

Succeeding in Mental Health Reform: Critical Elements

**Centre for Addiction and Mental Health (CAMH)
Response to
Toronto-Peel Mental Health Implementation Task Force**

October 2002



Centre
for Addiction and
Mental Health
Centre de
toxicomanie et
de santé mentale

Succeeding in Mental Health Reform: Critical Elements
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TABLE OF CONTENTS

Introduction 1

Process 2

Key Messages 3

Positive Aspects of the Report 3

Critical Success Factors 4

Client Centred Care 4

Service/Program Delivery 4

System Integration 5

Accountability 6

Research and Education 7

Health Promotion, Public Policy and System Support 8

Other Factors 8

Priorities for Action 9

Criteria-based Assessment of Recommendations 10

Client Centred Care 10

Service/Program Delivery 12

System Integration 13

Accountability 14

Research and Education 15

Health Promotion, Public Policy and System Support 16

Appendix A Summary of the Recommendations from Building the System to Make It Happen 18

Appendix B Assessment Criteria Developed by CAMH..... 21

Appendix C Summary of Research on System Integration 24

Appendix D Board Resolution 26

Endnotes 30

Introduction

The Centre for Addiction and Mental Health (CAMH) wants to be an active voice in shaping the future mental health and addictions system in Ontario. Mental health reform in Ontario has been underway for years. Current work is based on: *Putting People First: The Reform of Mental Health Services in Ontario* which outlines a policy framework for reform;¹ *Making It Happen: Implementation Plan for Mental Health Reform* which provides an implementation plan;² and, *Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario* which describes improvements to addiction treatment services.³ As well, the Health Services Restructuring Commission made recommendations to the Minister of Health to build a community-based mental health system in Ontario which included the establishment of nine regional implementation task forces.⁴

The Minister established the Task Forces and the Toronto-Peel Mental Health Implementation Task Force (the Task Force) has released its phase two report for consultation. The Task Force describes the current mental health system as one in which there "is a significant need to enhance the service and support continuum in specific areas, with a particular emphasis on housing and housing supports, educational and vocational services and supports and peer supports," and that there "is a significant need to improve service and support accessibility and delivery so that it is much more co-ordinated and integrated."⁵ The report contains recommendations to improve co-ordination and integration of mental health services and supports in the Toronto-Peel region and proposes a new governance and management model for the region. A brief summary of the Task Force's recommendations can be found in Appendix A. The Task Force has asked for feedback on its work to date.

In advance of the release of the Task Force report, the Board of CAMH approved a set of criteria to be used to assess the advantages and disadvantages of future models of governance and the re-organization of services. These criteria were developed under the following categories:

- Client centred care;
- Service/program delivery;
- System integration;
- Accountability;
- Research and Education;
- Health Promotion, Public Policy and System Support.

The criteria were based upon important principles articulated in CAMH's 1999 strategic plan;⁶ CAMH's 2002 functional program;⁷ board discussions on system integration and regionalization; research evidence from the mental health integration literature;⁸ and the objectives set out in the

provincial government's mental health policy documents as referenced above. More detailed information about the criteria can be found in Appendix B.

Process

A Working Group consisting of CAMH Staff and Board members met on three occasions to review the proposals of the Mental Health Implementation Task Force in accordance with the criteria approved by the Board of Trustees and to provide a report to the Board based on this review. This group was comprised of:

Board Members:

- Jamie Anderson
- Daniel Burns
- Betsy McKelvey
- Marnie Shepherd

Staff:

- Joanne Campbell
- Peter Coleridge
- Gail Czukar
- David Goldbloom
- Georgina Veldhorst
- Dale Butterill (Advisor)

Consultant & Writer

- Cathy Fooks

The Board considered this group's report and, after full discussion, approved the motion set out in Appendix D as its response to the Task Force proposals.

Overview of this Response

This document is organized as follows:

- *Positive Aspects of the Report*: this section outlines the overall elements of the Task Force's report that CAMH supports.
- *Critical Success Factors*: the section outlines the conditions under which reform of the mental health and addiction systems could proceed.
- *Priorities for Action*: this section suggests immediate priorities for government action regardless of governance models.
- *Criteria-based Assessment of Recommendations*: this section assesses the recommendations in the report using the criteria developed by CAMH.

Key Messages

- CAMH commends the Task Force for its comprehensive and thoughtful work
- CAMH supports many of the recommendations contained in the report
- CAMH believes that critical success factors must be in place to achieve real reform
- CAMH sees real opportunities for improvements in consumer and system outcomes that could be achieved immediately regardless of changes in governance and management models
- CAMH commits to continue working with the Task Force and others to move reform forward

Positive Aspects of the Report

CAMH supports many aspects of the Task Force's report.

- We agree that mental health issues have not received the funding nor profile of other health issues and that stigma and discrimination are significant barriers to reform;
- We agree that mental illness is different from physical illness and thus the responses need to be different;
- We agree there is a need for sizeable investments and that commitment is required to protect the funding base, particularly when attempting to increase community capacity;
- We agree with a client centred approach based on a focus on recovery and the important role of families;
- We agree that an appropriate range and capacity of services and supports is not currently in place and that realignment must occur;
- We agree that existing services and supports are fragmented and hard to access;
- We agree there is insufficient collaboration and coordination among providers and funders;
- We agree there is a need for increased accountability through performance measures based on outcomes and a regular evaluation process;
- We agree that within the funding base, specific funds must be designated for health promotion programs and the development of health promotion plans;
- We agree with the linkage between treatment and determinants of health such as housing and employment;
- We agree with the importance of research, education and the need for investments in evaluation research as well as knowledge transfer activities;
- We agree with a focus on system planning rather than individual agency planning and with citizen-based decision making structures to undertake the work.

