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Mercredi 28 avril 2010

Select Committee on Mental Health and Addictions

Mental health and addictions strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 28 April 2010

Mercredi 28 avril 2010

The committee met at 1555 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

LHIN COLLABORATIVE

The Chair (Mr. Kevin Daniel Flynn): Sorry to hold you up. One member, in particular, has been asking about the LHINs, and I was hoping he would be here today, but he must be otherwise—that was Bas Balkissoon from Scarborough, who has been talking about where the LHINs fit into this throughout the committee proceedings. He may have had some questions for you that maybe the others don't, but I'm sure he can correspond with you.

I'm just going to turn it over to you. Thank you for coming. For the other members, Bill is the lead in the Mississauga LHIN but is also working with the collaborative, and this is a presentation actually from the collaborative. Is that right?

Mr. Bill MacLeod: I can clarify that. Thank you very much for meeting this afternoon. It's such a nice day out there, and I appreciate the time to come and talk to you about mental health and addictions.

I'm going to introduce my associate Angela Jacobs. She will be making part of the presentation, as well, on a particular area that we've been investing dollars in in the Mississauga Halton LHIN.

I'm here representing all of the LHIN CEOs. We had a discussion amongst ourselves and agreed that I could come and try to do the best I could to represent all 14 of the LHINs. I'm also chair of the LHIN Collaborative, which is a group that has been put together. It represents leadership from the LHINs but also leadership from the various sectors of the field. Six sectors, plus public health, primary care and Cancer Care Ontario, are represented with the LHIN Collaborative, and I can talk a little bit more about that.

Then I want to give you a bit of an overview of what we've been able to do at Mississauga Halton, because it's a little bit easier for me to speak about some of the specifics that we've been doing in mental health and addictions in our own LHIN, and that's this document here; that's a handout.

Then Angela will take you through a presentation of a new initiative that we're just launching—in fact, early next week—that will be a further investment of funding into expanding the services of mental health and addictions.

I know we've got 45 minutes. I'm going to try to go fairly quickly because I know that's to include time for questions as well.

First of all, on behalf of all of the LHINs, I think we're quite appreciative of the time with the committee to talk about mental health and addictions and talk about some of the things that we see coming down the road and how the system could be improved. I believe that's very much what the committee is also trying to understand: what the issues are and how to get at improving those.

While all LHINs are inherently different from a geographic and from the population that geography contains in terms of the distribution, the makeup of the population, the age distribution, all kinds of different characteristics, and that really shows the uniqueness of our province, what was common across all LHINs was that when we went out to do our integrated health system planning—which was the first order of business for LHINs when they were created: to go out and talk to the community, engage the community and understand what issues the community sees—universally we got back the common theme of mental health and addictions. It's an area that consistently, wherever you are across the province, is felt by citizens to need attention and improvement.

The common themes that we heard—again, I'm going to go quickly because I'm sure you've heard all of these by now, but I do feel it's important to reiterate some of them.

Navigating the system is tough. People, when you go and talk to them, find it very difficult to find their way through the mental health and addictions systems. In response to that, many of the LHINs have started to implement the so-called "no wrong door" approach to mental health. I think you've probably heard about that, but we can talk about some of that later.

There's also this need for significant interaction between the mental health sector and all sorts of other sectors, whether it's the primary care sector—and I know you received a presentation from the Canadian Mental Health Association and the Ontario association of community mental health and addictions programs.

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When those sectors—and I shamelessly put in a plug for the LHINs at this point—all dealt with the Ministry of

Health as sectors, you could often get all the way up to the Deputy Minister of Health before there was a crossover manager; in other words, the way the community health branch moved up and reported to an assistant deputy minister or director and then it was really the deputy minister's job to actually put these things together, and it really isn't his job.

So that's where the LHINs come into their prime, because the folks in my LHIN—and we're a small group. The Ministry of Health has 4,000 employees. I think they're down from where they used to be, but it's still a very large organization. My organization is small. I have less than 30 staff. The folks who are dealing with housing, who are dealing with mental health and addictions, who are dealing with community support services, who are dealing with the hospital side of things, and the ones who are dealing with primary care, if I threw a bucket of water in the air, all of them would get wet, because they sit that close together. So that's the way in which we're able to bring that integration at the sector level, at the LHIN level. I think that's an important thing to remember, and I'm going to come back to that.

One of the other areas that was a common theme was the need for a common language and tools for measuring outcomes. There's a broad variety of ways in which people think that the system performs and a broad variety of ways in which the system is measured right now, and we need to bring that down to a common way of approaching that.

Universally, we found that agencies themselves were saying, "You know what? The way we've been funded in the past, there are significant efficiencies that we can gain if you can bring about some back office integration, some co-location of our services and some shared training and development within our sector." Those were themes, again, that universally, regardless of the underlying population, the LHINs found as they went out and consulted with citizens.

Each LHIN—again, I want to make sure you appreciate it. Because it is a priority, each LHIN is looking at what resources they've got and how to bring those resources to bear on this problem. So while there aren't new resources necessarily all the time in particular areas, we're finding ways to use the existing resources to bring about addressing those themes. I'm here to say that each LHIN is making progress, very definitely.

