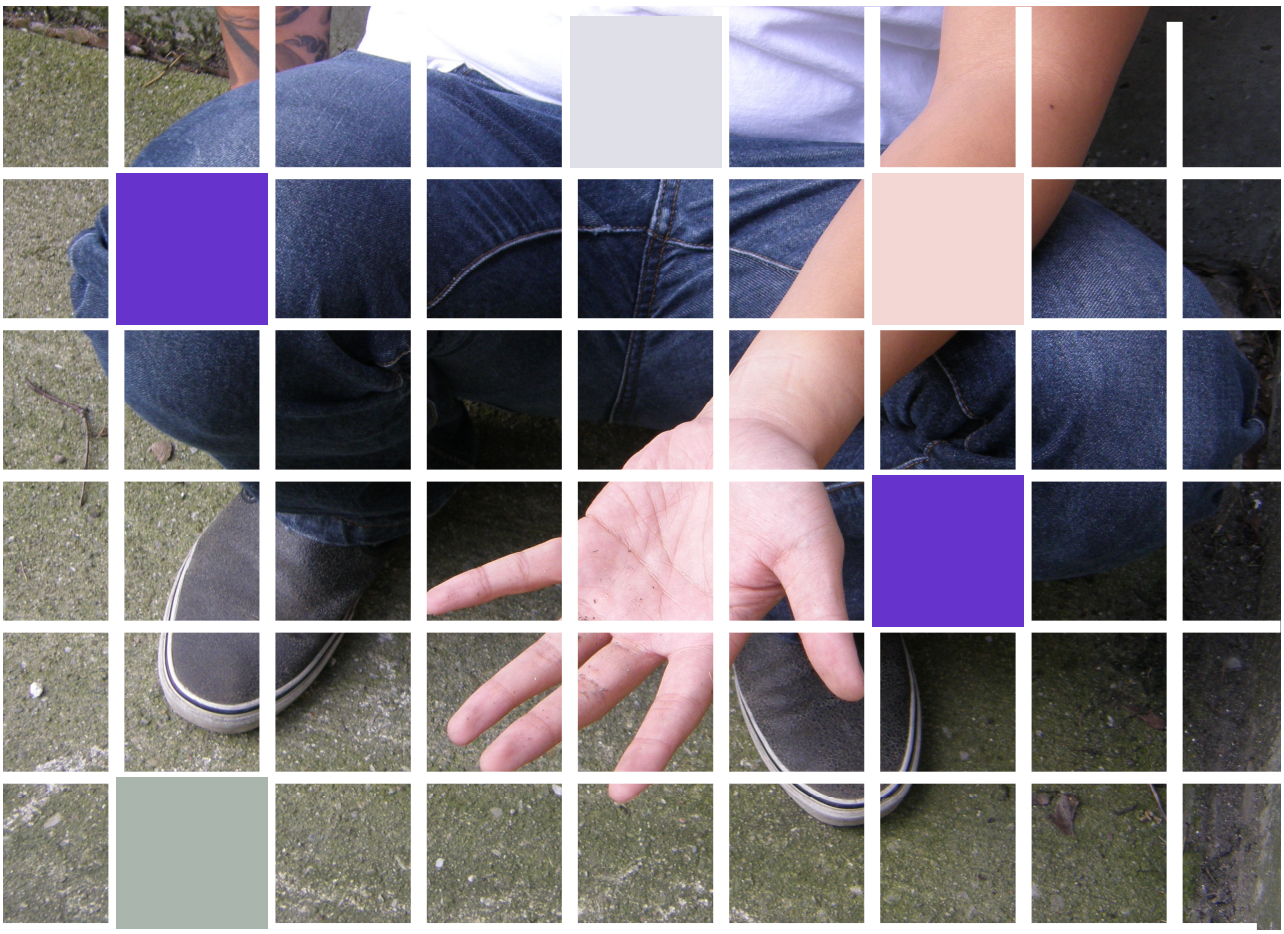
No Place To Go

It's time to take another look at restructuring of mental health in Southwestern Ontario



A report by the
Ontario Public Service Employees Union
September 20, 2010

OPSEU Ontario Public Service Employees Union
SEFPO Syndicat des employés de la fonction publique de l'Ontario

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Ontario Public Service Employees Union / September 20, 2010

C O N T E N T S

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SUMMARY

A major restructuring of mental health beds is taking place throughout Southwestern Ontario. Regional Mental Health Care London and St. Thomas are both being rebuilt over the next four years. When the new facilities are occupied in 2014-15, it is expected the total number of beds will be a little more than half of the present number (from 450 to 245 beds, with an option to expand into 12 more beds).

