Thunder Bay and District Service Collaborative:
Identified system gaps, priority areas, and recommended next steps

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camh PSSP
Provincial System Support Program

Contents

Introduction

The Thunder Bay and District Service Collaborative is part of the System Improvement through Service Collaboratives (SISC) initiative, supported by the Centre for Addiction and Mental Health's (CAMH) Provincial System Support Program (PSSP). SISC is part of the *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, a 10-year mental health and addictions strategy committed to transforming the mental health and addiction services for all Ontarians.

In line with the pillars of Ontario's Comprehensive Mental health and Addictions Strategy, the PSSP at CAMH is positioned to offer technical implementation expertise to communities considering systems change in the areas of addictions and mental health, through Service Collaboratives.

PSSP will offer the appropriate level of staff support to build agency and systems capacity toward the successful implementation of the projects, processes, or polices. PSSP's support will be flexible and targeted to the project or program's immediate needs, regardless of the stage of implementation.

The information in this report was produced as part of a Capacity Assessment process to inform the focus of the Thunder Bay and District Service Collaborative. A Capacity Assessment is an ongoing process that aims to describe the needs, strengths, and assets of a community in a way that will help support the development, planning, implementation and evaluation of an intervention.

This report provides a summary of themes and priority areas that were identified through community data collection carried out from June 2016 – early January 2017. Information supporting these priority areas were compiled into gap statements to set the stage for the next phase of this initiative, during which the Service Collaborative will select the gap to address.

Community Engagement Summary

As part of the capacity assessment process, the CAMH PSSP Regional Implementation Team supporting the Thunder Bay and District Service Collaborative engaged with the community in the following ways:

1. Key informant interviews
2. Stakeholder gathering (community consultation)
3. Service collaborative meetings
4. Defining the top three gaps stakeholder questionnaire

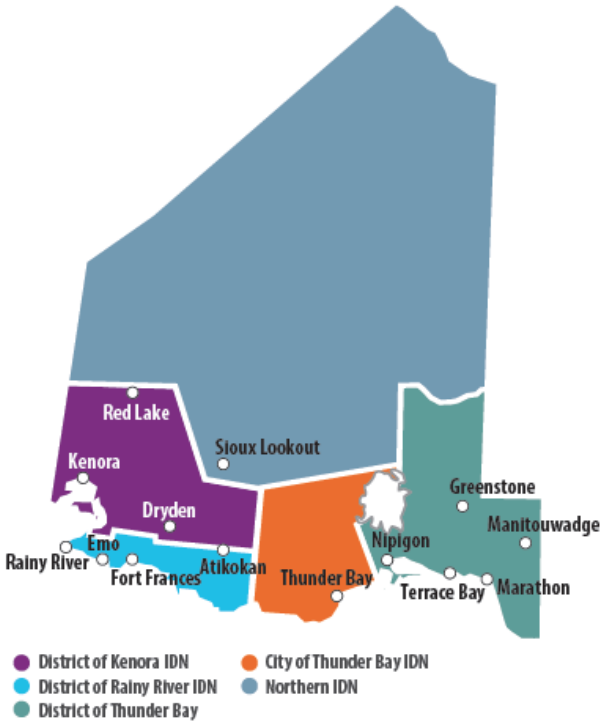
Information collected from the key informant interviews, stakeholder gathering/community consultation, service collaborative meetings, and stakeholder questionnaire informed this report.

Engagement Initiative	**Total Participants**	**Sectors Represented**
Key Informant Interviews	13	Community mental health and addictions Corrections Culturally based services Developmental disabilities Education Employment Family services Housing Hospital mental health and addictions Justice Peer support services Primary Care
Stakeholder Gathering / Community Consultation September 2016	22	
Service Collaborative Meetings October 2016 November 2016	 26 23	
Defining the Top Three Gaps Stakeholder Questionnaire January 2017	15	

General Demographic Profile

As shown in the figure below, Northwestern Ontario is comprised of five Integrated District Networks (IDNs)[1]; within each IDN are Local Health Hubs (LHHs). The District of Thunder Bay IDN[2] is comprised of five LHHs– Greenstone, Manitouwadge Marathon, Nipigon, and Terrace Bay; The City of Thunder Bay IDN[3] is comprised of one LHH – Thunder Bay.

