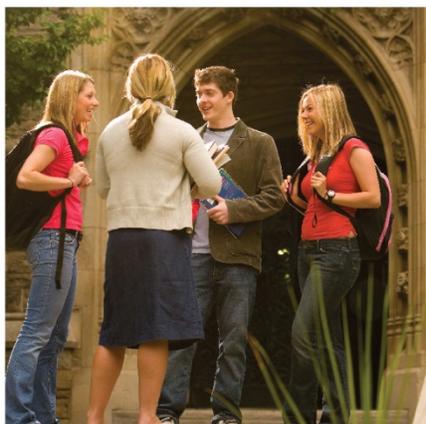


DEFINING THE MENTAL HEALTH
AND ADDICTIONS 'BASKET OF
CORE SERVICES' TO BE PUBLICLY
FUNDED IN ONTARIO



EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Defining the Mental Health and Addictions 'Basket of Core Services' to be
Publicly Funded in Ontario**

24 June 2016

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed with the aspects of the problem presented in the evidence brief, which discussed adult Ontarians experiencing the full continuum of mental health and addictions challenges, the numerous providers currently involved in the delivery of care, and the heterogeneous array of services that are contracted by Local Health Integration Networks. Building on this, participants focused on the way in which the continuum of mental health and addictions needs was conceptualized in the brief as three distinct population groups, opting instead for a framework based on four levels of complexity.

In deliberating about the three elements, participants were hesitant to prioritize certain services over others and instead vocalized a number of principles that they felt should underpin the delivery of mental health and/or addictions services. These principles included, among others: developing services that are reflective of the voices of those with lived experience; ensuring there are set standards and accountability measures for any services; supporting flexibility and choice in services; and providing services that support patients holistically and across the life course. There was widespread agreement on the need to reorient the system to include more prevention and targeted promotion services including stigma reduction, suicide prevention, screening in primary care for substance use as well as for depression and anxiety, and harm reduction. Additionally, participants discussed the importance of strong communities and the need for services that address the social determinants of health to be integrated throughout the basket of services. Participants acknowledged that an ‘upstream’ approach needed to be balanced with the continued delivery of high-quality acute services for those individuals who will continue to require that level of care. A focus was placed throughout deliberations on the need for addictions services to be more prominent within the basket.

In considering the implementation of the basket, participants noted questions regarding feasibility, specifically in the infrastructure and competencies needed to link across the continuum of needs, as well as the importance of a transparent implementation process and public communication plan. The next steps for this process include convening a citizen panel in July comprised of a diverse group of Ontarians whose perspective will be an additional input for the Basket of Core Mental Health and Addictions Services’ Task Group to consider. The expectation is that the Task Group will develop recommendations on the basket of core services, shaped by all of the inputs they have sought, with a plan to submit their recommendations to the Mental Health and Addictions Leadership Advisory Council, and ultimately from the council to the Ministry of Health and Long-Term Care over the summer.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed that the problem underlying the need for a basket of core services could be understood in relation to four aspects of the problem:

- adult Ontarians experience the full continuum of mental health and addictions challenges;
- the basket of publicly funded services across this full continuum has not been defined for adults;
- many providers are involved in the delivery of services; and
- mental health and addictions agencies and hospitals are contracted to deliver a heterogeneous array of services, and some services are not publicly funded.

However, some participants expressed concern regarding the way in which the continuum of needs was conceptualized. In particular, while there was agreement that a framework of some kind was needed, the division of this continuum into the three distinct groups – 1) the general population and individuals at risk of mental health and/or substance use problems; 2) individuals with mild and moderate mental health and/or substance use problems; and 3) individuals with severe and persistent mental illness and/or addictions – was a point of contention among participants.

