

# **Where It Is Needed, When It Is Needed:**

**Building better collaborations to deliver comprehensive  
services to Community Mental Health and Addiction  
consumers, clients, and caregivers in Ontario's communities**

**A Discussion Paper  
Prepared by the Ontario Federation of  
Community Mental Health & Addiction  
Programs**

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## Executive Summary

The providers of Community Mental Health and Addiction Programs together with the providers of Home and Community Care in Ontario are uniquely positioned to collaborate to better meet the needs of clients, consumers and their families. Emerging from over a decade of base budget funding freezes, public policy changes, and increased demands for services, the community mental health and addictions sector is faced with pressures related to service access and service coordination. Collaborations which enhance access and coordination, in particular in the area of home and community care services would enable people with mental health and addiction issues to live in the community with a better quality of life and sustainable independence.

It is a well established fact, supported the Hollander and Romanow reports<sup>1</sup> that prevention models of community health and social services reduce costs in the overall healthcare system. Leff., Trieman, Knapp and Hallam (2000) also concluded that community based care is more cost-effective than hospital care. **It is well known that people prefer to live independently in their own homes**, but often clients with serious mental illness require intensive case management and intervention to support them in this goal. Even with the costs associated with intensive case management, the costs are still less than repeat acute episodic treatments in hospital. Without this link, homelessness or at risk of homelessness is a frequent outcome.

This paper outlines the benefits of community based intensive case management and the development of local community networks which encompass both the mental health and addiction service providers and the home and community care service providers to better address the needs of clients and consumers; **where and when they need it most...in their home/community**. The largest shared base of clients is the seniors' population, although many multi-service community support agencies provide programs to multi-generational clients. The development of formal linkages to streamline access to service referrals allows the maximization of extensive skills and knowledge which already exist in the community services field in both sectors. It is possible to develop case management models, based on prevention and support, through existing services in the two sectors thereby maximizing resources and streamlining access to service to the advantage of all concerned.

There is also an added benefit in many communities where there are community support agencies, which also provide home care services (therapies, nursing, homemaking). In addition, opportunities also exist to establish networks among community mental health and addiction services and community health centres and Family Health Teams as part of the Primary Care Reform initiatives currently underway in Ontario.

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<sup>1</sup> Hollander, Marcus, Chappell, Neena, Final Report of the National Evaluation of the Cost-Effectiveness of Home Care, August 2002 & Building on Values, The Future of Health Care in Canada, Commission on the Future of Health Care in Canada, November 2002

The most at-risk population are those individuals who are socially isolated in the community. Although a referral for supportive services or treatment may actually be made, if the wait list is six months to two years, these individuals can become “lost between the cracks’ because of a lack of central coordination of the necessary basket of services for individuals. A recent report out of London, Ontario <sup>2</sup> suggests that these individuals are more likely to access emergency services (police, paramedics and ultimately emergency rooms under police supervision). It is also important to share evidence which suggests low-income seniors, with mental health issues, are seriously under-served and in need of specialized support.

### **Recommendations:**

- ✍✍ Retain and foster intensive case management in the community where it is better able to address client/consumer needs in a more timely and appropriate manner and establish formal linkages with cross-sector agencies to provide comprehensive service to support clients/consumers in the community
- ✍✍ Continue to access contracted home care services via the CCAC which is established to address acute medical needs more so than preventative, social and chronic disability needs
- ✍✍ Establish networks in local communities to raise awareness of the breadth of services available to common client/consumers, especially in the areas of prevention, lifestyle and broader health (ie nutrition)
- ✍✍ Identify opportunities to share administrative and technological resources to improve services to clients

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<sup>2</sup> Key Informant Interviews, M. Connoy, Executive Director, Mission Services, London, May 2004

## Sector Overview

The Ontario Federation of Community Mental Health and Addiction Programs, OFCMHAP, (“The Federation”), brings together over 200 community mental health & addictions services in the province of Ontario to help members provide effective and accountable high quality services. Agencies receive funding from a variety of sources including MOHLTC , fundraising, COM SOC, United Way funding, etc. The Federation envisions a community mental health and addiction system which is accessible, flexible, comprehensive and responsive to the needs of individuals, families, and communities, shaped by many partnerships, respectful of human dignity and rights, and accountable to those it serves. The outcome of the lack of budget increases to keep pace with system demands has resulted in the following outcomes:

