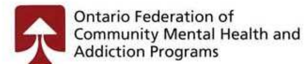
A FOCUS ON ADDICTIONS AND MENTAL HEALTH:

REVIEW OF LHIN INTEGRATED HEALTH SERVICE PLANS



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ADDICTIONS ONTARIO is a non-profit, charitable organization representing individuals and facilities providing addiction services. Addictions Ontario has provided leadership for excellence in addiction services in Ontario by developing and promoting quality standards of care, and disseminating information that helps members to effectively meet the needs of their clients.

THE CANADIAN MENTAL HEALTH ASSOCIATION (CMHA), ONTARIO, is a non-profit provincial association committed to improving services and supports for people with mental illness and their families, and to the promotion of mental health in Ontario. With 32 branches that provide community mental health services throughout the province, CMHA Ontario achieves its mission through public education, knowledge transfer, analysis of public issues and advocacy for healthy public policy and an effective and efficient health system.

THE CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH) is Canada's leading mental health and addiction teaching hospital. CAMH works to transform the lives of people affected by addiction and mental illness, by applying the latest in scientific advances, through integrated and compassionate clinical practice, health promotion, education and research. CAMH has central facilities located in Toronto and 32 community sites throughout the province.

THE ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS represents more than 230 front-line, community-based providers who recognize clients and their families as the core of their organizations, and who ensure clients' and family members' basic human rights and dignity. Since 1988, the Federation has envisioned a community mental health and addiction system that is accessible, flexible, comprehensive and responsive to the needs of individuals, families and communities; and that is shaped by many partnerships, by dignity and by accountability to those it serves.

ERRATA: PAGE 22

APPENDIX 1: INDIVIDUAL IHSP SUMMARIES
NORTH SIMCOE MUSKOKA LHIN (LHIN 12)

The original review stated that there was a draft IHSP prepared by outside consultants who sought input from but did not consult extensively with the mental health and addiction system group.

The correction is: "Mental health and addiction stakeholders participated in a series of community consultations organized by consultants for the LHIN. The IHSP was prepared by LHIN staff, based on a comprehensive current state assessment that included a review of mental health and addiction reports completed in the last five years and feedback from the mental health and addiction system group on this review."

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EXECUTIVE SUMMARY

A review of the Local Health Integration Network (LHIN) first integrated health service plans (IHSP) was undertaken by the partnership of Addictions Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addictions Programs. **The purpose of this review was to assess the extent to which these plans address addiction and mental health issues.** The criteria for assessing the IHSPs were based on the critical success factors for mental health and addictions identified in the partnership's 2005 position paper "A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario".

KEY FINDINGS

- Every LHIN is addressing addictions and mental health to some extent, although the sector is a priority in only half the LHINs.
- In focusing exclusively on integration, access issues and service gaps are not consistently addressed within all LHINs.
    - Barriers to access are sometimes underestimated. IHSPs often state that accessibility of services will be improved by improving people's access to information about services, making the system easier to navigate, and coordinating intake between agencies. While these issues are important, other barriers to accessing services, such as those facing marginalized groups are often missed.
    - The chronic underfunding of the sector and the resulting service gaps are often not acknowledged.
- The importance of housing, income, employment and social supports for people with addictions and mental health concerns are recognized by very few LHINs. Even fewer have made plans to address these as determinants of the health.
- Most LHINs do not demonstrate an understanding of the importance of involving consumers and families in the planning, delivery, and evaluation of services.
- The importance of peer support programs is not recognized by many LHINs.
- Diversity is being addressed almost exclusively through breaking down language barriers. There is little recognition or commitment to culturally competent services.
- Where the addiction and mental health sector's voice was united and strong throughout a LHIN, the sector was more likely to be consulted and to have impact on the LHIN's priorities and planning.

RECOMMENDATIONS

1. Ensure that a strong addictions and mental health system is considered a provincial strategic priority.

2. Maintain a focus on addictions and mental health in each LHIN.

3. Working collectively in the sector is critical – consumers, families and service providers working together.

4. Reviewing the capacity of the existing service system is a critical next step .

5. Ensure a clearer focus on the critical success factors for mental health and addictions.

CRITICAL SUCCESS FACTORS FOR ADDICTION AND MENTAL HEALTH

The following critical success factors are drawn from the partnership 2005 position paper, "A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario":

- Addiction and mental health care will be fully integrated within a transformed system.

- Consumers and families will be involved in all aspects of planning, decision-making, implementation and service delivery.

- People across Ontario will have access to the best mental health and addiction services in their communities, supported by widely shared research findings, best practices and professional development.

- There will be a continuum of mental health and addiction services and supports from community-based to hospital care, and including consumer and family initiatives.

- Access to housing, income, employment, social supports and other determinants of health will be acknowledged and supported as critical aspects of treatment and recovery.

- Mechanisms for addressing the historical marginalization, stigma and under-funding of addiction and mental health services will be in place.

- Equitable and transparent mechanisms will be in place to guide funding decisions for the sector.

- The needs of diverse, rural and remote communities will be met.

INTRODUCTION

This review is part of the collaborative work of Addictions Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addictions Programs. Together, these four organizations are committed to raising the profile of mental illness and addictions in Ontario, and to supporting the needs of those living with mental health and addictions problems, their families, and their communities.

WHAT WE DID AND WHY

Why we reviewed addictions and mental health planning in the IHSPs
The purpose of this review of the Local Health Integration Network (LHIN) integrated health service plans (IHSP) is to assess the extent to which these plans address addiction and mental health issues. In their initial Integration Priority Reports (2005), 13 of 14 LHINs identified addiction and mental health as priorities. This review aims to assess whether or not the LHINs' initial priorities were translated into their action plans for the next three years. The intent is to continue to assess the LHINs' plans on a regular basis to ensure that addiction and mental health issues stay on the agenda, and to continue to identify and share promising practices in LHIN planning.

Who this report is intended for – stakeholders, government and LHINs
This report is intended for several audiences: community mental health and addictions health service providers, consumer and family groups, the Ministry of Health and Long-Term Care (MOHLTC), LHIN board and staff members, and anyone else concerned about how mental health and addictions services and supports are faring within the restructured health system. Our hope is that this report will be seen as a tool for understanding what is happening across the province in the sector, and to spark some thinking about how to ensure a strong province-wide system of supports for people with addictions and mental health issues as the restructuring of the health system continues.

