice and this has certainly contributed to the success of this initiative.

I also established three Operations Committees: Programs, Finance and Labour Relations/Human Resources to support this process. The committees, each with representatives from the four hospitals involved, the Ministry of Health and Long Term Care and Trillium Health Centre met regularly to define and resolve the issues surrounding the proposed transfers and to make recommendations to me that would allow for a timely and efficient transfer process.

## **Acute/Long-Term Psychiatric Specialty Beds**

While this was not part of my original mandate it became clear, early on, that the issues requiring resolution surrounding both the acute care and specialized care beds were closely related to the transfer of the community programs. Therefore, the findings and recommended solution for the beds proposed and agreed upon by all parties, is included in Appendix A.

Overshadowing much of this work is the constraint we have been under due to the lack of a clear timeline for the transfer of NBPH to NEMHC. Much of the work in North Bay is related to post transfer issues between NEMHC and the NBGH. Sudbury is also affected by the transfer date due to the current proposed disposition of the long-term psychiatric specialty services for North Bay (61 beds) and Sudbury (31 beds).

In addition, a recent evidenced based survey conducted at both HRSRH and NEMHC using the InterQual Medical Review Criteria for Mental Health tool indicated a need for more acute care mental health beds than the currently proposed 39 for Sudbury. With the current immature community based mental health care system and allowing for an 85% occupancy rate a minimum of 60 acute care mental health beds are required to provide adequate Schedule 1 services by HRSRH to the Districts of Sudbury and Manitoulin.

As the community system matures over time, the need for in-patient acute mental health beds for the District can be reviewed for reduction to 48 with the goal of creating a 12 bed specialized longer-term regional service in Sudbury to fill a significant need for access to treatment for individuals with persistent serious mental illness in the Northeast.

During the community consultations, both North Bay and Sudbury voiced the preferred model for the optimum delivery of specialized psychiatric services would be to leave the adult specialized mental health beds in North Bay operated by the NEMHC. Preliminary discussions of such an option have revealed that it may be possible to achieve this model without any major capital requirement in North Bay through innovative partnerships with Long-Term Care facilities in the area which would serve the psychogeriatric population now housed at the NBPH. It is also feasible to find a group home model to accommodate the developmentally disabled with SMI currently at the NBPH.

It was a challenge to find the right solution for both communities regarding in-patient beds for short-term acute care in Sudbury and long-term rehabilitative care in North Bay. Both communities expressed deep concern over the current proposed disposition of the long-term specialty psychiatric beds and Sudbury is also concerned over the proposed 39 acute bed downsizing directed by the HSRC. These issues, if not resolved to the communities' satisfaction, will continue to plague the mental health system in both Sudbury/Manitoulin and Nipissing Districts as well as the whole Northeast region. It is important to remember that many other communities require access to services offered in Sudbury and North Bay as well.

## **Community Mental Health and Addictions Program Transfers**

The Operations Committees and the Sudbury Advisory Committee have provided their support for the transfer of the district level mental health and addiction programs identified below and the HRSRH and NEMHC have agreed to receive the programs.

### **Community Programs:**

- Assertive Community Treatment Team 1, Sudbury
- Assertive Community Treatment Team 2, Sudbury
- Case Management / Positive Steps
- Psychogeriatric Outreach Programs
- Concurrent Disorders, Sudbury
- Community Treatment Orders, Sudbury
- Pinegate Addictions, Treatment—Problem Gambling
- Pinegate Addictions Withdrawal Management Programs

### **Community Clinics:**

- Espanola Clinic
- Manitoulin Clinic
- Suicide Prevention, Espanola
- New Directions, Hanmer Valley East
- Walden Help Centre, Lively
- East Algoma Clinic

Program currently operated by HRSRH with a regional focus whose governance will transfer to NEMHC:

- Eating Disorders Clinic, Regional Program Component

The Operations Committees and the North Bay Advisory Committee have provided their support for the transfer of the district level mental health and addiction programs identified below and the NBGH has agreed to receive the programs.

### **Community Programs:**

- Assertive Community Treatment Team 1, North Bay
- Assertive Community Treatment Team 2, North Bay
- Rehabilitation Resources
- Dr. Claude Ranger Clinic
- Concurrent Disorders, North Bay
- Community Treatment Orders Coordination, North Bay

**NOTE:** *In North Bay, the transfer of community mental health programs can NOT occur until after the transfer (previously referred to as divestment) of the North Bay Psychiatric Hospital (NBPH) to the Northeast Mental Health Centre has been completed. A date for the NBPH transfer has not yet been determined.*

## **Funding**

As part of the consensus building process, pressures on various transferring programs have come to light. Our financial analysis indicates that a number of these programs have experienced shortfalls in funding, both one-time and base funding, estimated to be between \$1.6 M. These shortfalls are due to issues of staff salary levelling, operating deficits and so on. These financial pressures need relief if we are going to be successful in this endeavour. Innovative programs such as vocational training at the Rehabilitation Resources program in North Bay and the Eating Disorder program in Sudbury demonstrate that providers working in the mental health field are committed to using their limited resources in creative ways. The community mental health programs in both communities need additional financial resources to effectively serve their clients.

## **Governance**

The transfer of community mental health/addiction programs as announced by the Minister (to HRSRH and NBGH) responds to requests for local governance of local mental health/addiction programs. It will allow the NEMHC Board to focus on its regional mandate for the delivery of complex specialized mental health services for Northeastern Ontario.

To ensure the sustainability of this system enhancement, it is recommended that a Mental Health/Addictions Advisory Council be established with representatives from the NEMHC, Adult Mental Health and Addictions District Planning Groups, NEON, and appropriate Aboriginal cultures. This Council's primary mandate would be to advise on mental health design and enhancements, and would be directly accountable to the Northeast Local Health Integration Network (LHIN). Further, it is recommended that a sub-group of this Advisory body be established to focus on the many and complex issues of mental health and addictions in Aboriginal and francophone populations.

## **Implementation**

The implementation planning process is well underway in Sudbury, in anticipation of a favorable response to my recommendations concerning these transfers. This same process can be easily duplicated in North Bay at the appropriate time. A similar process needs to be established as soon as the acute mental health bed recommendations are announced for Sudbury. I am also recommending that, Eileen Mahood, Healthcare Consultant on this project, be retained to facilitate the implementation of the acute care bed transfer from NEMHC to HRSRH in accordance with the timelines recommended in this report. Further, Eileen should undertake to facilitate the planning process necessary in North Bay within the parameters established by this project

Our process truly engaged all stakeholders, built consensus and recognized the bed issues were integrally linked to the transfer process and that an integrated solution would best suit all the parties. The changes proposed will position an integrated mental health and

addiction system in Northeastern Ontario for the implementation of their LHIN and support the government's health transformation agenda.

I respectfully submit my report to the Minister for deliberation.

***Ken White, Facilitator***

## *Background*

On November 19, 2004, the Minister of Health and Long Term Care, George Smitherman, announced that local and district community mental health and addictions programs serving Sudbury will be transferred from the Northeast Mental Health Centre (NEMHC) to the Hôpital Regional de Sudbury Regional Hospital (HRSRH). As well, the Minister also announced that once the pending transfer of the North Bay Psychiatric Hospital (NBPH) to the Northeast Mental Health Centre has occurred, local and district mental health and addictions programs serving North Bay and area will be transferred to the North Bay General Hospital (NBGH). This would mean that NEMHC will truly focus on its role as a specialized mental health provider serving the entire Northeast Ontario Region.

The primary purpose of my mandate was to ensure an efficient and effective transfer of acute and community district mental health and addiction services from NEMHC to HRSRH and to NBGH. Additionally, I was to develop a model and implementation plan that would facilitate the transfer of the governance of district level community mental health and addiction programs currently within the NEMHC to the HRSRH and the NBGH. Finally, I was to recommend solutions for the transfer of acute and long-term specialized beds in Sudbury and North Bay.

In fulfilling my mandate I have:

- Consulted with district level stakeholders;
- Identified, reviewed and assessed the issues impacting on the transfer of programs;
- Developed options and recommendations for transferring the programs identified, including milestones and associated timelines;
- Recommended the most appropriate governance structures and;
- Implemented communication plans explaining the process and rationale for transferring the programs.

From the outset, I clearly indicated that the patient is at the centre of this initiative. The goal is to further the integration and coordination of mental health and addictions services to respond to the needs of the clients and the communities served. The patient will not notice a change to the way he/she receives and accesses services but every opportunity to enhance community services and streamline access should be capitalized on in the implementation phase. A continuum of service options must be available to all Northeast clients requiring mental health care, from the community programs, crisis intervention and acute care in each District, to rehabilitation and in some instances to long-term psychiatric care for the Northeast region from the NEMHC. The goal is to have the appropriate service delivered in the appropriate setting by the most appropriate person in close proximity to the patient's family and support network.

