Presentation to Standing Committee on Social Policy

Canadian Mental Health Association
Ontario
Mental health for all

Association canadienne pour la santé mentale
Ontario
La santé mentale pour tous

Local Health System Integration Act Review:

Canadian Mental Health Association, Ontario Division

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1 INTRODUCTION

Thank you Mr. Chair, and members of the committee. We're very pleased to be here today, to share our views on the Local Health System Integration Act with you. I'm so pleased to introduce my colleagues – leaders in three of our branches, Marion Quigley, from our Sudbury-Manitoulin Branch; Tim Simboli from our Ottawa Branch and Steve Lurie from our Toronto Branch. Marion, Tim and Steve all agreed to participate with me today to offer up a regional perspective when we are answering questions.

I know that a few of the MPPs around the table today also served on the Select Committee on Mental Health and Addictions. Before the Select committee began its deliberations, a number of you publicly expressed your interest in improving the mental health and addictions sector in our province. I know from experience that the MPPs that served on the Select Committee, amongst others, continue to have a keen interest in shining a spotlight on the tremendous need that exists in the mental health and addictions sector. While our task today is to discuss the Local Health System Integration Act, I think it's important to point out that the MPPs here possess a better-than-average understanding of the mental health and addictions sector, and we feel very fortunate as a result.

2 ABOUT CMHA ONTARIO

Before we get into the details of the Act, I'd like to share some background on our organization. The Canadian Mental Health Association was founded in 1918 and is amongst the oldest voluntary organizations in Canada. Across the country there are 120 branches and here in Ontario there are 31. We serve 50,000 Ontarians each year through a myriad of programs that include housing supports; public education programs; counseling; court supports and justice related services; seniors programs, family programs; wellness; workplace mental health etc. I could go on. Our Mission is "*To Make Mental Health Possible for All*."

I would like to offer a personal observation about our work for a moment – the success of CMHA is directly related to our branches offering programs that respect their local population and reflect the community they serve. As a relative newcomer to this organization it has been my observation, as I've traveled across Ontario that our branches have responded to the changing needs of their communities. In some cases, for example, this means offering programs to support seniors suffering from isolation and depression in communities where the population is aging. Fort Frances is a good example – as the paper mills closed and industry moved out, so too did the next generation – not surprisingly. The CMHA Branch has a Clubhouse Model which seniors can access daily, providing them with a social network, and additional supports for living independently which helps them remain in their home and out of more expensive mental health or long-term care programs and facilities. This is "community-based" at its best in my view.

This is one example of many across the province which serve to reinforce the value of community-based services. The Drummond Report references the value of the community-based system, and the importance of ensuring that any change to the system put the client at the centre always been

our belief. I'm proud to tell you that our work puts the client at the centre. I would like to share two brief stories to give you further sense of our work across the province.

A gentleman who we will call James (not his real name) was referred to the Mental Health Court Diversion Program of our Leeds Grenville Branch, following a charge of "Causing a Disturbance." James was 48 at the time, of aboriginal origin, suffering from bi-polar disorder and when unwell, presented very loudly and with rapidity of thought and expression. He came across as agitated, belligerent, argumentative and verbally combative. At six feet tall, he may be perceived as threatening, but he was not acting out. At the time of his referral, it was learned that James was a survivor of childhood sexual abuse; a chronic user or cannabis and was not taking his medication. He had also not seen his physician for a significant period of time and was estranged from his case manager.

Through the Mental Health Court Diversion Plan, James agreed to reconnect with his physician and participate in the psychiatric outpatient referral; be amenable to treatment recommendations; have regular contact with a case manager and check in regularly with the CMHA Court Diversion Worker while maintaining the peace. James successfully completed the plan in May of 2013 and his charge was stayed. Throughout the diversion process, James attended appointments and maintained contact with his case management team. He has subsequently ceased use of cannabis, re-engaged with his psychiatrist and is medication compliant. At his request, he maintains contact with the court diversion worker and now drops in to say hello. There has been no known additional police involvement at this time.

One last brief story... Larry Woodhouse, a real name I should tell you, as he insisted that I use it, has been accessing service at CMHA Oxford County. Larry came to learn about CMHA when his supervisor noticed he was not coping well in the workplace and invited staff from CMHA in to speak with him. Larry said at the first meeting with these staff that he learned coping skills, and was given the number to the CMHA crisis line in the form of a fridge magnet. He used the number frequently and subsequently received case management services with our Branch. Larry had a history of mental illness and suicidal ideation has indicated that in no uncertain terms that he is alive today because of CMHA. He has been asked to speak publicly about his experience by Mike McMahon, the Executive Director of the Oxford County Branch which he has done, raising money for the local United Way, which also funds the Branch. Larry described his numerous speaking engagements as "kinda cool" and a highlight of his life.

