



**CANADIAN MENTAL
HEALTH ASSOCIATION, ONTARIO**

**ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE, ONTARIO**

Environmental Scan

National Snapshot of Community Mental Health Services in the Context of Regionalization

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Regionalization Environmental Scan

Table of Contents

Executive Summary.....	i
1. Introduction	1
Scope.....	1
Approach.....	1
Limitations.....	2
2. Creation of Regionalized Structures in Canadian Provinces.....	2
Realignment of Provincial Responsibilities.....	3
Budgets for RHAs	5
Evaluation of Regionalization Efforts.....	5
Recentralization	5
3. Mental Health Services & Supports in Regionalized Systems	6
Policy Setting.....	6
System Planning.....	7
Funding	8
Basket of Services	9
Availability and Access to Services.....	9
Accountability	10
Performance Monitoring	11
Program Standards	11
System Integration.....	11
4. Summary of Key Findings from Provinces Undergoing Regionalization.....	12
5. Ontario Experience To-Date	13
The Local Health Integration Networks	13
Policy Setting.....	13
Funding	14
Program Standards	14
Performance Monitoring	14
Evaluation of Regionalization and Community Mental Health	14
6. Lessons for Ontario	16
Appendix: Summary of Provincial Structures and Mental Health Services.....	17
References.....	22

Executive Summary

The introduction of the Local Health Integration Networks (LHINs) in Ontario has changed the landscape for the policy, planning and delivery of community mental health services and supports. Although Ontario's approach is unique in Canada, there is much that can be learned from approximately 15 years of experience of regionalization in other provinces.

This paper provides a snapshot of the provincial and regional contexts in which community mental health services and supports are delivered. Data were gathered through open-ended telephone interviews with key informants.

Summary of Key Findings from Provinces Undergoing Regionalization

- Approaches to regionalization of health care services across Canada have varied and evolved over approximately 15 years of experience with regionalization.
- The restructuring of responsibilities under regionalization has led to a reduction in capacity for mental health planning at the provincial level.
- Lack of clarity regarding provincial and regional roles has meant that provincial mental health plans have not been implemented as intended, due to confusion over who is accountable for what.
- The involvement of the Regional Health Authorities (RHAs) in provincial planning has often shifted discussions towards operational issues and away from provincial strategy.
- Mental health services that are provided in hospitals and outpatient clinics that incorporate psychiatric services are included under all regional health structures. Community mental health services and supports are not always provided under the regional structures, but may be provided through contractual arrangements between the regional health authorities and community organizations.
- Mental health services vary in type, availability and accessibility across RHAs and between provinces.
- RHAs have been challenged to manage competing demands for health care within a system of finite resources. The needs of an under-funded mental health system have been in competition with acute care, home care and other health service demands. These pressures have been exacerbated by fiscal constraints, human resource shortages and increased demands on performance.
- RHAs have tended to move away from protected mental health funding and towards funding mental health services from the same regional health budgets as other health services.
- Contractual agreements between RHAs and community mental health agencies have proven onerous and have had a negative impact on the organization's resources.

Regionalization Environmental Scan

- There is increasing emphasis on accountability, transparency and health system performance in all regional structures.
- Nova Scotia is the only province with mental health care standards but it has been unable to implement them fully due to a lack of funding.
- Little evidence was found of mental health system integration as a result of regionalization. Mental health and addiction services appear to be in the early stages of dialogue about integration. Integration with primary care and chronic disease management was not evident in the interviews.
- Recentralization in Alberta, New Brunswick and Prince Edward Island may be in part a response to gaps created by loss of provincial capacity and the need to have more consistent approaches to service across regions.

Lessons for Ontario

- Understanding and adapting to new roles at the provincial, regional and local levels is fundamental to a successful transition during regionalization. This transformation must be driven by clear provincial policy that directs and integrates the activities at the regional and local level.
- Ontario's current mental health policy is more comprehensive than many other provinces and recognizes the important role that community mental health services play in supporting the recovery of people with serious mental illness. Ontario should ensure that regionalization does not divert attention away from continuing to formulate and implement mental health policies and directions that support recovery.
- The new stewardship role of the Ontario Ministry of Health and Long-Term Care (MOHLTC) continues to support and enable dialogue and consultation between ministry staff and stakeholders at the provincial level.
- In Ontario, continued collaboration among provincial organizations should be encouraged and utilized to provide advice on mental health policy development, provincial system planning, standard setting and performance monitoring.
- Community mental health agencies in Ontario that are small to medium size need to build capacity to be able to respond to the demands generated by their new relationship with their LHIN.
- The delineation of authority, roles and functions between the MOHLTC and the LHINs needs to be clarified.
- Mental health program standards are under development in Ontario. Adequate funding is necessary to support implementation of standards.
- Provincial organizations need to support the sector by building capacity to help them demonstrate performance results and assist their ability to adapt to change.

1. Introduction

Community mental health services and supports are essential to support the recovery of people with a serious mental illness (SMI). In Ontario, the introduction of Local Health Integration Networks (LHINs) has changed the environment for policy-making, planning and delivery of community mental health services. Ontario's approach to regionalization has been unique to Canada, in that the LHINs have authority over the planning, funding, and evaluation of health services in their geographic boundary, but local service providers retain their individual corporate entities and governance. Nonetheless, there is much that can be learned from the experience of community mental health agencies in other provinces following regionalization.

The Canadian Mental Health Association (CMHA), Ontario has developed a Canada-wide snapshot of the organization and provision of community mental health services and supports in the context of regionalization. This overview is intended to identify experience in other provinces that can inform Ontario policy-makers, decision-makers and service providers concerned with enhancing community mental health services, as this province's health system transformation proceeds.

Scope

Community mental health services and supports have been broadly defined as programs for adults (18 to 65 years) with a serious mental illness (SMI). Individuals using these programs reside in the community and access the programs in community-based settings.