Critical Success Factors

The Task Force has outlined a series of reform proposals to reorganize services at the local level and create a new management and governance model regionally. A number of factors must be in place to implement reforms effectively and to demonstrate improvements over current arrangements. These factors are critical to achieving success and without them, real improvements in the quality of life for clients will not occur. They are based on our Board discussions and a review of the literature.⁹

Client Centred Care

- *Client Choice Must be Protected*

CAMH supports the proposal to streamline access to the system through a reorganized information and referral system. However, centralized information and referral services should not limit the range and capacity of services and programs available to clients and client choice must be protected.

- *Commitment to Multi-cultural Services and Programs*

Toronto and Peel have a diverse population. It is imperative that an appropriate range of culturally-sensitive services and programs are available in each of the local areas envisioned in the Task Force report. This is especially important in a centralized information and referral system.

- *Commitment to Services Close to Home*

Any reorganization of local services, programs and agencies must adhere to the principle that clients can receive services close to home. Restructuring at the local level should not lead to increased travel for clients to access services or programs and a commitment is required to uphold this service benchmark.

- *Clarify the Appointment Process*

The Task Force states there will be an initial appointment of clients and family members to the regional mental health board but does not state how individuals will be selected, how long they will serve on the board or what is to occur after the initial appointment process. Clear guidelines are required for the appointment of regional mental health board members and their terms of office.

Service/Program Delivery

- *Inclusion of Addiction*

The Task Force has not included a focus on addiction issues. This is a serious oversight given the high rate of concurrent disorders between addictions and mental health and given that the government has recently merged the mental health and addiction portfolios within its own administrative structure. Addiction services and programs must be included in any new system for mental health reform.

- *Criteria for the Selection of Lead Agencies*

The Task Force has proposed the selection of lead agencies at the local level for information and referral, and for case management, but it has not indicated how those agencies will be chosen. Clear criteria are required for the selection and funding of these agencies. As well, a review and evaluation process should be specified to assess effectiveness.

- *Provide Costing Information and Determine the Regional Budget*

The Task Force has not outlined what it views to be the current budget allocation for the Toronto-Peel region nor has it described how that envelope should be determined. Funding that is currently distributed through a variety of programs would have to be pooled into one envelope over which the regional mental health board would have allocative authority. Alternate mechanisms need to be explored to more closely align physicians and hospitals with the mental health and addiction system given their extremely important role in front-line care. As well, a plan is needed to deal with the non-institutional drug costs currently covered through the Ontario Drug Benefit Plan and services provided through non-Ministry of Health and Long-term Care programs.

CAMH applauds the Task Force for insisting the provincial government protect mental health and addictions dollars. However, we note that this commitment has been made in the past, only to see mental health services cut back during restructuring efforts.

System Integration

- *Facilitate Clinical Integration*

The Task Force has focused on service agreements with providers of clinical services and the sharing of clients, resources and best practice information as a way of reorganizing services at the local level. It does not appear to be envisioning clinical integration. International research suggests that integrating providers at the corporate level has no relationship to integration at the local patient-care level and it is clinical integration that is crucial to improving client outcomes.¹⁰ A clear plan for the integration of clinical services (not just purchase of them) is needed.

- *Provide Appropriate Resources*

The research literature and the Ontario experiences with the Health Services Restructuring Commission make it clear that adequate resources are required to support the integration process. Resources are required up front for transition work and for infrastructure requirements. The Task Force has identified the need for these resources but there is no dollar amount at this point. Specific funding proposals are needed.

- *Specify the Size of Local Delivery Networks*

The size and scope of the network appears to influence the likelihood of success. Research to date indicates that smaller communities appear to have been more successful with integration over larger communities. Thus, models will need to be "sized" appropriately. Durbin et al state "it seems to help if the number of existing community mental health services organizations is not too large. While efforts to streamline access and integrate services are evident in almost all regions of Ontario, the least progress seems to have been made in Toronto, by far the largest and most densely populated service area."¹¹ More work is needed to determine the appropriate size of local delivery networks.

Accountability.

- *Clarify Sector-specific Governance Authority in the Absence of Overall Regionalization in Health Care*

Ontario is the only Canadian province that has not moved towards regional delivery of health care.¹² Therefore, it is not clear how a sector-specific governance authority will operate in a jurisdiction without other regional authorities for the general health care system. Most provinces with regional authorities include mental health in the funding envelope and service responsibility thus integrating mental health services and programs with the rest of the health care community.¹ The Task Force must make clear how it envisages the regional mental health board working with other parts of the health care system such as primary care, home care and long term care. Without these linkages, there will not be integration or continuity of care for clients.

- *Provide Legal Authority for the Regional Mental Health Board*

The Task Force clearly envisions the Board will be given authority through legislation. How will this legislation fit with authorities given to others through existing statutes such as *The Ministry of Health Act*, *the Public Hospitals Act* and *The Regulated Health Professions Act*? The

¹ Alberta and New Brunswick exclude mental health services from the regional health authority but have provincial level agencies specific to mental health. Manitoba includes mental health services in the regional health authority ambit but excludes addiction services, which are centralized.

regional mental health board will require the authority to realign or merge local services, settle disputes with or between local service providers, and with the Ministry of Health and Long-term Care. It will also need the authority to negotiate directly with health care organizations such as the OMA and unions such as CUPE, ONA or OPSEU.

Accountability and protection for sharing client information, clients, resources and responsibility for system performance must also be given to the Board in legislation.

- *Clarify Roles*

Local mental health networks are to provide input to the regional board. Advisory councils are to provide input to the regional board. The regional board is to provide input to the Ministry of Health and Long-term Care. A provincial coordinating group and a management information network are to provide coordination and oversee parts of implementation. Clients, families and providers are to be involved in some structures but not all. These roles need to be clarified and decision making authority needs to be clear.

