

RETHINKING THE QUEEN STREET SITE

FUNCTIONAL PROGRAM

PART I: INTRODUCTION

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BACKGROUND

This Functional Program is the result of extensive internal and external consultations pertaining to the role, scope and service offerings of the Centre for Addiction and Mental Health (CAMH).

It has been based on planning done by CAMH related to its programs, the needs of its clients/patients and its role within Toronto, the Greater Toronto Area and the Province of Ontario in addictions and mental health services.

It also reflects the Centre's strong belief in the benefits of bringing together onto a main site the programs and services currently spread across the four sites of CAMH's constituent organizations:

- The Queen Street Mental Health Centre on Queen Street West;
- The Addiction Research Foundation on Russell Street;
- The Clarke Institute of Psychiatry on College Street; and
- The Donwood Institute on Brentcliffe Road.

This Functional Program is provided under separate cover but is integral to the capital planning submission being made to the Ministry of Health and Long Term Care (MOHLTC). The complementary document "CAMH Facilities Master Plan" will include the other elements of this submission – Site Plan, Facilities Master Plan, Capital Cost Estimate and an Implementation Schedule.

CONTENT OF THIS FUNCTIONAL PROGRAM REPORT

The Functional Program contains the main informational elements required by the MOHLTC for such a document:

- Introduction to and Planning Context for the Study,
- Role and Scope of the Centre's future programs and services,
- Future operational parameters of these programs and services, whether they be direct care, clinical support or facilities support services,
- Current and projected workload,
- Current and projected staffing, and
- Future design requirements, including external relationships to other CAMH services, locational requirements, internal relationships and design concepts and the space requirements of all functions.

This Functional Program Report is assembled into three parts and associated appendices:

Part I: Introduction

This section outlines the project parameters and summarizes the outcome of the functional programming process. Topics in this section cover external influences to the planning process such as:

- the HSRC directives;
- messages from recent community consultations;
- principles contained in Making It Happen and Setting the Course;
- CAMH's provincial mandate (based on HSRC directives) to work with providers and other partners across Ontario to improve the quality and accessibility of addiction and mental health services; and
- Best practice in addictions and mental health, as well as internal influences such as:
 - the need for accessibility to CAMH's services by its stakeholders;
 - the need for seamless care by CAMH clients/patients; and
 - the need for integration among CAMH's services and increased collaboration with external addictions and mental health services.

Part I concludes with summary tables of Workload and Staffing for 2000/01, 2001/02, 2002/03 (workload only), 2003/04 and a table outlining the projected Space Requirements for 2003/04.

Part II: Operationalizing the New CAMH Clinical Program Principles

Part II outlines the overarching service delivery principles and the internal approaches and the organizational structure put in place to support these principles. Topics include the populations being served, the intake and referral processes as well as the process for expanding service capacity.

Part III: Functional Program Component Sections (not included in this *Executive Summary* document)

This section describes each of the future functional components or areas at CAMH. Part III is further divided into two main sub-parts titled - PHASE ONE and SUBSEQUENT PHASES. The functional components included in each of the two sub-parts relate to the phasing of the development of the facility(s).

PHASE ONE: *A component is included only once in the binder.* The inclusion of a component section in PHASE ONE indicates that all or part of the services and related space requirements found in that component will form part of the first phase development of the new CAMH facility(s). The first page of each component contained under the PHASE ONE tab indicates which part of the component will be developed in PHASE ONE and which will wait for later or subsequent phases of development.

SUBSEQUENT PHASES: All services and related space requirements in the components located in the SUBSEQUENT PHASES tab will be developed in later or subsequent phases of the project following Phase One development.

TABLE OF CONTENTS: The table of contents is sub-divided into Phase One and Subsequent Phases and clearly indicates the components that will be developed in either Phase One, Subsequent Phases or in both.

The functional components located in each of the two main sub-parts – Phase One and Subsequent Phases - are further organized under the following broad categories:

- Group A – Client/Patient Care Programs,
- Group B – Clinical Support Programs & Services,
- Group C – Research,
- Group D – Administration and Facility Support Services.

The format for the description of each functional area is outlined in the next section “Format of Functional Program Component Sections”.

Appendices

Appendices outlining overarching approaches to food services, materials management, pharmacy services, safety and security and workplace strategies are provided at the back of the Functional Program.

The appendices include two additional documents. One is a Letter of Intent between CAMH and The William Osler Hospital for the provision of CAMH services in Peel Region.

The other document is a Functional Program for the addition of a 6-bed Women’s Medium Secure Forensic Unit to the Law and Mental Health Program. This FP was submitted to the Ministry of Health and Long-Term Care in January, 2004. It provides back-up information for the revisions made to the LAMH component found in this Functional Program.

Inclusions & Exclusions from this Report

The HSRC has indicated that a number of services currently offered at CAMH should be considered for repatriation into the Peel Region.

Based on the Hub-Satellite model of service delivery and HSRC recommendations concerning Peel Region, the Functional Program outlines all CAMH programs and services including associated workload volumes and staffing, whether they are to be located on-site or at an off-site location. However, it only provides the facilities (space) requirements for those components to be located on-site at the Queen Street property.

The following table provides a summary of elements included in the functional component sections:

Clinical Function	Services Described	Workload Defined	Clinical Staffing Req'ts	Support Staffing Req'ts	Facilities
On-site					
- Bedded Services	✓	✓	✓	✓	✓
- Non-Bedded Services	✓	✓	✓	✓	✓
Off-site					
- Bedded Services	✓	✓	✓	✓	✗
- Non-Bedded Services	✓	✓	✓	✓	✗
Peel¹					
- Bedded Services	✓	✓	✓	✗	✗
- Non-Bedded Services	✓	✓	✓	✗	✗

Notes & Assumptions:

1. The resources related to Support Services staffing for the Peel beds are assumed to be provided through contract arrangement with the host organization that is chosen as the site for CAMH to operate its Peel beds.

**Format of Functional Program
Component Sections**

The basic 'building block' for physically organizing health facilities projects is the FUNCTIONAL COMPONENT. A functional component can be defined as a grouping of activities and assigned spaces that are physically related by their common mission to satisfy a specific group of functions or operations. A functional component may or may not be synonymous with a department since the term 'department' refers to an administrative organization and not a physical organization.

Each component statement is formatted according to the following headings:

FUNCTIONAL DESCRIPTION, providing information on the future general services of the component and its basic features or characteristics.

OPERATIONAL DESCRIPTION, providing information on the proposed operation of the component internally, as well as in relation to other components.

WORKLOAD, summarizing the existing and projected future workload in appropriate work units, including assumptions used in developing the projections. This information is used to estimate both the staffing and space requirements of the component.

In this Functional Program for CAMH, future workloads are estimated for the first full year of operations following the move into the newly consolidated and rebuilt facility at Queen Street West site. The year 2003/04 has been used as the planning horizon to correspond to the timeline of the directives provided by the Health Services Restructuring Commission (HSRC). However, this date should be interpreted to be the first full year of operation of the programs and services, whatever the date may be, of the move to new facilities.

STAFFING, summarizing the existing staffing in terms of full-time equivalents (FTEs), as well as providing estimates of future FTEs, including assumptions used in developing the projections. These estimates are used to project space requirements and operating costs. The figures are also useful to the architect in estimating maximum occupancy load conditions for fire exiting requirements (e.g. corridor calculations, etc.).

In this Functional Program for CAMH, the staffing estimates are provided for the first full year of operations following the move into the facilities; in this case this is presented as the year 2003/04 in order to allow the correlation of workload to staffing.

DESIGN CRITERIA, outlines external (or inter-component) relationship criteria and internal relationship/concepts to be incorporated into the design of the component. The following definitions have been used to prescribe these relationships:

- 'Direct access by internal circulation' means components that are horizontally contiguous or linked internally.
- 'Direct access by general circulation' means a minimal amount of horizontal general circulation or direct vertical circulation.
- 'Convenient access by general circulation' means components linked by substantial horizontal and/or vertical general circulation.

This section also lists the net space requirements for the component based on 2003/04 workload and staffing projections. The space requirements list indicates the number

of rooms or spaces (units), the net square feet per room or space (nsf/unit), the total net square feet for each space type and provides supplementary remarks that help explain the use of the space. In addition, the spaces/rooms are grouped to indicate to the architect those that create operationally related clusters.

Finally, total net areas (and in cases subtotals of clusters) are converted to “blocks of space” by applying a Planning Factor (sometimes referred to as plng factor). This increased area, referred to as the “component gross area” or “Departmental Gross area” then becomes one of the major planning/blocking tools used by the architect in the early design phase of the capital project.

In this Functional Program for CAMH, a column is included that allows the comparison of current net area to proposed area. The comparison has not been carried out in this case as compiling this information is complicated by the fact that programs and services are currently spread across four sites and that significant changes have been made to the manner in which programs and services are delivered in the proposed plan.

Wherever available, the formulae and guidelines contained in the other relevant and appropriate planning studies have been used to determine space requirements. In addition, appropriate levels of space utilization have been reviewed in the course of calculating the numbers of various types of rooms and function and activities have been recognized in determining room size. In particular, the Workplace Strategy document prepared by the Workplace Strategy Working Group during the course of the Functional Program project and presented in the Appendices, outlines office and workstations guidelines.

The extent of change anticipated to the organization and its facilities has resulted in the Functional Program Design Criteria for the clinical programs being built around a ‘standardized model’ for each of the inpatient care and non-bedded client/patient services, modified only to the extent necessary to meet the needs of each individual care program.

This approach promotes the concept that space must be designed in a flexible manner to support changes resulting from maturation of the programs and services and in turn will support CAMH in meeting the clients’/patients’ and the communities’ changing needs over time.

STUDY PARTICIPANTS

The extent of individuals participating in the development of the Functional Program has been very broad. This section provides a summary of the manner in which these individuals were involved and the extent of the various groups' involvement internally and externally.

The study was guided by several senior level committees including:

- the **Board of Trustees**, including various board committees, was involved in contributing to the site redevelopment planning through their advice, staff presentations and written comments;
- the **Senior Management Group**, acting as the Study Steering Committee received regular updates (e.g. on the progress of clinical program reconfiguration) and dealt with corporate-wide issues;
- the **Programs Committee**, drawn together from clinical programs, education and research portfolios, directed the process to re-evaluate clinical program structure, integration of teaching, research and health promotion and provided direction on issues that arose that were within the purview of this group;
- the **Operations Committee**, drawn together from the clinical support, administrative and facilities services portfolios, provided input and direction to Working Groups responsible for developing the future, overarching systems related to Food Services, Materials Management, Pharmaceutical Services/ Systems, Security and Safety strategies and Workplace Strategy; in addition, the Operations Committee provided the peer review for the proposed plan for Education and Health Promotion (EHP);
- **Working Groups** (referred to above) were formed to set down the proposed framework to be followed by all planning teams in their development of the detailed services, operations, staffing and space details for their areas. Working Groups covered the following systems: Food Services, Pharmaceutical Services, Materials Management, Security/Safety and Workplace Strategy;
- **Planning Teams** were formed to work with RPG in the development of the Functional Program components statements; these planning teams were made up of a cross section of directors, managers, frontline staff and physicians, as most appropriate to each team; and

- the **Redevelopment Project Planning Committee**, made up of representatives of CAMH, the urban planning, architectural and engineering consultants and RPG, to ensure that the parallel planning related to site and facilities were congruent and that all allied tasks were proceeding in a timely manner.