What we did – reviewed the plans and talked to key informants in the sector
Our preparatory work involved a review of each of the IHSPs and interviews with key informants in each LHIN. In most LHINs this included the consumer/survivor initiative (CSI) lead, a Canadian Mental Health Association (CMHA) Executive Director, and a Centre for Addiction and Mental Health (CAMH) system planner. Member organizations of the Federation and other service providers in leadership positions in the addiction and mental health networks of some LHINs were surveyed as well.

The IHSPs were reviewed after the final versions were made publicly available (November 2006 to January 2007). Key informants were interviewed between December 2006 and February 2007.

How we assessed the plans - criteria for the review

In keeping with the critical success factors described in the partnership's 2005 position paper "A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario"[1], we identified 15 criteria for evaluating the content, development, and implementation planning for the IHSPs. Ten of these criteria were rated based on what was written in the IHSP document, while the remaining six were rated using a combination of what was written in the IHSP, key informants' information about the development of the IHSP, and key informant/LHIN communication about planning for implementation as of January/February 2007.

Each of the criteria shown on the attached graph (Appendix 2) is rated on a scale of 0 to 3. A score of 0, represented by a box with no shading, indicates that there was no mention of the issue in the IHSP or that it was not referenced during the planning or implementation stages. A score of 1, represented by slight shading, indicates that the issue was mentioned; 3 that it was strongly addressed, and 2 that it fell somewhere in between. A brief summary for each LHIN is provided, explaining key issues in that LHIN and why those ratings were given.

WHAT WE FOUND

Overall, the review found good news for addiction and mental health. Every LHIN has addressed addiction and mental health issues to some extent, although their responses differ in depth and breadth. Some of these differences may relate to differences in local needs and resources in each LHIN, although generally addictions and mental health issues do not differ widely between LHINs. Other differences are due to the different approaches to planning taken by each LHIN. With no detailed direction from the Ministry of Health and Long-Term Care (MOHLTC) to ensure common planning practices, the depth and breadth of the IHSPs vary widely.

Addiction and mental health a priority in 7 LHINs and a sub-priority in 5 LHINs

Addiction and mental health were recognized as either a **priority (7)** or a **significant area of focus (5)** in 12 of the 14 IHSPs. In the 7 LHINs where mental health and addictions were identified as priorities, the IHSPs tended to describe a vision for the addiction and mental health system and indicate what aspects of the system they would focus on. In the case of the Hamilton Niagara Haldimand Brant IHSP, there was only one issue and area for action - concurrent disorders.

In five other LHINs, addiction and mental health issues are a sub-priority or a focus under another priority: integrated health system (1); access to health care (3); access to primary care (1); and chronic disease prevention and management (1). As a sub-priority or a sub-focus, addiction and mental health issues are addressed and action is usually indicated – though not to the same degree as when it is a priority on its own.

[1] Available at http://www.camh.net/Public_policy/Public_policy_papers/transformationsector_paper05.html

Of the remaining two LHINs, the North East LHIN IHSP makes reference to future planning for addiction and mental health issues, and the Erie St. Clair LHIN IHSP includes a sub-priority related to mental health (under the priority of reducing dependence on hospitals) but not addictions. The latter IHSP also describes several addictions and mental health integration projects already under way related to several IHSP priorities.

ADDRESSING CRITICAL SUCCESS FACTORS FOR ADDICTIONS AND MENTAL HEALTH

Service delivery issues: access, integration, and service gaps

Access, integration, and service gaps were usually addressed as a set of intertwined issues, and were a common theme in all the IHSPs, but with different degrees of emphasis. Because of the mandate to create an *integrated* health service plan, some LHINs addressed only integration issues. In focusing exclusively on integration, significant access issues and service gaps were sometimes not addressed.

Those that focused exclusively on integration sometimes underestimated the **barriers to access**, seeing them as a lack of available information about where to go for services, difficulty in navigating the system, and/or uncoordinated intake systems. These definitions of barriers to access do not recognize other systemic and more complex barriers to access, particularly those facing marginalized groups, which may require something beyond improved public information, support for navigation and coordinated intake.

Nor does focusing exclusively on integration acknowledge the **chronic under funding of the sector and the resulting service gaps**. While most LHINs did make reference to service gaps, few acknowledged that the addiction and mental health system is under-resourced and that to truly address service gaps, more resources must be found. Exceptions include the Central LHIN, which has developed a scale for the networks to use in assessing their resource needs, and the South East LHIN, which speaks about increasing the number of services and their capacity.

LHINs that fail to address service gaps independently of integration issues risk overlooking fundamental systemic problems. For example, if there is no withdrawal management service in a LHIN, simply integrating two or three existing services will not create one, and the IHSP has not effectively addressed a real access problem. This may be why there is relatively little specific action on addiction issues – there are few services to integrate.

LHIN environmental scans and community engagement strategies uncovered a full range of issues in the health care system. The development of the IHSPs was an opportunity to identify needs that require new funding as well as those that can be resolved through integration. Most LHINs recognized this in including improved access to housing for

seniors and/or improved access to primary care, both of which require new investments. It was rare, however, for the IHSPs to address the need for increased funding for addictions and mental health services and supports.

Concurrent disorders
Concurrent disorder services were identified as a service gap in several LHINs, but many of the IHSPs, written at the high level that they were, did not include any discussion of concurrent disorders in their action plans. Notable exceptions include Hamilton Niagara Haldimand Brant, Toronto Central, Mississauga Halton, and Erie St. Clair. It is not clear that LHINs who have plans to address concurrent disorders understand that effective services require more than good communication between existing addictions service providers and mental health service providers.

Social determinants of health
Overall, the social determinants of health (such as housing, income, and employment/training) were not well addressed. Housing gaps were recognized in several IHSPs, though usually for seniors rather than people with addictions or mental illnesses. The impact of poverty on people's health was also recognized in many IHSPs, though, again, not specifically in terms of addiction and mental health. Although many LHINs recognize the importance of the social determinants to the health of the population, most LHINs do not appear to view a focus on the determinants of health as their area of responsibility. Those that do, do not have plans related to addictions and mental health. One exception is Central East, which plans to address housing and employment as a critical component of care for people with addiction and mental health issues.