I have encouraged all involved to contact me with their feedback, suggestions and questions. Several individuals and organizations have taken advantage of this offer and have provided me with useful thoughts and suggestions. I have also consulted with the

NEMHC, HRSRH and NBGH to obtain their support for accepting the programs identified for transfer. I held meetings with physicians, including psychiatrists, in North Bay and Sudbury to engage them in the process and to obtain their input on the proposed program transfers. As a result of this consultation process, consensus has been reached in both communities with a satisfactory result of the programs to be transferred, as identified in this report, when accepted by the Minister.

In addition, early in process it became evident that it would be very hard to find a satisfactory solution in both communities if the bed issue was not addressed at the same time as the community program transfers. As a result of this consultation process, consensus has been reached on both the disposition of the 31 specialty psychiatric beds and the appropriate number of short-stay acute care beds needed in Sudbury. When accepted by the Minister, a win-win situation will exist for both North Bay and Sudbury. As a result of this process, I have included recommendations on the beds in an appendix to this report recognizing that these issues are beyond the scope of my mandate.

## *Community and Stakeholder “Buy-in”*

### *Consultation with District Level Stakeholders*

#### *1. Advisory Committees:*

To assist with this initiative, I established two Advisory Committees, one in North Bay and one in Sudbury, comprised of community leaders representing various health system perspectives. The Advisory Committees have provided me with valuable advice on the timely, efficient and effective transfer of community district mental health and addictions services and have brought forward their independent community perspectives into the process.

The role of the two Advisory Committees is to:

- Review reports and recommendations;
- Identify issues related to the transfer of programs and services and identify potential solutions;
- Review and provide advice on the role of the Hospitals Advisory Committees and relationship with hospitals and other community mental health and addictions services; and
- Review and provide advice on the proposed model and implementation plan to facilitate the transfer of governance of district level community mental health and addictions programs currently with NEMHC to HRSRH and NBGH.

#### *2. Operations Committees:*

I also established three Operations Committees: Programs, Finance and Labour Relations/Human Resources to support this process. The committees, each with representatives from the four hospitals involved, the Ministry of Health and Long Term

Care and Trillium Health Centre, began meeting in January 2005 and will continue to meet until this process is complete. A Communications Task Group was also established to provide communication support and advice to the Operations Committees and myself as Facilitator to ensure consistent and regular communication to all relevant stakeholders.

To date, all the Operations Committees have:

- Met regularly since January 2005
- Discussed key issues around their mandate with all parties involved
- Worked collaboratively between committees in the development of their recommendations to me
- Reached consensus on recommendations coming forward in this interim report.

#### **a) Programs Committee**

*Mandate:* To produce an inventory of Mental Health Programs to be transferred, review hard pressures issues and make recommendations to the Facilitator.

The Programs Operations Committee inventoried the current community mental health and addictions programs in the Sudbury/Manitoulin District (17 programs), and in the Nipissing District (15 programs plus 2 programs funded from the NBPH). Their inventory included annualized funding, service type and Full Time Equivalents, and established which were district level programs, and which were regional programs. Consensus was achieved on the appropriate sponsorship for each program and recommendations for program transfers were provided to both the Advisory Committees and myself.

In addition, the Committee identified the hard pressures representing critical gaps in the current mental health and addictions service delivery system in both districts that are relevant to successful community program transfer and for which there was no current funding source. Consultation with the District Adult Mental Health Planning Groups in Sudbury and North Bay helped the Program Committee identify these pressures and they are articulated in the report.

The Program Committee also considered other submissions such as the Aboriginal mental health issues as reported by Advisory group member, Barbara Burton. This work will be very helpful in future deliberations and priority setting to inform future funding opportunities.

#### **b) Finance Committee**

*Mandate:* To review the cost model and develop recommendations for the identified Mental Health and Addictions Programs to be transferred to ensure appropriate levels of resources.

The Finance Operations Committee has reviewed each of the specific Community Mental Health and Addictions Programs in the Sudbury area. The work of this committee is

intended to provide a high level financial overview of the programs, and does not replace the due diligence process that will be required by the Hôpital Regional Sudbury Regional Hospital (HRSRH) and North East Mental Health Centre (NEMHC).

The work of the Finance Operations Committee to date has focused on the Sudbury program transfers due to the anticipated timing of the transfer of beds from North Bay Psychiatric Hospital to Sudbury. The principles developed through this work will also be utilized for the transfer of Community Mental Health programs for the North Bay area.

In anticipation of the transfer of the acute beds from NEMHC to HRSRH, it is suggested that the physicians transfer with the programs and move from Algoma to HRSRH. This involves the development of an outpatient clinic where the physicians can offer service and cover inpatient care, and yet remain somewhat independent of the other Hospital operations. Costs are still being evaluated, but are currently offered through NEMHC, so will involve a transfer only.

#### *NEMHC Current Deficit*

As the Finance Group has reviewed the activities related to Community Mental Health and Addiction Services in Sudbury, it has come to our attention that NEMHC is currently in deficit. The Committee has not reviewed the details of the deficit, except as it has been relevant to these specific program elements noted in this report. We also recognize that this is largely outside the mandate of the committee however, it would not seem appropriate to ignore this deficit when other recommendations are being made regarding the program structure for Sudbury. NEMHC is currently projecting a deficit in the 2005/06 fiscal year of approximately \$330,000 in community mental health program #1004.

#### **c) Human Resources/Labour Relations**

*Mandate:* To develop the guiding principles of program transfer to facilitate a smooth, people focused movement of staff and physicians in support of the Mental Health and Addiction Programs to be transferred.

This Committee prepared the Principles for Program Transfer document (Appendix B) after review of several source documents outlining processes for the transfer of staff. The guiding principles that have been developed will assist in minimizing disruption of the workforce and ensure that patient care needs remain the focus of our outcomes. The transfer process will be as transparent as possible. Employees will be regularly informed of the progress of the integration and impact it will have on them. Individuals are valued and will be treated in a fair and equitable manner. Staff input will be sought when possible and local negotiations will adhere to the defined principles.

Detailed staff and costing information has been prepared and exchanged between NEMHC and HRSRH. Salary adjustments at NEMHC have kept pace with those in the hospital industry.

A meeting with Hospital and Union Representatives in Sudbury was held on March 31, 2005 in Sudbury. Representatives of the Human Resources Departments of both HRSRH and the NEMHC attended as well as representatives from CUPE, ONA and OPSEU. The union representatives expressed concern that there had been limited communications to date. They proposed several “principles” that they believed to be necessary in any transfer and these have been included in the Principles attached.

To date, a meeting has not been held with the union representatives in North Bay at the request of the negotiators for Management Board Secretariat. Staff lists have not as yet been exchanged. Separate negotiations on the transfer of staff from NBPH to NEMHC are being conducted by the Ministry of Health. Once the transfers from NBPH to NEMHC have occurred, staff transfers to NBGH can be considered.

### ***3. Communications:***

As noted earlier in this report, a Communications Task Group was established to provide communication support and advice. The group ensured consistent and regular communication to interested stakeholders related to the transfer of community based mental health programs from Northeast Mental Health Centre/North Bay Psychiatric Hospital to North Bay General Hospital; and from Northeast Mental Health Centre to Hôpital Regional Sudbury Regional Hospital.

As Facilitator, I have been the lead spokesperson for the project. The Communications Task Group will continue to be responsible for developing key messages and related communication material. CEO’s and Board Chairs have been and will continue to be the lead spokesperson for their respective institutions. The Communications Task Group will continue to embark on additional communications activities to ensure the process is open and transparent, until my mandate is complete.

Media releases and progress updates to the partners were issued on a regular basis coinciding with the Advisory Committees meetings. I provided media updates following each meeting of the two community advisory committees and answered questions. The names of Media Liaison contacts (representing NBGH, NBPH, HRSRH, and NEMHC) have been provided to assist with the coordination of media activities in Sudbury and North Bay and responding to issues in a timely manner.

The primary targets for communication are the two Community Advisory Committees and the partner hospitals. Consistent messages and communication material has already and will continue to be shared with the members of the Advisory Committees at the meetings and made available to the participating hospitals immediately following the meetings.

For issues with broad impact on human resources, special and targeted activities will be initiated directly with the labour groups/unions affected as is required according to labour agreements and acceptable practices. The community was kept informed through regular

media releases and updates. As the project unfolds, additional activities will be required and will be implemented.

#### ***4. Facilitator's and Consultant's Activities***

At the start of this process, I requested some additional support from the Ministry to help with the implementation plan for this process. The Ministry of Health and Long-Term Care (MOHLTC) engaged Eileen Mahood, a Healthcare Consultant, to work with me and the community partners on this project.

Over the past number of months, both Eileen and I along with other members of Trillium Health Centre and the Ministry of Health have been active participants in the Operations Committees, as well as the Advisory Committee meetings.