In addition to the common themes that we came across through our integrated health services plans, we agreed that with the LHIN Collaborative, in our partnership with the agencies, we would work on this problem collectively as well. So we've identified a lady by the name of Marion Emo, who used to be the executive director of one of the CCACs—no, sorry; I'm wrong. She actually was the executive director of one of the district health councils. She's taking the lead in this on behalf of the LHIN Collaborative. We're assembling a group of representatives from primary care, the mental health sector itself, and the community support services sector, as well as representation from hospitals, to look at how to make that collaborative work well, primarily around the area of sharing best practice. One of the great things about our system is that because we've created areas of devolution of responsibility, what you're finding are significant attempts to find new ways of doing things, new approaches and innovation, and one of the things that's good is that you find better ways of doing things. Where it's bad is if you don't have a mechanism to rapidly share those best practices. So one of the responsibilities of LHINC, the LHIN Collaborative, is to rapidly share best practices. That's one of the key themes that this group will be working on.

I'm going to shift from there, talking at the provincial level, to talking a little bit about what we've been able to do at Mississauga Halton. I'd ask you to turn to the handout. Again, very quickly, I'm just going to run you through some of the accomplishments. I apologize that the pages aren't numbered, but it's three quarters of the way through the slide deck, and it says, "Accomplishments for 2009-10."

Again, some of these are fairly straightforward: some of the community engagement activities that we've been able to take on; the education programs that we've been able to put in place that allow all of the agencies in our LHIN to participate and enjoy an education program that none of them would have been able to put on individually.

We're working with the ministry to look at MIS definitions, to make sure that when people are calling something a visit, a clinic involvement or whatever it is that we're identifying as the unit of measure, there is a way of consistently looking at that across all agencies. It's a significant problem now because there are not universal ways in which these are defined.

We've gathered and ranked quality indicators, which was an important piece of work. We didn't really invent much, but it was bringing the players together to say, "How do you measure quality? Is there a common way that we can look at how quality should be measured across all agencies?"

Again, we've been spending a lot of time looking at access to services, and Angela is going to talk to you about a significant gap we found and what we've been able to do about that.

We've established a collaborative table for both youth and adults. There's a real disconnect around youth with mental health and addictions issues. The fact that we've actually got a Ministry of Children and Youth Services also adds to that because, again, you've now not just got a Ministry of Health, but you've got another ministry that's involved.

On that topic, it's also important to understand, as I'm sure you do, that you've got the ministry of justice that's involved and you've got a range of other ministries that are also involved in the whole area of mental health and addictions, how they are brought to bear on this problem and how the LHINs are able to work across all of those ministries to bring the local resources together to deal with these problems.

So that's, very quickly, some of the things we've been doing. I didn't want to cover all of them because, again, I recognize that our time is a bit short.

I'm going to turn it over to Angela right now to fairly quickly walk you through a specific program that we found and one that we're going to be launching, as I say, this month.

Ms. Angela Jacobs: I did provide a handout, and I'm sorry; it's probably a little bit of an eye chart because I put three on one page.

Anyway, I just wanted to talk to you about this initiative that we are launching next week. It's called Strengthening Community Supports for Concurrent Disorders. It came about as a result of a report that came out of SEEI—and you'll see that in the package that Bill provided as well—in that we saw that our LHIN, which is LHIN number 6, on the far right, was the only LHIN that showed an increase in early returns for mental health and addictions clients to the ER. This was, I think, from 2006 to 2007. We formed a working group and we decided to take a look at why we were such an anomaly. So we set up a group of health care service providers from our LHIN, mental health and addictions, and some data people, and we started to go into the data itself. We showed that we actually had a three-year increase in return rates for mental health and addiction clients to our ER; 23% of them were repeat visits within 30 days. Most of them were related to substance abuse; 23% were related to depression and anxiety. Some 32% were what we call young people—we go all the way up to age 30, actually, ages 17 to 30.

Of those, only 29% were admitted to hospital, which shows that, again, the emergency department is not a good place for these patients. We wanted to look at how we can actually help that.

So our working group came up with 10 strategies, and the top three to address this particular population of substance abuse combined with mental health: We needed to look at a bridging program from the ED to community services, we didn't have enough capacity in our LHIN around chemical withdrawal, and we needed intensive case management for people with concurrent disorders: those clients who have a substance abuse as well as a mental health issue.

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This is our system as it kind of looks now. There are a lot of silos in the system. As a client comes out of the ED, they're discharged. They may be referred to a service, but they could take weeks to get to that service. Again, that's one of the issues why they end up back in the ED. Even if they are able to find a service and need to go through chemical withdrawal, there's usually a long wait for that. Then, if they go through the chemical withdrawal system, there's a wait of up to 12 to 28 weeks for referral to case management. So, at any point in that system, that client could be on their own—chances of a relapse are very high—and end up back in the ED.

What we looked at, and what we're developing, is this continuum of service to support the client right through the continuum they need for getting help so they're fully supported and we reduce relapse rates and, hopefully, repeat visits to ED. I'll tell you how this program is working.