Diversity
LHINs with very culturally diverse populations were more likely to have considered diversity than others. The issue, however, was often framed as a problem of simple language barriers. More complex issues were identified, but the focus for action was narrow. Though several IHSPs, such as Toronto Central's, did talk about the need for culturally competent services, they failed to commit to solutions that went beyond breaking down language barriers.

Consumers and families
Most LHINs did not recognize families and consumers as a community of interest with a major stake in the system, which is striking given that patient-centred care is a focus of health system reform. While some IHSPs acknowledge the importance of consumer and family involvement in planning, delivery and evaluation of services, most of these do not have any plan of action to ensure consumer and family involvement. Two notable exceptions are the Central and Toronto Central LHINs.

It is widely acknowledged by the field that access to peer support is critical for people with addiction or mental health problems as well as their families, and should be funded adequately. Most LHIN plans are too high level for this kind of detail, but those that list

important gaps in services rarely include consumer and family-led initiatives. Although five LHINs acknowledged that it is a need, no LHINs included action on this issue.

PLANNING PROCESS

In keeping with Ministry community engagement requirements, all LHINs engaged the public during their planning, generally by holding open houses to introduce themselves to the community. Most LHINs went on to do more in-depth consultation by meeting with networks, developing consultation groups (such as expert panels), and meeting individually with stakeholders. All LHINs sought feedback on their draft IHSPs, but many final IHSPs differed little from the drafts that went out for feedback. Some stakeholders felt that their feedback was not addressed. One notable exception was Central East LHIN. Many key informants commented on the very strong sense of inclusion and respect they and others felt in their interactions with their LHIN.

Addiction and mental health network involvement in planning

Addiction and mental health stakeholders were involved in IHSP planning to varying degrees. In some LHINs the impetus came from the networks, which initiated meetings with the LHIN staff and worked hard to have their voices heard. In other LHINs, LHIN boards and staff members invited addiction and mental health networks and stakeholders to participate in the planning process, in some cases providing staffing to support the networks to write the plans, and in other cases ensuring that their own writers were well-connected to the networks.

Because LHIN geographic areas differ from many historical service boundaries, most existing addiction and mental health networks were not active LHIN-wide (with the notable exception of Champlain). Due to the challenges in bringing addiction and mental health tables together, some groups have joined together while others have chosen to remain separate with strong links. Many smaller addiction and mental health networks have begun to link with one another to ensure consistent or unified messaging and to have a strong presence in the IHSP planning. In many LHINs these linkages are still in the early stages of development so the LHIN-wide voice was not strong and united. In general (but not always), where the sector's voice was united and strong, the network was more likely to be actively consulted and to have an impact.

Involvement of consumers and families in planning

The methods and extent of consumer and family involvement in planning varied from LHIN to LHIN. These ranged from invitations to attend LHIN open houses, to family and consumer focus groups, to participation at addiction and mental health planning tables that in turn worked with the LHIN to develop the plan. Toronto Central LHIN made the most notable effort to get families and consumers involved in planning, with roughly 200 consumers and family members participating in their addiction and mental health action planning day. However, while Toronto Central's outreach to consumers and families clearly had the greatest *breadth* of all LHINs, Champlain LHIN may have had the

greatest *depth* of involvement. At the Champlain mental health table, consumer and family representatives have been intimately involved in developing a system plan that includes detailed plans for consumer and family priorities.

The mechanism for consultation used by the LHINs impacted the extent to which consumers and families were involved. For example, where LHINs consulted the community through IHSP advisory committees, consumer and family participation was minimal. These advisory committees included a range of health service providers and rarely, if ever, included consumer and family representatives. Where the LHIN consulted directly with addiction and mental health networks, consumer and family input was dependant on the strength of their presence at these networks. Just as in the case of the addiction and mental health networks, consumers and families had the strongest voice when they acted as organized groups rather than as individuals.

The level of consumer involvement was also a function of the CSI leads and the networks they worked with. The **CSI Network Lead** is a Ministry-mandated and funded role meant to help ensure and facilitate consumer participation in decision-making in the LHINs. For several reasons, however, the initiation of this role did not result in a consistent level of consumer involvement across the LHINs. First, since there were no parameters to govern the CSI Lead's role, the way each lead involved consumers varied from LHIN to LHIN. Second, CSI networks were themselves operating in different ways in different LHINs. For example, the Champlain LHIN had a pre-existing LHIN-wide CSI network with a history of involvement in system planning. Other CSI networks, such as that of the South West LHIN, have only one person involved in system planning. In other LHINs, where LHIN-wide networks are not yet in place, there are several smaller networks with varying degrees of capacity for system planning. Third, the understanding and recognition of the CSI leads and their roles varied from LHIN to LHIN. These circumstances greatly impacted consumer involvement in decision-making.

There is no mandate or funding from the Ministry to support family involvement. Many family groups in Ontario primarily provide peer support and are not actively involved in advocacy and system planning. The strongest family involvement was in the LHINs where the Family Mental Health Alliance (FMHA) was active: the FMHA felt that it was able to make significant inroads into increasing LHIN awareness of the importance of families in Central West, Toronto Central and Central LHINs.

IMPLEMENTATION

In general, IHSP implementation strategies are vague. Some IHSPs include an action plan but no implementation strategy. Others include objectives, activities, deliverables and a time frame but no next steps. In several LHINs implementation planning began after the IHSPs were submitted so the plans are not included in the IHSP.

In some LHINs, the addiction and mental health system networks were charged with implementation planning. While pleased to be given the lead, there is some concern about how to maintain communication with the LHIN to ensure that their work is in keeping with the LHIN's intent, and about how to complete this work with limited human and financial resources. In other cases, the LHIN has created action teams to continue with implementation, rather than relying upon existing networks with established relationships. In these cases, people had to apply for a place on an action team as **individuals**, rather than as representatives of networks, an approach that does not foster coordination and communication with the sector.

WHERE TO FROM HERE?

1. ***Ensure that a strong addictions and mental health system is considered a provincial strategic priority***

   A provincial strategic direction related to addiction and mental health would have been effective in ensuring that all LHINs directly addressed addiction and mental health issues as a priority. This is evident by looking at another part of the health system - chronic disease prevention and management – and how prominently it figured in the IHSPs.