In addition, either myself and/or Eileen has:

- Met with Shelley Martel, MPP Nickel Belt
- Met with the psychiatrists in both Sudbury and North Bay to listen to their concerns and issues.
- Met with Barbara Burton, member of the Sudbury Advisory Committee and representative of the Near North First Nations, to discuss the issues and gaps facing on and off reserve communities in the Sudbury/North Bay region.
- Met with the Sudbury-Manitoulin District Adult Mental Health and Addiction Planning Group
- Met with the Northern Shores Adult Mental Health and Addiction System Group
- Conducted a survey of northern communities with Schedule 1 Facilities regarding the practice of Psychiatry in Kenora, North Bay, Sault Ste. Marie, Sudbury, Thunder Bay and Timmins (See Appendix D)
- Met with the Sudbury hospitals involved in the Sudbury-Manitoulin District Community Mental Health Program transfers, namely the Hôpital Regional de Sudbury Regional Hospital (HRSRH) and the Northeast Mental Health Centre (NEMHC)
- Discussed with North Bay General Hospital (NBGH) the agreed to process to be undertaken between the NBGH and NEMHC, once the transfer of the North Bay Psychiatric Hospital (NBPH) to NEMHC has been completed, to effect the transfer of the recommended North Bay Community Mental Health Programs
- Discussed with Dr. R. Koka, the Sudbury Psychiatrists position on local governance for all programs in Sudbury, the need for more acute care beds than the current proposed 39, the concerns over the Regional Children's Psychiatric Program and the critical timing of all of the transfers happening quickly.
- Eileen is currently facilitating the hospitals due diligence processes in Sudbury and is also working closely with the Sudbury Hospitals in developing their implementation plans for the community program transfers.

It is important to note that final discussions are still pending with the Minister and Ministry officials, Advisory Committees, Mayors in Sudbury and North Bay, along with the MPP's from the affected areas.

## *Findings*

### *Community District Programs*

The programs affected by the process are mental health and addictions programs that offer front line services and support to residents of the District of Nipissing for the programs transferred from NEMHC to NBGH. For the programs transferred to HRSRH from NEMHC, these mental health and addictions programs serve primarily the residents of the Districts of Manitoulin/Sudbury. The programs affected are community-based programs that complement the local addictions system and support the adult mental health acute services provided by the Schedule 1 Facility, HRSRH, in Sudbury and the North Bay Psychiatric Hospital (NBPH).

In Sudbury they include:

- Two Assertive Community Treatment Teams
- Case Management / Positive Steps
- Psychogeriatric Outreach Programs
- Concurrent Disorders, Sudbury
- Community Treatment Orders, Sudbury
- Pinegate Addictions, Treatment—Problem Gambling
- Pinegate Addictions Withdrawal Management Programs
- Espanola Clinic
- Manitoulin Clinic
- Suicide Prevention, Espanola
- New Directions, Hanmer Valley East
- Walden Help Centre, Lively
- East Algoma Clinic

In North Bay they include:

- Two Assertive Community Treatment Teams
- Rehabilitation Resources
- Dr. Claude Ranger Clinic
- Concurrent Disorders, North Bay
- Community Treatment Orders Coordination, North Bay

### **Recommendations:**

- **That the transfer of the above noted community mental health and addictions programs in Sudbury/Manitoulin be moved forward expeditiously from NEMHC to HRSRH and;**
- **That the above noted community mental health programs in North Bay be moved expeditiously from NEMHC to North Bay General Hospital (NBGH) post transfer of the NBPH to NEMHC.**

In addition, HRSRH currently operates both the district level and the regional component of the Eating Disorders Clinic and it is agreed that the regional consultative part of the program should be governed by NEMHC in their role as the Northeast regional psychiatric service provider.

**Recommendation:**

- **That the regional component of the Eating Disorders Clinic be transferred from HRSRH to NEMHC.**

*Transfer Timelines*

Throughout the course of this initiative it has become evident that these are complex and entangled issues that are being resolved to the satisfaction of all parties. With that in mind, and the expectation that each hospital will undertake its own due diligence process an aggressive timeline for implementation must be established to ensure successful completion of all the transfers. For the community programs, this process is well underway in Sudbury. However, we recognize that summer in the North is not the best time to shift staff from one employer to another. Therefore, it is reasonable to expect that HRSRH and NEMHC complete all of the work for the community program transfers by June 30, 2005 and actually implement the transfers effective October 1, 2005. The community program transfers are on hold in North Bay until after the NBPH transfer is complete.

**Recommendation:**

- **That the NEMHC and HRSRH complete their implementation plans by June 30, 2005 and implement the community program transfers October 1, 2005.**

**Note:** I would suggest that Eileen Mahood, who has acted as Healthcare Consultant and who is very knowledgeable in this area, is ideal to ensure this process continues to move forward.

*Aboriginal Issues*

One issue that requires further work than is possible within the scope of these program transfers is the many needs of the aboriginal population living in the Northeast, both on and off reserves. A recent report from the Anishinabek Health Commission's Mental Health Planning Session recognized the increasing shift from alcohol to drug use among aboriginals; suicide and/or attempts in late teens/young adult aboriginals; the need for qualified mental health workers with culturally appropriate training; and the need to recognize a continuum of care requirement throughout the generations, from childhood to old age.

One positive step that can be immediately taken, to begin addressing these and other pressing issues of mental health among aboriginals, is support for the creation of an Aboriginal Mental Health Coordinator at the NEMHC. This position would be able to

work with Northeast District Adult Mental Health and Addictions Planning Groups to identify the community mental health and addiction service gaps for Aboriginals both on and off reserve. Although outside of my mandate, I have received documentation related to this complex issue from aboriginal representatives on my Community Advisory Committees. I have appended their concerns to this report as Appendix C.

### **Recommendation:**

- **That a Mental Health/Addictions Advisory Council be established with representatives from appropriate Aboriginal cultures and be directly accountable to the Northeast LHIN. Further a sub-group be established to specifically focus and make recommendations on the complex issues of mental health and addictions in Aboriginal populations.**

### ***Funding***

It is recognized that there are a number of details requiring attention by the sending and receiving hospitals in order to ensure the due diligence process is completed for each program being transferred. It may become evident during the due diligence process that there are financial barriers which need to be removed before the transfers can be completed since the hospitals are unwilling to accept programs in deficit unless the MOHLTC commits to resolving these issues in a timely fashion.

As part of the consensus building process, issues of pressures on various transferring programs have come to light. These financial pressures need relief if we are going to be successful in this program transfer. Both one-time and base funding needs have been identified in this report, estimated to be approximately \$1.6 M. One-time funding will be approximately \$417,500; new base funding will be approximately \$1,190,000.

### **Summary of Funding Requirements**

1. In Sudbury, enhance funding in the amount of \$1,390,000 which includes:

#### **One-Time:**

- Training and orientation costs for staff transferring from NEMHC to HRSRH in the amount of \$200,000 (80 FTE's)
- HRSRH's legal and IT costs associated with the transfer, estimated to be at least \$100,000

#### **Base:**

- Funding to HRSRH to support the \$330,000 program deficit in Community Mental Health Program #1004.
- New annualized funding of \$200,000 to NISA to stabilize this consumer/survivor program.

- New annualized funding of \$200,000 for clinical positions to begin the process of developing a robust mental health outpatient clinic program in Sudbury.
- New annualized funding of \$200,000 to allow for consolidated community programs, enhancing service delivery
- New annualized funding is provided to HRSRH to support wage harmonization, estimated to be \$160,000.

2. In North Bay, enhance funding in the amount of \$217,500 which includes:

**One-Time:**

- Funding for training and orientation costs, to NBGH estimated to be \$117,500.

**Base:**

- 1 FTE clinical position in the community mental health psychogeriatric program annualized at approximately \$100,000.

### *Hard Pressures*

Several systemic issues have been identified as part of the process to facilitate the transfer of community district mental health programs from NEMHC to local hospitals in Sudbury and North Bay. Many of these issues are already known to the Ministry of Health and Long-Term Care and have been identified as pressures. However, most of the pressures identified do not fall within the parameters of current funding initiatives (i.e., Health Accord, Forensic Funding).

In order to expedite the smooth and timely transfer of the recommended programs, these hard pressures require immediate attention.

The Program Operations Committee engaged the two local district mental health and addictions planning tables in Sudbury/Manitoulin and Nipissing to submit a list of what they had identified as system gaps to the committee and myself as Facilitator.

In meetings with the two Advisory Committees and the Psychiatrist groups in the districts. I extended the offer to submit their identified gaps to the committee as well. This has resulted in an extensive list that will need further review; however four hard pressures in the Sudbury/Manitoulin District and two in the Nipissing District have been identified as needing consideration to allow for the smooth transfer of the community programs to the identified agencies, namely HRSRH and NBGH.

## *Hard Pressures Background and Recommendations*

### **Sudbury**

#### **1. Consolidated Accommodation**

Hôpital Regional Sudbury Regional Hospital will be receiving a variety of community mental health and addictions programs along with staff from NEMHC in the current transfer process. The issue of adequate facilities in the community has been a long-standing issue for these programs, and in just the City of Greater Sudbury, the programs are scattered in 5 separate locations.

The mandate of providing district mental health and addiction services in an integrated, streamlined manner, where the client is the focus, and efficiencies can be realized is critical. Support is required for a long-term lease agreement so that HRSRH can accommodate their community mental health and addiction programs, and potentially other mental health service providers in a consolidated site to improve service delivery for the clients and achieve maximum efficiency in program administration. It is the intent, with the signing of a long-term lease agreement, that any leasehold improvements would be the responsibility of the landlord.

