Executive Summary

In 2011, The Ontario government released a comprehensive, multi-year mental health and addictions strategy entitled *Open Minds, Healthy Minds*. The strategy identified the need for "timely access to health and social services", "services (that are) integrated so people have easy access to the right mix of supports", and "better coordination across health and other human services in an effort to reduce wait times for services, decrease the number of repeat emergency department visits and unplanned hospital readmissions, and improve appropriate service linkages and referrals from the justice system. (*Open Minds, Healthy Minds*, p.8)

Prior to, and since the release of *Open Minds, Healthy Minds*, a number of coordinated or centralized[1] access models for mental health and addictions have proliferated across the province with the goal of streamlining entry and simplifying access to the service system through the consistent use of standardized processes and tools for assessment and referral. These models, while sharing similar core principles, have developed largely independently with limited clarity on what successful coordinated access mechanisms should look like, minimal standardization across jurisdictions, and, lack of a framework to help understand the degree to which these models are meeting their objectives.

Recognizing these limitations and the absence of available provincial level literature on coordinated access models, Addictions and Mental Health Ontario (AMHO) and the Centre for Addictions and Mental Health (CAMH) Provincial System Support Program (PSSP) partnered on a project in 2016 to review the current status of coordinated and centralized access for mental health and addiction services across Ontario.

The review revealed an absence of conclusive evidence on best practices in coordinated access system design, implementation and operation. Interviews with key stakeholders revealed strong support for coordinated access mechanisms in the mental health and addiction sector across Ontario but also a current lack of information about the effectiveness of these models in the Ontario context. Given these findings, the research report recommended an evaluation of coordinated access models in Ontario in conjunction with the creation of a provincial-level logic model to help guide the details of the evaluation plan as well as further development of performance indicators to measure and monitor outcomes.

Based on these findings, a proposal for a second phase of work aimed at evaluating a subset of provincial coordinated access models identified in the review as "complex" was submitted. The need for this evaluation was supported by the 20-member Mental Health and Addictions Leadership Advisory Council (MHALAC), which was appointed by the Minister of Health and Long-Term Care in 2014, as well as the Coordinated Access LHIN Work Group, which was formed in 2016.

The evaluation, which was conducted from January to June, 2017, sought to answer two questions:

[1] In the interest of brevity we will use the term coordinated access assuming that most of the Ontario models also imply a high degree of centralization.

1. What has been the impact of Ontario's coordinated access models for the mental health and addictions system?[2]

2. What aspects of the coordinated access models have contributed to the identified impact?

The evaluation design was informed by multiple stakeholders including LHINs, the Ministry of Health and Long-Term Care, service providers, coordinated access providers, and people with lived experience and their families. Inputs into the evaluation included site visits with the in-scope coordinated access providers, surveying of various stakeholder groups, group and/or individual consultations, and a review of administrative data.

Early on in the evaluation, a number of contextual factors were revealed that need to be considered in reviewing the findings and the recommendations, namely:

- The operations, structure, and success of the coordinated access services are dependent to some degree on local governance structures and operations of referral partners. For example, some providers only make a certain number or percentage of appointments available for access providers to book into; this may impact the ability of coordinated access to support timely access to the right provider
- The mandate of each coordinated access provider is generally determined by the LHIN, agency partners and/or host organization. Mandates may influence the scope and scale of coordinated access. For example, some coordinated access services are mandated to refer to only LHIN-funded services, which may impact matching and waitlists
- Each of the coordinated access services is in a different stage of development; findings reflect a point in time
- Many of the coordinated access providers engage in continuous improvement. Some access services are in the process of implementing changes to address some of the opportunities that were identified through stakeholder input; stakeholders may not be aware of these changes, and the impact of these changes may take some time to realize

Findings

The analysis of evaluation inputs revealed that stakeholder opinions regarding coordinated access are mixed, with most feeling that the impact of coordinated access has not been overwhelming positive or negative. Service providers in particular expressed some skepticism, noting that while coordinated access services have been useful in some ways, they have not yet been successful in effectively addressing the many factors that precipitated their evolution including challenges with service navigation, screening and matching services to client needs, and decreasing wait times.

[2] "System" refers to specialized mental health and addiction services as well as other health and social services which provide treatment and support to people with mental health and addiction related challenges.

Although service providers, people with lived experience, and family members expressed familiarity with particular coordinated access services, they did not seem to have an in-depth understanding of the work of the access services or their offerings. When asked what specific regional coordinated access services were set up to do, service provider and LHIN responses were varied, demonstrating a lack of clarity regarding goals and objectives; this was true regardless of the maturity of the access service.

LHIN and service provider stakeholders were also challenged to identify the outcomes of coordinated access, and in particular the impact that coordinated access has had on people with lived experience, families, and the broader mental health and addictions sector. This lack of understanding may be attributed in part to limitations in the relationships and connectedness between coordinated access services and their local partners and service providers.

The findings speak to the absence of standard processes and tools to assist in engaging clients and family members and facilitating access to services. At a local level, the findings also reflect the challenges that coordinated access models have faced in adapting to and managing the constraints within their local context, for example, limitations in mandate, governance structures, opportunities for referral placement and IT infrastructure. Limited insights into the changing nature of coordinated access at the local level and their ongoing development also likely contributed to perceptions of impact, recognizing that the implementation of local system change takes time to actualize.

