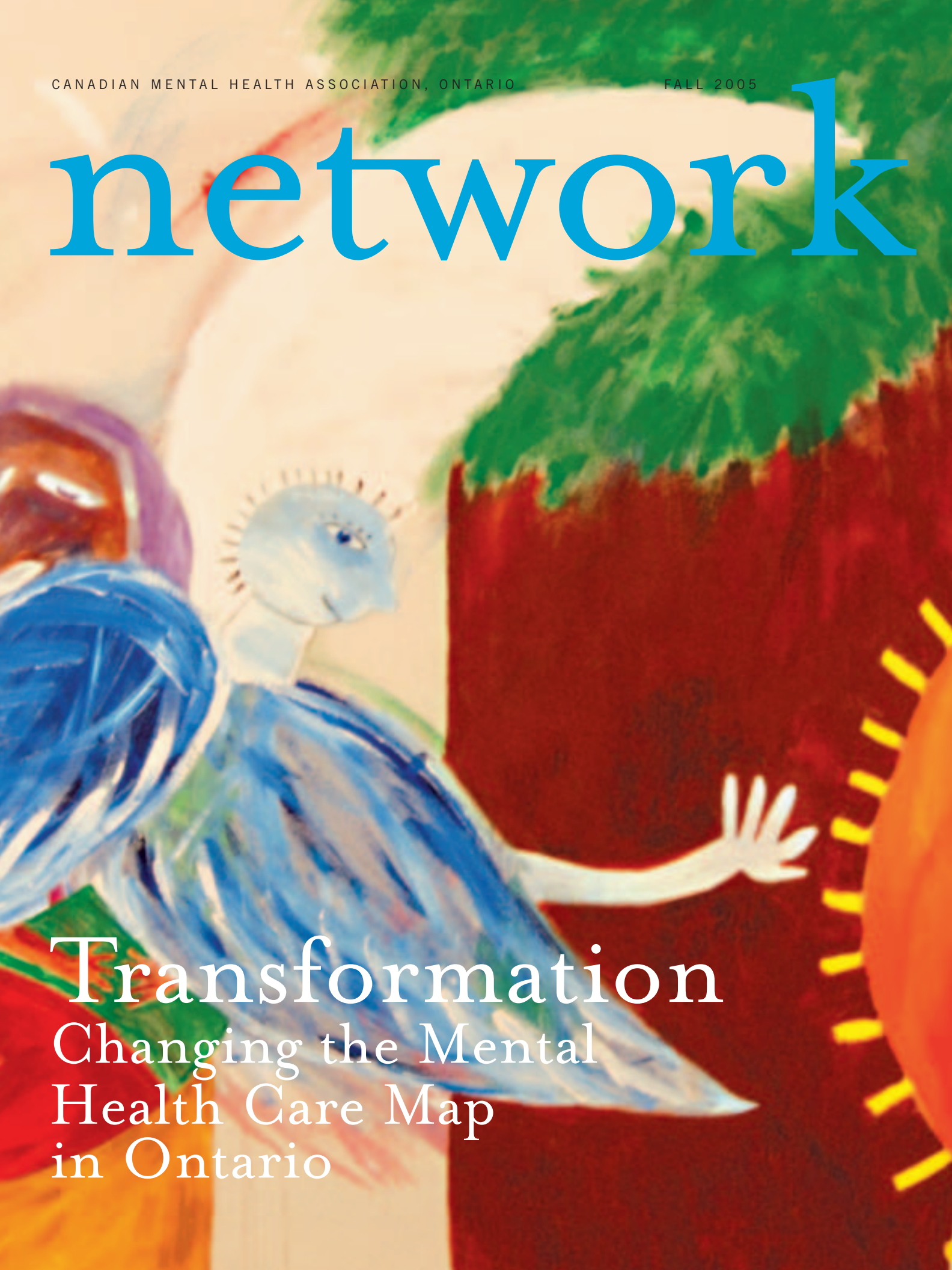
CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO FALL 2005

network



Transformation

Changing the Mental Health Care Map in Ontario

network
Fall 2005
VOL. 21 NO. 2

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CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO
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OUR MISSION
To provide leadership in advocacy and service delivery for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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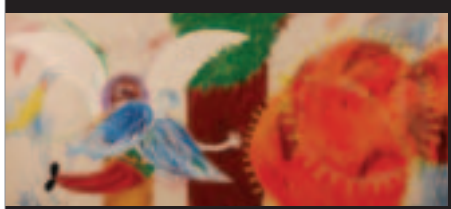

Re: Cover

Donna Husiak, *Icarus* (acrylic on canvas, 9' x 4'). Reproduced by permission. One of nine original paintings, by various artists, inspired by stories from Ovid's *Metamorphoses*. Commissioned by the Workman Theatre Project, in partnership with the Centre for Addiction and Mental Health, for the exhibition "From Myth to Muse."

The Time Is Now to Make a Difference

Karen McGrath, BSW, MBA
Chief Executive Officer

The health care system is on the cusp of a significant change in Ontario. Early in its mandate, the McGuinty government announced that it was planning to transform the health system and that the transformation would be Ontario style — a made-in-Ontario solution. The transformation was eventually to affect the way in which services were delivered, but the beginning step would be planning, coordination and management.

To this end, the government organized Ontario into 14 Local Health Integration Networks (LHINs), conducted needs assessments in these regions, and most recently named three board members and the CEO for each of these networks. Next steps include passing legislation to give the LHINs their formal mandates and beginning discussions with all the current service providers in each LHIN area.

I would argue that the average Ontarian does not even know the transformation is occurring. They are concerned about whether or not they can get the services they need when they need them, but the unfortunate reality is that many people still cannot, so the transformation has not really moved to the person level yet.

The Canadian Mental Health Association, Ontario — along with its partners, the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addiction Programs — has been following the transformation quite closely. In fact, the partnership arose because of the transformation and our united concern that mental health services must be maintained and enhanced throughout the transformation process and beyond.

The community-based mental health system in Ontario has recently seen significant investment — in fact, the first investment in some 17 years. This investment has meant expansion of existing services, as well as development of new services, to address the needs of the seriously mentally ill in our province. Canadian Mental Health Association branches have been recipients of this investment.

Our ongoing commitment is to continue to monitor the development of the LHINs and to ensure that each one is responsive to mental health needs within its own jurisdiction. We also want to work on continuity across LHINs to make sure that the same range and quality of services can be found in each of the LHIN areas. Mental health and addiction services were rated in the top three priorities in all the LHIN areas of this province when the community consultations and needs assessments were conducted by the Ministry of Health and Long-Term Care late last year. It is now important that the LHIN volunteers and staff translate this need into the reality of service provision in their area.

There are many good mental health service providers out there. Of course, I would rank CMHA branches at the top. It is now time for a united message from us all — a message that not only reiterates the need for a full range of accessible community-based mental health services in all areas of the province, but also reaffirms CMHA's core value that consumers and family members must be at the heart of the transformation. When the transformation moves to the level of the person and that person is a mental health consumer who is unable to get service in their community, it will be too late. The time is now to make a difference to the community-based mental health system in Ontario.

Karen McGrath is the chief executive officer of CMHA, Ontario. She has served as CEO for Health and Community Services, Newfoundland and Labrador, and as a surveyor for the Canadian Council on Health Services Accreditation.

Team Work

Let's say you're a 19-year-old woman sitting in your family doctor's office.

You've been on medication for anxiety for a few years but lately your panic attacks have been much more frequent. You find your symptoms embarrassing, so you don't want to talk about them with your friends or family. You're not eating well, and you're feeling pretty isolated.

Besides adjusting your meds, your doctor wants you to talk to a dietician. And she has another suggestion: talk to a mental health worker about trying some cognitive behavioural therapy, which can help reduce anxiety symptoms. The mental health worker should also have information about joining a peer support group in the area, where you can meet some people who are going through what you're going through.

Now... let's say the mental health agency and the dietician are just down the hall.

That's the idea behind family health teams, a key part of the transformation agenda in Ontario. And CMHA, Windsor-Essex County Branch is one of the agencies putting that idea into practice in Leamington, a small community in Essex County near Windsor.

