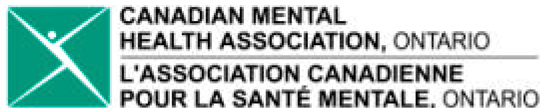
Proceedings from the
Making Ourselves Heard

COMMUNITY MENTAL HEALTH AND ADDICTION SECTOR WORKING SESSION

September 14, 2004



Submitted by Adair Roberts & Associates
to the Canadian Mental Health Association Ontario, Ontario Federation of Community Mental Health and Addiction Programs and Centre for Addiction and Mental Health

November 8, 2004

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Executive summary

On February 24, 2004, the Government of Ontario announced its intent to transform the healthcare system. During the summer, the Minister of Health and Long-Term Care elaborated on what is planned to be a significant transformation agenda for the system, to be implemented through fourteen Transformation Projects. As part of the Creating a System Transformation Project, the Government indicated that it intends the Ministry of Health and Long-Term Care to relate in new ways to the health care system through the establishment of Local Health Integration Networks (LHINs).

In response to the Government's announcements, the Ontario Federation of Community and Mental Health and Addiction Programs (OFCMHAP), as part of its *Making Ourselves Heard* initiative[1], partnered with the Canadian Mental Health Association (CMHA) Ontario and the Centre for Addiction and Mental Health (CAMH) to convene a full-day working session on Tuesday September 14, 2004 at the Radisson Hotel Toronto East in Toronto. The three organizations had been working together for over a year as part of a larger effort to make the community mental health and addiction sector heard as a strong, important and unified part of Ontario's healthcare system.

By the end of the working session, the attendees had:

- Developed a preliminary set of key principles and early advice to the Government which they could begin communicating immediately upon leaving the working session regarding the sector's involvement in the Transformation Agenda and LHIN implementation as it unfolds;
- Developed preliminary thinking about and possible implementation suggestions for the Government regarding the sector's role in the other 13 Transformation Projects; and
- Reached agreement to continue working together and to implement a set of next steps outlined in section 4 of this summary of the day's proceedings

This document should be viewed as a reference document that records attendees' preliminary thinking regarding the Government's Transformation Agenda plans (as they were known and understood at the time). It is organized into four parts:

1. *Background and context* – background to, purpose of, format and agenda of, and deliverables achieved from the September 14, 2004 Working Session

[1] In early 2004, the Ontario Federation of Community Mental Health and Addiction Programs launched *Making Ourselves Heard,* an initiative to develop and implement a plan to strengthen the community mental health and addiction sector's capacity to be seen and heard as a critical component of Ontario's health care system. Underlying this initiative is the belief that building the sector's capacity to organize itself to speak and advocate on its own behalf should increase: i) understanding of mental health and addiction services and their role in a strong health care system; ii) the sector's real and perceived unity of voice; iii) political, bureaucratic and public support of the sector; and iv) the sector's ability to pursue and achieve common goals.

2. *Principles and early advice to the Government regarding Transformation Agenda and LHIN implementation* – lists generated by attendees regarding the potential strengths and challenges of the LHINs for consumers, families, and the community mental health and addiction sector, as well as a list of preliminary principles and early advice regarding Transformation Agenda and LHIN implementation (based on available information to-date)
3. *Early thinking regarding the remaining Transformation Projects* – lists generated by attendees regarding the potential benefits and challenges of the remaining Transformation Projects for consumers and the community mental health and addiction sector, possible role(s) and contribution(s) for and by the sector in each project, and early thinking and possible implementation suggestions for each project
4. *Next steps* – a list of agreed-upon next steps for the host organizations and their members as the Transformation Agenda process unfolds

It is important to note a number of caveats regarding the material included in this document. These caveats include the following:

?? At the time of the Working Session, very little public information had been released in relation to the Transformation Agenda and its 14 projects. Attendees responded to the questions posed to them subject to the proviso that they did not yet know much about the projects, nor how they would be implemented.

?? Because of time constraints and varying levels of understanding of each of the projects, each Transformation Project was not discussed to the same level of detail. The Creating a System Transformation Project, which includes the Local Health Integration Networks, received the greatest amount of attention from the entire group. However, it is important to note that in addition to the establishment of Local Health Integrated Networks, the Creating a System Transformation Project includes emphasis on decision support requirements (e.g., review and restructuring of MOHLTC information management practices and systems) and non-clinical administrative operations in acute and community health services (e.g., assessment of opportunities for cost-effective pooling and sharing of common approaches and resources). These topics were not discussed during the working session.

?? Because of time constraints, the large number of projects to address, and the fact that little detailed information was available to attendees about each project, consensus was not sought around the possible advice generated, except in relation to LHIN implementation. Section 3 of this document simply lists the bullet points generated during the afternoon's breakout groups, and should be viewed only as a starting point for future work to be done on each of these initiatives. To that end, following the breakout groups, attendees were asked to sign up for work groups through which to do further work on each topic area if required.

Notwithstanding these caveats, thanks to the enthusiastic and positive participation of over 130 attendees, the Working Session served as an excellent starting point for the

community mental health and addiction sector to contribute to the on-going planning and implementation of the Government's Transformation Agenda. The ideas generated during the session have and will continue to serve as important input to the development of on-going advice to the Government as it releases additional information on the Transformation Agenda and as it requests input from organizations and sectors regarding its plans. In this way, the community mental health and addiction sector can continue to build on the success of the September 14, 2004 Working Session, developing and providing advice to the Government regarding how to ensure that the Transformation Agenda will benefit people living with mental health and addiction needs, and ensuring that it is seen and heard as a critical component of Ontario's transformed health care system.

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1 Background and context

A. Background

On February 24, 2004, the Government of Ontario announced its intent to transform the healthcare system. During the summer, the Minister of Health and Long-Term Care elaborated on what is planned to be a significant transformation agenda for the system, to be implemented through fourteen Transformation Projects.

The Government indicated that it aims to transform and make the healthcare system sustainable by reducing the system's reliance on hospital-based services, enhancing community-based services, and ensuring integration of services across the health care continuum. Some of the Transformation Project topic areas have particular relevance to the mental health and addiction sector, including Creating a System, Investing in Community, Quality and Accountability, Family Health Teams, and Health Human Resources.

As part of the Creating a System Transformation Project, the Government indicated that it intends the MOHLTC to relate in new ways to the healthcare system through the establishment of Local Health Integration Networks (LHINs). The purpose of LHINs is to ease the movement of people across the continuum of care so that they get the best care, in the most appropriate setting, when they need it. The specific roles and design of the LHINs are still under development but they are expected to plan, coordinate, integrate, manage and fund health services within a defined geographic area. Existing healthcare providers will continue to provide care and treatment services and organizational boards will remain intact.

In response to the Government's announcements, the Ontario Federation of Community and Mental Health and Addiction Programs (OFCMHAP), as part of its *Making Ourselves Heard* initiative[2], partnered with the Canadian Mental Health Association (CMHA) Ontario and the Centre for Addiction and Mental Health (CAMH) to convene a full-day working session on Tuesday September 14, 2004 at the Radisson Hotel Toronto East in Toronto. The three organizations had been working together for over a year as part of a larger effort to make the sector heard as a strong, important and unified part of Ontario's healthcare system.

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[2] In early 2004, the Ontario Federation of Community Mental Health and Addiction Programs launched *Making Ourselves Heard,* an initiative to develop and implement a plan to strengthen the community mental health and addiction sector's capacity to be seen and heard as a critical component of Ontario's health care system. Underlying this initiative is the belief that building the sector's capacity to organize itself to speak and advocate on its own behalf should increase: i) understanding of mental health and addiction services and their role in a strong health care system; ii) the sector's real and perceived unity of voice; iii) political, bureaucratic and public support of the sector; and iv) the sector's ability to pursue and achieve common goals.

Members and staff of each organization were invited to attend the working session. In recognition of the fact that that the community mental health and addiction sector is and must be connected to all parts of the health care system, the host organizations also invited some other guests with whom their organizations had been working in relation to their intersection with and/or interest in the sector – representatives from the Alliance for Mental Health Services, the former Mental Health Implementation Task Forces, and representatives from both the Ministry of Health and Long-Term Care and the Minister's Office. Please see Appendix A – List of Attendees, for a complete list of attendees at the session.

B. Purpose of the September 14, 2004 working session

The purpose of the working session was to create a forum for members of the mental health and addiction sector to come together to:

- Share information regarding the Government's Transformation Agenda for the health care system and explore the potential opportunities that this new agenda offers the sector;
- Develop a set of principles and strategy governing the mental health and addiction sector's ongoing involvement in and influence on the Transformation Agenda implementation process as it unfolds; and
- Begin to craft advice for the Government and others of influence regarding what the mental health and addiction sector's role should be in the planned Local Health Integration Networks and selected of the other Transformation Projects.

The intent was to come away from the working session having achieved the following outcomes – that is, having:

- Developed a small number of key messages for the sector to begin communicating immediately upon leaving the working session, together with preliminary development of what was to become a more comprehensive set of values/principles to govern the sector's involvement in and influence on the Transformation Agenda implementation process as it unfolds
- Developed preliminary thinking and advice to the Government regarding the sector's role should be in the planned Local Health Integrated Networks and other Transformation Projects
- Secured the attendees' agreement regarding the need to continue working together so as to further develop and ultimately deliver the material generated during the working session to decision-makers, together with a plan as to how best to do so

Overall, the working session was to be viewed as the start of a process through which the mental health and addiction sector's voice becomes heard and incorporated positively into the Government's planning for transformation of the healthcare system.