In this report The District of Thunder Bay IDN will be referred to as "The District" and The City of Thunder Bay IDN will be referred to as "Thunder Bay."



Source: North West LHIN, District of Thunder Bay, Integrated District Network Health Profile (2015).

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[1] North West Local Health Integration Network, District of Thunder Bay, Integrated District Network Health Profile (2015).

[2] **District of Thunder Bay LHHs:**
Greenstone LHH: Greenstone, Long Lake No. 58 First Nation, Ginoogaming First Nation, Aroland First Nation, Animbiigoo Zaagi'igan Anishinaabek (Lake Nipigon)
Manitouwadge LHH: Manitouwadge
Marathon LHH: Marathon, Pic River First Nation, Pic Mobert First Nation
Nipigon LHH: Nipigon, Red Rock, Dorion, Lake Helen First Nation, Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay)
Terrace Bay LHH: Terrace Bay, Schreiber, Pays Plat First Nation

[3] **Thunder Bay LHH:** Thunder Bay, Thunder Bay Unorganized (Armstrong, Fowler), Oliver Paipoonge, Shuniah, Neebing, Fort William First Nation, Conmee, O'Connor, Gillies, Whitesand First Nation, Gull River (Gull Bay First Nation), Lac des Mille Lacs, Bingwi Neyaashi Anishinaabek (Sand Point First Nation), Seine River 22A2

The following represent demographic information[4] for The District and Thunder Bay.

In 2011, the total population of The District and Thunder Bay was 145,804. A breakdown by LHH is as follows:

Greenstone	5,619
Manitouwadge	2,105
Marathon	4,037
Nipigon	3,396
Terrace Bay	2,672
Thunder Bay	127,975

The District and Thunder Bay have a low population density at 1.48/km^2, compared to Ontario at 14.14/km^2.

There are a total of 14 First Nations Communities (FNC) in the region; nine in The District and four in Thunder Bay.

A breakdown of First Nations Communities by LHH, percentage of Aboriginal Identity, and name of FNC is as follows:

LHH Name	Number of FNCs within LHH	% of Aboriginal Identity[5,6]	First Nation Community name(s)
Greenstone	4	35.3%	Long Lake No. 58 First Nation; Ginoogaming First Nation; Aroland First Nation; Animbiigoo Zaagi'igan Anishinaabek (Lake Nipigon) First Nation
Manitouwadge	0	5.7%	
Marathon	2	20.2%	Pic River First Nation; Pic Mobert First Nation
Nipigon	2	29.2%	Lake Helen First Nation; Biinjitiwaabik Zaaging Anishinaabek (Rocky Bay) First Nation
Terrace Bay	1	5.8%	Pays Plat First Nation
Thunder Bay	5	8.3%	Fort William First Nation; Whitesand First Nation; Gull River (Gull Bay) First Nation; Bingwi Neyaashi Anishinaabek (Sand Point) First Nation; Seine River 22A2

[4] Statistics Canada. 2011 Census.
[5] Statistics Canada. 2006 Census; Statistics Canada. 2011 National Household Survey (NHS).
[6] Aboriginal Identity information from the 2011 NHS was suppressed for data quality or confidentiality reasons.

In 2011, 13.0% of the District LHH communities indicated that their mother tongue was French; this number was considerably lower for Thunder Bay, at just 2.7%. Greenstone, Manitouwadge, Marathon, and Nipigon each have one designated Francophone community. Terrace Bay and Thunder Bay do not have any designated Francophone communities.

For additional demographic information:

Statistics Canada (2011). Census Profile.
http://www12.statcan.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E