At this time, HRSRH's current community programs are inappropriately located in warehouse facilities with abundant health and safety issues. With the impending transfer of even more community programs, it is the ideal time to co-locate all the programs in appropriate facilities. This will, of course, increase the overhead to market rent costs but will resolve the health and safety issues and provide greatly improved access for clients with one-stop shopping when all the programs are housed together.

#### **Recommendation:**

- **That new annualized funding of \$200,000 to allow for consolidated community programs, to address workplace health and safety issues; improve service access and; enhance service delivery.**

#### **2. Northern Initiative for Social Action (NISA)**

NISA is a consumer initiative with an occupational rehabilitation focus for mental health consumers/survivors in the City of Greater Sudbury. NISA strives to establish, maintain and operate a non-profit community employment, training and volunteer centre for consumers of mental health services, with a view to returning them to the workforce.

They currently operate a number of innovative programs such as:

- The Northern Computer Recycling Depot (NCRD) – teaching computer maintenance and repair

- The Artist's loft – support for clients to participate, develop fine art skills and exhibit work in community settings
- The Writer's Circle and The Open Minds Quarterly – support to develop writing skills and publish work online or in a quarterly journal
- The Dandelion Café – coffee shop operation in the Algoma site of the NEMHC providing training and employment in the retail sector

The organization reports that 43% of their members have moved on to some form of remunerated work since attending their programs.

NISA is not a transfer payment agency and has never received funding directly from the Ministry of Health and Long-Term Care. NISA was previously supported by the Northeast Mental Health Centre (NEMHC) and continues to be provided with programming space and minimal operating costs (heat, hydro, and telephone) at the Sudbury site. Currently 99 members regularly attend the program and clients are often referred to the program upon discharge from the acute care setting.

Currently, NISA is receiving short-term funding, on a one-time fiscal year basis, from FedNor. FedNor stepped in to allow the program to continue when other sources of revenue failed to sustain the program last year.

**Recommendation:**

- **That new annualized funding of \$200,000 is provided to stabilize this consumer/survivor program.**

**3. Orientation and Training**

The HRSRH has identified the need for one-time funds to orient and train the approximate 100 people (80 FTEs) who will be transferring with the programs from NEMHC. These new staff will require the general orientation to the policies and procedures of the HRSRH and while they have program knowledge they will need training in the data collection and clinical charting methods used at the hospital. There is precedence for this one time request as funds were provided to HRSRH by the MOHLTC for the same type of orientation and training when HRSRH received the Sudbury Cancer Treatment Centre. The MOHLTC has indicated a formula of \$2500.00/employee is used as a ministry guideline for this activity.

**Recommendation:**

- **That one-time funding for training and orientation costs for transferring staff be allocated, estimated to be \$200,000.**

#### **4. Outpatient Clinic Enhancement**

The HRSRH has identified the need for a transitional day program in Sudbury before there could be any reductions in acute mental health inpatient beds. This request flowed through the Sudbury Manitoulin Adult Mental Health and Addictions District Planning Group, and was referred to the Program Operations Committee.

All parties recognize the need for a “transitional community based program”, however further discussion and planning is required to ensure a seamless integrated system, and efficient use of resources.

Funds to support the two core clinical positions that work with the psychiatrists as part of a district level program, to facilitate the timely discharge of Schedule 1 patients to community based programs are needed. Expansion of this program in future years is anticipated once the systemic need is more clearly articulated.

#### **Recommendation:**

- **That new annualized funding of \$200,000 be allocated to begin the process of developing a robust mental health outpatient clinic program in Sudbury.**

#### **Overhead and Other Related Expenses**

As part of the overall program transfers of both Community Mental Health Services and the eventual transfer of Inpatient Mental Health Beds, it will be necessary for NEMHC and HRSRH to review and develop a recommendation for the appropriate level of administrative and overhead support for each of the programs on a going forward basis. At this point, it would be difficult to assess the potential funding implications for either or both parties.

#### **Recommendations:**

- **That NEMHC and HRSRH review their respective current overhead structure and identify all potential changes in service that can reasonably be predicted as a result of the community transfers noted to date, and with the pending transfer of acute inpatient beds**
- **That transitional funding be provided to NEMHC to support the \$330,000 of estimated allocated overhead noted above as part of the Community Mental Health Program transfer and the \$60,000 of allocated overhead in support of the Pinegate activities, taking into consideration any opportunities that might result from the point above.**

As you will note, there are a number of outstanding issues yet to be resolved. My recommendation is that these issues should be addressed between the sending and receiving organizations, in consultation with the Ministry of Health, including:

- Accrued vacation liability
- Legal and Information Technology costs not yet finalized,

- Overhead expenses for Pinegate and the community programs, and
- Potential unionization costs.

## **North Bay**

### **1. Psychogeriatric Services**

The North Bay Psychiatric Hospital (NBPH) is slated to reduce its tertiary bed capacity from 255 to 144. These changes will bring about pressure for enhanced community based services for this rapidly growing population with increasingly complex needs. As beds close at NBPH, integration and coordination of primary care, CCAC, long-term care, mental health and addictions services will be essential to avoid or reduce costly unnecessary hospital admissions.

Currently, in the Nipissing District there are no dedicated district-level resources to provide psychogeriatric services. There is some limited local support from the regional inpatient program at NBPH to provide consultation to the Nipissing District and area. A clinical liaison position for CCAC(s), psychogeriatric community resources and Interim Strategies Group, addiction services and all other parts of the system would enhance community programming capacity in North Bay. The position would be placed in an existing community-based mental health program.

#### **Recommendation:**

- **That new annualized funding of approximately \$100,000 be allocated to support 1 FTE clinical position in community mental health programs in North Bay for psychogeriatric services.**

### **2. Orientation and Training**

Similar to the identified need in Sudbury for one-time costs for orientation and training when the NEMHC staff transfer to the HRSRH, there will be costs in North Bay when staff of the NEMHC transfer to the NBGH. MOHLTC guidelines suggest \$2500.00/employee for this activity.

#### **Recommendation:**

- **That one-time funding for training and orientation costs, estimated to be \$117,500 be available to the NBGH.**

### **3. Overhead and Other Related Expenses**

As part of the overall program transfers of both Community Mental Health Services and the eventual transfer of Inpatient Mental Health beds, it will be necessary for NEMHC and NBGH to review and develop a recommendation for the appropriate level of

administrative and overhead support for each of the programs on a going forward basis following the transfer of the NBPH to NEMHC. At this point, it would be difficult to assess the potential funding implications for either or both parties.

## ***Recommendations for Sudbury/Manitoulin***

### ***1. Principles for Program Transfer***

*The Operations Committees and the Advisory Committees have provided their support for the Guiding Principles which will assist in minimizing disruption of the workforce and ensure that patient care needs remain the focus of our outcomes (Appendix B).*

Therefore, it is recommended that

- **MOHLTC recognize and approve the Principles for Program Transfer as developed by the stakeholders for use with the affected transfers.**

### ***2. Program Transfers***

*The Operations Committees and the Advisory Committees have provided their support for the transfer of the district level mental health and addiction programs identified below and the HRSRH and NEMHC have agreed to receive the programs.*

Therefore, it is recommended that

- **Programs affected in Manitoulin and Sudbury Districts, currently operated by NEMHC with a district focus whose governance will transfer to HRSRH, those being:**

#### **Community Programs:**

- Assertive Community Treatment Team 1, Sudbury
- Assertive Community Treatment Team 2, Sudbury
- Case Management / Positive Steps
- Psychogeriatric Outreach Programs
- Concurrent Disorders, Sudbury
- Community Treatment Orders, Sudbury
- Pinegate Addictions, Treatment—Problem Gambling
- Pinegate Addictions Withdrawal Management Programs

#### **Community Clinics:**

- Espanola Clinic
- Manitoulin Clinic
- Suicide Prevention, Espanola
- New Directions, Hanmer Valley East
- Walden Help Centre, Lively
- East Algoma Clinic

**Program currently operated by HRSRH with a regional focus whose governance will transfer to NEMHC:**

- Eating Disorders Clinic, Regional Program Component

## ***Recommendations for North Bay/Nipissing***

### ***1. Program Transfers***

*The Operations Committees and the Advisory Committees have provided their support for the transfer of the district level mental health and addiction programs identified below and NBGH have agreed to receive the programs.*

**Therefore, it is recommended that**

- **The list of Programs affected in Nipissing District currently being operated by NBPH with a district focus whose governance will be transferred to NBGH, those being:**

#### **Community Programs:**

- Assertive Community Treatment Team 1, North Bay
- Assertive Community Treatment Team 2, North Bay
- Rehabilitation Resources
- Dr. Claude Ranger Clinic
- Concurrent Disorders, North Bay
- Community Treatment Orders Coordination, North Bay

**NOTE:** *In North Bay, the transfer of community mental health programs can NOT occur until after the transfer (previously referred to as divestment) of the North Bay Psychiatric Hospital (NBPH) to the Northeast Mental Health Centre has been completed. A date for the NBPH transfer has not yet been determined.*

### ***2. Go-Forward for North Bay Parties***

I see the need to immediately begin some dialogue in North Bay among the NBPH, NEMHC and NBGH even though the date for transfer of the NBPH has yet to be announced. There are several issues that can be worked on right now regardless of timelines.