The CMHA branch and its partners — Leamington District Memorial Hospital, Hospice of Windsor and a community health centre named Teen Health Centre — had been talking about creating a "basket of services," which would involve collocating services from each of the partners at one site. They had been considering whether to propose a community health centre to the Ministry of Health and Long-Term Care when it announced in late 2004 that it was no longer going to create community health centres and would instead focus on creating family health teams.

Family health teams aren't a radical departure from other models of collaborative care, but they are a departure from how most family doctors in Ontario now work. The concept is simple enough: health professionals will work in a team environment, collaborating on patient care. Doctors, nurses, nurse practitioners, social workers, dieticians, therapists, and so on — all under the same roof. While every family health team will have a core medical staff of doctors, nurses and nurse practitioners, the specialties of other health professionals on staff will vary depending on community needs. The point is more effective and efficient care.

Let's say you're a mental health worker at a satellite office of a CMHA branch located in the office of a family health team. You're in the office kitchen heating up your lunch when one of the doctors on staff, who's waiting for the microwave, asks about your work. You mention the supportive housing program, the court diversion program that steers clients with mental illness away from the criminal justice system, and the cognitive behavioural therapy program. And you mention the anxiety disorder support group you facilitate.

That's interesting, the doctor says. She didn't know there was an anxiety disorder support group in town.

From a doctor's point of view, referring patients to a community mental health agency that's part of a family health team means "someone in the next office," says Dr. Robert Page, the chief of medical staff at Leamington District Memorial Hospital. Working together closely and talking about one another's capabilities in providing care is one of the advantages of the family health team model.

Dr. Nick Kates, a McMaster University professor of psychiatry and expert on collaborative care, says that the interdisciplinary approach is the heart of the family health team model. Delivering optimum care, he says, means "being able to work together, to share responsibilities, to support each other, to deliver treatments that are complementary.... All of that really demands collaboration." Kates says family health teams are also focusing on helping patients manage chronic diseases and on promoting health.

When Kates and colleagues studied the effectiveness of collaborations between mental health care providers and health service organizations — which offer similar but somewhat less comprehensive care than family health teams — they found that the model "increases access to services, is highly rated by people using the service, and reduces a lot of the stigma. It's much easier to be seen in a family physician's office," Kates says, "particularly when mental health services are less available in the community."

> Collaborations help maintain the essential link between mental health care and primary care. Pam Hines says it's difficult to support clients' mental health needs when their basic medical needs are neglected. What appear to be flare-ups of mental health problems are often related to physical ailments.

Once the ministry called for proposals for family health teams, the four partners, including CMHA, Windsor-Essex County Branch, submitted a proposal for Leamington. Earlier this year, the ministry announced that the Leamington and Area Family Health Team will be one of the first in the province to open its doors. That should happen in 2006.

The partners have identified certain population groups that need specific attention. The Leamington area has significant numbers of migrant workers and Low German-speaking Mennonites, says Pam Hines, the executive director of CMHA, Windsor-Essex County Branch. In fact, the branch created a position just to work with the Low German-speaking population.

The third group that the family health team will focus on is people with mental illness. Not because there is a particularly high rate of mental illness in the area, but because people with mental illness suffer what Hines calls "adverse selection."

CELEBRATING ON THE DAY THE MINISTRY OF HEALTH AND LONG-TERM CARE ANNOUNCED THAT IT HAD ACCEPTED THE LEAMINGTON AND AREA FAMILY HEALTH TEAM PROPOSAL. FROM LEFT: DR. ROBERT PAGE; JANE WIENS, CHAIR OF LEAMINGTON DISTRICT MEMORIAL HOSPITAL (LDMH) BOARD; PAT HOY, MPP, CHATHAM KENT ESSEX; SHEILA GORDON, EXECUTIVE DIRECTOR OF TEEN HEALTH CENTRE; BARB TIESSEN, LDMH; PAMELA HINES, CEO, CMHA, WINDSOR-ESSEX COUNTY BRANCH; CAROL DERBYSHIRE, EXECUTIVE DIRECTOR, HOSPICE; WARREN CHANT, CEO, LDMH; BRIAN GREY, FHT HARROW; AND BRUCE COZIER, MPP, ESSEX.

"Any new doctors who are taking on clients avoid our client population" — people with serious mental illness — "because they're more complicated," Hines says.

Hines says Leamington is one of the most underserved communities in Canada. Page estimates that the area is short 20 to 30 family doctors, and has no practicing psychiatrist. One retired doctor moved to the area, Page says, and "just let it be known that he'd be willing to see the odd person to help out." Soon he had a full practice.

In fact, it was the lack of primary care for people with mental illness in the community that prompted CMHA, Windsor-Essex County Branch to launch primary care initiatives of its own over four years ago. The branch now has a nurse practitioner delivering on-site primary care to clients.

Family health teams are a key part of the transformation agenda in Ontario, and CMHA, Windsor-Essex County Branch is one of four partners putting that idea into practice in the small community of Leamington.

Joining a family health team didn't require a big shift in how the branch approaches client care. It already partners with Windsor Regional Hospital to offer a mental health program for older adults, and will soon host a satellite office of a community health centre at the branch's main location in Windsor.

These collaborations help maintain the essential link between mental health care and primary care. Hines says it's difficult to support clients' mental health needs when their basic medical needs are neglected. What appear to be flare-ups of mental health problems are often related to physical ailments, she notes. A kidney infection, for example, could make a client's psychiatric medication less effective. What seems to a mental health worker to be voice hearing, says Hines, may be a very bad ear infection.

Still, it's not yet clear exactly how the CMHA branch's day-to-day involvement in the Leamington family health team will take shape. The partners are working on a business plan, and have proposed hiring a social worker, a cognitive behavioural therapist and an addictions therapist. The CMHA branch will have a satellite office on the family health team's premises, and will focus on clients with serious mental illness, linking newly diagnosed or undiagnosed clients to early intervention services.

Some people have expressed concern, says Hines, that primary care settings that directly provide mental health services will act as "competition" with mental health agencies. But from her point of view, most mental health agencies focus

on clients with serious mental illness, while people with more moderate mental illness have few options outside their family doctor's office. Also, she thinks primary care is an ideal setting for identifying early psychosis.

"I think every community should have one primary care setting that specializes in mental health," Hines adds. The doctors wouldn't work exclusively in mental health care, she suggests, but could lend their knowledge to other primary care providers and help patients find their way to mental health agencies in the community.

She also suggests more support for doctors who are caring for people with a serious mental illness. And she wants the health system to deal with the whole person, "not silos of physical and mental health."

There's been progress lately on collaborative health care, she says, but "more work needs to be done."

Let's say you're a health professional working in a private practice. Why change the way you work?

Collaboration, in Page's view, is more than most doctors can manage, given their workloads. "I actually think physicians are running so hard and so fast in most cases to try and manage the workload that they have, in our area anyhow, [that] they don't have time to think about what they're doing."

While there may be ways to make more money as a doctor than working in a family health team, Page says there are other reasons doctors would want to join a collaborative practice. One of the main attractions for doctors is getting off what Page calls the "treadmill."

"If it takes you half an hour to see a particular individual and work through their problem, then that's fine. You're not worrying about the fact that you're only being paid so much to see this patient and in order to generate an income and pay all your expenses you've got to keep on that treadmill."

Kates has seen many collaborations between mental health care providers and family doctors. The key, he says, is to plan collaboratively and work as partners. The partners must be willing to learn from one another, to understand each other's limitations, and develop shared and realistic goals based on local needs and resources.

"It's not a question of saying, 'Let's take a program that was developed in Hamilton or Ottawa or Toronto and try that in our community.' It's a question of saying, 'What do we want to achieve? What are the principles that we want to make sure we follow in developing this program? And how then can we put it in place?'"

Page has observed that younger doctors feel more comfortable working in a collaborative environment, but Kates thinks age is not a factor. The actual experience of working in a new way, he says, makes the difference.

"My experience has been that when you talk to physicians of any age who have been involved in collaborative partnerships that work, they'll say, 'I can't understand how

People with mental illness suffer what Pam Hines calls "adverse selection." Explains Hines: "Any new doctors who are taking on clients avoid our client population" — people with serious mental illness — "because they're more complicated."