   While both addictions and mental health and chronic disease prevention and management were the subject of much discussion during the planning process, chronic disease prevention and management was explicitly identified as a government priority while addictions and mental health services were not. In the end chronic disease prevention and management is a priority in 11 LHINs and in the other three LHINs it is clearly identified as a critical system-wide issue. Despite the fact that mental health and addictions were clearly identified as a priority in 13 LHINs in the first community engagement exercise in December 2005, only 7 LHINs maintained it as a priority in their IHSPs. Clearly, a provincial strategic priority would make a difference.

   In the case of chronic disease prevention and management, the Ministry of Health and Long-Term Care provided not only a strategic priority but also a model that LHINs could choose to follow. This resulted in a degree of consistency across the province in both the identification of issues and the approach to planning for disease prevention and management, unlike planning for addictions and mental health that varies widely.

2. ***Maintain a focus on addictions and mental health in each LHIN***

   Despite a lack of a strong provincial direction, addictions and mental health are on the radar in all LHINs. It is important to maintain a focus on the sector in each LHIN to ensure that this continues to be the case. One aspect of this is to create a focus on addictions and mental health system issues **within existing LHIN priorities and action areas**. For example, alternate levels of care (ALC) are identified in many

IHSPs as a seniors' issue: people taking up beds in hospital when they might be well-suited for long-term care homes or supportive housing. ALC is rarely spoken of in the context of addiction and mental health: the need to provide appropriate community mental health services and supports to keep people out of hospitals and emergency rooms. An exception is North East LHIN, where addiction and mental health providers have been invited to a discussion about ALC.

3. ***Working with others in the sector is critical – consumers, families and service providers.***

   When the sector is more organized, there is more opportunity for influence and meaningful participation in LHIN planning and implementation. When there is good communication through a LHIN-wide network or series of networks, there is more consistency in stakeholder perceptions of what is happening and more opportunity for a united voice. Where the networks are not strong and the LHIN works through individual service providers or several different networks, issues tend to be addressed on an issue by issue basis, rather than looking at a comprehensive approach to the addictions and mental health systems.

   The consumer and family voice is stronger when consumers and families are organized. Organized consumer and family voices linked to LHIN-wide service-provider/consumer/family networks further improves the opportunity to increase LHIN awareness of the importance of consumer and family involvement.

4. ***Reviewing the capacity of the existing service system is a critical next step***

   It is essential that the LHINs review the capacity of the addictions and mental health service sector and analyze service gaps. Although the mental health sector has received new funding in the past four years, and the addictions sector is slated to receive new funding in the coming year, there are significant service gaps in mental health and addictions services. Clarity is needed around service gaps that may be addressed through integration and gaps that will require new resources.

5. ***Ensure a clearer focus on critical success factors***

   More work is needed to ensure that the critical success factors for addictions and mental health are integrated into LHIN planning and implementation.

CRITICAL SUCCESS FACTORS FOR ADDICTION AND MENTAL HEALTH

The following critical success factors are drawn from the partnership 2005 position paper, "A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario":

- Addiction and mental health care will be fully integrated within a transformed system.

- Consumers and families will be involved in all aspects of planning, decision-making, implementation and service delivery.
- People across Ontario will have access to the best mental health and addiction services in their communities, supported by widely shared research findings, best practices and professional development.
- There will be a continuum of mental health and addiction services and supports from community-based to hospital care, and including consumer and family initiatives.
- Access to housing, income, employment, social supports and other determinants of health will be acknowledged and supported as critical aspects of treatment and recovery.
- Mechanisms for addressing the historical marginalization, stigma and under-funding of addiction and mental health services will be in place.
- Equitable and transparent mechanisms will be in place to guide funding decisions for the sector.
- The needs of diverse, rural and remote communities will be met.

CONCLUSION

As restructuring of the health care system continues, and LHINs take on more responsibility it will be important for the addictions and mental health sector to have a strong united voice in each LHIN and provincially to influence planning and funding. Addictions Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health, and the Ontario Federation of Community Mental Health and Addictions Programs are committed to maintaining a presence provincially and to supporting a strong local voice. A report on how the addictions and mental health sector is progressing across the province will be completed in another year.

Appendix 1:
Individual IHSP Summaries

Integrated Health Service Plan: Erie St. Clair LHIN (1)

Addiction and Mental Health in the Plan

The Erie St. Clair IHSP focuses on 8 broad strategic integration directions, with one or more strategic projects attached to each. There is one strategic project that focuses on the mental health system - divestment of mental health services as a means of reducing dependence on hospital-based services. There are no strategic projects focusing on addictions.

The LHIN consulted widely with health service providers to identify integration projects already underway in the catchment area and noted them as "enabling" projects. There are 5 mental health enabling projects, 2 addictions enabling projects and 1concurrent disorders enabling project.

Addressing Critical Success Factors for Addiction and Mental Health

The IHSP does not deal directly with the addictions and mental health system, although the divestment project may look at the system overall. The action plan for this project is fairly high level so the specific critical factors are not addressed other than concurrent disorders as an enabling project, and it is therefore difficult to assess the extent to which the LHIN intends to address system issues for the addiction and mental health sector. Integration is strongly emphasized throughout the plan. It is not clear how access issues and gaps in service will be addressed.

Planning Process

Stakeholders had an opportunity for input through written submissions about integration initiatives they were currently developing or felt they could develop with LHIN support. Although there were representatives from the addiction and mental health sector on the IHSP advisory committee, there was no LHIN-wide system for sharing and validating the input received from different networks and different parts of the sector.

There was no targeted consultation with consumers or families, only general flyers inviting people to open houses. The development of a consumer network to participate in LHIN planning began after the IHSP was completed.

Implementation

The IHSP describes a structure for project work plans and includes deliverables, outcomes and measures of success for each project. It does not define the implementation process or identify who will be involved. The LHIN has been in discussion with stakeholders involved in the enabling projects to explore how to proceed with these. The LHIN appears to be looking to agencies that are leaders in integration to play a key role. There has been not yet been any public discussion of how the IHSP will be implemented.

Integrated Health Service Plan: South West (2)

Addiction and Mental Health in the Plan

Addiction and mental health issues are identified as a sub-priority under the primary care priority and are also discussed under the priorities of chronic disease prevention and management and access to the right services in the right place at the right time.

An objective within the primary care priority area is to improve access to comprehensive primary health care, with an emphasis on early intervention and wellness, for people with addictions and mental health conditions. The action plan speaks to integration and identification of service gaps.

Within the chronic disease priority area, a quick action project is proposed for people with diabetes and mental illness, and the LHIN will focus on the mental health population in its implementation of chronic disease prevention and management in year two.

