Addictions & Mental Health Ontario | Dépendances & santé mentale d'Ontario

camh PSSP
Provincial System Support Program

Evaluation of Coordinated Access Mechanisms in Ontario

September 17, 2017

FINAL

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Main Messages

- **Context -** AMHO and CAMH/PSSP partnered on a project in 2016 to review the current status of coordinated access for mental health and addictions across Ontario. Based on the findings of phase one, a second phase of the project was undertaken to evaluate a subset of provincial coordinated access models.
- **Methodology -** The evaluation was informed by multiple stakeholder engagements including: consultations with the caregiver/family reference panel, site visits with coordinated access providers, surveys, one-on-one interviews with people with lived experience/family and data review.
- **Findings -** While not able to definitively identify the impact of coordinated access, there were clear perceptions about the features of coordinated access that do or could contribute to success:
    - Having a range of options for accessing coordinated access (e.g., online, satellite services)
    - Providing live answer rather than call-back to enable responding to immediate needs and decrease the risk of people falling through the cracks
    - Having skilled staff with a range of expertise and knowledge of the mental health and addictions system
    - Providing the right type and intensity of service from first point of contact
    - Effectively and actively managing waitlists
    - Building strong partnerships with a broad range of service providers
    - Enhancing relationships with service providers to build trust and buy-in
    - Improving knowledge/information management
    - Using more integrated client relationship management databases
    - Better promotion of coordinated access services

Key Recommendations

1. **Leadership**: MOHLTC should take on a leadership role, in collaboration with the LHINs, in providing strategic direction, and oversight for coordinated access
2. **Roles:** As part of its leadership role described in Recommendation #1 above, MOHLTC, in partnership with the LHINs, should define the respective roles of ConnexOntario and regional coordinated access models
3. **Standardization:** The Mental Health and Addictions Coordinated Access Working Group should continue to develop standardized definitions for coordinated access and performance indicators for evaluation
4. **Community of Practice:** 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
5. **Continued Investment:** Guided by the Coordinated Access Working Group, MOHLTC 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

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.

Background and Context

In 2011, The Ontario government released a comprehensive, multi-year mental health and addictions strategy entitled *Open Minds, Healthy Minds*. The strategy, which aims to transform the mental health and addictions system, is guided by four overarching goals:

1. Improve mental health and well-being for all Ontarians;
2. Create healthy, resilient, inclusive communities;
3. Identify mental health and addictions problems early and intervene; and
4. Provide timely, high quality, integrated, person-directed health and other human services

The strategy recognizes 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 – such as housing, income support, employment and the justice system." The transformation of the mental health and addiction system as outlined in *Open Minds, Healthy Minds*, is expected to result in shorter wait times for services, fewer repeat emergency department visits and unplanned hospital readmissions, and more appropriate service linkages and referrals from the justice system. (*Open Minds, Healthy Minds*, p.8)

The need for more streamlined access to mental health and addiction services in Ontario has long been recognized by providers across the province. As a result, prior to, and since the release of *Open Minds, Healthy Minds*, a number of coordinated or centralized[3] access models for mental health and addictions have proliferated across the province with the hope 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 to review the current status of coordinated and centralized access for mental health and addiction services across Ontario. The first phase of this work, led by Dr. Brian Rush and supported by Birpreet Saini (AMHO), culminated in a report in June 2016, which provided a descriptive environmental scan that drew on multiple data sources, including an exhaustive literature review, interviews with mental health and addiction leads at each of the 14 LHINs, and follow-up interviews with representatives from the majority of Ontario's coordinated access services.

The review categorized coordinated access mechanism for mental health and addictions into two broad groupings:

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[3] 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. Complex models, which provide a centralized access point(s), operate under a more decentralized model or are based on a combination/hybrid approach; and

2. Less complex models, which may involve a warm hand-off to other services, integration or co-locations of services, and/or use of common screening and assessment processes or a common referral form across multiple providers.

Overall, the report 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.

A proposal for a second phase aimed at evaluating the more complex coordinated access mechanisms in Ontario was submitted by AMHO, Dr. Brian Rush and PSSP in December, 2016. The need for this evaluation has been 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.

Evaluation Objectives

This evaluation focuses on LHINs that were identified in the June 2016 review as complex models (see Table 1). There is recognition that the selection of these more complex models is based on the 2016 environment and that these and other models across the project will no doubt have evolved since the release of the Phase I report.

Table 1: List of coordinated access mechanisms included in the evaluation

LHIN	Coordinated Access Mechanism
Central LHIN	• Streamlined Access
Champlain LHIN	• Ottawa Addiction and Access Referral Services
Mississauga Halton LHIN	• one-Link
South West LHIN	• Reach Out
Toronto Central LHIN	• Access CAMH • Central Access (Withdrawal Management) • Coordinated Access to Addiction Services • The Access Point
Waterloo Wellington LHIN	• Here 24/7

LHIN	Coordinated Access Mechanism
Provincial	• ConnexOntario

The objectives of this evaluation, as outlined in the proposal, are to identify:

- The success of these models in improving access to mental health and addictions treatment/support and continuity of care;
- Key features of these models that appear to be contributing to or impeding the achievement of outcomes; and
- Key organizational or system-level contextual factors that appear to be contributing to or impeding the success of these models.

Approach and Methodology

An evaluation plan was submitted to the Ministry of Health and Long-Term Care in March 2017, outlining the approach and methodology to guide the evaluation of complex coordinated access mechanisms for mental health and addictions.

The evaluation plan was informed primarily by two consultations that were held with various health system stakeholders in December 2016 and January 2017, and a logic model that was developed and refined based on inputs from these consultations (see Appendix 1). The plan outlined two broad evaluation questions that were identified by stakeholders as being crucial:

1. What has been the impact of Ontario's coordinated access models for the mental health and addictions system?[4]

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

Stakeholders noted that the evaluation questions should be considered in the context of identifying opportunities for standardization across coordinated access models, noting that some level of standardization is necessary, while having different perspectives on what should be standardized and to what degree.

The evaluation plan also laid out recommendations for data inputs, as described below, and an evaluation framework (see Appendix 2).

Data Inputs

Considerable stakeholder input and feedback was provided on potential sources of information to inform the evaluation plan, including data collection strategies.

[4] "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.

Case studies were initially explored as a potential methodology; it was however decided by participants in the two early consultations that case studies involving focus groups, and/or individual/small group interviews would not be feasible given the time frame for this evaluation. These stakeholders also expressed concern regarding validity and reliability of data from a small number of case studies given the differentiation across the many access models. A robust sample would be required across models/regions in Ontario in order to effectively analyze and draw conclusions from this type of research strategy. Considering this feedback, as well as other stakeholder inputs, the evaluation team decided that data to answer the evaluation questions could be gathered through surveys of stakeholders and a review of administrative data involving the complex models identified in Phase I.

Site Visits

In early-to-mid-April 2017, members of the evaluation team conducted site visits with each of the coordinated access providers for the purpose of:

- Reviewing and getting input into the evaluation plan;
- Exploring local relationships of relevance to the evaluation;
- Discussing stakeholder engagement; and
- Discussing the availability of existing administrative data.

Site visits also provided an opportunity to gain a better understanding of the unique context in which each of the coordinated access providers operates, with coordinated access providers sharing background information related to the establishment and sustainment of the coordinated access service.

Stakeholder Engagement

Evaluation input from people with lived experience began with two consultations that were held with the Ontario Mental Health and Addictions Leadership Advisory Council Caregiver and Family Member Reference Panels in April 2017. The consultations served two purposes:

1. Gain insight from reference panel members on their experiences and/or perceptions of coordinated access, including input on benefits, risks, and challenges; and
2. Obtain feedback on recommended approach to engaging stakeholders, particularly people with lived experience.

Reference panel members suggested using a multi-pronged approach for engaging people with lived experience. Focus groups, one-on-one interviews and surveys/short forms were all suggested as potential tools for engagement.

Based on input from the reference panel, and feedback from coordinated access providers, a decision was made to create and distribute a short questionnaire/form for people with lived experience that could be completed online or on paper; an option was also provided for a one-on-one interview with a member of the evaluation team. The varied approaches to engagement supported an equitable approach, enabling people with lived experience to engage in a way that met their individual needs and reduced barriers to participation.

Building on the logic model, evaluation plan and framework, customized questionnaires were developed for the various target stakeholder groups as identified in the evaluation plan:

- Mental health and addiction service providers
- People with lived experience/family
- LHIN representatives from regions with a complex coordinated access mechanism
- Ministry of Health and Long-Term Care representatives and LHIN representatives from regions without a complex coordinated access mechanism

Depending on the stakeholder group, questionnaires were designed to elicit insights on the specific complex coordinated access model that the survey respondent was most familiar with and/or to provide broader insights on coordinated access from a provincial perspective. At the conclusion of each questionnaire, respondents were invited to complete the questionnaire for other coordinated access models.

The questionnaire for mental health and addiction service providers was developed first, with the understanding that the questions would form the foundation for all other stakeholder surveys. The surveys included questions to elicit perspectives on equitable access to care. A draft of the questionnaire was sent to all of the complex coordinated access providers and an opportunity for feedback was given. The questionnaire was also sent to a number of individuals outside of the evaluation for feedback on flow, language, and survey tool usability. Feedback was collected and the questionnaire was adapted as appropriate. Questions were adapted accordingly for the remaining stakeholder groups.

The complex coordinated access providers were asked to provide a list of stakeholders for each of the stakeholder groups who could be invited to complete the questionnaire. The list of Ministry of Health and Long-Term Care stakeholders was supplemented by a Ministry representative from the Mental Health and Addictions Branch.

For all stakeholders, except people with lived experience, an email invitation to complete the questionnaire was sent from the AMHO CEO or the evaluation team. Surveys were generally kept open for two weeks or longer, with an email reminder sent after approximately one week. The survey for people with lived experience was distributed by the complex coordinated access providers using their method of choice e.g., email distribution, hard copy, posting on their website. Providers were asked to ensure a random sampling to avoid any bias.

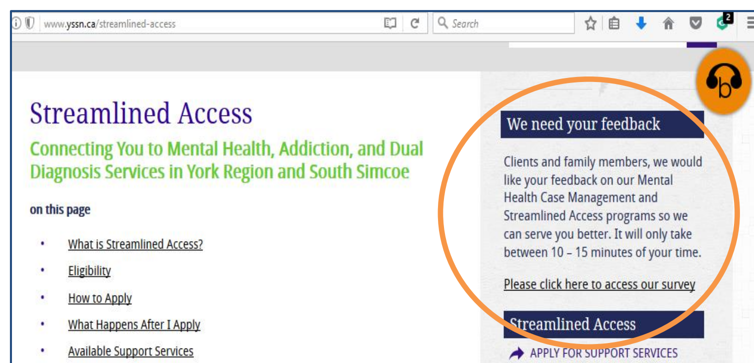


Table 2 below details the number of questionnaires that were distributed.

Table 2: Stakeholder Survey Distribution

Stakeholder Group	# of Questionnaires Distributed
People with lived experience	Unknown*
Mental health and addiction service providers	282
LHIN representatives from regions without a complex coordinated access model	10
LHIN representatives from regions with a complex coordinated access model	13
Ministry of Health and Long-Term Care representatives	14

*The number of surveys distributed to individuals with lived experience is unknown due to the variable approach in distribution method by each of the access providers.

It was deemed by the evaluation team that the questionnaire for mental health and addiction and other providers would not be appropriate for Access CAMH, as it primarily acts as a coordinated access mechanism for CAMH services only; rather, two consultations were held with staff and internal partners, as well as some one-on-one interviews for individuals who were not able to attend one of the consultations.

Administrative Data

Each of the coordinated access providers was sent a request for data specific to their program. Data for 2014-2016 was requested where available, including information on utilization of their services, referral patterns, wait times etc. (see Appendix 3). Coordinated access providers were also asked to submit budget information for each year of operation where available (see Appendix 4).

Data from Ontario Perception of Care (OPOC), Health Quality Ontario (HQO) and other sources was also collected and reviewed.

Analysis

Questionnaires and other stakeholder inputs were analyzed using an inductive approach, which allowed for themes to emerge from the data rather than utilizing pre-determined themes. Data were first analyzed by individual coordinated access model and stakeholder group, and then across models and stakeholder groups. Findings from the questionnaires were compared to inputs from consultations and quantitative data and examined for similarities and differences.

Following the analysis, individual meetings were held with each of the coordinated access providers for the purpose of reviewing the high-level overarching findings as well as any findings specific to the coordinated access provider. An opportunity was given to speak to the findings and provide context or other inputs to be included in this report. These provider responses are included within the report.

Contextual Considerations

In reviewing the findings, it is important to consider the context within which each of the coordinated access services currently operates, recognizing that the data and stakeholder inputs may be impacted by multiple factors and may not reveal the full picture of coordinated access. Considerations include:

- 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 hold appointments, which 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; stakeholder perceptions speak to the current state, and do not necessarily reflect the continuous development that is taking place within each of the coordinated access services
- It may be too soon to determine the impact of coordinated access services that are in the early stages of implementation
- 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

In addition to the above considerations regarding the context in which the coordinated access services operate, findings should also be reviewed in light of the following:

- The availability of data varied across coordinated access providers, impacted in part by the stage of development / maturity of the access model
- Data definitions and parameters, as well as definition of the various aspects of coordinated access are not consistent, making it difficult to compare data across coordinated access providers
- Survey response rate for some stakeholder groups, and for some coordinated access services were low, impacting the confidence with which the findings can be interpreted
- Stakeholder inputs reveal perceptions and do not necessarily provide a fulsome view of coordinated access services

Profiles of each of the coordinated access services included within the scope of this evaluation can be found in Appendix 5.

Findings

The findings have been organized to align with the two key evaluation questions:

3. What has been the impact of Ontario's coordinated access models for the mental health and addictions system?[5]

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

The initial intent was to report on findings for each of the access services, however, given their unique operations and community context as well as uneven and low response rates, results could not be confidently interpreted by program. As a result, the findings, which reflect a point in time, are reported in aggregate across all access services and stakeholder groups. Findings that were unique to a particular access service, or stakeholder group are noted where they exist.

Findings are reported by themes, which were generated through ideas or inputs that were consistently communicated or demonstrated across the majority, but not necessarily all of the stakeholders and data inputs. Quotes from different stakeholder groups are embedded within the findings. Quotes from people with lived experience and providers are specific to their own experience with coordinated access, while quotes from LHIN representatives reflect a broader perspective.

Coordinated access provider responses to these themes are included where available.