In addition to the above, several **workshop-style planning sessions** were held to develop the details of new configurations of programs and services, including issues such as:

- New clinical program configurations and service delivery approaches: reviewing possible approaches based on findings from research, site visits, etc.; and
- Staffing Models: Assessing alternate types of clinical team requirements based on client/patient groupings/acuity.

External stakeholders including the Peel Region District Health Council and the Toronto District Health Council have been included in the planning through:

- participation in discussion regarding service repatriation; and
- participation in presentations and open houses about the proposed redevelopment.

Client/patients and families have been included in the planning through:

- participation in presentations and open houses about the proposed redevelopment;
- participation in the client/patient and family services discussions through a dedicated planning team (*Central Patient and Family Services* component); and
- discussions that have been held within programs about the proposed programs and services.

PLANNING PARAMETERS

HSRC Directions

The Health Services Restructuring Commission (HSRC), as part of the report for Toronto health care services, directed the four previously-noted organizations to merge to create a single mental health and addictions organization.

The role of the new organization was intended to represent the collective services provided by the previously independent organization, including:

- acute mental health (i.e. equivalent to the role of a mental health program within a community general hospital), now referred to, by the MOHLTC as ‘intensive services’;
- specialized mental health (i.e. a role as a regional specialized mental health service provider, previously referred to by the HSRC as ‘longer term’ mental health);
- addictions services, including assessment, intervention, education and support services to partners across Ontario; and
- research, education and policy development, including prevention, health promotion and information dissemination involving addiction and mental health providers and other partners across Ontario.

The bed complement as outlined by the HSRC is illustrated below. In addition to the system changes outlined by the HSRC, the MOHLTC has been reviewing the Forensic System in light of the difficulties experienced by the criminal justice system in accessing the resources of the provincial mental health forensic system. As a result, additional beds have been added to some of the existing Forensic services providers across the province, including CAMH.

Given these increases, the bed numbers shown in the table that follows are future planning targets that include these additional beds awarded to CAMH by the MOHLTC.

<i>Type</i>	<i>Current Beds</i>	<i>HSRC Directives¹</i>	<i>Additional MOHLTC Approvals</i>	<i>Future Beds⁵</i>
Mental Health				
Acute	57	79		66
Specialized	355	391 ¹		367
Subtotal:	412	470	0	433
Other				
Addictions	47	47		48
Addictions - Detox	20	--- ²		20
Forensic	129 ³	43	65 (+6) ⁴	134
Subtotal:	196	90	91	202
TOTAL	608	560	91	635

Notes & Assumptions:

1. HSRC directed specialized beds includes an allocation of 104 beds for Peel Region.
2. Addictions directives from HSRC excluded the count of the 20 detox beds currently located off-site; these are to be retained in the future scope of CAMH services.
3. Forensic Beds numbers include the 20 new medium secure beds approved and operational in 2002 within existing space at the Queen Street site.
4. Forensic bed numbers include the 6 new Women's Medium Secure Forensic beds to be located in existing space at the Queen Street site. These beds were added to LAMH in a Functional Program submitted to the MoHLTC in January, 2004.
5. 'Future Beds' does not necessarily equal the total of the preceding columns.

Planning Horizon

The HSRC identified their target year as 2003/04 when assigning bed complements and other clinical scope changes.

The HSRC also undertook research on the future bed planning targets for mental health. As a result of concerns raised by mental health care providers and others about the bed planning targets that were contained in the draft system recommendations, the HSRC modified its stance that beds/1,000 would not be reduced to 30 from 31 until sufficient complement of community mental health services were in place such that the mental health client/patients would not be left stranded by lack of services.

Although the implementation of the CAMH directives will extend significantly beyond the HSRC's 2003/04 target year, the planning herein reflects the HSRC directives, modified only by the additional beds allocated to Forensics by the MOHLTC as outlined in the table above.

It is assumed that any additional beds that may be needed due to population growth and/or aging will be offset to some extent by the reduction of the bed planning ratio as additional community services are put in place through reinvestment initiatives.

As noted earlier in this document, while the planning targets for workload, staffing and space are presented as 2003/04, the actual date, in reality, will be a number of years later – the first full year of operation following CAMH occupying its redeveloped facilities as Queen Street site.

Previous Planning Studies

Previous Planning Studies that have been undertaken for the Centre for Addiction and Mental Health, and its four predecessor organizations, addressing the facilities include:

- CAMH Program Planning: 3 year horizon – undertaken internally by the Centre's Programs, addressed more immediate development plans related to service delivery; while these plans were used as background information for the Functional Programming process, they have been eclipsed by the Clinical Program and service plans included in the Functional Program;
- Functional and Facilities Assessment: of the facilities utilization and building and engineering systems condition assessments undertaken as part of the due diligence process prior to the merger of the Donwood Institute, the Clarke Institute, Addiction Research Foundation and Queen Street Mental Health Centre (the Resource Planning Group Inc. and Parkin Architects, 1997); and
- CAMH Strategic Plan for Physical Space Site Analysis Study: including the outcome of program visioning sessions and site selection analysis of three site scenarios including:
 - 1) a new building at Queen Street,
 - 2) a new building at the Clarke/ARF site, and
 - 3) the renovation of the Clarke site augmented by new buildings at the Queen Street site (HOK Program Management Healthcare Services, October 4, 1999).

System Planning Principles

Many planning documents and planning tables have been developed in Ontario over the past 5 years. The results of the reports and/or deliberations provide a set of system and service principles for mental health and addictions programs and services. Such work includes:

- *Making It Happen*, a report prepared by the Ministry of Health and Long Term Care in Ontario outlining mental health system reform and service delivery changes that will improve client/patient care and accessibility for mental health services;
- *Setting the Course*, a report prepared by the Ministry of Health and Long Term Care in Ontario outlining addiction system reform and service delivery changes that will improve client/patient care and accessibility for addiction services;
- *Best Practices in Mental Health*, a report prepared by the former Clarke Consulting Group for Health Canada outlining the research studies undertaken on the approach to and efficacy of various mental health services;
- A variety of reports on roles of and services in acute and specialized mental health sectors, including recommendations on the nature of the interface between mental health sectors, developed for Southwestern Ontario by the former Clarke Consulting Group;
- The *Comprehensive Assessment Project* reports for a number of Ontario's Provincial Psychiatric Hospitals wherein the needs of client/patients were assessed with a view to identifying services and supports needed by PPH client/patients to allow them to live in the community;
- Deliberations and in some cases, resulting documentation from the Mental Health Implementation Task Forces across Ontario; these task forces have been set up to oversee and provide recommendations to the MOHLTC on the array and timing of mental health services reconfiguration and development to create a comprehensive, robust system of services following the current divestment of the PPH's across the province; and
- Stakeholders meeting across the province set up to plan the Centre's provincial role with regard to supporting addiction and mental health systems and community sectors throughout Ontario.

These documents and deliberations are resulting in common key principles related to client/patient-centred service delivery, including:

- Providing services close to home,
- Minimizing the disruption to the lives of client/patients receiving care by minimizing the amount of time spent away from the home environment (i.e. as an inpatient admitted to a bed), and
- Working with partners in care to create a seamless continuum of mental health and addictions services.

Other system issues of importance to CAMH include:

- promoting clinical excellence through research and education,
- assisting with capacity building within the overall mental health and addiction systems through external consultations, educational activities, conferencing and other information dissemination techniques to provide latest treatment, best practice and health promotion findings, and
- developing the capacity and methods of information exchange, including the use of tele-technologies in order to enhance/support access to the needed services within the necessary timeframe and in the location appropriate to the client/patient and the caregiver.

Finally, the Mental Health Implementation Task Force is now in the midst of its deliberations related to all parts of the system and the needs and strategies for implementing services and systems changes that help better coordinate and integrate the services provided by the multitude of mental health agencies and organizations across the region.

Messages from External Consultations

Over the past four years CAMH has consulted broadly with stakeholders on the consolidation of the four organizations into CAMH and more recently on the proposed Master Plan and Functional Program.

CAMH has conducted a number of separate meetings with external groups, including the Mental Health Implementation Task Force, the Ontario Substance Abuse Bureau Implementation Team, the Program and Services Advisory Committees, clients/patients, politicians, neighbors and over 500 people attended Open Houses, presentations and meetings with groups and individuals. Consultation sessions were held for staff members across the organization.

People in the community indicated that they are pleased with the consultation process and feel that they have been heard. In general, the feedback has been extremely positive. People for the most part support the directions both on the Master Plan and the Functional Program.

Specific to the Functional Program, members of the Mental Health Implementation Task Force indicated that the organization was “on the right track” and “very consistent with the work that is being done on the Task Force”. The OSAB implementation team in Toronto made similar observations and noted that the changes were consistent with planning in the addictions field.

The community and staff were particularly pleased with the focus on client/patient-centred care, and that the organization is willing to see itself as part of the system, and address areas that need improvement – service access issues in particular. The Consultation Assessment Triage and Support Program that is discussed in detail in this functional program, was particularly well received, as was the direction taken with the development of care facilitators. Overwhelming positive support feedback was received on the development of alternate milieu beds and day programs that will help bridge existing gaps between institutional and community-based care.

Provincial service providers and other stakeholders indicated support for enhanced access to best practices research-based resources and educational opportunities. There was also clear endorsement from a variety of stakeholders of the Centre's need to provide leadership in treatment, research, and system capacity building for concurrent disorders.

It is anticipated that the feedback from community agencies, the community at large and staff will continue to guide planning in a meaningful way as CAMH moves toward design development.

Clinical Program Principles

This section will outline some of the key principles developed and the overall approach to their organization and operationalization.

Specialized and Intensive Services

It has been assumed, as outlined in the directives from the Health Services Restructuring Commission (HSRC) that CAMH's mental health programs will continue to maintain both specialized and intensive roles.

In general, *specialized* services are defined as those serving client/patients with:

- severe and persistent mental illness accompanied by aggression, medication non-compliance, dangerousness to self or others, inappropriate sexual behaviour,
- addictions and concurrent disorders (psychiatric illness and substance abuse/ misuse);
- geriatric population (mental illness and age/ age related illness),
- dual diagnosis (mental illness and developmental disability),
- neuropsychiatric disorders and acquired brain injury, and
- other groups such as Eating Disorders, First-Episode or Personality Disorders ... "may be treated appropriately in tertiary-level programs" ... "because they represent significant treatment challenges academic health sciences centres have an important role to play".