The recommendations for these cuts come from a 13-year old Health Restructuring Commission (HSRC) report, however, the HSRC strongly recommended that bed cuts only take place *after* appropriate community supports have been put in place. Report after report would suggest this has never taken place. The most recent report from the Office of the Auditor General of Ontario reports that community-based funding for mental health is far from the targets set by the HSRC.

While decision-makers (Ministry of Health, LHINs, Hospitals) have been quick to make the bed cuts, they have never fulfilled their obligations to replace these services. This has created a significant burden for families of mentally ill individuals and a cost estimated to be $39 billion per year to Ontario's economy.

The Ontario Public Service Employees Union represents 1288 workers at Regional Mental Health Care London and St. Thomas. The 450 beds they operate are frequently full. With expected population growth coupled with issues around an aging population, OPSEU contends that the loss of beds to the London area will only shift care needs onto families, homeless shelters, the police, corrections and other agencies. This would be a tragedy – especially when mental illness is usually treatable.

Earlier this year patients, their families and 56 workers were told that 50 special mental health care beds would be moving from London to Kitchener's Grand River Hospital beginning in September. They uprooted their families, sold and bought houses, and enrolled their kids in new schools only to discover that the transfer had never been formally agreed to by the participating hospitals, and that the LHINs had not even had a chance to deliberate on the plans.

Further, the redevelopment of the existing Regional Mental Health Care facilities was well under way prior to any broader discussions on whether the assumptions contained in the call for proposals met the needs of the region's mental health community. As public-private hospitals, there will be little flexibility in adjusting these projects once the final contracts are signed in 2011.

While the transfer to Grand River is too advanced to delay without further impacting on families that have already borne a significant cost surrounding this summer's debacle, the rest of the plan should be placed on hold until an updated needs assessment can be made.

That includes withdrawing the bidding process for the two new RMHC facilities at London Parkwood and in St. Thomas.

That assessment should also take into account the 10-year provincial mental health strategy, which is expected before the end of this year.

OPSEU would reiterate the original call of the HSRC to keep beds in place until such time appropriate community-based services are established.

Finally, placing fiscal restraint on a sector which is under increased stress during difficult economic times is counterproductive. It is time the province stepped up and provided the financial resources to match its rhetoric around mental health care. The $2.5 billion allocated to mental health care by the province is simply not enough to address the challenges the province faces. Shuffling where those resources are allocated will not produce the results Ontarians are looking for.

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A major restructuring of mental health beds is taking place throughout Southwestern Ontario. Regional Mental Health Care London and St. Thomas are both being rebuilt over the next four years. When the new facilities are occupied in 2014-15, it is expected the total number of beds will be a little more than half of the present number (from 450 to 245 beds, with an option to expand into 12 more beds).

138 beds will be moving to other facilities in the region. The Ontario Public Service Employees Union is concerned that 67 beds remain unaccounted for, and our members have been told there could be as fewer as 80 beds when the reconfiguration is complete. OPSEU members working at these facilities report to us these beds are frequently full.

For many of our patients, we are concerned that they will have no place to go.

Where will they go in 2014?

Occupancy rates for non-forensic beds at RMHC London and St. Thomas

July 23, 2010 — 93.9% occupancy with available beds
July 30, 2010 — 94.7% occupancy with available beds
August 5, 2010 — 96.4% occupancy with available beds
August 13, 2010 — 97.0% occupancy with available beds

St. Thomas' Forensic program routinely runs at 102 per cent capacity. Leave of Absence beds are frequently used on an interim basis.

Improved community supports and more effective drug treatments have dramatically reduced the number of beds needed in the province. In 1960 there were more than 47,000 mental health beds across Canada – about half of them located in Ontario. Today, with double the population, Ontario has about 4,000 mental health beds, less than 2,000 in provincial psychiatric hospitals (PPHs).

Nobody is calling for a return to the 1960s bed levels. However, the rate at which beds have been cut has far exceeded the resources available to treat patients in the community. This is a continual theme in reports on Ontario's mental health care, including the 1997, 2002 and 2008 reviews by the office of Ontario's Auditor General.

While the target bed numbers are drawn from the 13-year-old recommendations of the 1997 Health Services Restructuring Commission, the HSRC also places considerable emphasis on ensuring community supports are in place before implementation of bed reductions. This was never done. Instead, the beds have been cut with empty promises of appropriate community care.

While the government has been steadily reducing the number of beds to its interim target of 35 beds per 100,000 residents (the final target is 30 beds per 100,000), there has not been a comparative rise in community-based mental health funding. To meet its interim bed target, 60 per cent of mental health funding was to be allocated in the community. Yet the 2008 Ontario Auditor's report noted, for every $39 spent on community based care in 2006/07, $61 was spent on institutionalized services. In short, we're not even close to target.

Further, the auditor noted that these community agencies were struggling with annual funding increases of 1.5 per cent. Not only were these agencies not narrowing the gap, but according to the Auditor, "service providers indicated that, as a result, they were significantly challenged in their ability to maintain community service levels and qualified staff."