C. Format and agenda

The session was divided into three primary components which included the following:

- *Presentations* – by the Ministry of Health and Long-Term Care regarding the Government's planned Transformation Agenda (provided by George Zegarac, Assistant Deputy Minister, Community Health Division, and Mary Kardos-Burton, Assistant Deputy Minister, Acute Services Division, in the morning and Dennis Helm, Director, Office of Strategic Projects, over lunch)[3]
- Plenary discussions – regarding potential opportunities and challenges for the community mental health and addiction sector arising from implementation of the Local Health Integration Networks (in the morning), and a review of principles, key messages and proposed next steps emerging from the morning session to be used to guide the sector as it participates in the Transformation Agenda and LHIN implementation as both unfold (in the afternoon)
- Breakout groups – regarding potential opportunities, challenges and possible roles for the community mental health and addiction sector arising from implementation of the each of the Government's remaining Transformation Projects (in the afternoon)

The session was hosted and moderated by representatives of the three host organizations – Barbara Everett, former CEO of CMHA Ontario, David Kelly, Executive Director, OFCMHAP, and Paul Garfinkel, President and CEO, CAMH. The plenary discussions were facilitated by Adair Roberts, Principal, Adair Roberts & Associates. Please see Appendix B – Agenda, to review the working session's agenda.

D. Deliverables achieved

Each of the desired outcomes from the day was achieved. By the end of the working session, the attendees had:

- Developed a preliminary set of key principles and early advice to the Government which they could begin communicating immediately upon leaving the working session regarding the sector's involvement in the Transformation Agenda and LHIN implementation process as it unfolds;
- Developed preliminary thinking about and possible implementation suggestions for the Government regarding the sector's role in the other 13 Transformation Projects; and
- Reached agreement to continue working together and to implement a set of next steps outlined in section 4 of this summary of the day's proceedings

[3] A conference call had been scheduled with The Honourable George Smitherman, Minister of Health and Long-Term Care, however his participation in the First Ministers' Conference that day ultimately precluded his participation. In his place, Ellen Silver, Senior Policy Advisor, made some remarks on behalf of the Minister.

2 Principles and early advice to the Government regarding Transformation Agenda and LHIN implementation

The "Creating A System" Transformation Project has as its centerpiece the creation of Local Health Integration Networks (LHINs) which will have the responsibility to plan, coordinate, integrate, manage and fund health services within defined geographic areas. As previously outlined, the purpose of LHINs is to ease the movement of people across the continuum of care so that they get the best care, in the most appropriate setting, when they need it.

While LHINs fall under the Transformation Project "Creating A System", they are also the enabling structure through which many of the Transformation Agenda's other priorities will be achieved, such as reduced wait times, investment in community, and improved accountability. As such, LHINs were deemed as warranting in-depth discussion by all attendees.

During the morning plenary session, attendees discussed the possible implications of the LHINs for consumers, families, and the community mental health and addiction sector. More specifically, attendees addressed the following three questions:

- What are the strengths of the Government's planned Local Health Integration Networks for consumers, families, and the community mental health and addiction sector?
- What are the challenges posed by the LHINs for consumers, families and the community mental health and addiction sector?
- What advice do you have for the Government and the community mental health and addiction sector as the LHINs are designed and implemented?

Attendees' answers to each of the above questions are outlined below.

A. Strengths of the LHINs

Subject to the proviso that they did not yet know much about the LHINs nor how they would be implemented, attendees generated a list of ***potential*** strengths of the LHINs for consumers, families and the community mental health and addiction sector. **Implemented *effectively*, LHINs could:**

i. Increase the opportunity for and likelihood of true collaboration and integration developing among healthcare providers through the:
    - Development of respect and trust among within- and cross-sectoral partners through the holding of consistently attended, regular meetings

- ?? Development of stronger relationships among front-line workers
- ?? Reduction of stigma and misunderstanding among service providers regarding mental health and addiction issues
- ?? Identification and pursuit of resource-sharing opportunities across organizations and sectors
- ?? Inclusion of the mental health and addiction sector within the broader healthcare system, versus isolating it on its own

ii. Improve service to consumers and families through the:

- ?? Establishment of "horizontal" accountability contracts among service providers in local areas as well as with the LHINs/MOHLTC
- ?? Ability to focus more clearly on specific target areas, such as coordinating access (which could be improved by building on existing relationships and by funding existing and newly developing coordinated access initiatives)
- ?? Establishment of a more seamless continuum of care through which consumers and families can move (e.g., into and out of hospital and community-based services)
- ?? Exporting of the mental health and addiction "story" into other venues/ disease management strategies (i.e., integration of the existing "head and body" divide)
- ?? Diffusion and adoption of new ways of doing things which are learned from exposure to new partners and sectors
- ?? Requiring of more consistent inclusion of family and friends as part of a person's care team, together with the provision of education and supports to allow and facilitate this
- ?? Opportunity to adopt a recovery orientation more broadly across the healthcare system
- ?? Provision of a platform from which to do quality monitoring and improvement work

iii. Respond to and meet local community needs more effectively, as LHINs provide an opportunity:

- ?? To reduce duplication of services
- ?? For the strength of a small community agency to shine through
- ?? To identify and address the unique "fail points" in the system, community by community
- ?? To build on existing community strengths from the "bottom-up"

iv. Ensure consumers are full actors within the system (versus being acted upon), through their meaningful inclusion in the planning, decision-making, service delivery and monitoring roles of the LHINs, together with the provision of increased resources to consumer organizations

v. Preserve volunteer capacity by allowing local Boards to continue to exist

vi. Increase opportunities for cross-system (versus sectoral-based) research and training

vii. Result in the development of a collective sense of responsibility for the health outcomes of individuals and the community, including creation of a greater sense of ownership for the whole system (versus solely one's own part)

B. Challenges posed by the LHINs

Again, subject to the proviso that they did not yet know much about the LHINs nor how they would be implemented, attendees generated a list of ***potential*** challenges posed by the LHINs for consumers, families and the community mental health and addiction sector. **Implemented *ineffectively*, LHINs could:**

i. Cause the mental health and addiction sector to become even more of an "orphan" within the healthcare system by:

    ?? Reducing its priority within the overall healthcare system

    ?? Not recognizing and ensuring that identifying and addressing people's mental health and addiction needs is part of everyone's role in the system

    ?? Reinforcing the currently uneven playing field (i.e., relative to other health sectors) for the community mental health and addiction sector as it joins the LHINs (e.g., by not enhancing the community mental health and addiction sector's capacity and infrastructure (e.g., information systems, training) so that the sector can effectively participate and play its defined role in the system)

    ?? Maintaining existing priority-setting approaches by entrenching decision-making based on existing referral patterns, the current emphasis on medical care versus community health needs, and erroneous beliefs about the "nature" of mental health and addiction consumers, rather than making decisions based on prevalence, severity, impact, and consumer need information

ii. De-emphasize the voice of consumers, families and small community-based organizations, particularly if the LHINs are implemented and managed:

    ?? In a "top-down" fashion

    ?? So as not to include consumer, family and community-based representation and voices (nor the capacity-building needed to facilitate consumer and family participation)

    ?? So as to undo and not create space for the ongoing work of existing networks, committees, and alliances

    ?? Through a "political" versus "democratic" and/or "needs-based" process

iii. Reduce collaboration and integration across the system by:

- ?? Maintaining existing barriers to collaboration and integration (e.g., different funding mechanisms, policy frameworks, and expectations), both within the healthcare sector and across sectors (e.g., community and social services, education) – which suggests that the Government and Ministries must have a significant role in making it easier for the sectors to work together
- ?? Adding new barriers through excessive administrative demands in relation to reporting and communication with the LHINs
- ?? Undoing existing collaborative initiatives that happen to cross the newly defined LHIN boundaries
- ?? Excluding portions of the healthcare system from the LHINs, and/or maintaining silos/"special deals" for various sectors

iv. Measure and track the "wrong" outcomes for consumers of mental health and addiction services and supports (i.e., focus only on medical-model, quantitative measures rather than on critical quality of life-based and qualitative measures)

v. Reduce the system's ability to respond effectively to marginalized populations/ those with very complex needs and/or cause consumers to be "dumped back" to their families and friends without sufficient supports in the drive toward efficiency and reduced hospitalization

vi. Reduce emphasis on health promotion and prevention initiatives in the face of a strong focus on acute services

vii. Reduce consistency and quality of service and support availability and provision across the province by:

- ?? Exacerbating existing capacity inequities by basing LHIN boundaries on existing referral patterns rather than on population needs
- ?? Over-emphasizing community-based planning in the absence of a strong, coherent provincial policy framework, standards, and research and training agenda
- ?? Undoing existing and hampering further development of what are effective provincially-based initiatives and resources

C. Development of preliminary principles and early advice to the Government regarding Transformation Agenda (including LHIN) implementation

Attendees brainstormed a long list of possible advice for the Government regarding how to design and implement the LHINs so that they benefit consumers and families living with mental health and addiction needs. During lunch, these points were synthesized by host organization representatives and the session's facilitator to a smaller, preliminary set of points which attendees could begin communicating immediately upon leaving the working session. Consensus around these ten points was secured from the attendees during the working session's afternoon plenary session. The ten points are as follows:

1. Addictions must be part of the system (i.e., not left out of the Local Health Integration Networks)
2. Mental health and addictions is integral to transformation of the healthcare system and must be at the table
3. Consumers and families must have voice, to be effected through:
    - Investment in consumer and family organizations
    - Participation in LHINs (as defined in legislation and policy)
    - Support for consumer and family member participation (i.e., provision of training, transportation, etc.)
    - Recognition of consumer and family initiatives as being important parts of the system
4. Mental health and addictions' funding must continue to be enhanced so as to allow the sector to play its full role in the system (i.e., in terms of increased capacity and provision of supports to be equal, effective partners – i.e., with investments in IT/IS etc.)
5. The transformed system must use a broad definition of health – which would result in investments and priority being given to such areas as housing, education, employment and social-recreational support services
6. LHINs must include all parts of the system (i.e., no side doors or deals) and all of the system's funding in their funding envelopes
7. Accountability relationships must be horizontal (i.e., among organizations) as well as vertical (i.e., between consumers-families-providers-LHINs-government)
8. LHINs must have be given a level of authority and resourcing (i.e., training, staffing, IT/IS) to be able to do their jobs effectively
9. The litmus test of the LHINs is their ability to meet the health needs of the most marginalized populations in their communities
10. The transformed health care system must treat and fund mental health and addictions like other parts of the system (i.e., based on population need, prevalence and severity, not moral judgments)

Additional points were flagged by attendees as being important to incorporate into a more refined synthesis of the above points. These points included the following – the importance of:

- Ensuring that prevention and health promotion has a clear and enhanced role within the overall system
- Cross-sectoral representation and linkages (i.e., social services, education, justice)
- Not simply transplanting medical language and models onto the community-based parts of the system

- ?? Not basing the definition of LHIN geographies on current referral patterns alone (as these often reflect, and could reinforce, current inequities in the distribution of resources)
- ?? Not basing LHIN membership on existing resource allocations, size and numbers of organizations
- ?? Building on existing strengths and networks
- ?? Ensuring that the process is a bottom-up, and not top-down process only

Finally, a number of strategies were suggested to support implementation of the preliminary principles and early advice generated by the attendees:

- ?? Active contribution on the part of the sector to the development of the policy framework for the Transformation Agenda and the LHINs
- ?? Seeking of legislation regarding addiction and mental health sector and consumer and family role and representation
- ?? Maintaining of capacity at the provincial level to establish, promote and support implementation of province-wide policy, standards, and coordination across LHINs, as well as to ensure, coordinate and support the delivery of selected province-wide services and supports

Finally, it is important to note that in addition to the establishment of Local Health Integration Networks, the Creating a System Transformation Project includes emphasis on decision support requirements (e.g., review and restructuring of MOHLTC information management practices and systems) and non-clinical administrative operations in acute and community health services (e.g., assessment of opportunities for cost-effective pooling and sharing of common approaches and resources). These topics were not discussed during the working session.

3 Early thinking regarding the remaining Transformation Projects

In addition to "Creating A System", the Government announced 13 other Transformation Projects. These projects include the following:

- ?? Reduced Wait Times Framework
- ?? Chronic Disease Prevention and Management
- ?? Health Human Resources
- ?? Population Health
- ?? Public Health Renewal
- ?? Quality and Accountability
- ?? Critical Care Capacity
- ?? Investing In Community
- ?? Family Health Teams
- ?? Managing Drug Program Growth
- ?? System Multi-Year Funding
- ?? E-Health Strategy
- ?? Aligning Internal Resources

Attendees were divided into six breakout groups, each of which discussed two to three of the above Transformation Projects. Please see Appendix C – Breakout Groups, for a list of participants in each breakout group and the projects they discussed. The purpose of each breakout group was to generate, for each project, early thinking and possible suggestions for the Government and for the community mental health and addiction sector regarding how best to proceed with each initiative and what the role of the community mental health and addiction sector should be in each.

More specifically, for each Transformation Project, attendees addressed the following four questions:

i. While not a lot is known about this project, what might the benefits of this Transformation Project be for consumers and for the community mental health and addiction sector?

ii. What might be the challenges associated with this Transformation Project for consumers and for our sector?

iii. How can the community mental health and addiction sector contribute to the Government's agenda in relation to this Transformation Project – what role could and should the sector play?

iv. What advice do you have for the Government and our sector as this Transformation Project is designed and implemented?

Attendees' answers to each of the above questions by Transformation Project are outlined below.

Caveats regarding the following material

It is important to note a number of caveats regarding the following material. These caveats include the following:

- ?? At the time of the Working Session, very little public information had been released in relation to the Transformation Projects discussed below. Attendees responded to the questions listed above subject to the proviso that they did not yet know much about the projects, nor how they would be implemented.
- ?? Because of time constraints and varying levels of understanding of each of the projects, each Transformation Project was not discussed to the same level of detail
- ?? Because of time constraints, the large number of projects to address, and the fact that little detailed information was available to attendees about each project, consensus was not sought around the possible advice generated. The material below simply lists the bullet points generated through the afternoon's breakout groups, and should be viewed only as a starting point for future work to be done on each of these initiatives. To that end, following the breakout groups, attendees were asked to sign up for work groups through which to do further work on each topic area if required.

3A. Reduced wait times framework

As outlined in early Government communications, the "Reduced Wait Times Framework" project includes development of an overall wait time framework, together with specific focus on cataracts, joint replacement, cancer, and MRI/CT, and including the development of registries, benchmarks and standards.

i. Potential benefits

Implemented *effectively*, the reduced wait times framework project could:

- ?? Improve timeliness of service for consumers and families
- ?? Provide important information to the system which could be used in planning and for advocacy purposes (e.g., as information currently captured by the Drug and Alcohol Registry of Treatment (DART) is being used today)

- ?? Lend support to existing and future projects that are working to coordinate access and measure, monitor and improve waiting times for service

ii. Potential challenges

Planned and/or implemented *ineffectively*, the reduced wait times framework project could:

- ?? Exclude mental health and addiction services and supports (e.g., there is currently no mention of either area in the project's key areas of focus)
- ?? Not capture the true nature of demand because: i) the wait lists for community mental health and addiction services are often so long that many people opt out of accessing services; ii) the specific services and their wait lists are not accessible to and therefore not accessed by severely marginalized groups (e.g., people who are homeless, people from different ethnocultural groups who cannot find culturally appropriate services); and/or iii) the stigma of mental health and addiction causes people to not seek help when they need it
- ?? Focus only on getting the infrastructure in place to measure wait times without: i) defining what constitutes an "appropriate or acceptable" wait time (including determining and measuring what happens to people while they wait); and/or ii) addressing the root causes of "inappropriate or unacceptable" wait times

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- ?? Participate as one of the project's key focus areas
- ?? Build on existing systems (e.g., DART)
- ?? Be supported to implement existing and develop new projects to coordinate access to various services (e.g., supportive housing, individual support services) which would provide information on wait times to the project and the means through which to analyze and address them

iv. Early thinking and possible implementation suggestions[4]

As the Government plans and implements the reduced wait times project, it could:

- ?? Include mental health and addiction services and supports as a key area of focus within the project

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[4] Please be reminded that because of time constraints, the large number of projects to address, and the fact that very little detailed information was available to attendees about each Transformation Project, consensus was not sought around the early thinking and possible implementation suggestions generated by group members. Attendees were asked to sign up for work groups through which to do further work on each topic area if required, which could alter the specific suggestions and advice the sector provides to the Government regarding the planning and implementation of each project.

- ?? Establish as the project's overarching goal that people in Ontario should be able to access the specific services and supports they need in a timely way
- ?? Establish clear wait time benchmarks and standards for each service and support under consideration
- ?? Establish a central registry for acute care mental health and addiction beds
- ?? Ensure strong linkages to the primary care system
- ?? Support and fund existing work done on coordinating access to mental health and addiction services

3B. Chronic disease prevention and management

As outlined in early Government communications, the "Chronic Disease Prevention and Management" project includes development of an overall chronic disease prevention and management framework, including prevention and promotion initiatives in primary health care models and clinical management, together with specific focus on diabetes, osteoporosis and HIV/AIDS.

i. Potential benefits

Implemented *effectively*, the chronic disease prevention and management project could:

- ?? Increase consumer and family access to and support needed prevention and early intervention initiatives and practices, which would improve consumer outcomes and quality of life
- ?? Reduce the number of acute episodes for those living with existing chronic disease
- ?? Increase the appropriateness of hospital admissions and use of acute care resources
- ?? Recognize and enhance the role of family members and friends in a person's care and support

ii. Potential challenges

Planned and/or implemented *ineffectively*, the chronic disease prevention and management project could:

- ?? Exclude or not adequately address mental health and addictions issues within the framework depending on who is contributing to its formation (or further stigmatize such issues by not addressing current decision-making practices in this area that are based on moralistic versus incidence, prevalence, severity and level of need –based grounds)

?? Not be sufficiently responsive to the needs of marginalized and/or under-served populations, again depending how the framework is constructed and by whom

?? Be too prescriptive either by not incorporating the full continuum of services and supports needed by consumers of mental health and addiction services, (including peer and family supports), or by not allowing the flexibility required in terms of the unique "package" of services and supports required to support a given consumer's recovery process

?? Not be resourced appropriately to meet the needs of consumers and families

?? Under-acknowledge and therefore not incorporate the fact that recovery is possible from chronic disease, into the chronic disease prevention and management framework

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

?? Contribute its expertise and research-based evidence regarding health promotion, prevention and management of – and recovery from – mental health and addiction problems

?? Demonstrate the importance of consumer- and family-driven supports and services