The primary focus of this investigation is on community mental health services and supports within regionalized health systems. These services are part of a broad continuum of mental health services, including primary health care, hospital in-patient and outpatient services, and addiction services. They are, therefore, part of an interdependent system to support individuals with a mental illness and their families.

Approach

Information was gathered through open-ended key informant interviews with 18 individuals across Canada. Interviews were mainly conducted by telephone. Relevant documents, ministry and regional health authority (RHA) websites and literature were reviewed to further clarify or enhance information gained through the interview process.

Executive Directors/ CEOs of Canadian Mental Health Association provincial divisions were interviewed. Eight additional key informants were identified by CMHA divisional Executive Directors/ CEOs to provide further perspective on the current context for the delivery of community mental health services.

Limitations

This overview presents a snapshot of regionalization at a particular point in time. During the course of the investigation, two provinces announced a shift from regionalization to more centralized structures. The investigations were conducted in summer 2008. Some additional information was added to the report in fall 2008 and into 2009 to reflect both these changes and the publication of two key reports in Ontario: an evaluation of the devolution of authority in Ontario and the Auditor General of Ontario's value-for-money audit of community mental health services.

It is further recognized that community mental health services and supports are not necessarily comparable across provinces due to different provincial mental health plans, strategies and identified population needs.

The approach is also limited by the number and selection of key informants interviewed.

2. Creation of Regionalized Structures in Canadian Provinces

Canadian provinces began to create regional structures for the delivery and governance of health services starting in the 1990s. Commonly referred to as regional health authorities (RHAs), these structures were intended to address fragmentation in health services delivery, inefficient use of health system capacity, and to decentralize planning and decision-making about health system function and funding to the local level. Provincial governments devolved authority to regional structures by enacting legislation that provided a mandate to directly plan, fund and manage these services. Legislation also centralized governance authority for local health care organizations into RHAs. The boards of local organizations were dissolved and the RHA became the employer for most health services within that geographic region.

Regionalization has now been tried in every province. Implementation occurred at different times and with different regional structures. Despite the fact that the provinces have implemented regionalization for similar reasons, no two jurisdictions have implemented identical systems. Each regionalization model reflects the unique set of circumstances in that province.¹

The degree of success of regionalization has varied across provinces, yet there is general agreement that regionalization is designed to produce:

- less fragmentation in the system,
- less duplication of services provided in hospitals and
- partnership development.²

Many health services are included within the authority of the regional structure, such as hospitals, community care, home care and long-term care facilities. Services generally excluded from RHAs include physician services, primary care, pharmaceuticals and laboratories. In Ontario, public health services and emergency medical services are also excluded from the LHIN mandate.

Mental health services provided in hospital or outpatient settings that include psychiatric treatment are usually provided under the regional structures. By comparison, community mental health services and supports such as housing, employment, vocational services and income maintenance programs that do not involve psychiatric treatment may or may not be included in the regionally governed basket of services, with included supports and service providers varying across the provinces.

In Newfoundland and Quebec, social services are included under the regional structure. In these provinces, the RHA provides many of the community mental health supports. In Ontario, supportive housing services and some employment support programs are funded through the LHINs. [See Section 3 and the Appendix for a summary of the different baskets of community mental health services and supports provided within and outside of regional structures in each province.]

Regional structures have undergone considerable changes over time and continue to evolve. Provinces have reconfigured the RHAs by changing regional boundaries and the number of regional structures, as well as making other adjustments to enhance service and operational efficiency.

Realignment of Provincial Responsibilities

With the devolution of authority from provincial to regional health structures, the scope of provincial responsibilities has realigned. Provincial staff have been reduced or redeployed to other areas of government. Many were hired by RHAs to balance provincial and regional roles. Information from key informants indicated that reduced provincial capacity has resulted in loss of expertise, particularly for mental health policy and planning. The role of remaining provincial staff is often constrained due to decreased human and other resources, and a shifted mandate.

Legislation supporting regionalization places a strong emphasis on the regional role and its authority. Provincial programs, particularly for tertiary services, have been distributed to the regions. For instance, a psychiatric facility may become the responsibility of the RHA in which it is geographically located.

The new role for the regions in coordinating what were formerly provincial responsibilities has translated into a stronger role for the regions on provincial committees. This involvement has tended to shift the focus of provincial workgroups from broader policy and strategic planning to more regional and operational issues.

In order to address gaps generated by the shift in authority to RHAs and the government's new roles, most provinces have created advisory bodies and/or crown organizations to maintain some level of focus and expertise on mental health at the provincial level.

The governments of Saskatchewan, Manitoba, Nova Scotia, New Brunswick and most recently Ontario have established provincial advisory committees to monitor and consult on provincial mental health needs and service delivery. Representation has been drawn from the health professions, community based agencies, not-for-profit organizations, and consumers and family

members. Ministries/Departments of Health have tended to use these committees for consultation rather than direction setting, thus limiting their influence. However, the Provincial Mental Health Advisory Committee in Nova Scotia has been instrumental in the development of standards for mental health care. In Ontario, the Minister's Advisory Group on Mental Health and Addictions was established in the fall of 2008 to advise on the development of the province's 10-year mental health and addictions strategy.

In other provinces, crown organizations were created with defined roles for providing and/or monitoring mental health services. The former Alberta Mental Health Board (AMHB) is the best example. Originally, this organization was responsible for the delivery of mental health services in Alberta, as mental health services were not initially included in services governed by the RHAs. In 2004, it was decided that mental health services would be shifted to the RHAs and integrated with physical health care services. Thereafter, the AMHB became a provincial advisory agency dealing with system-wide mental health services issues. The most recent restructuring, effective April 1, 2009, dissolved the AMHB, along with the other 11 provincial health authorities, into the new centralized Alberta Health Services. An advisory committee will be created to report to the new centralized provincial authority on mental health services and mental wellness.³

In British Columbia, the Provincial Health Services Authority (PHSA) is the only provincial health authority, working alongside five regional authorities that serve distinct geographic areas of B.C. The primary role of the PHSA is to ensure that BC residents have access to a coordinated network of high quality specialized services. The PHSA focuses exclusively on provincial programs and operates provincial agencies, including the B.C. Children's Hospital and the B.C. Transplant Society. By planning, coordinating and evaluating specialized health services, the PHSA works with all regional health authorities across B.C. to provide health care for people who require provincial services, including individuals with serious mental illnesses. B.C. Mental Health and Addiction Services (BCMHAS) is an agency of the PHSA that provides a range of provincial mental health services including specialized tertiary mental health treatment services for children and adults, forensic psychiatric services, and mental health promotion. The president of the BCMHAS serves on the executive council of the PHSA.

