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JANUARY 13, 2016
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Durham Regional Police Services Constable Meghan Naccarato and public health nurse Yolanda Diston are partners with the Mobile Crisis Intervention Team. Together they are kept busy fielding a steady stream of crisis calls each day in Durham
Read Part 1 of a 4 part series, pg. 10

Special Report

DURHAM'S DAILY CRISIS CRUSADERS

Ron Pietroniro / Metroland

P.3 PROVINCIAL BY-ELECTION EXPECTED FEB. 11 P.15 ARTS NIGHT AT OSHAWA SCHOOL

Part 1

On the road with Durham's Mobile Crisis Intervention Team

Specially trained police, mental health workers field a steady stream of crisis calls

DURHAM — DRPS Constable Meghan Naccarato and public health nurse Yolanda Diston are partners with the Mobile Crisis Intervention Team.

Ron Pietroniro / Metroland

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It's 10 a.m. on a perfect, sunny summer morning.

As Constable Meghan Naccarato's unmarked police car zips along the streets of Durham Region, the scene outside is idyllic.

Kids on summer vacation riding their bikes. Moms with strollers. People strolling with their dogs.

All the while, the laptop screen in front of her scrolls an endless stream of police calls, and the radio crackles with reports of people for whom this morning is not so peaceful.

In Pickering, a man is suffering from a bloody self-inflicted head wound.

In Ajax, a woman has downed two bottles of sleeping pills in an attempt to end her life.

In Oshawa, a half-naked man is sleeping -- or passed out -- on the street.

This is an average morning for Durham's Mobile Crisis Intervention Teams, which consist of a police officer specially trained to deal with mental health issues, and either a nurse or crisis worker from Durham Mental Health Services.

Durham currently has two teams -- and, as with most communities, there is a need for more.

"We have to pick and choose the calls we go to, because we can't go to them all," says Const. Naccarato, who is travelling alongside DMHS nurse Yolanda Diston.

In this case, they pass on the head injury and suicide attempt because those people need immediate medical help before mental health supports.

Moments later the radio comes to life again -- this time the report is of a 23-year-old man in Ajax who is suffering from psychosis.

He and his family members are distraught and in need of support.

As their car heads for the highway, Ms. Diston -- a mental health nurse for the past 20 years -- checks in with DMHS to see if there is any information on the man in crisis.

In this case he isn't known to the organization.

The team never knows what kind of reception they will get when they approach someone in crisis.

"People are usually happy to see us," Const. Naccarato says. "But, there are also those people that don't have insight into their own mental health. They may not think they need help, they may not want us there. You never know what's going to happen."

When they arrive on the quiet residential street, a marked DRPS cruiser is already at the house.

MCIT is always dispatched as a secondary unit. Regular police officers respond first to assess the situation and make sure it's safe for the mental health team to work.

Unlike her co-workers, Const. Naccarato doesn't wear a uniform -- she's dressed in plainclothes with a badge, gun and

radio tucked inside a windbreaker.

Ms. Diston is also dressed casually and their unmarked black car doesn't scream "police."

While the vehicle is decked out with all the necessary features -- including full lights and sirens -- families appreciate that its presence in their driveway is a bit more discreet.

"It helps make people more comfortable," Ms. Diston explains. "We're not intimidating. We're two friendly women who are just here to talk to you. You can almost see them exhale. They feel at ease."

At the house in Ajax, an agitated young man is pacing on lawn as his mother watches from the porch.

Bags containing the man's possessions are scattered on the driveway and he is wearing a pair of purple latex gloves, one of which has ripped.

Ms. Diston steps inside with the mother, placing a comforting hand on her shoulder, while Const. Naccarato talks quietly to the man, then offers him a new glove from her bag.

"We have to earn their trust before we can help them," she explains later. "These are very sensitive issues. It may take us some time to slow everything down and find out what's happening. Sometimes we can be at a call for hours. And that's OK."

Eventually, the team is able to help arrange for the man to go to a shelter in Toronto -- at his request -- and provide support referrals for the family.

"That was a good call," Ms. Diston says, back in the car. "We listened and we were able to connect them with services. Everything ended on a good note."

The first MCIT was established in Toronto in 2000, in response to an inquest into the death of Edmond Yu, a schizophrenic man who was shot by police while wielding a hammer on a bus in 1997.

Teams have since expanded into communities across the GTA.

Their existence has been heralded as a way to prevent people with mental illness from unnecessarily being apprehended by police and taken to emergency rooms -- and to potentially lessen deadly encounters between police and those in crisis.

Supporters say that plan is working.

"They have diverted so many people who before this would have been apprehended and taken to the ER. Now that's much more rare," says Kelly Strachan, a program co-ordinator with DMHS. "We're getting great feedback from the families. Even if someone does have to be apprehended, they say it's being done with more dignity now."

However, some critics question how MCITs can prevent mentally ill people from being hurt or killed by police, if the teams only get involved after frontline cops have deemed a situation to be safe.

MCIT members in most communities aren't allowed to engage with people who have weapons, or who are behaving violently.