It's not like reallocating existing funds will work. The World Health Organization says governments should aim to spend 8 cents per health-care dollar on mental health. New Zealand spends 10 cents. Britain spends 8 cents. Ontario manages just 5.4 cents.

Yet, remarkably, the government tried to suggest the problem was fast-rising hospital costs, not lack of investment in community-based care.

"The Alzheimer's Society of Ontario projects that the number of Ontarians with dementia is expected to double within the next 25 years."

The London Economic Development Corporation projects the city's population to top 425,000 by 2026 which is an increase of 75,000 people. However, even by the HSRC modest standards, 12 additional beds will not be enough to compensate for that level of growth. Establishing a target of 35 beds per 100,000, it would mean the city would require an additional 26 beds by 2026 to maintain the same level of care. What about longer term projections? In 2026 the new facilities will be 12-years old (assuming they are built on time).

One has to question whether the more than decade old targets take into consideration more recent projections. For example, the Alzheimer's Society of Ontario projects that the number of Ontarians with dementia is expected to double within the next 25 years. While the Health Restructuring Commission did its work in a boom economy, the characteristics of the present economy are very different, and are having an impact on mental health care.

People are losing jobs and with that loss comes many consequences. Often people go through a grieving process. People can lose their homes because of it, their relationships and because of compounded grief and stressors people are unable to cope. It can become a crisis situation where access to treatment needs to be readily available.

This often includes hospitalization to keep the individual safe and to provide coping skills/mechanisms to allow the individual to be able to participate in life again.

We still need beds

Mental illness is a complex illness, with many forms and diagnoses, and with barriers and difficulties with each diagnosis. There are many re occurrences because of either non-compliance with medication or because medications need adjustment for various medical/physical needs for the individual.

Health Services Restructuring Commission benchmarks (for 2003)

Total adult mental health beds - 35 beds/100,000 residents
Acute care mental health beds - 21 beds/1000,000
Long term mental health beds - 14 beds/100,000
Child/adolescents mental health beds - 7/100,000

When this happens the individual decompensates -- sometimes very quickly and with great consequences. Psychosis or mania develops and symptomatic behaviours ensue. Persons with mental illness can become quite disruptive in their home environment as well as in the community at large, often requiring the intervention of Police Services, Paramedics and Mental Health Workers. Families of these individuals often need support as they are unable to manage the behaviours and symptoms of the illness. People are in crisis situations due to mental illness.

Whether it is a crisis situation or a re stabilization of mental illness/an exacerbation of symptoms, these individuals often require hospitalization to re stabilize the symptoms of the various and varying mental illnesses. Once stabilized through an intensive treatment program, the individuals can be discharged back to the community/home with appropriate supports and resources available, often provided through RMHC London and St. Thomas.

Just having community resources available to the individual does not negate a need for hospitalization. It certainly will help, and sometimes prevent a hospitalization, however we will always require beds to be available for utilization during an exacerbation of symptoms, during a crisis, and especially for the individuals due to severe decompensation of their illness or dementia. Specialized units are needed in order to provide quality of care and a safe and controlled environment for these mental health needs.

Impacts on the individual, on the community

Mental illness can lead people to lose their jobs, their homes, their friends – and according to the government's own discussion paper "Every Door Is The Right Door" – their lives.

The discussion paper estimates the economic impact of mental health and addictions on Ontario to be $33.9 billion per year, the largest share ($28.7 billion) being in lost productivity.

Ontario spends $2.5 billion to treat mental illness (hospitals, community programs, drugs and other medical costs), and a further $452 million on Children's and Youth mental health. "Every Door Is The Right Door" estimates that for every $1 spent on mental health and addictions, it saves $7 in health costs and $30 in lost productivity and social costs.

London's police force has been particularly vocal on this issue, noting they had doubled the time they spend dealing with people with serious mental illness in recent years. According to a 2000 research paper, mental health and addictions in Ontario costs $2.3 billion in law enforcement services.

Average wait times for community mental health services "was somewhere over 180 days."

In July of this year London's Police Chief said during CJBK's morning show that he could properly deliver services for Mental Health if he had another $5 million in his budget. He said a typical Saturday night would result in eight or nine mental health-related calls.

(See Policing and Corrections on page 18)

OPSEU members are concerned that the sizeable reduction in London's beds will not be matched by appropriate investments in community-based services. According to the Auditor's report, average wait times for community mental health services "was somewhere over 180 days." A 2007 report by the Fraser Institute suggested "a great many people with mental illness are experiencing a deterioration of their condition before they get the care they need."

The current planning targets appear to be too short to put in place the kind of replacement services to facilitate the loss of this many beds. Nor has there been a re-evaluation of the HSRC targets to determine whether they remain relevant.