By comparison, community mental health services in Prince Edward Island and New Brunswick are directly overseen by the Departments of Health. Whereas the provision of mental health services by the P.E.I. Department of Health is a result of recentralization of the health authorities in 2005, the Mental Health Services Division of the New Brunswick Department of Health directly manages 13 Community Mental Health Centres distributed across the province's two RHAs.

Finally, in many provinces voluntary coalitions or partnerships have formed among health service providers, community-based and not-for-profit organizations, and consumer and family member groups to monitor mental health services delivery and to communicate collective concerns to government. Informants identified the existence of such partnerships in British Columbia, Alberta, Saskatchewan, Nova Scotia, Newfoundland and Ontario.

Budgets for RHAs

A funding allocation is determined for each RHA by the provincial ministry or department of health. In Alberta and Quebec, the allocation is derived from a population needs-based funding formula. Other provinces are in the process of developing population needs-based funding formulae. In the remaining provinces, the method for determining the regional allocations is not clear.

Evaluation of Regionalization Efforts

In February 2008, Manitoba released the Report of the Manitoba Regional Health Authority External Review Committee. The report identified fundamental changes to systems and structures that would be required to meet the provincial government's goals of regionalization.⁴ Recommended changes included increased devolution of authority to the RHAs, establishment of more quantifiable performance measures by the province for the RHAs, increased transparency, accountability and compensation at the RHA governance level, and improved RHA community engagement mechanisms. The review committee also identified the need for a transparent funding model for allocating funds to RHAs. The report also recommended that Manitoba Health and Healthy Living identify how to best deliver mental health and addictions services in a more integrated manner at the regional level.

In 2008, Ontario released a review of the effectiveness of the devolution of authority over the planning, funding and evaluation of the health system from the MOHLTC to the LHINs. The review concluded with 28 recommendations, many focusing on the need for clearer delineation of the provincial and LHIN roles in decision-making and priority-setting, greater collaboration across and between the LHINs and the MOHLTC, and taking into account the resource limitations of the LHINs and the MOHLTC in developing reporting requirements and information management protocol. [See Section 5 for greater detail about this review.]

Recentralization

Recently, two provinces have recentralized authority for health services from a regionalization model, while a third province has reduced the number of RHAs from eight to two, restructuring its health authorities in a semi-centralized model.

In 2005, Prince Edward Island recentralized its five regional health authorities back to the authority of the Department of Health. The province recentralized to reduce administrative duplication and provide services more efficiently for the province's population of 135,000. Recentralization also involved a reduction of regional staff.

In May 2008, Alberta announced its fourth health system restructuring in 15 years. Following a previous reduction in the number of RHAs from 17 to nine in 2003, the government announced the full recentralization of the nine remaining RHAs, along with the Alberta Mental Health Board, the Alberta Alcohol and Drug Abuse Commission and the Cancer Board, under the new Alberta Health Services Board, effective April 1, 2009. The new provincial governance model was

rationalized as an administrative change to make the health care system more patient-focused through a strengthened provincial approach to managing health care, including service delivery, health human resources and access to primary care.⁵ The board will establish a mental health advisory council to provide advice on province-wide mental health service delivery and mental wellness.

In 2008, New Brunswick reduced its RHAs from eight to two. The new structure is intended to better meet residents' clinical needs by providing access to a larger network of services and health care providers, and improving the consistency of services and programs being provided and funded across the regions. The amalgamation was also designed to reduce duplication of back office functions within RHAs and eliminate competition between RHAs for limited resources.⁶ A third public body, the New Brunswick Health Council, was created to promote and improve health system performance through citizen engagement and health system performance monitoring and reporting.

Other provinces may also be considering amalgamating RHAs. In 2003, two RHAs merged in Manitoba, reducing the province's regions to 11. Informants reported that the current Saskatchewan government has raised the possibility of recentralization of the 12 RHAs that collectively serve a population of 1,000,000.

3. Mental Health Services and Supports in Regionalized Systems

Policy Setting

Provincial ministries or departments of health are responsible for the development of mental health policy. The introduction of regionalization has precipitated the reduction of staff at the provincial level, often resulting in a loss of expertise in the mental health and addictions area. This reduced capacity has also meant loss of leadership in mental health, including inter-ministerial collaboration that can support recovery from mental illness.

Policy is heavily influenced by the values and political leanings of the government, as well as input from government bureaucrats and stakeholder consultation. Arms-length provincial structures created by government, such as the former AMHB in Alberta, the PHSA in British Columbia or the provincial mental health advisory committees in other provinces, have most consistently provided advice on policy development as provinces have moved into regionalization. Decentralization has also created opportunities for RHAs to provide regional input into mental health policy.

Following regionalization, the development, adoption and implementation of mental health policies has varied across provinces. Provincial mental health plans were developed between 1998 and 2003 by Saskatchewan, Manitoba and Nova Scotia, following regionalization. These plans continue to be the foundation for each province's mental health system directions. A second cluster of mental health system planning occurred in Alberta and Quebec in 2004-2005 following the inclusion of mental health service planning under the RHAs. New Brunswick

released a review of its mental health system in early 2009 that will be used to assist the Department of Health in developing strategic priorities. Ontario is also in the process of developing a new mental health and addictions strategy.

Provincial mental health associations have historically influenced mental health policy directions. Since regionalization, however, non-governmental organizations at the provincial level have tended to face decreasing opportunities to be fully engaged in the policy-making process due to the decentralization of health system planning to regional bodies.