It's a rule in place to protect the mental health nurse or crisis worker, who is an unarmed "civilian."

But when it comes to a situation like the death of Sammy Yatim -- an 18-year-old Toronto man shot by Toronto police in July 2013 after he brandished a knife on a streetcar -- the rule means an MCIT would have been powerless to help.

There is at least one exception to the rule -- the Hamilton Police Service and St. Joseph's Healthcare Hamilton have a Mobile Crisis Rapid Response Team, made up of a uniformed officer and mental health nurse, that is the first responder when geographically closest to a call.

Ms. Strachan, from DMHS, says work is underway to establish best practices and create more consistency in how different MCITs across the GTA operate.

In Durham, for example, an MCIT is generally available weekdays during the day and evening, because stats show that's when there is the highest number of calls from people with mental health issues or emotional distress.

Some MCITs respond to calls for people who have overdosed or are drunk or high, others don't.

DURHAM MENTAL HEALTH SERVICES BY THE NUMBERS

- Calls received by CALL crisis line: 19,816
- Mobile visits: 1,150
- Clients that accessed a crisis bed: 85
- Clients with no fixed address: 401
- Clients with no source of income: 87

-- Statistics are for the period of Jan. 1 to Dec. 31, 2014

While mental health is the focus, the Durham MCITs also help people in general crisis.

As Ms. Diston points out, there is often a mental health component to issues like homelessness or family violence. The teams also do followups, checking in on past clients to see how they're doing.

Members of the public can't call Durham's MCITs directly.

About 90 per cent of calls come from 911, the rest filter through the DMHS Crisis Access Linkage Line, which Ms. Strachan describes as a "one-stop shop" for mental health concerns.

CALL gets more than 19,000 calls a year, fielded by a small team of five full-time and two part-time staff. At any one time there is a maximum of three staff manning the phones.

"Sometimes it's something as simple as 'how do I find a local psychiatrist?' Other times it's way more complex," Ms. Strachan notes.

Given the staffing limitations, Ms. Strachan says DMHS has had to wrestle with whether CALL callers should get a busy signal or answering machine if no one can pick up right away -- or whether the line should just keep ringing.

"Of course people are upset when they call and don't get an answer, who wouldn't be?" she says. "Unfortunately, that's how we're funded right now. We do the best with what we have."

She says there is "huge pressure" in Durham Region for more crisis response resources such as the phone line and MCIT.

Officials are working on it, but the process is lengthy and bureaucratic.

Durham Mental Health Services and the Canadian Mental Health Association recently partnered on a "community crisis review" project, to determine the status of all crisis resources offered through the Central East Local Health Integration Network.

After "extensive" community consultation, a series of 10 priority recommendations was presented to the LHIN board in June.

They include standardization of services and collaboration between health-care providers and other service providers to develop a "shared care model."

The next step is to develop an action plan to implement the recommendations and a full report is expected in March 2016.

Back in the car, the radio and computer are abuzz again as Const. Naccarato and Ms. Diston move on to the next call.

They're headed to the Oshawa Centre where a client from Pinewood Centre is experiencing a psychotic episode.

As the car manoeuvres into the mall parking lot, another suicide attempt comes over the radio.

Next week, Part 2: On the front lines with Durham Mental Health Services

Durham's Mobile Crisis Intervention Team

In 2004, Durham Mental Health Services received Health Accord Funding to initialize a partnership with Durham Regional Police that would see the two organizations working closely together in a uniformed fashion to provide support and services to a vulnerable population group: mentally ill individuals that had come into contact with police and the justice system.

Several years later, an independent evaluation of the program was completed. One of the recommendations was that there was a need and desire to have psychiatrically trained registered nurse as part of the team. At that point, Ontario Shores became a partner in the program and provided the registered nurse.

In early 2013, program and agency changes resulted in Durham Mental Health Services taking on full responsibility for the program and in turn Ontario Shores withdrew from the partnership. Durham Mental Health Services hired a psychiatric nurse and assigned a community mental worker to the team as well.

In 2014, due to increasing demand for service as well as incredibly positive feedback from both partners, clients and the community in general, a second team became operational and continues to this day.

Source: Durham Mental Health Services

Part 2

On the front lines with Durham Mental Health Services

Crisis services help residents with mental illness access resources within community

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The nondescript brick home looks like any other, sitting on a corner lot in a busy area of Whitby.

Inside the home there is a cozy sitting room, a kitchen with all the amenities and several bedrooms. The only thing giving away its true purpose as a crisis bed location operated by Durham Mental Health Services (DMHS) is a group of basement offices.

"We try to make it as much of a home environment as possible," said Denise Allen, program co-ordinator for DMHS.

The facility is just one of many services offered by DMHS, which works with area hospitals and other community organizations to co-ordinate mental health resources for patients in Durham Region.

Many who come into the crisis bed units, located in Ajax and Whitby, first contact DMHS through its hotline, operated 24/7 by community mental health workers. Clients are also referred from area hospitals, court programs and other services, or accepted as walk-ins when needed.

"We try not to have any closed doors," Ms. Allen explained.

