SHARING TOGETHER

FULL REPORT

Developing an evidence priority agenda for Ontario's mental health, substance use, and addictions system

JANUARY 2018

Evidence Exchange Network

Evidence Exchange Network (EENet) is a province-wide knowledge exchange network. We connect stakeholders of Ontario's mental health and addictions system with each other and with the evidence they need to make decisions. Located in the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH), the network includes researchers, clinicians, service providers, system planners, policymakers, persons with lived experience, and families.

Provincial System Support Program

PSSP at CAMH works together with communities and service providers across Ontario to move evidence to action. PSSP works to create sustainable, system-level change and to mobilize implementation support for Ontario's Comprehensive Mental Health and Addictions Strategy. With offices in Toronto and across the province, PSSP is on the ground, collaborating with stakeholders to build a better system through our work in implementation, health equity and engagement, knowledge exchange, evaluation and information management.

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EENet
Evidence Exchange Network
Mental Health and Addictions

www.eenet.ca

camh PSSP
Provincial System
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How to cite this document

Harrison, A., Yip, A., and Saxena, N. (2018). Sharing Together: Developing an evidence priority agenda for Ontario's mental health, substance use, and addictions system. Toronto: Evidence Exchange Network (EENet), Provincial System Support Program, Centre for Addiction and Mental Health.

Acknowledgements

Sharing Together would like to thank the Working Group members, including Mary Hanna and Jason Guriel; the EENet Steering Committee; the EENet Persons with Lived Experience and Family Member Advisory Panel; the PSSP CAMH dialogue facilitators; the Francophone team, including Aliou Sene and Alfred Cormier; the PSSP CAMH regional administrative staff; PSSP CAMH's Performance Measurement and Evaluation Research team; Rossana Coriandoli; Adrian Mattes; the final report reviewers, including Lisa Brown, Janis Cramp, Betty-Lou Kristy, Faith Rockburne, Liz Wigfull; and finally, all the participants that helped co-create the evidence priority agenda.

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SHARING TOGETHER

FULL REPORT

THE EXECUTIVE SUMMARY

Sharing Together is an Evidence Exchange Network (EENet) initiative that aims to promote the use of evidence to improve the health care experience, quality of care, and the overall health and wellbeing of all Ontarians.

Through Sharing Together, stakeholders shared their perspectives and and identified the evidence they need, so they can better do their work and navigate the mental health, substance use, and addictions system. Results of a review of key policy and planning documents, including recommendations made by the Mental Health and Addictions Leadership Advisory Council, were used to ground stakeholder discussions in current system priorities.

Eight dialogues were held across Ontario between January and April 2017, in French and English. Next, an online survey was conducted to prioritize the evidence needs identified during the dialogues, and to obtain input from stakeholders who were unable to attend the dialogues. Participants in Sharing Together included persons with lived experience, family members, caregivers, direct service providers, agency leaders, policymakers, researchers, and system planners.

Based on feedback received during early planning consultations for Sharing Together, the terms "substance use" and "addictions" were included throughout the Sharing Together process when referencing the system. Use of both terms acknowledges the full continuum of experiences of individuals who use substances, including recreational use, problematic use, dependency, or addictions.

For a glossary of additional terms, see Appendix A.

Sharing Together participants identified the evidence they need related to 10 evidence themes and prioritized two evidence needs within each of these themes:

Access to services

- Waitlist management strategies, including effective interim supports for individuals on waitlists
- How to engage individuals who are hard to reach in service delivery (such as those from marginalized populations and rural communities)

Children and youth, including transition-age youth

- Strength-based and trauma-informed interventions for children and youth that integrate mental health, substance use, and addictions
- How to best support vulnerable and at-risk youth

Continuum of housing and homelessness

- Effectiveness of different approaches across the continuum of housing and homelessness
- Transitional housing models and services for different populations

Culturally safe and competent care that reflects cultural knowledge

- How to provide core services that are accessible, culturally safe, and trauma-informed
- How to define culturally safe and culturally competent care in service delivery

Effectiveness of services

- How to define effectiveness of services from the perspective of service users, family members, and caregivers
- How to address service provider burnout and compassion fatigue at the organizational and system level

Harm reduction

- Effective harm reduction approaches for harmful behaviours, substance use, and various types of addictions
- How to reduce stigma and increase awareness of harm reduction

Integrated healthcare

- Best practices, protocols, and policies that increase collaboration and information sharing between service providers
- Integrated healthcare approaches for rural and underserviced areas, and marginalized populations

Prevention and promotion, including suicide prevention

- Coordinated mental health, substance use, and addictions prevention and promotion strategies, across the lifespan
- School-based interventions for prevention, promotion, and early intervention (including suicide prevention)

Standardized care

- Factors that make standardized care effective, efficient, and appropriate
- Standardized care pathways (for example, acute care to community, or primary care to specialty care)

Supporting the voices of persons with lived experience, family members, and caregivers

- How to effectively and meaningfully engage persons with lived experience, family members, and caregivers in decision-making, and outcomes of integrating their experiences in organizational processes and system-level initiatives
- Strategies for service providers to build trust and reduce stigma that are informed by service users.

These evidence needs are further discussed in the co-created evidence priority agenda (page 14), which highlights a range of opportunities to develop and use evidence for system transformation. Importantly, these findings align with and support the objectives of provincial initiatives aimed at improving Ontario's mental health, substance use, and addictions system. This includes the key recommendations proposed by the Mental Health and Addictions Leadership Advisory Council.[2]

For example, participants identified the need to better engage with and consider the expertise of marginalized populations, including remote communities and Indigenous peoples, to improve access to culturally safe and appropriate services. This aligns with the Council's focus on health equity considerations to support system transformation. Sharing Together also aligns with the goals outlined in the Ministry of Health and Long-term Care's Patients First: Action Plan for Health Care,[3] which highlights the need to help people make evidence-informed decisions about their health, improve access to care, and strengthen coordinated and integrated care.