System Planning

Within a decentralized system, the provincial role is to set direction in mental health system planning, whereas the role of the regional authority is to implement provincial directions in service planning and/or delivery at the regional and local levels. However, lessons from Canada indicate this role delineation is not always clear. The April 2008 report of the Alberta Auditor General found a lack of clarity in differentiating the roles of the Alberta Ministry of Health and Wellness, the Alberta Mental Health Board and the RHAs in implementing the 2004 Alberta Mental Health Plan. Role confusion and the lack of accountability for monitoring progress resulted in delays in implementation of this plan with subsequent impact on mental health services.⁷

A review of the effectiveness of the devolution of authority from the Ontario Ministry of Health and Long-Term Care to the 14 Local Health Integration Networks noted similar challenges in role delineation for decision-making and priority-setting between the LHINs and the MOHLTC for the health system in general. Specific to mental health, the 2008 report of Ontario's Auditor General recommended that the MOHLTC improve their coordination within the LHINs and provide greater data and knowledge transfer support to the LHINs in order to ensure consistent, equitable and timely access to community mental health services and supports across the province.⁸

In 2007, the Public Health Agency of Canada released a needs assessment of mental health in the Atlantic Region that identified a significant need for mental health resources in those provinces.⁹ Currently, an organizational review of mental health services is underway in Prince Edward Island and is likely to result in structural changes that streamline their mental health system.

Some provinces have moved to better integrate consumers' lived experience into system planning. The provincial mental health advisory bodies established by the ministries or ministers of health in Saskatchewan, Manitoba, Ontario, Quebec and Nova Scotia have sought out consumer and family membership and/or have developed subcommittees that specifically address consumer and family issues. In Quebec, mental health consumer involvement is required in the planning of mental health services at the local service network level. Furthermore, the Nova Scotia Mental Health Steering Committee identified "facilitating meaningful ways for consumers, families and communities to influence mental health policy and services" as one of its top four priorities.¹⁰

Funding

Across the provinces, the majority of funding allocated to mental health is allocated to hospital and community-based mental health services that provide psychiatric services, in order to meet the requirements of the provincial mental health act and specified provincial policy directions for treatment services. Funding for these mental health services are allocated from the RHAs' global budgets in most provinces, including British Columbia, Saskatchewan, Manitoba, Quebec, New Brunswick, Newfoundland and formerly Alberta. The P.E.I. Department of Health directly allocates resources.

While many RHAs initially protected mental health funding, this practice has waned over the years. For example, the Alberta Mental Health Board continued to provide direct mental health services until 2004, when adult mental health services were transferred to the RHAs to be integrated with physical health services. Specific mental health funding for mental health services was similarly eliminated in Saskatchewan.

Currently, only Nova Scotia and Ontario have protected funding envelopes for some mental health services. In Nova Scotia, the DHAs receive non-portable funding for mental health services; in other words, this funding cannot be transferred to fund other parts of the district health care system. However, there is pressure to remove this provision. Similarly, in Ontario, dedicated Health Accord and Service Enhancement funding is flowed from the MOHLTC through the LHINs to fund a range of crisis and justice-related services. Unspent dedicated funds can be re-allocated by the LHIN on a one-time basis to other mental health programs.

By contrast, RHAs in most provinces have the authority to move allocated funds between and within sectors from within their global budgets. Concern was identified that mental health funds can, and in certain cases have been, diverted by the regional authority to other parts of the health system, leaving the mental health sector vulnerable. For example, in Saskatchewan, funds were reallocated from a psychiatric facility to address financial pressures in other hospitals. Due to lack of available data, these concerns were not able to be substantiated in terms of the impact on user needs.

Community mental health services and supports in a number of provinces are funded by RHAs through contracts for service with autonomous non-governmental organizations. As a result, considerable staff time in these not-for-profit community agencies is directed to securing and maintaining funding. Contracts or grants frequently come with stringent limitations and reporting requirements that consume the resources of small to medium size organizations, resulting in diverted attention from client needs. Some funding for community mental health supports are flowed through the RHAs from different ministries. For example, housing and vocational services in Saskatchewan and P.E.I. are funded through the provincial departments of social services. The Department of Health in New Brunswick directly funds community-based not-for-profit organizations to provide peer and family support services and public education programs.

Some community-based mental health agencies have closed due to financial pressures, despite the need for these services. Many of those interviewed indicated tension between the mental health services delivered by the RHAs and community-based support services. Some were

concerned that the RHAs would develop their own community mental health support programs rather than contract out to existing not-for-profit community-based agencies.

Basket of Services

A significant portion of mental health services within RHAs is directed to providers and programs which include a medical treatment component. At minimum, all provinces provide institutional-based (in-patient and outpatient) mental health treatment services. These are either directly provided by the RHAs who directly manage service delivery, or contracted through service agreements between the region and independent service provider organizations, such as in Ontario and Quebec. RHAs also fund and/or directly provide formal mental health services with a psychiatric treatment component that are provided in the community, such as in community mental health clinics and crisis intervention and early intervention programs.

Arrangements for delivering a broader range of community-based mental health services and supports vary widely across provinces. Some province's mental health clinics are located in community settings and delivered by not-for-profit community-based organizations. More frequently, the RHA contracts with community mental health agencies to provide a range of non-psychiatric services and supports. These providers are accountable to, but not directly governed by, the regions.

Most community mental health services and supports have historically been provided by small to medium sized, not-for-profit, community-based agencies governed by their own boards. These organizations usually fall outside of the services directly provided by the RHAs. However, because services such as supportive housing and employment support are an important part of the continuum of mental health services that support recovery, RHAs frequently contract with providers to deliver them in local communities.

The RHAs in Newfoundland and Quebec also oversee the delivery of some social services. As a result, there may be more direct linkages to community mental health supports.