"We're often the first point of contact for people with the mental health system. It's important to remember that you identify what your crisis is, because it looks different to everyone," she explained, noting the many degrees of mental health and mental illness are important to remember when it comes to battling stigma.

"For one person it may be that they've had an episode and been arrested. Someone else may have had a rough week, they haven't been sleeping, they're having more symptoms than normal and they need support. Others might be in a situation where they've lost housing or a relationship breaks down. Everyone is different."

"It's important to remember people can have mental health even if they have a mental illness, and your mental health can be compromised even if you have no mental illness," added David Clarke, co-ordinator of communications and training for DMHS.

"There are more options than hospitalization or incarceration. We offer clients the 24-hour support they need in a comfortable environment and a chance to work on any goals they may have with our staff."

WHITBY -- Denise Allen, a program coordinator with the Ajax Crisis Program, at the Whitby Crisis Program facility in Whitby.

Ryan Pfeiffer / Metroland

There is always at least two staff onsite, and at least one awake on shift throughout the night. Community mental health workers and peer support workers, who have experience with the mental health system, help operate the crisis facility as well as numerous other DMHS programs.

No matter the issue, staff members are trained to connect clients with the right programs at the right time. That could include a stay in the crisis bed facility, telephone support, a visit from DMHS's mobile crisis team, information about mental health and how to navigate the system, or a referral to other DMHS or community programs.

"If you come to DMHS you will leave with support of some kind," Mr. Clarke said.

"We could be a sole support for people or a doorway to other services offered by DMHS or other organizations."

Awareness of community mental health services is key to getting clients the help they need. For many who don't know the system, the hospital or police may be the first contact they reach out to when they or a family member is in need of help, but it may not be what the individual needs.

"For some clients, community-based support may be all they need," Mr. Clarke said.

The organization maintains close ties to other community organizations, partnerships Ms. Allen describes as crucial to the delivery of services in the region.

"There are lots of really interesting partnerships and we're doing a lot of creative problem-solving by working together," she explained, noting staff recently sat down to discuss areas of service that were lacking in the region and couldn't come up with any, though capacity is always an issue.

"There's rarely a night we don't have a bed filled, we're always looking at ways to reserve beds or stack beds but that's difficult when you're dealing with crisis," she explained.

"If someone's not coping well then our phone teams and crisis teams will try to support them until a bed becomes available," she continued, noting the phone lines are also very busy, with some callers having to wait for team members to phone them back, although a response is guaranteed within 90 minutes.

"Our phone lines are very busy so we're always looking at ways to expand our capacity there," Ms. Allen said.

"Our peer support program is also expanding and that will continue because it's been a very positive program with a lot of amazing feedback. There's an element of hope there for clients to see people who have come out on the other side."

Staff pay close attention to the experiences of clients and peer support workers to identify any problem areas and address them as part of the continuing evolution of services in the area.

"When people think about health and health services options they think about hospitals instead of homes like this, which can be a temporary support like the hospital and often just as effective," Mr. Clarke explained.

"If people thought of this as their first option from a system standpoint I think that would be ideal."

For more information visit www.dmhs.ca. To reach the DMHS crisis line call 905-666-0483 or toll-free at 1-800-742-1890.

New partnership to focus on human rights at Ontario Shores

Ontario Human Rights Commission partners with facility to develop capacity

Ontario Shores Centre for Mental Health Sciences in Whitby is teaming up with the Ontario Human Rights Commission to help further develop human rights within its organization.

The organizations recently signed a project charter that sets out a number of goals for the next three years, including to identify and eliminate any practices or policies that may not be in line with the Ontario Human Rights Code and setting the stage for the development of new organizational practices and services created with a human rights focus.

"This is a wonderful collaborative partnership that has been enthusiastically embraced by our Ontario Shores team," said Barb Mildon, vice-president of practice, human resources, research and chief nursing executive.

"The enthusiasm and interest around this project has been tremendous and I have no doubt this work will enhance our organization and better serve patients, and current and future staff."

Staff of Ontario Shores initially reached out to the Human Rights Council to commend it on a Minds That Matter report, which detailed the discrimination faced by people living with a mental health disorder or addiction.

"In the Minds that Matter report, the (Ontario Human Rights Council) had identified an interest in connecting and working with a leading mental health centre," said Karim Mamdani, president and CEO of Ontario Shores.