Intensive services, as defined by the MOHLTC, which are incorporated in CAMH's role include:

- Rapid Assessment and Admitting Services for CAMH patients experiencing an immediate psychiatric or addictions crisis,
- Short term inpatient assessment,
- Stabilization and short-term inpatient treatment of the severely and acutely mentally ill,
- Discharge planning,
- Consultation within the hospital and to the community,
- Day hospital services, and
- Outpatient services.

Service Continuum

CAMH will enhance the continuum of care through the enhancement of existing day treatment and specialized outpatient services. CAMH is planning for five new day treatment services that will be developed to serve clients/patients with concurrent

mood and anxiety disorders and addictions, women with trauma, and transitional age youth and young adults with addictions and concurrent disorders.

Best practice in the addictions and mental health fields clearly indicates that day treatment can be an effective way to prevent the need for inpatient or residential admission. For instance, available day treatment services have been demonstrated to reduce the average length of stay for inpatient admission for various populations.

For clients requiring an inpatient stay, day treatment services provide a comprehensive step-down approach that facilitates a client/patient's discharge and re-integration into the community. Along with specialized outpatient services tailored to the targeted needs of specific populations, the expansion of day treatment services allow for specialized care to be provided in the least restrictive and most effective manner for each client/patient.

Other Clinical Guidelines

The Planning Teams in the course of developing the new approach to clinical program structure and service delivery, developed the following guidelines:

- Client/patient-centred care – develop a client/patient-focused structure,
- Capacity – enhance capacity within CAMH and also building system capacity,
- Access – improve access for clients/patients, families and system providers,
- Continuity of care – promote seamless care from the perspective of clients/patients, families and system providers,
- Standards and excellence – foster ongoing improvement in standards of care and excellence, and
- Knowledge-based services – facilitate ongoing and effective contributions to the knowledge base (i.e. through teaching and research).

Best Practice

As part of the functional programming process, best practices and innovative systems were investigated. This included bringing experts from Boulder, Colorado; Philadelphia, Pennsylvania; Port Coquitlam, British Columbia and London, England to CAMH to consult with Clinical Programs, and CAMH staff and physicians

visiting innovative centres including Victoria State, Australia and North Birmingham, England. The key findings from these jurisdictions and the visiting experts were as follows:

- in order to provide services in a less restrictive, least costly environment, a full range of service intensities is required;
- better care could be provided in de-institutionalized setting for many clients, although care in a more traditional mental health facility will still be needed for others;
- for many clients, recovery is enhanced when their environment is disrupted as little as possible;
- the physical environment of care is an important component to recovery;
- early intervention in severe and persistent mental illness needs to be an area of focus in the mental health system; and
- rehabilitation and vocational services need to be integrated into care.

These findings have been incorporated into the Functional Program through initiatives such as the Alternate Milieu (AM) environment, expanded early intervention service, and mobile treatment teams.

Other Broad Issues

- Concurrent Disorders – ensure that program realignment facilitates integration of mental health and addictions services,
- Health Promotion – ensure that program realignment facilitates integration of health promotion activities and programs to provide clients/patients with a full continuum of care,
- Existing Systems – ensure that program realignment enables CAMH to be an effective systems player,
- Health care trends – ensure that the program realignment anticipates the future population needs and understanding of health care trends,
- Core Competency – identify CAMH’s core competencies and its niche locally, nationally and internationally,
- Socio-ethnic Diversity – ensure that programs and services are formulated for and delivered by individuals capable of meeting the diverse socio-ethnic needs of the clients/patients, and
- Flexibility – ensure program realignment is flexible in order to respond to changing needs.

Emerging Program Themes

The review of the clinical programs undertaken by CAMH as part of the current planning has resulted in some key changes to programs, services, roles and responsibilities.

In light of the anticipated client/patient population, no one service within the mental health and addictions sector is likely to be the single answer to assisting the client/patient and their condition. Therefore, the following themes were considered while developing an approach to providing mental health and addictions services within a new program structure:

- **Accessibility** – Create an integrated and coordinated system to gain access to the Centre that supports care to clients/patients on a short-term basis (e.g. a client/patient seeks care during a time of short-term crisis) as well as on an ongoing basis if specialized care continues to be required. This support can be in the form of direct care on an inpatient basis, on an outpatient basis, or partnerships with another care-provider or agency external to CAMH. Thus, the process for clients/patients to access CAMH must allow for multiple ports of entry into its system of care and services.
- **Care Facilitation** – Create a system of ‘Care Facilitators’ to support clients/patients in accessing appropriate services within the array of services provided both internally at CAMH and outside the Centre.
- **Programs with “permeable walls”** – While a client/patient may be best linked to one specific program, the participation of clinical team members from other CAMH programs will be key to supporting the mental health and addictions clients/patients.
- **Link with Provincial Services** – Create an organization of programs that extend into and link with the community, such that client/patient movement and clinical exchange can occur easily between CAMH’s programs and programs and services provided by other caregiver organizations, regardless of whether these are individual practitioners, external agencies, other Schedule 1 facilities and the like.
- **Support Transitioning** – Create a system that supports clients/patients as they are seeking care, receiving care and transitioning from CAMH care to external care providers. Identifying a care facilitation process will assist clients/patients in receiving the care and supports needed in the continuum of services provided.

- Client/Patient Advocacy – Create a system that supports client/patient advocacy related to both system and client-centered issues and to direct clients/patients support. The multitude of service agencies and care providers and the complex needs of many clients/patients combine to create situations where the needed array of services is not being provided.
- Research and Capacity Building – Create an organization that supports CAMH’s role in the province when it comes to generating and sharing new understanding, treatments and health promotion programs for a broad array of mental illnesses and addictions, particularly where this is much less likely to be done in the Schedule 1 facilities.

Hub Satellite Model

The key emerging theme that was explored while realigning programs and services was the development of the Hub/Satellite model.

The focus is to create a system of programs that allows placement of specialized services operated by CAMH into the community to the greatest extent possible and feasible. The Centre is using the term “Hub” to define the services that will reside at the new consolidated site on Queen Street West and “Satellite” to define services that can be located in community locations either independently of or co-located with other community mental health and addictions agencies.

A sampling of the guiding principles that emerged from the Hub/Satellite work group is listed below. A Hub/Satellite approach to service delivery may be explored where:

- a service is complementary and non-duplicating with other services and values, in terms of meeting the needs of clients/patients, is added from partnering in the community;
- accessibility to clients/patients is enhanced by delivering care in locations that best suit clients/patients and meet their needs (for its regional mandate, this pertains to Peel in addition to Toronto);
- continuity of care is achievable both in terms of relating to other CAMH programs and services at the Hub and relating to community agencies/care-providers of significance to a particular client/patient;

- a community partner's accessibility at the Hub or one of CAMH's satellites enhances the services available to clients/patients in need. In effect, the CAMH becomes a satellite of other care agencies;
- cost effective and service delivery efficiency can be achieved. Services must be organized and delivered in a manner that makes best use of scarce resources and optimally meets CAMH's multiple mandates; and
- technologies can be leveraged in order to change in a positive way the manner in which work is done and communication occurs.

This model is widely supported by CAMH programs and services and by the community, and will evolve over time. As per discussions to-date, the services that will be offered **off site** in a "to-be-determined" satellite location, include the following:

Functional Component	Service	Projected FTE 2003/04	Projected Wkld 2003/04
CATS	Central Assess + Triage	13.00	3,280 visits
Addictions	Withdrawal Management Beds	[14.11]	20 Beds
	MAARS	[7.70]	1,700 visits
	Lesbigay Services	3.83	3,900 visits
	Aboriginal Services	1.00 +[5.50]	1,500 visits
	Back-on-Track Services	[2.05]	12,593 visits
	Problem Gambling	[13.68]	1,800 visits
Child, Youth & Family	Adolescent Outpatient Services (Addictions + SAPPACY)	[3.80]	1,800 visits
Dual Diagnosis	Resource Services	[8.50]	1,800 visits
Law & Mental Health	Outpatient Specialty Programs	3.50	3,315 visits
Mood & Anxiety	Alternate Milieu Beds ³	21.46	24 beds
Geriatric Mental Health	Alternate Milieu Beds	15.70	12 beds
	Peel Beds	13.75	12 beds
	Community Assess + Treatment	n/a	28,708 visits
	Day Treatment	1.00	n/a
	PACE Peel	2.45	7,177 visits
Schizophrenia	Alternate Milieu Beds	47.25	36 beds
	Peel Beds	33.71	52 beds
	Outpatient Services		
	- On-site Team visits	n/a	21,720 visits

Functional Component	Service	Projected FTE 2003/04	Projected Wkld 2003/04
	- Off-site Team visits	27.80	40,795 visits
	- Peel Service visits	10.00	14,585 visits
	- Other Votes	[22.00]	25,195 visits
Provincial Services	HIV Program	[3.00]	n/a
	Problem Gambling	[6.00]	n/a
	Community Programs:	63.40	80,000 contact
Central Assess. & Therapy	Vocational Services	8.00	10,600 visits
	Educational Services	1.00	1,326 visits
	OT/ PT/ TR	2.00 + (4.20)	3,126 visits
Clinical/Policy Research	Regulatory Policy / Social Factors and Prevention	11.90 + [28.10]	n/a

Notes and Assumptions:

1. FTE in brackets [] are funded from a source other than the CAMH core budget.
2. Only services with staff located off-site have been included in this table. Most if not all Clinical Programs will offer transitional services that take staff members into the community.
3. For an explanation of the concept of Alternate Milieu beds, refer to inpatient services types and locations starting on page 27.

CAMH's Provincial Mandate

As the largest provincial mental health and addictions agency, academically affiliated and with a significant research role, CAMH has a multitude of mandates, including:

Client/Patient Care

CAMH's mandate in relation to client/patient care can be defined as follows:

- local service provision as both a Schedule 1 and a specialized service provider to addictions and mental health clients/patients;

- regional, specialized service provision, where the approach to care delivery may be direct care, consultative support to a local care provider or agency, or partnership care, wherein a set of joint roles are established to manage specific clients/patients with chronic, complex issues;
- provincial specialized services, wherein the direct care role tends to give way to one that is more consultative in nature, usually due to distances and the economics of travel; and
- provincial, national and international role in information dissemination and education related to findings on approaches to care, either in terms of disseminating the results of its own research, bringing together from across the country, continent or world those have their own findings to share.

Education

Training Mental Health & Addictions Professionals

CAMH's mandate in relation to education can be defined as one of a significant role in training all types of mental health, addictions and associated health professionals to meet the local, provincial and national needs for such trained professionals.

CAMH has and will continue to maintain a strong and significant affiliation with the University of Toronto and other Ontario educational institutions.