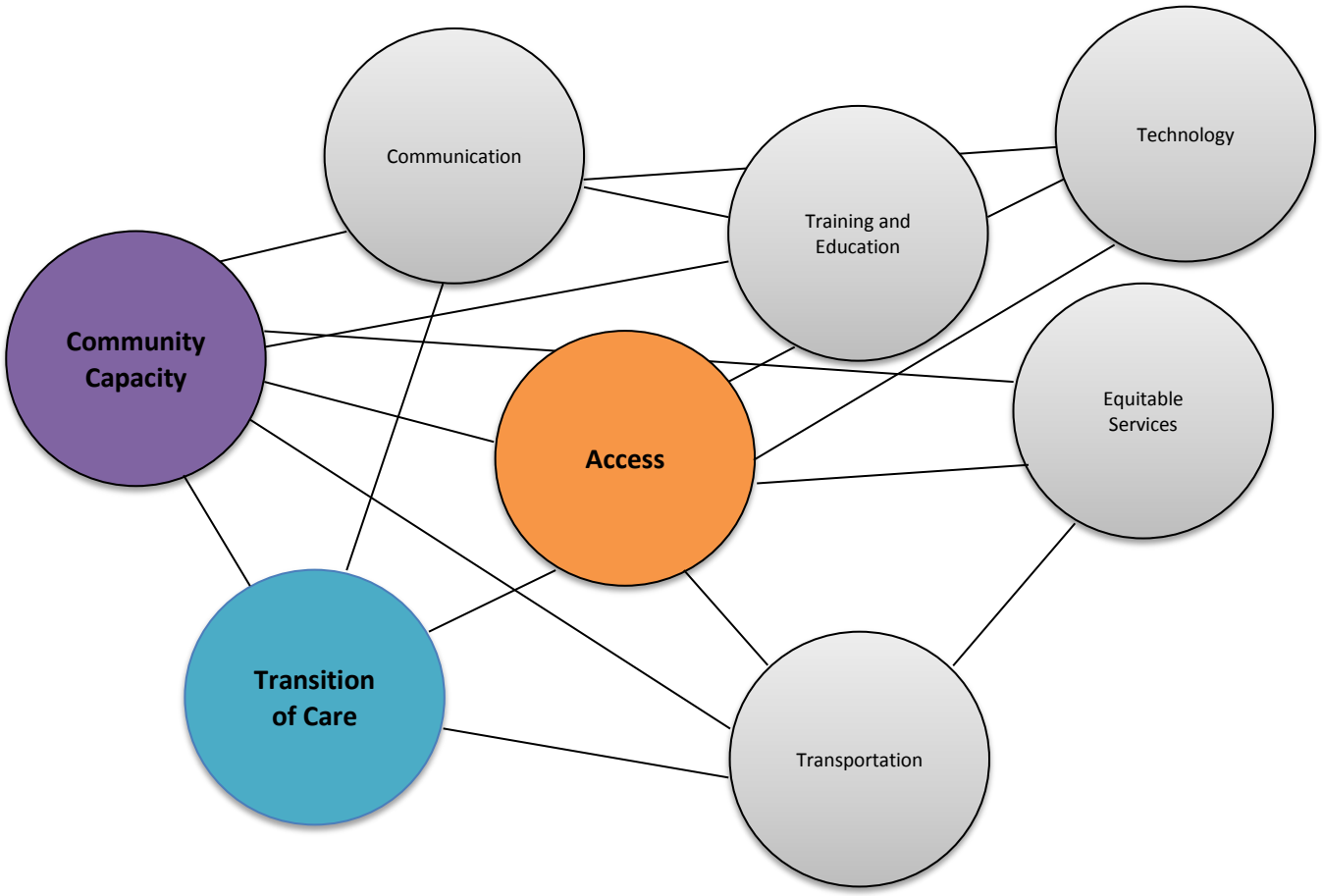
Statistics Canada (2011). National Health Survey (NHS).
http://www12.statcan.ca/nhs-enm/2011/dp-pd/aprof/index.cfm?Lang=E

District of Thunder Bay Integrated District Network Health Profile (2015). North West LHIN. Retrieved January 3, 2017 from:
http://www.northwestlhin.on.ca/resources/ReportsPublications.aspx

City of Thunder Bay Integrated District Network Health Profile (2015). North West LHIN. Retrieved January 4, 2017 from:
http://www.northwestlhin.on.ca/resources/ReportsPublications.aspx

Themes Identified and Linkages

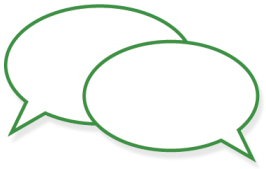
Eight themes were identified in relation to the improvement of the mental health and substance use system emerged from the Thunder Bay and District community engagement process. These priority areas highlight areas that require attention and pose challenges in the District. Many system gaps identified within these priority areas were linked with one another and spoke to more than one priority area. The following figure represents identified priority areas and linkages.