- ?? Longer waiting lists
- ?? Increased use of other, more expensive institutional services
- ?? Increased stress on consumers/clients, families and communities
- ?? Increased pressure on health and social services, and most notably, police and correctional services
- ?? Increased pressure on emergency services

Seriously mentally ill clients often have multiple health issues, which require care, and management such as diabetes, high blood pressure, obesity-related health issues, smoking related health issues etc. Therefore the complexity of a consumer/client’s health issues needs to be more intensively managed.<sup>3</sup>

The Ontario Community Support Association (OCSA) represents more than 360 not-for-profit community agencies, 25,000 staff and 100,000 volunteers across Ontario. Most agencies receive about 60% of their funding from the Ministry of Health & Long Term Care, with the remainder of their budgets from a variety of community sources such as local donors, foundations and the United Way. OCSA members believe a comprehensive home and community care system includes services, which, with greater collaboration between the sectors has the potential to address several of the negative outcomes identified above.

This is supported by Leff, Trieman, Knapp and Hallam (200) who studied more than 1,100 long stay patients discharged from two psychiatric hospitals in the U.K., following them for up to 13 years. The study concluded that, when provided with appropriate community support, these former patients experienced:

- ?? Increased skill in using community facilities
- ?? Improved activities of daily living
- ?? Increased number of social contacts with “ordinary” members of the public (rather than fellow patients or health service professionals)

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<sup>3</sup> Key Informant Interviews, W. Czarny, Executive Director, Waterloo Regional Homes for Mental Health, May 2004

- ?? Greatly improved quality of life
- ?? Significantly fewer restrictions in their living environment

As a consequence of these improvements, 84% of these individuals expressed a preference for remaining in the community, five years after discharge from hospital.

## Shared Goals

There is an exciting opportunity to provide specialized **primary and secondary prevention** measures that will enable people with mental health and/or addiction issues to live independently in the community. A significant key to this is linking clients with a family physician and ensuring that there is someone in the community to support regular and consistent access to medical services, medication management if needed and intervention through intensive case management to assist clients living with serious mental and chronic health issues.

Common shared goals for community health include a system that:

1. Ensures efficient and effective support to those in need;
2. Prevents or delays physical deterioration and the onset of more serious health problems;
3. Enables people to maintain or regain productivity with rehabilitation/harm reduction services;
4. Promotes independence and self-reliance of people with disabilities (physical and mental health issues) and addictions;
5. Supports families in their role as primary caregivers; and
6. Provides for the uniform availability of essential services in all parts of Ontario.

The Ontario Ministry of Health released “Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports” (2003) and stated among its principles:

People with serious mental illness will achieve greater independence; that is the ability to live in the community with the least intervention from formal services and, to the greatest extent possible, make their own decisions.

Services should be built on individual strengths and work with the individual to provide and/or link them to formal and other community resources. A broad range of resources is considered, including mental health resources, other community resources and informal support networks.

These principles clearly signal the Ministry’s support for greater collaboration between the sectors serving the clients and consumers of mental health and addiction programs.

## **Focus on Client Groups:**

Recognizing that both sectors serve a broad range of clients in terms of demographics, however, it is evident that complexity of ageing affects not only seniors but also those adults in the 50-65 age group as well as adults with disabilities which may be compounded by the ageing process. This group is especially at risk of falling through the cracks as they are excluded from parameters of senior support services. It is also important to include the group of caregivers who are aging and caring for adult children who suffer from mental and physical disabilities or addiction related issues while also dealing with their own developing illnesses and disabilities.

For low-income seniors, there are **unique aging-related risk factors** that often **seriously destabilize tenancy, leading to a high risk of homelessness:**

- ? ? cognitive disorders such as dementia;
- ? ? senile squalor and anti social behavior;
- ? ? elder abuse, primarily financial abuse by relatives;
- ? ? mental health issues such as paranoia, often in tandem with dementia;
- ? ? refusal to accept help as a result of fear, cognitive disorders, and/or mental health issues;
- ? ? increasing isolation from friends and relatives through death and illness;
- ? ? increasing isolation from the community as a result of health and behavioral issues;
- ? ? physical frailty and inability to cope;
- ? ? loss of second language skills with aging (immigrants)

The list above can be viewed as a bell-weather for people of any age, with serious mental health, addiction and chronic disabilities living in the community without adequate support of intensive case management and intervention to assist them in accessing appropriate and timely health & social services.