- *Assess the Fit of a Contractual Approach with Insurance-based Funding*

Under the redesigned system, service delivery will occur through contracts between the regional mental health board and local service providers. How does the Task Force envision a contractual approach, based on agreed to service targets and funding, fitting with an insurance system in which eligible citizens are entitled to service when they need it? The Task Force must identify how the contracts will deal with the possibility that service utilization levels exceed funding agreements. We do not want to repeat the experience of community care access centres.

- *Clarify Arm's Length Relationships*

The Task Force stresses that the regional mental health board will maintain an arm's length relationship with the provincial government. Yet, how will such a relationship be maintained when the Ministry of Health and Long-term Care approves the strategic plan and the business plans, and allocates the funds? The Task Force needs to specify who has final authority and accountability for funding and allocation decisions.

- *Clarify the Role of District Health Councils*

District Health Councils are currently mandated to undertake local and regional planning and provide advice to the government on resource allocation. Durbin et al identified the role of the District Health Council as important and the need for strong leadership at that level.¹³ The Task Force does not reference the District Health Council at all in its document.

The Task Force needs to clarify whether or not it feels the DHCs have a role in mental health service and program planning.

Research and Education

- *Assess the Fit of Provincial Functions at the Regional Level*

The Task Force stresses the importance of education and research as part of knowledge transfer but does not indicate how a local and regional funding model would be able to support resources for education and research which have traditionally been funded at the provincial level. Nor does the report indicate how these activities will be co-ordinated with other research programs. The Task Force needs to specify a clear plan for setting research and education priorities at the provincial, regional and local level and outline how funding will be allocated.

- *Provide an Evaluation Process*

The report does not outline a time frame within which the proposals would be evaluated. The Task Force must specify a period of experimentation with an evaluation at the end. As well a sunset clause is required if the evaluation deems the new arrangements to be harmful or ineffective.

Health Promotion, Public Policy and System Support

- *Integrate the Role of Health Promotion and Prevention Programs*

The Task Force treats health promotion and prevention programs as "system supports" and not as elements of system design. CAMH views health promotion and prevention programs as part of the mental health and addiction system. They should not be treated independently and should be included as part of the system design recommendations.

Other Critical Success Factors

In addition to the criteria developed by CAMH, Durbin et al identified further factors for success.¹⁴

- *Provide a Longer Time Frame*

System integration isn't easy and requires a long time horizon. Rushing into the process without allowing all involved to get used to the idea and plan changes creates problems. The Task Force has proposed a 2-year time for transition work. This is not enough time given the size of the communities involved. A longer transition plan and implementation period is required.

- *Involve Providers*

The involvement of service and program providers from the beginning of the process is a crucial part of implementation success. They need to be full participants. The Task Force feels that they should be involved through contract arrangements but not part of the decision-making structure as the regional level. There is to be a professional/provider advisory council to provide input to the regional board. This gives the appearance of viewing these constituencies as service providers but not partners in the integration process. These providers must be part of the reform discussion from the start.

- *Overcome Resistance*

System integration means that relationships amongst providers, clients, government and others will change. In some cases, this will mean a loss of autonomy and there will be resistance. This needs to be explicitly identified and overcome. Supports will be required to spend time developing consensus, providing regular communication about progress, and continually checking with the stakeholders on their views. The Task Force identifies a number of risks in moving forward but does not mention expected resistance to change. Authority and incentives must be provided to the regional mental health board to move the process forward.

- *Provide Leadership and Political Will*

Leadership and political will is required from the clinical leaders, provider organizations and government. Respected clinical leaders provide bridges to the broader clinical community and given that integrating clinical care is also one of the success factors, those bridges will be vital throughout the integration process. Government leadership is also crucial. If government is seen to be less than enthusiastic about the process or only willing to implement selective aspects of reform, the process is unlikely to succeed.

Priorities for Action

Many of the proposals in the Task Force report are supported by the available research evidence and make intuitive sense. CAMH agrees with the philosophic approach, the need for streamlined access to comprehensive services, and more investments in mental health services, health promotion programs and system supports. Better co-ordination and integration of services that are more accountable to clients, families, providers and citizens are required. The mechanisms to achieve these goals will be debated for some time.

While the debate unfolds, CAMH believes there are a number of areas where action could be taken now, regardless of new governance models, which would greatly improve the quality of life for people with mental illness and addiction.

1) Invest in Supportive Housing and Housing Supports

The Task Force is right in identifying the need to increase the amount of affordable housing and housing supports. The federal government has indicated in its recent Speech from the Throne that it will work with provinces to create more affordable housing. The Ontario Government should not wait until other aspects of mental health reform are underway to begin development of new housing stock and housing support programs.

2) Improve Access to Services and Programs

The Task Force is right in identifying the need for a centralized information and referral system. Investments could begin now to put this in place. We do not need to wait to sort through the governance and management models to create the database and infrastructure required.

3) Invest in Early Intervention

Early intervention and first episode programs have a crucial role to play in assisting young people with mental illness to achieve the highest possible level of recovery, and in minimizing the impacts of early episodes of mental illness. Programs for young people and their families will also increase the cultural competence of the system and should be given much more support immediately.

4) Invest in Employment

Employment and educational supports are key determinants of mental health and should be made a significant priority for immediate investment by the government. Programs must be supported to assist people with mental illness and addictions to obtain and retain meaningful paid work through episodes of illness. Education and other efforts are needed with employers, as well as the general public, to address stigma and discrimination as part of an employment strategy.

5) Invest in Information Systems

The Task Force is right in identifying the need for better coordination of services and measurement of outcomes and the need for a provincial information system. Part of the reason for not achieving these system goals to date has been the lack of management and decision support information systems. Managers in the mental health and addiction system have had very little ability to track and compare service and outcome data. Work should begin immediately on developing the infrastructure for a mental health and addictions management information system. Both the federal and provincial governments are funding the development of health information highways and some of the resources should be devoted to the mental health and addictions area.