Ultimately, participants felt that a conceptualization of needs according to complexity was preferable to a conceptualization based on broad population groups. The advantages of a continuum based on complexity were that it could better address community services beyond those in the health sector, as well as the social determinants of health. A complexity approach was also felt to be more inclusive of addictions. One participant suggested that re-defining the continuum of needs this way would result in four levels of complexity rather than the three population groups used in the brief.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a potentially comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and an approach for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed;" and
- 10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

DELIBERATION ABOUT ADDRESSING THE PROBLEM

The deliberation about services that should be included in a basket of core services began with (and sometimes returned to) a general conversation about the seven criteria for deliberation outlined in the brief. These criteria were identified to assist participants in making decisions about what services should be included in a basket of core services:

- 1) burden of disease (i.e., need);
- 2) benefits and harms of the services (i.e., the balance between desirable and undesirable effects);
- 3) values and preferences about the outcomes achieved and the balance between benefits and harms;
- 4) resource use, which includes both budget impact and cost-effectiveness;
- 5) impact on health equity;
- 6) acceptability to stakeholders; and
- 7) feasibility of implementation.

Participants identified that the rationales they most commonly drew from to prioritize services were primarily based on criterion two (benefits and harms of the services) and criterion six (acceptability of services to stakeholders). Criterion seven (feasibility of implementation) also elicited discussion from participants, with there being broad agreement about the need to balance flexibility with consistency in implementing a basket approach. In particular, participants expressed a need for the basket to be flexible enough to be tailored to specific community contexts in volumes that meet local needs, and in a way that is achievable given the existing service landscape, but consistent enough for all Ontarians to feel they have comparable access to a comparable mix of services.

While all participants agreed that services included in the basket must meet the mental health and addictions needs of individuals across the entire continuum of care, they raised concerns over equity and the need to distinguish among approaches to care, services and interventions. They also identified several system principles that should underpin a basket of core services. We describe each of these in turn below.

Considering equity

Participants raised a number of equity considerations during their deliberations, most commonly in relation to particular equity-seeking groups who may have mental health and addictions needs that may not be addressed well by a standard basket of core services. While many of these groups were identified in the evidence brief, participants drew attention to justice-involved individuals, transition-aged youth and older adults. Additionally, some disagreement arose as to whether specific services for indigenous peoples (e.g., services built around traditional teachings and cultural practices such as sweat lodge or food security services) should be embedded within the basket of core services, or whether indigenous peoples should have a separate basket. Ultimately it was determined that greater representation and input of indigenous groups should be sought prior to continuing this discussion. Members of the Mental Health and Addictions Leadership Advisory Council who were present at the dialogue shared that there is a parallel process underway being led by First Nations, Inuit and Métis peoples, with the support of the Ministry of Health and Long-Term Care, that is focused on addressing issues such as this. They emphasized that there continues to be coordination and communication across both efforts.

Distinguishing among approaches to care, services and interventions

In general, participants felt it was helpful to distinguish principles and approaches to care from the services and interventions themselves, however, they felt both were needed as part of a basket of core services. There were several places where this was apparent during the discussion. For example, while it is true that harm reduction is both an approach, a model of treatment and a service, a number of participants brought forward the concern that these pieces were often being conflated. Similarly, peer support can reflect a principle of peer-involvement, a model of care or a particular type of service provider. Participants cautioned that

reducing these concepts to the service level could diminish their value and impact on the system. The following approaches to care were deemed important for Ontario to incorporate as it moves forward with the basket of core services:

- concurrent disorders approach;
- cultural sensitivity and safety;
- harm reduction;
- peer support;
- recovery; and
- trauma-informed care.

A few participants suggested that the services presented in the evidence brief were in fact a mix of services and interventions, which they felt were two different things, and that care would need to be taken in categorizing them appropriately in the basket. Participants felt that services were similar to a package of care and supports (e.g., social skills training), and interventions were more specific and could often be delivered within a service (e.g., cognitive behavioural therapy). There was no discussion about whether the basket of core services should be focused on services or interventions. However, some participants acknowledged that understanding the evidence base at both levels was still helpful.

Identifying system principles

Throughout the deliberation, dialogue participants were asked to consider which mental health and addictions services they would prioritize to be included in the basket of core services, and why. In response to this question, participants often hesitated to advocate for select services for fear of removing others from the basket. Instead what was frequently vocalized were principles that should underpin the delivery of services. For instance, participants highlighted the need:

- for services to be well-defined and inclusive of the voices of people with lived experience;
- to set standards and have measures of accountability;
- for the system, and in particular the basket of core services, to operate transparently;
- for flexibility and choice to be integrated into service use;
- for the system to accommodate new knowledge and support promising practices;
- to coordinate across levels and sites of care (e.g., primary care and public health);
- to help people build resilience and strength; and
- to look at people holistically and across the lifespan.