Whether they are in subsidized housing, private rental accommodation, their own home or on the street, low-income seniors share a number of risk factors in common with other vulnerable groups. These were identified in the *Community Action Plan for Homelessness in Hamilton, 2001* including:

- ? ? poverty
- ? ? social isolation
- ? ? illiteracy
- ? ? immigrants who have difficulty with English and/or French
- ? ? alcohol or other substance abuse

**Collaboration between community mental health and addiction agencies and community support agencies would enable improved opportunities for:**

- ? ? Advocacy and intervention for consumers/clients faced with eviction notices.

- ? ? Collaboration with partners to achieve early identification of seniors and persons with disabilities who suffer from mental health and/or addiction issues leading to relative homelessness or risk homelessness, followed by preventative interventions.
- ? ? Improvement of outreach services focused on high-risk low-income people who are homeless, suffer from relative homelessness, or are at risk of homelessness.

Leaders in the community mental health and addiction services agree that those people in our communities suffering from **moderate** mental health issues are also at risk due to additional health factors such as smoking (and its related health issues), obesity, diabetes, asthma, and conditions affecting mobility.

It is for this client base in particular that formal networks, which include local community support service links, would be most beneficial. Consider *as an example* the roster of services offered by a Community Support agency as part of their Crisis Intervention and Assistance Program, when considering this list it is important to keep in mind that community support agencies also provide programs such as Meals on Wheels, attendant care, homemaking assistance etc:

- ?? Community information
- ?? Problem identification and service coordination
- ?? Crisis intervention
- ?? Home visits with clients who are unable to access office sites
- ?? Ongoing outreach and long-term monitoring
- ?? Providing support and assistance in coping
- ?? Locating and arranging resources
- ?? Training, supervising and supporting volunteers
- ?? Working in partnership with a wide range of providers of community services and funding bodies<sup>4</sup>

In the Community Mental Health and Addiction Services sector the above services are often offered through their intensive case management services. In smaller communities around the province these services are often offered by either community mental health service providers or home and community care service providers. A greater collaboration between the two would lead to identification of the local basket of services available in a community followed by the development of improved case management and intervention within local communities with providers already experienced and established in the provision of these services.

In Thunder Bay, there is already a community coalition which has representatives of both home and community care providers and community mental health and addiction providers working together to better coordinate services for consumer/clients in their community. This model should be more closely examined as a template for other communities in the province.<sup>5</sup>

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<sup>4</sup> Senior Link Client Intervention and Assistance Program Outline

<sup>5</sup> Key Informant Interviews. J. McReynolds, May 2004

## The Evidence

### **The scale of the problem is illustrated by data from reports and community agencies:**

- ? ? 36% of people who experience homelessness have a mental illness and it is estimated that 66% of homelessness seniors have a mental illness<sup>6</sup>.
- ? ? Mayor's Action Task Force on Homelessness (1999), found people with addictions in the Hamilton area are at higher risk of homelessness<sup>7</sup>
- ? ? The Middlesex-London Health Unit wrote an extensive report on senile squalor in which they noted that seniors often refuse help and are forced into eviction.<sup>8</sup>
- ? ? The Middlesex-London Health Unit has a registry of 15-25 people at any time and they report a 50% mortality rate within one year.
- ? ? A survey of learning needs for shelter staff in Toronto ranked cognitive impairment, medications and aging, addictions and aging, and elder abuse in the top 10 learning needs<sup>9</sup>.

### **The literature on seniors and homelessness is not extensive, but it does support the view that there are prevention issues specific to low-income seniors:**

- ? ? DeMallie suggests that older and younger individuals have different vulnerabilities to homelessness.<sup>10</sup>
- ? ? Reilly, describes an ecological approach to assessing health risk and applies it to a sample of elderly homeless people within the context of a single day in a single urban setting revealing a number of risk factors specific to older persons.<sup>11</sup>
- ? ? Keigher and Greenblatt found homelessness to be significantly associated with factors common to low-income seniors, including low income, dementia, living alone, and an unstable residential history.<sup>12</sup>

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<sup>6</sup> Homelessness and Mental Illness in the Hamilton-Wentworth Region, Cook, p., Schofield R., 1995

<sup>7</sup> Social Planning and Research Council, Progress Report on Homelessness in Hamilton, 2003

<sup>8</sup> Task Force on Senile Squalor, Final Report, April 2001, Middlesex-London Health Unit

<sup>9</sup> Learning Needs Study for Shelter Staff, The Aging and Homelessness Project, Regional Geriatric Program of Ontario, [www.rgp.toronto.on.ca](http://www.rgp.toronto.on.ca)

<sup>10</sup> DeMallie, D. et al. (1997) Psychiatric disorders among the homeless: A comparison of older and younger groups. *The Gerontologist*, 37, 61-66.