Criteria-based Assessment of Recommendations

The criteria developed by CAMH are assessed below using the evidence from the research literature on system integration. (This has been summarized in Appendix C.)

Client Centred Care

The new model must ensure that client centred care is a priority for redesigned services or a new governance structure. CAMH has defined a client centred focus as "reflecting an active partnership between the person receiving care and the providers of care which recognizes that the client is a whole person with social, physical, emotional, spiritual and psychological needs who, wherever possible, will make informed choices about his/her care."¹⁵ A successful model that is client centred would:

- improve client outcomes;
- improve client choice in services and supports, including health promotion programs;
- promote client advocacy;
- promote the participation of clients in the planning, provision and governance of services, as well as their own individual service plans;
- ensure that clients are represented in the governing structure;
- ensure the participation of family members of clients;
- promote the values of diverse cultures;
- reflect a broad definition of health;
- promote best practices (e.g. that benefit clients).

Overall, CAMH feels the Task Force has clearly focused on designing a system and a governance model that is client centred. The easy points of entry to the system, the organized network of service providers, the individualized funding formula, the composition of the regional mental health board and the involvement of clients in decision making structures, the creation of advisory councils, the recognition of the importance of the role of families, all support a client centred approach. However, there are a few points of caution.

First, is the issue of linking system integration to improved client outcomes. The Task Force makes it clear that its recommendations are made in the hope of making the system "centred, first and foremost, on supporting consumers' recovery," to "improve the quality of life of all people and their families living with serious mental illness" and achieving "excellent consumer need-driven outcomes."¹⁶ This is important philosophically but CAMH cautions the Task Force to be clear that the impacts of system integration on long-term individual client outcomes have yet to be demonstrated.¹⁷

Second, we raise the issue of how centralized information and referral affects client choice. It will certainly simplify the first point of contact for clients and their families and will hopefully increase rapid access to needed services. CAMH supports the idea of a "211" information line and a network of providers available to clients and is already working on the development of such a service. However, we will need to monitor the service carefully to ensure it does not limit choice of provider once needs have been determined.

Third, clients and family members will be members of the regional mental health board, although the Task Force has not indicated how they will be selected from a local list. As well, the Task Force has proposed a client advisory council and a family advisory council for the regional mental health board. It is not clear what role these councils play and it is not clear why there are separate councils for each group and we question whether perpetuating these silos is the best way to integrate advice.

Fourth, CAMH has included an indicator in its list to assess whether the recommendations support a diversity of cultures. It is crucial that any reorganization of local services does not minimize the importance of culturally-sensitive services and programs.

Service/Program Delivery

In any reorganization of services or programs or under any new governance arrangements, the impact on current service delivery must be assessed carefully. A number of impacts should be examined -- service accessibility to existing and new clients, the location of services and programs vis-à-vis the location of clients, the effect on continuity of care and in particular what happens to specialised treatment programs, and the role of health promotion programs. A successful model would:

- improve access of clients to services, including those currently not accessing services;
- provide services closer to home for clients;
- minimize the amount of time clients spend away from home;
- enhance the capacity to provide a very wide range of services, treatments and client supports, including housing, social supports, self-help programs, and family support programs;
- enhance specialised and intensive services;
- refocus and balance system resources to ensure that they serve people with serious and persistent mental illness;
- support health promotion programs;
- enhance continuity of care for clients;
- be based on good evidence and best practice information.

Overall, the Task Force has indicated its recommendations are to improve accessibility, comprehensiveness and integration, and will be evidence and community-based.¹⁸ CAMH supports all of these ideas. Again, a few cautions.

First, it is not clear from the Task Force report how individuals not currently accessing services will be more likely to access services under this redesign. There is reference to provincial level media campaigns but these generally do not reach hard to reach populations.

Second, it is not clear how the creation of local networks will occur and thus it is hard to assess whether clients will be closer or further away from services. The Task Force should establish a principle that local means close to home.

Third, the report references the need for improved intensive and specialised services but leaves the acquisition of those services to the regional mental health board through a service agreement with local providers. How will this occur if the services are not available locally?

Fourth, the report does describe a levels of service approach but does not address the need for psychiatric beds vis-à-vis alternatives in the community. The linkage between supportive housing and other community-based supports and the utilization of psychiatric beds needs to be made more strongly.

Fifth, the generation of knowledge and best practice information and the monitoring of usage appear to be at the provincial and regional levels. Yet, service and program delivery is at the local level. It is not clear how the dissemination occurs and what the monitoring mechanisms will be.

System Integration

A number of definitions exist for system integration efforts. Shortell et al have defined an integrated system as a "network of organizations that provides or arranges to provide a co-ordinated continuum of acute, ambulatory and non-acute residential care services to a defined population, and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."¹⁹ Devers et al have defined it as "the extent to which patient/client care services are co-ordinated across various functions, activities and units of operation."²⁰ Successful system integration would:

Succeeding In Mental Health Reform: Critical Elements
CAMH Response to the Toronto-Peel Mental Health Implementation Task Force

- improve service coordination at the local and regional levels;
- improve linkage between local and provincial-level program/service providers;
- facilitate providers working together to create a seamless care continuum;
- improve shared treatment planning;
- improve co-operative health promotion programming;
- include specific proposals for transition processes between providers, programs, and communities;
- identify specific linkages with addiction services;
- identify specific linkages with primary care services;
- improve linkages with the broader community of services and supports – social services, housing, employment, counseling, etc;
- decrease duplication and multiple points of entry;
- be given sufficient legal authority or other incentives to effectively manage the integration process;
- not be unduly costly to implement.