We've got a LHIN-wide program, again, not specifically around regions—Halton region versus Mississauga. This is a LHIN-wide program. We're investing in three supports: crisis supports, chemical withdrawal management and enhanced concurrent disorder case management. So they're going to create seamless, timely support for these clients who have addictions and/or concurrent disorders as they go through the system.

CMHA Halton is actually our program lead, and they are working with a lot of our other HSPs in our LHIN, so we're going to reduce the number of different referral forms—we're actually going to use this as a way to integrate our system. Not only is this new program going to be integrated into all of our existing system itself, we're going to make this as seamless as possible because all the handoffs we have between providers are where there could be issues. They're going to respond to urgent referrals. There's going to be a commitment to actually prioritize these clients who come out of the ER or who come out of in-patient units. So they have been treated—they've had a call for help—and you can actually work with them immediately rather than giving them time to think about it or relapse.

With the crisis management, it is the community agencies that will be providing this, but they will get a call from our EDs that someone has shown up in the ED with these particular characteristics. They will go into the ED and support that person through the ED experience, if required, and then help them to either connect with other supports or support them as required until they can meet with case management. Again, this will provide the safety support needed, if any, during a period of probably increased suicide rates.

Now, if required and if needed, they can go through chemical withdrawal management, which is not the typical withdrawal management you think of; this now is actually best practices community withdrawal. It can be done in their homes; it can be done in the offices in evening hours. It is actually taking the service to the clients, as required, and reduces the risk of relapse. But while they're in this program and even when they come out, there will be associated concurrent disorder case managers who will support this client until they actually connect directly to longer term case management to keep them clean, sober etc.

We're enhancing case management around concurrent disorders as well. There are pockets in our LHIN that are actually lacking in some services, so we're actually targeting this geographically as well to provide supports. These case managers will accept urgent referrals from the ED, because again you don't want to have a 28-week wait period for someone who has shown up in the ED seeking help. We're hoping to improve the flow of the system for these clients and to strengthen linkages with existing community programs, as Bill mentioned.

We have services that provide help to many of these clients in our LHIN, but the linkages aren't there. Again, you need this navigator, which is what the case management will do. We've got COAST teams, we've got safe beds, crisis beds, ACT teams, intensive case management, connect with primary care physicians, seniors, youth services—whatever other community services some of these clients might need.

This is just a bit of a pictorial illustration of what this system will do. We've got our three hospitals in our LHIN with their emergency departments. One of our providers will have two concurrent case managers and the other will have another concurrent case manager. These are addiction councillors, case managers who will actually go into the ED. Then there's withdrawal management to providers. This, of course, is going to be LHIN-wide—we've had withdrawal management in the Mississauga portion of our LHIN but not in the Halton portion, and then longer-term case management for concurrent disorders as well as connecting with all the services below. In total, we are investing $1.5 million for 17 new full-time-equivalent staff.

Now, we're big on performance and accountability, so we would like to see about an 80% reduction in early return ED visits—those that are less than 30 days—for substance abuse and concurrent disorder clients, and a 10% reduction in new visits to the ED for these particular types of clients. We expect to see a reduced stay in our hospitals as well. Sometimes they have a difficult time discharging in-patients because there's nowhere for them to go because, again, the wait times for some of our community services are very long. Hopefully, we will increase client satisfaction and experience and provide increased access to concurrent disorders in our LHIN. That's it.

Mr. Bill MacLeod: Thanks, Angela.

I thought I'd leave you with a couple of thoughts. One really ties exactly in to this, in that one of the roles that I believe the LHINs can play remarkably well is integration across sectors and bringing all forms of health providers together to integrate services, so that the patient/client sees this as a seamless service that's delivered at the local level. That includes primary care. One of the things we struggle with at times is that people say, although it's patently not true, because the LHIN act doesn't preclude us from being involved in primary care, "You don't have anything to do with primary care." Just that thought often forms a barrier. So one of the things we think is quite important is that there is, in fact, a reinforcement of the LHINs' role in primary care, coordinating best practices in primary care and officially linking primary care with the rest of the system.

Our LHIN is one that has a significant number of hospital-based primary care physicians, but even in our LHIN, only 50% of primary care physicians are actually attached to hospitals. So you have 50% of the primary care physicians out there, virtually unattached to the system, and I think it's important that the LHIN can form that integrating or attaching kind of role from the primary care system to the rest of the system.

The second thought is about the need for a provincial entity—I use the word "entity" in the sense of not necessarily an agency but potentially an agency—to take a leadership role to look at what are clinical best practices; to look at clinical performance and outcomes, and how it's measured, how it varies from region to region; where to set benchmarks in terms of requirements for improvement; to develop a regional presence that works with the LHINs and brings that clinical expertise to work with the LHINs and use the LHINs' planning authority, funding authority and integration authority to achieve that true integration of the system—but predominantly bring the evidence.