<sup>11</sup> Reilly, F. (1994) An ecological approach to health risk: A case study of urban elderly homeless people. *Public Health Nursing*, 11, 305-314.

<sup>12</sup> Keigher, S. & Greenblatt, S. (1992) Housing emergencies and the etiology of homelessness among the urban elderly. *The Gerontologist*, 32, 457-465.

An analysis based on the Determinant of Health: Personal Health Practices and Coping Skills shows that personal health practices relate to those things we do in our every day life that can influence our health. Coping skills relate to our ability to handle the stresses and challenges of life. The following are some of these essential practices:

- ?? Seniors and persons with disabilities may require assistance with food preparation and feeding for proper nutrition and a balanced diet.
- ?? Adequate personal hygiene is important for the prevention and management of infections and skin conditions and to avoid the complications that may develop from inadequate toileting. There are also benefits from daily oral dental hygiene.
- ?? There is a need to provide for a hygienic environment including the cleaning of bathrooms and kitchens and the control of dust for those with asthmatic conditions and other allergies.
- ?? Exercise is necessary to maintain or restore functional capacity. This may involve assisted walking or follow up exercises according to a therapist's plan of treatment.

**Discussions were held to assess the accessibility of current services. Unfortunately, many existing services have proven to be inaccessible to clients with serious mental health and addiction issues:**

- ? ? The Integrated Service Plan for Substance Treatment Abuse in Hamilton reports that only 2% of service users are over the age of 65 and highlights this as a major gap in services<sup>13</sup>.
- ? ? People who are at risk of being homeless or are already homeless also find accessing health care difficult. They oftentimes no longer have a health card which makes access especially difficult. If they do not have identification it can be expensive to get the necessary papers to be able to access health care<sup>14</sup>
- ? ? The Middlesex-London Health Unit and community agencies report that frailty, isolation, cognitive disorders, mental illnesses and trust issues are barriers to service access<sup>15</sup>. Low-income seniors are often unable to remember appointments or medications, they lack mobility and are suspicious of community support workers.

## **Addressing Primary, Secondary and Tertiary Prevention**

### **Primary Prevention**

As has already been stated, due to significant access- to-service issues and wait lists that can range from six months to two years, it is imperative that clients do not “fall through

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<sup>13</sup> Integrated Service Plan for Substance Abuse in Hamilton, February 2000

<sup>14</sup> Our Homes Our Streets, Homelessness in Hamilton-Wentworth, 1999, Social Planning and Research Council, Brown, S and Todd, S.

<sup>15</sup> Task Force on Senile Squalor, Final Report, April 2001, Middlesex-London Health Unit

the cracks” or become “lost” in our communities. The provision of onsite prevention services in low-income seniors’ buildings and neighbourhoods exist through home and community care programs. The focus on health, functional abilities, literacy and comprehension, financial and social risk factors and interventions to address those risks must be supported by both community case management and service coordination and on an outreach basis. To that end the following chart supports the intrinsic value of linking community mental health and addiction services with home and community care services.

<b>Determinant 1: Personal Health Practices and Coping Skills</b>	
These include smoking, exercise, proper diet/nutrition, personal hygiene, clean living environment, alcohol consumption, injury prevention, coping skills and the ability to handle stress and the challenges life presents.	
<b>Related Mental Health and Addiction Programs</b>	<b>Health Outcomes</b>
<ul style="list-style-type: none"> <li>?? Health Promotion/Education</li> <li>?? Housing</li> <li>?? Income Supports and Services</li> <li>?? Peer Supports</li> <li>?? Self-Help and Alternative Supports</li> <li>?? Drop-Ins</li> <li>?? Vocational and Employment programs</li> <li>?? Consumer –Run Businesses</li> <li>?? Family Supports</li> <li>?? Social/Recreational programs</li> <li>?? 24 Hour Crisis Telephone Lines</li> <li>?? Mobile Crisis Teams</li> <li>?? Safe Beds</li> <li>?? Intensive Case Management</li> <li>?? Mobile Outreach Teams</li> </ul>	<ul style="list-style-type: none"> <li>?? Prevents premature or repeated institutionalization</li> <li>?? Supports client independence and maximum level of functioning</li> <li>?? Supports/maintains the client safely in their own home</li> <li>?? Supports re-entry to workforce</li> <li>?? Supports prevention of homelessness</li> <li>?? Early detection and intervention when change in mental health status occurs</li> <li>?? Prevents escalating duplicity of health issues by improving access to health system</li> <li>?? Facilitates mobility of client, continued participation in community life</li> <li>?? Allows clients to regain quality of life through harm reduction</li> <li>?? Prevents caregiver burnout</li> </ul>
<b>Related Community Support Service</b>	<b>Health Outcomes</b>
<ul style="list-style-type: none"> <li>?? Attendant Care</li> <li>?? Personal Support Services</li> <li>?? Meals on Wheels</li> <li>?? Congregate Dining</li> </ul>	<ul style="list-style-type: none"> <li>?? Prevents premature institutionalization</li> <li>?? Supports client independence and maximum level of</li> </ul>