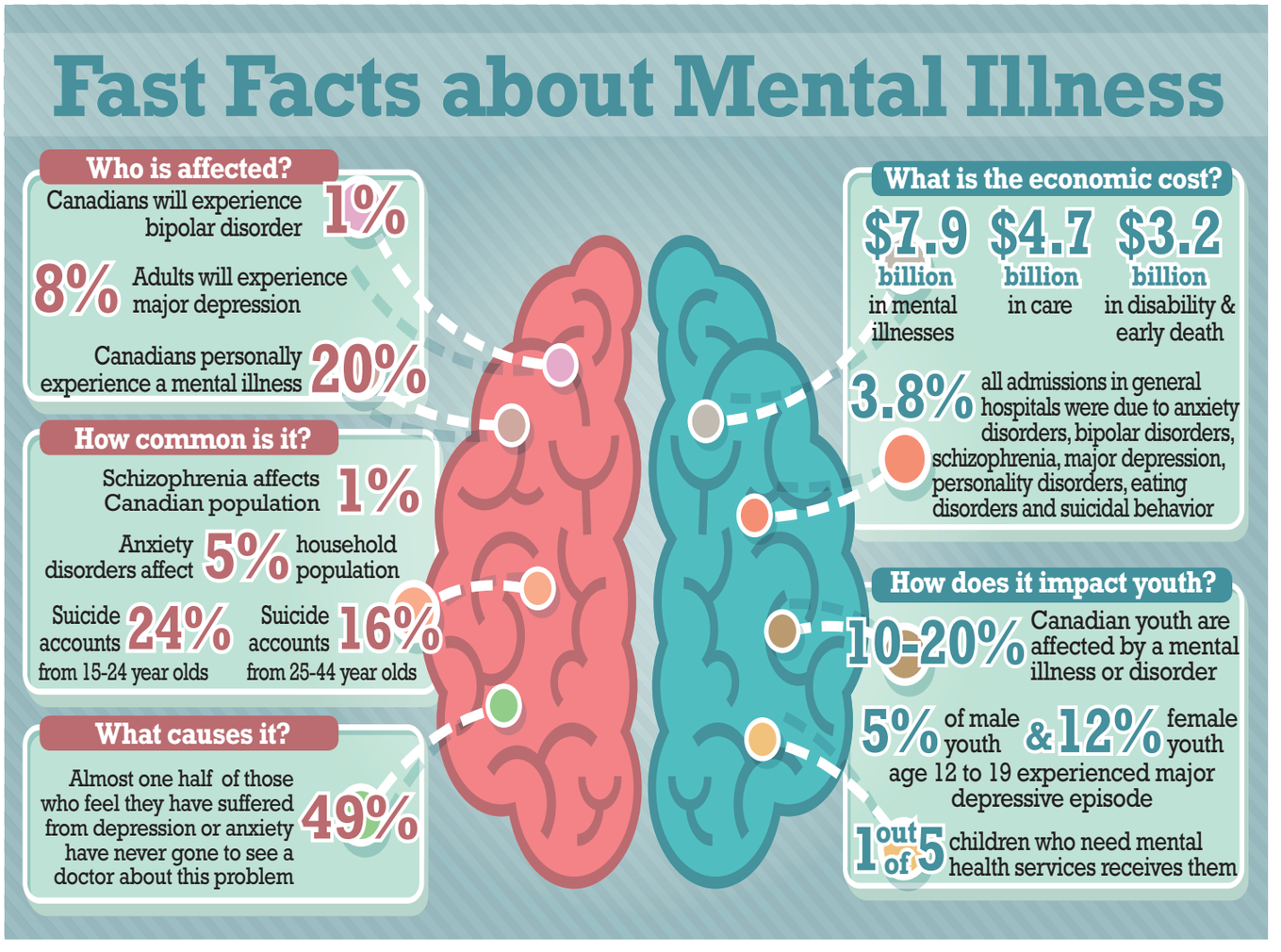
"We started a dialogue to see how we could advance human rights here in our own organization. We are extremely excited to champion this work in hopes it will benefit other hospitals and health-care organizations going forward."

The project will focus on three key areas: services, training and employment. It will include support from teams representing various occupations, both clinical and non-clinical, union and management, as well as patients and their families.

"When we considered working with a mental health centre, we were looking for a leader committed to embedding human rights in all of its operations," said Ruth Goba, interim chief commissioner of the Human Rights Commission.

"Ontario Shores has made the commitment to be this leader. The benefits will be felt by the people who work there, those who interact with the centre, and most importantly, the people who are receiving vital mental health services."

Next Part 3: Whitby's Ontario Shores innovations changing mental health landscape



Durham profiles in recovery

The Interviews

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When Matthew Ranghel was sent to a mental health centre in Penetanguishene after being found not criminally responsible for a crime, his hallucinations were at an all-time high.

"I was very sick," he said. "It's been going on for a few years."

He suffered from delusions, hallucinations and false beliefs.

He spent a few years in Penetanguishene before the Ontario Review Board deemed Mr. Ranghel less of a threat because of good behaviour. He was medication compliant, but the medication wasn't working.

His hallucinations were still so vivid he had trouble breathing, speaking or holding a conversation with anyone.

"It was pretty bad," he said. "My mind wasn't lucid or clear. It was all foggy."

Mr. Ranghel was then admitted to Ontario Shores' forensic rehabilitation unit, where nurses and his health team administered a new approach to mixing medication. "It is trial by error," he said. "It's a difficult process to begin, because you're dealing with human beings and they're suffering. The doctors don't want to see you suffering. They want to see you living to the best of their ability."

After six months on new medication, his symptoms decreased. He remembers watching TV like he did every other day. Typically, he heard voices talking to him as he watched, but this particular morning he noticed something new: silence -- at least in his head.