Regardless of perspective, there was a general sense that coordinated access is a work in progress, with multiple opportunities to enhance services and contribute to better outcomes for individuals with lived experience and for the mental health and addictions system. Considering these findings, as well as the limitations and considerations identified earlier, the evaluation question “What has been the impact of Ontario’s coordinated access models for the mental health and addictions system?” may be considered premature.

While not able to definitively identify the impact of coordinated access on individuals with lived experience, families, service providers and the broader mental health and addictions system, there were clear perceptions about the features of coordinated access that do or could contribute to success as well as some features that could be better standardized provincially. Overall, stakeholders felt that coordinated access could address gaps in the system by:

1. Having a range of options for accessing coordinated access (e.g., online, satellite services)
2. Providing live answer rather than call-back to enable responding to immediate needs and decrease the risk of people falling through the cracks
3. Having skilled staff with a range of expertise and knowledge of the mental health and addictions system
4. Providing the right type and intensity of service from first point of contact (e.g., crisis intervention, brief intervention)
5. Effectively and actively managing waitlists
6. Building strong partnerships with a broad range of service providers
7. Enhancing relationships with service providers to build trust and buy-in

8. Improving knowledge/information management
9. Using more integrated client relationship management databases
10. Better promotion of coordinated access services

Direct scheduling was also noted to be an area where there may be opportunities to improve coordinated access, however, feelings about this were more mixed.

The findings also revealed some questions regarding the relationship between local coordinated access and ConnexOntario. Some individuals wondered about the value of having both regional and provincial coordinated access services. Recognizing this, as well as the evolving mental health and addictions sector, and ConnexOntario's unique position as a provincial resource, it may be timely to examine their ongoing role, and explore ways in which regional coordinated access services can be more effectively linked with ConnexOntario. The need for this is evidenced by recent data that suggests that the number of calls received by ConnexOntario from regions that have their own local robust coordinated access service have increased over the past year. This requires further analysis to identify contributing factors.

In considering the role of ConnexOntario moving forward, thought should be given to their potential for leadership, growing capacity in providing IT infrastructure and support, unique position in providing access to provincial mental health and addiction services (e.g., residential beds), and their role in provincial data collection and dissemination for planning purposes.

Recommendations

Five recommendations have been identified based on the findings.

1. *The Ministry of Health and Long-Term Care should take on a leadership role, in collaboration with the LHINs, in providing strategic direction, and oversight for coordinated access, including evaluation, performance measurement, and change management. Performance measurement should include the use of a standardized provincial scorecard, based on the provincial logic model developed for this evaluation.* The findings demonstrate that coordinated access models have developed with different goals and objectives, making it challenging to understand the impact from a provincial point of view and demonstrate overall value, which subsequently would help to achieve buy-in from the mental health and addictions sector. Provincial leadership is necessary to provide/reaffirm strategic visioning, and to determine and guide implementation of standardized features. As with other initiatives of this nature, this type of governance and oversight is crucial to future success of coordinated access. Governance structures at the provincial and local level are critical in ensuring accountability, alignment of provider and partner practice with agreed upon protocols and participation agreements, and removal of barriers that may impact the ability of coordinated access to achieve stated goals and objectives.

2. *As part of its leadership role described in Recommendation #1 above, the Ministry of Health and Long-Term Care, in partnership with the LHINs, should define the respective roles of ConnexOntario and regional coordinated access models.* There is a need to clarify these roles, eliminate duplication, and maximize synergies between regional and provincial models, while exploring opportunities for how they can best support and work with one another. There is recognition that the roles of ConnexOntario and regional coordinated access may need to be

customized in different regions, depending, for example, on the availability, type and maturity of regional coordinated access, and the local context (e.g., rural, remote, urban).

3. *The Mental Health and Addictions Coordinated Access Working Group should continue to develop standardized definitions for coordinated access and performance indicators for evaluation.* The absence of standard definitions for the different aspects/activities of coordinated access and for performance indicators creates limitations in the ability to compare across coordinated access services. The Coordinated Access Working Group's efforts in this area are critical to future endeavors to understand the impact of coordinated access.

4. *The Coordinated Access Working Group, ConnexOntario, or another provincial body should lead and coordinate efforts to implement a provincial community of practice to facilitate collaboration across coordinated access providers, including sharing of lessons learned, and identification of future opportunities.* While some informal relationships exist across coordinated access services, a more formalized collaborative could help to increase standardization and minimize duplication. A community of practice would enable coordinated access services to share information on common challenges and successes as well as learnings that influence implementation. As one coordinated access provider said, "There is significant value in the power of learning from one another".

5. *Guided by the Coordinated Access Working Group, the Ministry of Health and Long-Term Care should support further investigation of the features of coordinated access that are seen to have a positive impact on individuals with lived experience, families, providers, and the broader mental health and addictions system.* The gaps in coordinated access that were identified and the aspects of coordinated access that are working well converged throughout this evaluation. Focusing on these specific aspects over a longer period of time and identifying what contributes to their success or perceived success may provide valuable lessons to inform next steps and to guide implementation where appropriate.