It has also been less recognized the role modern institutions play in delivering services in the communities they serve. As beds are cut, the ability of these institutions to link up services with the community is diminished.

Lack of Process

In 2006 the province created 14 new regional planning bodies called the Local Health Integration Networks (LHINs).

The LHINs were to consult communities within their jurisdiction and draft appropriate service plans based on those consultations.

The LHINs were also to facilitate integrations – usually between two or more health providers. A LHIN integration can include partnering with another health care provider, amalgamate services from several providers, transferring services to another entity, coordinating services between partners, or to ceasing to provide service.

Given the significant changes in an advanced stage of planning, it was our assumption that the LHIN had already deliberated on this proposal, taking into consideration how the changes fit within the regional integrated health service plan.

We were surprised to learn that no integration proposal had come before the LHIN despite the fact that many of the assumptions behind the plan were in various stages of implementation. That included notice to workers and clients of a transfer this fall of 50 beds to Grand River Hospital. Workers are now expected to go through the month of October. Clients are to follow at the end of the month - provided the LHIN does not oppose the "integration." In addition, a tender had been issued for the building of the two new hospital sites at London Parkwood and in St. Thomas. These tenders would include the new bed counts. The bids are to close in December.

While OPSEU has been informed of the changing landscape for inpatient mental health care, there has never been a formal proposal that we, or any other community stakeholder, has been able to view.

Given stakeholders have an obligation under their accountability agreements with the LHINs to consult on significant changes in service delivery, this appears not to have taken place.

Responding to our inquiry, Michael Barrett, CEO of the South West LHIN, states in a July 29, 2010 letter to OPSEU: "Although each of the proposed divestments arises as a result of HSRC directions, because the Local Health System Integration Act (LHSIA) came into law subsequent to the directions, the hospitals are required to give notice to the LHINs under S. 27 of LHSIA. The LHIN must then consider the divestment of Tier II services within the context of LHSIA and the integration process that is set out in s. 27 of the legislation. This process is complex as ultimately it involves four LHINs (South West, Waterloo-Wellington, Erie-St. Clair and Hamilton Niagara Haldimand Brant) and five hospitals. The South West and Waterloo-Wellington LHIN have not yet

received a Notice of Integration from the hospitals, but we anticipate one will be submitted in the upcoming weeks. The LHINs will consider the submission against our usual criteria which includes ensuring adequate community engagement throughout the process."

The Integration Proposal for this transfer were received by the South West and Waterloo Wellington LHINs on August 27, 2010.

It is expected that the first transfer to Cambridge will be discussed as part of the September 22 South West LHIN board meeting.

S. 27 of LHSIA states that a health service provider may integrate its services with another person or entity if it provides notice of integration to the network (unless exempted by regulation). The integration shall not take place until 60 days have passed since giving notice (if required). Oddly, under LHSIA, the LHIN only needs to issue a decision provided it decides against the integration proposal, of which they must give notice of a decision before the 60 day period is up. Only the notice of the LHIN's actual decision need be made public, of which time 30 days is given for the public to respond to that decision. Again, that would be dependent only a negative decision.

"The Integration Proposal for this transfer were received by the South West and Waterloo Wellington LHINs on August 27, 2010."

Originally the hospital told the affected OPSEU members that they would be making the transfer to Grand River at the beginning of September – prior to any opportunity for the LHIN to evaluate the integration proposal.

The confusion may have stemmed from the idea that such a transfer didn't need to go before the LHIN given the Regional Mental Health Centre was following the recommendations of the HSRC.

While OPSEU does not wish to further delay the upcoming transfer to Grand River Hospital, our members, the patients, and their families were denied an opportunity to have meaningful input into this plan. While the hospital claims such a plan is intended to bring patients closer to home, there is mixed evidence to suggest that this is what is taking place. For the workers, they definitely will be taken further from their existing homes. For patients, we have no definitive numbers of how many are returning to be closer to their home communities, and whether they and their families actually wish to do so. It is these kinds of questions that the public should have had the opportunity to ask.

What is also disturbing is that clearly there is a larger plan at play, whereas the LHIN is treating each transfer on its own merits rather than giving the opportunity for wider public discussion on how mental health beds are to be distributed throughout the region. Will next year's transfer of 59 beds to Windsor follow a similar path?

The transfer to Grand River Hospital

The confusion over the transfer to Grand River Hospital has been the subject of much coverage in the local media.

Referred to as a Tier II divestment (Tier I involved divestment of the psychiatric hospitals from the direct management of the Ministry of Health and Long Term Care, Tier III to community based agencies), the original plan had been to transfer 50 beds from Regional Mental Health Care – London to Kitchener's Grand River Hospital.