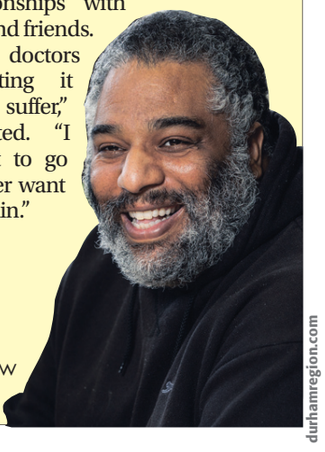
"I thought wait a minute, all I can hear is the TV," he said. "So I saw the doctor and the doctor was like, well that's good, so we have the medication right, we just need to see how it affects you long term."

It's been four and a half years since and Mr. Ranghel's now back in the community, living in a group home in Whitby and no longer experiencing symptoms. He was officially discharged on July 2, 2015.

"It was a very special day for me," he said. "Because everything I worked for had come to fruition."

With his darkest days behind him, Mr. Ranghel's now looking to improve his life and relationships with his family and friends.

"If the doctors aren't getting it right, you suffer," he lamented. "I never want to go back. I never want to suffer again."



Matthew Ranghel

Part 3

Whitby's Ontario Shores innovations changing mental health landscape

Patient information easily accessed and shared among professionals means variations of time, costs and resources are reduced

Todd McEwen
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The sprawling, metallic and glass-filled lobby of Ontario Shores Centre for Mental Health Sciences is a fitting representation of what's hidden behind the south Whitby facility's walls.

It's modern, quiet, state of the art, beaming with light and easily overwhelming.

One wrong turn down a hallway can leave you longing for a map or directory with a star pinpointing your location.

But Ontario Shores doesn't distribute maps for navigating its labyrinth of stairways and corridors; it's just another stop in a series of twists and turns patients seeking mental health treatment are expected to learn and adapt to.

Imagine trying to navigate a half-million-square-foot facility, consisting of eight wings and three storeys, for the first time. Now imagine trying to navigate a healthcare system that professionals say is underfunded and services millions of people who are fighting for access.

Both can be daunting, but it's the latter that's more of a concern to patients and officials of Ontario Shores.

"In communities, mental health supports can be very confusing on where you should go," said Cynthia Weaver, the youth administrative director of Ontario Shores. "I find that families get very concrete, and depending on the urgency of the issue, they'll go straight to the emergency room."

Ontario Shores is usually the final stop for patients who have already been through a long and exhausting journey in a system that Ontario Shores officials say is fiscally constrained and struggling to create greater means of accessing its services.

"Mental health has been underfunded for decades. It's already constrained. It's already been underfunded, so further cuts to that might leave potentially dire kind of scenarios," said Dr. Ian Dawe, Ontario Shores' physician-in-chief. "There's still a lot of work that needs to be done and that work has everything to do with increasing access, increasing transitions through the system."

Ontario Shores, at the foot of Gordon Street near Lake Ontario, exists among a mix of suburban and commercial landscapes. The hospital provides a wide range of specialized treatment services for complex mental health issues. Often, patients arriving at Ontario Shores have already logged time at another hospital, usually a short-term stay at a general hospital.

"Inpatient care is still the core mandate," Dr. Dawe said. "People arrive at our hospital for inpatient care, via another hospital."

A patient's journey to Ontario Shores typically starts with a community-based practitioner or admission to an emergency department. From there, patients stay at the general hospital anywhere between a couple days to a few weeks, depending on the severity of their illness. If they still require intensive or long-term services, Ontario Shores is able to provide that.

"It provides a much different level of care delivery and the ability to work with people over time," Dr. Dawe said. "A specialized hospital still backs up all the other organizations in a strategic way, but more and more so we're broadening our services beyond that."

Historically, Ontario Shores fell under the designation of "specialized" hospital and largely "backed up" other hospitals with patient care. In 1997, the Ministry of Health and Long Term Care recommended Ontario Shores divest and operate under the Public Hospital Act. This allowed Ontario Shores to broaden its reach as a stand-alone hospital and progress beyond its closed-door, subspecialized approach of the past.

"It became much more open and able to serve people from across many different needs," Dr. Dawe said.

Now, the hospital serves a population of residents across the province with a staff of 1,200 people. It's equipped with just under 350 inpatient beds, which are split between the forensics unit (about 30 per cent population), seniors' care, geriatrics and dementia, and child and adolescent care.

Locally, Ontario Shores is partnered with multiple community services and hospitals including Lakeridge Health Corporation, Durham Mental Health Services, Northumberland Hills Hospital and others in Scarborough and Peterborough regions. The hospital offers mood, metabolic and weight management clinics to women, and memory clinics. There are also prompt care, borderline personality disorder self-regulation and traumatic stress clinics as well as a forensics unit for people found not criminally responsible by the justice system.

The majority of patients admitted to Ontario Shores are struggling with depression, schizophrenia and dementia.

"Between those three diagnostic groups, that covers a fairly significant chunk of the types of patients that we see," Dr. Dawe said.

According to Health Canada, schizophrenia affects about one per cent of the adult population; anxiety disorders affect 12 per cent; eight per cent of adults will experience major depression at some point; one per cent will experience bipolar disorder and three per cent of women will be affected by an eating disorder at some point in their lifetime.