3 THE LOCAL HEALTH SYSTEM INTEGRATION ACT

One of the advantages of not being amongst the first to present to the committee is that you have the benefit of hearing and reading about what others that have gone before you have said and to understand different viewpoints. I read the presentation by Saad Rafi, the former Deputy Minister of Health and Long-Term Care with great interest. The matter of how the regionalization or decentralization of health care services came about and the evolution of the LHIN structure is a matter of public record. So too is the purpose of the Act – to "provide for an integrated health system to improve the health of Ontarians through better access to high quality health services,

coordinated health care in local health systems and across the province and effective and efficient management of the health systems at the local level by local health integration networks." We're not the first province to go down this road, and while we could debate today whether we should have, or what could or should exist instead of the LHINs, we would prefer to focus our comments on the existing structure and offer up some observations to share with you. In part, this is due to the fact that representing 31 branches across 14 LHINs, it is perhaps not surprising that experiences differ. Overall, we are supportive of LHIN Structure.We would like to highlight what has worked particularly well, and offer up some areas where there is some room for improvement which we hope will assist you in your deliberations.

For the purposes of this presentation, we'll mirror the contents of the Local Health System Integration Act and provide comments on Community Engagement; Funding; Accountability and Integration and we'll also provide further thoughts on Quality Improvement and Governance, both of which are integral to the system in our view. We'll also reflect on the recommendations contained in the Drummond Report, which we understand have been referenced throughout this review exercise as well.

4 COMMUNITY ENGAGEMENT & GOVERNANCE

Some LHINs operate with an openness and transparency to their work, they engage local boards as well as staff of community-based organizations, but this is not always the case. CMHA welcomes interaction at a governance level with LHIN Boards. It has been our experience that this has been a fruitful endeavor for both parties and has been mutually beneficial and necessary when large undertakings, such as an amalgamation of organizations takes place. A good example of how working together brings change to community – LHIN and CMHA local branches.

This government has brought forward many initiatives in reforming the health care system. The LHIN's are an important example, but so too are the more recent Service Collaboratives and Health Links. They are all valuable and there are many examples where they have been very successful. However, community-based organizations, such as our branches, often struggle to keep up. There is a strong desire to be at every table, and indeed there is an expectation that we will be, but the administrative burden is high and without a clear provincial objective of how all of these initiatives inter-relate, it can become unmanageable. We are hoping that with the pending implementation of years four through ten of the ten year strategy, will assist in providing clearer provincial direction.

4.1 PROVINCIAL GOVERNANCE

We are pleased to be part of the ongoing discussion about years four through 10 of the mental health strategy with the Ministry of Health and Long-Term Care. While the Ministry considers its future priorities regarding mental health and addictions, we would simply reflect that dramatically changing the governance structure of mental health and addictions as stated in the Select Committee on Mental Health and Addictions report is not a priority for us at this time. The

resources necessary to do so would be far better spent providing additional housing and other mental health and addiction related supports. Much can be done within government and the community-based system to better coordinate programs and service delivery, including through the LHIN structure. There are currently far more Ministries than there ever have been focused on mental health and addictions, and there are structures and processes within government that could link them together. They need to be utilized. The Canadian Mental Health Association is currently exploring options along with other community partners on how best to achieve efficient system-wide planning provincially.

5 FUNDING

To begin with, we would like to offer up some data to show both the size and scope of the need for mental health care from a global, national and provincial perspective. Some of this information comes from a document that my colleague Steve Lurie has produced on the current system titled "Why Can't Canada Spend More on Mental Health." This will be formally published very shortly and we have provided copies for you today for your interest. These statistics are really just to demonstrate the scope of mental health and addiction related issues, and why it's necessary to get the funding and delivery system right, first and foremost for the client and their family, for our health care system in communities and for the economy as a whole.

It is worth noting, from a global perspective, that:

- The World Health Organization notes that mental illness accounts for 13% of the world's disease burden.
- We are falling behind other high income countries when it comes to spending on mental health at 7.2 % compared to most others who spend 10% or more.

In Canada:

The following points reflect the impact of the lack of available treatment and supports nationally, the resulting effect on our economy and also how mental health compares to physical health issues.

- The Mental Health Commission of Canada has indicated that as few as one in three adults and one in four children receive mental health treatment and support when needed.
- The MHCC has also noted that the cost of mental health related issues is $50 billion per year to our economy.
- 6.7 million Canadians out of a total population of 37 million are living with mental illness, compared to 2.2 million living with type 2 diabetes.
- The Mental Health Commission of Canada recommends that at least 9% of health spending should be on mental health, and a further 2% increase in social spending is also needed.