**Therefore, it is recommended that**

- **The three North Bay parties begin discussions with the purpose of expediting the timelines for smooth transfer of the recommended community program transfers in North Bay.**

## ***Summary of Recommendations:***

1. The MOHLTC recognize and approve the Principles for Program Transfer as developed by the stakeholders for use with the affected transfers (Appendix B).
2. Transfer the Programs currently governed and operated by NEMHC with a Sudbury/Manitoulin District focus to HRSRH, those being:
  - Community Programs:**
    - Assertive Community Treatment Team 1, Sudbury
    - Assertive Community Treatment Team 2, Sudbury
    - Case Management / Positive Steps
    - Psychogeriatric Outreach Programs
    - Concurrent Disorders, Sudbury
    - Community Treatment Orders, Sudbury
    - Pinegate Addictions, Treatment—Problem Gambling
    - Pinegate Addictions Withdrawal Management Programs
  - Community Clinics:**
    - Espanola Clinic
    - Manitoulin Clinic
    - Suicide Prevention, Espanola
    - New Directions, Hanmer Valley East
    - Walden Help Centre, Lively
    - East Algoma Clinic, Elliot Lake
3. Transfer the Regional Program component of the Eating Disorders Program currently operated by HRSRH to NEMHC.
4. Complete the implementation plan for the community program transfers in Sudbury by June 30, 2005 and implement by October 1, 2005.
5. In Sudbury, enhance funding in the amount of \$1,390,000 which includes:
  - Annualized funding is to HRSRH to support the \$330,000 program deficit in Community Mental Health Program #1004.
  - New annualized funding of \$200,000 to NISA to stabilize this consumer/survivor program.
  - New annualized funding of \$200,000 for clinical positions to begin the process of developing a robust mental health outpatient clinic program in Sudbury.
  - New annualized funding of \$200,000 to allow for consolidated community programs, enhancing service delivery.
  - New annualized funding is provided to HRSRH to support wage harmonization, estimated to be \$160,000.
  - One-time training and orientation costs for staff transferring from NEMHC to HSRH in the amount of \$200,000 (80 FTE's)
  - HRSRH's one-time legal and IT costs associated with the transfer, estimated to be at least \$100,000

6. In North Bay:

- Transfer the Programs currently being governed and operated by NBPH with a Nipissing District focus to NBGH, those being:

**Community Programs**

- Assertive Community Treatment Team 1, North Bay
- Assertive Community Treatment Team 2, North Bay
- Rehabilitation Resources
- Dr. Claude Ranger Clinic
- Concurrent Disorders, North Bay
- Community Treatment Orders Coordination, North Bay

**NOTE:** *In North Bay, the transfer of community mental health programs can NOT occur until after the transfer (previously referred to as divestment) of the North Bay Psychiatric Hospital (NBPH) to the Northeast Mental Health Centre has been completed. A date for the NBPH transfer has not yet been determined.*

7. Encourage the three parties in North Bay, comprised of NBPH, NBGH and NEMHC, begin discussions to ensure a smooth transfer of community programs.
8. In North Bay, enhance funding in the amount of \$217,500 which includes:
  - Annualized funding for 1 FTE clinical position in the community mental health program annualized at approximately \$100,000.
  - One-time funding for training and orientation costs, estimated to be \$117,500 for staff transferring from the NEMHC to the NBGH.

***Recommendations from Appendix A:***

1. That the MOHLTC announce long-term psychiatric services will be concentrated in North Bay to allow the NEMHC to focus on best practice models of care in a consolidated environment; and
2. Announce an increased number of short-stay acute care mental health beds to be governed and operated by the HRSRH from the current proposed 39 to 60; and
3. Confirm that over time, within the 60 beds in Sudbury, 12 beds will become specialized longer-term regional service beds; and
4. That these 12 specialized beds be operated by HRSRH and that the HRSRH be accountable to NEMHC for ensuring their use is consistent with the intent described.
5. That the NEMHC and HRSRH should complete their implementation plan for the bed transfer by October 30, 2005 and should execute that plan as soon as possible, but no later than December 31, 2005.

## *Conclusion*

I would like to take this opportunity to thank the Advisory Committees members and the Operations Committee members for their dedication and commitment to this process. As well, I would like to thank the Operations Committee Chairs: Brian Edmonds, Finance; Sally Lewis, Labour Relations; Nancy Cornwell, Programs and; Benoit Long, Communications; along with Janice Beazley, who has helped immensely with the data gathering, analysis and coordination of this process. Thanks also to Eileen Mahood, Healthcare Consultant, for her role in data gathering, facilitation and moving the implementation process forward. Of course, I would be remiss if I did not also thank the Ministry of Health, North Region Branch, Ann Matte and her staff for their terrific support, cooperation and work in coordinating all the logistics for meetings and the gathering of information in Sudbury and North Bay.

As a result of the various committees, system planning groups and task group work undertaken during this process, it has become apparent that there is a large need to ensure sustainability and enhanced quality of care for people with mental illness in the Districts of Sudbury, Manitoulin and Nipissing.

Clients using these services should not experience access difficulties as a result of the transfers. Rather, a consolidated program operation will enhance the quality of care experienced by individuals living in the communities with serious mental illness. To achieve these goals, an estimated \$1.6M has been identified, so far, to erase program deficits, enhance community programming and position Sudbury and North Bay to fulfill their mandates in mental health.

Timelines for the transfers of the community programs have been finalized and I recommend the consultant, Eileen Mahood, work closely with the NEMHC, NBGH and HRSRH to ensure due diligence matters are addressed in order to satisfy the fiduciary responsibilities of the respective boards. The implementation will occur using the guiding principles to identify the programs to be transferred, and will respect collective agreements currently in place and industry best practices and will ensure fair and adequate treatment of staff. This phase will include extensive consultation with the employer, their staff and bargaining agents.

I plan to discuss my final recommendations with the Advisory Committees as well as connecting with the local politicians. In order for the implementation to proceed, I look forward to your final confirmation on the recommendations included in this report.

## APPENDIX A

### *Acute Mental Health care Beds in Sudbury and Specialized Psychiatric Care Beds in North Bay and Sudbury and Regional Children's Services in Sudbury*

Currently, Sudbury is operating 68 acute care beds (24 at HRSRH and 44 at NEMHC) but according to HSRC directives, Sudbury is directed to have 39 acute care beds. The timeline for this downsizing has not been established but HRSRH is planning for a 39 bed unit in the new single site hospital now under construction. It is estimated that it will be 5-7 years before HRSRH would be able to accommodate acute mental health patients in the new facility. It should also be noted, that the medical community never accepted the HSRC directive as an achievable target and is now collecting evidence to substantiate the need for more than 39 acute care mental health beds in Sudbury to serve the Sudbury/Manitoulin Districts. One argument raised is the size of the City of Greater Sudbury vs. the City of North Bay since North Bay is slated to have 40 acute care mental health beds in the new NBGH facility. It is very likely that this issue will continue to be controversial and very high profile in the community if the number of acute care mental health beds remains at 39.

Currently, North Bay has 42 acute care mental health beds available with 6 beds sited at the NBGH and the rest sited at the NBPH. The original HSRC directives for acute mental health beds in North Bay was 30 however, a recommendation of the Northeast Mental Health Implementation Task Force (NEMHITF) to increase the acute beds in North Bay to 40 was approved by the Ministry, changing the HSRC directives, and the planning of the new NBGH facility includes 40 acute care mental health beds.

Of course, Sudbury/Manitoulin Districts and area served by HSRH as the Schedule 1 Facility is larger with a greater population density than North Bay and area to be served by the NBGH when it becomes the Schedule 1 Facility for Nipissing and Temiskaming Districts. Part of the Sudbury argument for more beds is wrapped up in this perceived bias towards North Bay.

Complicating the issue of acute care mental health beds in Sudbury is the proposed transfer of 31 long-term specialized psychiatric beds from the NEMHC, post-transfer of the NBPH, from North Bay to Sudbury. This has never been a popular proposal and throughout this facilitation it has been apparent that the North Bay municipality intends to make this an issue of job loss to the community if the proposal goes forward. With the imminent announcement date for the transfer of the NBPH to the NEMHC we can anticipate this becoming a hot issue soon.

Further, the Sudbury medical community, particularly the psychiatrists, does not want the 31 specialized beds to come from North Bay to Sudbury. Without an increase in the acute mental health bed number for Sudbury, there would be similar job loss in Sudbury as is anticipated in North Bay. More importantly, it will be very difficult to efficiently achieve quality care for the 31 long-term patients since this would be a very small

program with no economies of scale regarding program supports such as social workers, occupational therapists, recreational therapists, etc. if operated by NEMHC at the Sudbury site. During the community consultations both North Bay and Sudbury voiced the preferred model for the optimum delivery of specialized psychiatric services was to leave all the specialized beds in North Bay operated by the NEMHC. Preliminary discussions of such an option have revealed that it may be possible to achieve this model without any major capital expenditures in North Bay through innovative partnerships with Long-Term Care facilities in the area to serve the Psychogeriatric population now housed at the NBPH.