The latter diagnostic group is now being treated at Ontario Shores in a one-of-a-kind eating disorders unit that opened last October. It provides children and adolescents an extended recovery period that allows them to develop healthy eating habits and provides psychological intervention. The 12-bed unit is the only one in Ontario.

"We're the last stop in the provincial system," Ms. Weaver said. "The kids that are entering into our resource have exhausted other services. There's probably some significant behavioural intervention that needs to happen because the child has had a significant journey with mental illness and the community supports haven't worked, to that point."

Ms. Weaver explained the usual journey for an adolescent who ends up at Ontario Shores begins in an emergency room of a general hospital.

"Their medical stability has gotten to a point where there's fear that the child might die because of starvation," she said.

Children may spend anywhere from seven to 10 days in an acute-care hospital before returning to a medically stable point. However, what the services aren't doing is offering coping mechanisms for the disease, Ms. Weaver said. Instead, children are reinstated back into their communities following their stints in hospital without proper education on ways to maintain their health's stability. At Ontario Shores, their health team looks at appropriate medication and behavioral supports for its patients as well as what the transition back into the community should look like.

The health team consists of psychology, psychiatry and social workers, as well as occupational therapy and a 24/7 support team with nurses and child workers.

"We utilize all the resources in the hospital in order to give the kids an environment that is least like a hospital as possible," Ms. Weaver said. "If you walk down the adolescent unit, or into the eating disorders unit, we really tried not to make the environment look institutional."

The furniture was selected to be comfortable and eye-pleasing, the walls are decorated in murals and it all exists within an infection-controlled environment. The youth are allowed to engage in online activity, although they're given limited access to social media.

"Some social media could be detrimental to recovery," Ms. Weaver said. "But we do have to give them access they would have on the outside."

That outside world access includes trips to local restaurants and community events, so patients can learn to shed their fear of eating in public.

"The kids that come into us have a fear of eating in front of anyone and a fear of food," Ms. Weaver said. "It's trying to re-learn the normalization of food intake.

"So the program has to look at rebuilding the thought process."

One of the ways Ontario Shores achieves that is by involving the patient's family through video conference calls and opening its visitation hours "as much as possible." By opening that two-way street, it provides patients with a lifeline that remains constant, even after they're discharged, and it provides families with a sense of therapy and relief because by the time families reach Ontario Shores, it's already been a "fairly long" process, Ms. Weaver explained.

"They've been traumatized," she said, "because they haven't been able to help their own kids ... and that's a very helpless situation. They need a lot of support when they reach us."

That's when Ontario Shores' family resource centre enters the equation. The space, which is a room full of armchairs, tables and in a well-lit atmosphere, allows families to connect with each other as a system of support. Ontario Shores offers family education sessions, workshops and training.

"Families are the one support that (kids are) constantly going back to that's going to be consistent for them," Ms. Weaver said. "So there is some legality around patients wanting their families involved, but if we can make it a positive experience, then we'd always choose to have their families involved."

ONTARIO SHORES BY THE NUMBERS

Revenue: $129,494,000 (2014/15)
Expenses: $125,534,000 (2014/15)
Staff: 1,200
Outpatient visits per year: 60,000
Average length of stay: 62 days (2014/15)
Founded: 1911 by architect James Govan
Age of admission: 13-18 (11.2 per cent); 19-34 (33.1); 35-54 (32.8); over 55 (22.9)
Visiting hours: 9 a.m. to 9 p.m./ seven days a week
Psychotic disorders admissions: 60.2 per cent
Mood disorders admissions: 16.9 per cent
Cognitive disorders admissions: 9.8 per cent

Outside the youth eating disorders clinic, Ontario Shores sees other children and young adults affected by a myriad of mental health issues: depression, anxiety and mood disorders are among the most common.

"There's an increase in mood and anxiety for the last 10 years," Ms. Weaver said. "The communication kids have now is totally different than 10 years ago. The peer dynamic is so different. Everything's now and everyone's connected."

And it's a similar effort to connect everyone and easily share information that's become the uphill battle Dr. Dawe's crusaded within the mental health sector for years.

He sees a simple future: a medical landscape where patient information is easily accessed and shared among professional peers and families so the variations of time, costs and resources are reduced, and therefore, more people can be treated in a timely and effective manner. Basically, he wants a paperless medical field. That process has already started with Ontario Shores, and according to Dr. Dawe, it's been working.

"We have a lot of new initiatives over the last few years on the technology front that's allowed us to be more successful on the reduction of variations," he said.

Mainly, Ontario Shores has a computer system that provides new transparency on data and allows physicians and caregivers to know where their practice's variation stands in comparison to their peers. Ontario Shores received the computer system last May.

"It's ideal for a number of reasons," Dr. Dawe said. "It reveals how they practise in real time compared to everyone else. That has led to some extraordinary change."

With its technology investment, the hospital's also launched an initiative known as Patient Portal, which provides web-based access to medical records. Individual patients, family members and other health-care providers are all given access to the online portfolio in order to share information freely, rather than clog the system.