Overall, the Task Force has made recommendations that fit with the research evidence at a general level -- that is, they recommend an arm's length manager with pooled funds and performance targets to provide services for a defined population. However, the Task Force has not outlined its reasoning in the choice of a regional authority as the governance mechanism as opposed to other integration models such as an umbrella group or consolidating organizations.

The indicators CAMH developed for system integration focus largely on linkage to others -- how will primary care, long term care, home care, and addictions services be linked to mental health services? As the regional mental health board will not have an equivalent partner in these other care domains, it is therefore not clear who would be negotiating service agreements, linkages, and funding arrangements locally.

Second, it not clear whether the regional mental health board will have the legal authority to mandate local networks. The report does reference service alignment and mergers but is it the Task Force's intent that the Board could legally require these reforms?

Third, the report lacks costing information and it is therefore not possible at this point to estimate the costs involved during the transition phase and beyond. If we look to the lessons from the Health Services Restructuring Commission, we should not expect cost savings from consolidation and the transition monies will need to be identified and provided early on in the process.

Accountability

Increasingly, we hear calls for improved accountability in health care - citizens want open and transparent governance structures and they want to understand how their tax dollars are being spent.²¹ Thus, any new proposals for service integration should be assessed on the basis of how they improve accountability to clients, providers and citizens. An accountable system would:

- clarify the roles and responsibilities of the provincial government, any proposed new governance structures, service providers, and health professionals;
- improve accountability to clients and families;
- improve accountabilities for service delivery, program design, funding, policy and planning;
- increase the cost-effectiveness of services and programs;
- identify performance expectations;
- include proposals for measuring performance expectations;
- protect and enhance mental health and addictions funding;
- ensure that investments and re-investments in mental health and addictions services will support reform;
- ensure that investments and re-investments will increase capacity for the overall mental health and addictions system;
- increase equity in resource allocation and distribution;
- improve the quality of information about clients, services and programs;
- promote knowledge transfer programs;
- improve information gathering and dissemination;
- include proposals for evaluation of the new model itself.

Overall, the Task Force has outlined a general approach to establishing who is responsible for what. The Ministry of Health and Long-term Care is responsible for setting policy, establishing service levels, creating the funding envelopes and protecting the funding base, and monitoring the regional and local systems against standards and policy. The regional mental health board is responsible for allocating the funding envelope at the local level, contracting with service providers, monitoring performance targets, integrating local services, and ensuring client and stakeholder input. The local providers are responsible for delivering streamlined services and reporting service and outcome information to the regional mental health board.

Within this mix, however, some accountabilities are not so clear. How are disputes between the levels to be resolved? Who is accountable for labour relations negotiations? Who has final budget authority - the Ministry or the regional mental health board?

Second, what is the relationship between the provincial co-ordinating committee, the provincial information management network and the regional mental health board? It would appear that mental health promotion plans and information management strategies will be developed at the provincial, not regional, level. If so, does this presuppose a uniform structure regionally?

Third, a number of advisory structures are proposed -- the client, family and provider advisory councils to the regional mental health board as well as the local delivery networks to provide input to the regional board. What is the relationship of all these structures and how will the board deal with conflicting inputs?

Fourth, the report states that the regional mental health board will be "charged" with advocating in other areas of government to resources dedicated to mental health. We wonder how effective this will be given that the health budget is already larger than any other provincial spending envelope.

Fifth, as mentioned previously, the report does not propose an evaluation strategy for the new model. In order to be accountable, this will be required.

Research and Education

An integrated service system (and the services and programs that comprise it) must be able to demonstrate that it supports innovative change, is based upon the best evidence available and includes a continuous improvement culture in its plans for the future. This requires excellence in research, scholarship, education and transfer of knowledge. CAMH has always been committed to excellence and leadership in these activities.²² Research, education and other activities that support the transfer of knowledge and information to service providers across the province may be viewed by a local authority as less important than pressing local service issues, but they must be considered by CAMH in thinking through its role with respect to any future governance model. A successful integration model would:

- promote and expand research in mental health and addictions;
- ensure support for a broad range of research, including basic, clinical, service delivery, and social/prevention policy issues in mental health and addictions;
- promote broad-based education and teaching in mental health and addictions and in related areas (e.g. dual diagnosis, concurrent disorders);
- include a provincial focus for a generator and disseminator of new understanding, treatments and health promotion programs for mental illnesses and addictions.

Overall, the Task Force has recognized the need for more resources dedicated to research, education and evaluation of new initiatives. This is an important step forward. What is not clear, however, is where the investments will reside and how research and education priorities will be determined. Is the provincial committee setting these priorities or is the regional mental health board identifying what it needs? It appears both are expected to identify priorities and fund activities.

Second, the regional mental health board will presumably focus on its region as the area in which it must support knowledge generation and transfer. However, if the provincial system would benefit from these activities, does the region have a responsibility to share knowledge at the provincial level?

Health Promotion, Public Policy and System Support

CAMH also has an important role in providing leadership in health promotion, influencing change through public policy development, and improving the quality and accessibility of addiction and mental health services.²³ Although these types of activities may be viewed as less important than pressing local service issues, they are essential to the development and maintenance of successfully integrated systems throughout the province, as well as to the ongoing support of reform in mental health and addictions. A successful model would:

- facilitate system and community partnerships in developing evidence based health promotion programs;
- facilitate system and community education and outreach across the province to ensure excellence in research, scholarship and education;
- include a provincial focus for a policy voice and advocate for the needs of mental health and addiction clients and the system in general;
- facilitate the sharing of knowledge in treatment and health promotion to improve the quality and accessibility of client services, integration of the system, and innovation.