Resolving the outstanding conflict between North Bay and Sudbury lies with the ability of the Ministry to support the communities' solution regarding beds. All the parties concurred that the best solution is to leave the 31 adult long-term specialty psychiatric beds in North Bay that were proposed to move, under the governance of the NEMHC. However, in discussions with the Ministry of Health and based on my recommendation of 60 acute care beds in Sudbury, there was serious concern with the acute care bed numbers and such a sharp reduction in long term care beds in Sudbury. Therefore, it was concluded that over time 12 of the 60 beds in Sudbury would become longer-term, specialized regional beds. Further, I recommend that these 12 beds be operated by HRSRH and that the hospital be accountable to NEMHC for ensuring their use is consistent with the intent described. This results in NEMHC operating the specialized psychiatric beds and 54 forensic beds in North Bay following transfer of the NBPH to them. The resources attached to the 19 remaining beds in North Bay from the original 31 proposed for Sudbury will require further planning.

It also includes increasing the number of acute care mental health beds in Sudbury from the current 39 to 60 based on evidence of increased need, using the InterQual Medical Review Criteria for Mental Health. This survey was undertaken on April 14 - 17, 2005 on all 68 acute care mental health beds currently in use at HRSRH and NEMHC. This snapshot revealed that if no patients stayed beyond their expected length of stay, a minimum of 45 acute mental health beds would be required but that number assumes there is an efficient and fully functioning community mental health system, including full day treatment programs in place and 100% occupancy. Allowing for 85% occupancy and some ALC patients due to lack of community services and the large geography of the District, it is the hospital's estimation that an absolute minimum of 60 beds are required to meet the demands for Schedule 1 services in the Districts of Sudbury and Manitoulin.

It is recognized that, if there is significant reinvestment in community based programs including a fully functioning day treatment facility, addictions program, supportive housing and other community mental health programs, it would be possible to further reduce this bed number over time allowing bed space to accommodate 12 specialized Long-Term Regional beds, creating a unit such as the Clinical Rehabilitation Evaluation Unit (CREU) currently operating at the NBPH. This unit targets individuals with persistent serious mental illness who have exhausted the communities' ability to support them. The program provides innovative, specialized tertiary mental health care designed

to prevent long-term admissions, promote community re-integration and bridge local district services and the specialized programs of NEMHC.

The resolution of these bed issues in both North Bay and Sudbury are seen as cost neutral regarding both operating and capital costs through the development of creative and innovative partnerships. In addition, the recommendations satisfy the goals of quality patient care, community consensus and political peace.

### **Recommendations:**

- **That the MOHLTC announce long-term psychiatric services will be concentrated in North Bay to allow the NEMHC to focus on best practice models of care in a consolidated environment; and**
- **Announce an increased number of short-stay acute care mental health beds to be governed and operated by the HRSRH from the current proposed 39 to 60; and**
- **Confirm that over time, within the 60 beds in Sudbury, 12 beds will become specialized longer-term regional service beds; and**
- **That these 12 specialized beds be operated by HRSRH and that the HRSRH be accountable to NEMHC for ensuring their use is consistent with the intent described.**

### *Transfer Timelines*

The bed issues, while resolved, require more time to complete the implementation planning process. It is important to finalize the short-stay acute care beds transfers from NEMHC to Sudbury in close proximity to the timeframe established for the community program transfers in order to maintain the integrated solution agreed to by all parties.

### **Recommendation:**

- **That the NEMHC and HRSRH should complete their implementation plan for the bed transfer by October 30, 2005 and should execute that plan as soon as possible, but no later than December 31, 2005.**

### *Regional Children's Services*

To improve the service delivery model for the Regional Psychiatric Children's Program and allow for all the adult acute inpatient beds to be located on the Algoma site, it will be necessary to relocate the current 12 children's beds to the HRSRH while NEMHC will retain the governance of this program. A Service Agreement can be used between NEMHC and HRSRH to ensure an effective program is delivered for Northeast children in need of inpatient specialty services.

The timeline for this move will be determined during the operational planning for the bed transfers.

## **APPENDIX B**

### ***PRINCIPLES FOR PROGRAM TRANSFER***

#### **Overarching Statement of Principle**

The guiding principles are developed to minimize disruption of the workforce and ensure that patient care needs remain the focus of our outcomes. The process will be as transparent as possible. Employees will be regularly informed of the progress of the integration and impact it will have on them. Individuals are valued and will be treated in a fair and equitable manner. Staff input will be sought when possible and local negotiations will adhere to the defined principles

#### **Seniority and Service**

- Seniority will be maintained for all affected staff.
- Integrated seniority and service will be the goal for all transfers.

#### **Wages**

- Integration onto receiving hospitals' pay grid.
- No salary reductions on transfer.
- Red-circling will apply until catch-up if required.
- Pay equity will be maintained.

#### **Benefits** (e.g. Extended Health, Dental)

- No new waiting period.
- New employer benefit plans apply to transferred staff.
- Sick leave plan to be HOODIP or equivalent.
- The receiving hospital shall not assume the debt for any transferring employees.

#### **Vacation**

- Maintain vacation entitlement or move to new employers, whichever is greater, until catch up to new employer plan.
- Carry over in excess of receiving employers plan will be allowed reasonable time frame to adjust and take vacation.

#### **Access to work**

- Every effort will be made to avoid involuntary layoffs of clinical staff.
- If excess staff then an integrated seniority/service list will be utilized to issue notice of layoff and offer voluntary exit options to all sites.
- Potentially affected employers will have access to vacant positions in both the sending and receiving hospitals after the normal posting processes have been followed.

## **Communications**

Communications with affected staff and with their representatives shall be made in a timely manner.

## **Training/Orientation**

Effective orientation/training will be offered to all transferred employees.

## **Limitations on Employees to be transferred**

Only active employees will be transferred. Employees are on WSIB or LTD stay with sending organization until able to return to work and then offered job.

## **Terms and conditions of Employment**

The terms and conditions and policies and procedures of the receiving organization will apply. There will be no new probationary period.

Special Work arrangements i.e. Shift rotations, hours of work will be considered on an individual basis contingent upon the patient care/ service needs of the receiving organization.

## **Contingent Liabilities**

Programs which are being transferred are supported by a number of services, equipment and property considerations which may not be exclusive to the transferring program. In determining the financial implications of these issues, the following principles shall apply:

- The receiving hospital shall not assume identifiable contingent liabilities as a direct result of the program transfers.
- Ministry of Health shall not require revised service agreements for a minimum of six months to allow reconciliation of costs contingent liabilities.
- Any changes to the Service Agreements shall be negotiated by the parties in advance.
- All efforts shall be undertaken to minimize costs to the receiving hospitals.
- Lower cost opportunities (such as leases versus mortgages) shall be explored and discussed prior to final decisions.
- Access to services shall be maximized and every effort be made to minimize costs on a “go forward” basis.

## **Funds**

Designated funds will be transferred with the programs.

## **Financial Reporting**

Financial Reporting of the designated funds transferred with the programs shall be maintained in the same manner in the receiving hospital as it had in the transferring hospital.

## APPENDIX C

### ***RECOMMENDATIONS RE: FACILITATOR'S MANDATE NORTH BAY/SUDBURY COMMUNITY ADVISORY GROUP ABORIGINAL ISSUES***

The restructuring that is occurring now within the Northeast Mental Health Centre is an excellent opportunity for strategic planning, and the development of Aboriginal programs and services which will benefit all of the Aboriginal peoples within the Northeast region, and to ensure that Aboriginal Services are strengthened and enhanced to effectively assist and compliment the long-term development of First Nation's community wellness. Throughout this discussion, when the term "hospitals" is used, it signifies HRSRH, NBGH and NEMHC. As beds and programs are being transferred to HRSRH, it is important that the Sudbury Regional Hospital also develop similar services.

The report for the Anishinabek Health Commission's Mental Health Planning Session (March 2 & 3, 2005) highlights some of the key points which should be kept in mind during this process.

- a) Suicide is a major component of intentional injury rates among Aboriginals in their late teens and early adult years.
- b) There is an increasing shift from alcohol abuse to heavy drug use, both prescription and illicit drugs (p. 12).
- c) There is a strong need to prevent children's mental health issues from being separated from that of adults, given the intergenerational issues, and therefore the need for qualified mental health providers to provide a continuum of care (p. 21).
- d) The current service gaps (p. 25-27) and priority rankings (p. 31-32) and priority initiatives (p. 34-36) identified in the report, provide a good place to work from in looking to how this current opportunity can be capitalized upon to move the broader agenda forward.