In Ontario:

- The Drummond Report cites that "estimates of the economic costs of mental health and addictions are pegged at $39 billion annually, with productivity losses accounting for 74 per cent of the costs."

- According to public accounts, community mental health funding comprises 2.5 to 3% of LHIN funding. As previously mentioned, the Mental Health Commission has stated it should be 9%.
- There are 441, 027 unique individuals served by ALL community mental health and addictions programs annually in Ontario at a cost of $51 for these services compared to $138 for in-patient/physician based mental health services.

As stated, these figures demonstrate the tremendous need and funding shortfall that exists. We use this information in working with the Ministry of Health and Long Term-Care and with the LHIN's, to reinforce the need to make further strategic investments.

The Drummond report recommended the following "Support a gradual shift to mechanisms that ensure a continuum of care and care that is community-based. Funding for community-based care may need to grow at a higher rate in the short to medium term in order to build capacity and take pressure off acute care facilities; on the other hand, with a shift away from a hospital focus, hospital budgets could grow less rapidly than the average." There is evidence of this over the past few years, and there is no doubt that further investments in housing, peer support, employment, case management, Assertive Community Treatment, early psychosis intervention etc. will further alleviate the higher costs associated with hospital or institutionalized care.

5.1 FUNDING COORDINATION

There are some practical implications to having two funders for some community-based services. Specifically, the funding for supports within housing is the responsibility of the LHINs. The funding for bricks and mortar and rent supplements lies with the Ministry of Health and Long-Term Care. As previously indicated, housing is the highest need across Ontario when it comes to supports for those living with mental illness and addictions. The process for getting approval for new housing with supports, however, is exceptionally difficult to navigate because it requires coordinated funding. In one particular branch example, the Ministry of Health had provided funding for rent subsidies but this did not correspond with additional staffing dollars from the LHINs, leaving the agency to manage considerably more service with existing staff. That same agency received a sizable investment of additional dollars from the city where they're located for considerably more rent subsidies over a five-year period, but again the LHIN would not approve additional resources in the form of additional staff to manage increased service delivery. This makes any attempt to sustain a "Housing First" approach extremely difficult within communities, despite the fact that considerable literature points to this as a worthy goal.

5.2 FUNDING TRANSPARENCY

While soliciting feedback from our branches for this presentation, it was noted that often funding is not applied equitably or consistently across the system. Perhaps not surprisingly, there is strong competition for dollars and a lack of clear direction on priority items as it relates to funding. Dollars may be provided to new "start up" programs, leaving those programs that had proven successful without resources. This points to the need for better coordination more than anything

else – strong partnerships must rely on healthy communications so that all partners feel engaged and included in how decisions are made.

5.3 DEFINITIONS

There is further sense of a lack of coordination amongst LHINs around fiscal matters. This is best evidenced by different definitions that are used across LHINs. Some branches are advised that their administrative budgets include rent, others do not; some suggest the cap is a certain percentage, and it may be very different in the neighbouring LHIN. This is clearly not deliberate and not intended to handicap any organization, however, simple agreement amongst the LHIN's on the terms and their use across the province will help organizations achieve their targets and share best practices more easily with one another.

6 ACCOUNTABILITY

Considerable effort has been made to engage the community-based organizations on the refinement of the MSAA, or multi-sector accountability agreement. The MSAA table has met very regularly under the able leadership of Louise Paquette of the North East LHIN. There has been a respectful exchange and ideas raised by the community sector were listened to, and taken back for further consultation and decision making. It has been a good process, and we're pleased that it will continue into the future. This partnership-building is important for all parties. The community based sector worked hard to "do their homework" to offer up important insight and provide the best possible information and feedback to the larger group, which we hope and believe was beneficial to the LHIN table and will ultimately be seen in a much more workable, agreeable MSAA template for all parties.

7 QUALITY IMPROVEMENT

As you know, The Excellent Care For All Act (ECFAA) legislates annual Quality Improvement Plans for every health care organization.

The Canadian Mental Health Association in Ontario has embraced this requirement, and before we were mandated to do so by the Local Health Integration Networks, we set to work provincially to develop our own template for use in mental health and addictions. Leadership for this exercise began with our Executive Director Network, made up of the CEOs of all 31 branches who meet regularly throughout the year. Linda Gallacher, CEO of the Durham Branch spearheaded our efforts in this area, by engaging a small working group of her colleagues to initiate a plan of action. It was recognized early on that the templates that were being developed by hospitals had little relevance to the community-based system of mental health and addictions, so we set out to develop our own. Surveys were conducted to see what amount of work had been done on quality improvement within our branches. Armed with that information, a working group of skilled staff in our branches was struck, and they in turn developed a draft template. The template was then shared with Addictions and Mental Health Ontario for their input. To their great credit, they were

very willing and anxious to work with us to ensure that the template was suitable for their agencies as well, so that ultimately we would have one template for the entire sector. David Kelly, Executive Director of Addictions and Mental Health Ontario and I have worked together to bring this template to provincial officials including Health Quality Ontario and the Health Quality Branch at the Ministry of Health and Long-Term Care. The template has been well received, and we have subsequently been asked to consider what resources might be necessary for its implementation. We have done so and submitted a proposal to the Ministry.