I functioned before this was set up.' And some of these collaborations involve a big shift — sharing office space or having other people working in the office. But if there is a willingness to make that kind of leap, I think almost everybody who's gone into that kind of relationship has found not only does it improve patient outcomes but it makes practicing that much more enjoyable and supportive."

Jeff Kraemer is the e-content developer for CMHA, Ontario.

FOR MORE INFORMATION

FAMILY HEALTH TEAMS
www.health.gov.on.ca/transformation

CMHA, WINDSOR-ESSEX COUNTY BRANCH
www.cmha-wecb.on.ca

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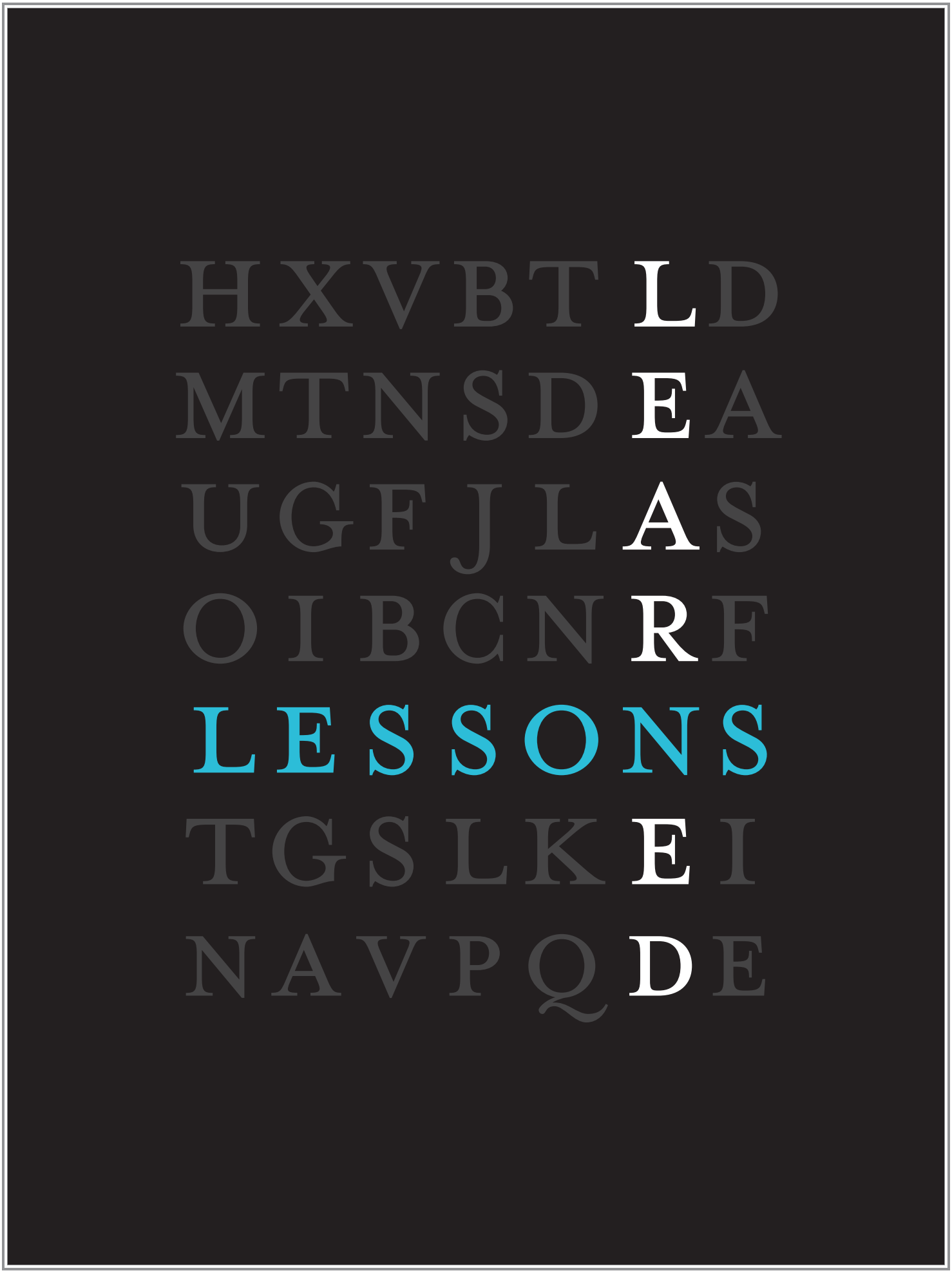
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Quebec started the trend in 1989. Alberta has been on board for 11 years. And Prince Edward Island was doing it for years but decided in April 2005 to go in the opposite direction. The trend is regionalization — shifting responsibility for health care services from the provincial level to local communities and regions.

Now this province has taken its own first steps toward a "made in Ontario" model of regional health care. In September 2004, Minister of Health and Long-Term Care George Smitherman announced the creation of Local Health Integration Networks. Called LHINs for short, these new organizations will eventually be responsible for planning, coordinating, and funding the delivery of health care services within 14 geographical regions.

What does this transformation in health care mean for community mental health services, including the 33 CMHA branches in cities, towns and rural communities across Ontario? What does it mean for the health care system as a whole? And, most importantly, but perhaps the most difficult to know, what will regionalization mean for people with mental health problems and their families?

Ontario's Plan for Transformation

Moving towards a regional system of service delivery is just one part of the Ontario government's plan to transform the entire health care system. Smitherman says the goal is to make Ontarians the healthiest Canadians, which can be achieved by making the health care system function as a true system.

A new patient-centred and community-based health care system will relieve pressure on hospitals by investing in five key areas of community-based health care: long-term care, home care, primary health care through the creation of 150 family health teams, community mental health, and a revitalized public health system that focuses on prevention.

Yes, health care will become the responsibility of the 14 LHINs, but don't confuse them with other types of regional health authorities, the ministry cautions. Unlike the models implemented in other provinces, LHINs will not directly provide health care services. Instead, they will work with local health care organizations, such as CMHA branches, which will keep their own voluntary boards of directors. Each region will have its own LHIN, but the boundaries will be "permeable," so that people can still get health care from different regions if necessary.

While mental health advocates in Ontario have responded positively to the renewed commitment to community-based care, and the government's investment in community mental health services, there are still questions about what we can expect from LHINs.

One way we can begin to answer these questions — and to know what questions to ask — is to look at what happened in other parts of Canada where regional health care systems have already been tried. If experience is a good teacher, what can Ontarians learn from the other provinces?

Partnerships among Mental Health Advocates

Mental health advocates in other provinces stress the importance of getting mental health on the agenda right at the beginning of the transformation process. The best way to do that is through partnership.

In British Columbia, alliances among provincial mental health groups have developed at different stages of the regionalization process. The most recent partnership is the broad-based BC Alliance for Accountable Mental Health and Addictions Services, which includes CMHA, BC Division. Alberta led the way in Canada with the development of the Alberta Alliance on Mental Illness and Mental Health to unify the voice of the sector. Tracy Ryan, executive director of CMHA, New Brunswick Division, says of the collaboration among players at her end of the country, including government, "We work together in this province. We have built strong partnerships."

Ontario seems to have learned this lesson. Three of the leading provincial organizations — the Canadian Mental Health Association, Ontario, the Centre for Addiction and Mental Health, and the Ontario Federation of Community Mental Health and Addiction Programs — have developed a collaborative response to the transformation agenda. Together, they have supported their members, staff, clients and boards to ensure that mental health and addictions are a priority in the planning taking place in each LHIN region, as well as pressing for the same priority at the provincial level.

Promoting the Provincial Role

Mental health advocates recognize that one of the strengths of regionalized health care is that decision making is brought down to the local level. Grassroots organizations like CMHA branches and consumer self-help groups have always stressed the importance of community involvement in decisions about mental health prevention, promotion and treatment services.

> Mental health advocates in other provinces stress the importance of getting mental health on the agenda right at the beginning of the transformation process. The best way to do that is through partnership.

But advocates in provinces where regionalization has occurred say that it's still essential to have strong provincial leadership to guide the development of mental health reform. Without some structure at the provincial level, decisions about what to fund are decided in each region.