1. That an Aboriginal Regional Mental Health Council be developed to provide the links required between the existing regional specialized outreach services, on and off reserve district level services, and the Northeast Mental Health Centre. Three local councils should deal with issues in each of the Manitoulin Island, Sudbury, and Nipissing areas, and meet regionally 3 to 4 times a year. This area should be divided into three local council's because of the differing peoples, cultures and dialects in each area. The Manitoulin Island area is primarily Odawa; Sudbury is urban Aboriginal from several cultures; and Nipissing is Algonkian and Cree. Each area has distinct needs and methods of problem solving. The differences between the people of Manitoulin Island, Sudbury, and the Nipissing area are so great, that social, psychological and spiritual problems require different solutions which must be dealt with by persons familiar with the local customs.

2. That the Northeast Mental Health Centre continues in creating an Aboriginal Regional Mental Health Coordinator position that will support the Council, and assist with problems in all three local Council areas. Hopefully the Coordinator will also look for creative ways to get around the funding barriers as well as accomplish the goals of the job description.

3. We also feel very strongly that an Outreach / Liaison Worker should be hired for each of the three local Council areas to deal with gaps throughout the system and set up formal networks between the communities and the care-givers. New funding would be required for these positions. The Aboriginal Regional Mental Health Coordinator will supervise these positions through regular and ongoing interaction. It will be the duty of each of these Outreach / Liaison Workers to develop the local Council and ensure that all local stakeholders can provide input, including; elders, native child and family services, First Nations, resource people, community health workers, and native mental health workers. As well, the outreach worker will arrange for a diagnostics team as needed, prepare research, and look for opportunities for work within the concurrent disorders area, withdrawal management and crisis intervention expansions. The more Aboriginal workers there are within the mainstream, the greater the opportunities for linkages to the on-reserve providers, despite the jurisdictional funding challenges.

The Coordinator and the Outreach / Liaison Workers should also provide regular and ongoing workshops to native and non-native agencies and

communities in areas such as FASD, alcohol and drug, and the workings of the mental health hospitals themselves. Most Aboriginal people do not know what they can expect to happen to their family members should they require hospitalization. Even those working within the mental health field in Aboriginal agencies have almost no idea of what happens in the hospitals. An on-going orientation and information session on how the hospitals function, what programs are there, and what outside community resources are available would go a long way in alleviating these concerns.

4. Also, each district Mental Health and Addictions provider group should be required to work with the Aboriginal agencies and communities within their area to collectively address the challenges related to services for Aboriginal citizens, both on and off reserve.

Perhaps some planning dollars could be allocated to move this forward over the next year. The relevant items could be taken from the March 2005 Anishinabek Health Commission report and specifically worked on from the perspective of mainstream services.

5. There is a need to enhance current funding levels within existing off-reserve Aboriginal Services, specifically for mental health and addictions screening, raising awareness, etc., perhaps with the expectation that a close collaboration be developed between those workers and mainstream providers through the district planning tables.

6. There should also be ongoing workshops for all staff, in all of the hospitals, from the CEO to the cleaning staff, about the different Aboriginal cultures and peoples, including their social structures and cultural uniqueness.

7. In addition, there must be an Aboriginal Patient Advocate in all of the hospitals. It might also be helpful to establish a patient committee to meet with the Advocate to discuss their needs and wants. An example of the kind of problem that a patient committee might need help with is organizing social and planning times for patients on different wards who are of the same tribal affiliation. It helps with loneliness and gives them an opportunity to interact with others who speak their language and are from their own culture. This Advocate could service both inpatients and outpatients.

8. Another important issue to keep in mind is that spirituality is a very important resource in healing the spirit of Aboriginal people. So it is vital that all three hospitals keep an Elder (preferably one male and one female) on contract to help those who are hospitalized, and to provide them the opportunity to practice their spirituality. Concessions need to be made to allow for spiritual ceremonies for those requiring them for patient healing, life passages and death.

9. While the jurisdictional funding issues are acknowledged, it is our belief that with creatively, e.g. a “services in kind” barter system, these can be mitigated. For instance, some training dollars could be allocated to support specialized skills development for all providers that could be opened up to on-reserve providers potentially without charge, in exchange for something in return for the off-reserve providers, such as training in culturally competent care or Fetal Alcohol issues (as per some of the recommendations from the Community Justice Program Needs Assessment Reports for North Bay and Sault Ste. Marie that I prepared), or physician training re the issue of increasing prescription drug abuse, etc., i.e. a “services in kind” barter system – if no money has to change hands perhaps we can overcome some of the funding barriers.

10. Likewise, specialized clinical supervision could be addressed with “job exchange programs or opportunities” being developed as a way of providing access to specialized training at the hospitals for on-reserve workers in exchange for awareness and cultural competence training on-reserve for hospital staff. Issues could be worked out with some creative thinking here.

**APPENDIX D**

**PSYCHIATRY SURVEY  
NORTHERN ONTARIO**

**MAY 2005**

**Prepared by  
Eileen Mahood, Healthcare Consultant**

**For  
Ken White, Facilitator  
And  
The Ministry of Health and Long-Term Care**

# **Psychiatry Survey Northern Ontario May 2005**

## **Introduction**

To gain understanding of the current issues facing communities in the recruitment and retention of psychiatrists and the administrative support infrastructure required for psychiatrists practicing in northern Ontario, a survey was conducted in March/April 2005 of communities with practicing psychiatrists and Schedule 1 facilities. These communities include Kenora, North Bay, Sault Ste. Marie, Sudbury, Thunder Bay and Timmins.

## **Methodology**

Telephone interviews were held with psychiatrists and/or hospital personnel to determine the practice patterns of psychiatrists, service provisions to the Schedule 1 Facility, compensation models and/or in-kind supports that are in place for this discipline.

## **Overview**

The Schedule 1 Hospitals in the Northwest communities of Kenora and Thunder Bay and in the Northeast communities of North Bay, Sault Ste. Marie, Sudbury and Timmins offer mental health services as part of acute hospital services defined in the Mental Health Act. Schedule 1's must provide mental health programming for in-patient, outpatient, emergency and day services and provide consultation and education services to local agencies.

To meet the mandate as a Schedule 1 Facility, it is imperative that the services of resident psychiatrists be available. This has required innovation, creativity and flexibility on the part of these northern hospitals to recruit and more importantly retain psychiatrists. With specialized psychiatric services available in only two (2) northern regional sites, Thunder Bay and North Bay, it is essential that mental health patients have access to acute services as close to home as possible. Even with the northern Schedule 1 Hospitals operating in the urban centres of the North, many patients have to travel large distances to access these services. Many smaller northern hospitals depend on the Schedule 1 District service to accommodate patients from their hospital in the Schedule 1 Facility. The services are part of the continuum of mental health care from primary care, to community services, to acute hospital care, to specialized psychiatric care.

The sustainability of the mental health system in the North is weakened by the lack of an adequate number of psychiatrists practicing in northern Ontario.

According to the Royal College of Physicians and Surgeons (RCPS), the ratio of psychiatrists to the population should be 1:8650. With that in mind, northern Ontario should have a complement of at least 55 Psychiatrists. Currently, there are 18 vacancies among communities designated under the Ministry of Health and Long-term Care's (MOHLTC) Underserviced Area Program (UAP). Vacancies exist in all the Schedule 1 communities except North Bay with the most extreme need currently in Sudbury where seven (7) Psychiatrists are needed to reach an identified complement of 20.

Many northern communities with small hospitals require the services of a Psychiatrist for outpatient clinic programs and some resident Psychiatrists do provide outreach clinic services in these communities but there are far greater program needs than can be met by the current northern Psychiatrists. The MOHLTC supports an innovative program called The Ontario Psychiatric Outreach Program (OPOP) to supply psychiatrists to the many communities in the North not served by northern resident Psychiatrists.

The OPOP program is a network comprised of the University of Toronto, Department of Psychiatry, the University of Western Ontario's Extended Campus Program, the University of Ottawa's Francophone Psychiatric Outreach Program and the Northern Academic Health Science Network. This innovative program, while originally meant to be a temporary measure, has in fact, become part of the fabric of service delivery for mental health in the North. In 2003/04 the program provided 1392 Psychiatric consultation days, 936 Telepsychiatry sessions and 319 distance education sessions. Of equal importance to the service provision component of the program they also provide psychiatry residents with exposure to northern communities. In 2003/04 the program provided 1647 resident core rotation days. Without these services many patients experiencing serious mental illness would have had to leave their community and support system to access psychiatric services.

It is recognized that the need for recruiting and retaining Psychiatrists creates an atmosphere of intense competition among northern communities. Scarce resources and the aging population of physicians in this discipline results in communities providing a variety of incentives to attract and keep psychiatrists in their communities.

While there are unique differences in the various communities, all Schedule 1 Facilities in the North are providing administrative supports to psychiatrists. These supports minimally include office space, secretarial support and transcription services. A wide variety exists in the amount of support (number of secretaries, number of offices, etc) provided and one community is charging a very minimal rent fee for offices in the hospital.