Survey Respondent Overview

The tables below provide an overview of the number of respondents for each of the surveys. Response rates varied by question, and at times, within questions where there were multiple response options. Five individuals with lived experience requested a one-on-one interview, however, only three responded to the outreach to schedule an interview, and only two attended the interview.

Table 3: Number of Stakeholder Survey Respondents

Model	Providers (Response rate* = 47%)		LHINS (Response rate* = 67%)		Ministry of Health and Long-Term Care (Response rate* = 0%)	
	Started Survey	Completed Survey	Started Survey	Completed Survey	Started Survey	Completed Survey
Here 24/7	21	14	0	0	0	0
The Access Point	30	23	2	0	0	0
Coordinated Access	8	6	0	0	0	0
Central Access	3	1	0	0	0	0
Reach Out	11	7	1	1	0	0
one-Link	15	11	1	0	0	0
OAARS	11	10	0	0	0	0
Streamlined Access	13	6	0	0	0	0
ConnexOntario	21	14	4	3	0	0

[5] "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.

Model	Providers (Response rate* = 47%)		LHINS (Response rate* = 67%)		Ministry of Health and Long-Term Care (Response rate* = 0%)	
	Started Survey	Completed Survey	Started Survey	Completed Survey	Started Survey	Completed Survey
General	N/A		8	6	0	0
TOTAL	**133**	**92**	**16**	**10**	**0**	**0**
For Access CAMH, consultations took place with 7 provider participants. *Response rates based on the number of individuals who started the survey						

Table 4: Number of People with Lived Experience Respondents

Model	People with Lived Experience			
	Started Survey	Completed Survey	Requested Interview	Participated in Interview
Here 24/7	3	3	N/A	N/A
The Access Point	0	0	N/A	N/A
Coordinated Access	0	0	N/A	N/A
Central Access	0	0	N/A	N/A
Access CAMH	14	14	N/A	N/A
Reach Out	0	0	N/A	N/A
one-Link	0	0	N/A	N/A
OAARS	3	3	N/A	N/A
Streamlined Access	18	18	N/A	N/A
ConnexOntario	0	0	N/A	N/A
Unknown			5	2
TOTAL	**38**	**38**	**5**	**2**

Of the provider respondents, the majority (66%) work in a community or non-residential setting; 35% of all provider respondents work primarily in a mental health setting, and 29% work primarily in an addictions setting. The majority of provider respondents worked in an administrative/leadership role. Most of the provider respondents have some experience and interaction with coordinated access, either through making referrals, receiving referrals, and/or through other interactions such as participation in planning or other committees.

Figure 1: Setting

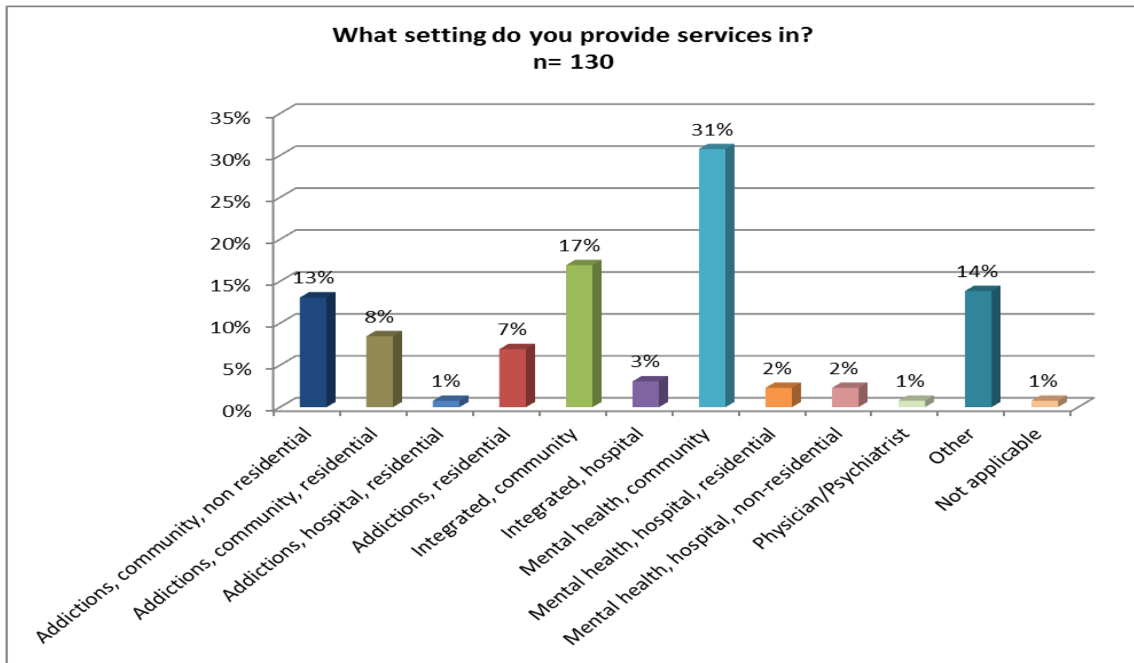


Figure 2: Primary role

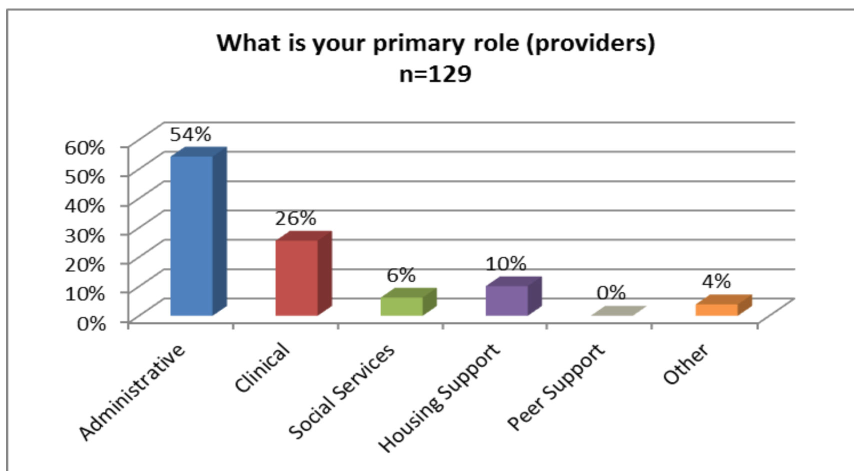


Figure 3: Making referrals

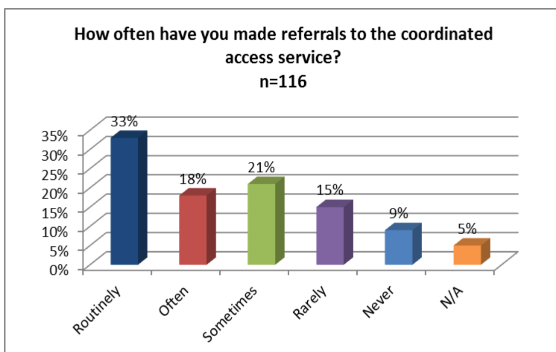
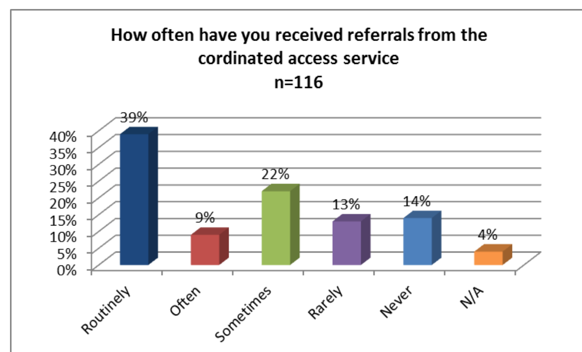


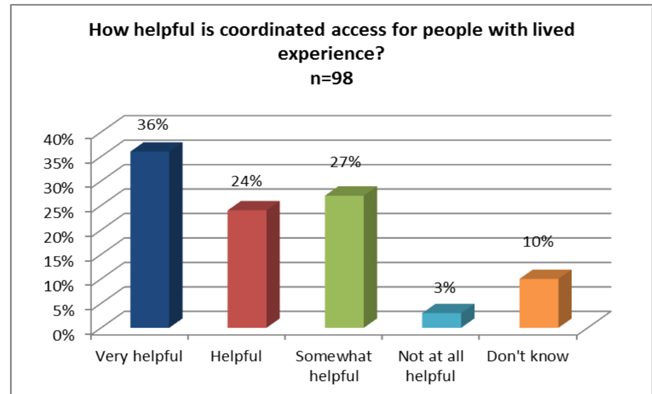
Figure 4: Receiving referrals



What has been the impact of Ontario's coordinated access models for the mental health and addictions system?

There were some mixed perspectives about the value and effectiveness of coordinated access. Overall, however, the concept of coordinated access - which was primarily seen as a providing a single point of access for referrals to the mental health and addictions system - was viewed positively and was seen by the majority of stakeholders as having had some impact for people with lived experience, families, providers, and more globally, the mental health and addictions system. When asked specifically about how helpful coordinated access is for each of these stakeholder groups, the degree of helpfulness was fairly evenly split across "very helpful", "helpful" and "somewhat helpful", with most stakeholders feeling that coordinated access is more helpful for people with lived experience than any other group.

Figure 5: Helpfulness of coordinated access for people with lived



While some providers felt that coordinated access can at times feel like an extra layer of bureaucracy providing limited value, other stakeholders felt that without it, the system would "return to the chaos that existed before", making it more difficult, confusing, inefficient, and costly to access the broad range of mental health and addiction services that are available. Coordinated access has the potential, it was suggested, to add value by providing a clear picture of volumes, allowing providers to right-size their internal processes. When it is working well, coordinated access can also, it was suggested, help providers to see if the pathways that exist within their own programs or organizations are meeting the needs of those that they serve.

Figure 6: Helpfulness of coordinated access for families

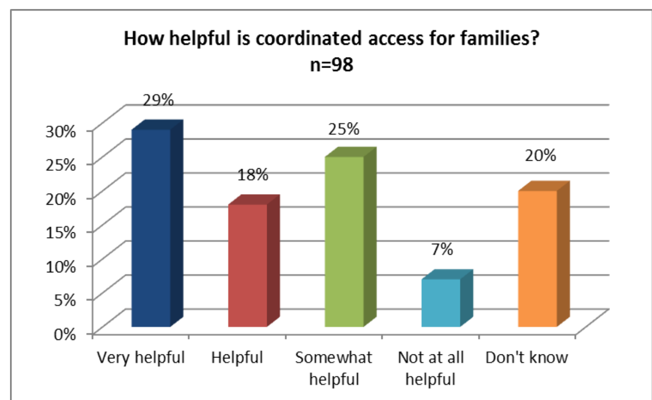
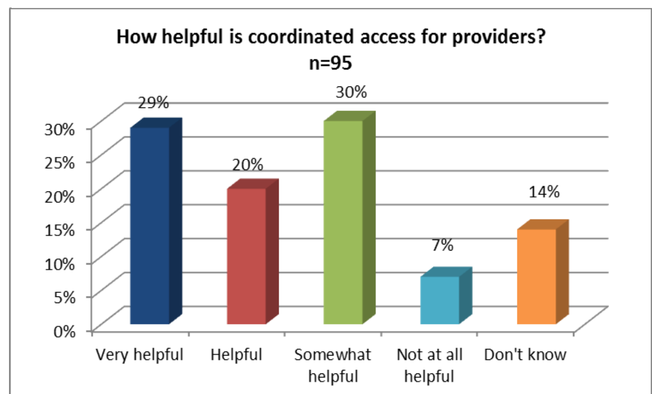


Figure 7: Helpfulness of coordinated access for providers

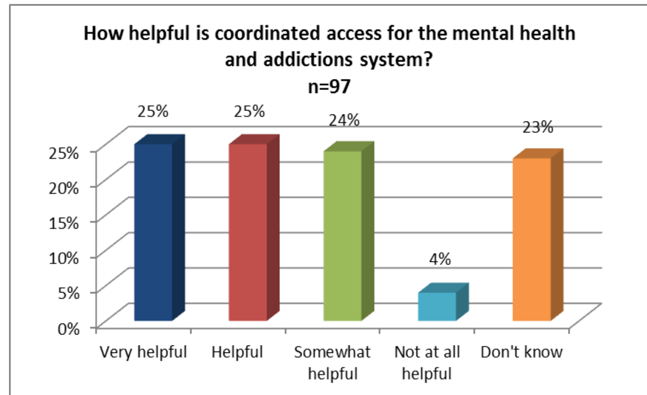


"When not well, (you don't have) the energy to try to access the services on (your) own; it can be really daunting to figure out who to call"

Individuals with lived experience in particular identified that having a single place to access services can be valuable when you are vulnerable and overwhelmed, particularly if there are language and

cultural differences that may make it more challenging to access the system on your own. They at times described coordinated access as providing value as a safe environment with staff that are knowledgeable and sensitive to their needs. Some reference panel participants also mentioned the value of having a "single form" to complete and a "single waitlist" through coordinated access.

Figure 8: Helpfulness of coordinated access for mh&a system



When asked how effective coordinated access is in providing the foundational services outlined in the logic model, not one service was seen as being provided very effectively; only intake (40%), screening (45%), and making the right referrals (46%) were seen as being provided somewhat effectively.

> "When you are in the thick of it you don't always know what your needs are so you really need someone who can help you to sort that through at the beginning"
> ~Person with lived experience

> "Generally feel it's not working well but has the right idea. The concept is good, the delivery is not working as it should"
> ~Provider

While acknowledging that coordinated access is helpful for different populations, the majority of stakeholders felt that more work is needed to improve coordinated access and make it more effective for individuals with lived experience, their families, service providers, and the broader health system. This perspective was seen across stakeholder groups, with the majority of stakeholders seemingly feeling that coordinated access is somewhere in the middle of the spectrum in terms of its impact and effect i.e., across questions where there was a Likert scale, there were few stakeholders who responded strongly on the positive or negative ends of the scale. In thinking about how to improve coordinated access, a small number of stakeholders wondered about the differentiation between regional coordinated access and ConnexOntario.

Overall, effectiveness of coordinated access was closely aligned to perspectives on the capacity both of the coordinated access services, and the system that each of the services is attached to. There was a general consensus that to actualize the benefits of coordinated access and fully realize its potential, we need to work on capacity across different points of the access journey. If done correctly, coordinated access could, it was felt, lead to more informed conversations about, and responses to health system gaps and priorities.

Perceived impact of coordinated access with different populations

When asked what the impact would be if coordinated access did not exist, stakeholders generally agreed that there would be at least some level of impact, primarily for people with lived experience and the health system, with the least impact to mental health and addiction providers.