I raise this with you to demonstrate our efforts in partnering and ensuring we are meeting and exceeding all requirements of the Ministry and our LHIN funders. This partnership is one example of many that happen provincially to ensure the best use of resources across mental health and addictions as well as other broader social service organizations as well.

It must be said that while a focus on quality is important, for us to achieve success, quality must be objectively measured through standardized methodology using consistent definitions. Having the capacity within organizations is also critical and at the moment, all of these criteria are missing. We will continue to advocate for these needs.

8 INTEGRATION

Since the advent of the Local Health Integration Network, a considerable amount of integration has taken place across the health care sector. Some of it involves bringing programs together and in some cases organizations in an attempt to enhance service delivery. The Canadian Mental Health Association has done a great deal of work in integrating primary and mental health care, and we will continue to play a role as a resource to the LHINs for this work.

It has been our experience to date, that the most successful integration of community-based organizations has resulted from local decision making by interested parties.

The parties identify where they could collaborate or in some cases merge to benefit the consumer, and present the concept to the LHIN. With LHIN support and guidance, these mergers have worked well to the benefit of the most important stakeholders, those accessing the service. It is our view that the decision to integrate services or merge organizations should be taken with only this stakeholder group in mind – the consumer. These decisions should focus on how the consumer can best access the most appropriate service – in the right place, at the right time. As the Drummond Report recommended, "the system should be centred on the patient, not the institutions and practitioners in the health care system." We are pleased that many of our branches have expanded as a result of integration with other organizations to provide better access to the most appropriate treatment for our consumers.

We have been concerned in some situations where the focus appears to be integration for the sake of integration, with simply having fewer organizations being the objective. In some cases, the decision to integrate organizations has not followed a constructive process involving stakeholders. We would respectfully recommend that the following steps be considered before formal action is taken to merge organizations:

- Focus solely on client service as the primary objective.
- Analyze client data from across the catchment area to ensure there is evidence of the need for system change. This can be done by using the Ontario Perception of Care Tool for Mental Health and Addiction Services. This will allow for a representative sample of the needs of the community.
- Conduct a thorough cost analysis in a transparent fashion. It should include the following measures:
    - human resources cost impact analysis of merging unionized and non-unionized positions regionally (if applicable), as well as hospital and community sponsored wage grids
    - harmonization costs across sectors, as well as pension, benefits, employment contracts and severance costs to be borne by the LHIN
    - incorporation and dissolution costs attributable to agency mergers to be borne by the LHIN
    - long-term lease and mortgage commitment transfer costs where/as applicable to be borne by the LHIN
    - legal costs inherent to dissolution and new incorporation to be borne by the LHIN
- Consider that there is comprehensive literature that exists detailing the negative impacts of forced mergers and benefit of strategic alliances. The alliances can be more successful at less cost
- Consider all options including other investments that may prove more beneficial for local service delivery, such as electronic infrastructure to assist in the effective utilization of records for all providers.

Most concerning is the myth that integration saves money. Often there are insufficient resources to start, leaving no savings at the end of the process. Instead, CMHA Ontario recommends that the decision to integrate be made based on what makes the most sense from a client perspective including how best to access the system.

9 CONCLUSIONS:

We are pleased to partner with the Local Health Integration Networks across the province to provide the very best service to consumers in need of mental health and addiction supports. We believe that only through respectful collaboration can we ensure that the system is operating efficiently and well, to the benefit of the consumer.

We provided a number of recommendations through this presentation – all of them doable, and we are happy to be engaged with all 14 LHINs across the province in achieving our collective goals.

Our recommendations include:

- Additional emphasis on openness and engagement with the boards and staff of community-based mental health and addictions organizations
- Transparency in funding decisions
- A recognition of the need for further investments in our sector to meet the needs

- Clearer definitions on financial matters
- Agreement on standardized methodology to ensure our Quality Improvement work is successful and meaningful
- Integration for the sole purpose of improved client service; and an open, transparent, engaging process with community partners before proceeding

Thank you for the opportunity to appear here today. A special thanks to the Clerk of the Committee, Valerie, for her efficient response to our request to participate. Along with my colleagues I am very pleased to answer your questions.