Overall, the Task Force has identified these elements as important parts of the new system and appears to have placed responsibility with the provincial co-ordinating committee. But again we are not clear on how this links to local identification of needs and regional responsibility for planning and implementation.

Appendix A

Summary of Recommendations **From Building the Systems to Make it Happen** **Report of the Toronto-Peel Mental Health Implementation Task Force**

The Toronto-Peel Mental Health Implementation Task Force (the Task Force) was established to recommend how to implement a restructured mental health system for Toronto and Peel.

Specifically it was to:

- Create mental health systems that are comprehensive, integrated, accessible and accountable;
- Support directives from the Health Services Restructuring Commission with respect to increased community capacity for people with serious mental illness.

The Task Force has made recommendations to change both current service delivery and current governance and management structures.

Service Delivery Recommendations

These recommendations focus on redesigned services at the local level to streamline access for individuals and their families, integrate services, and ensure a comprehensive continuum of supports and services. Local care delivery systems would be created containing the following functions:

- A "211" information line to provide information about available services;
- A lead agency for information and referral (roll over from various phone lines) networked to local providers;
- Selected organizations to undertake intake and triage networked to local providers;
- Networked emergency rooms and crisis response system;
- Regional bed registry;
- Service agreements with Schedule 1 hospitals and community agencies;
- A lead agency for intensive case management;
- Integration of intensive case management, assertive community treatment teams and housing support services;
- Established protocols for access to housing and housing supports;
- Enhanced access to psychiatric and primary care mental health services through incentives for shared care and establishing increased Community Health Centre capacity;
- Established protocols for access to specialised services;
- Population-based funding tailored to individual needs;
- Establish a local care delivery network as a forum for local input to regional decisions (there are to be six of these -- four in Toronto and 2 in Peel);

These local care delivery systems would be accountable to a regional mental health board for delivering services through performance contracts and would be required to report performance and outcome information to the Board on a regular basis.

Governance and System Management Recommendations

These recommendations focus on creating a regional mental health board to oversee system capacity and monitor results. The Board would be responsible for:

- Allocating a regional budget envelope at the local level - a dedicated portion must be earmarked for mental health promotion, human resources and information management;
- Establishing performance indicators and monitoring local service providers against them;
- Facilitating linkage with primary care, long term care and other associated systems such as child and family services or corrections;
- Submitting strategic plan and annual business plan for the region to the Ministry - this must include a mental health promotion action plan;
- Develop the local care delivery systems through establishing networks, alliances and mergers and consolidations where appropriate.

Initially, Board members will be appointed by the Minister from locally generated nominations. There will be 3 consumers, 2 family members, 5 mental health content experts, 3 at-large members, the Boards CEO and an ex-officio member from the University of Toronto. The Board will have three advisory councils - a consumer council, a family council and a professional-provider council to offer ongoing feedback about implementation.

Role of the Ministry of Health and Long-term Care

The role of the provincial Ministry will be to:

- Set mental health policy;
- Set service volumes;
- Approve regional plans and allocate funding envelopes;
- Monitor regional and local performance;
- Protect and enhance mental health budget;
- Establish and support the provincial co-ordinating committee;
- Establish and support the provincial information management network.

Role of the Provincial Co-ordinating Board

The Ministry will establish a provincial co-ordinating board to provide leadership, advocacy, education and communication support across the province. It will co-ordinate efforts at the provincial level for mental health promotion strategies, media campaigns and human resource standards.

Role of the Provincial Information Management Network

The Ministry will also establish a provincial information management network to develop an information management framework and co-ordinate implementation across the province.

Appendix B Assessment Criteria Developed by the CAMH Board

The Board of CAMH agreed to use six assessment criteria to evaluate proposals for restructuring or integrating mental health services. The Board also articulated a set of outcomes to be achieved under criterion.

Client Centred Care

If it is client centred, the new model should:

- improve client outcomes;
- improve client choice in services and supports, including health promotion programs;
- promote client advocacy;
- promote the participation of clients in the planning, provision and governance of services, as well as their own individual service plans;
- ensure that clients are represented in the governing structure;
- ensure the participation of family members of clients;
- promote the values of diverse cultures;
- reflect a broad definition of health;
- promote best practices (e.g. that benefit clients).

Service/Program Delivery

If the new model is going to improve service and program delivery, it should:

- improve access of clients to services, including those currently not accessing services;
- provide services closer to home for clients;
- minimize the amount of time clients spend away from home;
- enhance the capacity to provide a very wide range of services, treatments and client supports, including housing, social supports, self-help programs, and family support programs;
- enhance specialized and intensive services;
- refocus and balance system resources to ensure that they serve people with serious and persistent mental illness;
- support health promotion programs;
- enhance continuity of care for clients;
- be based on good evidence and best practice information.

System Integration

If the new models being proposed in Ontario are to improve system integration, they will need to be assessed on how they achieve better alignment of services. The new model should:

- improve service coordination at the local and regional levels;
- improve linkage between local and provincial-level program/service providers;
- facilitate providers working together to create a seamless care continuum;
- improve shared treatment planning;
- improve co-operative health promotion programming;
- include specific proposals for transition processes between providers, programs, and communities;
- identify specific linkages with addiction services;
- identify specific linkages with primary care services;
- improve linkages with the broader community of services and supports – social services, housing, employment, counseling, etc;
- decrease duplication and multiple points of entry;
- be given sufficient legal authority or other incentives to effectively manage the integration process;
- not be unduly costly to implement.