Element 1 – Defining the basket of services for the general population and those at risk of mental health and/or substance use problems

Participants were strongly supportive of the inclusion of preventive services and an upstream approach, often reiterating that the current system focuses too heavily on acute care. Services that were most commonly prioritized by participants in element 1 were stigma reduction, suicide prevention, screening in primary care for substance use as well as depression and anxiety, and harm reduction including overdose prevention. Participants frequently mentioned that both system-navigation services and peer support should be brought into this element, but that 'managed alcohol' was a service better handled in element 3. After extensive deliberation, broad agreement was reached that befriending services should be re-labelled (or at least jointly identified) as services to prevent social isolation, and that these are important to include in the basket.

In discussing element 1, dialogue participants recognized that some services may be key for the general population and those at risk, but should be funded by sources other than the government. The most notable examples of such services were those that could be funded by employers and employee-assistance programs,

including workplace wellbeing and prevention of depression in the workplace, and those that could be funded by major corporations, such as Bell Let's Talk. Additionally, participants noted the importance of strong links between mental health and addictions services, and both primary care and public health. They indicated that for the general population these connections provide an early entry point into mental health and addictions services, and can help to mitigate the need for more intensive or acute services from the specialized mental health and addictions sector.

Participants frequently emphasized the importance of acknowledging the social determinants of health across all population groups. While participants agreed that services to assist with the social determinants should be prioritized for those most in need, many felt that prioritizing support for some of the social determinants - particularly employment and education supports, community inclusion efforts to reduce social isolation and housing - at an earlier stage could help mitigate mental health and addictions challenges from developing, or could serve to promote an earlier recovery.

Element 2 – Defining the basket of services for those with mild to moderate mental health and/or substance use problems

Participants once again noted that the current publicly funded service sector was not designed to adequately address the needs of those with mild to moderate mental health and/or substance use problems, acknowledging that the current community sector's roots stem from the efforts to deinstitutionalize people with more serious or persistent needs. Given this, participants agreed that this element was an important area in which to enhance public investment. The most commonly prioritized services for this element were crisis services, centralized access and intake, supported employment and supported education. In particular, participants highlighted the importance of emergency psychiatry within crisis services, and interventions that veered away from police-based approaches. One participant provided an example of a new mental health and addictions crisis centre that is available in the South West Local Health Integration Network as a promising approach.

Participants noted that both harm-reduction and self-management services should run throughout the entire continuum of needs and across all three elements. Some participants suggested that there was a missing emphasis on addictions services, specifically on community-based modalities, that could be integrated into this element, such as community withdrawal management. Additionally, some participants identified specific services and interventions that they felt were missing from this element, including psychological therapies like dialectic behavioural therapy and motivational interviewing, as well as day treatment. Finally, participants discussed whether to integrate the current sub-systems of care targeting select diagnosis-based groups, such as problem gambling and eating disorder treatments, or whether these services should be left separate. A general agreement was reached that services directed towards eating disorders should be integrated into the basket, but that problem gambling services should continue to be separate due to the discrete funding streams targeting these services.

Element 3 – Defining the basket of services for those with severe and persistent mental illness and/or addictions

In discussing element 3, there were some concerns expressed that the array of proposed services contained within the evidence brief favoured discrete services and time-limited approaches. Participants suggested that these do not adequately align with the chronic disease management approach needed for those with persistent, life-long mental health and/or addictions challenges. The services that were most often prioritized in this element were early intervention for psychosis, primary day and night care, intensive case management, and harm-reduction services with an emphasis on medical withdrawal management. Participants identified that electro-convulsive therapy was missing from the list of services provided in the evidence brief. Participants also felt that services to support transition of individuals across services should be available in

both the second and third elements, with several participants identifying them as navigation services. Further, participants discussed particular transition points that people with severe and persistent mental illness and/or addictions may experience, and which are important for future services to target, including transitions between acute care and the community, transitions from youth to adult services (i.e., transition-aged youth), and transitions between adult and older adult services.