The beds planned in the transfer included:

- 32 beds for severe and persistent mental illness
- 7 beds for Transition Unit
- 11 psycho geriatric beds

Within these numbers there is a capacity for Concurrent (Addictions and Mental Health Disorder) and Dual Diagnosis Disorders (IQ below 70 as well as a mental disorder).

Employees were given the opportunity to transfer with the beds. Letters polling relevant workers on their interest in transferring to Grand River were initially mailed out in March 2010.

On April 19, 2010 another letter was sent to employees letting them know of an information session for those considering the transfer.

Letters also went out on May 11, 2010 to family members of patients on wards H1 and P1 to inform them these units would be decommissioned. They were also informed of the opportunity to transfer to Grand River Hospital in Kitchener-Waterloo. The family members of clients on ward H1 were told that the 24-bed unit would close at the end of August, 2010.

On June 4, 2010 letters were sent to 56 employees confirming approval of the request to transfer to the Specialized Mental Health Program at Grand River Hospital effective September, 2010. The letter makes it clear "at that time, you will become an employee of Grand River Hospital in all respects."

In July OPSEU raised its own concerns about a lack of public process in the transfers. In a July 7, 2010 letter to Health Minister Deb Matthews, OPSEU President Warren (Smokey) Thomas asked why the LHIN process hadn't been followed: "We are concerned that the transfers and cuts to beds from this facility (RMHC) are presently underway without any of the process normally associated with an integration decision, including consultations of families, staff, patients, and other key stakeholders by the Local Health Integration Network or the hospital. There does not appear to be any comprehensive public disclosure on the overall plan, including costs, rationale, or how it fits with an overall regional mental health strategy."

OPSEU never received a reply to this letter from the Minister's office.

OPSEU Local 152 President Kim McDowell also wrote a letter to the SW LHIN on July 8 and July 22 requesting consultation, open forums, transparency, and confirmation of the transfer. She requested that the LHINs reconsider the number of beds for the mental health facility for London. McDowell has been invited to attend the September 22nd board meeting – as an observer.

Employees were informed by the beginning of August that there was a problem with the transfer to Kitchener. Many had already made arrangements to move to the Kitchener area. With spouses having given up their jobs, houses sold, and new houses bought, the 56 employees suddenly found themselves in limbo.

The issue was Schedule 1 beds for Cambridge.

Schedule 1 beds are acute care mental health beds for clients who are placed on an Application for Psychiatric Assessment (APA) or Form 1. These applications are prepared by a psychiatrist if the individual is deemed at risk for harm to self, or harm to others due to a psychiatric disorder. Schedule 1 beds are intended for a 72-hour assessment period. At the end of the 72 hours permitted by a Form 1, the person must either be released, be admitted as a voluntary patient, or continue to be held as an involuntary patient with a *certificate of involuntary admission* (Form 3). A Form 3 application must be filled by a different psychiatrist.

Under the original HSRC plan, 75 beds were to go to the Kitchener/Waterloo/ Cambridge region. In addition to the 50 specialized mental health beds, the plan had called for 25 Schedule 1 beds. Area residents had long complained of the lack of acute care mental health beds and were distressed to find the 25 beds missing from the transfer.

Parent Elaine Paton told the *London Free Press* that the region had been waiting for 15 years to see acute care mental health beds come to the Kitchener area. Paton had spent six months making the three-hour return trip from Kitchener to visit her son who was receiving mental health care in London. "You want to reassure your children," she

said. "You want to see them every day. My son tells me all the time seeing his family was really important in his recovery."

The question of who was going to continue doing Schedule 1 work had not been resolved between the transferring hospitals.

RMHC-L took the position that the transfer of beds was to include Schedule one beds. Kitchener's Grand River Hospital refused to take on the Schedule 1 beds, while the Cambridge Hospital was seeking funding for them. In addition, there was confusion over whether Cambridge had been given money to previously fund the beds, but had diverted it to other uses.

"St. Joseph's began the transfer knowing that this issue remained outstanding."

This outstanding issue regarding the Schedule 1 beds was known for at least 10 months, however St. Joseph's began the transfer knowing that this issue remained outstanding.

While employees had been told to prepare to move, no transfer agreement had actually been signed by the two hospitals.

Come late August this situation placed employees in a compromised and difficult position, having to commute back to London, St. Thomas and Strathroy to continue their employment with St. Joseph's Regional Mental Health Care. They had been led to believe they would be starting at Grand River September 1.

The issue was resolved August 20, 2010 when Health Minister Deb Matthews provided funding for 25 Schedule one beds -- 16 in Cambridge and 9 in Kitchener. The areas need to be constructed at these two sites, so RMHC-L will be funded to continue the Schedule 1 work until March/April 2011.

48 psycho geriatric beds decommissioned in London

According to the Canadian Institute for Health Information, the overwhelming majority of mental health inpatients (71.2%) show no sign of aggression. About one in five demonstrate less-severe aggression, while 8% demonstrate severe aggressive behaviour in their first three days after admission.