One of the agencies we're working very closely with is Cancer Care Ontario. I think you're aware of their role and how they have established regional presence. The LHINs work very closely with that regional presence, and as CCO continues to roll out their role in chronic kidney disease, the same approach is being taken. We're working with the clinical experts, but implementing that at the local level. I'm not suggesting that Cancer Care Ontario should become the agency, but I am suggesting that we should look at that model and look at a provincial entity that does bring that kind of expertise, that evidence base and the ability to pull together best practices and data to inform clinical decision-making at that regional level.

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With that, I'm going to end, and open up for questions for either Angela or myself. Again, I express my thanks for the opportunity to present to you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Bill. Just for the edification of us all, your definition of a young person is anybody from 17 to 30; is that right?

Mr. Bill MacLeod: We've been looking at children and youth, and then young adults, and we're also trying to look at the mental health issues of our seniors. It's a very significant problem. The system is often not well designed to deal with mental health issues, and unfortunately, the behavioural issues that arise in a senior with mental health problems start to push them into institutionalization much too quickly—

The Chair (Mr. Kevin Daniel Flynn): I was thinking about the other end of the age spectrum, though. If I show up and I'm 18 or 19, you seem to have a plan for me. You've got something you'd do with me based on this flow chart. If I was a mom or a dad and I showed up with my 12-year-old who was going through anxiety or depression, somebody else funds that then? Is that MCYS? Do you act differently then? Do you do something differently? Does that cause confusion or problems for you?

Ms. Angela Jacobs: Actually, we call a youth in our system, I think, 16 or above. But anyone who shows up to a hospital—whatever age—obviously is treated.

We're just launching this and we need to see what the need is around this, because, again, to take somebody who's 15 into some of these services that we fund, community mental health and addiction services—their mandate is not necessarily those younger than 16.

The Chair (Mr. Kevin Daniel Flynn): But do you have a plan for them?

Ms. Angela Jacobs: We have a task group that is working in conjunction with MCYS around the transitional-age youth.

The Chair (Mr. Kevin Daniel Flynn): Okay, because we're getting a lot of—I think the first group we heard from was Parents for Children's Mental Health, and since then, there has been some criticism levelled at the system in general about how we're not paying attention to children's mental health issues.

We've had discussions as a group between ourselves about how the one is funded by the Ministry of Health and the one is funded MCYS. I guess it's a little early to tell if that's causing any problems for the LHINs?

Mr. Bill MacLeod: It's almost a mental model issue. While the LHINs are truly provincial agencies, our boards are appointed by the Legislature through the Public Appointments Secretariat process. We're also seen as somehow creatures of the Ministry of Health, so it's often difficult for us to get other ministries to see that, "Oh, yes, you're a crown agency. We can work with you at the local level."

That's not a problem. We're quite open to that, but it's not always seen as open on the other side, and that partly has to do with this notion of health gobbling things up. The reason why I think we have a Ministry of Health Promotion is that we're trying to not have health be defined as everything, and therefore, every ministry is somehow under the jurisdiction of the Ministry of Health. There is this kind of creative tension, I guess, going on, and we're finding that when we get to meet with folks face to face, they understand the issue and understand we can be helpful and not trying to take over their responsibility.

The Chair (Mr. Kevin Daniel Flynn): Questions? Christine.

Mrs. Christine Elliott: My question was really a variation on that because the transitions are being presented to us as being quite problematic. Would it be fair to say that it doesn't make your job any easier, the fact that you don't have specific responsibility for children and youth in order to be able to plan accordingly? You're sort of dependent on those groups to come to the table and offer their services to you?

Mr. Bill MacLeod: Again, it's a little bit variable from LHIN to LHIN in terms of who the players are and that kind of thing. But you're right, when we're the funder and we ask people to come to a table and help us plan, most people show up. It's sort of good politics to come and keep the funder happy. But for those that we don't fund, we still have a planning role and responsibility. It's a little tougher to get them to fully engage with us at times.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Jeff, then Liz, then Maria.

Mr. Jeff Leal: Thanks very much. I apologize for coming in a bit late.

It seems to me your LHIN has certainly picked up on the mental health issue. How did that come about? I mean, board members—I know there is the overall mandate of LHINs in the province of Ontario. But just quickly reviewing your slide deck, your particular LHIN seems to have picked up on the mental health issue and forged forward to bring about integrated services and case management. How did that evolve for your particular LHIN?

Mr. Bill MacLeod: I think the early part of my presentation indicated that in fact all LHINs had identified mental health and addiction as an important issue. If you look at—

Mr. Jeff Leal: It just seems to me some are more advanced than others.

Mr. Bill MacLeod: Only because I think we're presenting today and I'm a little more comfortable presenting what we're doing than, say, Waterloo Wellington, which I know is doing great things as well. Erie St. Clair is actively working in this. North Simcoe Muskoka, again, is looking at the co-location issue and the common hosting approach to bring and integrate services.

I want to kind of disabuse you of the notion that we're somehow the only folks doing this. I'm a type A personality, so I would hope we're doing it better or just as well as anyone else in the province—probably better—

Mr. Jeff Leal: I wanted to give you that opportunity.

Mr. Bill MacLeod: So if it turns out that you find we are leaders, I'm glad that we are leaders because that's what I would like to see Mississauga Halton be.