Availability and Access to Services

All provinces provide a basket of mental health services, available through a combination of RHA delivered services and those provided by community-based agencies. However, concern was frequently expressed that provinces lack the capacity to provide an appropriate continuum of mental health services and supports to meet unmet needs.

Variation in services from region to region is compounded by waiting lists for services that can last up to two to three years. While there are questions about how waiting lists are compiled for different services, there is consistency in reporting waiting lists. Where possible, other alternatives, such as telemedicine, have been introduced to mitigate the situation. For example, Cape Breton, Nova Scotia has a telemedicine link to Scotland for psychiatric consultation.

Lack of data, particularly for community mental health services and supports, makes it difficult to track utilization patterns and assess equitable access to services.

In many provinces, specialized mental health services, such as tertiary psychiatric facilities and services for special populations, have been transferred to the RHAs in urban areas, or to other specialized/tertiary providers also existing in more populated areas. These programs are intended to serve clients from outside the sponsoring RHA. However, individuals with serious mental illnesses in rural and remote areas are being burdened by having to travel to more populated centres to gain access to services.

In addition, health human resource shortages of mental health personnel, especially psychiatrists, are having an impact on access to mental health services in most provinces. A reduced supply of mental health personnel makes it difficult to attract and retain staff experienced in case management, crisis support or other services, particularly in rural and northern areas. In addition, salary disparities between institutions and community-based services are heightening the challenge of recruiting and retaining staff in community-based mental health services.

Waiting lists for services are frequently related to health human resource shortages. This places pressure on existing service providers to maintain individuals until they can be seen by mental health agencies and specialists. Patterns in many provinces indicate that family physicians are carrying a large part of this burden with little connection to community mental health support services.

Accountability

Accountability for expenditures and service delivery is a major focus of regionalization. Some provincial legislation contains provisions about transparency and requirements for RHAs to engage the public. Some provinces have also put in place detailed service and/or performance agreements with the individual RHAs regarding expected deliverables and outcomes. In addition, RHAs are expected to comply with relevant legislation affecting their operation, such as a provincial *Mental Health Act* or privacy legislation.

RHAs also contract out some services and have service agreements with organizations outside of their mandated services. In Quebec, ninety-five health and social service networks have agreements for specific deliverables with eighteen Regional Health and Social Service Boards, adding another dimension of accountability.

Despite explicit legislative requirements and specific service agreements, lack of clarity can occur about roles and responsibilities. For example, the Alberta Auditor General's Report identified that despite the 2004 Alberta Mental Health Plan defining roles and responsibilities for the province, the AMHB, the RHAs and service providers, implementation of the plan was delayed due to confusion in the interpretation of those roles and weak monitoring mechanisms.¹¹

Performance Monitoring

While performance indicator development is proceeding in many provinces, no jurisdiction has yet implemented broad-based monitoring of the mental health system. In most provinces, mental health data is limited and largely focused on hospital and physician utilization. Indicators for community mental health programs and support services are particularly few in most provinces. Ontario initiated considerable work in developing a mental health scorecard that could be used at the LHIN level in 2006, but it has not been implemented. Key informants also noted that there is little sharing of best practices for community mental health programs and support services across RHAs.

The Report of the Manitoba Regional Health Authority External Review Committee indicated that the accountability relationship between Manitoba Health and Healthy Living and the RHAs does not include quantifiable performance targets. Greater use of performance targets has been recommended in the Manitoba review, in order to demonstrate accountability for results and ensure RHAs are able to pursue provincial as well as local priorities.¹²

Program Standards

Nova Scotia is the only province that has developed a set of core standards for mental health services, but funding constraints have inhibited full implementation. Other provinces, such as British Columbia and Ontario, are at various stages of developing standards for community-based mental health services. Provision of adequate funding to implement and monitor standards is a key consideration.

Given the absence of program standards for mental health services in most provinces, key informants described a lack of knowledge about promising practices that could enhance the delivery of mental health services.

System Integration

Progress on integration of the mental health system is described as sporadic and inconsistent across the country. Within some RHAs, coordination exists between various mental health services that are hospital or outpatient-based, including psychiatric services.

The most problematic area appears to be the transition point between the psychiatric-based mental health services provided within an RHA's jurisdiction, and community-based mental health agencies outside the RHA structure.

System navigation – acquiring the right service at the right time and in the right place – is not part of the lexicon in most provinces. However, in Quebec, Local Service Networks have a mandate to ensure access and continuity of services for the population in their geographic area, with a particular focus on vulnerable populations, such as those with a mental illness.

4. Summary of Key Findings from Provinces Undergoing Regionalization

- Approaches to regionalization of health care services across Canada have varied and evolved over approximately 15 years.
- There is increasing emphasis on accountability, transparency and health system performance in all provinces.
- The restructuring of responsibilities under regionalization has led to a reduction in capacity for mental health policy and planning at the provincial level.
- Lack of clarity regarding provincial and regional roles has impeded implementation of provincial mental health plans due to confusion over who is accountable for what.
- Quebec and Newfoundland and Labrador include social services within the mandate of their RHAs.
- Mental health funding within the RHAs varies among provinces.
 - Hospitals and outpatient clinics that incorporate psychiatric services are funded under all RHAs.
 - Funding for community mental health services and supports may or may not be included under the RHAs.
 - RHAs have tended to shift from protected funding towards funding mental health services under global budgets, which are subject to reallocation decisions given competing health sector priorities.
- Little evidence was found of mental health system integration as a result of regionalization.
 - Mental health and addiction services appear to be in the early stages of dialogue about integration.
 - Integration with primary care and chronic disease management was not evident in the interviews.
- Nova Scotia is the only province with mental health care standards, but it has been unable to implement them fully due to the lack of funding.
- Recentralization in Alberta, New Brunswick and Prince Edward Island may be in part a response to gaps created by loss of provincial capacity, difficulties in implementing standards for health system planning and the need to have more equitable approaches to the delivery of services across regions. Administrative costs and duplication of services may also have served as a driver to reduce the number of RHAs.