?? Nutrition Counselling	functioning
?? Transportation and Escort (grocery shopping, doctor's appointments)	?? Maintains the client safely in their own home
?? Home Help/Homemaking	?? Early detection and intervention when change in health status occurs
?? Home Maintenance	?? Prevention of deterioration of living environment
?? Social/ Recreational programs	?? Facilitates mobility of client, continued participation in community life
?? Client Intervention and Assistance	?? Allows clients to regain mobility and productivity after a health crisis
?? Supportive Housing	
?? Foot Care	
?? Life Skills Outreach	
?? Volunteer Hospice	
?? Adult/Alzheimer Day Programs	
?? Caregiver Support	
?? Volunteer Visiting	

### **Secondary Prevention**

There exists today networks of community programs in many communities, which meet to discuss the service challenges and emerging needs of their communities. In London, a recent report was completed by an alliance of public service providers. The report supports enhancement of the community mental health and addiction programs case management and intervention by outlining the impacts of system service gaps on auxiliary services such as police, public libraries, school boards, fire department. These broader collaborations with community partners serve and enhance outreach services to identify clients suffering from mental health and addiction issues.

In the Thunder Bay model, referenced earlier in this paper, a community network group has been established with representatives from all sectors. The primary benefit of this network is first and foremost gaining awareness among agencies and service providers of the full scope of services and programs available to clients and consumers in a community. This ultimately contributes to increased effectiveness in providing community based intensive case management when there is established collaboration among community service providers.

Moreover, a model based on a local community network can lead to improved relationships and partnerships between the sectors and providing the potential for increased access to home and community care services (such as homemaking, meals, transportation, day programs) for mental health and addiction clients and consumers. Information sharing, joint education and cross-education opportunities can also be explored and developed, thereby increasing the knowledge base within each sector.

### **Tertiary Prevention**

Many clients may access services from a variety of community agencies. These are the “ebb and flow” clients who would best and more effectively be served by a more comprehensive network of community services that would see a client with multiple

health issues (physical and mental) receive intensive case management by either the mental health & addictions service provider or the home and community care service provider based on the most logical and beneficial source for the particular client. This would ensure that the client is connected to appropriate community services as well as required home care services.

Since both community support agencies and community mental health and addiction agencies already have expertise in the more comprehensive case management models, it is more cost effective to determine the most appropriate community provider rather than creating this service within a system removed from direct services and the community such as the Community Care Access Centre system.

Supportive Housing sites would certainly benefit from a model of collaboration as access to nursing, medical and homemaking services are especially critical to their higher needs populations. Through collaboration with home and community care agencies, in particular multi-service agencies, tenants in these locations would benefit by accessing the complete basket of community support services while concurrently accessing intensive case management for their mental health and addiction related disabilities.

## **Linking to Primary Care through Community Health Centres and Family Health Teams**

Primary Care reform in Ontario was announced by the former government in 1996. The goals for establishing a new model of service delivery were:

- ?? Improved access
- ?? Improved quality and continuity of care
- ?? Increased patient and provider satisfaction
- ?? Increased cost effectiveness<sup>16</sup>

Today there are 52 community health centres in Ontario. One of the key drivers of Primary Care reform has been the encouragement of increased emphasis on health promotion, prevention and patient education.

Community Health Centres (CHCs) combine direct patient care with affiliated health-centred services including therapies, wellness programs, community outreach programs affiliated with local neighbourhood communities and schools. Formal networks or linkages with CHCs would enhance the lives of community mental health & addiction program consumers with a direct link between the support services offered in the community and the medical and rehabilitative care of the community health centre. Often in communities there is fundamental lack of awareness of programs offered by community health centres.