We also have a commitment to share best practices, and that's the notion of the LHIN Collaborative and why all LHINs have committed jointly to funding it and why the ministry has committed to put—about half the funding for LHINC comes from the Ministry of Health itself, so that we can see what works well and then very rapidly adopt that.

The analogy we use is the very best companies in the world allow local creativity and innovation and experimentation, but once they find something that works, then they adopt this rapid-cycle-adoption approach and very quickly bring in those things that work best. I use that as a way to come back full circle to say that's why we need a provincial entity, that's why we need somebody who is also involved in looking at this, bringing the clinical expertise the way Cancer Care Ontario brings clinical expertise to the system as a whole, to the province as a whole.

Mr. Jeff Leal: So you see the LHINs as a pretty good platform to have integration and provide case management etc. in this field?

Mr. Bill MacLeod: Absolutely. I had personal career opportunities in a whole lot of different places but I really saw LHINs as a very valuable role for improving the system and integrating it at the local level.

Mr. Jeff Leal: So, Bill, where were you before you became the chief executive officer at the Mississauga Halton LHIN?

Mr. Bill MacLeod: I was in Hamilton, working first as the interim president and CEO, when they were under supervision—

Mr. Jeff Leal: Oh, of the hospital in Hamilton?

Mr. Bill MacLeod: Yes. The supervisor brought me in, and then the CEO, when we recruited a permanent CEO, asked me to stay and work on some special projects. What I thought was going to be a two-year stint turned out to be seven. My last role there was vice-president, research and development, for Hamilton Health Sciences.

Mr. Jeff Leal: Angela, where were you before? I'm always interested in background, you know, because LHINs are a new entity.

Ms. Angela Jacobs: Right. Actually, I don't come from a health care background at all.

Mr. Jeff Leal: Okay.

Ms. Angela Jacobs: I actually have process improvement, a six sigma black belt consulting and the automotive industry.

Mr. Jeff Leal: Interesting. Okay, very good. Thanks for your responses. I appreciate that.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Jeff. Liz?

Mrs. Liz Sandals: All sorts of questions occur to me here, so I'll just start going through them. And congratulations on putting a process together.

You've got here that CMHA Halton is the program lead, and that's true in Mississauga as well as Halton?

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Mr. Bill MacLeod: Yes. One of the criterion we established was that if we were going to fund a new program that it had to be for the whole of the LHIN. One of the agencies could take the lead in that, but they had to see it as serving not their traditional catchment area, but in fact working with the other agencies to serve all of the people in the LHIN.

Mrs. Liz Sandals: So when you say they've got the lead, what does that mean in practical terms?

Mr. Bill MacLeod: That they will work with all of the providers that were identified—and I apologize; some of the names—we're great for all these acronyms in health care. PAARC, for example, is one of the providers on that slide deck. Adapt is another provider. So CMHA Halton will work with all of those providers to make sure that this is a seamless integrated program across the whole LHIN.

Mrs. Liz Sandals: So you've still got the pre-existing providers.

Mr. Bill MacLeod: Yes.

Mrs. Liz Sandals: But there's more coordination than there used to be.

Mr. Bill MacLeod: Absolutely.

Ms. Angela Jacobs: CMHA Halton has primary responsibility and accountability for the entire program, and they have memorandums of understanding with each of our providers around their accountabilities. So they are managing the entire program and all of the integration.

Mrs. Liz Sandals: At one point, there is a reference here to chemical withdrawal. I'm assuming that that means both drug and alcohol?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: So when you get the referral to this withdrawal program—it was previously a community withdrawal program, not a residential withdrawal program.

Ms. Angela Jacobs: It was always a community withdrawal program, but there was not the capacity to have a LHIN-wide program. It only served residents of Mississauga, and there was a long waiting list.

Mrs. Liz Sandals: So that program has been expanded. There are a lot more workers, a lot more places where you can physically go to meet with your caseworker or whatever?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: That particular service has expanded. Were there other services that shrank, or was it just that there was only one service and it didn't cover the whole LHIN?

Ms. Angela Jacobs: That was the case: one service.

Mrs. Liz Sandals: Okay. And then you go to concurrent case management. Who's doing the case management?

Ms. Angela Jacobs: We've got three providers. CMHA Halton is doing some of it; Trillium Health Centre, in their community mental health program, is doing some of it; and Adapt is also doing some of it.

Mrs. Liz Sandals: And were those three organizations—same question as before—previously doing case management?

Ms. Angela Jacobs: Yes, they were.

Mrs. Liz Sandals: And were there other organizations that were previously doing case management and no longer do case management?

Ms. Angela Jacobs: No. This is purely new funding, new investments. We've just increased the existing capacity in case management.

Mrs. Liz Sandals: So you say that you've broadened the catchment area, so to speak.

Ms. Angela Jacobs: Right.

Mr. Bill MacLeod: And ensured that it is universal across the whole of the geography, so that there weren't gaps occurring. One of the problems with the historical system is that various entities would come into being and get funded, but it was almost a patchwork quilt with a lot of holes in it.