New Brunswick is at a mid-point in the process of regionalization. While regional health authorities have been in place since 2003, mental health services have continued to be overseen by the provincial Mental Health Services Division of the Department of Health and Wellness. This year mental health services will also become regionalized, and advocates are concerned. "One of our worries," says Ryan, "is that we may in time lose the Mental Health Services Division, which means that we may lose the visibility and the strong focus on mental health that it provides."

While regionalization makes a strong provincial voice all the more important, it can also threaten the existence and stability of existing organizations. Part of the problem is related to funding. In Alberta, provincial mental health organizations, like CMHA, Alberta Division and the Alberta Mental Health Self Help Network, a consumer-run organization, were told to apply for their funding through the regional health authority where their head office was based. According to Carmela Hutchison, president of the Network's board of directors, provincial organizations were successful in "making the case to keep provincial organizations provincially funded." The Network felt that this was essential in making sure they were able to adequately serve and represent their 2200 members in the nine different regions of the province.

A diverse range of advocates have recently formed the BC Alliance for Accountable Mental Health and Addictions Services. In addition to traditional partners, such as CMHA, BC Division and consumer-run groups like the CSX Mental Health Society and the CMHA Consumer Development Project of Okanagan, the Alliance also includes the John Howard Society of BC and the Vancouver Police Department.

One of the Alliance's demands to government is the creation of a provincial mental health and addictions authority. This provincial authority would oversee planning and implementation. According to the Alliance, even when new funding is invested, "without a clear linkage to a provincial mental health and addictions plan and an accountability framework we will not know if funds have actually made a difference" ("From Marginalization to Recovery through Leadership," March 2005).

Local Advocates in Every Region

In addition to a provincial voice for mental health and addictions, there need to be strong advocates at the regional level, where the major decisions around allocation of funding and resources will be made. "Consistency is going to be our biggest issue across the province," says Ryan as the process of regionalization of mental health service takes place in New Brunswick.

Hutchison warns that regionalization can result in an uneven approach to planning and service delivery. In Alberta, for example, only two regional authorities, in Calgary and Lethbridge, have regional mental health advisory committees to provide consumer input on mental health issues. Hutchison says that these committees exist "because people in those regions actually got out there and took the initiative" to make them happen.

The potential for regional health authorities to be responsible for decision making on all aspects of health care, including mental health, means that mental health advocates have important work to do. "There's a lot of education that needs to be done with the regional health authorities," says Ryan, "because unfortunately each regional health authority board does not have a seat for someone with a mental health background."

Consumer Involvement from Start to Finish

Hutchison stresses that consumers and consumer-run organizations need to be involved from the get-go. "If they're not involved in the beginning of regional planning," she says, "they won't be there in the end." She warns that in a system where health care planning takes place at the regional level, "what doesn't get in the plan, doesn't get funded."

Ontario has a long history of provincial funding for consumer-controlled organizations, and advocates are determined to see that consumer involvement continues and thrives in a transformed system. According to a paper prepared by three leading mental health and addiction organizations, including CMHA Ontario, one of the critical success factors for the new system is that "consumers and families will be involved in all aspects of planning, decision-making, implementation and service delivery" ("A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario," July 2005).

Assessing the Impact on Consumers and Families

Does shifting control over health care services to local regions make a difference for individual consumers and their families? "In some places things got better, in some places things got worse, and in some places things stayed the same," says Hutchison. In other words, "Overall, things are the same as before in that access to services is still a random process. We need to make it so that it's not random."

While one of the proposed benefits of regional health authorities is integration of services so that families don't have to navigate a disconnected array of services, advocates warn that there are also potential downsides. In a situation where all services are provided by the regional authority, consumers risk being cut off from all their supports if they are banned as a result of their behaviour while in treatment, a situation that Hutchison has encountered in her peer support work.

Measuring the impact of regionalization on the quality of life of consumers and their families is challenging, since mental health services are only one part of what people need for recovery. Hutchison observes that consumer self-help groups that don't receive government funding aren't included in the regional health plans. They end up not being recognized as part of the mental health system. The result is that funded agencies may not refer people to these unfunded groups, and the resources and experiences they can offer people are overlooked. Other government-funded services such as housing or income security can also have a huge impact on consumers' lives but aren't always included in mental health planning.

According to the BC Alliance, regionalization has ultimately not led to any dramatic improvements in the day-to-day life of many people with mental health and addiction issues. The Alliance reports that, "despite previous initiatives in mental health and addictions service reforms that have resulted in some needed improvements and expansion of services," people with mental illness and addictions are still disproportionately living in poverty and homelessness and inadequately housed, and are at increased risk of contact with the police and involvement in the criminal justice system.

Consumers and consumer-run organizations need to be involved from the get-go. "If they're not involved in the beginning of regional planning," says Carmela Hutchison, "they won't be there in the end."

In contrast, Hutchison says that consumers in Alberta have recently benefited from a significant increase in payments under the monthly provincial disability income plan (Assured Income for the Severely Handicapped), as well as an increased allowance in the amount of money that they can earn from work while still receiving support.

Regardless of final outcomes, advocates often describe the stress and confusion that accompanies the process of changing to a regionalized system. In many provinces, regional boundaries were developed and then restructured at a later date. For example, Alberta had 17 regional health authorities that were reduced in 2003 to nine. This instability meant confusion for advocates who tried to help people navigate the health care system.

According to Hutchison, at one point in the transition her local regional health authority couldn't even tell her how many beds for psychiatric treatment were available in the region. There was, she says, "a lot of flux and confusion." Ryan reports the same process in New Brunswick, where "everybody's just working it out as they go along."

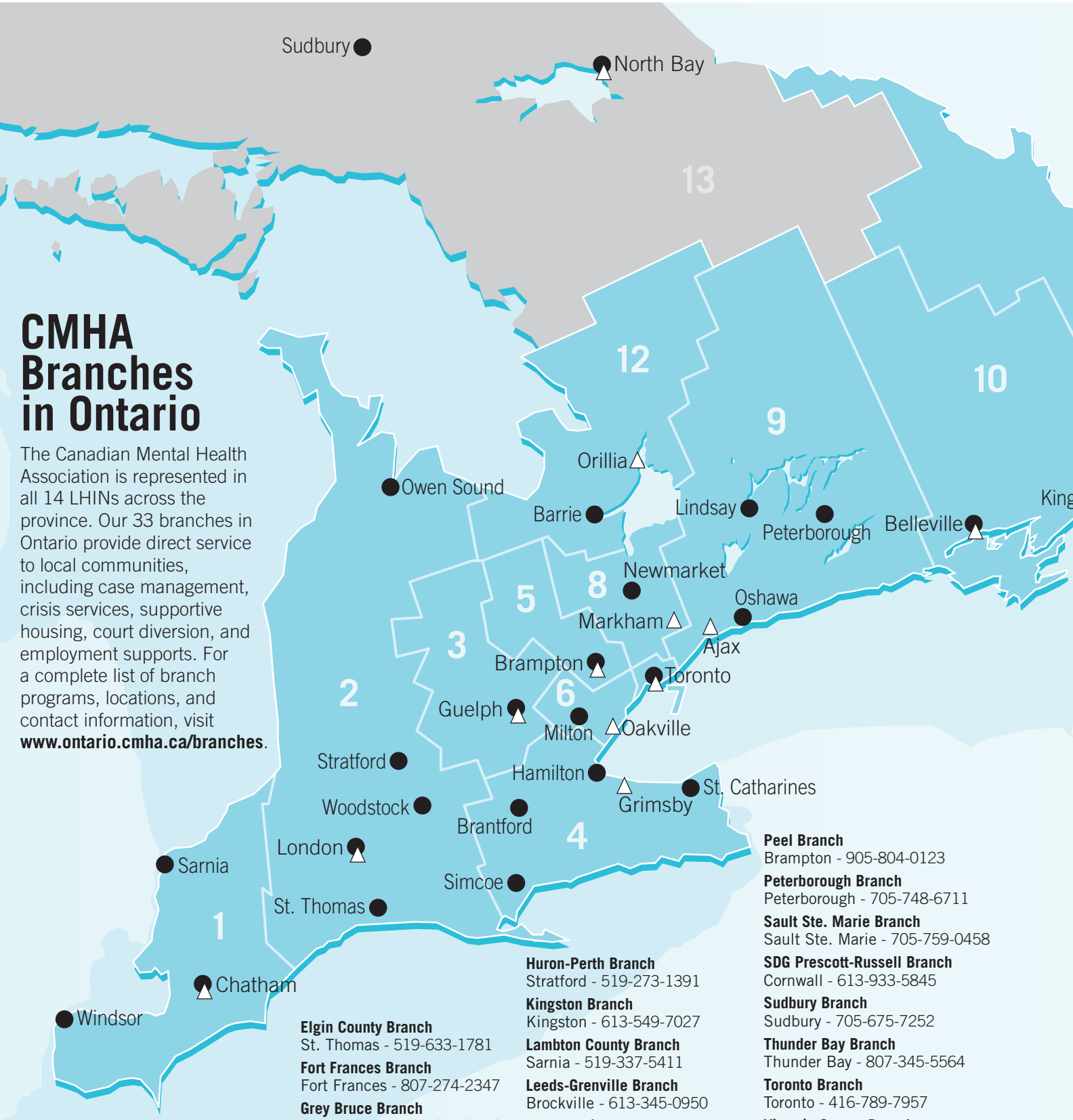
Mental health advocates in other provinces have experienced benefits and drawbacks in the shift to regional health care. Often, the way people are engaged in the process is as important as the outcomes.