Priority Areas and Gaps Identified

Community Capacity

Each community is unique, has various services available, and there isn't a one-size-fits-all approach that will work for The District.



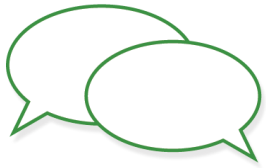
Gaps Identified by the community

Several gaps were identified related to community capacity in The District, including:

- Hiring and retaining qualified staff is difficult; wages are lower.
- There is an out-migration of youth to urban-centres.
- There is a lack of aftercare services following acute inpatient or residential treatment admissions; There is a lack of beds for substance abuse in individual communities (Detox).
- There are a lack of treatment centres for addictions and a lack of trauma treatment centres.
- There is a need for mental health nurses in District High Schools.
- Technology can be unreliable (e.g. OTN) and is not relational; outside specialists may not understand the context of Northwestern Ontario.
- The sparse geography often requires client's leave their home communities to receive care.
- Travel time required between communities is lengthy; weather/road conditions affect travel; infrastructure can also be an issue in some communities.
- There is limited funding in The District.

Transition of Care/Discharge Planning

The system is fragmented in terms of transition of care/discharge back to community; communication needs improvement and consent is an issue.



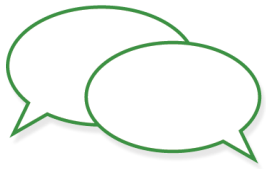
Gaps Identified by the community

Several gaps were identified related to transition of care/discharge planning, including:

- There is lack of a formal discharge plan before the client returns to their community.
- The treatment plan is not communicated or does not exist; health professional(s) are not kept in the loop.
- Clients are discharged back to the community without the knowledge of the provider/community.
- A care pathway is needed.
- The transition from a remote community to an urban center is difficult.
- Transportation time and costs are an issue.
- There is a lack of engagement in aftercare and breakdowns when a client leaves treatment.
- Intakes drop off and the process has to start over.
- There is not a central point of intake.
- The system is difficult to navigate.
- Need to be aware of privacy legislation; consent is a barrier and is often not provided to multiple agencies or revoked.

Equitable Access and Access to Quality Services

Appropriate services for specific populations are lacking. High quality services are offered, but often there are long wait times due to limited resources.



Gaps Identified by the community

Several barriers to accessing high quality, equitable services were noted, including:

- There is minimal or no funding available to increase service delivery/address transportation issues.
- Funding is population-based and not equitable.
- There is difficulty attracting and retaining quality staff; retraining new staff is time consuming and costly.
- There is a lack of transportation to and from services; transportation costs must often be absorbed by clients and their family members.
- When an individual decides they are ready for help, there are long wait times for services.
- There is a lack of access to specialized services (Psychiatry, psychology, OT, PT, etc.).
- There are privacy issues when using OTN (i.e. family member may need to translate if services are in a different language, or a staff member may be needed in the room to monitor OTN equipment).
- Culturally relevant and linguistically appropriate services are not always available (i.e. French language services, various of dialects of FNIM languages); Translation services are not available.
- Although a wide range of services exist, they are not always focused on specific populations (FNIM, francophone, LGBTQTTIA, transition-aged youth, men's issues).
- There is a lack of training and education related to specific populations (FNIM, francophone, and LGBTQTTIA) which may require different approaches to service delivery and understanding differences related to stigma.

Defining the Top Three Gaps Questionnaire: Analysis and Results

Service Collaborative stakeholders were asked to define the terms: community capacity, transition of care, and access. There were 15 responses to the survey. Qualitative results were analyzed thematically and common themes were grouped and summarized.

Community Capacity

Key words: Supports (5), linking services (4), working together (2), knowledge (2), process (2).

Community capacity is the ability to respond to client needs with adequate, appropriate and timely services inside or outside of the community for as long as required. It includes identifying what resources are available in the community, determining if there are a lack of services where there is a need, and recognizing if there are a duplication of services. If services are required outside of the community, there is a process in place that includes the patient, providers and care team in both communities. Communication continues among this group and the patients' return to the community and necessary services upon return are planned. If there is staff turnover, the transition to the new provider is smooth and seamless.

Community capacity involves empowered residents and stakeholders working together to deal effectively with problems and challenges and develop solutions that are appropriate for their needs. Services and resources (including human) are strengthened and linked.