The most significant perceived impact identified would be the ability for people to get to the right mental health and addiction services, while other impacts were largely unknown by stakeholders. This perception of impact aligns with stakeholder views regarding the foundational purpose of coordinated access, which

most stakeholders expressed, is to provide information and referral and to link people with the right agencies and services.

Figure 9: Impact if coordinated access did not exist

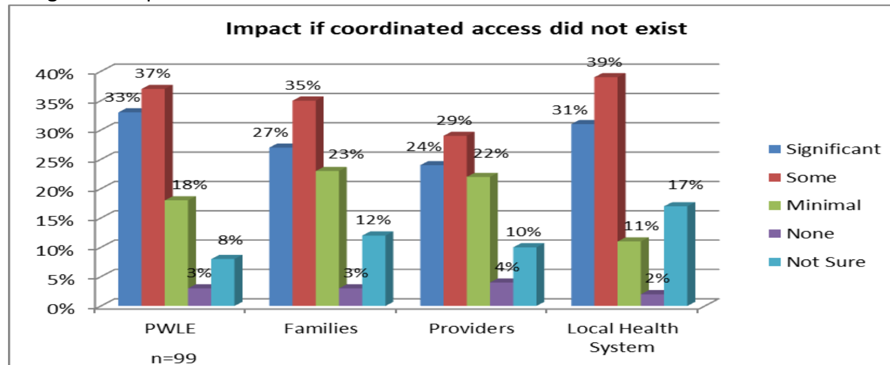


Figure 10: Impact of coordinated access

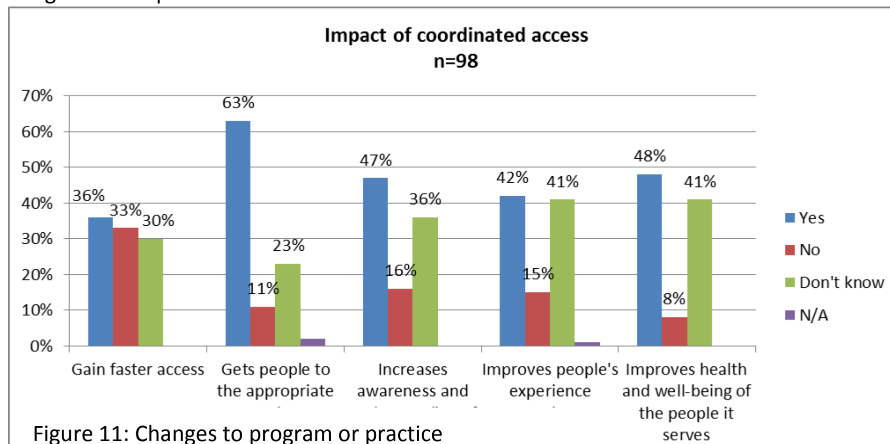
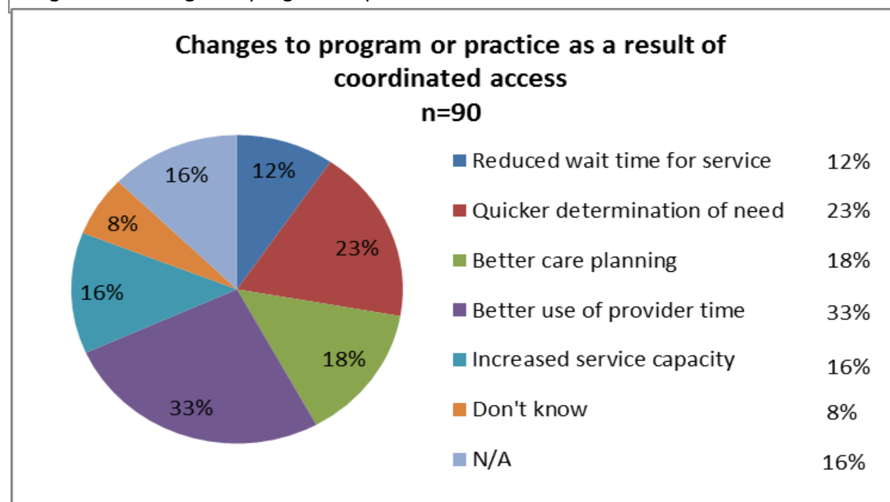


Figure 11: Changes to program or practice



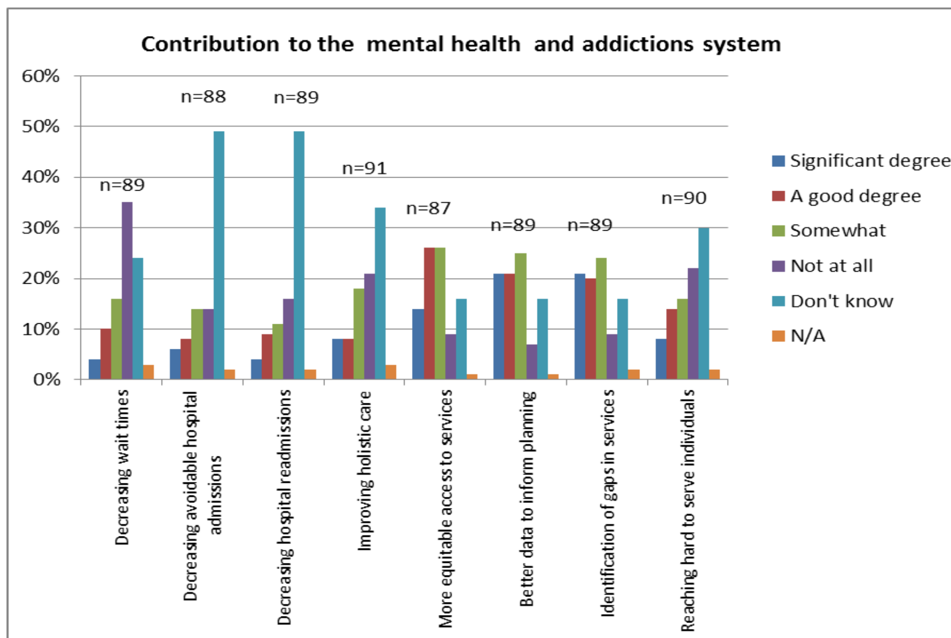
Although providers did not appear to feel strongly that coordinated access is a benefit to them, there was some recognition that coordinated access has, to some extent, helped this group to utilize their time more effectively. It appears, in reviewing various comments and inputs from stakeholders that this is attributed to the shifting of intake and assessment processes from the providers to coordinated access, in instances where the providers do not replicate these processes.

Across stakeholder groups, including people with lived experience, wait times for services were consistently seen as a challenge. System capacity issues, which are beyond the control of coordinated access services, were frequently cited as contributing to this bottleneck; there was also some acknowledgement that other external factors may also contribute to wait times, i.e., the extent to which providers offer spaces. These views on wait times are generally seen throughout the sector, with reports from Healthy Quality Ontario, Canadian Institute for Health Information, and Centre for Addiction and Mental Health often citing waits of up to one year for therapeutic intervention, and increases in emergency department visits for mental health related issues (particularly amongst young people) as a result of long wait times for services.

> "I am unclear why we keep expecting coordinated access to decrease wait times. I believe it creates vastly improved experience at service initiation. The navigation function's value cannot be emphasized enough, nor can the value of quick response at the time the client reaches out for help." ~Provider

In addition to the impact of system capacity on wait times, at least ten providers, in relation to six different coordinated access services suggested that coordinated access seems to have led to an increase in wait times for service, both at the service provider level, and more broadly throughout the system. Although the overall number of individuals raising this concern was small, it is worth noting as these were independent perceptions that were not directly elicited. Overall, lengthy wait times, it was suggested, could be addressed by expanding referral scope to divert people to services with lower utilization and/or offering other services through coordinated access that may address short-term need; both of these are addressed in the section outlining factors that contribute to the impact of coordinated access. It should be noted that there were some stakeholders who felt that coordinated access should not be about decreasing wait times, and that the value of coordinated access is much broader. It was also acknowledged by some stakeholders that there have always been issues with wait times in mental health and addictions, although perhaps at different parts of the journey.

Figure 12: Contribution



For the most part, stakeholders were not confident in identifying how coordinated access has contributed to the mental health and addictions system as a whole, although there was some recognition that coordinated access has had some impact on identifying gaps in services (65% of respondent indicated that coordinated access has either significantly, to a good degree, or somewhat contributed to identifying gaps in services), providing better data to inform planning (67% of respondents indicated that coordinated access has either significantly, to a good degree, or somewhat contributed to better data), and contributing to more equitable access to mental health and addiction services to "a significant degree" (14%) "a good degree" (26%) or "somewhat" good degree (26%).

What populations has coordinated access impacted the most?

> "(Coordinated access is good for) those that are less marginalized, that is, those more connected to services and likely to encounter promotional material that would direct them" ~Provider

Provider, LHIN and Ministry stakeholders were asked to identify which populations are best served by coordinated access. While a number of stakeholders felt that coordinated access is good at serving a variety of populations and people with multiple needs, others felt coordinated access is more effective for those with low or moderate mental health and addiction needs and those who are less marginalized. Coordinated Access to Addiction Services was the only coordinated access model where respondents unanimously felt that marginalized and homeless individuals and families are well-served; it should be noted however that the sample size was very low (8). ConnexOntario was noted as being effective in servicing more rural populations where there are no local coordinated access models.

The challenges in serving more vulnerable and complex populations were attributed in part to limitations in the ways in which people can connect with coordinated access. For example, many of the coordinated access providers currently are not able to offer a live answer, which can be difficult, particularly for transient populations and youth.

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

Recognizing that different coordinated access models are in different stages of development and operating in unique community contexts, stakeholders provided their perspectives on aspects of coordinated access that they felt are working well, as well as aspects that they think would help to increase the contribution and impact of coordinated access. These two viewpoints often converged with current success factors, and factors that stakeholders felt would improve coordinated access being the same.

Having a range of options for accessing coordinated access

> "Have actual people physically be at locations where these vulnerable people are (i.e., shelters, transitional housing, hospitals)" ~Provider

> "…If we could email and text people we would be able to reach people more efficiently" ~Coordinated Access Provider

As noted earlier, it can be difficult, particularly for more complex and marginalized populations, to connect with coordinated access services. There was a general perception from stakeholders across stakeholder groups that offering a range of options to address and meet the needs of the different ways in which people connect with services would be useful. A number of stakeholders suggested exploring opportunities to conduct outreach, for example, establishing satellite coordinated access services where people, particularly those that are more vulnerable, already congregate.

Others suggested more effective utilization of technology e.g. text and email, and better use of websites to make information more accessible for people with different literacy and technology skills.

Coordinated access providers recognized the value of offering different access points to meet the needs of diverse populations. For example, Reach Out has been working with the local Canadian Mental Health

Association to develop a walk-in program that will enable those in need of services to get connected right away. An example of this, it was noted, already exists locally within addiction services, where individuals can walk-in and receive intake services on-the-spot, leaving with a scheduled appointment and a list of support groups that can be accessed immediately.

Other access providers noted that they are exploring the feasibility of more online access, recognizing that appropriate resources are required to manage and maintain all points of access.

Providing live answer rather than call-back

Those coordinated access services that offer live answer on their phone lines were generally perceived as being more effective than those who do not. Stakeholders generally felt that it is critical to be able to respond to the need when it arises, particularly for those who are more vulnerable. It was noted that there is an administrative burden associated with following-up with calls/referrals where there is not live answer, often requiring multiple call-backs before reaching the individual seeking information/services. It was generally felt that live answer can minimize this administrative burden, freeing up time of access providers to engage in more valuable activities. Live answer, it was suggested, is also more client focused, and can decrease the risk of people falling through the cracks. From a service provider perspective, live answer was seen as helping to speed up the process of clients getting to them for services, and streamlining their intake processes.

> "One of the things that our partners say has worked best is having staff to answer the phone live Monday to Friday"
> ~Coordinated access provider

> "Our assistants aren't playing as much phone tag. People are getting to the right appointment more quickly" ~Provider

Coordinated access providers recognized the value of live answer. Many of those who are not currently able to provide this service noted that it is a part of their longer-term vision and strategy. The Access Point, for example, transitioned to live answer and first call resolution approximately one year ago, and is now live answering 95% of the more than 750 calls per week. Coordinated access providers acknowledged however that providing live answer can be costly, and requires the right staffing model, including management and quality oversight to ensure that it is working effectively.

Having the right staff with the right skill set

Coordinated access providers that have skilled staff with a range of expertise in mental health and/or addictions were generally perceived to be more effective than those who primarily operate with lower-skilled generalists. Stakeholders generally felt that it is critical to have staff that has some degree of clinical reasoning as well as experience and understanding of the mental health and addictions system. Ideally, it was suggested, coordinated access services should have a staff mix that includes a range of clinical professionals e.g., masters level social workers, nurses, psychologists and physicians. With this expertise in place, stakeholder suggested that coordinated access can provide more accurate and meaningful

> "(it's good to) have people with lived experience dealing with similar issues, and having someone to listen non-judgmentally"
> ~Person with lived experience

> "If people are able to call and have somebody informed who cares, that will undoubtedly improve their experience"
> ~LHIN

assessment, and triage, which will in turn, it was suggested, improve matching and potentially wait times. The availability of immediate access to clinicians through coordinated access was also seen as useful for more complex and crisis-oriented calls. A number of stakeholders also noted the value of including people with lived experience (peer support) as a part of the staff mix. This was particularly prevalent amongst reference panel participants who indicated that peer support may in fact be the only service that an individual needs, and that people with lived experience are best equipped to help navigate the system, as they have been through it.

Regardless of expertise, stakeholders indicated that it is critical for coordinated access staff to have compassion, be non-judgmental, and be active listeners – qualities that were noted to be present across a number of coordinated access providers. Staff, it was noted, should also be consistent in their approach and in the type of information that they provide.

There was broad recognition that in addition to having the right skill mix, coordinated access providers need to have the right staffing levels. Human resource capacity and funding to support this were consistently identified as a challenge. Access providers who felt that they have adequate staffing levels identified that this was an important factor in their success.

A number of coordinated access providers noted that they do employ staff with a range of clinical and mental health and/or addictions expertise. The Access Points' eight service navigators and two team leads have a range of backgrounds and credentials including psychiatry, social work, registered psychotherapy, OT, child and youth work, mental health case management, and mental health crisis response. All of their staff have experience working in the community mental health and addictions sector, in diverse areas such as criminal justice, youth, homeless and supportive housing. The Access Point staff group is able to speak to applicants in more than ten of the languages commonly spoken in the GTA, including 4 of the top 5 languages requested by applicants.

one-Link also indicated that they have 10 full-time equivalent staff, including social service workers, masters level social workers and addiction service workers, as well as housing experts. It was noted however that retention can be an issue, as skilled professionals often prefer face-to-face and more intensive interactions with the client-base.