The final word of experience comes from New Brunswick: "Communicate, communicate, communicate," stresses Joy Bacon, who took on the role of acting executive director for CMHA, New Brunswick Division in 2004-05, while Ryan was on maternity leave. "Communicate up, down, circles, lateral if you need to. You can never have too much information out there. People are going to speculate regardless. Unless you're sharing the information, people will fill the void with their own ideas about what's happening."

Heather McKee is a community mental health analyst for CMHA, Ontario.

CMHA Branches in Ontario

The Canadian Mental Health Association is represented in all 14 LHINs across the province. Our 33 branches in Ontario provide direct service to local communities, including case management, crisis services, supportive housing, court diversion, and employment supports. For a complete list of branch programs, locations, and contact information, visit **www.ontario.cmha.ca/branches**.



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TRANSFORMING ONTARIO

Local Health Integration Networks

Local Health Integration Networks (LHINs) are a key part of the provincial government's plan to transform health care in Ontario. These 14 regional organizations will be responsible for planning, integrating and funding local health services, including hospitals, community care access centres, home care, long-term care, mental health and addiction programs, community health centres, and community support services. New 1-800 numbers have been set up to ensure that the public, stakeholders and providers are able to access LHIN CEOs and board members. For more information, including detailed LHIN maps, population health profiles, a list of communities and health service providers within each LHIN, and news bulletins, visit **www.health.gov.on.ca/transformation**.

1. **Erie St. Clair**
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   London - 1-866-294-5446
3. **Waterloo Wellington**
   Guelph - 1-866-306-5446
4. **Hamilton Niagara Haldimand Brant**
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6. **Mississauga Halton**
   Oakville - 1-866-371-5446
7. **Toronto Central**
   Toronto - 1-866-383-5446
8. **Central**
   Markham - 1-866-392-5446
9. **Central East**
   Ajax - 1-866-804-5446
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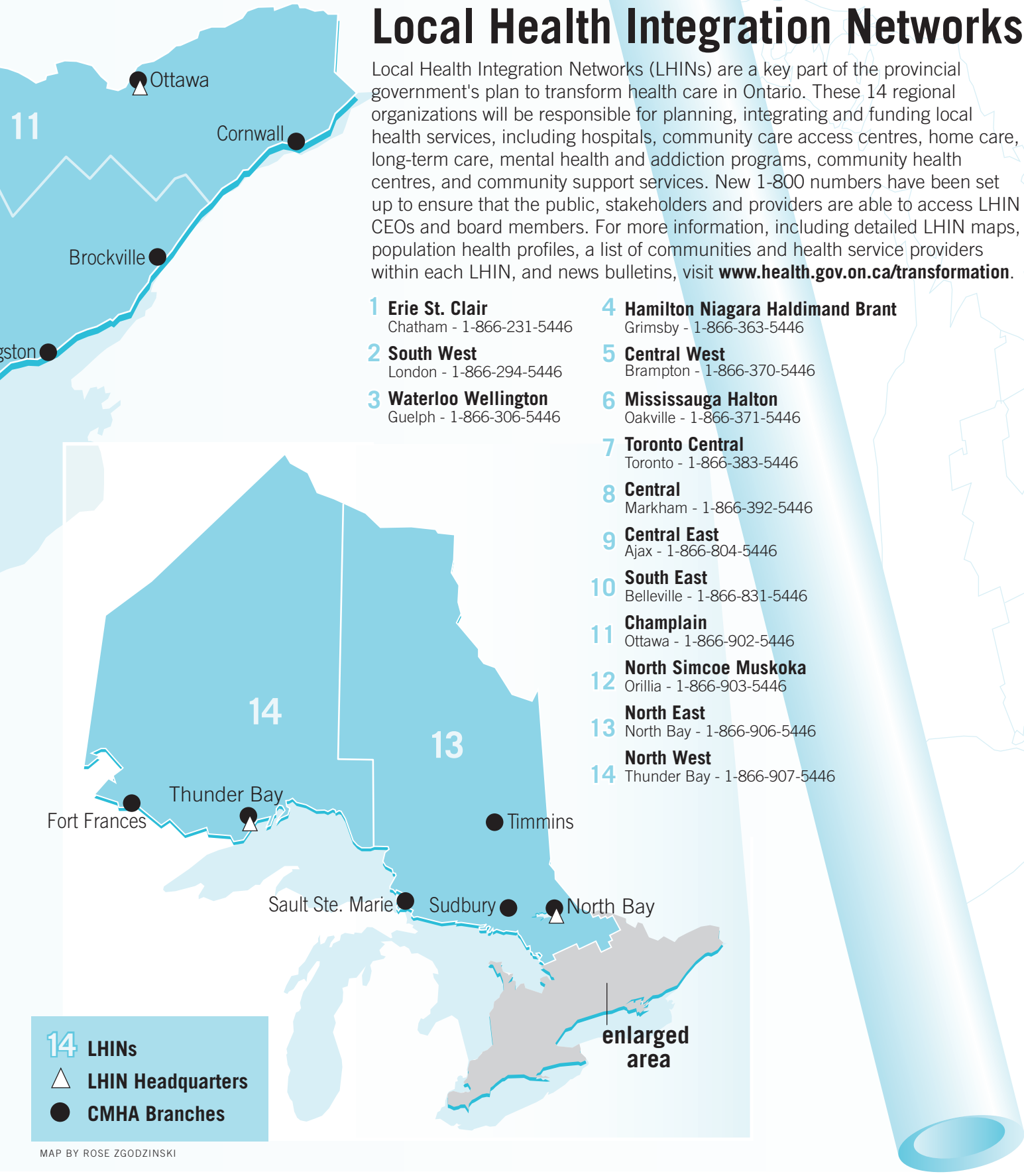
    Belleville - 1-866-831-5446
11. **Champlain**
    Ottawa - 1-866-902-5446
12. **North Simcoe Muskoka**
    Orillia - 1-866-903-5446
13. **North East**
    North Bay - 1-866-906-5446
14. **North West**
    Thunder Bay - 1-866-907-5446



MAP BY ROSE ZGODZINSKI

Setting *the* Table *for* Recovery

When George Smitherman announced his government's plan to transform the province's health care system, it sounded to some like a step towards their ideal goal — a recovery framework for mental health services. In his speech on September 9, 2004, before an audience of health-care policy-makers, providers and advocates, Ontario's Minister of Health and Long-Term Care outlined the essence of this transformation: "The ultimate goal is a system that embraces keeping people well and caring for them when they are sick."

Recovery has become an important concept in mental health. Given the appropriate supports, people with mental illness can and do lead productive, fulfilling lives. Recognition of this fact should be central to the delivery of mental health services. A recovery framework encompasses all aspects of the individual's health — not only their health care needs, but also their basic needs for shelter, food and clothing. It involves the health of the individual's body and mind, their social networks, their community, and their spiritual and emotional life. Most importantly, recovery necessitates active participation by consumer/survivors in every aspect of the mental health system, from service design to delivery.