In the paper “Bringing the Pieces Together: Shared –Care in Family Practice” The Ontario College of Family Physicians makes the following observation in supporting greater shared-care between family physicians and community services:

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<sup>16</sup> Evaluation of Primary Care Reform Pilots PWC, 2001

The organization of home care and institutionally based continuing care is structured differently province to province. In Ontario, the Community Care Access Centres are responsible for purchasing, but not providing, home care and for institutional placement services. With more acute care substitution being delivered in the community, CCACs are hard-pressed to deliver the level of care that allows patients with ongoing chronic problems to live with dignity in their homes. Access issues, including complicated, time-consuming paperwork, drive family doctors to send patients to Emergency departments as the entry point to community services. Often, unnecessary hospitalizations are the result.<sup>17</sup>

Clearly greater collaboration between community services and family physicians is being encouraged. Building on that model, we can look to Community Health Centres as logical partners in shared care as well.

### **Collaboration opportunities with Community Support Services**

Community Support Services are intended to maintain and prevent deterioration (the type of services that Hollander and Tessaro found to be effective in terms of health outcome and efficient in terms of cost avoidance). In addition to these personal health practices, there are also coping skills that are of similar importance. One of these involves ongoing assistance to those with impaired mental capacity. For example, over one-quarter of all seniors are reported as having memory problems.<sup>18</sup> **The other involves advocacy assistance to the “at risk” population in coping with emergencies and crises that are beyond their capacity to cope.** Population Health research has shown that major unrelieved stress can have a significant impact on health.<sup>19</sup>

Client intervention services, life skills training and social programs may all assist in not only improving a person’s ability to cope with difficult and stressful situations, but in preventing acute episodes related to mental health and addiction issues.

With the identification of community support service agencies already offering a basket of services, in particular multi-services agencies offering services to the broader public, a unique opportunity exists to build formal networks (as in the Thunder Bay model cited earlier) and linkages to provide both intensive and comprehensive case management without creating more duplication in the community service sector.

It is important to note that in communities across the province comprehensive case management services are being offered, although not always funded, in both community mental health and addiction programs as well as in community support services. It is imperative that we build on the services and expertise, which is already in place through a

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<sup>17</sup> Bringing the Pieces Together, J. Kasperski, June 2002

<sup>18</sup> Statistics Canada, A Portrait of Seniors in Canada, 3<sup>rd</sup> edition, Table 4.14

<sup>19</sup> The impact of stress on health in the general population is made by R. G. Evans and R. L. Stoddart ‘Producing Health & Consuming Care’ in Evans et al

collaborative model. For example, it may be most beneficial that a client with predominantly serious mental health issues receives case management from a community mental health provider who collaborates with a community support service provider to ensure their family receives appropriate respite.

Similarly, a consumer with chronic addiction issues, and suffering from a cognitive impairment, may be more appropriately supported through a harm reduction model in order to create the opportunity to access services such as a day program. The first step is to focus on a local level and identify the opportunities for collaboration by first creating awareness of services available from both sectors. Secondly there must be collaboration to identify how access is created or improved to increase capacity within each community.

## **Conclusion**

The Romanow Commission was critical of home care eligibility requirements that would require a physical disability or difficulties with activities of daily living and hence deny access to persons with mental health or addictions issues:

Treating people effectively in the community rather than in institutions or hospitals *requires* home care, particularly in order to ensure that people with mental illnesses continue to take their medications appropriately and do not need repeated re-admissions.<sup>20</sup>

The recent Ontario Budget has recognized the needs of the community mental health sector by expanding community mental health services, including access to case management, crisis response and early intervention services. By partnering with family physicians, community health centres and the home and community support services already in existence in many areas of the province, community mental health service providers are well positioned to have a positive impact not only on their clients' needs but on Ontario's health care system as a whole.

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<sup>20</sup> Building on Values, The Future of Health Care in Canada, Commission on the Future of Health Care in Canada, November 2002, p. 179

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## **Resources**

M. Connoy, Executive Director, Mission Services, London

W. Czarny, Executive Director, Waterloo Regional Homes for Mental Health

Dr. J. Kasperski, Executive Director, Ontario College of Family Physicians, member Ontario Home and Community Care Council

J. McReynolds, CEO, Ontario Community Support Association, member Ontario Home and Community Care Council

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