## **Observations**

1. Since the Mental Health Act (MHA) requires Schedule 1 Facilities to provide in-patient, outpatient and emergency services, designated Schedule 1 hospitals in northern Ontario are providing office space, secretarial support and transcription services to psychiatrists providing services to the Schedule 1 hospital to ensure they maintain privileges at the hospital.
2. Since northern Ontario is short many psychiatrists, recruitment and retention initiatives in various communities use in-kind incentives such as office space and secretarial support to get and keep what few psychiatrists they have.
3. The competition for psychiatrists is very strong around the province with the exceptions of Ottawa and Toronto. Even in the Ottawa/Toronto scene it is still difficult to get psychiatrists to serve the Schedule 1 Facility beds and the serious mentally ill (SMI) population.
4. Provincially, psychiatrist clusters can be found at the Academic Health Science Centres (AHSC) with salary/ alternate payment plan (APP) arrangements/ fee-for-service (FFS) and/or mixed compensation models in place to ensure teaching, research and service delivery is available to the medical schools and teaching hospitals in the AHSCs.
5. Practicing psychiatrists in the North report that without the current added incentives, or if available incentives were withdrawn, they would leave northern Ontario for greener pastures.

# COMMUNITY SURVEY

## ***Kenora***

There is one (1) full-time psychiatrist and one (1) full-time GP psychiatrist in Kenora providing the complete range of mental health services, including Schedule 1 services, to a large geographical area of NW Ontario. Outreach clinics in other communities such as Sioux Lookout and Ft. Francis are also supported from Kenora.

There is a blended compensation model consisting of APP and capped FFS. Both physicians participate in the compensation model. There are two (2) vacancies.

The Schedule 1 Facility (Lake-of-the-Woods Hospital) provides in-kind office space, secretarial support and transcription services on site. The outpatient clinic is located in the hospital.

## ***North Bay***

With the location of a MOHLTC Psychiatric Hospital in North Bay, the current psychiatric services are provided, almost exclusively, by psychiatrists, GP Psychiatrists and GPs employed by the North Bay Psychiatric Hospital (NBPH). There is one (1) community psychiatrist in North Bay who does not provide services at the North Bay General Hospital (NBGH) nor at the NBPH.

In November of 2004 a NBPH Medical Staff Human Resources Report indicated a current psychiatrist staff of 20.275 FTEs with the pending retirement of 3 FTEs. The report indicated a staffing need of an additional 9.2 FTEs, which includes the vacancies from the pending retirements, to provide adequate service for the Acute, Community and Forensic Programs, the Seniors Mental Health Program and the Regional Specialized Program. In addition to these numbers, there are three (3) psychiatrists that provide services to a variety of NBPH outreach programs. Also, there are four (4) GP Psychiatrists and two (2) GPs providing a variety of psychiatric services including on-call at both the NBPH and the NBGH.

Due to the unique circumstances of the pending transfer of the NBPH, psychiatrist recruitment and retention continues to be a significant challenge in North Bay. Complicating the issue is the lack of a current contract, since December 2004, between the physicians and the MOHLTC. Once transfer occurs, the psychiatrists, GP psychiatrists and GPs currently employed by the NBPH will become employees of the Northeast Mental Health Centre (NEMHC). The uncertainty of the timing for all these changes combined with the lack of contract continues to hamper recruitment and retention efforts.

The NBPH is currently providing Schedule 1 services in North Bay but post transfer the plan includes a tier 2 transfer of these services from NEMHC to the NBGH.

There is a blended model of compensation that includes salary and benefits plus after-hours FFS. The FFS clerical billing support is not provided for by the NBPH. Sessional fees are also available to non-salaried North Bay psychiatrists for approved services.

As staff, psychiatrists are provided office space, secretarial and transcription services at the NBPH site.

At this time, three (3) of the NGPH psychiatrists provide services at the NBGH. The NBGH will become the Schedule 1 Facility for North Bay when the new hospital is built and plans include the provision of office space, secretarial and transcription services to be made available to psychiatrists at the new NBGH site.

### ***Sault Ste. Marie***

There are currently five (5) psychiatrists in Sault Ste. Marie (SSM) with an expected sixth one to arrive in the summer of 2005. There are also two (2) GP psychiatrists and all seven (7) serve the Schedule 1 Facility in SSM. Even though recruitment and retention initiatives are heavily supported by the city of SSM from casino profits (approximately 400k) last year, there is still a challenge in recruiting sufficient psychiatrists to SSM.

The MOHLTC's UAP identifies one (1) vacancy existing in SSM but the community estimates that there is still a need for 4-6 additional psychiatrists to adequately serve the Schedule 1 Sault Area Hospital (SAH) and the District of Algoma.

The compensation model for psychiatry in SSM is FFS and Sessional Fees. In addition, the Assertive Community Treatment Team (ACTT) has salary dollars for 1 FT psychiatrist who is attached to the team and counted in the number of psychiatrists currently serving SSM.

Office space, secretarial and transcription services are provided as in-kind contributions from the Schedule 1 Facility (SAH) and the outpatient clinic is located in the hospital.

SSM is in the process of a capital project for a new single site hospital in the community. This project is currently facing downsizing challenges that currently include moving psychiatrist offices off-site from the new hospital. Even if that occurs, the hospital plans to continue to administratively supporting psychiatrists at the off-site venue.

## ***Sudbury***

There are currently 13 psychiatrists practicing in Sudbury. Two (2) are child psychiatrists and one (1) is a community psychiatrist not providing service to the Schedule 1 Facility, the Hopital de Sudbury Regional Hospital (HRSRH) nor to the NEMHC. It is recognized by the Underserviced Area Program (UAP) of the Ministry of Health and Long-Term Care (MOHLTC) that there should be 20 psychiatrists for the Districts of Sudbury/Manitoulin. There are currently seven (7) vacancies.

Recruitment and retention incentives include: a team of four (4) GPs for psychiatry on-call after 5pm/weekends/stat holidays, particularly for emergency coverage at HRSRH but they may be called from the NEMHC on an emergency basis as well; a GP Medical Advisor to complete patient physicals upon admission to the Schedule 1 acute care beds at HRSRH or to the NEMHC; and an arrangement with University of Western Ontario (UWO) for some financial remuneration and partial secretarial support to the chief-of-staff. The recruitment challenges continue for the seven (7) vacancies with the psychiatrists expressing concern over the inability to increase sessional fee dollars in Sudbury and the current uncertainties regarding acute bed availability in the future.

The compensation model is FFS with Sessional Fees and the UWO/MOHLTC arrangement. In addition, the two (2) ACTTs have salary dollars for the psychiatrists serving the ACTTs.

Office space, secretarial support and transcription services are available as in-kind from the NEMHC with a portion of the secretarial support coming from the UWO arrangement. In-patient services are at NEMHC and HRSRH. Outpatient clinics are at NEMHC and HRSRH with some being off-site in the community. In addition, NEMHC operates outpatient clinics in the towns of Walden, Espanola, Elliot Lake and Little Current on Manitoulin Island.

## ***Timmins***

There are 2 psychiatrists in Timmins providing Schedule 1 services. The UAP/MOHLTC recognizes there should be 5 psychiatrists for Timmins. The District of Cochrane is geographically large and while the Schedule 1 Facility, the Timmins and District Hospital (TDH) services the whole district, outpatient clinics outside of the City of Timmins are provided from a variety of other sources such as The Ontario Psychiatric Outreach Program and are limited. The James Bay coastal communities are served by separate arrangements with psychiatrists from the McMaster Academic Health Science Centre.

Recruitment and retention continues to be a major challenge with heavy-duty on-call responsibilities for the two (2) psychiatrists. A GP shared-care model is used

to support the psychiatrists with in-patient care. In addition, psychiatry locum services, from the MOHLTC's urgent locum program, are used for on-call relief.

The compensational model is a blend of FFS, Sessional Fees and a guaranteed minimal income plan from the hospital.

Office space, secretarial support and transcription services are available as in-kind from the Schedule 1 Facility (TDH) but the psychiatrists do pay a very, very small rent fee.

### ***Thunder Bay***

The divestment of the Thunder Bay Psychiatric Hospital (TBPH) has been completed and the Thunder Bay psychiatrists who were employees of the TBPH are currently employees of the St. Joseph's Care Group (SJCG). There are currently 17 psychiatrists in Thunder Bay with one (1) community psychiatrist not providing in-patient care or outpatient clinic care. Three (3) psychiatrists are dedicated to the Forensics Program, one (1) is a Child/Adolescent psychiatrist and only one (1) psychiatrist is providing service to the Schedule 1 Facility, the Thunder Bay Regional Hospital (TBRH).

Recruitment and retention continue as a challenge with acute care services needing more psychiatrists. Locum psychiatrists are used to relieve the pressure on resident psychiatrists. Thunder Bay is currently recruiting an additional Child/Adolescent psychiatrist.

The compensation model is FFS and Sessional Fees. Recently, the psychiatrists were involved in MOHLTC negotiations for an alternate payment plan (APP) but those negotiations were unsuccessful. There are currently two (2) vacancies.

Office space, secretarial and transcription services are provided as in-kind from the SJCG. The psychiatrist offices are physically located at the old Lakehead Psychiatric Hospital. Office space is also available at the Schedule 1 Facility, TBRH.