While 11 psycho geriatric beds are being made available at Grand River, it is far fewer than the 24 being decommissioned in London. RMHC-L is trying to move the patients on this unit to two remaining units as well as to long term care facilities. RMHC has closed 48 of these beds in the last 18 months.

These patients are considered to be among the most difficult to care for. In May of this year 76 risk events were recorded on this unit - most of these events representing aggressive behaviour.

These behaviours are either predictable or unpredictable aggressive impulsive and combative behaviours such as striking, punching, kicking.

Some of these events occur towards other clients requiring staff to intervene, some of these events occur while giving care, *requiring at least two or more persons to give care*.

Some of these events require planned interventions from extra staff members from other units, some of these events are Code Whites which is an emergency overhead page for extra staff to assist due to a violent client.

Many of these clients require restraints for safety for self or others. Some of these clients have chronic unpredictable mobility issues. These clients also require a locked facility to keep them safe from wandering. Many of these clients require intensive specialized treatment to manage care needs, and provide stability in a controlled environment.

"Clients are admitted to this ward, H1, as a last alternative, as safety of staff and other frail elderly is compromised in long term care facilities."

The staff at RMHC has extensive experience and skills in managing the aggressive behaviours of these patients on these units.

While the RMHC would like to move these patients into long term care settings, there are too few facilities with both the physical capacity and staff training to handle these kinds of patients.

When OPSEU presented before the City of London's Community and Protection Services Committee on August 23, we brought with us a letter from Sue Cornell, whose husband had been on ward H1 for a year.

Cornell's 58-year-old husband had been diagnosed with Picks Disease, a form of early onset dementia.

Cornell writes: "These types of clients are very difficult to manage as medication and other treatments are not effective or easy to adjust. Clients are admitted to this ward, H1, as a last alternative, as safety of staff and other frail elderly is compromised in long term care facilities. This is why LTC facilities are reluctant to admit male early onset dementia." Cornell adds: "The frustration as a family member is there is no other place for these types of clients."

Cornell reports that RMHC-L had been able to manage her husband's care and needs, providing stability for him and her family. At RMHC-L the treatment team assists her husband through the course of his disease in a controlled environment. "It may not be the most IDEAL environment," she writes, "however it is the BEST available to us."

Cornell said her husband had been admitted to RMHC after the long term care facility he was in was unable to manage his behaviour. His bed was held by the facility at a cost to her while he was at RMHC. On the very last day that his bed could be held, the long term care home told her he couldn't come back.

A definition of integration under the LHINs can also include ceasing to provide a service. 48 specialized mental health beds have disappeared from London's health services, and yet there is an absence of consultation and discussion on the issue.

A smaller RMHC may affect community-based services

While much attention has been paid to delivering mental health services in the community, it is often forgotten the Ontario psychiatric hospitals provide considerable outpatient services.

Non bedded programs at Regional Mental Health Care London and St. Thomas provide services to 2144 clients between the two sites. The kinds of services and programs provided include:

Office visits with doctor and/or clinician. Clients come in to see the doctor and or clinician for Intramuscular injection ordered either every 2 weeks or once a month. Assessments are done in regards to how the client is doing, and a review of medications as well as what other specific individual needs the clients have. The Doctor and Clinician develop a plan of care which includes continued stabilization of meds, regular home or office visits by clinicians, housing needs/supports and various groups that clients can become involved in.

There are several educational and support groups provided to educate and support clients with their various needs such as diabetes, healthy living, social maintenance group, skills building group, fitness group, concurrent disorder group, persuasion group as well as psychotherapy groups.

Groups are lead by various clinicians, such as dieticians, occupational therapists, nurses, social workers, and therapeutic recreationists. There are other groups which help clients build on their various talents in art and music, as well as in health and recreation.

Other entities that RMHC partners with are, Western Ontario Therapeutic Community Hostel (WOTCH), Community Mental Health Centre (CMHA), Hutton House, Alternative to Competitive Employment (ACE) in St. Thomas, and Andrews Resource Centre (ARC).

OPSEU is concerned that as the psychiatric hospitals continue to be downsized, that the ability to delivery community-based services will also be diminished.

Ontario Shores, the former Whitby Mental Health Centre, has been cutting community-based services to the community to balance its budget.

Under financial pressure, Ontario Shores closed its Oshawa site for Beacon House earlier this year. Beacon House is a residential treatment program serving individuals with complex personality problems that have resulted in psychiatric hospitalizations and frequent involvement with community services.

Ontario Shores also closed Challenging Directions Enterprises, a Whitby-based outpatient workshop that provides work experience to 75-80 clients each day. The sheltered workshop closed its doors February 23rd.