Accountability

Any new proposals for service integration should be assessed on the basis of how they improve accountability to client, providers and citizens. The new model should:

- clarify the roles and responsibilities of the provincial government, any proposed new governance structures, service providers, and health professionals;
- improve accountability to clients and families;
- improve accountabilities for service delivery, program design, funding, policy and planning;
- increase the cost-effectiveness of services and programs;
- identify performance expectations;
- include proposals for measuring performance expectations;
- protect and enhance mental health and addictions funding;
- ensure that investments and re-investments in mental health and addictions services will support reform;
- ensure that investments and re-investments will increase capacity for the overall mental health and addictions system;
- increase equity in resource allocation and distribution;
- improve the quality of information about clients, services and programs;
- promote knowledge transfer programs;
- improve information gathering and dissemination;
- include proposals for evaluation of the new model itself.

Research and Education

Research, education and other activities that support the dissemination of knowledge and information could be viewed as less important than a focus on local service issues. However, CAMH must consider the impact of new models on these activities. The new model should:

- promote and expand research in mental health and addictions;
- ensure support for a broad range of research, including basic, clinical, service delivery, and social/prevention policy issues in mental health and addictions;
- promote broad-based education and teaching in mental health and addictions and in related areas (e.g. dual diagnosis, concurrent disorders);
- include a provincial focus for a generator and disseminator of new understanding, treatments and health promotion programs for mental illnesses and addictions.

Health Promotion, Public Policy and System Support

These activities may also be viewed as less important than dealing with local services issues. However, they are essential to the development and maintenance of successful, integrated systems and to the ongoing support of reform in mental health and addictions. The new model should:

- facilitate system and community partnerships in developing evidence based health promotion programs;
- facilitate system and community education and outreach across the province to ensure excellence in research, scholarship and education;
- include a provincial focus for a policy voice and advocate for the needs of mental health and addiction clients and the system in general;
- facilitate the sharing of knowledge in treatment and health promotion to improve the quality and accessibility of client services, integration of the system, and innovation.

Appendix C Summary of Strategies for Mental Health System Integration: A Review.
Final Report by Durbin et al (2001), Health Systems Research and Consulting Unit, CAMH

A recent review of the literature prepared by the Health Systems Research and Consulting Unit at CAMH identified the following elements of an integrated mental health system:

- the availability of a full continuum of services and supports, responsibility for a defined population, and clinical and financial accountability for outcomes;
- arm's length manager to act as a single point of accountability for the provision of care to a defined population;
- the system manager has control over a pooled envelope of funding that covers the full range of services;
- performance targets for system monitoring;
- three models of governance appear to have the best success for integration: umbrella group, regional authority or consolidated organizations;
- the regional authority was thought to be the most compelling on feasibility and performance grounds;
- a full range of stakeholders must be represented regardless of the governance model chosen;
- intermediate benefits of system integration include a fuller continuum of care, the use of best practice programs and treatment protocols, more appropriate service mix for the population being served, integrated information systems and client records, timelier access to services and greater client satisfaction;
- longer term benefits of system integration include increased accountability and system responsiveness.

It is important to note that the research evidence on the impact of system integration on individual client outcomes was weak due to the complexity of demonstrating such a linkage. As well, the researchers caution that while there may be some cost savings in reducing administrative duplication, there is a need for significant investment in other supports such as information systems and labour realignments. Therefore, it is unlikely there will be true cost savings.

The review also identified lessons learned and suggests the following conditions are required to increase the chances of success:

- Integrating providers at the corporate level has no relationship to integration at the local patient-care level; clinical integration is most important to improve client outcomes;
- Adequate resources are required to support the integration process;

Succeeding In Mental Health Reform: Critical Elements

CAMH Response to the Toronto-Peel Mental Health Implementation Task Force

- A long time frame is required;
- Hospitals and other providers must be brought into the process as full participants;
- Changed relationships will mean a loss of autonomy for some - resistance to this is expected and needs to be overcome;
- Leadership is required from respected clinicians and provider organizations;
- Leadership and political will is required from government;
- Size and scope of the network is important - smaller communities appear to have been more successful with integration over larger communities - models will need to "sized" appropriately;
- Legal issues need careful attention so that there is accountability and protection for sharing client information, client, resources and responsibility for system performance.

Appendix D: System Integration: CAMH Response to Toronto-Peel Mental Health Implementation Task Force Phase 2 Consultation Document

CAMH Board of Trustees
Approved: October 10, 2002

Whereas CAMH believes strongly that reform of the mental health and addictions system must continue in a positive direction;

Whereas CAMH commends the Toronto-Peel Mental Health Implementation Task Force for the work that it has done to develop a plan for the range and capacity of services and supports that are needed in Toronto and Peel, and for a system design, system responsiveness and system supports; and

Whereas CAMH is committed to being an active voice in shaping the future mental health and addictions system in Ontario:

NOW THEREFORE BE IT RESOLVED THAT CAMH communicate the following response on mental health reform and system design to the Toronto-Peel Mental Health Implementation Task Force and the Minister of Health:

General Provincial and System Perspective

1. CAMH agrees with the statement of the problems in the mental health system as set out in the Toronto-Peel Mental Health Implementation Task Force report (see pages 12-14) and believes that these apply to the system across the province:
 - a. The range and capacity of certain needed services (and supports) are simply not there;
 - b. Existing services and supports are fragmented and hard to access and navigate by consumers and families
 - c. There is insufficient collaboration and coordination among the various providers and funders of services and supports
 - d. There is a need for increased accountability at the program, agency, system and Ministry level for outcomes achieved

We would add three points to this statement:

- e. Funding for the mental health and addictions system is still very inadequate in light of the importance and human cost of these health problems
- f. Not enough has been done to address the stigma and discrimination issues
- g. There needs to be a continued sharp focus on client-centered care and improvement in uniformity of quality of care across the province.

2. **Services and Supports:** New investment in the range and capacity of services and supports is a paramount priority for the mental health and addictions system, especially in:
 - a. housing/housing supports;
 - b. improved access,
 - c. early intervention, and
 - d. employment (a wide variety of programs to assist people with mental illness and addictions to obtain and/or retain employment).Funding for information system infrastructure to support these programs is also essential.