Addressing Critical Success Factors for Addiction and Mental Health

Concurrent disorders are noted as complex issues to overcome when addressing mental illness as a chronic disease. Diversity is not discussed as such although the LHIN plans to address access to health services for newcomers, aboriginals and Francophones. No specific action is planned for either.

The Planning Process

There are several large networks and some small networks in the LHIN's catchment area, some of which have had addiction and mental health service providers working together for over a year and other that are just integrating. A LHIN-wide addiction and mental health "table" is in development.

The Consumer Survivor Initiatives (CSI) "lead", who is the coordinator of the pre-existing consumer network, is actively involved in system planning. Other consumers/consumer organizations are not actively involved. Service providers organized family and consumer focus groups in some parts of the LHIN as part of the LHIN community engagement strategy.

The LHIN consulted with many of the networks as they developed the plan. Addictions and mental health were represented on the IHSP advisory group and on the expert panels. These groups did not develop the plan with the LHIN but provided feedback on the LHIN's independent planning.

Implementation

The implementation strategy involves forming priority action teams to address each objective in the IHSP. The LHIN is not organizing these teams based on representation from relevant health networks but has put out a call to individuals to volunteer for their first, second and third choices. It is not yet clear whether the sector will be appropriately represented in the relevant teams.

Integrated Health Service Plan: Waterloo Wellington (3)

Addiction and Mental Health in the Plan

Improving access to addiction and mental health services is a sub priority within the broader priority of improving access. Access to emergency crisis services and primary care are the two key areas of focus. In addition there is an emphasis on broader access to mental health and addictions services for specific populations: people with disabilities, older adults and adolescents.

Addressing Critical Success Factors for Addiction and Mental Health

The broader social determinants of health are not discussed in the context of mental health and addictions, although in other parts of the plan, appropriate housing is recognized as a critical component of the health system, and action is planned to ensure that it is available. However it is important to note that the community has received funding for supportive mental health housing and is still implementing these projects.

Diversity is not a discussed as such, but the IHSP identifies a long list of specific and vulnerable populations for whom the LHIN wants to improve access.

Planning Process

The plan was developed with minimal connection with the mental health and addiction network, although the network is strong and organized, includes consumer representation and had a history of working closely with the District Health Council, prior to the creation of the LHINs.

Implementation

The IHSP is very high level and the plan for mental health and addictions is vague – the LHIN will develop, implement and evaluate a plan to address service gaps.

Implementation is to be achieved through a health system planning forum, "communities of interest round tables" (similar to priority action teams identified by other LHINs), and working with the existing health system networks.

The network had a number of integration projects in process prior to the LHIN planning process and these are moving ahead independent of LHIN involvement.

Integrated Health Service Plan: Hamilton Niagara Haldimand Brant (4)

Addiction and Mental Health in the Plan

Mental health and addictions is one of seven priorities for the Hamilton Niagara Haldimand Brant LHIN. However, the action plan for mental health and addictions is limited to access to services for people with concurrent disorders.

There is also some discussion of the need to improve assessment and treatment services for children and youth, under the priority of coordinating services for children and youth.

Addressing Critical Success Factors for Addiction and Mental Health

The action plan to improve concurrent disorders services involves the integration of mental health and addictions services through: sharing program successes, promoting best practices, developing a plan for cross-training, investigating inter-agency teams, and developing protocols for shared care and collaboration between mental health and addictions programs.

The plan acknowledges that health status is influenced by the social determinants of health and that the LHIN has a responsibility to work within the health system and across sectors to improve population health status. However, there is no plan to act on this statement. Similarly, the importance of cultural diversity in health services is noted but is not addressed in the action plan beyond working with francophone and aboriginal communities on health service issues.

The IHSP mentions a currently operating project to integrate peer support workers in mental health agencies but does not suggest any further support for consumer or family initiatives.

Planning Process

There are 6 local mental health and addiction networks operating in this catchment area and a LHIN-wide “table” is beginning to come together. The LHIN invited local networks to develop proposals for integration priorities and selected one from among the initial five recommendations that were made.

Consumers and families were minimally involved in the planning process, through their participation in the local networks and the LHIN-wide table. ALHIN-wide network of consumers/consumer organizations is in development.

Implementation

There is no implementation strategy. The mental health and addiction table has requested a meeting with the LHIN to discuss how to proceed.

Integrated Health Service Plan: Central West (5)

Addiction and Mental Health in the Plan

The LHIN identified three broad strategies for improving local health services: enhanced integration, increased capacity and improved access. Out of these emerged eight priorities, one of which was mental health and addictions.

Addressing Critical Success Factors for Addiction and Mental Health

The IHSP addresses the lack of available mental health and addictions services within this LHIN, noting that Central West ranked lowest in per capita spending in mental health and addictions, that many residents are known to go outside the LHIN area to receive services, and that health service providers ranked access to mental health and addiction services as the second worst in the LHIN relative to other health services.

The IHSP is clear in recognizing these access issues. It speaks about integration of services and the continuum of care, citing the "no wrong door" approach. However, it does not commit to specific action to increase the level of service as a means of addressing the gaps. Rather, there is discussion of their intention to develop an inventory of services and templates and protocols for service agreements.

Other critical success factors such as a focus on the social determinants of health and concurrent disorders are not mentioned in the plan. Diversity, which is a prominent issue in this LHIN where over 40% of residents are visible minorities, is not addressed in the mental health and addictions section; however responsiveness to cultural diversity is identified as a general priority.

Planning Process

A variety of stakeholders were involved in consultations about the IHSP, including mental health and addictions networks.

Input was also received from consumers and families, and efforts were made to involve CSIs in the planning process. However, it is uncertain what will be done with this input now that the planning is in the hands of a Steering Committee, which explicitly does not include consumers and families.

Implementation

Overall, the mental health and addictions component of the IHSP was a "plan to plan". While the plan does spotlight some of the key issues, the actual action planning and implementation has been left in the hands of a Steering Committee made up of service providers. This group is charged with the task of identifying gaps in the system, defining partnerships among service organizations, defining the new model of integrated health services, and ensuring the transition from the old model to the new. Details about how the Steering Committee will be accountable to both the LHIN and the public at large and what opportunities there will be to provide input on this plan are not provided.