Capacity Building in the System

In addition, CAMH's mandate includes one of using its knowledge and expertise to assist in building capacity in external mental health, addictions and related agencies/organizations to allow the needs of these populations to be met at all stages of treatment, health promotion and rehabilitation.

Client/Patient and Family Education

CAMH is committed to assisting clients/patients and their families with their level of understanding about their mental illness and/or addiction. CAMH assumes that clients/patients who do not have a 'family' in the traditional interpretation will nonetheless have other significant individuals in their lives who form the 'family'. These individuals will be encouraged to participate and be involved with the education and management of the client/patient's condition to the extent that they are able.

Client/patient and family education will include providing information and support related to:

- a specific illness, condition or event,
- access to general information about mental health and addictions,
- access to information about CAMH's programs and services, and
- access to information about services provided by others within the region (e.g., Community Mental Health and Addiction Agencies, Schedule 1 facilities).

Research

CAMH's mandate with regard to research can be defined as the enhancement of treatment and education through shared knowledge, and the transfer of such knowledge gained from research endeavours into evidence-based practice. Research at CAMH will have three main thrusts:

- the recent creation of a Clinical Research Group at CAMH, which will continue to evolve as clinical research initiatives within each clinical program are brought under the department's umbrella;
- Social Prevention & Health Policy Group will conduct research, both basic and applied, that holds the promise of reducing the burden of harm from mental health problems and alcohol, tobacco and other drugs, and disseminating this information to the research community, the public, policy makers, and program developers. Researchers in the department are also directly involved in the product development phase of projects and ensure that the research is translated into effective products such as information booklets, videos and training materials; and
- The Neurosciences Research Group will continue to be focused on examining the causes of psychiatric disorders and addiction by examining the cellular and intra-cellular mechanisms involved in normal and abnormal brain function.

Systems & Approaches for Facilitating Access & Promoting Client-Centred Care

The Consultation Assessment Triage and Support (CATS) Services will be the primary access point for new clients/patients seeking the specialized mental health and addictions services offered by CAMH.

As one of its primary functions, CATS will coordinate Consultation Liaison Services serving Schedule 1 facilities in Toronto and other facilitates as appropriate (e.g., Hospital for Sick Children emergency services), and medical practitioners across Ontario thereby initiating the screening and triage process for patients with severe and persistent mental health and addictions problems.

A function of ‘Care Facilitation’ (may also be referred to as Service Coordination) will be developed within the role of all CAMH clinicians. As a Care Facilitator, the clinician will work with other members of the clinical team and across programs to guide and link their assigned client/patient to the most appropriate services.

Care facilitators will have a range of roles in relation to each referral – in the event that the best apparent disposition is to another external organization, the role will be to work with the client/patient until the linkage is established and treatment started within that other organization. In the event that the required services are to be provided within CAMH, the Care Facilitator will assist the client/patient during linkage development internally, including the inclusion of the family and any other significant others identified by the client/patient. Note that the care facilitation functions will also exist within the clinical teams of designated CAMH programs such as an outpatient team, inpatient team, a home care team, etc.

For community agencies who have received and taken into care a client/patient who was previously seen by a CAMH Care Facilitator, the Care Facilitators will be the link back into the CAMH CATS services and CAMH’s clinical programs in the event that the client/patient’s care needs escalate, or it becomes apparent that there are clinical issues which the external agency/caregiver cannot manage.

Care Facilitators on this Team will work closely with caregivers and clients/patients entering CAMH’s system of care, to identify the most appropriate services and service milieu, whether it is inpatient, outpatient or community-based services.

The core Team will rely on designated specialists within CAMH clinical programs to assist with developing differential diagnoses and to assist with determining the most appropriate client/patient management, either within programs internally at CAMH or with external hospitals and/or community agencies/caregivers.

Proposed Programs and Services

The new approach to program structuring recognizes that many of the traditional program boundaries must be crossed if CAMH is to provide appropriate, relevant and effective patient-centred care. Importantly, there will be increased focus on concurrent disorders capacity building and service development. This is consistent with the Concurrent Disorders Best Practice Guidelines published by Health Canada in 2002.

Staff in all mental health programs will have the capacity to screen, identify, and treat mild to moderate addiction issues of their clients/patients and staff in the addictions program will have capacity to do the same for their clients/patients' mild to moderate mental health issues.

Specialized services with staff who have expertise in both addictions and mental health will be designed to meet the needs of those clients/patients with serious mental illness and addictions (e.g., concurrent addiction and borderline personality disorder; schizophrenia and addictions; severe mood/anxiety disorders and addictions). To facilitate these initiatives, an office of Concurrent Disorders Capacity Building will be established to focus on internal capacity building and service development. Members to be named to this team have been instrumental in the development of Health Canada's Concurrent Disorders Best Practice Guidelines. This team will work with staff from the Education and Health Promotion area to facilitate external capacity building in the system.

Other examples of where current boundaries will be crossed as follows:

- care needs of children and youth often include both mental health and addictions care, as the onset of mental illness occurs at a time in their lives when peer pressure, and experimentation and oppositional pressures are strong;
- mental health needs of women frequently co-exist with trauma, socio-economic pressures, substance use/abuse and other situations; and
- the needs of the elderly who come into contact with CAMH are often a combination of mental illness (including dementia), substance use/abuse (which in this case may stem from prescription medication), medication conditions, etc. In fact, some assessments of the elderly in care with mental health organizations have identified up to 10 co-existing medical conditions.

The Proposed Programs

The proposed programs (described in detail in subsequent sections of this report), respond to CAMH's mandates in acute mental health, specialized mental health, addictions and forensic services.

The service that will act as the major, coordinated access mechanism for CAMH is the Consultation, Assessment, Triage and Support Program (key access elements of this program are described above). This program will also be the mechanism to engage clinicians of CAMH programs in the assessment, triaging and prioritization process for admission/access to care.

In addition to the CATS program noted above, the following Client/Patient Care Programs will be supported:

- Addictions Program,
- Child, Youth and Family Program,
- Dual Diagnosis Program,
- Law & Mental Health (Forensics) Program,
- Mood & Anxiety Program,
- Geriatric Mental Health Program,
- Schizophrenia Program, and
- Women's Program.

Due to the complex nature of the client's/patient's needs, program planning has identified the need for significant linkages among programs and services. It is anticipated that there will be few clients/patients that will require the services from one program/service only. Each client/patient will be involved in the development of an individual plan of care that will consist of services from across the programs of the Centre as well as those provided by other community partners.

Inpatient Services Types and Locations

A review of approaches to delivering care in other jurisdictions has prompted some new thinking about the nature of the future CAMH clients/patients, the makings of a 'supportive care environment' and the manner in which CAMH can best approach its future method of delivering care.

Types of Inpatient Care Units

This analysis has resulted in CAMH developing two different types of care environments from which to provide inpatient care – referred to herein as ‘core’ beds and ‘alternate milieu’ beds. These bed types are defined as follows:

- **Core Facility beds** are located in a main client/patient care complex on-site at the Queen Street site, intimately linked to CAMH’s key clinical support services, also located in the main complex. These beds will provide the environment needed to support the care of those most acutely ill and in need of clinical services that comprehensively address their complex, specialized needs. Clients/patients will typically have higher diagnostic needs, or will be in need of constant observation to reduce the risk of elopement and self harm;

These units will tend to have clients/patients who are least able to move out of their home area (client/patient unit) to receive clinical care/therapy and rehabilitation-oriented services. Thus, the construct of these units reflects the need to provide on-unit therapy and leisure/socialization activities.

In spite of being located within the main complex, the core inpatient units are intended to be comfortable and calming. To the greatest extent possible, design will move away from a ‘traditional’ acute care model of an inpatient unit and surfaces and finishes will de-institutionalize the built environment.

- **Alternate Milieu (AM) beds** are designed as beds that will be both on-site at Queen Street and off-site in the community for those clients/patients still having complex, specialized clinical care needs. These beds can be ‘step-down’ from core beds or provide an alternate environment for care and treatment to the more traditional hospital unit.

By way of background, most inpatient environments in Ontario, whether psychiatric, specialty or general hospitals, are based on similar models and design principles that focus on physical medicine and conform to the typical nursing ward. This approach is appropriate for many psychiatric patients but it is now recognized that particular sub-populations can benefit from innovative and specialized designs. Emerging best practices in Canada and internationally emphasize the development of environments that are more flexible and that do not assume a ‘one size fits all’ approach. Based on this, CAMH is committed to developing state-of-the-art design for alternate milieu beds.

Clients/patients utilizing the AM beds are past the crisis/stabilization or investigative services phase of their illness, but are still in need of inpatient treatment for complex and severe mental illness, addiction or concurrent disorders. Issues of security and safety are not as great a concern for this sub-group. These patients will be able to move from their 'houses' to services on-site and/or in the community for clinical care and leisure/socialization activities.

Flexibility is one of the key aspects of the AM setting. Details in the Functional Component sections illustrate how different Clinical Programs have used this setting in different ways. Addictions has made use of the AM setting to facilitate the on-site residential treatment service while the Mood and Anxiety program has altered staffing levels to accommodate the provision of a high level of care to clients/patients who may respond more quickly to therapy in a more home-like setting. Schizophrenia, on the other hand, has used the setting to accommodate longer-term rehabilitation clients/patients to enhance their transition to community services to the greatest extent possible.

The importance of the physical environment and the creative use of staff and program models are cited as key ingredients in developing programs that both meet client/patient needs and by so doing may help contain costs within healthcare.

Location of Inpatient Care Units

This consideration of an appropriate care environment, along with the directives from the HSRC to provide the specialized mental health and addictions services to the Peel Region, has resulted in bed locations being reflected in two ways in the proposed plan:

- **Peel Beds:** Those clients/patients from Peel Region seeking care will be able to access the full spectrum of specialized mental health and addiction services, delivered locally in the Peel Region, when appropriate as well as at the Queen Street Site. Of the 104 inpatient beds currently at CAMH that are designated for Peel Region by the HSRC, approximately 64 will be located within Peel (allocated to Schizophrenia and Geriatric Mental Health Program) with the balance being provided within the specialized programs bed allocations located at the Queen Street site.

- **Hub versus Satellite Beds:** Beds designated as Alternate Milieu are planned for both on-site and off-site locations. While 162 AM beds are planned on-site, 92 AM beds associated with Mood & Anxiety, Geriatric Mental Health, Schizophrenia and Addictions (detox beds) Programs are actually planned to be located off-site within the context of this Functional Program. Providing a less institutional setting in a range of locations allows for flexibility in care planning, while still addressing the complex, specialized needs of this client/patient population.

Profile of These Inpatient Care Units

Five categories of inpatient care needs have been identified, reflecting both client/patient characteristics, acuity of care requirements and anticipated length of time in inpatient care.