Mental health service providers still have some distance to go to make this philosophy a reality, but a recovery framework has become a widely accepted model for mental health care. "Recovery is the objective we all agree upon," notes David Reville, a consumer/survivor and social policy and community development consultant, in a recent supplement in *Canadian Public Policy.* "But recovery comprises many different elements and there is no one-size-fits-all formula."

With the transformation agenda, the provincial government seems to be embracing the idea of putting health care consumers first in health care planning. During his speech, Minister Smitherman spoke about a system driven by the needs of the patient. But not everyone in the system is sure that the results will bear out this promise. For many involved in the mental health field, from consumer/survivors to service providers, the critical question is, Will the transformation agenda support or inhibit a recovery framework for mental health services?

Of the several initiatives undertaken by the transformation agenda, none seems more relevant to consumer/survivors and mental health service providers than the development of Local Health Integration Networks (LHINs).

LHINs are regional bodies set up to plan, administer and eventually fund health care services within communities. The policy of regionalizing health care planning is a widespread one, with almost every province across Canada currently employing some type of regional model. But the jury is still out on the impact of regionalization on mental health care. Some feel that LHINs may serve to more accurately reflect local needs, allowing service providers to be more responsive and collaborative. Others express concern that LHINs might focus too exclusively on a medical model of health care, overlooking other necessary conditions for recovery: stable, affordable housing, appropriate income supports, employment, educational and training opportunities, and peer and social supports.

Shawn Lauzon, executive director of the Ontario Peer Development Initiative (OPDI), a provincial association of consumer/survivor organizations and initiatives, sees the potential of LHINs. "I believe that's where the transformation agenda is going — to make sure that there is a holistic approach to health that will include housing, education, income, the determinants of health." On the other hand, Diana Capponi, a psychiatric survivor and coordinator of the Employment Works! program at the Centre for Addiction and Mental Health, says, "My fear is that [the LHIN model] is very much a medical model, and that the gains we have made [in the community sector] will be lost."

The concern some providers have is that if LHINs don't incorporate an understanding of the broader determinants of health, they will be unable to truly support a recovery model of mental health care. Brigitte Witkowski, executive director of Mainstay Housing, the largest non-profit provider of supportive housing in Toronto, says, "We look at the biomedical needs, but the biomedical system is not set up to look at social and environmental issues. If the response to the question 'What are my health needs?' is, 'I need not to have shootings in my community,' then the doctor listening will say, 'Well, nothing for me to do here!'"

> For many consumer/survivors, coming to the table isn't easy. "How do you tell people who have been told they are irrelevant for so long to turn around and be their own advocate and demand that they get what they need to live…We need to focus on developing the skills and abilities of the people who can speak to it directly." — Victor Willis

In some ways, the language of the transformation agenda underscores the concern — language such as "patient." Witkowski notes, "People need access to medical treatment, particularly if they are living with severe and persistent mental illness. But if you are coming from community supports, you are only a 'patient' while you're receiving that treatment. The rest of the time, you're a tenant, an employee, a citizen."

If the LHINs do focus on the traditional medical model of health care, the need for community mental health agencies to compete with high-profile organizations within the system for resources is worrisome to many. LHINs will eventually allocate funding for much of the health care system, including hospitals, long-term care facilities, community care access centres, community health clinics and addictions agencies. As Reville notes, "Part of the problem for consumer/survivors is that the health field is extremely

PEDRO ALDERETE,
I'M A PATIENT
(TRANSFER DRAWING ON WOOD,
SIX 12" X 12" PANELS)

competitive and survivors don't have the sexiest stories to tell, because of the stigma. So sometimes it's easier to tell the cancer care story."

"I don't see myself able to compete with MRIs, cancer care or any of the other things Ontarians want from their health system," agrees Victor Willis, executive director of the Parkdale Activity and Recreation Centre, a community centre offering support to consumer/survivors. "We have report after report that identifies the need for community services to be available and accessible. But how does that pan out when the competition for health care dollars is pretty steep, and when push comes to shove, MRIs and knee replacements take precedence?"

The other question is whether a medical model that emphasizes measurable results will take into account the more difficult to measure qualitative outcomes of many community programs. For example, Witkowski sees the quality of life experienced by consumer/survivors living in her organization's housing improve through their participation in a tenants association. "These are health strategies that have an outcome, and the challenge of measuring them is that they are on an individual basis in a group setting. We know that their health outcomes are improving — they are interacting better with other areas of the health care system. It can measure that they don't go to the hospital as much, but it doesn't measure other aspects that are incredibly important. We are talking about people's self-perceptions and their ability to navigate the world around them."

Not only does a recovery framework require an understanding of health care that extends beyond purely medical types of treatment, it fundamentally requires the active participation of the system's users. But while mental health care service providers had a strong presence at the LHIN consultation workshops that were held in the months following Minister Smitherman's initial announcement, it remains unclear whether, or how, health care consumers, and specifically psychiatric consumer/survivors, will be consulted. A community engagement process has been promised, and on September 16, 2005, the ministry announced a series of public information meetings about the LHINs, but no consultations with those who actually use the services have been scheduled.

Even if those consultations take place, as Willis notes, for many consumer/survivors, coming to the table isn't easy. "How do you tell people who have been told they are irrelevant for so long to turn around and be their own advocate and demand that they get what they need to live… We need to focus on developing the skills and abilities of the people who can speak to it directly. It's where the focus has to be for a LHIN, I believe."

Another challenge is finding the resources consumer/survivors require to get to the table — travel costs, child care and other expenses. So far, the ministry has provided no funding for any organization or individual to participate in consultation about LHIN development. While some consumer/survivor organizations did participate in the consultation workshops, for many, the costs were too high. "The operating budgets of consumer/survivor initiatives don't have high travel lines, and they have lower numbers of staff, so their ability to participate is hampered in that way," says Lauzon. When the workshops were taking place, he continues, "the ministry was asked if there were going to be any reimbursements to support some of the under-resourced organizations. There were none."

Consumer/survivors are challenging the ministry to do the difficult work necessary to bring representatives to the table, using consumer/survivor initiatives (CSIs) as a model. "Consumer/survivor initiatives by their very nature have always been membership-driven, community-based organizations, and there's always a dialogue between the membership, staff and board to ensure everyone is online," notes Raymond Cheng, a peer advisor at OPDI. "If everyone that is participating in the LHIN process wants to make sure that they are speaking for a patient-centred system of care, it would be appropriate for them to think about the way [CSIs] operate, the way we try to be responsive, and to consider whether they are taking the same stand."

However consultation happens, it's a necessary component of a recovery framework. As Willis argues, "A recovery system has survivors at every level. Will the LHINs have

survivors involved at every level, and who are they going to be? The table has to be set for them."

Integration has been a theme of the transformation agenda from the beginning. That critical September 2004 speech by Minister Smitherman referred several times to the need to "build a more integrated, patient-centred health care system." The mental health sector has responded to this call for greater collaboration with enthusiasm. The 14 community workshops held in November and December of 2004 allowed community mental health service providers to work together in an unprecedented fashion, with very positive results — according to the ministry, mental health and addiction services were named as a priority in each one. The process has helped organizations within the sector build stronger relationships, something that everyone agrees is a positive outcome.

According to Shawn Lauzon, the workshops "alerted a number of CSIs to start looking at their community partners and joining in to make sure that mental health was a strong focus in the outcomes of the consultations." As a result, he says, collaboration between organizations "occurred and can continue." Diana Capponi also feels that partnerships are key for the success of both consumer/survivor organizations and service providers: "CSIs need to ensure that their partners are integrating the recovery message, and get them talking about the importance of their initiatives."

While one of the early outcomes of the transformation agenda is that community partners have taken positive steps toward better integration and collaboration, it is not clear that those in government are taking similar steps. More than one ministry is responsible for the various programs that are so important to ensuring the health of consumer/survivors — in addition to mental health services funded primarily by the Ministry of Health and Long-Term Care, income support and disability issues fall to the Ministry of Community and Social Services, affordable housing is funded through Municipal Affairs and Housing, and children's mental health services are provided through Children and Youth Services.

> For many involved in the mental health field, from consumer/survivors to service providers, the critical question is, Will the transformation agenda support or inhibit a recovery framework for mental health services?