CAMH provides access to clinical expertise through triaging conducted by information and referral workers. This was seen as a critical component to their success.

Those access providers that utilize generalists noted that this can be effective when the right training and supervision is in place. For example, OAARS system navigators have a 97% acceptance rate of referrals, suggesting that the skills exist to appropriately match to services.

Providing the right types and intensity of services

> "It would have been helpful to have been offered more stop-gap alternatives"
>
> ~Person with lived experience

Those coordinated access providers who offered the widest breadth of services, and particularly those who were able to provide quick access to crisis intervention, were generally perceived across stakeholder groups as being the most effective.

Stakeholders communicated that the impact of coordinated access could be vastly improved if coordinated access providers had the capacity and skill to provide support – including crisis, brief intervention and low-level case management - while waiting for services, and/or as a service in and of itself. This was perceived to be one of the most significant gaps in coordinated access. Being able to provide these services and supports, it was suggested, could divert those with less intensive needs, and/or could minimize the risk of progression of need/deterioration for those who currently "languish on wait lists". At least one stakeholder also suggested that brief intervention through coordinated access could be used as a preventative measure for individuals who have received intensive services in the past, and may need brief touchpoints for maintenance purposes.

> "I do think it has an impact if we can do a 10 minute intervention. We may be able to provide them with what they need, which may alleviate the need to access services elsewhere""
>
> ~Coordinated access provider

Provision of support for families through coordinated access was also perceived to be a gap across stakeholder groups. One respondent with lived experience specifically highlighted the gap in services for parents of adult children who decline to access services; these families, it was suggested, have nowhere to turn, and "don't fit" into the mold of the few support systems that are available for families.

Coordinated Access providers generally agreed with the perceived gap in services offered through coordinated access, with many noting that they have been exploring ways to better meet the needs of individuals who may benefit from more immediate intervention. Streamlined Access indicated that they have developed linkages for mobile crisis response, and have up-skilled coordinated access workers to be able to provide crisis support. In addition, the potential for a multi-partner table to discuss complex cases is being explored. Some services have also been put in place for caregivers.

OAARS has also implemented supports for family members and continues to explore ways to enhance these services through partnerships, for example with Rideau Wood. In addition, OAARS began this year to provide bridging services for those who have been identified as having more immediate needs. Families experiencing an addiction crisis can receive services instantaneously through a community withdrawal team that maintains open spaces on the caseload for the purpose of managing these immediate needs. The team will provide information, talk to youth, assess the level of risk/danger and work on fast-tracking the family towards services.

The Access Point, through new screening tools and triage process, as well as a Rapid Response pilot is looking to stream people who need less intensive services to alternative options rather than to the long-term wait list, and/or to prioritize those with urgent needs into more rapid service. The Rapid Response pilot will provide 8-10 weeks of service to new referrals in targeted zones across the City. A Test of Change

initiative to serve people who are homeless more quickly is also in development. This work is being informed by efforts of other coordinated access services and is building on literature reviews conducted by The Access Point as part of their quality improvement work. A key challenge in this implementation, it was suggested, will be the lack of capacity amongst providers.

Coordinated Access to Addictions Services has similarly explored opportunities to meet more immediate needs by developing targeted services for repeat/frequent system users. The implementation of the Toronto Community Addictions Team, which provides intensive care management for this population, has, they reported, reduced emergency room visits significantly.

Since its launch, one-Link has been providing support to clients while they are waiting for service; this was identified as a key aspect of the model.An example of this is the implementation of a Cognitive Behavioural Therapy program for individuals who are waitlisted for services and who meet the criteria. In addition, to meet the needs of families and other caregivers, one-Link has provided Safe Talk training to provide families and caregivers with upfront skills to deal with a loved one who experiences suicidal ideation.

Effective and active management of waitlists

As noted earlier, wait times for services was seen as a significant challenge. There seemed to be a general perception, particularly from providers, that part of the challenge is the way in which waitlists are managed. Some stakeholders suggested that waitlist management could be more active, with coordinated access providers regularly checking in with people on the waitlist. Some coordinated access providers noted however that this type of waitlist management is not always effective and has been demonstrated in other sectors to be administratively burdensome and expensive, depending on how it is implemented.

" If they hold the waitlist, I feel they should manage it. There are people sitting on the list for year…and when they come up on the list they are nowhere to be found, creating more work for outside agencies"
~Coordinated access provider

One person with lived experience who participated in a one-on-one interview noted that he often wondered where he was on the waitlist for service; it was up to him, he said, to check-in regarding waitlist status. Although this individual did not express concerns with having to do this, he noted that it would be nice to have another way of knowing when services might become available and making sure that he wasn't forgotten. It should be noted that service users calling in to check status on a waitlist can add to call volumes and potentially to phone queue wait times for live answer, and/or increase the number of call-backs required.

Coordinated access providers recognized challenges with waitlists and many indicated that they are developing waitlist strategies. Some of these strategies include the provision of a "service sooner" model that offers brief interventions through coordinated access, as well as other impactful strategies as noted in this report.

Reach Out indicated that the region purposely did not implement a single point of access to mental health and addictions because there was concern that it would create a bottleneck; Reach Out in and of itself is

one component of a larger coordinated access strategy. Part of Reach Out's waitlist strategy is the development of partnerships with agencies that can provide less-intensive support for those who are waiting for more complex considerations. Reach Out suggested that a platform/electronic tool to coordinate providers in the region would be useful for waitlist management so that they can more realistically and accurately track wait times. This was also suggested by other coordinated access providers who noted that while ConnexOntario does track wait times, the data can be skewed as it is self-reported by providers; there is a perception that the wait times provided are sometimes inflated in an effort to secure more resources and funding.

OAARS implemented an online waitlist in December 2014 utilizing EMHware. Every partner agency that is included in the inter-agency agreement for participation in coordinated access has a secure access so they can utilize the EMHware platform. Referrals and service offers can be managed online, enabling OAARS to generate real time reports that provide a comprehensive picture of wait times. OAARS provides oversight to the waitlist, but it is based on the data entered by providers. The waitlist management system has, OAARS said, enabled them to streamline wait times by minimizing the number of people on multiple waitlists and directing people to the most appropriate service with the fastest access. OAARS noted that although their average wait time for assessment is 2-3 weeks, it used to be close to three months.

The Access Point has a number of wait list management strategies in place depending on available funding/staffing resources. The waitlist is actively managed to determine ongoing eligibility and need for service as well as to update assessments or service requests. Applicant status and wait times are regularly monitored for the purpose of problem solving vacancies that are difficult to fill, or identifying clients who experience barriers to access. The Access Point has also undertaken a wait list analysis of all support services by LHIN sub-regions to identify referral and placement patterns across the City and client needs and demographics. Their next step is to convene providers to review data in their regions and develop a strategy to plan capacity to reduce wait lists.

From a housing perspective, The Access Point has undertaken a supportive housing wait list analysis in partnership with The Wellesley Institute and CMHA Toronto. This work is expected to result in the development of screening options for supportive housing that might make it possible to divert and prioritize supportive housing applicants and/or to plan stock more effectively as current agreements expire or new supportive housing allocations are made available.

Streamlined Access is using a number of assessment tools to assist with the prioritization of wait lists. They include Locus for case management and ACTT teams, VI-SPADAT for housing programs, and GAIN SS for addictions. Streamlined Access staff are trained in ASSIST, and use the Crisis Triage Rating Scale. A 3:1 ratio for prioritization is used meaning that three individuals are picked up immediately based on scoring and immediate need and one is picked up from chronological date.

Direct scheduling in to service providers

There were some mixed feelings from stakeholders regarding the value of coordinated access engaging in direct scheduling for their provider partners. Some stakeholder indicated that direct scheduling is helpful in that it frees up time for service providers, and also enables coordinated access providers to have a comprehensive birds-eye view on system capacity. Others felt that it can make it more challenging for providers and may, for example, impact wait times and appropriate matching.

Coordinated access providers did not generally speak to the impact of direct scheduling. Access CAMH, one of the coordinated access providers that consistently schedules directly into provider programs, noted that they continue to work with providers to ensure that this is mutually beneficial. Providers working with Access CAMH appreciated these efforts, and for the most part felt that this was a useful service. The few CAMH providers who do not use direct scheduling because of nuances in their programs, noted that they would like to consider this in the future.

ConnexOntario has, it appears, taken on a more prominent role in scheduling across the province. Streamlined Access reported that ConnexOntario schedules intake appointments for calls received by individuals within Streamlined Access' catchment area. Reach Out is utilizing ConnexOntario's scheduling platform; however they utilize it to send referrals, rather than schedule appointments.

Having strong partnerships with a broad range of service providers

"There are some support groups that have low numbers that could accommodate – especially people on wait lists" ~Provider

"We can't continue to isolate mental health and addictions from one another and from the rest of health care" ~LHIN

" I would like to see all programs in the region use this service as there are frequently programs that I never knew existed for my patients" ~Provider

Almost all stakeholders felt that coordinated access would be more impactful if there was a broader range of local services included within their scope, with some stakeholders also suggesting that coordinated access would be more beneficial if services were enabled to facilitate referrals outside of their LHIN. Stakeholders generally perceived it to be a limitation when coordinated access could only refer to LHIN funded mental health and addiction services, noting that there are often non-LHIN funded services that have capacity and are being underutilized. A few stakeholders also indicated that having separate/siloed access services for mental health and addictions negatively impacts the ability to provide service navigation and get people to the right services that best meet their needs. Although this sentiment was not seen consistently from respondents, it is worth noting, as it was identified in a few open-ended comments without being specifically elicited.

When asked what providers should be included as a part of coordinated access, a number of stakeholders suggested housing and regional programs, police and the justice system, income support programs, and physicians/psychiatrists.

Coordinated access providers generally agreed that referring to partners outside of their mandate/scope is beneficial for people with lived experience, providers, and the system as a whole. Many indicated that they are doing this, though often informally. It was widely recognized that expanding partnerships is good

for people with lived experience as it gets them to the most appropriate service, not just the most appropriate service within the network, and can minimize bottlenecks for services.

OAARS indicated that while their mandate is addictions, close to 70% of the individuals who contact them for services have a mental health problem as well. While OAARS is not set-up to conduct a full mental health assessment, they will refer to services that provide both mental health and addictions care.

one-Link noted that they will also provide information on services beyond those that are LHIN-funded; however, they are not able to initiate the referral and cannot formally track uptake and outcomes.

Streamlined Access has established case resolution and situation tables with partners beyond those that are LHIN-funded. They work closely with Developmental Services Ontario in serving individuals with a dual diagnosis and Behavioural Supports Ontario for geriatrics with complex behaviours.

Access CAMH has also started forming partnership with key providers outside of CAMH (namely Jean Tweed, John Howard Society and the Gerstein Centre). Where it is identified upon intake that an individual can be better served by one of these organizations and they are not already a client of CAMH, Access CAMH will refer out.

Service provider trust and buy-in

Having a strong and collaborative relationship between coordinated access and the service providers that it links with was seen as being critical for success and ensuring that clients receive equitable care. A number of stakeholders commented that these relationships currently need work and that there appears to be a lack of trust and buy-in from many of the service providers. A small number of service providers noted themselves that they re-do work already done by coordinated access, because they feel, for example, that the assessment/eligibility determination was not well done. At least five providers responding to different coordinated access services indicated without explicitly being asked that they find coordinated access duplicates their own processes, noting that they prefer to maintain control over the pathways that their clients are following as well as waitlists.

> "Agencies don't want to relinquish control over their niche and intake – they want to choose who they want to serve. All agencies need to be on the same page if they are going to be part of the Coordinated Access"
> ~Reference panel

Having strong relationships, it was suggested, can help improve matching, improving the experience for the client and for the service provider. Coordinated access providers who reported strong relationships with mental health and addiction providers in their network indicated that having these partnerships mandated from senior leadership as part of a strategic vision helped to achieve buy-in. They also noted that regular interactions e.g., sending coordinated access staff to the providers for site visits on a regular basis helped in building relationships and increasing appropriate matching as coordinated access staff gain a better understanding of the services provided.

> "It requires a lot of change management. It's hard for programs to give up their spots for us"
> ~Coordinated access provider

Coordinated access services recognized the importance of partnerships with providers, and acknowledged that this has at times been a challenge. Some coordinated access providers agreed with the suggestion that mandating these partnerships and establishing accountability to ensure that providers are engaged and utilizing coordinated access services to their scope and scale would be useful.

"How as a system do we address those players who aren't collaborating and being true partners and who work behind the scenes and do their own thing"
~Coordinated access provider

Some coordinated access providers have implemented and/or are exploring opportunities to engage more meaningfully with their partners and to build relationships. Streamlined Access noted that they have implemented a dispute resolution process with partners as a means of addressing concern.

Reach Out is a part of a cross-county collaborative where agencies come together to look for opportunities for improvement in the care of individuals experiencing mental health issues. For example, in Elgin County, it was noted that there was a 6 month wait for psychiatry at CMHA. The collaborative examined the processes to determine where it was breaking down; they found that all of the referrals from CMHA were only scheduled in to the 1 day a week when the psychiatrists worked at CMHA, rather than also scheduling into appointments that exist in other settings where the psychiatrist works; once realized this, wait times decreased to 2-3 weeks.

OAARS and Access CAMH have both implemented initiatives where information and referral specialists/navigators meet with providers to learn more about their services and to build relationships.

The Access Point has taken on a role as a convenor to problem solve areas in which there are capacity gaps or the need for better, more integrated responses to referral and placement in service. They have convened 10+ provider meetings since September 2016 to address service gaps by geography, service type or sector e.g. Etobicoke service gaps, ICM homeless response, ACT and EPI catchment and criteria gaps, CAMH inpatient team focus groups.

Coordinated Access to Addictions Services has engaged in co-design with partners to determine together how they will achieve the outcomes that they want.

one-Link is working with providers to help them understand the access services and to build trust.

Better knowledge/information management

"There needs to be better ways of keeping information up-to-date and having a better understanding of the resources available"
~Coordinated access provider

Knowledge and information management was seen as a critical success factor for coordinated access. Coordinated access providers, and other stakeholders noted that it has been a challenge to obtain and maintain the right level of information. Without this, the ability to match appropriately and service navigate are impacted. Implementing a centralized knowledge base was identified as a potential solution.

Coordinated access providers generally agreed that knowledge management is a challenge. Information changes constantly and it can be difficult to keep it up-to-date, particularly given limited resources.