"Although, it seems reasonable and necessary in a world where everyone's data is everywhere," he said. "In health care, that hasn't been the case historically. We're working on that."

As an example, an elderly patient was discharged recently from Ontario Shores. His family signed up for the Patient Portal initiative, predicting that the patient's health, although better, could fluctuate in the future.

"Symptoms fluctuate, they get better, then sicker, then better again, so in our patient discharge records, we outlined a whole series of things of what to look out for, should this person ever get sick again," Dr. Dawe said.

The patient did get sick again. He was rushed to an emergency department where he was in the care of a physician who was unfamiliar with the patient and didn't have access to his medical chart or history.

"We kind of predicted this," Dr. Dawe said. "So we included it in our discharge file."

However, the patient was too sick to direct staff to the Patient Portal and an emergency room doctor was close to admitting the patient when a man came running into the room.

"He said, 'No, don't admit my brother, here's what the specialist said to do," Dr. Dawe said, explaining the man had printed out his brother's medical information from the Patient Portal. "This was information the other doctors wouldn't have had access to. Once they saw it, they carried out the instructions and the person got much better."

The patient was discharged a few hours later.

"Thus, that technology avoided a $1,500-a-day admission (bill)," he said. "Just by creating a transparency and better flow of information.

"We're proud of that," he continued. "It's a real success story for us. At the end of the day it's a success for him. We're very mindful of who wins in that environment. It's the person and their family. We're glad to have played a successful role."

Dr. Dawe holds these success stories close to his heart. The Oakville resident is also a teacher in the undergraduate, postgraduate, continuing and public education programs of the department of psychiatry at the University of Toronto, and the mental health and addictions lead with Central East LHIN. Dr. Dawe's professional life essentially orbits around improving lives within the mental health-care system, which for him means increasing access and improving the flow of information.

"Ensuring access is really about the reduction of variation, which is the flip side of the coin to innovation. The challenge we have as health-care leaders is to do both while ensuring one doesn't cancel out the other," he said. "We're up for that challenge."

Next Part 4: Welcome home: Helping Not Criminally Responsible Durham patients find recovery

Durham profiles in recovery

The Interviews

Todd McEwen
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Chelsea Lall, 17, stopped going to school in Grade 10 after a suicide attempt.

For months following, she spent every morning staring at her ceiling or laptop for hours on end because she couldn't leave her room without facing an onslaught of anxiety.

"Or I'd go downstairs and I'd try to go outside, but I couldn't," she said. "I would get sick and start puking."

And that's when she would start hearing hostile voices.

"They'd tell me it was a trap, so don't go outside," she said. "So I spent six months in my house."

Now, she says she's barely in her house and those hostile voices are reduced to a faint whisper.

Chelsea spent half a year with Ontario Shores Centre for Mental Health Sciences learning to live a life not weighed down by anxiety attacks, depression and hallucinations.

"I've developed new relationships with peers that I haven't had before," she said. "I'm no longer isolating myself in my house."

Born in a small area of Clarington, Chelsea was cast as the only girl of colour in her school. She was bullied by her peers and soon developed social anxiety.

"I spent most of my Grade 9 year alone," she said. "I became the kid no one wanted to talk to."

The bullying escalated to the point where her classmates pushed her downstairs and taped razor blades to her locker with a note to slice her wrist open.

"The principal wouldn't do anything about it," she said. "They didn't investigate. Because it was just kids being kids."

Chelsea bounced around hospitals before being admitted to Ontario Shores Centre for Mental Health Sciences in December 2014. She wasn't sure what to expect of the speciality hospital, but soon learned to socialize among peers without an anxiety attack and how to control her thoughts and stay grounded when her anxiety is triggered.

Her voices and hallucinations, which used to appear as "creepy" and "disfigured" characters, are now distant shadows. She's aware that her mental illness is something that will likely follow her for the remainder of her life, but now she knows it's not something to be ashamed of.

"I can go through my day without dwelling about something," she said. "It'll be something that is always there. It's just how I handle it."

Chelsea Lall

Durham profiles in recovery

First Person

Meet Brad Hogg, an Oshawa resident who has struggled with schizophrenia. He shares his story here.

Name: Bradley Hogg
Age: 48
City: Oshawa
Occupation: Currently between jobs
Diagnosis: Schizophrenia

Being in the hospital for years and being discharged and then coming into a relatively normal life was very elating for me. I was in and out of the hospital for years. To give you an idea about how long I was in the hospital, my last day was in 2001 after staying in hospital for six years.

So when I did have a chance to get discharged and come back into the community, the transition from the hospital to a group home and then to my own place was just an incredible feeling.

You think I didn't have a typical life but I do think that it's more typical than what people think. I say that because one in four people have mental health issues some time in their life. I think a lot of people have when they don't have problems such as I had, I think they take for granted that they are healthy.

People say that health is the number one thing you can have. I feel that includes mental health as well. If you don't have mental health, you might not have a meaningful life.

You may think that, but what's actually true is that we can all have meaningful lives.