Public-Private Partnerships

The new facilities at London Parkwood and St. Thomas will be developed at public-private partnerships. Typically, most P3 hospitals in Ontario are design, finance, build and operate projects. While the two initial P3 projects – the William Osler Hospital and the Royal Ottawa Mental Health Centre were built as full P3s – including most non-clinical services, the new P3s are mostly confined to building maintenance.

At present bids are being sought for these two structures. The tender closes in December.

The problems of P3s have been well-documented.

The Office of the Auditor General of Ontario reviewed the William Olser project in 2008 after stories had emerged of more than $300 million in additional costs associated with the P3 model. The Auditor found, in fact, that the figure was much closer to $500 million – or about enough to build two William Osler hospitals under traditional financing and procurement.

While some of these additional costs were associated with the kind of ancillary services that are no longer part of these contracts, the Ontario auditor did note that the cost of borrowing from the private sector was much higher. In the case of the William Osler, it inflated the comparative cost of the P3 by $200 million alone.

The other aspect of a P3 development is much of the costing is shrouded in secrecy. OPSEU was part of a coalition that spent two years in the courts to seek access to the details behind the William Osler deal. When we won access to the majority of documents, we were told that it would be the same legal process (and expense) to see the parallel deal established to redevelop the Royal Ottawa.

Our members at the Royal Ottawa report that they have little control over their building. The hospital was overwhelmed by small charges for everything from access to a jug of water to hanging pictures on the wall. When changes were required after occupancy, the hospital could not go to tender to seek the best price on these changes.

"In Britain, fiscal restraint has had many calling for a renegotiation of the more than 100 P3 hospital deals."

In Britain, fiscal restraint has had many calling for a renegotiation of the more than 100 P3 hospital deals in that country. As budgets get tight, the contracts remain firm, leaving the UK no choice but to cut front-line clinical services.

OPSEU is concerned that building these structures as P3s will not give the province the flexibility to expand these projects at a later date without difficult negotiations with consortiums that have no incentive to offer value for money.

In the case of London Parkwood, 12 beds is not much of a buffer for the future, especially when the existing 450 beds are running at close to capacity.

We are also concerned that, like Britain, a growing percentage of health care costs will be tied up in inflexible long term contracts, making it difficult to invest long term in mental health services.

Profile: Regional Mental Health Care – London and St. Thomas

Regional Mental Health Care is a fully accredited mental health facility with 450 inpatient beds, 361 beds between the two sites in London and St. Thomas and 89 beds in the Forensic program at the St. Thomas site. RMHC provides high quality mental health and addiction services, both inpatient and outpatient at the tertiary and long term care level to residents of Southwestern Ontario, including Haldimand-Norfolk, and Waterloo-Wellington regions.

Patients come from London, St. Thomas, Windsor, Chatham, Sarnia, Cambridge, Norfolk, and Kitchener/Waterloo.

London is the Schedule 1 facility for Norfolk, Cambridge areas.

Services are provided by multidisciplinary teams and include assessment, treatment, rehabilitation, follow up and other community programs.

Assessment includes specialized assessment and initial stabilization with recommendations for further treatment, rehabilitation, and community integration.

Geriatric psychiatry serves clients generally over the age of 65.

Adolescent psychiatry serves adolescents between the ages of 13 and 18.

Dual Diagnosis serves adults between the ages of 18 and 64 with a developmental challenge (IQ below 70) as well as a mental care need.

The Mood and Anxiety diagnosis program both inpatient and outpatient, serve clients who have severe and complex mood and or anxiety disorder which have not responded to treatment.

The Psychosis program provides inpatient and ambulatory services to people with a psychotic disorder and supporting programs and services to facilitate and support clients in their recovery.

Services are also provided for deaf, deaf-blind, deafened or hard of hearing persons with a severe mental illness with communication methods such as ASL, Eng, Fre and total communication.

History of Regional Mental Health Care

Regional Mental Health Care London emerged from the former London Psychiatric Hospital which opened its doors on Highbury Ave in 1870. The 500 bed facility was instantly at capacity.

In the 1930's there were over 1700 patients. Dr. Richard Burke believed in the ideas of work therapy and included farming as a treatment for those with mental illness helping patients to focus on healthy activities. In the late 1800's almost all 900 patients were working in some capacity at the facility.

Regional Mental Health Care St. Thomas opened its doors on April 1 1939 and was its greatest capacity with over 2400 patients. The site included 460 acres of land for the facility's food and produce needs.

During the Second World War the site was used as a training ground for the Royal Canadian Air Force. The provincial government reopened the hospital in 1945 and by 1947 there were close to 1100 patients.

Restructuring

In January 2001 St. Joseph's Hospital took over governance at the St. Thomas site, and in February 2001 took over governance at the London site.

The reorganization of mental health care was ordered by the Health Care Restructuring Commission in 1997.