Coordinated access providers also indicated that while partners are encouraged to provide updates, this does not always happen.

The Access Point plans to update their comprehensive database by revisiting their 2015 review of all agency criteria which had a focus on standardizing eligibility and matching criteria for like programs and included an extensive consultation process with providers (e.g. work groups by service type which reviewed and developed standard criteria, sector-wide criteria workshops that convened the sector to discuss and align around criteria standards).

Have a single client database within (and potentially across) regions

A number of stakeholders indicated that having multiple and siloed databases that are not able to interact creates an administrative burden and can negatively impact the experience of coordinated access for providers. Providers who said that they have to re-enter data into other systems (e.g., DATIS and Novari), suggested that this additional administration time reduces direct-service capacity. Having a single centralized/common database within and potentially across regions was noted as a potential consideration to increase transparency and support better sharing of data and information. A small number of stakeholders also suggested that consideration be given to connecting digitally with agencies working closely with homeless populations and Ontario Works providers.

> "We need to work with multiple databases for every client and none of them connect to each other. It's a significant waste/inefficiency"
> ~Service provider

Coordinated access providers generally acknowledged the challenges with data management and sharing. Streamlined Access and The Access Point noted that limitations in technology have made it challenging for them to communicate and share information.

Better promotion of access services

> "I could have used this decades ago, as I lost decades of my life. Too bad my doctor (in region) did not know"
> ~Person with lived experience

A number of stakeholders mentioned that there appears to be a lack of awareness of coordinated access services and that a greater public profile is needed. This was seen in the surveys completed by people with lived experience, who were sometimes not able to identify which coordinated access service they had utilized, or to distinguish between coordinated access and the services that they received through providers. Similarly, a number of reference panel participant indicated that they were not familiar with coordinated access, and they were unclear about its purpose and the way in which coordinated access operates.

> "If I can't find (coordinated access) and I know technology, 90% of people will have no idea about it"
> ~Reference panel

There was general recognition by coordinated access providers that access services are not well advertised. Some coordinated access providers attributed this to funding; OAARS, for example, indicated

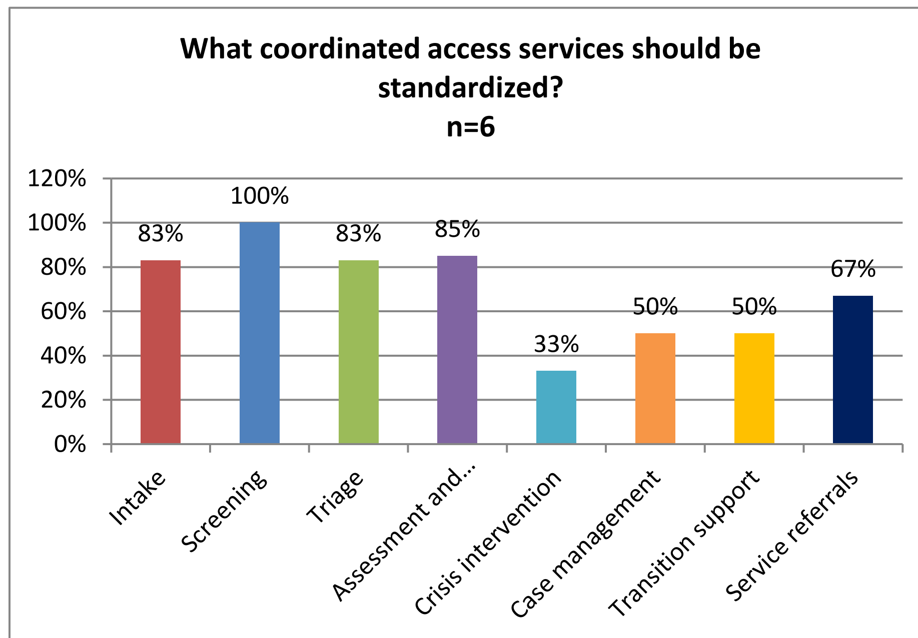
that the administrator's salary is not from the OAARS budget, and no time has been allocated for this role to engage in more promotion and maintain contact with partners.

What features of coordinated access models should be considered for standardization?

There was general acknowledgement from stakeholders that some standardization of coordinated access across the province would be beneficial, noting that some flexibility may still be required to adapt to local needs. Standardization was seen as an effective way to ensure that people with lived experience receive the same service experience and equitable care no matter where they are accessing services in Ontario. In a one-on-one interview, an individual with lived experience shared a personal story that speaks to the value of having some standardization across coordinated access in Ontario; this individual recalled the challenges in moving to a new region, and having to seek out local mental health support. Having already gone through this previously in a different region, this individual noted that he was unsure where to begin in his new environment, and that having a different process that was unclear left him feeling in limbo and vulnerable.

Standardization would also, it was suggested, improve data accuracy, and enhance the ability at the health system level to benchmark, with the goal of better understanding surpluses and gaps, as well as identifying areas for investment or adjustment.

Graph #10: Standardization



When specifically asked what coordinated access services should be standardized, the six LHIN representatives who responded to this question felt most strongly about screening, assessment, intake and triage. This was echoed to some degree in provider surveys, and in some conversations with coordinated access providers, where there was acknowledgement that there is variation in how people and organizations determine who needs what level and intensity of care; a few stakeholders felt that this could potentially be addressed through more consistent and objective decision making criteria and standardized assessment and intake processes and tools to more effectively match and triage.

Some stakeholders also suggested that a common basket or core set of services for coordinated access be considered. This might include, it was suggested, the breadth of services identified above, such as crisis intervention, family support, and peer support.

Discussion

Building on the environmental scan of Ontario's coordinated access models completed in June 2016, and with a view towards opportunities for improved standardization, this evaluation sought to understand the impact of Ontario's coordinated access models and the aspects of coordinated access that have contributed to its impact. Given limited available data and low stakeholder response rates, it was not feasible to draw conclusions about the participating coordinated access models. While the strength of findings may have been low for some specific access services, several consistent themes emerged in the aggregated data. While several challenges to understanding the impact of coordinated access were encountered, opportunities were evident for strengthening coordinated access in the province and promoting more standardization.

In considering the findings, and the discussion points below, it is important to keep in mind the context within which the coordinated access services developed as well as the environment in which they currently operate. Having developed independently from one another, with limited provincial strategic direction, coordinated access services have been adapting to an ever-changing landscape and operating within a mental health and addictions system that has limited capacity and varying degrees of pre-existing service coordination. Importantly, this provincial study of their impact and contributing factors is challenged to reflect the local *evolution* of these services and the community development process that has been required to bring them to their current state.

Answering the Evaluation Questions

Evaluation Question #1: What has been the impact of Ontario's coordinated access models for the mental health and addictions system?

Overall, stakeholder opinions regarding coordinated access were 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.

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.

These findings may reflect the relative independence with which these coordinated access models proliferated as well as the absence of a provincial strategic vision and guidelines for operationalizing, defining, monitoring and evaluating coordinated access. The findings also speak to the absence of standard processes and tools to assist in engaging clients and family members and facilitating access to services. The absence of these common tools and processes may well have contributed to evident challenges in the availability and quality of data necessary to inform effective planning as well as this evaluation.

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. This speaks to the need for change management protocols at all levels to ensure that there is a broad understanding of roles and responsibilities and that buy-in is achieved.

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.

Evaluation Question #2: What aspects of the coordinated access models have contributed to the identified impact?

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 utilizing skilled and knowledgeable staff and peers to provide more in-time services including crisis intervention, brief intervention and family support. Enhancing interdependent relationships with existing service providers and developing new partnerships in the community to provide access to a more robust range of services that address different intensity of need were also seen as being critical to success. Data and information management were also identified as areas where enhancements are needed, with potential for centralized provincial systems.

Implementing these features requires provincial and local visioning, support and commitment as well as collaboration across coordinated access models to share evaluation results and lessons learned, etc. If implementing more common features, evaluation criteria should be established in advance in order to determine the effectiveness of these strategies.

Provincial and Regional Considerations

While not a central theme, it is important to note that the relationship between local coordinated access and ConnexOntario was identified by some stakeholders as a point of confusion, with some individuals wondering about the value of having both regional and provincial coordinated access services.

Given this finding, 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

Based on the findings, a number of recommendations should be considered. The recommendations reflect the data and insights that were available to the evaluation team. These recommendations, and the overall learnings from this evaluation are important to consider not just within the current context, but also to inform future planning and/or expansion as it relates to the implementation of other relevant provincial initiatives in health and human services, including sub-region planning. Overall, the recommendations speak to the need for thoughtful planning, partnership, and leadership prior to implementation, utilizing evidence, evaluation, and best practices to guide the establishment and sustainment of these initiatives.

2. *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.

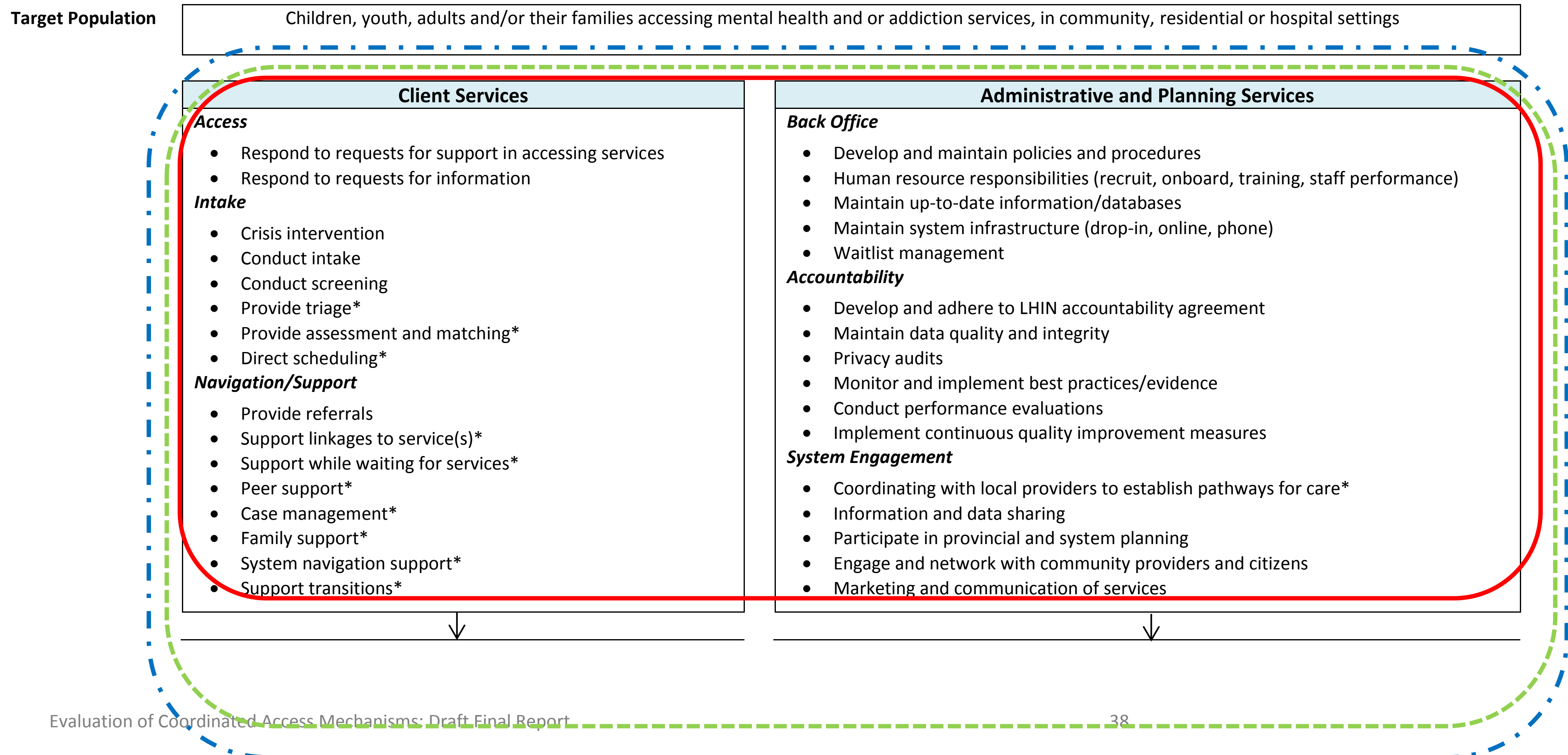
3. *As part of its leadership role described in Recommendation #1 above, the Ministry of Health and Long-Term Care, in partnership with the LHINs, should define the respective roles of ConnexOntario and regional coordinated access models.* There is a need to clarify these roles, eliminate duplication, 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).

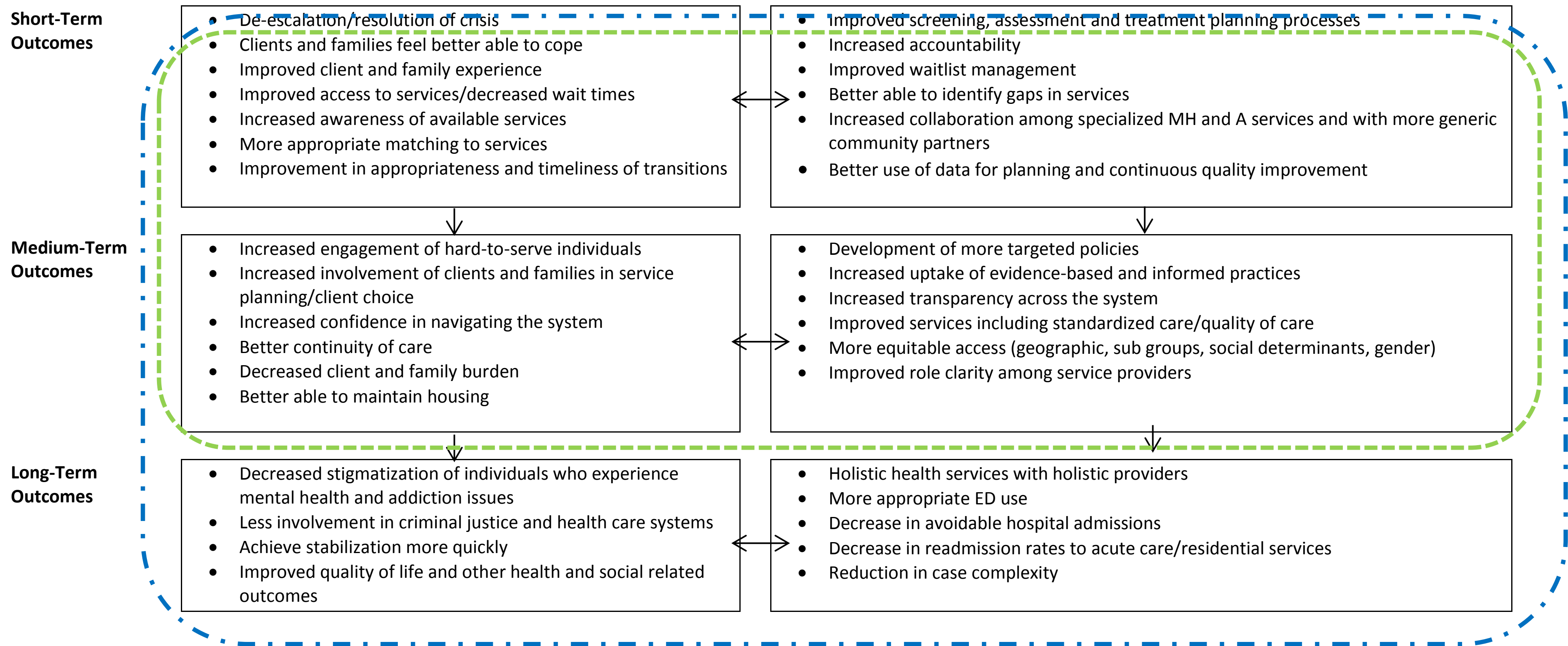
5. *The Mental Health and Addictions Coordinated Access Working Group should continue to develop standardized definitions for coordinated access and performance indicators for evaluation.* The absence of standard definitions for the different aspects/activities of coordinated access and for performance 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.