- A:** Acute crisis care requiring assessment and stabilization
- B:** Intensive specialty care (i.e., out of crisis but may require observation)
- C:** Shorter Term Intensive Rehabilitation
- D:** Specialized care provided over a longer term (i.e., Integrated Rehabilitation Model)
- E:** Protected Unit – (i.e., client/patient is stable but behaviour(s) (aggressive, wandering) negates ability to discharge to ACT Team)

The above unit types also reflect slightly different staffing models, including a different composition of the multidisciplinary care team.

In general, categories A and B are on-site at Queen Street and are considered “Core Facility” beds.

Categories C, D and E are those that are alternate milieu beds and may be on-site or off-site. Two exceptions exist. The Women’s Program has 18 beds in categories B and C. In this instance, special design features and staffing models have been identified to create the needed environment and support in an ‘alternate milieu’ location which may be located outside of a core inpatient complex. The Addictions Program is similar in that 12 Addictions Medicine beds (category B) are twined with 12 Residential Treatment beds. Also, in this case, the suggested location of this 24-bed unit is the AM complex.

Finally, the beds identified to be located in Peel Region are made up of categories B through E. Category A beds for Peel Region are those that would be available through the CATS program at the Queen Street site or, as this category is termed acute crisis care (i.e., assessments, stabilization) such beds could also be provided by a Schedule 1 facility. In Peel, this designation will be held by each of Trillium Healthcare Centre, the William Osler Hospital and Credit Valley Hospital.

CAMH OPERATING SYSTEMS

The operating systems that are planned, upon which all components are based, are summarized below.

Additional details are contained in the “Strategies Documents” in the appendices to the Functional Program. These Documents were developed with Centre-wide planning teams at the outset of the functional programming process.

In this way, each planning team, working to develop the individual functional component statements, had a context or framework within which to plan.

Food Services

CAMH will provide a flexible, client/patient-centred approach to the provision of food services through standardized systems and built facilities, which may be adapted, as required, to a variety of client/patient needs.

The Food Service consultant ARAMARK has determined that a number of operational building blocks must be in place to support the future efficiency and effectiveness of Food Services:

- common menus for like client/patient groups (e.g., acute/ crisis patients, longer-term client/patients and children and youth);
- standardized clinical nutrition terminology used across all programs that will enable a common diet therapy;
- computerized dietary department functions that will support the sharing of information about client/patients, nutritional requirements, menus, production and food inventories; and
- an on-going review of pre-prepared foods that will meet the nutritional requirements of clients/patients and will make the most effective use of the food services’ budget.

Meal service on-unit should support the residents’ therapeutic experience, and must be flexible to accommodate:

- longer stay and short stay clients/patients,
- client/patient’s ability to select meal times as appropriate,
- clients/patients who require assistance with eating,
- varying levels of safety/security with respect to dishware and cutlery, and
- variances in the food selection to accommodate therapeutic diets, texture modifications, ethnic/cultural preferences, etc.

The following table outlines six “food service” profiles of clients/patients that will be present at CAMH. The profiles vary with regard to the client/patient’s length of stay and ability to choose, and also suggests Services Styles that complements the Client/patient Profile.

	Client/Patient Profile	Service Style
1	Longer Stay Wants control over choice High Security	Tray Service Buffet Service
2	Longer stay Prefers choice at Point-of-Service	Buffet Service Select at Point-of-Service, may require assistance from multi-skill worker
3	Short Stay (e.g., Crisis Unit) Able to Choose	Tray Service Client/patient Marks menu and receives 1 st Choice unless Dietary Restrictions apply
4	Medium to Longer Stay Unable to make Choice High Clinical Control	Tray Service Menu is Preference-based
5	Medium to Longer Stay Able to make limited Choices High Clinical Control	Tray Service Client/patient marks own Menu
6	Able to Choose Responsible for Dietary Restrictions Have Off-Unit privileges	Buffet Service at designated food retail outlets on-site

Decentralized Rethermalization

Where a service is set up primarily for buffet or tray service, rethermalization will occur on the floor. Depending on the layout of the floor, a staff-access-only food services kitchen will be shared among a number of units on a floor.

Warewashing

While most wares and cutlery will be removed to Central Food Services for washing; an on-unit dishwasher will be available to assist in the clean-up of ADL activities.

Dining Alternatives

The opportunity to locate consumer-run businesses, as well as familiar franchised retail food outlets, on-site for use by inpatients, outpatients, families, staff and local residents will be pursued in a business case separate to this functional program and will take the place of a traditional staff cafeteria.

Materials Management

Services included in this group, and the approach to each, include:

- Purchasing and Warehousing:
 - all product will be managed through an agreed approach with Purchasing,
 - all product will be delivered on a “just-in-time” basis with limited user-location storage volumes,
 - ordering will be done electronically by the user,
 - fixed assets will be managed by Material Management to limit the amount of user location storage needs,
 - purchasing and warehousing of client/patient nutritional supplies will be managed through the Food Services Department,
 - Pharmaceutical Services will purchase, manage and warehouse its medications and related supplies – while product will be received at the main Shipping/ Receiving Dock, it will be held in a secure area and transported as soon as possible to the Department,
 - Clinical lab supplies will be managed directly by the Clinical Laboratory; specimens for testing (regional toxicology centre) will be delivered directly to the lab,
 - Research will be responsible for ordering, receiving and managing the supplies associated with the research programs; supplies will be delivered to the research receiving dock,
 - Housekeeping and Maintenance will receive their product through the main dock area and will immediately transport them to the final user location,
 - Marketing and Product Development will have a separate, secure storage area adjacent to the main stores area for ease of handling (*see Provincial Services component*);
- Distribution Services will be responsible for the movement of a number of items around the CAMH site including:
 - Specimens,
 - supplies ordered from Central Stores,
 - clean laundry and linen,
 - mail,
 - client/patients, under special circumstances – in most cases, client/patient will be accompanied, if required, by a staff member;

- Record Storage will be managed as follows, with some exceptions noted in component sections:
 - In-department for up to 2 years,
 - Off-site a further 5 years,
 - For some records off-site for a further maximum of 10 years;
- Linen/Laundry
 - Washers and dryers will be located on client/patient care units for client/patients who are able to do their own laundry and/or where this supports rehabilitation,
 - An external laundry service will be used for all flat items, uniforms and other general linen,
 - And exchange cart system will be used for flat items,
 - The Receiving dock will have the capacity to allow the external provider to leave the trailer parked at the dock with a weather-protecting sleeve;
- Mail Services
 - all mail services will be managed centrally within CAMH and will be the site for the receipt and distribution of courier packages;
- Central Sterile Product
 - No on-site facilities will be needed for any sterile client/patient product or instruments – this will be provided through a contract arrangement with an acute care hospital; exceptions to this external contract will be dentistry and research, which will have their own sterilization facilities;
- Waste Management
 - Recyclable waste will be separated at point-of-use,
 - Large capacity waste trolleys will be located strategically through the complex,
 - Biohazard waste will be collected and held for pick-up at the Research dock as Research is greatest generator of such waste,
 - Hazardous waste will be collected and held for pick-up at the Research dock, as Research is greatest generator of such waste.

Pharmacy Services

The following outlines future approaches to Pharmacy Services:

- Electronic order entry will be used. The computerized system will have a direct interface with the ADT/Lab/Administrative records that will provide context for ordering the prescription. Drug protocols on the electronic system will also inform the order being placed by the physician. A wireless technology along with the use of hand held devices for data input is most likely to be employed to support this system;
- The clinical pharmacist will be an integral part of the care team;
- Implementation of the latest technology will be crucial in supporting safe practices. CAMH will always be exploring the latest technologies (e.g., point of use dispensing units will be tested in 2001/02);
- CAMH will utilize the primary nursing model, which will enhance client/patient nurse communication and the accuracy of medication administered on the units;
- All inpatient units will have the ability to administer unit dose medications; point-of-use dispensing technology will be used;
- Clients/patients will be encouraged, where appropriate, to participate in and take responsibility for taking their medications;
- Each inpatient unit will have a medication room/cupboard with refrigerator, sink, medication dispensing unit(s) with network access, lockable cupboards, and the ability to appropriately store limited amounts of ward stock, narcotics and/or controlled drugs/targeted substances, and research medications;
- Client/patient identification methods that incorporate bar coding and/or a client/patient's photograph will be investigated to decrease the possibility of incorrectly administering drugs;
- The inclusion of an accredited pharmacy that serves the needs of CAMH's outpatients, staff and others has been planned as part of Pharmaceutical Services; and
- The dispensing of methadone will be held in a secure satellite pharmacy area, separate from other outpatient dispensing areas.

Safety and Security

The following outlines future approaches to Security and Safety:

- Client/patient care areas must be flexible in order to accommodate, at various times, the issues of separation and openness, privacy and community, control and freedom – to the greatest degree possible, technology will be used to unobtrusively create a safe environment while dealing with real concerns of staff and families;
- All client/patient units will be designed with a set of minimum standards for security features that are then available to be deployed as required;
- Rooms used by client/patients and staff must be sized to reduce the potential for physical injury in the event that a client/patient strikes out;
- Staff will be equipped with personal alarm/communication devices which will have integrated functions including telecommunications, messaging and paging, emergency alarm;
- Video cameras will be installed at all entrances, general corridors and parking areas;
- A photo ID card system will be used for staff identification, which will be paired with the function of access control;
- All court yards will be designed in an environmentally pleasing manner and will provide certain groups of client/patients with secure perimeters, maximizing freedom within;
- All Fire Exits will be secured by Maglocks creating access control through main entrances and exits;
- A system of client/patient identification is required and is still under discussion;
- One main security office on site will be set up with monitors for perimeter, entrance and corridor video cameras; a satellite office will be located in the Rapid Assessment and Admitting Service;
- An office will be provided in both Rapid Assessment and Admitting Service and in Law and Mental Health for police and corrections officers;
- Note that the Law & Mental Health program currently has a separate Security System and staff looking after their security needs (e.g., access to the unit, CCV surveillance). CAMH Security will provide support by responding to Emergency Codes in this area. In the future, the LAMH security function could be absorbed by central Security.

Workplace Strategy

The following outlines future approaches to Workplace Strategy:

- Universal Access: all newly built areas of the Centre will be designed considering universal access for the disabled, and the visually and hearing impaired;
- Workplace Standards: all workspaces are planned to reflect maximum flexibility yet be cognizant of the functions that must occur within the various programs and services; therefore a blend of offices, workstations and private interview/consultation rooms are reflected in the planning; specific area allocations have been followed in developing the space requirements in this Functional Program;
- All work areas will comply with ergonomic standards;
- Technology standards will be followed including:
 - All workstations will support computing devices,
 - The significant number of staff located and working off-site (for short or extended periods of time) will require external access to the internal data system,
 - CAMH will work towards a paperless environment – a transition state has been reflected in the planning,
 - Tele-technologies will be implemented to assist with delivery of clinical care in off-site locations whether these locations are CAMH satellites or community mental health or other health care agency locations, and
 - A Contact Centre will be established that integrates the functions of help desk, telecommunications, electronic data support.