Mrs. Liz Sandals: In fact, that has been one—the reason I'm sort of picking away at this is because one of the concerns that we have had is that, particularly with children's mental health but with adults as well, you get this whole host of agencies which may have overlapping responsibilities. So, for example, with something like case management or wait-lists or whatever, you may have three or four different agencies trying to manage the same individuals, and it's not actually clear that anybody can see the big picture, either about one individual or about the whole system, because nobody is actually

running the show; everybody is just seeing their own little piece of the show. That's what I'm trying to get a sense of. Through the way you've organized this, have you actually gotten rid of this sort of overlapping and nobody seeing the big picture?

Mr. Bill MacLeod: I don't think we've fixed it entirely, but we're moving a step closer to having that truly fully integrated system. I think the idea of having a regional entity that has that full responsibility and brings the clinical expertise as well—that's one of the things that the LHINs struggle with. Angela's great with the process improvement and how to organize a system, but the ability to bring the clinical expertise, best practices, outcome measurement and to set clearly achievable, clinically defined improvement benchmarks—I think that's something that the system would benefit from.

Mrs. Liz Sandals: Was identifying one lead agency key to putting this together?

Mr. Bill MacLeod: In our mind, it was. Yes. They weren't prepared to fund it as piecemeal.

Mrs. Liz Sandals: So you had to get somebody who actually was responsible for looking at the bigger picture.

Ms. Angela Jacobs: A lot of our health service providers—at least three of them—stepped up to volunteer for this role. So we went through our criteria and selected CMHA Halton.

Mrs. Liz Sandals: So there was actually almost an RFP for who's going to be lead?

Ms. Angela Jacobs: Yes.

Mrs. Liz Sandals: This is getting clearer to me. You made an interesting comment about 50% of the primary care physicians being outside the LHIN system because they're in a family health team or are individual practitioners whom you don't fund. So you've got no hold on these folks. If, instead, the person with the problem presents to one of these 50% of primary care physicians who are outside your system, can they refer to the CMHA lead and say, "Okay, I want you to put my patient, who didn't go to the emergency room, through this same track."?

Mr. Bill MacLeod: I'm not sure where we're at with this from that perspective. Part of the rationale for funding this was to reduce emergency stress and strain. Ideally—you're right. That would be where we would want to be able to end up. We'll have to see what resources we can bring to bear on that, because right now it's really the commitment—

Mrs. Liz Sandals: The track that you're on is really the LHIN trying to reduce pressure on emergency rooms and also looking at community funding of programs rather than hospital funding. So you're looking at that ALC, emergency-room, wait-time funding to do this, so if somebody is sort of outside the institutional bits, they may still be floating around there outside the institutional bits.

Mr. Bill MacLeod: Unfortunately, yes.

Mrs. Liz Sandals: That's really interesting. So now, let's go back to Kevin's 15-year-old. Now we've got a 15-year-old who presents to the emergency room with the same mental health and addiction issues. What happens to the 15-year-old who has got the same issues but wrong age?

Ms. Angela Jacobs: We were having those discussions—there is a steering committee that is implementing this program. We are having those discussions. No one's going to say, "This person can't come into this program." It's going to be on a case-by-case basis, but again, depending on the youth, how young they are, whether they're going to fit into these types of programs, where it's all going to be adult—

Mrs. Liz Sandals: So let's assume they don't fit into this particular track of programs. Then what?

Ms. Angela Jacobs: Good question.

Mrs. Liz Sandals: Okay, so we run into this falling-off-the-cliff thing. Okay.

Ms. Angela Jacobs: Yes, absolutely.

Mrs. Liz Sandals: Thank you. That's very helpful. Sorry if I sound like I'm picking away at you. I'm trying to understand what connects where.

The Chair (Mr. Kevin Daniel Flynn): Maria, did you have any questions?

Mrs. Maria Van Bommel: Just a couple of questions, because this has covered a lot of the things I was wondering about. How long has this process been on the ground—actually working on it?

Ms. Angela Jacobs: It hasn't, yet. We've just hired all the new staff. They have gone through, last week—

Mrs. Maria Van Bommel: So this hasn't really been tested yet?

Ms. Angela Jacobs: No. We had an orientation—

Mrs. Maria Van Bommel: Are there other jurisdictions that have something like this that you can use as a model or template for this?

Ms. Angela Jacobs: It was based on a similar model, not quite the community supports that we've provided, but North York hospital with Saint Elizabeth Health Care had done similar—like going into the ED with crisis workers to help facilitate that. We've gone a bit further and expanded a lot more of the community side of it, in terms of case management and withdrawal management. We started with the base of what they had done with the hospital and the ED department.

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Mrs. Maria Van Bommel: So are you basically running a demonstration for other LHINs? You mentioned other LHINs that were doing something similar. Are they doing this or are they doing something that's unique to their LHIN?

Mr. Bill MacLeod: When I mentioned other LHINs, some of them are working on other aspects of the mental health and addictions problem. What we're seeing, as I say, in North Simcoe Muskoka—I know they're looking at how to bring existing agencies together to this single-door, no-wrong-door concept. I think in Waterloo Wellington a similar approach is being made to make sure that the agencies are much more collaborative than they've been in the past.