Some respondents indicated that community capacity means having the knowledge, skills and processes in place to deliver the necessary services within the community; not having to access resources outside of the community.

Transition of Care

Key words: movement from one service/system to another (5), patient/client-centered (4), communication (3), support (3) smooth (2), seamless (2), warm handoff (2), involves circle of care(2).

Transition of care involves transferring a client from one healthcare provider, facility or organization to another. This should be led by the entity that the client is departing from providing a "warm handoff" to the entity the client is transitioning to. All people in the circle of care and support network should be included in the planning. Smooth and seamless transition involves working together, fluid and transparent communication, coordinated services, resources and supports that are client-driven and client centered. A coordinated transition

process ensures continuity of care and is a key component of effective client oriented system navigation.

Access

Key words: Availability of services/supports (4), Services within and outside of the community (4), timely manner (3), barriers are broken down (2).

Access is the ability of clients to receive the services and supports they require in a timely manner without long wait times. There are various points of entry to the system, but that does not prevent the client's ability to receive services. Funding, transportation, technology, geographic, and other barriers do not prevent the client from receiving services.

Most respondents alluded to equity, and one respondent indicated that access in The District is better described as equitable access, however, it needs to be put into context.

Some respondents indicated that access meant services are offered close to home, with a central point of contact, where clients are welcomed, provided with information and supported.

Summary of Existing Initiatives

The following existing initiatives were discussed at previous meetings as opportunities to explore further once a gap is selected.

- Central Intake Database (CID)
- Aboriginal patient navigators
- Mobile crisis response
- Youth suicide task force
- Research with Lakehead University, Dilico Anishinabek Family Care, and Nokiiwin Tribal Council (action based research)
- Train the trainer in communities for Chronic Pain – Dilico Anishinabek Family Care
- Thunder Bay Mental Health Program – allowed consent to all four programs involved
- Discharge Planning: Previous pilot projects like CMHA and police doing mobile response teams
- Community paramedicine program

Mental Health and Addiction Programs: Resource Directories

During our November 2016 Service Collaborative meeting, stakeholders identified the need for a mental health and addictions resource directory. There are three recent directories that exist for our region that contain this information and provide agency name, contact information, and program descriptions.

They are:

211 Ontario. Helpline and online database of Ontario's community and social services. (2017). http://www.211ontario.ca/basic-page/about

Demand Capacity Analysis for Mental Health and Addictions Services (2013). North West LHIN. http://www.northwestlhin.on.ca/resources/ReportsPublications.aspx

Disability Health and Resource Guide for Member First Nations of Nokiiwin Tribal Council (2016). Nokiiwin Tribal Council. www.nokiiwin.com/

Recommended Next Steps

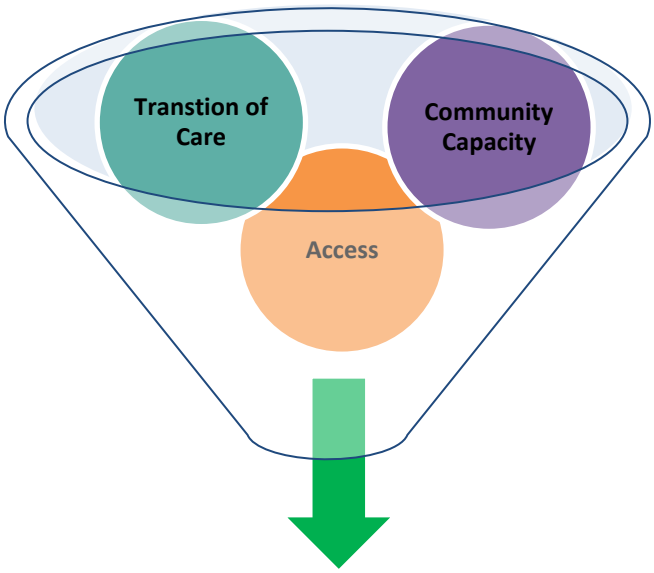
1. Continue discussion on existing initiatives:
   - What is missing?

2. Group discussion: Is there anything missing from this capacity assessment that would help inform the Service Collaborative?

3. Select a gap to move forward with.

4. Explore literature and existing initiatives related to gap selected (CAMH).

5. Determine appropriate intervention.



Gap selection