5. Ontario Experience to Date

This section explores in greater detail the similarities and differences of the Ontario experience with regionalization compared to the other provinces described above.

The Local Health Integration Networks

In 2005, Ontario created 14 Local Health Integration Networks that have a mandate through the *Local Health System Integration Act* for:

- local health system planning,
- community engagement,
- funding and allocation, and
- accountability and performance management.

Unlike most provinces, the governance of health care organizations in Ontario has not been centralized in the LHINs. Health care organizations' boards of directors remain in place, requiring LHINs to negotiate accountability agreements with every health system transfer payment agency they fund. Moreover, as LHINs are not direct providers of health care services they are not employers, as in other provinces.

Policy Setting

The role of the Ministry of Health and Long-Term Care in Ontario has also changed, as a result of legislation devolving authority to the LHINs. The MOHLTC has identified their new role to be one of stewardship within the new health environment. This new role involves setting strategic directions for the health system (legislation, regulation, policy) and putting indicators in place to monitor system performance.

Ontario's policy framework for mental health, *Making It Happen*, identifies a continuum of first line, intensive and specialized services to be provided, with a priority focus on meeting the needs of people with serious mental illnesses.¹³ These services are inclusive of a broad range of community mental health services and supports, and have historically been provided by transfer payment agencies of the MOHLTC. The framework was implemented prior to the development of the LHINs.

The Minister of Health and Long-Term Care in Ontario has established an Advisory Group on Mental Health and Addictions to contribute to the creation of a new 10-year provincial mental health and addictions strategy. The Advisory Group includes health service providers, researchers, consumers and family members. Also contributing to the development of the strategy is an all-party committee of the Ontario legislature developed to examine mental health and addictions services.

Funding

Funding of community mental health services and supports has been transferred to the LHINs. Some community mental health services receive designated funding from the MOHLTC, as described in the MOHLTC-LHIN Accountability Agreement. These protected funds are targeted to programs funded through the Health Accord or the Service Enhancement Initiative, an inter-ministerial partnership directed to keep people with mental illnesses out of the criminal justice system. The majority of mental health funds in Ontario are not protected.

Program Standards

Program standards have been established in Ontario for assertive community treatment teams, intensive case management and crisis response services. However, according to the Auditor General of Ontario's 2008 report, there appears to be little evidence that the MOHLTC or the LHINs are monitoring the standards in actual service.¹⁴ The MOHLTC has committed to establishing program standards for early psychosis intervention and short-term crisis residential beds.

Performance Monitoring

Ontario has developed electronic means to track client characteristics and service utilization of community mental health services and supports. Currently, there is almost 100 percent compliance with Management Information Systems (MIS)/Common Data Sets (CDS) data collected by all community mental health agencies for submission to the MOHLTC. However, data quality issues remain that need to be addressed. In addition, a provincial registry, Mental Health Service Information Ontario (MHSIO), stores information on more than 1000 different programs being offered by approximately 300 mental health organizations who receive a portion of funding from the LHINs and/or the MOHLTC. The MOHLTC has committed to work with ConnexOntario, the organization that maintains MHSIO, to report on wait times and establish provincial wait-time availability.¹⁵

Evaluation of Regionalization and Community Mental Health

The Systems Enhancement Evaluation Initiative (SEEI) was a multi-year research project funded by the MOHLTC to evaluate the impact of new investments in community mental health for crisis intervention, intensive case management, assertive community treatment, early intervention in psychosis and services for individuals in contact with the criminal justice system. The studies found that the increased funding has led to improved access and outcomes for mental health consumers, as well as increased system integration. However, the funding was unable to re-balance regional variation in services due to historical funding disparities that continue to exist. The final SEEI report will be released in May 2009.

In March 2008, Ontario initiated a review to examine the effectiveness and capacity of both the MOHLTC and the LHINs to adequately fulfill their roles under regionalization. The final report, prepared in September 2008, found that the transition of authority from the MOHLTC to the LHINs has demonstrated overall success. However, challenges remain due to the lack of clear role delineation for decision-making and priority-setting between the LHINs and the MOHLTC. The report sets out 28 recommendations to address issues impacting the LHINs' capacity to fulfill their roles and obligations. In particular, the report identified the need for clearer delineation of provincial and LHIN roles in decision-making and priority-setting, and highlighted challenges faced by the LHINs and the MOHLTC in collaborating across and between the organizations.

Recommendations for Ontario from the review include the need to improve: standardization of provincial program transfer from the MOHLTC to the LHINs; the capacity of the LHINs by enhancing staffing levels and organizational restructuring; reporting of outcome-oriented performance measures for LHINs; and management information processes between the MOHLTC and the LHINs. Recommendations also address the appointment process of LHIN directors.

The Auditor General of Ontario's value-for-money audit of community mental health, released in December 2008, assessed how well Ontario's publicly funded system is:

- meeting the needs of people requiring mental health treatment services;
- monitoring payments and services to ensure that relevant legislation, agreements and policies are followed; and
- measuring and reporting on the effectiveness of community mental health programs.¹⁶

A key finding of the report is that provincial spending on community mental health remains inadequate to meet needs, despite recent investments into the system. Funding to community mental health services represents only 39 percent of the provincial spending on health, which remains below the MOHLTC target of 60 percent of spending allocated to the community sector and 40 percent to institutional services. Recent substantial investments in the community mental health sector have been allocated to a few specific programs. The majority of service providers have instead received nominal base budget increases that do not match inflation and are insufficient to maintain service levels. As a result, services are being scaled back. The auditor general's report also found that historical inequities in per capita funding exist across the LHINs but adequate cost estimates based on regional variations in population needs and health inequities do not exist.

Despite the introduction of regionalization intended to better integrate the health system, the auditor's report found a lack of guidance and resources from the MOHLTC and the LHINs to assist community service providers in coordinating services. In addition, the report also highlights a shortage of appropriate supportive housing and the need for the LHINs and the MOHLTC to better monitor levels of services provided compared with program standards. The auditor also highlighted the need to improve data collection and monitoring processes and to establish appropriate accountability measures to better monitor third-party contracts.