In a previous environment, they all had their own individual relationship with the Ministry of Health. I think what we've brought is a requirement that they not only have relationship to the LHIN, but that whenever we meet with them, we're meeting with them collectively, that they develop a relationship with each other in that process as well.

To some extent, they're starting to see the advantages of working collectively together. There has always been, I think, in the field a strong sense of ownership of our program and how we developed it. It was often developed on the classic heroic leader who got involved, got a program up and going, fought with the government to get funding—whatever it took. So those organizations had a lot of independence built into them from that perspective, but what they're now seeing is, by working collaboratively and collectively together there's an ability to move forward.

As you know, the LHIN legislation doesn't allow us to interfere with their governance. We're not mandated to say, "Well, we're going to move you all together into one organization." But by bringing them together, I think they work much more collectively and much more synergistically together.

Ms. Angela Jacobs: Excuse me; can I just get back to your comment about the youth? I just wanted to correct something. They won't fall off the health care page. We have a lot of organizations in our LHIN that are not funded by us but they do provide those services to the youth. So the hospitals will connect with those particular organizations. But again, as you know, the capacity probably isn't there and there may be some wait times involved, but there are those types of programs specifically targeted at youth.

Mrs. Maria Van Bommel: And there's no coordination of those?

Ms. Angela Jacobs: There is.

Mr. Bill MacLeod: The Ministry of Children and Youth Services works to—

Mrs. Maria Van Bommel: But not through the LHIN?

Mr. Bill MacLeod: But it's not a LHIN coordination, yes.

Ms. Angela Jacobs: This is where our LHIN boundaries—

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I just had one last question. I was interested in your background, Angela, because you bring some objectivity to it, in a sense. People in health care tend to be really passionate about health care.

There was a lady who presented to us in Kingston. You could tell she had a strong business background. Her point was that you can grow and you can harvest and you can export and ship and import and retail a banana, and it ripens right on my counter, but she couldn't get mental health services for her kid. She wondered why the same business disciplines weren't applied to the provision of mental health services as they were applied to a banana, when she cared a lot more about her kids than she did about her bananas.

I thought that was a very good question, and I thought somebody with a background like yours would have a view on that.

Ms. Angela Jacobs: I have a view on a lot of ways the government's working. My private sector expectation versus what I see in terms of the public sector—so yes, sometimes I am a bit too vocal when I'm going around the halls of the LHIN.

From a business perspective as well, I do see—what would you call them?—inefficiencies or different ways that we can coordinate services and use the best of the funding we have. I do have that perspective, and even in this initiative that we're rolling out, I hope that I've been able to use that perspective in this particular initiative.

As we go through, we're going to track each individual who goes through this whole program so that we won't lose sight of them as they transition from one silo, if you want, or one provider to another provider, because as you know, in any system, as you do a hand-off between different people, different organizations, that's where you can actually have a lot of the issues.

The Chair (Mr. Kevin Daniel Flynn): Just off the top of your head, province-wide—I mean, including the region of Halton, obviously, and Mississauga—what do you see as the top three obstacles that either the system faces, professionals face, parents face or individuals and families face when someday they wake up and they've got an issue? They've got an addiction issue that has crept up on them or they've realized they've got a depression problem, anxiety—whatever. What are the three biggest obstacles that you think they face?

Ms. Angela Jacobs: I think the first obstacle—and I'm not sure how you would handle this because this is with regard to any physical ailment: You never know about the system until you need it. So when you need the system for your child or you need the system for your heart or you need the system for cancer, navigating the system is probably one of the biggest issues, I think, for anybody.

Maybe putting in a little plug for our LHIN, I find that some of these services—the funding hasn't kept up with the growth in the community in terms of per capita investments in some of these programs, mental health and addiction or community programs. I know that's province-wide, but I can also see other opportunities, and we touched a bit on that in terms of back-office integration.

But I think it's more with the silos. I see the silos between mental health and addictions; I see the silos between mental health and addictions and community programs; and I see those silos between them and the hospitals. I think it's really siloed, not only on the ground level but also on the system level, not on the ministry level.

Mr. Bill MacLeod: And often, the person you would want to turn to would be your primary care physician, Kevin. I think the system is confusing to those folks as well: Intelligent people who graduated all the way

through medical school, and they find it difficult to understand the system. So I think we need to improve that interface between primary care and the rest of the system so that that primary care organization, whether they're a solo practitioner or they operate in a family health team with other kinds of resources, has a way to access the system for these resources as well.

The Chair (Mr. Kevin Daniel Flynn): It seems to me that currently, it's almost a fluke of geography as to what service may be available to you. Are you finding that there really is not equity between the LHINs?

Mr. Bill MacLeod: Yes; I think that goes back to how often these organizations sprang up under that heroic leadership model, where somebody had a great idea and worked hard to get it in place and funded.

To some extent, I think the government tried to deal with that, and they continue to deal with that in terms of the distribution of resources. As Angela has pointed out, in high-growth communities, it's a further struggle simply because the community—as I point out, in our LHIN, it's like every year you take the communities of Bracebridge and Gravenhurst and you move them into the Mississauga Halton LHIN—and not just this year, but next year and the year after and the year after. The resources that are there in Bracebridge and Gravenhurst, whatever those resources are, everything from hospital beds to community resources, need to come when those people move into the community.