The Ontario government changed the way health care services are planned and managed through 14 Local Health Integration Networks in March, 2006. The LHINs plan, integrate, and fund local health services, including hospitals, Community Care Access Centres, community social services, long-term care homes, mental health and addiction services as well community health centres. London is under the jurisdiction of the SouthWest LHIN.

The SW LHIN is responsible for task of integrating mental health and addictions services across all levels of care within the main health-care system.

Two Public-Private Partnerships (P3's) will replace the two sites at Regional Mental Health Care London and St. Thomas. The two sites are expected to open in 2014 with far fewer beds. The London Parkwood site will open with 156 beds and space for an additional 12 beds. A new forensic mental health facility will open at the present site in St. Thomas with 89 beds.

There is also a plan divest beds to regional communities.

Divestment to Regional Hospitals

October 2010	50 beds	Grand River Hospital, Kitchener
June 2011	59 beds	Windsor Regional Hospital, Windsor
2012/13	14 beds	Hamilton
2013/14	15 beds	St. Thomas Elgin Hospital, St. Thomas
Total Divestment	138 beds	

The London community is expected to lose 218 mental health beds at the completion of this plan.

Police and Corrections

When appropriate mental health services are absent from our community, other services get utilized, from homeless shelters to police and corrections.

According to the Ontario government's discussion paper, "Every Door Is A Right Door," the province spends almost as much on law enforcement for individuals with mental health as it does providing mental health care.

Frequently the first indication of mental illness occurs when a person's behaviour attracts police attention. Often bizarre behaviour causes fear in family members or with in the general public. Persons with mental illness are three times more likely to have interactions with police.

In Ontario persons can be arrested/apprehended under the Mental Health Act, making the police, rather than health practitioners, an entry point for mental health services.

Persons with mental illness are arrested and jailed at a higher rate than non-mentally ill persons and for relatively minor offences which then increases the number of mentally ill persons in the correctional facilities which are already operating at their max. Many are charged with nuisance-type offences. According to a 2001 study by Kathleen Hartford, Lisa Heslop, Larry Stitt and Jeffrey S. Hoch, "Use of arrest and jails by the criminal justice system may indicate (a) a lack of diversion options available to the police when citizens file complaints, or (b) a lack of mental health treatment, or (c) a lack of housing and clubhouse options."

A large proportion of mentally ill persons spend time in custody because police officers believe that a homeless PMI (persons with mental illness) would fail to appear in court or lacks funds for bail. It is also possible that officers detain PMI because they believe that PMI require psychiatric assessment that could not be obtained otherwise. Finally officers may arrest and hold PMI in custody because they have exhausted other options, such as attempting to access hospitalization or support services.

Special Needs Units (SNU) have been set up at some correction facilities to provide an area for people with special needs, such as a psychiatric illness. These units are small -- London Middlesex Elgin Detention Centre has 25 beds which are always running at full capacity. At the London Middlesex Elgin Detention Centre, the inmates with a court ordered psychiatric assessment are waiting 35-40 days for the court ordered assessments to take place in RMHC's forensic program. These clients are often housed in the correction facility while they are waiting for the bed to become available in the forensic assessment program.

Who is in our beds?

Demographic Profile of People Admitted to an Ontario Inpatient Mental Health Bed (2007-08)

Age	Percentage admitted in inpatient bed (%)	Ontario General Population (%)
15-19	6.0	8.1
20-24	10.4	8.3
25-44	43.2	35.6
45-59	27.7	26.0
60+	13.8	21.9
Employment		
Labour Force Participation Rate	32.0	68.0
Employment Rate	23.6%	63.6%
Other Information		
% Male	50.6	49.0
% Married/Partner	29.0	59.5
% Completed High School	67.2	79.4
% With Post-Secondary Education	39.1	58.7

Source: Canadian Institute for Health Information

Recommendations:

1. A new assessment of regional mental health needs should be completed with input from the community, taking into consideration Ontario's emerging 10-year strategy (Every Door Is The Right Door). Until such time, a moratorium should be placed on cuts to both inpatient and outpatient services.

2. A detailed plan should be based on this updated assessment and subject to public input.

3. A principle be adopted that no mental health service be terminated until demand for those services has been met in an alternate setting that provides equivalent, if not improved quality services.

4. Any plan should take into consideration the broader social determinants of health, including education, housing, and employment.

5. Ontario should place on hold any public tender for replacement of Regional Mental Health Care London and St. Thomas until a needs assessment is completed. Private sector involvement in the replacement of these buildings should be restricted to design and construction only.

6. The jumble of community-based agencies needs to be better resourced and coordinated to provide effective alternatives to care.

7. Ontario needs to recognize that fiscal restraint during a period of high economic stress is counterproductive when it comes to mental health care.