Lessons for Ontario

- Understanding and adapting to new roles at the provincial, regional and local levels is fundamental to a successful transition during regionalization. This transformation must be driven by clear provincial policy that directs and integrates the activities at the regional and local level.
- Ontario's current mental health policy is more comprehensive than many other provinces, and recognizes the important role that community mental health services provide to support the recovery of people with serious mental illnesses. Ontario should ensure that regionalization does not divert attention away from continuing to formulate and implement mental health policies and directions that support recovery.
- The new stewardship role of the Ontario Ministry of Health and Long-Term Care continues to support and enable dialogue and consultation between MOHLTC staff and stakeholders at the provincial level.
- In Ontario, continued collaboration among provincial organizations should be encouraged and utilized to provide advice on mental health policy development, provincial system planning, standard setting and performance monitoring.
- The development of the Minister's Advisory Group on Mental Health and Addictions holds promise as a means to engage key stakeholders external to government in the development of provincial plans and strategies.
- Small to medium size community mental health agencies in Ontario need to build capacity to be able to respond to the demands generated by their new relationship with the LHINs.
- The delineation of authority, roles and functions between the MOHLTC and the LHINs needs to be clarified.
- Mental health program standards are under development in Ontario. Adequate funding is necessary to support implementation and monitoring of standards.
- Provincial organizations need to support the sector by building capacity to help them demonstrate performance results and assist their ability to adapt to change.

Appendix: Summary of Provincial Structures and Mental Health Services

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
Health Authority Structure	Five geographically based Health Authorities (HAs) created in 2001 provide services in 16 health service areas with boundaries based on geography and patient/physician referral patterns. The Provincial Health Service Authority (PHSA) coordinates provincial programs and specialized services. There were initially 52 HAs legislated in 1997.	Alberta Health Services Board established in May 2008 from the recentralization of 9 geographically based RHAs, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission. RHAs were first introduced in 1994.	Twelve geographically based RHAs or health regions were established in 2001. Regionalization was first introduced in 1992. Stakeholders suggest that government may be considering recentralization.	Eleven RHAs following the merger of 2 RHAs in 2003. RHAs were first established in 1997. Some non-dissolved hospitals and personal care homes opted out of the RHA structures.	Fourteen Local Health Integration Networks (LHINs) were developed in 2006 as geographically based crown agencies that plan, integrate and fund health services within geographic boundaries but do not directly provide services.
	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador
	The Quebec health system is managed by 16 Regional Health and Social Services Boards and two equivalent agencies that oversee 95 Local Service Networks. Local Service Networks are oriented around Health and Social Service Centres that provide accessible and continuous health and social services within their geographic catchment areas.	Two RHAs exist following the 2008 amalgamation of the 8 former RHAs. Health regionalization was introduced in 1992. The New Brunswick Health Council promotes and improves health system performance through citizen engagement and monitoring and reporting on health system performance.	Nine District Health Authorities (DHAs), in place since 2001, plan, manage, fund and deliver health services in all hospitals, community health services, mental health services and public health programs in their geographically-based districts. The IWK Health Centre is a tertiary hospital for children and youth not under DHA responsibility.	The Department of Health provides public health services, primary care, acute care, community hospital and continuing care services. In 2005, the health system was recentralized from five RHAs established in 1993-1994 in order to reduce administrative duplication. The five community hospital boards are directly accountable to the Department of Health.	Four geographically-based Regional Integrated Health Authorities (RIHAs) supervise, manage and control the delivery of health and community services, including primary and secondary health services, acute care, continuing and long-term care, health promotion, mental health and addictions, rehabilitation services, child protection services, childcare, and community health nursing.

Regionalization Environmental Scan

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
Role of Health Authorities	<p>HAs are committed to building a high-quality, patient-centred and sustainable health care system that is equitable, effective, efficient and accountable. HAs govern, plan, coordinate and deliver health care services at the regional level. The PHSA coordinates and/or provides specialized provincial services.</p>	<p>Alberta Health Services aims to provide a patient-focused health system that is accessible and sustainable for all Albertans with a mandate to provincially coordinate quality health services and supports.</p> <p>Alberta Health Services is responsible for the delivery of health care through programs and services at facilities throughout the province.</p>	<p>RHAs provide most of the health services in Saskatchewan with additional services contracted through affiliated organizations.</p>	<p>The RHAs deliver the majority of health services in the province and are responsible, within the context of provincial policy direction for assessing and prioritizing local needs and health goals and developing and managing an integrated local health care system.</p>	<p>LHINs are mandated to plan, integrate and fund health care services within their geographic boundaries. LHINs do not directly provide service.</p>
	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador
	<p>Regional Boards oversee the planning, organization and coordination of programs and services, and the allocation of resources based on the health and social service needs of their catchment population. The boards allocate the budgets of health care establishments and offer grants to community agencies, while ensuring efficient resource management.</p>	<p>The RHAs provide health services in their regions and are closely aligned to standardize the delivery of health care services based on a single provincial approach.</p> <p>The dual mandate of the health council is to provide residents with opportunities for meaningful input and dialogue on health matters, and to monitor the accountability of the health system.</p>	<p>DHAs govern, plan, manage, deliver, monitor and fund health services according to the health needs of their communities, including the delivery of acute through to tertiary care, as well as programs and services through their hospitals and clinics.</p>	<p>The Department of Health provides leadership in: maintaining and improving the health and well-being of residents; innovation and continuous improvement and providing administration and regulatory services to the health system; and high quality, client-centred health services through provision of public health services, primary care, acute care, community hospital and continuing care services.</p>	<p>RIHAs supervise, manage and control the delivery of health and community services. The actual delivery of programs and services are provided by community health boards. Institutional boards deliver hospital services and long-term accommodations to persons 65 years and older and persons suffering from chronic debilitating diseases.</p>