SUMMARIES

Workload Summary

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
PHASE ONE				
<u>Group A: Client/Patient Care Programs</u>				
A.2 Addictions				
<i>Non-Bedded Services</i>				
Outpatient Visits	79,823	96,116	108,178	93,095
Day Tx Attendances	1,884	incl.	incl.	15,750
<i>Existing Bedded Services</i>				
Medical Withdrawal/Res. Tx Beds	12	12	12	-
- Annual Days of Care	2,614	2,940	2,987	-
On-site Residential Treatment Beds	35	35	35	-
- Annual Days of Care	9,702	9,874	8,337	-
Off-site Withdrawal/Res. Tx Beds	20	20	20	-
- Annual Days of Care	5,034	5,647	5,212	-
<i>Future Bedded Services</i>				
AM Beds (Med. Withdrawal & Res. Tx)	-	-	-	24
- Annual Days of Care	-	-	-	7,446
On-site Alternate Milieu Beds (Res. Tx)	-	-	-	24
- Annual Days of Care	-	-	-	7,446
Off-site Alternate Milieu Beds (Res. Tx)	-	-	-	20
- Annual Days of Care	-	-	-	6,205
A.3 Child, Youth & Family				
<i>Non-Bedded Services</i>				
Child Outpatient Visits	incl. below	incl. below	incl. below	8,000
Adolescent Outpatient Visits	9,272	6,811	20,566	5,700
CD Adolescent Day Tx Attendances	n/a	n/a	n/a	6,144
Child Day Program Attendances	n/a	n/a	1,504	1,440
<i>Existing Bedded Services</i>	-	-	-	-
<i>Future Bedded Services</i>				
Core Beds (Adolescent)	-	-	-	12
- Annual Days of Care	-	-	-	3,942
A.6 Mood & Anxiety				
<i>Non-Bedded Services</i>				
Outpatient Visits	25,794	17,644	12,394	47,300
Day Treatment Attendances	n/a	n/a	n/a	3,072

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>PHASE ONE (Cont.)</i>				
<i>Mood & Anxiety (Cont.)</i>				
<i>Existing Bedded Services</i>	-	-	-	-
<i>Future Bedded Services</i>				
On-site Alternate Milieu Beds	-	-	-	24
- Annual Days of Care	-	-	-	8,322
Off-site Alternate Milieu Beds	-	-	-	24
- Annual Days of Care	-	-	-	8,322
A.7 Geriatric Mental Health²				
<i>Non-Bedded Services</i>				
Outpatient Visits	13,304	31,533	47,970	39,427
PACE – Peel Visits	n/a	500	400	7,177
Day Treatment Attendances	n/a	n/a	n/a	incl. above
<i>Existing Bedded Services</i>				
Inpatient Beds	79	79	69	-
- Annual Days of Care	19,390	16,098	16,995	-
<i>Future Bedded Services</i>				
Core Beds	-	-	-	24
- Annual Days of Care	-	-	-	7,884
On-site Alternate Milieu Beds	-	-	-	24
- Annual Days of Care	-	-	-	7,884
Off-site Alternate Milieu Beds	-	-	-	12
- Annual Days of Care	-	-	-	3,942
Peel Beds	-	-	-	12
- Annual Days of Care	-	-	-	3,942
Group B: Clinical Support Programs & Services				
B.1 Provincial Services				
Printing Projects	2,398	2,500	2,500	2,500
Resource Material Orders	5,999	5,429	4,906	4,500
B.2 Central Assessment & Therapy and CSRU				
Central Assessment & Therapy Visits	35,272	35,272	35,272	37,910
CSRU Visits	21,950	22,836	23,000	24,970
B.3 Central Patient and Family Services				
Community Relations	n/a	n/a	n/a	n/a

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>PHASE ONE (Cont.)</i>				
B.4 Diagnostic & Medical Services				
Clinical Laboratory Units	844,240	747,157	861,847	1,131,300
Electrodiagnostic Tests	1,655	1,141	1,207	1,825
Visiting Specialists Visits	1,339	225	310	1,440
Dental Clinic Visits	1,300	220	302	2,000
Minor Procedures (ECT, others)	2,612	1,140	2,116	3,200
Diagnostic Radiology Procedures – on-site	710	613	539	838
Diagnostic Radiology Procedures – off-site	73	104	88	115
B.6 Volunteer Res./Spiritual & Religious Care				
Registered Volunteers	700	793	934	985
Volunteer Hours	121,000	207,807	277,713	300,000
Community Clergy	83	30	24	40
Spiritual Care Client/Patient Visits	19,877	6,383	13,511	15,211
B.7 University of Toronto, Department of Psychiatry				
Grants Managed	n/a	40	40	40 – 50
Medical Students (Undergrad, Postgrad)	n/a	365	365	375
Group D: Admin. & Facility Support Services				
D.1 Administration	n/a	n/a	n/a	n/a
D.2 Information Management Group				
Admissions	3,980	3,851	3,732	4,300
Registrations	462,000	482,840	527,140	525,000
# of PC's supported	2,300	2,300	2,400	3,000
D.3 Finance, Purchasing & Materials Management				
Total Number of Beds	614	601	608	635
Requests to Purchase	6,900	7,200	7,100	5,900
Laundry Weight (kg)	252,150	251,139	248,653	260,000
D.4 Human Resources & Organizational Development				
Number of Staff (FTE's)	1,965	2,067	----	2,098
Occupational Health Visits	2,100	2,178	2,991	3,500
Infection Control Occurrence/Incidence Reports	2,000	150	192	3,000
D.5 Facility Management				
Building Area Cleaned (millions of SF)	1.4	1.4	1.4	1.0
Site area to be maintained (exterior) – acres	40	40	40	27
D.6 Food Services				
Total Meal Days	264,528	185,389	183,724	215,097
Retail Cafeteria/Vending	175,000	175,000	175,000	165,000
Functions per Year	500	500	500	500

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>PHASE ONE (Cont.)</i>				
D.7 Associates				
Physicians Supported	208	255	275	210
D.8 Staff Facilities				
Total Number of Staff (FTE's)	997	1,038	----	1,027
Total Number Other Funded (FTE's)	180	203	----	264
SUBSEQUENT PHASES				
<u>Group A: Client/Patient Care Programs</u>				
A.1 Consultation, Assessment, Triage & Support Service (CATS)²				
<i>Non-Bedded Services</i>				
Emergency Visits	4,704	5,016	4,895	-
Extended Assessments # of Patients Held	244	250	443	-
Crisis Follow-up Visits	864	1,700	2,192	-
Assessment & Psychotherapy Visits	4,112	6,950	1,804	-
Central Assessment & Triage Visits	-	-	-	15,120
Rapid Assessment and Admit Visits	-	-	-	2,520
<i>Existing Bedded Services</i>				
Acute Care Beds	6	6	6	-
- Annual Days of Care	2,104	2,083	2,126	-
Crisis/SOTU/General Psychiatry Beds	52	52	52	-
- Annual Days of Care	18,452	18,005	16,010	-
<i>Future Bedded Services</i>				
Core Beds	-	-	-	24
- Annual Days of Care	-	-	-	7,884
A.2 Addictions				
<i>Non-Bedded Services</i>				
Addiction Medicine Services Visits	2,263	incl.	incl.	12,000
Nicotine Dependence Visits	1,174	2,117	11,282	2,585
A.4 Dual Diagnosis²				
<i>Non-Bedded Services</i>				
Resource Services Visits	900	900	895	1,800
Day Treatment Attendances	n/a	2,250	2,250	3,840
<i>Existing Bedded Services</i>				
Dual Diagnosis Beds	19	19	15	-
- Annual Days of Care	4,201	4,390	4,573	-

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>SUBSEQUENT PHASES (Cont.)</i>				
<i>Future Bedded Services</i>				
Core Beds	-	-	-	15
- Annual Days of Care	-	-	-	4,927
A.5 Law & Mental Health				
<i>Non-Bedded Services</i>				
Outpatient Visits	11,992	10,120	17,059	19,738
ORB Hearing Days/Year	60	60	60	75
<i>Existing Bedded Services</i>				
Inpatient Beds	109	109	129	-
- Annual Days of Care	30,512	39,438	47,371	-
<i>Future Bedded Services</i>				
Core Beds	-	-	-	134
- Annual Days of Care	-	-	-	49,844
A.6 Mood & Anxiety				
<i>Future Bedded Services</i>				
Core Beds	-	-	-	12
- Annual Days of Care	-	-	-	3,940
A.8 Schizophrenia²				
<i>Non-Bedded Services</i>				
Outpatient Visits	160,820	162,910	149,044	144,275
<i>Existing Bedded Services</i>				
Inpatient Beds	260	247	248	-
- Annual Days of Care	90,462	81,613	75,814	-
<i>Future Bedded Services</i>				
Core Beds	-	-	-	60
- Annual Days of Care	-	-	-	19,710
On-site Alternate Milieu Beds	-	-	-	84
- Annual Days of Care	-	-	-	27,594
Off-site Alternate Milieu Beds	-	-	-	36
- Annual Days of Care	-	-	-	11,826
Peel Beds	-	-	-	52
- Annual Days of Care	-	-	-	17,082
A.9 Women's Program²				
<i>Non-Bedded Services</i>				
Outpatient Visits	1,819	4,190	10,329	4,000
Day Treatment Attendances	n/a	n/a	n/a	3,840
<i>Existing Bedded Services</i>				
Inpatient Beds	22	22	22	-
- Annual Days of Care	7,949	5,269	3,747	-

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>SUBSEQUENT PHASES (Cont.)</i>				
<i>Future Bedded Services</i>	-	-	-	18
On-site Alternate Milieu Beds	-	-	-	5,913
- Annual Days of Care				
<u>Group B: Clinical Support Programs & Services</u>				
<i>B.1 Provincial Services</i>				
Education & Training				
- CPE Courses	167	186	166	150
- # of Participants	6,470	5,470	4,752	4,500
Remedial Measures				
- Registered Participants	5,723	8,114	8,617	8,400
- Visits	(7,390)	(11,482)	(20,841)	(25,185)
Community Office Programs				
- Client/patient Contacts	165,160	148,291	114,981	80,000
Public Information Centre				
- # of Calls	79,100	48,357	49,000	78,764
Professional Discipline				
- Discipline & Medical Students	489	560	617	621
<i>B.2 Central Assessment & Therapy and CSRU</i>				
Wellness Centre Visits	12,499	10,937	10,937	13,943
<i>B.3 Central Patient and Family Services</i>				
Patient Advocate/Rights Advice - Visits	1,872	1,872	1,872	2,100
Family Council Meetings	213	327	327	440
Client/Patient Council Meetings	411	536	536	660
Information Resource Hub Contacts	440	490	490	535
<i>B.5 Pharmaceutical Services</i>				
Orders Processed	177,472	138,979	142,466	187,000
Total MIS Units	2,762,488	3,361,260	3,480,840	4,411,500
<u>Group C: Research</u>				
<i>C.1 Research Administration & Support</i>				
PET Studies – Research (core)	471	471	494	591
PET Studies – Clinical (CAMH global)	0	(n/a)	(n/a)	(2,300)
Psychopharmacology Lab Samples	6,750	1,165	850	1,406
Animals Housed Annually	7,009	6,932	7,138	8,235
<i>C.2 Clinical/Policy Research</i>				
Clinical Research Grants	93	87	91	106
Social Prevention & Health Policy Grants	76	87	82	95
Grant Amount (\$ millions)	16.1	18.2	20.3	23.5
Grant Amounts (\$ millions)	18	9.5	8.5	9.8