6. *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".

6. *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.

Appendix 1: Logic Model





*Services that are not offered by all providers. Note that services offered may be influenced by regional variations and/or the type of coordinated access model (e.g., mental health, addictions)

Appendix 2: Evaluation Framework

Evaluation Framework							
Target Questions	**Stakeholder Survey**					**Other Data Sources**	
	People with Lived Experience	**Representatives of Access Models**	**MH and A Service Providers**	**Non-Specialized Service Providers**	**Other Stakeholders**	**One-on-One Interviews**	**Administrative Data**
Evaluation Question #1: What has been the impact of Ontario's coordinated access models for the mental health and addictions system?							
1. Has experience of coordinated access met expectations?	x	x	x	x	x	x	
2. How have coordinated access models helped with fundamental systemic challenges in the system?		x	x	x	x	x	
3. How do coordinated access models fit with other provincial initiatives (e.g., ConnexOntario)?		x			x	x	
4. Has coordinated access helped in identifying system gaps or otherwise influenced local planning decision tables?		x	x	x	x	x	

Evaluation Framework							
Target Questions	Stakeholder Survey					Other Data Sources	
	People with Lived Experience	Representatives of Access Models	MH and A Service Providers	Non-Specialized Service Providers	Other Stakeholders	One-on-One Interviews	Administrative Data
5. What is the level of awareness of access models and programs in the community and how has this impacted level of coordination?	x	x	x	x	x	x	x
6. Are clients appropriately matched to services through coordinated access?	x	x	x	x		x	x
7. Are more people able to access treatment/services for the first time as a result of coordinated access?	x						x
8. How have access models impacted wait times for different points of care (i.e. first appointment, assessment, treatment intervention or support)							x
9. Have coordinated access mechanisms lead to more holistic care (i.e., have they improved identification of other client needs)?	x	x	x	x			x

Evaluation Framework							
Target Questions	**Stakeholder Survey**					**Other Data Sources**	
	People with Lived Experience	**Representatives of Access Models**	**MH and A Service Providers**	**Non-Specialized Service Providers**	**Other Stakeholders**	**One-on-One Interviews**	**Administrative Data**
10. What percent of clients who receive treatment/services come through a coordinated access model?			x	x			x
Evaluation Question #2: What aspects of the coordinated access models have contributed to the identified impact?							
11. Who are the users of coordinated access models (service mix and population)?							x
12. Are coordinated access services culturally appropriate?	x						
13. What are the critical success factors for a coordinated access model?	x	x	x	x	x	x	
14. Are the right types and levels of services being provided through coordinated access (what is the mix)?	x	x		x	x	x	x

Evaluation Framework							
Target Questions	**Stakeholder Survey**					**Other Data Sources**	
	People with Lived Experience	**Representatives of Access Models**	**MH and A Service Providers**	**Non-Specialized Service Providers**	**Other Stakeholders**	**One-on-One Interviews**	**Administrative Data**
15. Do providers of coordinated access have the right tools to match people to the right services?		x				x	
16. Has screening improved as a result of coordinated access?	x	x		x	x	x	
17. Are clients/ families/ caregivers involved in decision making about care? If yes, how?	x	x				x	

Appendix 3: Coordinated Access Service Data

Each of the coordinated access providers included in the evaluation were asked to provide data on populations served, contacts, referrals and wait times. Interpreting the data was challenging due to different data definitions (i.e., how wait times are defined), different inclusion criteria (i.e., the type of referrals included), and different ways of reporting the data (i.e., average wait time across programs, or average wait time by individual program).

Streamlined Access

Streamlined Access				
Data		2014	2015	2016
Gender	Male	48.1%	50.8%	49.9%
	Female	51.9%	48.9%	49.5%
	Transgender	Unknown	0.2%	0.3%
	Transexual	Unknown	0.1%	0.1%
Age	0-17 years	42.6%	10.6%	13.3%
	18-64 years	50.1%	87.0%	84.1%
	65+	7.3%	2.4%	2.6%
Service Request	Request for mental health services		68.8%	66.4%
	Request for addiction services		0.9%	0.8%
	Request for mental health and addiction services		27.7%	30.1%
Access Information	Volume/# of contacts	3,573	4,829	5,823
	Response time to contact	N/A	7.8 days	6.8 days
Referral information	Total # of referrals to providers	2	89	117
	% of individuals referred to service provider	0.4%	4.1%	4.7%
	% of contacts receiving follow-up call by CA	N/A	93.7%	90.6%
	Wait times from 1st contact to response	N/A	21.9 days	23.9 days
	Wait times from 1st contact to access to treatment	N/A	168	154
	Treatment outcome data	N/A	163 days	148 days

OAARS				
Data		2014	2015	2016
Age	0-17 years		3	8
	18-64 years		1,810	2,168
	65+		34	48
Access Information	Volume/# of contacts		1,847	2,224
Referral information	Total # of referrals to providers		1,541	2,146
	Referral within LHIN		1,541	2,146
	% of individuals referred to service provider		90%	91%
	Wait times from 1st contact to referral (days)		21.6	19.7
	Wait times from 1st contact to access to treatment (days)		32.7	33.3

The Access Point			
Data		Support Services	Housing
Gender	Male	4,850	5,835
	Female	4,223	3,753
	Not stated	52	148
Age	14-24	1,232	934
	25-64	7,128	8,221
	65+	908	669
Referral Source	Self	3,261	2,714
	Hospital	2,451	2,041
	Hostel/Shelter	1,201	2,273
	CMHA	1,131	1,389
	Other	687	948
	Rehabilitation Facility	438	286
	Criminal Justice System	133	219

The Access Point			
Data		Support Services	Housing
	Did not specify	6	10

The Access Point cont.				
Data		2014	2015	2016
Service Request	Request for mental health services			
	Request for addiction services			
	Request for mental health and addiction services			
	Referral to 1st contact – support services (days)	7	8	3
	Referral to 1st contact – supportive housing (days)	3	3	4
	Service navigator/peer support, assessments	10%	7%	7%
	Placing applicant in support service or supportive housing vacancy	8%	10%	7%
	Applicant call for status check/update	34%	45%	58%
	General information, request copy of file, support to complete application	8%	7%	3%
Access Information	Volume/# of contacts - inbound			48,707
	Volume /# of contacts - outbound			44,404
Referral information	Total referrals to MHSH	3,896	4,445	3,930
	Total referrals to MHJI	1,049	838	748
	Total referrals to SHPPSU	852	645	641
	Total referrals to ACTT	498	709	589
	Total referrals to ICM	2,992	3,809	3,233
	Total referrals to EPU	N/A	N/A	316
	% of contacts receiving follow-up call	40%	30%	25%
	Wait times from 1st contact to referral – support services (days)	12	19	10
	Wait times from 1st contact to referral – supportive housing (days)	0	0	0
	Wait times from 1st contact to access to treatment - support services(days)	2	4	5

The Access Point cont.				
Data		2014	2015	2016
	Wait times from 1st contact to access to treatment - supportive housing (days)	7	10	8

One-Link				
Data		2014	2015	2016
Service Request	Referrals for mental health services			5,666
	Referrals for addiction services			606
	Referrals for mental health and addiction services			572
Access Information	Volumes/# of contacts	1,035	6,443	11,329 (through Q3)
Referral information	Total # of referrals to providers		3,946	3,368 (through Q3)

Reach Out		
Data		2016 (September – December)
Gender	Male	1,767
	Female	2,030
	Not Identified	896
Age	0-19 years	153
	20-24 years	249
	25-34 years	507
	35-44 years	317
	45-54 years	254
	55-64 years	184
	65+ years	101
	Not identified	265
Service Request	Adjustment Disorder	22
	Alcohol	101

Reach Out		
Data		2016 (September – December)
	Amphetamines/Other Stimulants	1
	Anxiety Disorder	82
	Anxiety Disorder	313
	Autism Spectrum Disorder (ASD)	3
	Benzodiazepines	7
	Cannabis	26
	Cocaine	31
	Concurrent Disorders (Psychiatric plus Addiction)	49
	Crack	8
	Delirium, Dementia, and Amnestic and Cognitive Disorder	26
	Disorder of Childhood/Adolescence	19
	Dissociative Disorder	3
	Dual Diagnosis (Psychiatric plus Developmental Disability)	36
	Eating Disorder	10
	Ecstasy	1
	Fentanyl	2
	Heroin/Opium	10
	Lottery Tickets	1
	Mental Disorder due to General Medical Condition	9
	Methamphetamine	26
	Miscellaneous Non-Prescription	3
	Miscellaneous Prescription	6
	Mood Disorder	439
	Narcotic Analgesics	20
	None	2

Reach Out		
Data		**2016 (September – December)**
	Not Diagnosed	396
	Not Identified	92
	Oxycontin	10
	Personality Disorder	48
	Post-Traumatic Stress Disorder (PTSD)	66
	Postpartum Mood Disorder	5
	Schizophrenia and Other Psychotic Disorder	95
	Sexual and Gender Identity Disorder	1
	Sleep Disorder	2
	Slots	1
	Undifferentiated/Polysubstance	2
Access Information	Volumes/# of contacts	4,697

Access CAMH				
Data		**2014**	**2015**	**2016**
Access Information	Volume/# of contacts	15,518	19,959	20,018
Referral information	Total # of referrals to providers	10,401	18,200	18,742

Here 24/7				
Data		**2014**	**2015**	**2016**
Access Information	Volume/# of contacts	16,002	15,170	15,744
	Response time to contact (seconds)		11	7
	Live answer rate		70%	69%
Referral information	Wait times from 1st contact to assessment (days)		74	76
	Wait times from 1st contact to access to treatment (days)	350.7	173	242

Here 24/7				
Data		2014	2015	2016
	Acquired Brain Injury Services	4	2	4
	Allied Health		32	21
	Alzheimer Society	1		1
	Arbour Family Medical Centre		2	4
	ARCH		2	1
	Basic Needs		10	8
	Bev Berman Grief Services		1	
	CCAC & CSS	10	28	27
	Children's Mental Health		130	125
	Church		1	1
	City, Regional & County Services	6	18	15
	CMHA Peel Dufferin Access Line	1		24
	Colleges and Universities	15	31	27
	Community Care Concepts			1
	Community Living		2	
	Community Resource Centre		1	2
	County of Wellington		2	3
	Developmental Services	1	18	15
	Drop In Centre	2	3	4
	Drug and Alcohol Helpline	8	36	60
	Early Childhood	4	10	13
	Elizabeth Place	2	4	2
	Emergency Medical Services	3	4	2
	Employment	3	1	2
	Family and Children's Services	1	19	18

Here 24/7				
Data		2014	2015	2016
	Family Counselling Services	295	508	506
	front Door - Child and Youth MH Services			19
	GRT Mobility Plus			1
	Here 247 Partners		1,189	1085
	Holmes House	1	8	1
	Homelessness Supports/Housing	15	7	7
	Hospice	12	1	
	Hospitals	25	62	61
	Housing		19	15
	Immigrant Services		2	1
	Kerry's Place		2	2
	Lawyer	2	1	
	Legal Aid	5	6	9
	Meal on Wheels		1	
	Ministry of Community and Social Services			2
	Non-WWLHIN Canadian Mental Health Association		146	103
	Non-WWLHIN Mobile Crisis	4	7	8
	Norfolk Psychological Services & Private Company	4	22	24
	Northern Lights Canada		1	
	Not Applicable	7	8	4
	Ontario Disability Support Program		9	8
	Ontario Provincial Police	1	2	7
	Ontario Works	9	22	19
	Other & Self, Family	236	374	315
	Peer Support		194	63

Here 24/7				
Data		2014	2015	2016
	Police & Justice Services	41	99	77
	Primary Care	93	173	227
	Probation and Parole		1	1
	Public Health		4	2
	Salvation Army	3	3	1
	School Boards	4	1	3
	Self Help	73		239
	Service Canada	1	3	1
	Specialized Geriatric Services	2	14	7
	Woman Abuse/Domestic Violence	28	61	67
	YMCA		5	2

ConnexOntario				
Data		2014	2015	2016
Access Information	Volume/# of contacts	75,534	84,346	102,222
	% live answer	86%	88%	88%

Appendix 4: Budget

Streamlined Access					
Population					
	2012	***2013***	***2014***	***2015***	***2016***
Total population of the area served	1138261	1156579	1174898	1193216	1211534
Total # of people served	540	688	752	1069	1251

Note: Date range for individuals served is changed from fiscal year to calandar year in order to match census date range.

The population for 2012-2015 is a calculated estimate using 2011 and 2016 census.