We're not necessarily attuned to dealing with high growth. The province clearly has adopted a growth strategy, both from a population point of view and other points of view. I think it is important that areas of growth and areas that are designated as places to grow also have a way to get that infrastructure, whether it's community social service infrastructure or—and to some extent, the municipalities do a great job on the roads, the sewers, the police, the fire and that kind of thing, but it's some of the other infrastructure that suffers a little bit in those places-to-grow designated areas.

The Chair (Mr. Kevin Daniel Flynn): Great. Jeff?

Mr. Jeff Leal: If you had the legislative responsibility in terms of looking at the numerous entities that sometimes get involved in providing mental health services in order to reduce that number to make it more efficient in the delivery, would that be something that you would like to have, that power to expedite things?

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Mr. Bill MacLeod: It's one that you'd want to use very carefully because—

Mr. Jeff Leal: Oh, I agree.

Mr. Bill MacLeod: Simply because there's a tremendous resource we get in our health care system, particularly from the volunteer board, volunteer members of society who come and work with these agencies without expecting compensation, remuneration or reward. They do that because there's a sense of belonging or a sense of ownership or whatever, let alone the financial resources they contribute through fundraising and other kinds of things. You'd hate to see that lost simply because somebody felt, "Oh, we'll put these organizations together and they'll be more efficient somehow."

Mr. Jeff Leal: I don't mean to do it in a ruthless fashion, but after careful consideration.

Mr. Bill MacLeod: And in truth, we have that. If the LHINs see that it would be in the public interest to bring two organizations together, then they can do it in one of two ways. We have facilitated integration authority, so we could go to those two organizations and say, "We think you two really need to be together. We're going to provide a facilitator, we're going to provide a resource and we're going to help you work through coming voluntarily to that conclusion." If, in the end, they said, "For this reason or that reason, we don't agree that it's in the public interest," but the LHINs still saw it as being in the public interest, even more so perhaps after the results of a facilitated exercise, we can petition the minister and the minister has the authority to bring those entities together.

Mr. Jeff Leal: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: I was interested in your comments too on the back-office integration or consolidation, because you've obviously been thinking about that from a business model perspective, which is less dramatic perhaps than the total integration of the agencies. What sort of success have you had with back-office integration or maybe even front office? Because a lot of these little organizations have significant administration; it isn't just back-office functions. It's also that everybody has their own executive director, and while executive directors may be lovely people, there's a limit to how many of those you need in the province. So what sort of success have you had in the integration discussions?

Mr. Bill MacLeod: Quite reasonably good success. Things like common intake and assessment forms, for example—which is again a form of discontinuity because somebody wants to do it this way and somebody else wants to do it that way—are all things that we've been able to work on quite successfully. As I mentioned, the education and development program is now an integrated program across the sector, and the entities are seeing good results from that.

There is a provincial mandate to integrate the back-office systems through something called the community care information management program, CCIM. We're actively involved in that. In fact, our LHIN is one of the pilots right now for the mental health back-office integration on the financial side.

Mrs. Liz Sandals: But when you say "integration" in that context, you're talking about people all using the same systems or the same intake criteria so that you can communicate about measuring things or reporting things; you're not actually talking about—I don't know—a consortium that's going to do payroll for all the little agencies within the LHIN or something like that.

Ms. Angela Jacobs: We are working on two initiatives, actually. One is co-location, which you'll see in the package that Bill handed out. That's one of the task

groups, and we're looking at some of our mental health and addiction agencies sharing a location: sharing reception, some boardrooms, meeting rooms, places. But we're actually now expanding that, opening that up to a lot of community agencies, United Way and so on. We're looking for a location in Oakville and in Milton. We hope that, number one, some of these smaller agencies can move out of some of those locations that are not accessible; bus lines don't go there; they're in a dingy corner somewhere in Oakville or Mississauga where it's not a pleasant place to visit. So that you can get a nicer place to rent—

Mr. Bill MacLeod: But the rent was cheap.

Ms. Angela Jacobs: Yeah, but the rent was cheap; right. So that combining their resources, they'll actually get better access, and then you'll have a whole community in this building so that it's not stigmatized. As well, mental health and addictions is actually a health area—

Mrs. Liz Sandals: There are some other services.

Ms. Angela Jacobs: Yes, exactly. The other thing we're looking at is, some of our hospitals are in an organization called Shared Services West where they do bulk purchasing. So we're looking at how we can offer bulk purchasing to all of our community agencies to get the best price for them on everything they buy—computer software. That may roll out to something like perhaps financial accounting and maybe rolling that a little bit farther along that way, but it's still in the early stages right now.

The Chair (Mr. Kevin Daniel Flynn): Any more questions? Thank you very much for coming today.

Mr. Bill MacLeod: We very much appreciate your time. It's a great pleasure.

Ms. Angela Jacobs: Thank you.

The Chair (Mr. Kevin Daniel Flynn): That was really good information.

The committee adjourned at 1658.

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