Workload Indicator	Actual 2000/01	Actual 2001/02	Actual 2002/03	Projected 2003/04
<i>SUBSEQUENT PHASES (Cont.)</i>				
C.3 Neuroscience Research				
Grants	86	100	87	101
<u>Group D: Admin. & Facility Support Services</u>				
D.6 Food Services				
<i>Retail</i>				
Cafeteria/Vending (\$)	325,000	325,000	325,000	335,000
Functions per Year	1,000	1,000	1,000	1,000
D.8 Staff Facilities				
Total Number of Staff (FTE's)	969	1,031	----	1,071
Total Number Other Funded (FTE's)	464	475	----	645

Notes & Assumptions:

1. Current Workload may not match Ministry of Health data as numerous recounts have been conducted as part of the Functional Programming in an attempt to gain comparability with projected clusters and counting methods.

When reviewing bed numbers, the reader will note major shifts in bed allocations between programs due to shifts in CAMH's role in the provision of mental health and addiction services.

2. Support Services exclude volumes associated with the programs and services located in Peel Region, but include volumes associated with supporting the off-site beds.
3. For the purposes of this Functional Program, 'Attendances' used to count day treatment workload activity and 'Visits' used to count outpatient activity workload. The two measures are considered to be equal; both count as 1 visit to a health care provider at CAMH.

Staffing Summary

This staffing summary includes CAMH staff represented as FTE's, Physicians represented as FTE's regardless of remuneration arrangements, staffing and/or consultants represented as FTE's but funded through sources other than CAMH core budget and Research Assistants/Students/Volunteers represented as bodies.

	Actual 2000/01				Budget 2001/02				Projected 2003/04			
	FTE	Physicians { }	Other Funding []	Student & Other ^ <	FTE	Physicians { }	Other Funding []	Student & Other ^ <	FTE	Physicians { }	Other Funding []	Student & Other ^ <
PHASE ONE												
<u>Group A: Client/Patient Care Programs</u>												
A.2 Addictions	107.49	19.50	53.42	5	113.75	18.10	60.12	7	145.26	10.20	63.12	66
A.3 Child, Youth & Family	38.13	9.15	16.05	12	45.08	11.25	17.05	14	66.13	15.05	27.90	35
A.6 Mood & Anxiety	24.98	15.50	37.10	2	24.98	15.50	47.10	2	82.30	29.40	19.00	14
A.7 Geriatric Mental Health	116.22	3.82	3.00	18	118.22	5.82	4.00	18	110.15	10.50	14.00	30
Subtotal: Group A	286.82	47.97	109.57	37	302.03	50.67	128.27	41	403.84	65.15	124.02	145
<u>Group B: Clinical Support Programs & Services</u>												
B.1 Provincial Services	5.00	n/a	1.50	n/a	6.70	n/a	1.50	n/a	6.70	n/a	1.50	n/a
B.2 Central Assessment & Therapy and CSRU	45.96	n/a	11.37	13	46.10	n/a	12.40	14	40.10	n/a	14.37	16
B.3 Central Patient and Family Services	1.00	n/a	n/a	n/a	8.00	n/a	n/a	n/a	7.00	n/a	n/a	n/a
B.4 Diagnostic & Medical Services	30.76	n/a	0.20	n/a	30.76	n/a	0.20	n/a	31.87	n/a	13.50	n/a
B.6 Volunteer Res./Spirit'l & Religious Care	8.00	n/a	n/a	29	9.00	n/a	n/a	29	8.00	n/a	n/a	39
B.7 University of Toronto, Dept. of Psychiatry	1.50	n/a	13.00	4	1.50	n/a	13.00	4	1.50	n/a	13.00	4
Subtotal: Group B	92.22	n/a	26.07	46	102.06	n/a	27.10	47	95.17	n/a	42.37	59
<u>Group D: Administrative & Facility Support Services</u>												
D.1 Administration	49.30	n/a	12.00	n/a	54.00	n/a	16.00	n/a	51.10	n/a	20.00	5
D.2 Information Mgmt Group	114.90	n/a	6.10	n/a	120.00	n/a	7.10	n/a	110.00	n/a	35.20	n/a
D.3 Finance Purchasing & Material Management	46.50	n/a	n/a	n/a	45.50	n/a	n/a	n/a	38.00	n/a	n/a	n/a
D.4 Human Resources & Org'l Dev't	36.70	0.20	2.00	n/a	35.50	0.20	n/a	n/a	35.60	0.20	2.10	n/a
D.5 Facility Management ³	189.90	n/a	n/a	n/a	192.30	n/a	n/a	n/a	169.10	n/a	n/a	n/a
D.6 Food Services	50.90	n/a	4.00	n/a	55.60	n/a	4.00	n/a	43.60	n/a	3.00	n/a
D.7 Associates	n/a	n/a	9.00	n/a	n/a	n/a	9.00	n/a	n/a	n/a	12.00	n/a
D.8 Staff Facilities	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal: Group D	488.20	0.20	33.10	n/a	502.90	0.20	36.10	n/a	447.40	0.20	72.30	5
GRAND TOTAL: PHASE ONE	867.24	48.17	168.74	83	906.99	50.87	191.47	88	946.41	65.35	238.69	209

Staffing Summary

	Actual 2000/01				Budget 2001/02				Projected 2003/04			
	FTE	Physicians { }	Other Funding []	Student & Other < >	FTE	Physicians { }	Other Funding []	Student & Other < >	FTE	Physicians { }	Other Funding []	Student & Other < >
SUBSEQUENT PHASES												
<u>Group A: Client/Patient Care Programs</u>												
A.1 Consultation, Assessment, Triage & Support (CATS)	116.30	8.50	7.50	5	144.60	11.50	8.00	6	116.86	15.40	9.50	19
A.2 Addictions	24.08	5.65	n/a	4	24.58	5.65	n/a	4	24.08	5.65	4.00	n/a
A.4 Dual Diagnosis	35.68	1.85	5.90	10	34.57	2.30	7.90	13	32.05	2.75	12.50	13
A.5 Law & Mental Health ²	170.02	10.42	1.20	n/a	192.39	10.42	1.20	n/a	235.02	20.40	4.00	26.5
A.6 Mood & Anxiety	1.50	0.25	n/a	n/a	1.25	0.25	n/a	n/a	15.91	2.65	2.50	4
A.8 Schizophrenia	367.34	36.98	22.50	73	368.34	38.28	23.20	73	332.63	57.90	50.34	86
A.9 Women's Program	34.90	4.10	1.00	11	34.90	4.10	1.00	11	34.92	4.50	5.90	10
Subtotal: Group A	749.82	67.75	38.10	103	800.63	72.50	41.30	107	791.47	109.25	88.74	158.5
<u>Group B: Clinical Support Programs & Services</u>												
B.1 Provincial Services	145.60	n/a	24.75	12	152.00	n/a	29.00	16	149.30	n/a	35.00	16
B.2 Central Assessment & Therapy and CSRU	5.04	n/a	n/a	3.15	4.37	n/a	n/a	3.10	3.37	n/a	4.00	4
B.3 Central Patient and Family Services	3.90	n/a	4.00	33	8.50	n/a	4.00	33	14.00	n/a	10.00	37
B.5 Pharmaceutical Services	44.70	n/a	n/a	n/a	46.95	n/a	n/a	n/a	46.95	n/a	8.00	n/a
Subtotal: Group B	199.24	n/a	28.75	48.15	211.82	n/a	33.00	52.10	213.62	n/a	57.00	57
<u>Group C: Research</u>												
C.1 Research Admin. & Support												
CAMH Global ⁴	14.00	n/a	n/a	n/a	14.00	n/a	1.00	n/a	14.00	n/a	1.50	n/a
Core Research ⁴	18.50	n/a	28.00	4	18.50	n/a	31.00	4	21.85	n/a	34.15	4
C.2 Clinical/Policy Research												
Grant Funded	n/a	n/a	214.75	n/a	n/a	n/a	214.75	n/a	n/a	n/a	318.25	n/a
Core Funded	51.75	n/a	1.50	n/a	51.75	n/a	1.50	n/a	50.25	n/a	n/a	n/a
C.3 Neuroscience Research												
Grant Funded	n/a	n/a	157.65	n/a	n/a	n/a	157.65	n/a	n/a	n/a	165.00	n/a
Core Funded	64.85	n/a	n/a	n/a	64.85	n/a	n/a	n/a	60.00	n/a	n/a	n/a
Subtotal: Group C	149.10	n/a	401.90	4	149.10	n/a	405.90	4	146.10	n/a	518.90	4

Staffing Summary

	Actual 2000/01				Budget 2001/02				Projected 2003/04			
	FTE	Physicians { }	Other Funding []	Student & Other < >	FTE	Physicians { }	Other Funding []	Student & Other < >	FTE	Physicians { }	Other Funding []	Student & Other < >
SUBSEQUENT PHASES (Cont.)												
<u>Group D: Administrative & Facility Support Services</u>												
D.6 Food Services	n/a	n/a	6.00	n/a	n/a	n/a	6.00	n/a	n/a	n/a	5.00	n/a
D.8 Staff Facilities	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Subtotal: Group D	n/a	n/a	6.00	n/a	n/a	n/a	6.00	n/a	n/a	n/a	5.00	n/a
GRAND TOTAL: SUBSEQUENT PHASES	1,098.16	67.75	474.75	155.15	1,161.55	72.50	486.20	163.10	1,151.19	109.25	669.64	219.50
GRAND TOTAL: PHASE ONE and SUBSEQUENT PHASES	1,965.40	115.92	643.49	238.15	2,068.54	123.37	677.67	251.10	2,097.60	174.60	908.33	428.50

Notes & Assumptions:

1. Staffing complements include relief allocations for those staff covered for vacation, illness and statutory holidays; for projected staffing, a standardized allowance of 18% has been included.
2. The Law & Mental Health Budget 2001/02 FTE figure of 192.39 includes 19.67 FTE for 5 months of operation of the new medium secure unit (opened November 2001). Note that the Business Case being prepared in conjunction with the Functional Program includes the full staff complement for this unit at 47.73 FTEs; in addition, projected 2003/04 includes staffing of 14.60 FTEs for the new Women's Medium Secure 6-bed unit for a total staff of 235.02 FTEs.
3. Facility Management staffing from budget 2001/02 will be redeployed to patient care programs in the future.
4. "Core Research" FTEs are funded through the Ministry of Energy, Science & Technology, the CAMH Foundation or other ancillary resources and are therefore added into the Total FTE for this component.