Integrated Health Service Plan: Mississauga-Halton (6)

Addiction and Mental Health in the Plan

Integrating mental health and addiction services was one of five local integration priorities in the Mississauga-Halton IHSP, specifically, the integration of mental health and addictions services within the sector and across sectors to other levels of care.

Addressing Critical Success Factors for Addiction and Mental Health

The IHSP describes the current system as "fragmented", and gives priority to linking and coordinating services so that consumers can move easily from one part of the system to another. It speaks to the intent to develop a continuum of care based on best practices, using an early win approach which leverages current partnerships and concentrates on the development of new ones to enhance coordination.

Although these integration measures are intended to address access issues, the LHIN also recognizes other access issues such as the importance of consumer choice, limited emergency room capacity, the shortage of primary care physicians, and the need for transportation services.

In regard to other critical success factors: diversity considerations were not specifically addressed; the need for concurrent disorders services was noted as an issue, but no action was planned to address it; and there was no specific discussion of the importance of the social determinants of health, but they were noted in the action plan as part an overall integrative approach.

Planning Process

Mental health and addictions service providers were significant contributors to the planning process. They mobilized to form a Mental Health and Addictions Leaders Network, were heavily consulted during the IHSP planning process, and will continue to be involved during implementation. In contrast, consumer involvement was limited to individual participation in focus groups and there was no discussion of support for consumer/survivor initiatives within the plan.

Implementation

The LHIN has identified two different bodies to support the implementation of their strategies: a Rapid Action (RA) Team to address short- and mid-term issues, and a Detailed Planning and Action (DPA) Team to take the plan from high level to implementation. This DPA Team will be responsible for detailed implementation planning and execution, including implementation of performance monitoring. It is not clear, however, who will serve on these teams.

Integrated Health Service Plan: Toronto Central (7)

Addiction and Mental Health in the Plan

Mental health and addictions is one of three key areas of focus identified by the LHIN, along with seniors and rehabilitation. A 200-page background paper on addictions and mental health was drafted to inform the IHSP and 36 priorities in the area of mental health and addictions were identified. These were subsequently reduced to two core integration priorities for action in the final draft of the IHSP.

Addressing Critical Success Factors for Addiction and Mental Health

The first integration priority for addictions and mental health is to improve access to coordinated and integrated mental health and addictions services. Coordination and integration are seen as ways to maximize the effectiveness and impact of existing services and require individual organizations to work together to create the necessary linkages. The second priority is to improve coordination and integration of services for people with concurrent disorders.

Toronto Central LHIN addressed the importance of the social determinants of health and diversity but did not go into a great amount of detail in either of these areas. One point of action referred to increasing the capacity to provide culturally competent care to diverse service users; however it is not clear how this will be operationalized.

Planning Process

A truly notable aspect of this plan is the level of community engagement that occurred in its development. An Action Planning Day saw the attendance of over 350 people, half of whom were consumers and family members. These stakeholders identified the ongoing need for consumer/family involvement in system level decision-making. Mental health and addictions networks that had previously worked separately came together and collaborated to ensure a strong and united voice for the sector.

Implementation

As part of the implementation plan, Advisory Councils have been created for each of the three priority areas. The Mental Health and Addictions Advisory Council will move forward on next steps and will report to a coordinating committee of the LHIN. Membership on this council is open to both service providers and consumers and family members.

The plan is fairly high-level, and the addictions and mental health community will continue to be engaged to translate priorities into action.

Integrated Health Service Plan: Central (8)

Addiction and Mental Health in the Plan

Mental health and addictions is one of 7 planning priorities within 5 system-level goals for Central LHIN. The mental health and addictions plan is fairly detailed.

Addressing Critical Success Factors for Addiction and Mental Health

Improving access is one of the goals of the mental health and addictions priority. The access issue is largely understood as a matter of providing better information and coordinating intake, as well as making the system more inclusive for diverse cultural communities. The IHSP makes note of many gaps in mental health and addictions services, some of which may be addressed by integration while others may require "service enhancements". The inclusion of ethno cultural communities is also part of the action plan.

Employment and housing are recognized as having an impact on recovery and the action plan for mental health and addictions includes working across sectors (i.e. outside of health) on these issues. Concurrent disorders services are mentioned as lacking, although no specific action is planned to address this problem.

Notably, this LHIN has made a specific commitment to families and consumers. The action plan refers to developing community engagement strategies for families and consumers and for involving them in planning and evaluation. Other parts of the IHSP speak of the need for family support, consumer peer support, supported employment and consumer-run businesses although there is no action planned to build these functions into the system.

Planning Process

The mental health and addictions plan was written by members of the network, in collaboration with an outside consultant. There was also active involvement from family and consumer organizations, although there was no broad consultation beyond these groups. The LHIN has provided support for the development of a LHIN-wide network, and groups that approached the LHIN with their concerns felt that they were very well heard.

Implementation

The IHSP is vague on implementation strategies. The LHIN has since asked the addictions and mental health network to take the lead in implementation and sub-committees have begun work on specific action areas.

Integrated Health Service Plan: Central East (9)

Addiction and Mental Health in the Plan

Mental health and addiction services are identified as one of four priorities for change. There is a detailed mental health and addictions plan that outlines what the LHIN heard through consultations, and relates action items to five performance dimensions: people-centered, population health-conscious, accessible, integrated, and effective. The most notable aspect of Central East LHIN's Integrated Health Services Plan was its commitment to detailed, concrete action.

Addressing Critical Success Factors for Addiction and Mental Health

The Central East LHIN has the challenge of dealing with an extremely diverse population, with pockets of cultural diversity within the LHIN as well as a rural/urban mix across the LHIN. A lack of service providers able to speak to and understand the communities they are dealing with was identified as a particular challenge in Central East.

Another important issue related to cultural diversity was system navigation. During consultations it became evident that within the new immigrant population especially, there was a lack of knowledge about what services were available and how to access them. Solutions included a publicly accessible inventory of what agencies and programs were available and the enhanced capacity to provide culturally competent services. Shared resources and coordinated services were suggested as ways to allow consumers to move more easily from one area to another.

In addition, the LHIN has committed to working with service providers, public health and other sector community providers to promote health and prevent illness by influencing the broader determinants of health such as housing, which is seen as an issue in rural areas in particular.