Funding Source					
	2012/13	***2013/14***	***2014/15***	***2015/16***	***2016/17***
Funding Source(s)	lhin	lhin	lhin	lhin	lhin - increase reassigned from case mgmt
Funding Amount	$222,500	$288,548	$305,216	$305,216	$470,216
Operating Expenses					
	2012/13	***2013/14***	***2014/15***	***2015/16***	***2016/17***
Total FTEs	3.0fte	2.7fte	3.00fte	3.2 fte	5.2 fte
Total salaries	$181,901	$175,960	$194,970	$207,769	$361,423
Total salaries with benefits	$215,369	$208,690	$236,756	$251,286	$433,060
Technology and information systems	$0	$0	$20,000	$19,016	$15,000 from surplus
Marketing and communication	0	0	0	0	0

OAARS					
Population					
	2014	**2015**	**2016**	**2017**	**2018/ Required funding**
Total population of the area served	1230000	1230000	1230000	1230000	1230000
Total # of people served	1426	1504	1957	2443	2900
Funding Source					
	2014	**2015**	**2016**	**2017**	**2018/ Required funding**
Funding Source(s)	LHIN	LHIN	LHIN	LHIN	LHIN
Funding Amount	$330,969	$330,969	$330,969	$412,969	$737,026
Operating Expenses					
	2014	**2015**	**2016**	**2017**	**2018/ Required funding**
Total FTEs	4	4	4	5	7
Total salaries	$228,960	$228,960	$228,960	$289,640	$497,640
Total salaries with benefits	$308,104	$308,104	$308,104	$390,104	$627,026
Technology and information systems	$34,400	$31,400	$30,500	$29,200	$38,000
Marketing and communication	$12,000	$8,000	$8,000	$8,000	$15,000
Offices supplies-rent-houseKeeping- Training- Accreditation fees					$57,000

The Access Point	
Population	
	2017
Total population of the area served	3,000,000
Total # of people served	11,016
Funding Source	
	2017
Funding Source(s)	Central LHIN, TC LHIN
Funding Amount	$1,494,830
Operating Expenses	
	2017
Total FTEs	20
Total salaries	$1,006,758
Total salaries with benefits	$1,229,542
Technology and information systems	$51,115
Marketing and communication	$0

Reach Out	
Population	
	August 23 2016-May 31, 2017
Total population of the area served	663,607
Total # of people served	10,575
Funding Source	
	2017
Funding Source(s)	SW LHIN
Funding Amount	$119,000
Operating Expenses	
	2017
Total FTEs	1
Total salaries	
Total salaries with benefits	$70,000
Technology and information systems	
Marketing and communication	$35,000

Here 24/7					
Population					
	2013-14	***2014-15***	***2015-16***	***2016-17***	***2017-18***
Total population of the area served					
Total # of people served (Here 24/7 service only)	NA	10,534	11,365	11,453	4,964 (as of July 17, 2017)
Funding Source (Budgeted)					
	2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Funding Source(s)	LHIN	LHIN	LHIN	LHIN Groves General & North Wellington Healthcare	LHIN Groves General & North Wellington Healthcare
Funding Amount	$119,575	$3,051,743	$3,398,592	$3,387,037	$3,634,157
Operating Expenses (Budgeted)					
	2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Total FTEs			44.71	43.53	43.07
Total salaries	$98,822	$2,320,197	$2,428,061	$2,625,172	$2,852,495
Total salaries with benefits	$119,575	$2,848,764	$2,986,514	$3,181,549	$3,467,722
Technology and information systems		$0	$10,000	$7,000	$5,000
Marketing and communication		$53,770	$109,961	$95,486	$79,376

Appendix 5: Coordinated Access Profiles

In reviewing the evaluation results, it is important to have an understanding of each of the coordinated access services and the context within which they operate. As noted in the descriptive report, each of the models varies significantly with different priorities, influenced in part by the different players involved, and the structure and governance of local partners, including service providers. Each of the coordinated access services are at different stages of development and maturity. Many of the models have or continue to adapt over time depending on the changing needs in their community, leadership within or amongst key partners, and continuous feedback loops informed by stakeholder feedback.

Streamlined Access

Catchment area: York Region and South Simcoe
Access for: Mental health, addictions, dual diagnosis, and supports within housing
Ages served: 16 years of age and older
Funding source: Central LHIN

Streamlined Access, a program of York Support Services Network (YSSN), began providing services in 2007, with the goal of promoting timely, equitable and seamless access to mental health and addiction programs delivered by local organizations. Streamlined Access is part of a collaborative, multi-agency partnership made up of YSSN, Community Mental Health Association York and South Simcoe, Addiction Services of York Region, LOFT Community Services – Crosslinks Housing and Support Services, Southlake Regional Health Centre and The Krasman Centre. YSSN has been designated as the lead agency and holds fiduciary responsibility, as well as responsibility for leading the coordination and implementation of a collaborative governance model. (a weekly clinical table, an Operations Committee and a Steering Committee).

Core services include intensive case management (including specialty case management), immediate access to short term case management (for up to 3 months for those individuals who have applied for service or who are currently on the waitlist), assertive community treatment, psychogeriatric community treatment and supports within housing.

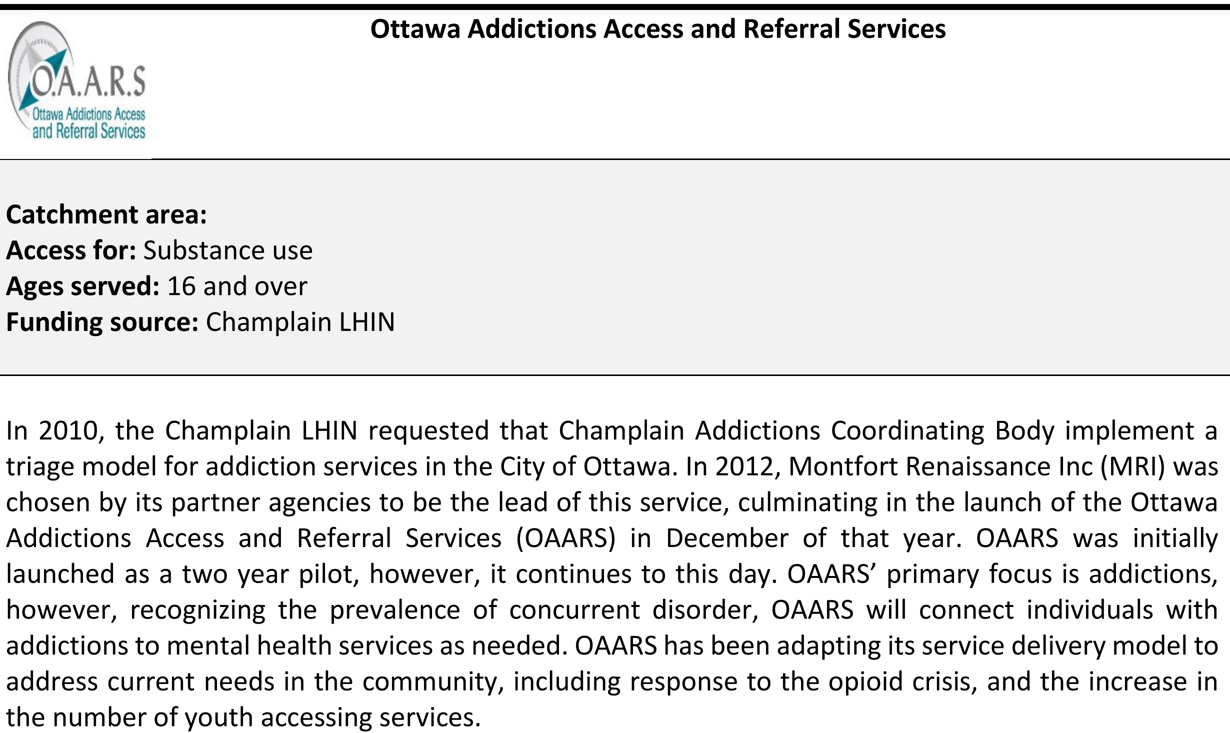
Application for services can be made by phone, in person (walk ins/office visit, occasionally a community visit is offered), fax or online. Active offers are made to ensure the Francophone community receives service, as well Streamlined Access has linkages for translation by telephone to AT&T and MCIS services. A TTY line can also be accessed for the hearing impaired community. Access workers conduct an assessment to identify needs, establish eligibility for services, provide information on services available, and link individuals to primary care services, peer support, and family support as needed. Vacancy managers are responsible for the waitlist management function including ongoing triage of the waitlists for all identified programs, including prioritization of the waitlist, matching identified vacancies with a prioritized person and identifying reasons for unsuccessful matching. Access

workers have been upskilled to be able to provide on-the-spot crisis support and will soon be able to facilitate admission to crisis beds

Streamlined Access staff are trained to utilize various assessment tools to assist with the prioritization of wait lists. They include Locus for case management and ACTT teams, VI-SPADAT for housing programs, and GAIN SS for addictions. Streamlined Access staff are trained in ASSIST, and use the Crisis Triage Rating Scale. A 3:1 ratio for prioritization is used meaning that three individuals are picked up based on urgent need (determined by scoring and immediate need), and one is picked up based on chronological date.

Streamlined Access collaborates with partners (including those that are not LHIN-funded) through situation tables. They work closely with The Access Point (which includes a joint appeal process); and Developmental Services Ontario in serving individuals with a dual diagnosis; and with Behavioural Supports Ontario for geriatrics with complex behaviours. Streamlined Access has also developed linkages to mobile crisis response, the development of crisis plan, and short term crisis beds through 310-COPE.

Various projects are currently in development, including implementation of a portal to facilitate referrals to York Region Paramedics, York Regional Police and York Region housing. A case resolution table through Streamlined Access is soon to be developed. Linkages for ConnexOntario to schedule appointments for referrals to Streamlined Access will be implemented shortly. The Streamlined Access Steering Committee is currently reviewing recommendations regarding the expansion of other mental health and addictions services being included under its umbrella, including other waitlist management strategies. We are currently working on the individual applicants being able to update their application with any changes online while waiting for services.



Ottawa Addictions Access and Referral Services

Catchment area:
Access for: Substance use
Ages served: 16 and over
Funding source: Champlain LHIN

In 2010, the Champlain LHIN requested that Champlain Addictions Coordinating Body implement a triage model for addiction services in the City of Ottawa. In 2012, Montfort Renaissance Inc (MRI) was chosen by its partner agencies to be the lead of this service, culminating in the launch of the Ottawa Addictions Access and Referral Services (OAARS) in December of that year. OAARS was initially launched as a two year pilot, however, it continues to this day. OAARS' primary focus is addictions, however, recognizing the prevalence of concurrent disorder, OAARS will connect individuals with addictions to mental health services as needed. OAARS has been adapting its service delivery model to address current needs in the community, including response to the opioid crisis, and the increase in the number of youth accessing services.

OAARS acts as a gateway to longer-term services and resources in the community. Referrals and consultations can take place by phone, or online, and can be made by providers, the justice system, shelters, community centres, or self-referral. OAARS responds to referrals within 24 business hours at which time a counsellor will set up an appointment for an assessment. During this assessment, navigators utilize provincial tools to provide screening, triage, brief assessment, and referral to addictions or addictions and mental health services and other sectors. OAARS system navigators have a 97% acceptance rate of referrals, suggesting that the skills exist to appropriately match to services.

While OAARS' mandate is addictions, close to 70% of the individuals who contact them for services have a concurrent mental health problem. While OAARS is not set-up to conduct a full mental health assessment, they will refer to services that provide both mental health and addictions care. Recognizing this need, Montfort Renaissance is currently implementing a pilot project to extend OAARS' scope by providing support to individuals experiencing more acute mental health needs; this project will enable navigators to connect individuals with a short-term service coordinator who supports planning, coordination, withdrawal management and short term counseling.

OAARS is equipped to provide supports for family members and continues to explore ways to enhance these services through partnerships, for example with Rideauwood. In addition, OAARS began this year to provide bridging services for those who have been identified as having more immediate needs. Families experiencing an addiction crisis can receive services instantaneously through a community withdrawal team that maintains open spaces on the caseload for the purpose of managing these immediate needs. The team will provide information, talk to youth, assess the level of risk/danger and work on fast-tracking the family towards services.

In December, 2014, OAARS implemented an online waitlist utilizing EMHware. Every partner agency that is included in the inter-agency agreement for participation in coordinated access has a secure access so they can utilize the EMHware platform. Referrals and service offers can be managed online, enabling OAARS to generate real time reports that provide a comprehensive picture of wait times. OAARS provides oversight to the waitlist, but it is based on the data entered by providers. The waitlist management system has, OAARS said, enabled them to streamline wait times by minimizing the number of people on multiple waitlists and directing people to the most appropriate service with the fastest access.

The Access Point
The Toronto Mental Health and Addictions Access Point

The Access Point

Catchment area: Steeles Avenue to Lake Ontario, Highway 427 to Port Union Road
Access for: mental health, addictions, dual diagnosis
Ages served: 14 years of age and older
Funding source: Central LHIN, Toronto Central LHIN

The Access Point provides centralized, coordinated access to Supportive Housing and support services (Intensive Case Management, Assertive Community Treatment and Early Psychosis Intervention) in the

City of Toronto. The Access Point was created in 2013 through the integration of two existing centralized access points, Access 1 and Coordinated Access to Supportive Housing. The Access Point has a single application form for all housing and support services that can be completed online, by fax or in person. The Access Point manages the intake, assessment, and electronic matching and referral functions for more than 50 providers. The Access Point also maintains the wait lists for supportive housing and support services.

The Access Point receives referrals directly from clients and families, or from professionals. People applying for services through The Access Point can reach staff (8 service navigators, 2 team leads, a peer support worker, and 3 client contact staff) by phone or through drop-in Monday to Friday from 9am-5pm. The Access Point has a first call resolution approach and on average answers 95% of all calls and has a 3% dropped call rate. Every person who applies for service through The Access Point is contacted by The Access Point staff; the average time between a referral and the first contact is 3 days.

The Access Point provides a range of services to applicants. In addition to completing assessments to screen people for eligibility, information and referral is offered to connect people to services and supports while they are waiting, clients are contacted to ensure their application is kept up to date, and some peer support is available through The Access Point Peer Support worker. Service Navigators at The Access Point have professional experience and qualifications consistent with those of other providers in the community-based mental health sector including social work, occupational therapy, mental health case management, mental health crisis work, child and youth work, addictions, homelessness and supportive housing case management. The Access Point staff group is able to speak to applicants in more than ten of the languages commonly spoken in the GTA including all of the top 5 languages requested by applicants.

Once an application is completed, The Access Point will determine eligibility for services and place people, as appropriate, on a waitlist. The waitlist is actively managed to determine ongoing eligibility and need for service as well as to update assessments or service requests. Applicant status and wait times are regularly monitored for the purpose of problem solving vacancies that are difficult to fill, and identifying clients who experience barriers to access. Short-term supports may be offered through service partners as needed for those on the waitlist.