The latest addition to this list is the new Ministry of Health Promotion, which will focus on health promotion and illness prevention. Mental health care is generally thought to exist on a continuum, with acute care at one end and mental health promotion and illness prevention at the other. The government's commitment to health promotion is appreciated by many in the field, but health care providers also wonder about the wisdom of creating what could be two different silos at opposite ends of the continuum. Raymond Cheng puts it this way: "Health promotion, in and of itself, is a very good thing, but right now, if it's taken away from the transformation agenda, that might in the long run cause the mental health sector to focus more on the acute care and disease management aspect of mental health, and that may not ring true to some people who envision that recovery can go further than something that goes with an OHIP health card."

Defining Recovery

"Recovery is a journey that must touch all aspects of the internal and external life of a person. The self is at the centre of this journey. Caring for and about the self includes meeting basic needs such as those for shelter, food and clothing, as well as attending to one's physical and emotional health. But it also includes acquiring sound judgment, perspective and maturity. It is a journey of social and relational connection — to home, family, friends and community. It entails discovering one's life purpose through work, education, volunteering, or social activism. Finally, it involves an active spiritual relationship with manifestations of the universal that may be pursued through formally organized religion, through reconnection with culture, or through secular pursuits such as music, art and nature."

— CMHA Ontario, "Recovery Rediscovered: Implications for the Ontario Mental Health System," March 2003

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(TRANSFER DRAWING ON WOOD,
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The concern some providers have is that if LHINs don't incorporate an understanding of the broader determinants of health, they will be unable to truly support a recovery model of mental health care.

The distance between silos is often reflected in the nature of the care an individual receives. His or her needs may be segmented by a system that does not see a whole person. According to Reville, "The siloing of the sector means that the people who are prescribing medication don't know anything about employment issues, for example." Capponi is also skeptical about the degree to which LHINs will be open to the importance of employment for consumer/survivors: "I worry about consumer-run businesses. How are the LHINs ever going to understand the importance of that?" Capponi sees a need to bring the government's various ministries together around mental health care. "It's well past due that there needs to be a ministry to coordinate all the silos that are created… Recovery isn't going to happen if all these interests are siloed."

Willis notes that the need for this function was identified by regional task forces set up by the province to examine mental health care in Ontario, which submitted their final reports in 2003. "The task forces identified that there needs to be inter-ministerial communication, and the LHINs don't address that. A person in Ontario who has a disability isn't siloed — they're a whole person, and they need housing, income support, health care."

The key to ensuring that recovery has a place on the transformation agenda is a unified, strong consumer/survivor voice, supported and encouraged by the entire mental health sector and the Ministry of Health and Long-Term Care. Reville calls for a reinvigorated consumer/survivor movement, but notes that it might not be an easy task. "One of the dilemmas for any grassroots movement is what mechanisms are in place to help you decide what your agenda is. There are many possible agendas, and it's totally appropriate for people to be working on different things."

The lack of funding for CSIs also continues to be an issue. "They have really limited resources," according to Capponi. "They started far behind the line to begin with, and they're getting further behind each year." Willis adds capacity-building to the community's list of needs. "We need to do some work to develop people so that they can participate equally. If you want a recovery-based system, you need to invest some resources to bring your people up to speed. It's a great deal of responsibility to be a representative of the larger community. You need to encourage people to make the commitment, provide training opportunities." Lauzon agrees: "There need to be processes in place to help build the capacity for people to participate in the most meaningful way."

With strong and meaningful consumer participation, and a LHIN paradigm that recognizes the importance of the determinants of health, recovery may indeed become a fixture of the transformation agenda. "The survivor community has benefited from the advocacy it did with the bureaucracy of the ministry years ago, so it will depend on whether the LHINs are aware that the paradigm has shifted, which would be a good thing," says Reville. "Or they will revert back to a strictly medical model."

What consumer/survivors and all stakeholders in the mental health system cannot afford to do is wait and see, because the transformation agenda is progressing apace. As Minister Smitherman said when he announced the transformation agenda, "Is now the time for change? Without a doubt in my mind."

Liz Scanlon is the public relations and policy coordinator for CMHA, Ontario.

e is for enabler

"Enabling One Person One Record" is the motto adopted by the Continuing Care e-Health Council. It alludes to an ideal vision of the future when the delivery of health care services will be streamlined by technology. The cornerstone of the e-health vision — some might say the holy grail — is the electronic health record (EHR), a single point of access to an individual's complete personal health information. If you switch doctors, you won't need to fill out another personal history. If you show up in the emergency department of your local hospital, or another hospital at the far end of the province for that matter, the nurses and physicians on staff will immediately know what medications you may be taking.

"Clients would like to know that when they go to see a professional they are recognized as a person," says John McKinley, acting executive director of both the Acute Services and Community Health Divisions within the Ministry of Health and Long-Term Care. "Every time they walk into an office, or a clinic, or if they have someone coming into their home, they won't have to go through their background and history again. There would be some way of capturing that information that would be available to them, so they won't have to answer the same historical, demographic questions time after time."

One look at Ontario's health care system — encompassing everything from family doctors, hospitals, and neighbourhood pharmacies to medical labs, diagnostic imaging, long-term care homes, addiction services and community mental health agencies — is enough to suggest that creating an EHR is an incredibly complex task. Don't expect to lay eyes on this particular grail for quite a few years to come.

In the meantime, several related e-health projects are well underway. Standards for financial information management are already in use by Community Care Access Centres and are now being implemented in the mental health and addictions sector. A secure communications network for sharing information has been built, and the Smart Systems for Health Agency is working feverishly to connect Ontario's thousands of health care providers. User registration and access to secure e-mail, already a reality in the hospital sector, are coming soon to the province's 1,500-plus continuing care organizations. Drug and laboratory information systems are in development. And projects have been launched to create common assessment tools and a system for making e-referrals.

None of these e-health initiatives is considered an end in itself. Rather, the government views e-health as an enabler of its transformation agenda.

"Overall, the reason for the transformation is to improve health outcomes," explains McKinley. "It's timely access in some areas, it's improved throughput, and it's all for the client. As an enabler, e-health supports access to primary care."

"It also leads to better evidence-based decision making, both on the provider side and for the ministry in its resource allocation models," he continues. "Since we're now moving to Local Health Integration Networks, where more local decision-making will be expected, they need good evidence of what does and what doesn't work for their investment strategies into the future. That's how I'd term e-health an enabler."

Easy access to health information may indeed make life easier for health system planners and care providers, but the concept of an electronic health record also raises flags for anyone concerned about privacy. The issue of privacy is particularly important for consumers of mental health and addiction services, because of real fears about stigma and discrimination. The *Personal Health Information Protection Act* (PHIPA), which came into effect on November 1, 2004, places a clear obligation on health care providers both to protect personal health information and to allow access when necessary. The need to meet the requirements of PHIPA makes building an e-health system that much more complex...

This article is continued online at www.ontario.cmha.ca/network.

Scott Mitchell is manager of the Knowledge Centre at CMHA Ontario.

E-Sources

Canada Health Infoway
www.infoway-inforoute.ca

eHealthOntario
www.ehealthontario.ca

Smart Systems for Health Agency
www.ssha.on.ca

Transforming Health Care
www.health.gov.on.ca/transformation

THE GOLD STANDARD

By Michelle Gold

Rules *of* Engagement

Building a responsive, accountable health system begins with an understanding of the public's experience and expectations for health care. In Canada, governments are responding to the demand for greater accountability by promising to involve citizens in discussions about health care. As Ontario becomes the last province to move towards a regionalized system of planning, coordinating and funding local health services, it too promises to engage the public.

IN October 2004, Health Minister George Smitherman announced a new "made-in-Ontario" model of localized health system coordination through the creation of Local Health Integration Networks (LHINs). The Ontario government intends to transfer the planning and funding for a significant portion of the health system to 14 LHIN area organizations over a phasing-in period that will extend until 2007. Supported by a board and professional staff, LHINs will include a local "community engagement" function.

Experience from other settings demonstrates that there isn't a one-size-fits-all approach to community engagement. While the language varies, most public participation frameworks identify a continuum of engagement. At its simplest level, information is communicated out to the public on a need-to-know basis. At increasingly intensive levels of participation, the public may be asked for input, be consulted, be involved in partnerships with decision-makers or, on rare occasions, delegated to the principal decision-maker role itself.