Planning Process

The LHIN planners held consultations with a wide range of stakeholders that included both local service providers and community members. Consumers and families did participate in consultations as individuals; however they did not mobilize to respond as a collective voice. The Central East LHIN benefited from a proactive mental health and addictions network that was well established before the LHINs were put into place. This network was able to build upon existing relationships and was empowered early on with the task of planning and implementation.

Implementation

The IHSP addresses the fact that a detailed implementation plan has not yet been created – and that this will be vital in prioritizing the many action items and turning this plan into reality.

Integrated Health Service Plan: South East (10)

Addiction and Mental Health in the Plan
Access to mental health services is a sub-priority under the South East LHIN's priority of access to care. The IHSP is fairy high level and there is not a great amount of detail to the action plan, which refers to investigating, developing plans and working with providers to reduce barriers to access and to increase the supply of services. Two key initiatives for this LHIN are shared care and access to services for people living in remote areas.

Addressing Critical Success Factors for Addiction and Mental Health
This LHIN perceives the needs of the addictions and mental health system primarily in terms of access issues. In mental health this includes crisis care, inpatient psychiatric care, ambulatory care and community support services, psycho-geriatric services, child and adolescent psychiatry, concurrent disorders, services for homeless people with mental health problems and forensic psychiatry. In addictions this includes distance from treatment, local withdrawal management or detoxification services, a lack of family physicians, and inadequate supportive housing.

There is no discussion of diversity although there is mention of aboriginal and francophone needs but not specific to mental health and addictions.

Planning Process
Representatives from the several local mental health and addictions networks on the Project Work Team worked with consultants who developed the plan. In this role, they provided feedback to the consultants and communicated to the networks, but provided little direct input into the IHSP. Consumers did provide input into the plan, although some CSI networks were more active than others in the planning process. Overall, the LHIN was engaged with the addictions and mental health stakeholder community.

Implementation
The plan was unclear about next steps, and did not provide an implementation strategy or structure for future stakeholder involvement.

Integrated Health Service Plan: Champlain (11)

Addiction and Mental Health in the Plan

Mental health and addictions is one of six priorities in the Champlain LHIN IHSP and access to services is another priority that includes mental health and addictions issues.

Addressing Critical Success Factors for Addiction and Mental Health

Mental health and addictions access issues and gaps in service are identified within the IHSP. A detailed list of needs and specific services that the LHIN feels should be addressed, provided and/or improved upon is included in the IHSP, including several addictions services.

The development of services for concurrent disorders is identified as an area of need but no related action is mentioned. The need for housing and supports is identified for several populations, including people with mental health and addictions concerns, but no action is planned to address housing needs. The IHSP states that diverse and special populations face barriers to access and defines special populations, but no specific action is identified.

Planning Process

The IHSP includes many of the points made in the reports written by mental health and addictions networks prior to the birth of the LHIN. Consumers and families participated in the planning process both through their representation at the mental health system group and through the CSI network which consulted broadly with consumers, and their priorities are felt to be reflected in the IHSP.

Implementation

The LHIN has left the details of how to prioritize and achieve its stated objectives to the addiction and mental health networks (which are two distinct bodies that work closely together), and has offered them financial and staff support to do this work.

Integrated Health Service Plan: North Simcoe Muskoka (12)

Addiction and Mental Health in the Plan

The North Simcoe Muskoka IHSP does not identify mental health and addictions as a priority and does not address mental health and addiction issues directly. Rather, there is some indication that mental health and addictions issues will be addressed in the context of many system-wide priorities –in particular chronic disease prevention and management and access to the right services at the right time. In addition, in achieving its priority of system integration, the plan is to work towards an integrated mental health and addictions system in the first three years, and in the third year to take the lessons learned and begin the integration of another health sector.

Addressing Critical Success Factors for Addiction and Mental Health

In its "Current State Assessment" the IHSP acknowledges that there are service gaps in the addiction and mental health system and in the Action Plan notes the need for an acute care bed registry, on-call psychiatry, and peer support services.

Influencing the factors that affect health is one of the priorities identified in the IHSP, although it is not specifically noted as important for people with mental illness and addictions. The action proposed for this is quite general - linking with the social services sector and community health centres – so it is difficult to know how well this action will address the needs of the mental health and addictions sector.

This LHIN has identified a variety of special populations and populations of focus and plans to assess their needs as part of the IHSP.

Planning Process

Mental health and addiction stakeholders participated in a series of community consultations organized by consultants for the LHIN. The IHSP was prepared by LHIN staff, based on a comprehensive current state assessment that included a review of mental health and addiction reports completed in the last five years and feedback from the mental health and addiction system group on this review.

Consumers and families who sit on the system leadership group were involved in the process to the extent the networks were involved in consultation. All the CSIs in the area sit at that table.

Implementation

The action steps outlined in the IHSP are to implement a regional acute care bed registry and a regional on-call psychiatry service, to offer peer support programs and to integrate the continuum of mental health and addictions services on the basis of a no wrong door approach. The LHIN has asked the mental health and addictions system leadership group to take the lead on these activities and new staff being hired by the LHIN are expected to provide support to the system leadership group.

Integrated Health Service Plan: North East (13)

Addiction and Mental Health in the Plan

There is only limited discussion about mental health and addictions in the North East LHIN IHSP. The LHIN chose not to focus on specific sectors but on system-wide issues. Integration across health sectors, with respect to the system-level priorities, is the primary focus of the IHSP.

The IHSP action plan calls for a planning day to develop a framework and action plans for improving access to mental health and addictions services. Another planning session on Alternative Levels of Care (ALC) is also called for in the IHSP action plan. In the analysis of health service utilization data, the LHIN specifically points out that people with mental health diagnoses are included in the calculation of ALC days. Wait times for access to psychiatry is an area identified for action.

Addressing Critical Success Factors for Addiction and Mental Health

The mental health and addictions planning day will explore improving access to mental health and addictions services.

The lack of supportive housing is noted as an issue that impacts on the health system generally.

Equity has been identified as a key value for the LHIN and the IHSP includes a framework for resource allocation, decision-making and outcome measurement that evaluates equity across various groups.

Consumers and families involved in the networks were involved to the extent that the networks were involved in consultations. No additional specific outreach to consumers and families took place.

The Planning Process

The LHIN encouraged the development of a LHIN-wide mental health and addictions network and met with the network as well as with some members individually to discuss its plans. The LHIN has advised the network that specific mental health and addictions planning will come in future years.