Regionalization Environmental Scan

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
Provincial Mental Health Capacity	<p>From 2001-2005, B.C. had a Minister of State for Mental Health and Addiction, as well as a Mental Health and Addiction Advisory Council. The B.C. Mental Health and Addiction Services (MHAS) provides a diverse range of mental health services to people across B.C., including specialized tertiary mental health treatment services, geriatric psychiatry, child and adolescent mental health services, forensic psychiatric services, research and knowledge exchange and mental health promotion.</p>	<p>The Alberta Mental Health Board previously served as a provincial health authority that oversaw and advanced Alberta's mental health system, serving in an advisory capacity to government and working with the RHAs and other organizations to address system-wide mental health issues. The Alberta Mental Health Board is now governed by the Alberta Health Services Board.</p>	<p>The Provincial Mental Health Advisory was established to advise the minister of health. There is consumer representation on the committee.</p>	<p>A Provincial Advisory Committee on Mental Health advises the province on issues relating to mental health. There is consumer participation on the committee and a sub-committee focused specifically on consumer and family member issues.</p> <p>The Chief Provincial Psychiatrist/Director of Psychiatric Services is responsible for administering Manitoba's <i>Mental Health Act</i></p>	<p>The Minister's Advisory Group on Mental Health and Addictions advises the Minister of Health and Long-Term Care on mental health and addictions priorities, and includes representation from consumers, family members, providers and researchers.</p> <p>The Select Committee on Mental Health and Addictions is an all-party legislative committee developed to determine mental health and addictions needs in the province.</p>
	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador
	<p>The 2005-2010 Action Plan for Mental Health guides provincial mental health policies. Quebec has launched a mental health information and awareness campaign.</p>	<p>New Brunswick Mental Health Services oversees the operation of 13 Community Mental Health Centres, and administers purchase-of-service contracts with regional hospital corporations for nine psychiatric units and two institutions.</p>	<p>The Mental Health Services Branch makes recommendations to the Department of Health on funding requirements for mental health at the district level. The Mental Health Steering Committee was formed by the deputy minister of health with broad representation.</p>	<p>The Department of Health oversees both community and hospital mental health services. Two specialized psychiatric hospitals are managed by the Department of Health.</p>	<p>The province enacted a new <i>Mental Health Care and Treatment Act</i> in 2007 that has expanded the range of services available for people with severe and persistent mental illness.</p>

Regionalization Environmental Scan

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
Funding of Mental Health Services	Allocated by the HAs from their global budgets. There is no protected mental health funding.	Allocated through a population health funding formula for health services. There is no protected mental health funding.	Allocated by the RHAs from their global funding. Mental health service funding envelopes were previously protected but this has been eliminated. Funding for housing and vocational services flows through the RHAs from the Department of Social Services.	Allocated through the RHAs. Manitoba Health directly funds Mental Health Self-Help and Public Education, the Selkirk Mental Health Centre (provincial residential facility) and the Provincial Special Needs Program in conjunction with the Departments of Justice and Family Services.	Dedicated Health Accord and Service Enhancement funding is flowed through the LHINs for Assertive Community Treatment teams, safe beds, court diversion, supportive housing, forensic services, consumer survivor initiatives, eating disorder services and sessional services. Unspent designated funds can be re-allocated by the LHIN on a one-time basis to other mental health programs.
	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador
	Allocated to the Regional Boards based on population health needs and ministry priorities. Regional Boards contract services from health care providers. Health and Social Service Centres are funded to provide mental health and addictions services.	Allocated from RHA global budgets. Most funding is allocated to hospital-based mental health services and the mental health centres. Mental health funding is not protected. Funding flows from the Department of Health to community-based agencies for the provision of support services.	Non-portable mental health funding is allocated to the DHAs for mental health services. Community-based program funding is not protected and is provided by the provincial mental health foundation and DHA grants. The Department of Community Services funds supportive housing.	Funding for mental health services is not protected. A significant percentage of the funding resources are allocated to hospital-based mental health services. Housing, income and vocational programs are provided through funding from the Department of Social Services.	Flows through the RIHAs. A significant percentage of the funding resources are allocated to treatment services. Mental health funding is not protected. There have been recent investments in increasing funding to community-based case management.

Regionalization Environmental Scan

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
Basket of Mental Health Services	HAs provide a range of mental health services and supports at the regional level to adults with serious mental illnesses through mental health centres. Supports are provided by the HAs or contracted by the HAs through community organizations. Specialized services are provided by B.C. MHAS.	Clinical mental health services and some community support services are provided through Alberta Health Services to Albertans with or at risk of developing severe and persistent mental illnesses. Other supports are contracted out to community-based organizations.	Mental Health Clinics are linked with in-patient mental health services. Clinics coordinate the provision of community mental health services through direct service delivery and/or contracts with community organizations for housing or psychosocial rehabilitation services.	RHAs are required to provide a broad range of mental health services and supports.	The LHINs fund and coordinate a broad range of hospital and community-based mental health services and supports for people with serious mental illnesses. Former provincial psychiatric facilities have been divested and are funded through the LHINs.
	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador
	A broad range of mental health services and supports are provided by community organizations contracted to the local service networks.	Thirteen Community Mental Health Centres provide mental health acute care and rehabilitative services through interdisciplinary mental health teams. Hospital-based psychiatric services are also within RHA scope.	DHAs provide crisis, emergency, in-patient and community-based clinical mental health treatment services, including case management, clubhouses and shared care. Supportive housing is provided through the Department of Community Services. Some additional community support services are contracted from non-governmental organizations.	Community mental health treatment and outreach services are provided in seven centres across the province for persons with mild to moderate mental health problems. Two centres also provide therapeutic services to people with serious and persistent mental illnesses. A provincial psychiatric facility and two community hospitals provide in-patient mental health services.	The RIHAs provide a broad range of mental health services to people with severe and persistent mental illnesses, including increased case management services provided in community settings. Employment supports are funded through a separate department but are affiliated with the RIHAs.

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