Space Requirements Summary

	Projected (nsf)	Projected (cgsf)
PHASE ONE		
Group A: Client/Patient Care Programs		
A.2 Addictions	50,269	68,360
AM Inpatient Unit – 12 beds	3,760	5,640
Modified AM Inpatient unit – 12 beds	3,895	5,840
AM Inpatient Unit – 24 beds	7,400	11,100
Day/Residential Treatment Services	10,152	13,200
Outpatient Services	21,892	28,460
Personality Disorders	2,270	2,950
Housekeeping Rooms	900	1,170
A.3 Child, Youth & Family	26,314	35,395
Core Inpatient Unit – 12 beds	5,928	8,890
Concurrent Disorders Adol. Day Tx & Outpatient Services	8,768	11,400
Child Day Tx Prog. & Outpatient Services	10,058	13,075
Program Administration & Intake	1,560	2,030
A.6 Mood & Anxiety	24,582	33,445
AM Inpatient Unit (On-site) – 24 beds	7,400	11,100
Day Treatment Services	1,818	2,365
Outpatient Services (4 pods)	15,364	19,980
A.7 Geriatric Mental Health	23,428	34,070
Core Inpatient Unit – 48 beds	18,058	27,090
Non-Bedded Services	5,370	6,980
Subtotal: Group A	124,595	171,270
Group B: Clinical Support		
B.1 Provincial Services	9,409	11,095
Print Shop	2,400	2,760
Marketing Warehouse	4,269	4,910
Archives	2,740	3,425

	Projected (nsf)	Projected (cgsf)
<i>PHASE ONE (cont.)</i>		
B.2 Central Assessment & Therapy and CSRU	22,626	27,895
Administration	820	1,065
Vocational Services	1,256	1,635
Vocational Training	2,905	3,340
Life Skills Centre	1,721	2,235
Classrooms	510	665
Psychological Assessment Service	1,668	2,170
Community Centre	3,550	4,085
Creative Arts Studio	5,526	6,630
Community Support & Research Unit (CSRU)	4,370	5,680
General Support	300	390
B.3 Central Patient and Family Services	700	910
Community Relations	700	910
B.4 Diagnostic & Medical Services	9,644	13,950
B.6 Volunteer Res./Spirit'l & Religious Care	4,149	5,270
B.7 University of Toronto, Dept. of Psychiatry	3,125	4,065
Subtotal: Group B	49,653	63,185
Group D: Admin. & Facility Support Services		
D.1 Administration	14,150	18,395
Administration	9,821	12,770
Foundation	3,166	4,115
Key Supports to SMG	1,163	1,510
D.2 Information Management Group	18,806	24,450
D.3 Finance Purchasing & Materials Management	9,624	11,715
Finance Office	1,648	2,145
Materials Management	7,976	9,570
D.4 Human Resources & Organizational Development	6,013	7,815
D.5 Facility Management	12,137	15,780
Facility Management	10,337	13,440
Waste Management Holding Rooms	1,800	2,340
D.6 Food Services	11,411	14,835
Food Services	10,477	13,620
Retail Food Services	934	1,215

	Projected (nsf)	Projected (cgsf)
<i>PHASE ONE (cont.)</i>		
<i>D.7 Associates</i>	1,630	2,120
<i>D.8 Staff Facilities</i>	5,380	6,455
Subtotal: Group D	79,150	101,565
TOTAL AREA (cgsf): PHASE ONE	253,400	336,020
Planning Factor		1.265
BUILDING GROSS AREA (bgsf): PHASE ONE		425,065
SUBSEQUENT PHASES		
Group A: Client/Patient Care Programs		
<i>A.1 Consultation, Assessment, Triage & Support (CATS)</i>	17,284	25,075
Core Inpatient Units – 24 beds	9,069	13,620
Administration	760	990
Central Assessment & Triage Services	2,720	3,535
Rapid Assessment & Admitting	3,595	5,390
Psychiatric Outreach	860	1,120
General Support	280	420
<i>A.2 Addictions</i>	5,683	7,390
Addiction Medicine & Nicotine Services	5,683	7,390
<i>A.4 Dual Diagnosis</i>	10,592	15,295
Core Inpatient Unit – 15 beds	7,638	11,455
Day Treatment Services	2,954	3,840
<i>A.5 Law & Mental Health</i>	29,730	43,550
Core Inpatient Unit – 60 beds	24,486	36,730
Non-Bedded Services	5,244	6,820
<i>A.6 Mood & Anxiety</i>	3,683	5,400
Core Inpatient Unit – 12 beds	3,063	4,595
Administration	620	805

	Projected (nsf)	Projected (cgsf)
<i>SUBSEQUENT PHASES (cont.)</i>		
A.8 Schizophrenia	67,376	98,220
Outpatient Services	13,707	17,820
Shared Support	540	705
Core Inpatient Unit – 60 beds	24,886	37,330
Core Inpatient Unit – 12 beds protected	6,043	9,065
AM Inpatient Units (On-site) – 72 beds	22,200	33,300
A 9 Women's Program	8,826	12,580
AM Inpatient Unit – 18 beds	5,530	8,295
Outpatient/Day Treatment Services	3,296	4,285
Subtotal: Group A	143,175	207,510
Group B: Clinical Support		
B.1 Provincial Services	50,396	61,030
EHP Administration	270	350
Education & Training	3,315	4,310
Eli Lilly Learning Centre	5,300	6,095
HIV Program	490	635
Product Design & Development	2,640	3,430
Business/Research Business Development	660	860
Marketing & Sales	1,030	1,340
Community Programs	2,734	3,555
Remedial Measures	1,170	1,520
Workman Theatre Project	18,380	21,140
Library	7,035	8,440
Public Information Centre	1,442	1,875
Student Amenities	4,650	5,815
General Support Spaces	1,280	1,665
B.2 Central Assessment & Therapy and CSRU	13,464	16,085
Occupational Therapy/Physiotherapy	3,486	4,530
Therapeutic Recreation	428	555
Gym/Fitness & Amenities (excl. existing)	7,470	8,590
Locker Room/Amenities	1,960	2,255
General Support	120	155
B.3 Central Patient and Family Services	8,045	10,460
Empowerment Services	3,330	4,330
Information Resource Hub	1,750	2,270
Client/Patient Leisure Library	1,845	2,400
Personal Care Centre	560	730
Clothes Line	560	730

	Projected (nsf)	Projected (cgsf)
<i>SUBSEQUENT PHASES (cont.)</i>		
B.5 Pharmaceutical Services	9,503	12,355
Central Pharmacy	7,038	9,150
Outpatient Pharmacy	2,465	3,205
Methadone Clinic (<i>see Addictions Component</i>)	(700)	(910)
Subtotal: Group B	81,408	99,930
Group C: Research		
C.1 Research Administration & Support	52,533	71,510
Research Administration	6,130	7,970
Animal Facilities	15,573	20,245
Animal Testing, Surgery, Necropsy	7,850	11,385
Instrument Equipment & Support	1,840	2,390
Psychopharmacology Lab	4,110	5,345
PET Centre – Research	14,420	20,910
Shipping/Receiving	2,610	3,265
C.2 Clinical/Policy Research	52,645	67,805
Office Clusters	46,455	60,375
Facility Support	6,190	7,430
C.3 Neuroscience Research	76,904	98,170
Visitor/Participant Area	5,510	7,165
Research Lab Clusters (7) & Direct Support	52,360	66,255
Shared Lab Support Area	12,904	16,780
Central Offices/Support Areas	6,130	7,970
Subtotal: Group C	182,082	237,485
Group D: Admin. & Facility Support Services		
D.3 Finance Purchasing & Materials Management	2,530	2,910
Garage Facilities	2,530	2,910
D.5 Facility Management	600	780
Waste Management Holding Rooms	600	780
D.6 Food Services	1,772	2,305
Retail Food Services	1,772	2,305
D.8 Staff Facilities	12,545	15,055
Subtotal: Group D	17,450	21,050

	Projected (nsf)	Projected (cgsf)
TOTAL AREA (cgsf): SUBSEQUENT PHASES	424,115	565,975
Planning Factor		1.265
BUILDING GROSS AREA (bgsf): SUBSEQUENT PHASES		715,960
TOTAL AREA (cgsf): PHASE ONE AND SUBSEQUENT PHASES	677,515	901,995
TOTAL BUILDING GROSS AREA (bgsf): PHASE ONE AND SUBSEQUENT PHASES		1,141,025

Notes & Assumptions:

1. Law & Mental Health Program space requirements only include the new Minimum Secure Units that will be located in new construction. (i.e., Space occupied on-site by LAMHP beds in the existing Queen St. Site Inpatient Unit 3 are not included.)
2. For comparison, existing space at the four CAMH sites is as follows:

	CSGF	BGSF
Addiction Research Foundation	177,600	267,450
Clark Institute	211,936	301,000
Queen Street Hospital	548,650	809,000
Donwood Institute	53,247	79,815
TOTAL	991,433	1,457,265

(Source: CAMH Facilities Planning and Development)

3. CAMH currently occupies approximately 14,850 cgsf of Research space at the University of Toronto campus.

4. Summary of Space per Bed Table

** Includes off-site beds*

	CGSF	BGSF
Patient Care Programs	378,780	479,157
Clinical Support	163,115	206,340
Research	237,485	300,419
Admin & Facilities	122,615	155,108
Existing Unit ³	86,956	110,000
Toronto Off-Site AM Beds ²	41,472	52,462
Peel Off-Site AM Beds ²	36,864	46,633
501 Queen St. Off-Site AM Beds ²	7,905	10,000
Total	1,075,192	1,360,119
Per bed Total ¹	1,693	2,142
Per bed (excl. Research) ¹	1,319	1,669
Per bed (excl. Res. and Prov. Services) ¹	1,205	1,525
Per bed (excl. Res. and Associates) ¹	1,316	1,665
Per bed (excl. Res., Prov. Services and Associates) ¹	1,208	1,521

Notes and Assumptions (Summary of Space per Bed)

1. **635 total beds;** these include 74 beds in Unit 3.
2. The cgsf for the AM Beds located off-site in Toronto and Peel were taken from the Master Plan. Minor changes to these numbers may be made when Functional Programming for these beds is completed.
3. Off-site beds require some added support spaces not included in the cgsf totals above.