?? Demonstrate successful models of inter-disciplinary service delivery in the management of mental health and addiction problems

?? Share data linking mental health and addiction issues with other chronic disease management priorities

?? Share the first-person stories of consumers and family members regarding what works for them in the management of chronic disease

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the chronic disease prevention and management project, it could:

?? Include mental health and addiction needs as a key area of focus within the project (including consideration of mental health and addiction needs both as "stand-alone" illnesses and as complements to other chronic diseases)

?? Ensure the development of new funding models to better support care and support delivery across the needed continuum of care (including funding of mental health and addiction care delivery in the home, supportive housing and employment supports)

?? Ensure and justify capacity enhancement by accounting for, understanding, and communicating the full costs of chronic mental health and addictions issues (e.g., the cost of mental health and addictions for employers, workplaces, and Ontario's productivity)

- ?? Facilitate the development of formal partnerships among major disease prevention and management players
- ?? Leverage technology (e.g., the e-health strategy) to support piloting of shared medical records

3C. Health human resources

As outlined in early Government communications, the "Health Human Resources" project includes development of an integrated health human resources framework, together with specific focus on more and appropriate use of doctors, more and appropriate use of nurses, other practitioners, maximizing the scope of practice, and development of a sector-wide strategy to increase flexibility in deployment.

i. Potential benefits

Implemented *effectively*, the health human resources project could:

- ?? Address existing wage inequalities both within the overall healthcare system and the community mental health and addiction sector itself, which make the sector an unattractive one in which to work
- ?? Better specify needed skills and competencies by role across the sector (particularly as one's educational background is not the best predictor of whether one is an effective mental health and addiction worker)
- ?? Better specify and address training needs across the sector so that they align better with the sector's priorities and goals, and ensure equity in the quality of services provided across the sector
- ?? Address existing workload demand pressures on current staff, in part by expanding roles of other professionals as part of the consumers' care team (e.g., including integration with family health team practices)
- ?? Recognize the importance and value of consumers and families working within the system, training and compensating them accordingly (e.g., salaries, allowance for consumer benefits costs, compensation for informal family supports) so as to increase their capacity within the sector
- ?? Realign family physician and psychiatrist compensation models (e.g., alternate payment plans, OHIP fee schedules) so as to better support the delivery of high quality mental health and addiction treatment and support

ii. Potential challenges

Planned and/or implemented *ineffectively*, the health human resources project could:

- ?? Exacerbate existing workload demand and wage disparity issues, further drawing away skilled workers from the sector

- ?? Not leverage the tremendous primary prevention and care opportunity posed by the creation of family health teams

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- ?? Participate in the development of a sectoral human resources strategy, particularly in relation to the development and implementation of the Local Health Integration Networks and the need to facilitate smoother transitions for consumers as their workers change roles within the system
- ?? Partner with other sectors to enhance their human resource capacity (e.g., have mental health and addiction teams to consult with other health and cross-sectoral professionals)
- ?? Participate in the development and implementation of integrated mental health and addiction training for all health professionals, including mental health and addictions' interaction with other health issues (e.g., developmental delay, HIV, acquired brain injury, etc.)

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the health human resources project, it could:

- ?? Include mental health and addiction human resources as a key area of focus within the project (e.g., including integration of such resources into current projects, such as the family health teams; establishment of incentives for the development of rural training networks)
- ?? Establish incentives and alternate payment plans for family physicians and psychiatrists in relation to the provision of mental health and addiction care
- ?? Address existing wage disparities between hospital- and community agency-based community mental health and addiction workers and with comparable professionals in other parts of the healthcare system
- ?? Develop a strategy to include peer, family and paraprofessional workers in the sector's human resources strategy, while at the same time avoiding sectoral wage depression
- ?? Develop innovative compensation schemes for families able to provide extensive informal supports

3D. Population health

As outlined in early Government communications, the "Population Health" project includes development of an overall population health framework, together with specific

focus on the development of strategies in relation to tobacco use, physical activity, nutrition, childhood obesity, and low birth weight.

i. Potential benefits

Implemented *effectively*, the population health project could:

- Relieve some of the pressure on community services and/or hospitals because of the positive impact of population health strategies on consumers and families
- Reinforce support for a recovery orientation in the planning and delivery of mental health and addiction services and supports
- Increase the general population's perception of the value of community-based care as being as valuable as acute care
- Increase the emphasis on identifying, tracking and reporting on population health trends and needs, which will: i) reduce stigma and society's current tendency to "individualize" mental health and addiction problems (i.e., blaming sufferers as the source of their own problems); ii) allow for the better addressing of the needs of Ontario's diverse populations; and iii) better anticipate population needs and resource requirements in the future (e.g., the effects of aging on the demand for mental health and addiction services and supports)
- Increase support for investment in the broader determinants of health (e.g., housing) which would have a direct impact on consumers' quality of life and recovery processes
- Lead to more timely intervention and emphasis on early self-care, early intervention and prevention activities

ii. Potential challenges

Planned and/or implemented *ineffectively*, the population health project could:

- Deemphasize the need to meet the needs of rare conditions and marginalized populations (i.e., ghetto-izing/not integrating them in the process)
- Increase stigmatization of people with mental health and addiction needs if such issues are not communicated about and addressed appropriately
- Ignore unique aspects of the mental health and addiction service and support continuum (i.e., self-help/peer support components of the system, the unique roles of different caregivers within the system)
- Over-standardize approaches used to improve population health issues, and/or not provide adequate resources to address the unique needs of local communities

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- Build on its long history of focusing on the broad determinants of health when working with consumers and families to construct and implement recovery plans
- Contribute its wealth of experience regarding how to effect behaviour change (e.g,. tobacco, other addictions)

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the population health project, it could:

- Include mental health and addiction services and supports as a key area of focus within the project
- Ensure that the self-identified population health needs of consumers are the priority for policy development, planning, and implementation/resourcing activities
- Emphasize the special expertise and knowledge of multicultural groups in project planning and implementation activities
- Dedicate resources for evaluation of any population health strategies and ensure they are in place and available over the appropriate timeframe

3E. Public health renewal

As outlined in early Government communications, the "Public Health Renewal" project includes development of an overall implementation strategy for public health renewal, together with specific focus on immunization, infection control and outbreak management, and the establishment of a provincial centre for disease control.

The working group assigned the public health renewal project did not have time to cover it fully during their discussions. While this project may be discussed by an ad hoc working group of session attendees at a future date, atendees' initial thoughts on the project included the need to:

- Develop a strategy for addressing public health factors that relate to mental health and addictions (including the spread of TB, Hepatitis C, and HIV within this population)
- Include the concept of harm reduction within the project's public health renewal strategies
- Address both the impact of public health issues (e.g., SARS) on the population with mental health and addiction issues (e.g., cancellation of group sessions in hospitals meant many people were "lost" to the system at critical points in their recovery, and many of these groups did not start up again, further impacting the recovery processes of current and future participants), and the mental health impacts of such crises on the broader population

?? Recognize and enhance the role of community-based programs in keeping people out of hospitals thereby facilitating disease control

3F. Quality and accountability

As outlined in early Government communications, the "Quality and Accountability" project includes specific focus on the development of strategies in relation to enhancing patient safety, investment in new medical strategies, workplace safety, performance reporting through the Ontario Health Quality Council, and the development and implementation of accountability frameworks.

i. Potential benefits

Implemented *effectively*, the quality and accountability project could:

?? Increase the system's focus on demonstrating quality of life (i.e., not just clinical symptom relief) and system outcomes that are important to consumers and families

?? Define success in ways that are inclusive of different populations and needs

?? Result in the establishment of an effective funding formula for mental health and addiction services that allows for the linkage of funding provided to outcomes achieved (which is currently not possible given the lack of a funding formula), and that ultimately will allow the development of true two-way accountability between funder and the funded

?? Allow comparisons by consumers as to the differences in the quality of service provided by community agencies (which is currently not possible given significant funding disparities across agencies)

?? Ensure a strong link between quality of service and accountability initiatives

ii. Potential challenges

Planned and/or implemented *ineffectively*, the quality and accountability project could:

?? Not allow consumers to judge the quality of services and supports being provided based on their ability to meet consumer-defined outcomes

?? Not achieve an appropriate balance between meeting clients' safety needs and their quality of life goals