Implementation

There are no specific next steps, objectives or outcomes detailed in the action plan and it is not yet clear whether or how stakeholders will be involved in implementation.

Integrated Health Service Plan: North West (14)

Addiction and Mental Health in the Plan

Access to mental health services is a sub-priority under the North West LHIN's "access to care" priority.

Addressing Critical Success Factors for Addiction and Mental Health

A number of key issues for the mental health and addictions are identified as access issues These are: crisis care, psycho-geriatric services, inpatient specialized addiction treatment, detox, withdrawal management programs, supportive housing, walk-in mental health services, safe beds, and services for children and youth. The plan is to address these through integration within the mental health and addictions system and through improved coordination and communication between health sectors. The plan mentions that there is an insufficient supply of services.

Two key initiatives for this LHIN are shared care and crisis services, both in the context of improving access to services for people living in remote areas.

Planning Process

Stakeholders spoke about the breadth and depth of the LHIN's community engagement in developing the IHSP. LHIN representatives traveled extensively across this large geographic area, held many meetings in many communities, took the initiative to meet individually with a wide variety of groups and service-providers, including family and consumer program representatives. However, the specific input from the field is not reflected in the IHSP.

Implementation

The IHSP is high level and there are few details with respect to next steps, implementation strategy or structure for stakeholder involvement.

Appendix 2:
IHSP Comparison Chart

An assessment of LHIN addictions and mental health planning in their integrated health service plans

		LHIN													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Action Plan in IHSP	Plan includes detailed action	Some discussion	Some discussion	No mention	Some discussion	No mention	Some discussion	Some discussion	Addressed somewhat	Strongly addressed	No mention	Addressed somewhat	Some discussion	No mention	No mention
	Plan includes action to address access problems in the system	Addressed somewhat	Some discussion	Some discussion	Some discussion	Addressed somewhat	Addressed somewhat	Addressed somewhat	Addressed somewhat	Strongly addressed	Addressed somewhat	Strongly addressed	Some discussion	Some discussion	Addressed somewhat
	Plan identifies action to ensure a better integrated mental health and addictions system	Addressed somewhat	Some discussion	Some discussion	Some discussion	Addressed somewhat	Strongly addressed	Strongly addressed	Strongly addressed	Strongly addressed	Some discussion	Strongly addressed	Addressed somewhat	Some discussion	Some discussion
	Service gaps in system identified	No mention	Some discussion	Some discussion	No mention	Some discussion	Addressed somewhat	Some discussion	Strongly addressed	Addressed somewhat	Addressed somewhat	Strongly addressed	Addressed somewhat	No mention	Some discussion
	The importance of building capacity in concurrent disorders is identified	Addressed somewhat	Some discussion	No mention	Strongly addressed	No mention	Some discussion	Strongly addressed	Some discussion	Some discussion	No mention	Addressed somewhat	No mention	No mention	No mention
	The social determinants of health are recognized as critical components of the mental health system	No mention	No mention	Some discussion	Some discussion	No mention	Some discussion	Some discussion	Addressed somewhat	Strongly addressed	Some discussion	Addressed somewhat	Addressed somewhat	Some discussion	Addressed somewhat
	There is action to address the needs of diverse/particular populations	Some discussion	Some discussion	Addressed somewhat	Some discussion	Addressed somewhat	No mention	Some discussion	Addressed somewhat	Strongly addressed	Some discussion	Addressed somewhat	Addressed somewhat	Some discussion	Addressed somewhat
	The important role for consumers and families is acknowledged	No mention	No mention	No mention	Some discussion	Some discussion	Some discussion	Strongly addressed	Strongly addressed	Some discussion	No mention	No mention	Some discussion	No mention	No mention
	The LHIN supports consumer- and family-led initiatives	No mention	No mention	No mention	No mention	No mention	No mention	Addressed somewhat	Addressed somewhat	Addressed somewhat	No mention	Addressed somewhat	Addressed somewhat	No mention	No mention
Planning and Implementation of IHSP	Consumers and families were involved in the planning process	Some discussion	Addressed somewhat	Some discussion	Some discussion	Some discussion	Some discussion	Strongly addressed	Addressed somewhat	Addressed somewhat	Addressed somewhat	Addressed somewhat	Some discussion	Some discussion	Addressed somewhat
	Mental health and addiction planning groups and network(s) were well-coordinated among themselves	Some discussion	Addressed somewhat	Addressed somewhat	Some discussion	Some discussion	Strongly addressed	Strongly addressed	Strongly addressed	Strongly addressed	Addressed somewhat	Strongly addressed	Addressed somewhat	Addressed somewhat	Addressed somewhat
	LHINs used mental health and addictions networks as a resource	Some discussion	Some discussion	Some discussion	Some discussion	Addressed somewhat	Strongly addressed	Strongly addressed	Strongly addressed	Strongly addressed	Addressed somewhat	Strongly addressed	Addressed somewhat	Addressed somewhat	Addressed somewhat
	Input from different groups was included in the plan	Addressed somewhat	Some discussion	Some discussion	Some discussion	Some discussion	Addressed somewhat	Addressed somewhat	Strongly addressed	Strongly addressed	Some discussion	Strongly addressed	Some discussion	Some discussion	Some discussion
	Implementation strategy is identified	Addressed somewhat	Addressed somewhat	Some discussion	Strongly addressed	Strongly addressed	Strongly addressed	Some discussion	Addressed somewhat	Strongly addressed	No mention	Addressed somewhat	Some discussion	Some discussion	No mention
	Structures for stakeholder involvement in implementation are identified	No mention	Strongly addressed	Addressed somewhat	Some discussion	Some discussion	Addressed somewhat	Addressed somewhat	Strongly addressed	Some discussion	No mention	Strongly addressed	Addressed somewhat	Some discussion	No mention

Key:

No mention	Some discussion	Addressed somewhat	Strongly addressed

Appendix 3:
LHIN Numbers and Names

LHIN	1	Erie St. Clair
LHIN	2	South West
LHIN	3	Waterloo Wellington
LHIN	4	Hamilton Niagara Halton Brant
LHIN	5	Central West
LHIN	6	Mississauga Halton
LHIN	7	Toronto Central
LHIN	8	Central
LHIN	9	Central East
LHIN	10	South East
LHIN	11	Champlain
LHIN	12	North Simcoe Muskoka
LHIN	13	North East
LHIN	14	North West