Much of the deliberations around this element surrounded whether to include pharmaceuticals, even though they are captured under a different funding mechanism, within the basket of core services. Many participants felt that – particularly for addictions services such as withdrawal management (including opioid management and anti-craving services) – this was essential.

Considering the full approach

In deliberating across all three elements, participants generally agreed on the importance of upstream services and on treating individuals earlier in order to prevent mental health and/or addictions problems from beginning, and to ensure problems that do develop are addressed adequately before becoming acute or persistent. That being said, all participants recognized the need to continue to provide high-quality acute services and services targeting those with more severe and persistent problems for those who need that level of care.

Across the three elements, participants considered how certain services could be bundled and provided as a package to improve their effectiveness, notably for some psychological therapies and pharmacological therapies. Participants also discussed bundling at a higher level, both in terms of bundling services to develop consistent service pathways as well as integration across levels of care, including primary, secondary and tertiary care and public health.

Throughout the deliberations the participants recognized that the evidence brief, which considers evidence at the systematic review level, had some limitations in its ability to inform the discussion about the basket of core services. In particular, many participants noted that mental health and addictions has traditionally not been an area of large research investments, resulting in fewer studies and therefore fewer reviews that provide helpful conclusions. They also noted that the systematic reviews that do exist tend to focus on services and interventions that lend themselves to research, such as pharmaceutical interventions and more discrete, time-limited services. The reviewers also tend not to reflect some of the newer and more promising services and approaches to care, such as peer support, where evidence is still accruing at the primary study level. Nonetheless, there was broad acknowledgement that it would be very difficult to search all of the primary studies encompassing such a broad array of services, and that the evidence brief was a helpful springboard for discussion.

Finally, participants recognized that the basket of core services will include services that are currently delivered through a number of funding sources. While some of the services fall within the typical purview of mental health and addictions and its budgets, others currently fall within the remit of home and community care, primary care, other specialty care, and public health. Still other services (such as some of those targeting people with mild to moderate needs in element 2) are currently delivered privately through out-of-pocket payments or through private insurance plans. Finally, other services are available through employers and employee assistance programs. The only times when the funding source was raised as part of the deliberations was regarding problem gambling services and services delivered in workplaces.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Implementation considerations regarding the basket more generally centred on feasibility, specifically whether sufficient infrastructure and provider capacity was available in the current system to support these changes. Participants also mentioned that funding a smaller array of services may attract providers who may not have the capacity or commitment to remain faithful to the service as it was intended to be delivered. This consideration ties closely to the principles of accountability and transparency mentioned previously in this summary. An extensive communication plan to help set expectations for system users was seen as essential by dialogue participants. Ideally, as noted by participants, the expectations would be based on standards with clear definitions, ideally similar to those used to define wait times in the province.

Additional considerations specific to the elements were discussed. For element 1 this included the challenge of emphasizing preventive services due to limitations in measurements, and time delays in providing outcomes. For element 3 this included needing to strike a balance between providing consistent services in each LHIN and seeking some flexibility for those services that are particularly needed or would be more efficiently provided only in select areas across the province.

Finally, participants reiterated their message that no matter what decisions are made it is important that the principles defined above are included as part of the description of the basket. There was broad agreement among participants that work should begin on these reforms and improvements to mental health and addictions services as soon as possible. Participants discussed the importance of balancing careful planning with developing the momentum needed to effect change.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

This stakeholder dialogue and evidence brief are part of a larger process being undertaken by the Mental Health and Addictions Leadership Advisory Council's 'Basket of Core Mental Health and Addictions Services' Task Group, which has been asked to define an initial basket of core services that should be publicly funded and available in all regions across the province. To date this process has included a jurisdictional scan, individual stakeholder consultations and a consultation day to discuss the implementation considerations, a consultation with a Persons With Lived Experience Reference Panel and a similar consultation with a Family and Caregivers Reference Panel (both convened by the Ministry of Health and Long-Term Care in support of the Mental Health and Addictions Leadership Advisory Council), among other efforts.

The next steps for this process include convening a citizen panel in July comprised of a cross-section of Ontarians whose perspective will be an additional input for the task group to consider. The expectation is that the task group will develop recommendations on the basket of core services, which will be submitted to the council and ultimately from the council to the Ministry of Health and Long-Term Care over the summer.



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