?? Insufficiently define what kinds of outcomes will be measured

?? Not measure real health outcomes in relation to mental health and addiction issues due to the substantial cost of collecting the information to do so

iii. Possible role(s) and contribution(s) for and by the sector

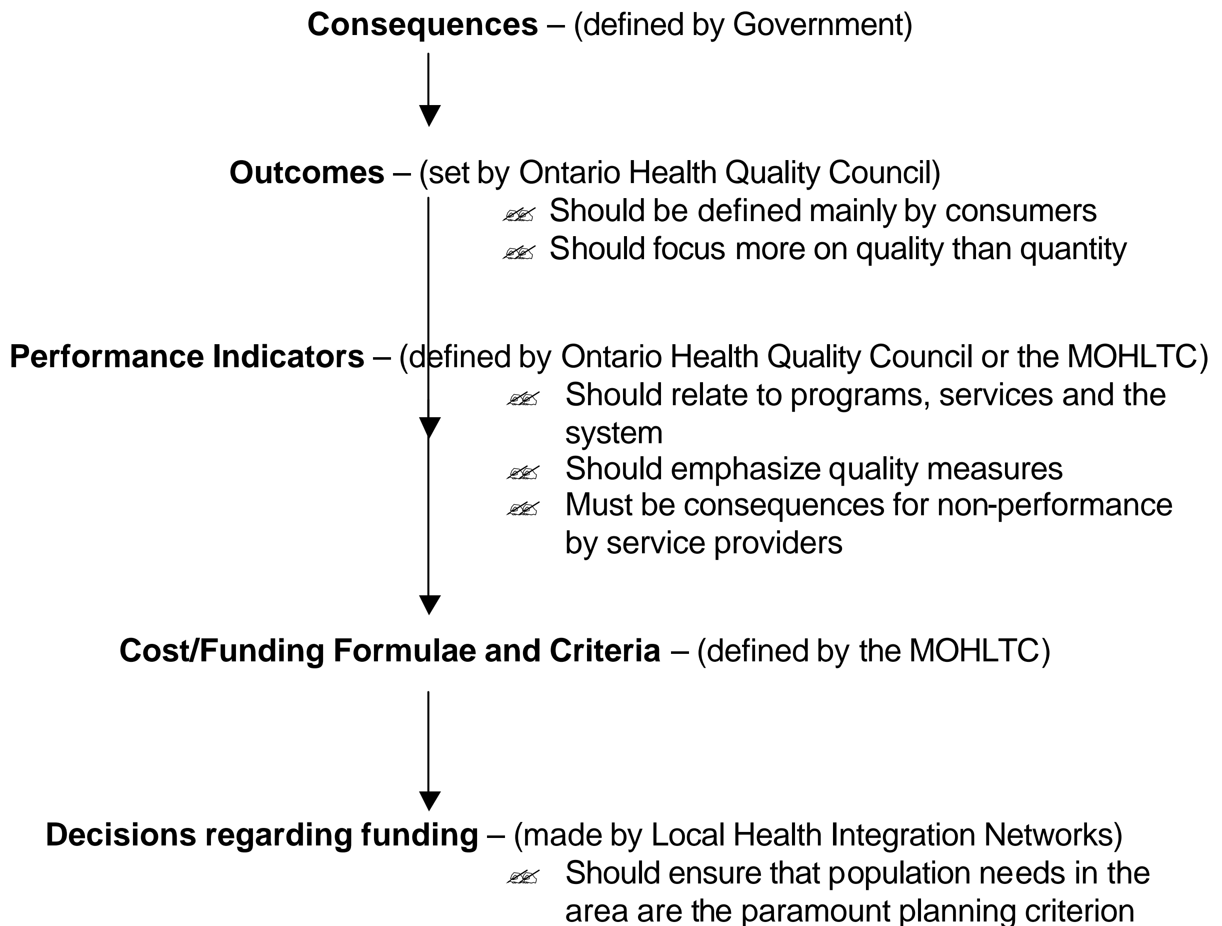
Depending on the specific nature of the project, the sector could:

?? Contribute its expertise and data regarding how its interventions have kept consumers housed and out of institutional settings (i.e., hospital and/or jail), as well as its experience measuring and tracking quality of life and system outcomes for diverse populations

?? Collaborate with the Government to bring together existing accountability frameworks (e.g., hospital score cards; agency quality of life measures; and consumer organizations' objectives to support consumers' ability to exit the mental health and addiction system) into a more coherent, consumer-focused whole

?? Collaborate with the Government to establish a service and support registry for mental health similar to that of the Drug and Alcohol Registry of Treatment (DART)

?? Partner with the Government and academics to develop an accountability framework that takes into account the following considerations:



iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the quality and accountability project, it could:

- Include mental health and addiction services and supports as a key area of focus within the project
- Consult with the sector regarding what it means by quality and accountability (which should include system level accountability and individual agency performance) and partner with service providers, academics, and particularly with consumers (including sampling consumers actually served in recent years) to develop the accountability framework
- Review whether the current competitive funding process should serve as the basis for funding reform given its uncertain linkage to accountability and the need more importantly, to ensure that the funding formula and allocation process is needs-based rather than simply competitive
- Consider development of a capitation funding model as an alternative (e.g., the UK developmentally handicapped services capitation funding model, tailored for Ontario)
- Ensure consequences for poor performance (or else consumers, families and service providers will not have confidence in the accountability framework)
- Focus on linking services and supports together and then linking these to key quality measures and outcomes as defined by consumers (which can then be used to determine if a system has been achieved through the Local Health Integration Networks rather than simply adding another layer of bureaucracy)
- Ensure defined outcome measures and accountability frameworks are inclusive of different populations and needs, and take into account socioeconomic status and the effect of poverty, as well as the fact that several different agencies are often involved with a given consumer
- Use external, non-partisan evaluators to evaluate outcomes
- Clearly define who will hold the Local Health Integration Networks accountable and how this will be done
- Develop and implement the accountability framework in a timely fashion and change it as needed (rather than spend 2-4 years "reinventing the wheel" or perfecting something before launch that will never, in fact, be perfect)

3G. Critical care capacity

As outlined in early Government communications, the "Critical Care Capacity" project includes specific focus on admission/discharge standards, critical care capacity, clinical planning and coordination and expansion of hospital services to support the implications of the reduced wait times framework.

i. Potential benefits

Implemented *effectively*, the critical care capacity project could:

?? Ensure the availability of this scarce resource when and where it is needed by consumers and families (i.e., freeing up of existing and enhancement of critical care capacity in areas which currently have little to none)

?? Reduce the number of times consumers end up in general hospital beds or in the halls with security guards because no psychiatric acute care beds are available

?? Improve the transitions for consumers from hospital to community-based care

ii. Potential challenges

Planned and/or implemented *ineffectively*, the critical care capacity project could:

?? Reduce critical/acute care capacity without having put in place needed alternatives

?? Increase expectations on the community-based sector without providing the sector with the requisite resources to do its work

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

?? Reduce pressure on this scarce resource if sufficiently resourced to do so in the community

?? Contribute to the development and implementation of more effective discharge planning standards and guidelines

?? Provide research-based models of effective alternatives to acute care (e.g., supportive housing, residential treatment, etc.) and ideas drawn from system planning work already completed

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the critical care capacity project, it could:

?? Include mental health and addiction acute care capacity as a key area of focus within the project

?? Invest appropriately in supportive housing and other appropriate acute care alternatives/preventors to reduce pressure on these more expensive hospital resources

?? Establish clear standards regarding discharge planning (including the need for case conferencing and system-wide collective accountability for effective discharges)

?? Ensure implementation of a clear outcome measurement and evaluation framework for this project

3H. *Investing in community*

As outlined in early Government communications by the Government, the "Investing in Community" project includes specific focus on development of an alternate level of care strategy to support a transition of acute care services to the community, enhancement of and public reporting on acute home care, and increasing community capacity in relation to mental health and long-term care services and supports.

i. Potential benefits

Implemented *effectively*, the investing in community project could:

- Preserve hospital resources for those who really need them
- Allow people to receive services and supports closer to where they live
- Reduce the mismatch between what people's needs are and the services they ultimately receive
- Allow for the development of services tailored to the needs of the people they serve (e.g., linguistically and culturally appropriate services that meet the needs of diverse, multicultural communities, including Aboriginal peoples)
- Increase access to community mental health and addiction services
- Expand consumer choice among available service and support options
- Reduce overall costs to the healthcare and broader social services system of mental health and addiction problems by reducing the use of more expensive institutional resources (e.g., hospitals, jails)
- Provide enhanced support to families who in turn will be better able to support their family members
- Support implementation of a recovery orientation across the system
- Reduce the stigma of mental health and addiction issues across the system
- Improve the public's perception and valuing of community-based care

ii. Potential challenges

Planned and/or implemented *ineffectively*, the investing in community project could:

- Reinforce existing "medical model" approaches that do not emphasize the importance and use of community-based supports such as supportive housing, drop-ins, and peer supports
- Repeat the "deinstitutionalization" mistakes of the past, where institution-based services were reduced but sufficient resources were not invested in the community to respond (e.g., in relation to service and support capacity, training, and de-stigmatization and government valuing of community-based services)

- ?? Become overly stringent in relation to criteria for accessing hospital care such that people who do need it are unable to access it
- ?? Not convince the public that they can receive more appropriate, convenient care in the community
- ?? Result in hospitals renaming themselves as "community deliverers of care" with little substantive change in how and where services and supports are delivered
- ?? Shift the locus of care from hospital to community without addressing the required linkages between hospital- and community-based care
- ?? Increase the role of family members without providing them with commensurate supports
- ?? Not address regional differences, such as the need to address transportation barriers and costs in the north of the province
- ?? Not address cross-sectoral barriers, such as disincentives to leaving ODSP, and the need for easy reentry to services as needed

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- ?? Actively share our expertise and advice in this area (including the provision of evidence-based data to support the transformation)
- ?? Roll out existing public education plans (if funded to do so)
- ?? Participate in the design and planning of community services and supports, and bring other community members to the table
- ?? Pilot new ideas and approaches in a variety of areas
- ?? Profile examples of effective community-based services and practices
- ?? Identify transition issues when supporting individuals' moves into the community
- ?? Foster increased dialogue between institutions and community service providers, identifying and working in partnership to address structural barriers to increased collaboration

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the investing in community project, it could:

- ?? Include addiction services and supports as a key area of focus within the project
- ?? Ensure a comprehensive policy framework is in place (e.g., enshrined in legislation) that uses a broad operating definition of community to guide the

transfer of hospital-based services to the community (making sure to leverage past policy work versus "reinventing the wheel")