3. **Concurrent Disorders:** There is inadequate recognition in the Task Force Report that addictions and mental illness frequently co-exist, and a re-designed system needs to reflect this reality in its services and improvements to access. Concurrent Disorders should be made a high priority for funding as well as policy development by the Ministry of Health and Long-Term Care.

4. **Health Promotion and Prevention** is underemphasized throughout the Task Force Report. Prevention and health promotion aspects of mental health and addictions have been underfunded and not adequately supported by provincial policy or program development for many years. There must be an increased emphasis and support for these activities.

5. **System Integration** is an essential strategy to sustain mental health reform and address the problems set out above. Active system planning and management is key to improving access to services and supports, implementing innovation and best practices, and improving the satisfaction of people using the mental health system and their families.

6. **Provincial Themes:** This document is excellent and provides a good basis for further action on mental health reform. However, we would strongly recommend that the distinction made in the paper between “The Mental Health System” and “Building Community Capacity” be eliminated, and the topics within each of these headings be integrated. The topics described under “Building Community Capacity” (i.e., peer support, family support, housing, early intervention, employment, income support, and advocacy and rights advice) are integral to the mental health system. CAMH priorities previously identified above, i.e., housing, early intervention and employment are key

elements, and we would add Health Promotion and Social Support to those already included in this paper.

The Toronto-Peel Implementation Task Force System Design Proposals:

7. The system design proposed by the Toronto-Peel Implementation Task Force:
 - Only if the following critical factors are included, a regional board model could be implemented:
 - 7.1 addictions must be included in an integrated regional board model;
 - 7.2 political commitment to mental health and addictions issues must be demonstrated by annual funding increases that are at least in step with the rest of the health system, or greater;
 - 7.3 commitment within the government bureaucracy and the Ministry of Health and Long-Term care to actively support the work of the regional board;
 - 7.4 funding for information infrastructure to improve access, services and supports;
 - 7.5 a pooled funding envelope must include funding for all first line, intensive and specialized services and supports in the mental health and addictions system, including Schedule 1 and specialty hospitals. It *cannot* be limited to, or begin with, only the programs and hospitals that are in the current Community Mental Health vote in the Ministry estimates. Regional boards must have control over a meaningful funding envelope.
 - 7.6 Primary care and physicians are key components of the mental health system. CAMH recognizes that funding for physicians is part of the health insurance scheme that is currently centrally negotiated with the OMA in Ontario, and that physician funding is not included in regional authorities across the country. However, this separation of physician funding makes integration efforts very difficult and creates significant barriers for organizing services for mental health and addictions clients, given the extremely important role of physicians in front-line care and access to the system. Alternate mechanisms need to be explored to more closely align physicians with the mental health and addictions system.
 - 7.7 Legislation should:
 - 7.7.1 define the range of services and supports and the expected outcomes of the system in each region;
 - 7.7.2 define roles and responsibilities, legal authority, and accountabilities; and
 - 7.7.3 support the appropriate flow of information about clients and services to facilitate continuity of care and support.
 - 7.8 Provision must be made for a provincial resource for research, knowledge transfer, prevention and health promotion to support the innovation and

implementation of best practices that are keys to the success of regional system integration efforts.

8. **Regional mental health (and addictions) board vs. regional health authority.** Ontario has not indicated an intention to regionalize its health care system. To implement a mental health and addictions board without this commitment to regionalization presents certain risks. Mental health and addictions could be marginalized as a “silo” apart from the mainstream health system. Historical funding patterns tell us there is a strong risk that such separation could result in frozen or reduced budgets for mental health and addictions in the fierce competition for health resources. On the other hand, being separate could be advantageous in achieving focused reform goals in the short-term. Over the long-term, however, a separate mental health and addictions board would likely increase marginalization of mental health and addictions if there is not a move to create regional health authorities more broadly in the health field.

Conclusion:

Only if the critical factors are present, as set out above, does CAMH support the system design report of the Task Force. It is absolutely imperative that political will and funding commitment be demonstrated in leading to the implementation of a new governance approach. There is significant danger in partial or half-hearted implementation of the regional board. The parts associated with system integration need to be seen as supporting the whole, and leaving out one or two will jeopardize the enterprise.

The cost of this governance system must be detailed and debated in comparison to other uses of the funds, and must be justified by the value it adds to the system, in demonstrable improvements for clients and families. The cost of implementing a new governance structure will be wasted and will not justify the risks associated with it unless all of the critical factors are included.

If government is not prepared at this time to fully implement the regional board, much that is in the report can be achieved by:

1. Clear political commitment by the government to making mental health and addictions a funding and policy priority, including immediate investment in the capacity and range of services and supports as set out in #2 above;
2. MOHLTC actively leading, and creating incentives for, service networks and other modes of collaboration among providers of services and supports in a creative, varied way, i.e., both horizontal and vertical integration;
3. MOHLTC creating a provincial advisory board to the Minister to continue to develop and support the work of the Task Forces.

However, if the government is prepared to create the conditions for success and implement a regional board approach to governance, CAMH believes that further consultation and work is required throughout the province to develop the policy, models, and legislation. In particular, the government must consult with the addictions sector on including addictions services in the scope of the regional board and such implementation must be planned and conducted in partnership with the addictions sector and based on principles in *Setting the Course*. A mechanism for physician involvement must also be developed.

CAMH very much wants to participate in this continuing dialogue.

Endnotes

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¹⁶ Toronto-Peel Mental Health Implementation Task Force (2002) *ibid*; 3.

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Succeeding In Mental Health Reform: Critical Elements

CAMH Response to the Toronto-Peel Mental Health Implementation Task Force

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²³ *ibid*