So far, the Ministry of Health and Long-Term Care has not provided details on how the LHINs will fulfil their obligation to engage the community. My hope is that the ministry will move beyond generic communication strategies and direct the LHINs to actively involve consumers and their families in decision-making.

In Australia, the National Mental Health Strategy indicates that "consumer and carer input is essential if improve-

ments in service delivery are to be achieved."[1] Australia has developed a Mental Health Statement of Rights and Responsibilities that specifies that mental health consumers and families have the right to represent their interests and contribute to the development of mental health policy and care. According to the Australian National Consumer and Carer Forum (NCCF), this directive has ensured that consumers of mental health services and families are empowered to participate in national mental health policy and planning. Conversely, observes NCCF, consumer and family participation has been less successful at the state level, where fewer policies exist to support the inclusion of mental health consumers. The lesson to be learned is that unless consumer/survivors and families are specifically recognized as important stakeholders to engage, they are less likely to become involved.

The Future Is Now

Mental health and addiction services were identified as a LHIN priority for integration by (primarily) health care providers attending a province-wide series of community consultations conducted by the Ministry of Health and Long-Term Care in late 2004. Notwithstanding the fact that the ministry's initial outreach focused only on health care providers, I remain cautiously optimistic that consumer/survivors and families will be engaged to enhance mental health services. But a wish and a dream won't get you there. Consumer/survivors and families must take initiative. Begin by educating yourself about what's taking place.[2]

The LHIN mandate suggests two probable options for consumer and family engagement. Given that the vision for LHINs is to create a more responsive "patient-centred" system, individuals should be able to provide input about their personal experiences, preferences and satisfaction with services during planning cycles to be conducted by the LHINs. This type of input, typically acquired by collecting information through focus groups, interviews, surveys, round tables or hearings, is compiled and analysed by health planners to identify key themes and issues requiring improvement that will need to be addressed by the health service system.

Consumers and families may also be more intensely involved with the LHINs, but only if they are able to navigate the system and demonstrate leadership. What does this mean? As a former health system planner, I know the reality is that consumers and families who are able to bring forward issues on behalf of their sector (while setting aside any personal agenda), who understand the underpinnings of the health care system, who are willing to incorporate the findings of health system planning and monitoring into deliberations, who are willing to work towards solutions among interest groups, and who have extraordinary patience — these are the people most likely to be identified as key "stakeholders" and be invited to consult and/or partner with others at the decision-making forums convened by the LHINs.

However, the onus should not be entirely on consumers and family members to dig their way in. To secure their own credibility, elite institutions such as government need to ensure their policies and protocols enable authentic community engagement. For example, engaging the public in local health system planning in Ontario was a function of the former District Health Councils (DHCs), which have now been closed by the ministry in anticipation of the new LHINs. When I worked at a DHC, we consulted with stakeholders who had historically been marginalized, including mental health consumer/survivors, to identify factors that would enhance their participation in local health system planning. We committed to improve our engagement processes by developing a set of ethical planning principles to guide our work. The lessons we learned are outlined below and should be reviewed by the new LHINs.

> My hope is that the ministry will move beyond generic communication strategies and direct the LHINs to actively involve consumers and their families in decision-making.

Know Your Community

Planning organizations such as LHINs need to become knowledgeable about their diverse populations by connecting directly with stakeholders and letting them speak in their own voices. The LHINs should reach out to historically marginalized stakeholders to learn what barriers exist and what accommodation strategies are needed to ensure that special populations can participate equally in community engagement.

Be Transparent

It will be important for the LHINs to accurately describe their authority, as well as their limitations. They will need to explain who will be involved, at what level, and how the information gathered will be used. LHINs need to be transparent as to whether they are engaging the community as a means to communicate information out, to ask for feedback, to publicly consult, or to partner in decision-making.

Support Meaningful Engagement

Meaningful community engagement is based on an informed and activated public. The design of the LHIN engagement process will be critical to enabling stakeholders to become more influential. Key components include clearly defining the role of participants; ensuring participants have the right kind and right amount of information, expressed in plain language, to confidently participate in the process; having sufficient resources to support involvement; and allowing adequate time.

Hire the Right Staff
LHINs need to recruit experienced staff who bring a range of strategies for engagement. Community engagement is a sophisticated function, requiring knowledge of system issues and strategic skills in facilitating and brokering relationships among stakeholders. The credibility of LHINs will depend on having staff with strong skills to involve the public.

Follow Up
Participants want to know the results of getting involved. This basic tenet is often overlooked by professionals who take the information and run. Decision-makers have an obligation to explain how the information provided by participants was used in order to arrive at decisions. Transparency and accountability are integral to the success of the engagement process.

Be Present at Other Times
Sustainable relationships are an important foundation for community engagement. Open and frequent communication promotes understanding, which increases the capacity for trust — a key component for successful engagement. LHINs need to maintain their presence and ensure their staff are delegated to community engagement on an ongoing basis.

Community engagement is a core strategy within the ministry's plan for the new LHINs. Expect, look for, and ask for opportunities to get involved. Interested consumer/survivors and families should become familiar with opportunities for engagement. Don't be shy about asking for what you need. Responsive and accountable governments recognize that local planning structures such as the new LHINs must accommodate the needs of the communities they are intended to serve.

Michelle Gold, MSW, MSc, is director of policy and planning at CMHA Ontario. Prior to joining CMHA Ontario, Michelle was manager of knowledge transfer at the Hamilton District Health Council.

1 Mental Health Council of Australia, "Consumer and Carer Participation Policy Template," 2001, available at www.aasw.asn.au/adobe/publications/mental/MH_cacp.pdf.

2 See the Ministry of Health and Long-Term Care website at www.health.gov.on.ca/transformation and stay up-to-date with information posted by the Canadian Mental Health Association, Ontario at www.ontario.cmha.ca/action.

CALENDAR

October 23-26, 2005
Making Gains in Mental Health and Addictions: Transformation – Challenges and Opportunities. Third annual joint conference of Addictions Ontario, Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, and Ontario Federation of Community Mental Health and Addiction Programs. London, Ontario. 705-454-8107, rachel@haliburtonhighlands.com, www.makinggains.ca.

November 2, 2005
Mental Health and Criminal Justice Conference of York Region. Canadian Mental Health Association, York Region Branch. Newmarket, Ontario. 905-841-3977 ext. 267, sbradford@cmha-yr.on.ca.

November 2-5, 2005
Dissemination – Transforming Lives Through Transforming Care. 21st Annual Meeting of the International Society for Traumatic Stress Studies: Toronto, Ontario. 847-480-9028, istss@istss.org, www.istss.org/meetings.

November 3-6, 2005
Ontario Non-Profit Housing Association 2005 Conference and Trade Show. Niagara Falls, Ontario. 1-800-297-6660, www.onpha.on.ca.

November 13-16, 2005
Issues of Substance. Canadian Centre on Substance Abuse National Conference. Toronto, Ontario. 613-235-4048 ext. 237, eharrison@ccsa.ca, www.ccsa.ca.

November 20-22, 2005
Psychiatrists in Blue: Policing with a Purpose. Canadian National Committee for Police/Mental Health Liaison. Vancouver, British Columbia. 613-233-1106, www.cacp.ca.

November 22-24, 2005
Leading the Way: Innovation, Transformation, Best Practice. Ontario Community Support Association Conference 2005. Alliston, Ontario. www.ocsa.on.ca.

November 28-30, 2005
Mental Health Research Showcase: Advancing Mental Health Through Research, Innovation and Knowledge Translation. Alberta Mental Health Board. Banff, Alberta. 780-436-0983 ext. 234, 1-866-436-0983 ext. 234, showcase@buksa.com, www.amhb.ab.ca/showcase.

November 30, 2005
Electronic Health Information and Privacy Conference. Ottawa Centre for Research and Innovation. Ottawa, Ontario. 613-828-6274 ext. 224, ecobill@ocri.ca, www.ocri.ca/ehip.

May 11-13, 2006
Sharing the Care: Practice and Promise. 7th National Conference on Shared Mental Health Care. Calgary, Alberta. www.shared-care.ca.

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