- Invest in enhancing a wide range of community-based service and support capacity (e.g., supportive housing, employment supports, consumer and family self-help) more equitably across the province before transferring service expectations from hospitals to the community
- Build on and replicate existing effective models of community-based care, with a particular emphasis on improving access to mental health and addiction services and supports
- Develop and launch a public education campaign to ensure the public understands that community-based care is effective and efficient care
- Address current wage differentials between hospital- and community agency-based workers including community mental health and addiction services
- Engage in a dialogue with labour rather than making this shift a battleground on which no one wins
- Develop and implement a comprehensive outcome measurement and evaluation plan which includes provisions to reward collaboration and innovation
- Develop and implement a community mental health and addiction services accreditation system

3l. Family health teams

As outlined in early Government communications, the "Family Health Teams" project includes enhancement of family health teams (including the development of governance structures for the teams) and self-care supports (i.e., establishment of priorities for expansion to ensure more equitable and broader-based distribution of existing self-care supports).

i. Potential benefits

Implemented *effectively*, the family health teams project could:

- Allow for the provision of integrated, determinants of health-based, holistic, multi-disciplinary care that includes mental health and addictions treatment and support in primary healthcare settings
- Increase the system's emphasis on health promotion, prevention, early identification and early intervention through increased use and cross-fertilization of experts and expertise across professions
- Increase access for consumers and families to better, more comprehensive primary mental health and addiction treatment and support – geographically, by time of day and culturally (through ethnoculturally diverse practitioners)

- Increase linkages among family health team practitioners and community mental health and addiction services and supports, allowing the latter to play a support and back-up role for clients with more complex needs and situations
- Increase the linkages made by practitioners between mind and body health needs and increase the opportunities for the sector to inform and participate in regional health strategies (e.g., stroke strategy, etc.)
- Reduce stigma around seeking help for and providing care to people with mental health and addiction needs

ii. Potential challenges

Planned and/or implemented *ineffectively*, the family health teams project could:

- Result in unnecessary proliferation of services if the teams seek to acquire their own mental health and addiction services versus linking with existing community-based resources
- Result in silos developing at the local level if the teams are allowed to get "territorial" over client bases and/or geographic mandates
- Exclude provision of holistic mental health and addiction primary care if teams: i) are not better educated about primary mental health and addiction treatment and support, and ii) are not reimbursed at appropriate levels for the range of primary mental health and addiction care services required
- Exclude marginalized and/or difficult-to-serve populations depending on how: i) teams are communicated about and promoted; ii) teams operate (e.g., will they have any outreach capacity?); iii) teams are constructed (e.g., diversity, philosophy, orientation); iv) client "membership" is determined and effected; and v) people without health cards are treated
- Be unable to respond to the diverse needs of local communities if they are forced to adhere to a given system standard of composition and way of practice

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- Provide capacity to serve family health team mental health and addiction clients in direct or back-up roles
- Provide useful tools for use by family health teams (e.g., toolkits, protocols etc.)
- Provide education and training in mental health and addiction issues to family health team members
- Serve as referral sources to family health teams

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the family health teams project it could:

- Include mental health and addiction services and supports as a key area of focus within the project (including mental health and addiction health promotion, prevention and education)
- Include family health teams within the Local Health Integration Networks
- Maintain flexibility regarding how models are designed and implemented across to province so as to be able to respond to unique local needs (including how "membership" is established to account for the highly transient nature of some segments of the population who live with mental health and addiction needs)
- Support the building of formal, partnership-based linkages between family health teams and community mental health and addition providers (to support the provision of primary mental health and addiction care and to ensure appropriate consumer transitions from primary to more intensive and specialized levels of care (and back again) as needed)
- Establish competencies for inclusion with family health teams, with particular emphasis on cultural and linguistic competencies
- Allow for (i.e., fund) family health teams to deliver complementary/alternative services to respond to diverse communities' needs
- Ensure family health teams are supported by adequate information technology systems that go beyond "transactions" only

3J. Managing drug program growth

As outlined in early Government communications, the "Managing Drug Program Growth" project includes emphasis on drug strategy and review (e.g., improving health outcomes through appropriate utilization and better prescribing practices) and managing drug program growth.

i. Potential benefits

Implemented *effectively*, the managing drug program growth project could:

- Reduce drug program costs allowing increased investment in direct community mental health and addiction services
- Improve family physician and psychiatric prescribing practices
- Improve access to newer psychiatric medications through their inclusion on ODSP and other formularies

ii. Potential challenges

Planned and/or implemented *ineffectively*, the managing drug program growth project could:

- Not achieve desired results because costs of the program are driven in large part by the power and pricing practices of drug companies
- Not integrate information technology systems sufficiently which would reduce the effectiveness of the project
- Neglect enhancing the needed linkages exist among psychiatrists, hospitals and community mental health services so as to allow for proper medication monitoring
- Not leverage community mental health and addiction providers' expertise in the drug area
- Continue to restrict access to newer drugs for consumers on ODSP, who only have access to older drugs that are already included on the formulary

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- Increase linkages among psychiatrists, hospitals and community agencies through implementation of shared care models (which could also support consumers who wish to reduce and taper medication without resulting in an increase in readmissions to hospital)
- Reduce reliance on medication through provision of community-based mental health and addiction services and supports
- Work together and with consumers and families to develop and implement a system to monitor medication compliance

iv. Planning and implementation advice

Finally, as the Government plans and implements the managing drug program growth project, it could:

- Invest in community-based mental health and addiction services so as to reduce consumers' reliance on medication
- Ensure the education of family physicians is enhanced regarding psychiatric needs so as to increase the appropriateness of their prescribing practices (which could also include enhancing the roles and education of psychologists, nurse practitioners, pharmacists and dieticians, among others, which could require legislation to support implementation of these broader roles)
- Develop, implement and monitor prescribing practice standards
- Ensure the provision of basic information regarding psychiatric medications to non-physician service providers

?? Increase the access to psychiatric expertise for addiction programs (e.g., through provision of sessional fees) who can then support and educate the psychiatrists in turn regarding addiction issues

3K. System multi-year funding strategy

As outlined in early Government communications, the "System Multi-Year Funding Strategy" project includes emphasis on the development of a multi-year funding strategy across the health sector to support planning, the achievement of performance targets, enhanced accountability and system transformation.

i. Potential benefits

Implemented *effectively*, the system multi-year funding project could:

?? Improve agency and sector planning and service delivery by allowing for the taking of a longer-term, strategic perspective regarding planned growth, program changes and innovations and system development

?? Improve continuity of service provision and relationships with consumers by allowing for follow-up over the medium-to-long term

?? Allow for increased flexibility in service planning to respond to changing local consumer needs and demographics

?? Increase stability for staff, programs and the sector, which will translate to increased stability for consumers who will know that services and supports will be there no matter where they are in their personal recovery processes

?? Allow for more staff time to be directed to service delivery by eliminating the need for some administration activities and costs

?? Reduce unproductive inter-agency competition

?? Provide the opportunity for better negotiated settlements with unions over multiple years, and for better pricing on external services and equipment

?? Increase the opportunity for monitoring and evaluation

ii. Potential challenges

Planned and/or implemented *ineffectively*, the system multi-year funding project could:

?? Lock-in "unsustainable" sector, agency and program budgets, particularly if resources are not available up-front to support the shift to multi-year funding

?? Result in less effective agency and sector planning and service delivery if agency and sector environmental scan and long-term planning skills are not enhanced at the same time

?? Prevent flexibility in service planning in response to changing local consumer needs and demographics

?? Reduce productive inter-agency competition and innovation

?? Result in escalation of costs and reductions in service if clear service standards and benchmarks are not also established within an overall accountability framework

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

?? Participate in the establishment of the overall accountability framework (e.g., standards regarding record-keeping, data collection, service definitions, service standards)

?? Demonstrate the value of having small-, medium- and large-sized organizations within the system

?? Participate in the establishment and on-going operation of "oversight" groups (e.g., joint MOHLTC and sector initiatives, LHINs, etc.)

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the system multi-year funding project, it could:

?? Explore the Ontario Community Health Centres' accreditation process as a model for community-based mental health and addiction services

?? Explore the United Way model of multi-year funding with a corresponding innovation fund for annual/emerging needs and on-going outcome evaluation

?? Ensure a level playing field for providers across sectors (i.e., in relation to level of adherence required to accountability frameworks, measures used, and technology and training available to deliver against the accountability frameworks)

?? Focus on priority issues within the system multi-year funding accountability framework (e.g., defining who is eligible for services, why and at what level)

3L. E-health strategy

As outlined in early Government communications, the "e-Health Strategy" project includes development of an e-Health Strategy Framework, including securing of technology infrastructure, development of business information strategies and systems including an electronic health record, and development of e-Health plans for the Local Health Integrated Networks.

i. Potential benefits

Implemented *effectively*, the e-health strategy project could:

?? Allow consumers to only have to “tell their story” once

?? Provide potentially faster access to services if consumer information is current, collected and ready for service provider review, together with easy access to updated vacancy lists

?? Reduce duplication of service (e.g., information-gathering, assessments, service provision)

?? Increase efficiency of service provision through service provider access to consistently updated files (e.g., easy access to the most current consumer and clinical perspective and status)

?? Improve the coordination and continuity of care within and across disciplines and sectors

?? Allow for better tracking of service utilization

?? Allow for earlier identification of emerging healthcare needs, trends, and training requirements

?? Allow for better evaluation of system responsiveness and appropriateness of service and support capacity in each local community

?? Empower consumers by allowing them access to their own files

ii. Potential challenges

Planned and/or implemented *ineffectively*, the e-health strategy project could:

?? Compromise informed consent and confidentiality requirements

?? Result in consumers being labeled even more permanently than they already are due to stigma and discrimination against those with mental health and addiction issues within the system

?? Get bogged down in or make inappropriate decisions regarding terminology and process definition and implementation (e.g., what can be recorded, where, and by whom; who “owns” and has access to the consumer information and for what purposes)

?? Challenge smaller organizations to comply due to the costs of upgrading information technology systems to support implementation the e-health strategy

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

?? Advocate individually and as a sector for upgrading of the sector’s information technology capacity now so as to be ready to fully participate in e-health strategy implementation

?? Support connection of existing efforts (e.g., telepsychiatry) to the e-health strategy

- Participate in and pay attention to surveys on e-health needs

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the e-health strategy project, it could:

- Include the unique aspects of electronic documentation of mental health and addiction consumer and service information as a key area of focus within the project
- Review information collection and sharing processes against existing legislation and agency legal requirements to ensure conformity
- Review and leverage the best of existing information security systems (e.g., ATMs)
- Strengthen community mental health and addiction sector organizations to enable them to better and more consistently identify and support their members' needs and contributions to the e-health strategy
- Keep the system as simple as possible as time spent recording information affects the time available to deliver services
- Ensure information provided about the project is in clear, understandable language
- Provide organizations with sufficient resources to implement desired changes (e.g., hardware, software, training tools and supports)
- Establish an aggressive but realistic timeframe for the e-health strategy implementation process

3M. Aligning internal resources

As outlined in early Government communications, the "Aligning Internal Resources" project includes a review of how the MOHLTC is organized to support MOHLTC operations and the Transformation Agenda.

i. Potential benefits

Implemented *effectively*, the aligning internal resources project could:

- Result in the MOHLTC directing its energies and resources to shift the current healthcare system from an illness treatment to a health-promoting model of care
- Shift resources to the local community level in regards to implementation of policy directions, program delivery and outcome evaluation

- Bring mental health and addiction resources in line with those spent on other sectors, and increase the proportion of time and resources spent on education, health promotion and prevention activities
- Rationalize the decision-making and funding process within the MOHLTC which will save consumers, families, and service providers time and money battling selected ineffective and/or non-sensical policies, processes and practices
- Create opportunities to better align MOHLTC policies and practices with those of other Ministries in ways beneficial to consumers and families
- Strengthen the role of consumers, families and the sector in contributing their expertise to MOHLTC work

ii. Potential challenges

Planned and/or implemented *ineffectively*, the aligning internal resources project could:

- Not be effective due to the challenges of long-standing entrenched interests and structural issues (e.g., unions) within the MOHLTC
- Not result in an increased emphasis on mental health and addiction issues because of a continued lack of understanding of the sector's issues within certain parts of the Ministry
- Cause disruption within the sector due to challenges faced by the MOHLTC managing internal change processes and their inherent growing pains

iii. Possible role(s) and contribution(s) for and by the sector

Depending on the specific nature of the project, the sector could:

- Participate as partners in the development of outcome measures and evaluation processes
- Articulate successes in MOHLTC realignment activities as they affect consumers, families and service providers
- Serve as a resource pool for secondments to the Ministry to support its internal realignment efforts

iv. Early thinking and possible implementation suggestions

Finally, as the Government plans and implements the aligning internal resources project, it could:

- Take the time needed to plan the internal change process well before rushing to implementation
- Ensure while the MOHLTC breaks down its internal silos, it still values its unique voices

- Develop strategies to minimize disruption to the system while planning and implementation proceeds (e.g,. actively consult with, maintain and fund small organizations because of their unique perspectives, knowledge and services to diverse, local communities)
- Establish an aggressive but realistic timeframe for the internal change process
- Ensure quality leadership is in place at all levels to manage the internal change process
- Ensure strong communications management processes are in place, particularly to Regional Offices and the field
- Ensure a contingency plan is in place to manage unforeseen setbacks
- Ensure a comprehensive evaluation strategy is in place, to which consumers, families and service providers have contributed

4 Next steps

As described previously, the September 14, 2004 working session was meant to be a starting point for an on-going process of discussion and the development of perspectives and advice regarding the community mental health and addiction sector's role in the transformation of the healthcare system.

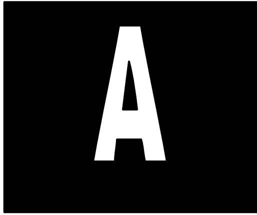
To that end, attendees discussed and agreed to the following next steps:

- Drafting and circulation of a summary of proceedings of the September 14, 2004 session for attendees' review and input [*contained here*]
- Drafting and quick distribution of agreed-upon key messages for the attendees' immediate use [*which took the form of a letter to the Minister which was circulated to host organization members and staff*]
- As needed, further development of sector principles, positions and perspectives into a paper or submission to the Government, steered by the host organization representatives and using ad hoc consultation and reference groups on various topics – participants of whom are to be drawn from those who indicated interest in working further on specific topics and the final product of which is to be circulated to attendees and other host organization members and staff for review and input [*on-going*]. One specific idea generated during discussion of this next step was the development of suggested indicators regarding what successful LHIN implementation would look like and result in if implemented effectively.
- Further discussion and development of sector thinking at currently known organization-specific meetings, including: [*on-going*]
  - CMHA Ontario – October
  - OFCMHAP – November
  - Making Gains Conference Plenary session
  - Government-sponsored sessions (to be scheduled)
- Exploration of other mechanisms to bring the host organization members and staff together going forward (e.g., virtually or otherwise) [*on-going*]

Post script:

Immediately following the working session, host organization representatives drafted a letter to the Minister of Health and Long-Term Care, providing him with an overview of the day's proceedings and a summary of its primary themes. This letter was posted on host organization websites. A public statement from the three host organizations was released in response to the Government's October 6, 2004 announcement, which again drew on the themes generated during the Working Session discussions. Finally, consistent with the next steps outlined in this summary of proceedings, host

organization representatives were also in the process of further synthesizing the ten points listed in section 2 above for review and use by their broader memberships, when the Government issued consultation questions in relation to the Local Health Integration Networks. Facing a short deadline, and using the material generated from the September 14, 2004 working session, the host organization representatives developed and submitted a response to the consultation questions, titled "Local Health Integration Networks: Response to Government Consultation Questions Released October 6$^{th.}$" Please see the document accompanying this summary of proceedings, "Since the September 14, 2004 Working Session," for the letter to the Minister, the public statement in response to the October 6, 2004 announcement, and the response to the Government's consultation questions.



Appendices

A. List of Attendees

B. Agenda

C. Breakout Groups

Making Ourselves Heard
Community Mental Health and Addiction Sector Working Session
September 14, 2004

Appendix A – List of Attendees

Achmatowicz, Jean - Mental Health Implementation Task Force
Adams, Susan - CMHA - Ontario
Alberti, Mary - Schizophrenia Society of Ontario
Allan, Helga - Support and Housing - Halton
Baker, Karen - CAMH
Birnberg, Peggy - Houselink
Black, Nancy - St. Joseph's Care Group
Boyko, Jennifer - CAMH
Bradley, Nancy - Jean Tweed Treatment Centre
Briggs, Linda Trillium Foundation
Brown, Louise - Association of General Hospital Psychiatric Services
Butterill, Dale - CAMH
Campbell, Joanne CAMH
Cant, Irene CMHA - Ontario
Caplan, Michelle - Ontario Hospital Association
Capponi, Diana - CAMH
Caro, Len CMHA - Chatham/Kent
Chambers, Jennifer - CAMH
Cheng, K.W. - Hong Fook Mental Health Association
Cheng, Raymond - OPDI
Chung, Raymond - Hong Fook Mental Health Association
Clark, Carrie - CAMH
Claxton, Teresa - Ontario Association of Patient Councils
Connoy, Martha - Mission Services of London Community Mental Health
Cook, Rose - Halton Peel DHC
Coombs, Michelle - Mainstay Housing
Corea, Larry - CAMH
Coston, Nevin - CAMH
Cripps, Mary Jane - Reconnect
Cunningham, Robert - Mental Health Services Hastings Prince Edward
Czukar, Gail - CAMH
Davies, Bill - Muskoka Parry Sound CMH Service
DeBruyn, Heather - CMHA Elgin Branch

Doherty, Diane - CMHA - Halton
Duncan, Donna - CAMH
Durbin, Janet - CAMH
Elkin, Diehl - WOTCH
Everett, Barbara - CMHA Ontario
Eves, Robert - COPA
Fellinger, Barry - Crest Centre
Finlayson, Brenda - CAMH
Foster, Robert - Wellington Psychiatric Outreach Program
Gagne, Mary-Anik - Canadian Collaborative Mental Health Initiative
Gallacher, Linda - CMHA Durham
Gallianardo, Anna CAMH
Gardiner, Pam - House of Friendship Addiction Services in Waterloo
Garfinkel, Paul - CAMH
Giesbrecht, Norman - CAMH
Goldman-Brown, Rochelle - Chai-Tikvah Foundation
Graveline, Chantel - COTA
Guyton, Alison - Habitat
Hall, Barbara - Health Results Team, MOHLTC
Harrison, Steven - Ontario Medical Association
Helm, Dennis - MOHLTC
Homayun, Cynthia - Chai Tikvah Foundation
Howse, Greg - Simcoe Outreach Services
Huehn, Vicky - FCMHS Kingston
Kardos-Burton, Mary - MOHLTC
Kelly, David - OFCMHAP
Kerr, Heather - Stonehenge
Kish, Stephen - CAMH
Kurzawa, George - CMHA Niagara
Kwok, Marie - Hong Fook Mental Health Association
Lauzier, Marie - York Support Services Network
Lediett, Vernon - Community Mental Health Clinic
Lipski, Ursula - Schizophrenia Society of Ontario
Lurie, Steve - CMHA Toronto Branch
MacKinnon, Marnie - MOHLTC
Macpherson, Scott - MOHLTC
Mann, Karen - CAMH
Martel, John - Mental Health Implementation Task Force