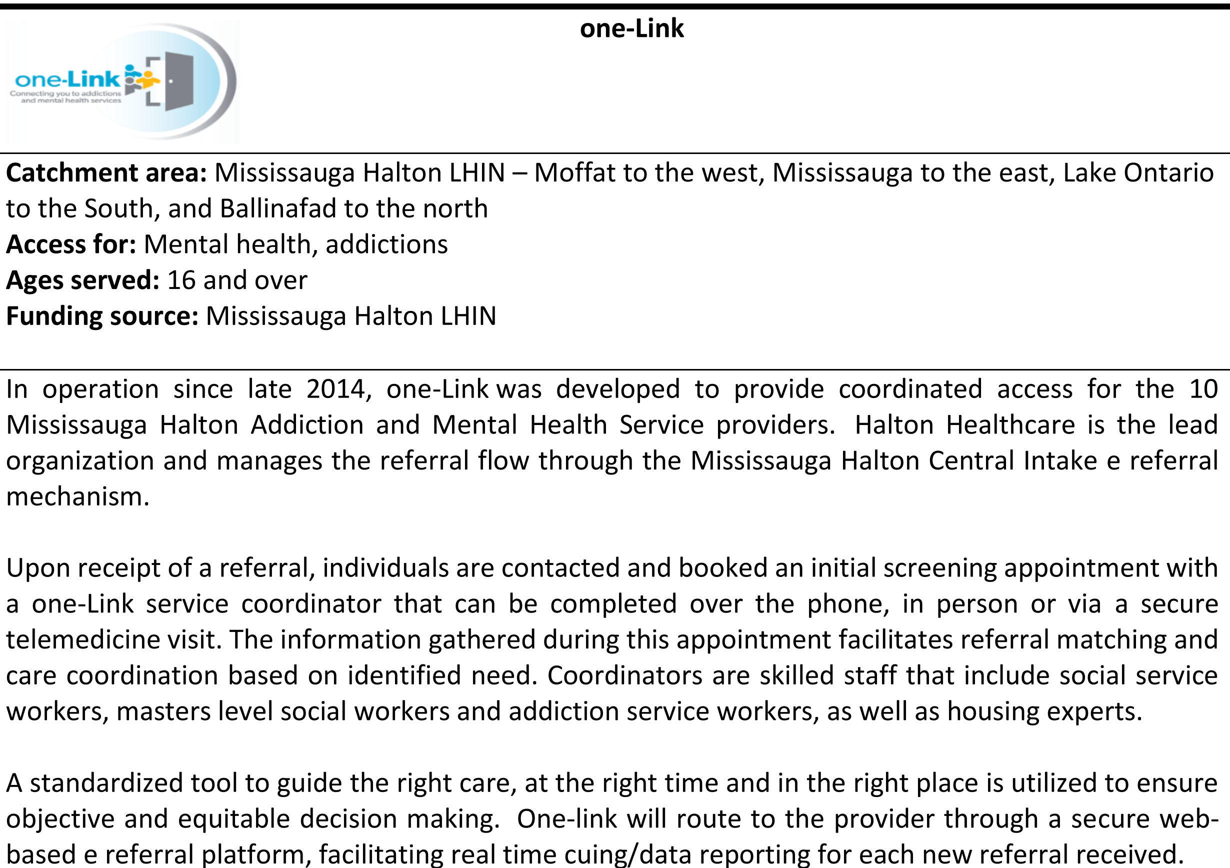
Applicant service requests and program eligibility criteria for all services accessed through The Access Point are maintained within a database that has electronic resource matching and referral functionality. Provider agencies login through a web based portal to submit vacancies based on pre-determined program and service criteria. The Access Point is notified electronically that a vacancy is available and the database provides a list of all the applicants who match the criteria for the service. When an applicant is matched to service, which on average takes 2 days for support services and 5 days for supportive housing vacancies, The Access Point notifies the provider electronically and the applicant file can be viewed by the provider through a secure database. The Access Point operates with a “no wrong door” policy, enabling applicants to have access to services regardless of where they start. The system allows for alternative access by individuals from various groups who would otherwise be disadvantaged by a centralized system (i.e., people who are homeless or who do not speak English).

Recognizing challenges with extensive wait times for services, The Access Point has undertaken a wait list analysis of all support services by LHIN sub-region to identify referral and placement patterns across the City and client needs and demographics. The Access Point will be convening providers to review

data in their regions and develop a strategy to plan capacity to reduce wait lists. From a housing perspective, The Access Point has undertaken a supportive housing wait list analysis in partnership with The Wellesley Institute and CMHA Toronto. This work is expected to result in the development of screening options for supportive housing that might make it possible to divert and prioritize supportive housing applicants and/or to plan stock more effectively as current agreements expire or new supportive housing allocations are made available.

The Access Point is in the process of implementing new screening tools to allow for triaging of applicants based on urgency. In addition, The Access Point initiated a Rapid Response pilot in the winter and spring of this year to stream people who need less intensive services to alternative options rather than to the long-term wait list. The Rapid Response pilot currently provides 8-10 weeks of service to new referrals in 12 targeted zones across the City. A Test of Change initiative to serve people who are homeless more quickly is also in development. This work is being informed by efforts of other coordinated access services and is building on literature reviews conducted by The Access Point as part of their quality improvement work.

The Access Point has taken on a role as a convenor to problem solve areas in which there are capacity gaps or the need for better, more integrated responses to referral and placement in service. They have convened 10+ provider meetings since September 2016 to address service gaps by geography, service type or sector e.g. Etobicoke service gaps, ICM homeless response, ACT and EPI catchment and criteria gaps, CAMH inpatient team focus groups.



one-Link

Catchment area: Mississauga Halton LHIN – Moffat to the west, Mississauga to the east, Lake Ontario to the South, and Ballinafad to the north
Access for: Mental health, addictions
Ages served: 16 and over
Funding source: Mississauga Halton LHIN

In operation since late 2014, one-Link was developed to provide coordinated access for the 10 Mississauga Halton Addiction and Mental Health Service providers. Halton Healthcare is the lead organization and manages the referral flow through the Mississauga Halton Central Intake e referral mechanism.

Upon receipt of a referral, individuals are contacted and booked an initial screening appointment with a one-Link service coordinator that can be completed over the phone, in person or via a secure telemedicine visit. The information gathered during this appointment facilitates referral matching and care coordination based on identified need. Coordinators are skilled staff that include social service workers, masters level social workers and addiction service workers, as well as housing experts.

A standardized tool to guide the right care, at the right time and in the right place is utilized to ensure objective and equitable decision making. One-link will route to the provider through a secure web-based e referral platform, facilitating real time cuing/data reporting for each new referral received.

Peer mentors and service coordinators provide supports sooner through check-in phone calls providing skill based tools and techniques to help a person while they may be on a waitlist for an identified service. To meet the needs of families and other caregivers, one-Link provides monthly SafeTalk training to provide families and caregivers with upfront skills to have supportive conversation around how to talk to someone who is experiencing suicidal ideation.

While one-Link only manages referrals for the 10 Mississauga Halton LHIN funded providers, information on other community-based services is provided based on the persons expressed or identified needs.

One-Link continues to adapt based on input received by its partners and referral sources and will in time expand to promote self-referral mechanisms as a point of entry.

Reach Out

Catchment area: London, Middlesex, Oxford and Elgin Counties
Access for: Mental health, addictions
Ages served: 12 years and older (addiction), 16 years of age and older (mental health)
Funding source: South West LHIN

Reach Out, in its current incarnation, began operations in August, 2016. It is a partnership of Addiction Services of Thames Valley and the Canadian Mental Health Association of London, Middlesex, Elgin and Oxford. Reach Out operates as part of a larger system, and is considered to be one component of a larger coordinated access system in the region.

Calls and webchats are answered by trained information and referral specialists, backed by a robust database of local service information. Specialists provide brief assessment and advice, access to crisis support and supportive listening, information and education, triage, and access to a range of mental health or addiction providers based on outcomes of common screening and assessment tools.

Reach Out provides referrals, if requested, using a web-based calendar, supported by ConnexOntario. Service agencies receive electronic notification of a referral, and respond directly to the service user within 48 hours of receipt of a referral.

Working with its partners, Reach Out has implemented a wait list management strategy, which includes partnerships with agencies that can provide less-intensive support for those who are waiting for more complex considerations. Currently, Reach Out is working with the local Canadian Mental Health Association to develop a walk-in program that will enable those in need of services to get connected right away. It is expected that this will mirror an already existing local walk-in service where individuals can receive intake services on-the-spot, leaving with a scheduled appointment and a list of support groups that can be accessed immediately.

Reach Out is exploring other platforms/electronic tool to coordinate providers in the region for waitlist management so that they can more realistically and accurately track wait times

Reach Out is a part of a cross-county collaborative where agencies come together to look for opportunities for improvement in the care of individuals experiencing mental health issues. For example, in Elgin County, it was noted that there was a 6 month wait for psychiatry at CMHA. The collaborative examined the processes to determine where it was breaking down; they found that all of the referrals from CMHA were only scheduled in to the 1 day a week when the psychiatrists worked at CMHA, rather than also scheduling into appointments that exist in other settings where the psychiatrist works; once realized this, wait times decreased to 2-3 weeks.

St. Michael's

Inspired Care.
Inspiring Science.

Coordinated Access to Addiction Services

Catchment area: City of Toronto
Access for: Addictions
Ages served: 16+
Funding source:

Coordinated Access to Addictions Services is a central number that individuals, family members and community agencies can call for addiction support within the City of Toronto.

Through Central Access, clients can speak to an addictions counselor who will assist them in finding the appropriate level of care for their needs. When a client calls they are asked a few brief questions about their situation. Based on this information, a range of options are presented and referrals are made to programs within the community. A face-to-face visit with a community transition worker can also be arranged for those who would rather discuss their options in person.

Coordinated Access provides links to 35 addiction support providers as well as a number of community based networks, including:

- Residential, day and community withdrawal services
- Residential and community treatment
- Services for people with concurrent mental health and substance use problems
- Services to minimize the harm caused by an addiction (e.g. needle exchange programs)
- Rapid access to medical clinics
- Community case workers
- Family programs

Central Access to Withdrawal Management

St. Michael's
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Catchment area: City of Toronto
Access for: Addictions
Ages served: 16+
Funding source:

Central Access to Withdrawal Management is the primary point of entry into the Toronto Withdrawal Management Services system referral system. The system is comprised of Residential, Community and Day Withdrawal Management programs run by St. Joseph's Health Centre, University Health Network, Toronto East General Hospital and St. Michael's Hospital.

Find Help/211 Toronto has been contracted by St. Michael's Hospital to provide the single point of access into withdrawal management. Information and referral specialists conduct a screening and discuss withdrawal service options, seeking the best level of care. Find Help manages referrals to in-patient withdrawal beds.

It should be noted that while the stakeholder response rates for Central Access to Withdrawal Management and Coordinated Access to Addiction Services were both low, there were some comments suggesting that these programs may benefit from integration. It was suggested that moving Central Access to Withdrawal Management into Coordinated Access to Addiction Services may benefit people with lived experience by providing a more comprehensive assessment, and opportunity to connect with a broader range of services and supports.

Access CAMH

Catchment area: CAMH services
Access for: Mental health and addictions
Ages served:
Funding source: Toronto Central LHIN

Access CAMH, implemented in 2014, provides centralized information, intake, dispositioning, and scheduling for all ambulatory referrals at CAMH, serving patients, family members, physicians, community health providers, and other stakeholders.

Support is provided through three lines based on type of caller – General (for mental health and general inquiries), Addictions, and Family (addictions specific); lines are staffed by department secretaries, information specialists and clinicians respectively.

Where feasible, calls are live answered during business hours; every effort is made to resolve calls on the first interaction. Standardized eligibility criteria, referral processes and screening tools are used to identify need and appropriately place people in the right CAMH service. Information and referral specialists can triage to a clinician specialist when the need arises.

Calls and referrals are tracked using a home grown referral tracking system and an electronic health record/I-Care scheduling system.

Here 24/7

1 844 437 3247
(HERE247)
Call anytime to access
Addictions, Mental Health
& Crisis Services
Waterloo Wellington Dufferin

Catchment area: Waterloo Wellington LHIN
Access for: Crisis, mental health and addictions
Ages served: Children and youth, adults and seniors
Funding source: Waterloo Wellington LHIN, Ministry of Children and Youth Services

Here 24/7, in operation for the past 3.5 years, is the front door to the addictions, mental health and crisis services provided by 11 agencies funded by the Waterloo Wellington LHIN.

Referrals can be made by phone, fax, or through walk-in. Service coordinators, many of whom have experience within the mental health and addiction sector as peers or in other capacities, conduct intake, assessment, referral and crisis support, as well as service appointment booking and waitlist management. Staff are concurrent capable, meaning that they are able to meet the needs of individuals experiencing mental health and/or addiction problems as well as provide concurrent capable crisis assessments and follow-up.

In an effort to provide the most appropriate service match, Here 24/7 has utilized a number of tools (including the LOCUS) to map the existing service pathways to a level of care. Here 24/7 is currently working with its partners to develop a tiered model of service, so that ALL health care services can be consistently mapped to the appropriate level of intensity. Here 24/7 operates an electronic portal to facilitate referrals to providers. They are currently creating a software tunnel to link Here 24/7 with the electronic medical record so that information can be shared in real-time with primary care.

Regionally, consideration is being given to create a single coordinated access platform to electronically connect all coordinated access mechanisms, i.e. stroke, diabetes and cancer care, to help primary care practitioners easily navigate our system and seamlessly make referrals from their EMR.

ConnexOntario

ConnexOntario
Health Services Information
Information sur les services de santé

Catchment area: Provincial
Access for: Mental health and addictions
Ages served:
Funding source: Ministry of Health and Long-Term Care

ConnexOntario operates three helplines that provide health services information and referral for people experiencing problems with alcohol and drugs, mental illness or gambling.

Information and referral specialists answer calls, emails and webchat requests 24/7. They provide contact information for services and supports in the caller's community; listen, offer support and

provide strategies to help people meet their goals; and provide basic education about gambling, drug or alcohol and mental health problems.

ConnexOntario maintains a robust database of information including current data about treatment beds (which includes mental health bed tracking, a bed availability dashboard and a provincial forensic bed registry), support groups, crisis lines, and other health services. Through their full-service, browser-based extranet application, organizations are able to view and print their organization, site and program details; update service availability and organization information; run reports detailing referrals to programs and the profile of individuals referred to their organization; and access tools designed to retrieve additional information about services throughout the province.

An agency calendar is maintained by ConnexOntario for communicating with providers, making appointments, and booking transportation. ConnexOntario has supported other coordinated access providers, such as Reach Out, in utilizing this calendar.

ConnexOntario plays a significant role in contributing statistical data for the development of public policy and strategic planning.