Viktor Frankl, who was in concentration camps during the Second World War, he believed that meaning is what we are all aspiring towards. He's talking about love in your work and through courageous times. I think that when you are in hospital, you need that courage to be able to get through the problems you have and then move on.

Everybody has different ideas of what a meaningful life is. I don't have a job or a wife and kids right now, but I can say I'm symptom-free and to be symptom-free is just a wonderful feeling.

When you're in the hospital, you can have faith and hope in order to get through the problems that you have. I think you have to try to accept what you have and make the best of it.

What I look forward to most today is being symptom-free. It's really difficult for someone to understand how you feel when you have a mental illness, but to be symptom free and know that you have so many opportunities in life, that's really uplifting and gratifying for me.

See the video of Mr. Hogg online at durhamregion.com.

Part 4

Welcome home: Helping Not Criminally Responsible Durham patients find recovery

Ryan Pfeiffer / Metroland

OSHAWA -- Duztin Leonard, left, and Andrew Paton, case managers with the Transitional Rehabilitative Housing Program, in one of the eight units their clients are transferred to after being patients at Ontario Shores Centre for Mental Health Sciences.

Intense supports needed to help some clients succeed in community once out of the hospital

Jennifer O'Meara
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After the breakdown, after the arrest, after the court assessment, after admission to a mental health hospital and possibly years of treatment -- what then?

When someone is on the road to recovery and ready to take that first big step out of the hospital, they need a specialized kind of support to succeed.

The transitional rehabilitative housing program, or TRHP, is designed to do that. It is designed to guide people who have been found Not Criminally Responsible due to mental illness back into the community. The specialized program was launched as a pilot partnership between two of the largest mental health services in the region, the Canadian Mental Health Association Durham and Ontario Shores Centre for Mental Health Sciences.

"There are real barriers to having them transfer out of hospital and into the community and safe, secure housing," said Lisa Matheson, TRHP team lead at Canadian Mental Health Association Durham.

The transitional housing gives people leaving the hospital a subsidized, furnished apartment, with intense support -- up to three visits a day, seven days a week, from mental health experts. The program targets people who are mentally ready but would otherwise find it impossible to move back into the community.

"People who have been in the hospital for a long time. People who haven't lived in the community. Some folks never have lived independently and really didn't have the skills to move into an apartment and be on their own," said Kim Stewart, a registered social worker with the forensic outpatient service with Ontario Shores.

The first six clients of the program, who had been in the Whitby facility for 10 years or longer, were moved from Ontario Shores into the transitional housing in 2010. TRHP staff drive newly-released clients to psychiatric and medical appointments, oversee medications, help with budgeting, meal planning and grocery shopping and support the client getting back to school or work.

TRHP staff is in almost daily contact with Ontario Shores about the mental health of the clients and whether they are meeting the conditions of release from the hospital.

"They maintain all ties to the hospital. These people are monitored," said Ms. Matheson. "The intensity flexes based on how the person is doing."

Since its launch, the program has been expanded to eight clients at a time. A couple of clients have had to be re-admitted to hospital from the rehabilitation housing, but that help comes sooner and the hospitalizations are briefer than they would be without the intense monitoring, explained Ms. Stewart. Without the transitional housing supports, a stressful life event could mean a client being re-hospitalized for a long time, losing their subsidized apartment and being put back on the wait list.

Only one TRHP client has been re-hospitalized for breaching the release conditions. For the clients who have graduated from transitional housing and moved on to alternate community supports on their way to an absolute discharge, there have been no re-admissions to hospital.

"Nine clients have transitioned through TRHP project. They moved into traditional mental health resources in the community," said Ms. Matheson. "Our guys have gone back to work, back to school, volunteered. If TRHP wasn't there most of these guys would have remained in hospital."

Ontario Shores has approximately 165 Not Criminally Responsible clients at a time. Once the Ontario Review Board has determined a client is well enough to return to the community with conditions, most of those clients are able to either live independently or return to living with their spouses, children or parents.

However there are some clients who are mentally ready but who need the extra support of the TRHP program. Moving out of the hospital allows them to gradually increase their independence. It also frees up hospital beds at Ontario Shores and saves money. The TRHP program saved approximately 2,000 hospital days in 2013, which means more than $1.5 million saved that year alone.

The program works with most people for a year to 18 months, depending on how they are doing. Once the client is discharged, they are transferred to other CMHA departments, gradually increasing their independence while keeping a support system in place. They maintain an apartment and don't have to move as they graduate from the system. It's designed to be seamless, and help the person maintain their connections to the community.

"We're really lucky here it's a one-step. In other communities it's a lot more piecemeal," said Ms. Stewart.

"It's working very well."

In the last decade the Ontario government has moved to try to keep people with serious mental illness out of the criminal justice and corrections systems by investing in court support programs, intensive case management, supportive housing and safe beds.

Across the province, transitional rehabilitation housing programs for forensic patients are all different. According to the local agencies, the Durham program is fortunate because CMHA Durham has access to housing, which can be a challenge elsewhere.

"I think we hope for it to expand, given the resources. We've definitely seen signs of success in many of our folks who have gone through the program," added Ms. Matheson.