McAllister, Janet - CAMH
McCamus, Michael -Family Mental Health Alliance
Mccool-Philbin, Lisa - Community Counselling Centre in North Bay
McDonald, Leslie - Habitat Services
McGrath, Rita - Minister's Office, MOHLTC
McGregor, Neil - CMHA Ontario
McKinnon, Brian - Alternatives
McReynolds, Joe - Ontario Community Support Association
Miller, Betty - CAMH
Milokavic, Sandy – CMHA Peel
Moll, Sandra - Ontario Association of Occupation Therapists
Moore, Rob - MOHLTC
Nailer, Wendy - Work Adjustment and Employment Support Program
Nason, Jim - LOFT
Notarandrea, Rida - Royal Ottawa Health Care Group
O'mara, John - Addiction Services for York Region
O'Shea, Michael - CAMH
Parsons, Karen - Peel Addiction Assessment and Referral Center
Pautler, Kate - Mental Health Implementation Task Force
Petrenko, Mike - CMHA London
Quick, Natalie - Ontario Association of Occupation Therapists
Quigley, Marion - CMHA Sudbury
Regehr, Tom - Clean & Sober Thinking "CAST"
Rickard, June - CMHA Ontario
Roberts, Adair - Adair Roberts & Associates
Robertson, John - CMHA Huron Perth
Rowley, Deseree - Homeward
Rush, Brian - CAMH
Santalab, Lillian -CAMH
Santamaura, Joyce - Family Mental Health Alliance
Sarang, Aseefa - Across Boundaries
Scanlon, Liz - CMHA Ontario
Schroen, Angela - CAMH
Selby, Peter - CAMH
Shanks, Judy - CMHA Cochrane Timiskaming Branch
Shaw, Sheila - CMHA - Fort Frances
Sidle, Nancy - COTA
Silver, Ellen - Minister's Office, MOHLTC

Simpson, David - Psychiatric Patient Advocate Office
Singer, Brenda - Progress Place
Skinner, Wayne - CAMH
Smither, Susan - CAMH
Stevens-Lavigne, Andrea - CAMH
Stevenson, Alan - CMHA Sarnia
Stockman, Sandy - Grey Bruce Community Health Corporation
Szathmary, Tunde - Family Mental Health Alliance
Szymezko, Chris - Support & Housing Halton
Teskey, Patricia - Schizophrenic Society
Tucker, Terrie - CAMH
Van Vliet, Elsa - MOHLTC
Vincent, Susan - DART
Weary, Walter - Community Resources Consultants of Toronto
Wereley, Trevor - CAMH
Whyte, Ron - Community Care Durham
Winger, Charlene - North Halton Mental Health Clinics
Witkowski, Brigitte - Mainstay Housing
Wolfe, Julie - CAMH
Wright, Marion - CMHA Ottawa
Zakoor, Colleen - CMHA York Region
Zarebski, John - CAMH
Zegarac, George - MOHLTC
Zosky, Jennifer – Reconnect Mental Health Services

Making Ourselves Heard

Community Mental Health and Addiction Sector Working Session

Appendix B – Agenda

September 14, 2004

1. Welcome and introductions

8:30 am *Coffee and light breakfast*

9:00 am Welcome, introductions and overview of the day's agenda

- ?? Barbara Everett, CEO, CMHA Ontario
- ?? Paul Garfinkel, President & CEO, CAMH
- ?? David Kelly, Executive Director, OFCMHAP

2. Background and context

9:15 am Overview of the Ministry of Health and Long-Term Care's Transformation Agenda

- ?? Presentation by Mr. George Zegarac, ADM, Community Health Division and Ms. Mary Kardos-Burton, ADM, Acute Services Division
- ?? Questions and answers

10:15 am *Break*

3. Implications for the sector

10:30 am Implications for the Community Mental Health and Addiction Sector

- ?? Group discussion

11:00 am Call from The Honourable George Smitherman, Minister of Health and Long-Term Care

11:15 am Implications for the Community Mental Health and Addiction Sector (cont'd)

- ?? Group discussion

12:15 pm *Lunch and presentation by Mr. Dennis Helm, Director, Office of Strategic Projects*

4. Transformation projects

1:00 pm Introduction to the afternoon's agenda

1:10 pm Transformation Projects – potential impact on and role for the Community Mental Health and Addiction Sector

- ?? Breakout groups

3:00 pm *Break*

5. Summary and next steps

3:15 pm Summary and next steps

4:00 pm *Meeting adjourns*

Making Ourselves Heard

Community Mental Health and Addiction Sector Working Session

Appendix C - Breakout Groups

Group	Topics	Members	Location
A	??System Multi-Year Funding ??eHealth Strategy	??Adams, Susan ??Allan, Helga ??Black, Nancy ??Briggs, Linda ??Connoy, Martha ??Coombs, Michelle ??Corea, Larry ??Elkin, D. ??Gallacher, Linda ??Gallianardo, Anna ??Garfinkel, Paul ??Goldman-Brown, Rochelle ??Helm, Dennis ??Lurie, Steve ??Martel, John ??McReynolds, J. ??Moll, Sandra ??Shanks, Judy ??Schroen, Angela ??Silver, Ellen ??Wright, Marion	??Boardroom 209 (upstairs) ??*Witkowski, Brigitte – Facilitator*

Group	Topics	Members	Location
B	??Family Health Teams ??Chronic Disease Prevention and Management Framework	??Boyko, Jennifer ??Bradley, Nancy ??Brown, Louise ??Chung, Raymond ??Cripps, Mary Jane ??Cunningham, Robert ??Fellinger, Barry ??Foster, Robert ??Guyton, Alison ??Lauzier, Marie ??Lipski, Ursula ??McCamus, Michael ??Nason, Jim ??Pautler, Kate ??Regehr, Tom ??Rickard, June ??Stevens-Lavigne, A. ??Van Vliet, Elsa ??Wereley, Trevor ??Wolfe, Julie	??Boardroom 210 (upstairs) ??*Duncan, Donna – Facilitator*
C	??Health Human Resources ??Critical Care Capacity	??Baker, Karen ??Cannon, Suzi ??Caplan, Michelle ??Capponi, Diana ??Clark, Carrie ??Cook, Rose ??Doherty, Diane ??Hall, Barbara ??Kardos-Burton, Mary ??Harrison, Steve ??MacKinnon, M. ??McCool-Philbin, Lisa ??McGrath, Rita ??McGregor, Neil ??Miller, Betty ??North, David ??Notarandrea, Rida ??O'Mara, John ??Singer, Brenda ??Smither, Susan ??Stevenson, Alan ??Stockman, Sandy ??Weary, Walter	??Boardroom 211 (upstairs) ??*Everett, Barbara – Facilitator*

Group	Topics	Members	Location
D	??Quality and Accountability ??Managing Drug Program Growth	??Alberti, Mary ??Cant, Irene ??Caro, Len ??Cheng, Raymond ??Eves, Robert ??Gagne, Marie-Anik ??Graveline, Chantel ??Howse, Greg ??Huehn, Vicki ??Kerr, Heather ??Kish, Stephen ??Macpherson, S. ??McKinnon, Brian ??Parsons, Karen ??Petrenko, Mike ??Rowley, Deseree ??Rush, Brian ??Teskey, Patricia ??Tucker, Terrie ??Whyte, Ron	??Ballroom ??*Czukar, Gail – Faciltator*
E	??Investing in Community ??Reduced Wait Times Framework	??Achmatowicz-MacLeod, J. ??Birnberg, Peggy ??Butterill, Dale ??Claxton, Theresa ??Coston, Nevin ??Davies, Bill ??DeBruyn, Heather ??Durbin, Janet ??Finlayson, Brenda ??Homayun, Cynthia ??Kurzawa, George ??Kwok, Marie ??Lediett, Vernon ??McDonald, Leslie ??Moore, Rob ??Nailer, Wendy ??Quigley, Marion ??Robertson, John ??Santamaura, Joyce ??Shaw, Sheila ??Skinner, Wayne ??Vincent, Susan ??Winger, Charlene	??Ballroom ??*Campbell, Joanne - Facilitator*

Group	Topics	Members	Location
F	?? Aligning Internal Resources ?? Population Health ?? Public Health Renewal	?? Chambers, Jennifer ?? Cheng, K.W. ?? Gardiner, Pam ?? Giesbrecht, Norman ?? McAllister, Janet ?? Milakovic, Sandy ?? O'Shea, Michael ?? Quick, Natalie ?? Santalab, Lillian ?? Sarang, Aseefa ?? Scanlon, Liz ?? Selby, Peter ?? Sidle, Nancy ?? Simpson, David ?? Szathmary, Tunde ?? Szymezto, Chris ?? Zegarac, George ?? Zakoor, Colleen ?? Zarebski, John ?? Zosky, Jennifer	?? Boardroom 212 (upstairs) ?? *Kelly, David - Facilitator*