The next steps will be for EENet and other stakeholders across the province to address the evidence needs identified through Sharing Together.

THE INTRODUCTION
Background

Stakeholders of Ontario's mental health, substance use, and addictions system* need evidence to inform their decisions. But to put evidence into practice, they must be meaningfully engaged to find out what evidence they require. Sharing Together examines the evidence stakeholders require to support system transformation by highlighting where evidence should be made available and easier to understand.

Sharing Together is an initiative of EENet that aims to promote the use of evidence by service providers, policymakers, and other stakeholders across the province. The ultimate goal: to improve the health experience, quality of care, and overall health and wellbeing of all Ontarians.

Key Messages

- **The Sharing Together evidence priority agenda aligns with current policy priorities and momentum in the system, and identifies areas that can drive new priorities.**
- **The agenda includes priority evidence themes such as: access to services, effectiveness of services, integrated healthcare, standardized care, and supporting the voices of persons with lived experience, family members and caregivers.**
- **Sharing Together used a co-creation approach to determine and prioritize where evidence should be made available and easier to understand to support transformation of Ontario's mental health, substance use, and addictions system.**
- **To move Ontario's mental health, substance use, and addictions evidence priority agenda forward, EENet and other partners in the system can use the co-created Sharing Together evidence priority agenda to:**
    - **improve access to evidence;**
    - **strengthen connections between stakeholders; and**
    - **help facilitate the use of evidence in system improvement initiatives.**

*Based on feedback received during early planning consultations for Sharing Together, the terms "substance use" and "addictions" were included throughout the Sharing Together process, when referencing the system. Use of both terms acknowledges the full continuum of experiences of individuals who use substances, including recreational use, problematic use, dependency, or addictions. For a glossary of additional terms, see Appendix A.

EENet is a knowledge exchange network that helps create and share evidence to build a better mental health, substance use, and addictions system in Ontario. Located in the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH), EENet includes researchers, clinicians, service providers, system planners, policymakers, persons with lived experience, family members, caregivers, and other stakeholders and sectors.

The EENet Steering Committee and the EENet Persons with Lived Experience and Family Member Advisory Panel were instrumental in helping to shape each stage of the Sharing Together process. The Steering Committee consists of provincial and national organizations, persons with lived experience, service providers, system planners, policymakers and researchers, who guide the work of the network. Members of the Panel provide expertise and lived experience as a form of evidence to EENet, and to other initiatives aimed at improving Ontario's mental health, substance use, and addictions system.

Sharing Together builds on the work of a 2011 EENet initiative, Creating Together,[1] which identified research priorities needed to improve the mental health, substance use, and addictions system with the participation of diverse stakeholders and sectors. The Sharing Together initiative looks beyond research and considers all forms of evidence. EENet's definition of evidence includes research evidence; practice-based evidence; the voices of people with lived experience, family members, and caregivers; and cultural knowledge.

The specific objectives of Sharing Together are to:

- **identify priority evidence needs related to mental health, substance use, and addictions in the areas of health promotion and prevention, early identification, treatment, and recovery across the lifespan;**
- **engage stakeholders to co-create an evidence priority agenda for Ontario's mental health, substance use, and addictions system;**
- **inform EENet's and partners' knowledge exchange activities; and**
- **support transformation of Ontario's mental health, substance use, and addictions system.**

EENet and other stakeholders across the province will work to address the needs identified through Sharing Together to support ongoing system improvement.

The Process

Sharing Together used a co-creation process to develop the evidence priority agenda. The Sharing Together team first scanned policy and planning documents related to Ontario's mental health, substance use, and addictions system. The findings from this scan helped to frame discussions at dialogues across the province.

51

A total of 51 policy and planning documents were reviewed.

For more information on this environmental scan, see Appendix C.

8

Eight dialogues were held with diverse stakeholders between January and April 2017.

Seven were in-person events in Thunder Bay, Barrie, London, Sudbury, Toronto, and Ottawa. One of the two Ottawa dialogues was held in French. The eighth dialogue was hosted using web conferencing with representatives from several of the Local Health Integration Networks (LHINs). For more information on the dialogue participants, see Appendix D.

An online survey was conducted to prioritize the evidence needs identified during the dialogues, and to obtain input from stakeholders who were not able to attend these events.

For more information on this survey and the participants, see Appendix E & F.

550

In total, over 550 individuals from different stakeholder groups and sectors came together to share their experiences and knowledge, and prioritize their evidence needs.

Participants expressed strong interest in the follow-up actions to Sharing Together, specifically with regards to responding to the identified evidence needs in their region and across the province. For detailed information on the Sharing Together process, see Appendix B.

Participants included persons with lived experience, family members, caregivers, direct service providers, agency leaders, policymakers, researchers, and system planners from diverse sectors.

A range of stakeholders identified as being from, or working with, marginalized populations also participated (for example, individuals experiencing homelessness and individuals from ethno-cultural and racialized groups).


Identify Evidence Themes
(Environmental Scan)
Prioritize Evidence Themes
(Dialogues)
Identify Evidence Needs
(Dialogues)
Prioritize Evidence Needs
(Survey)
Develop & Act on Evidence Priority Agenda

Overview of the Agenda

The Sharing Together evidence priority agenda includes both evidence themes and evidence needs. Evidence themes are general categories that group together related evidence needs. Evidence needs are specific areas within each evidence theme that require the collection of, access to, or creation of different sources of information.

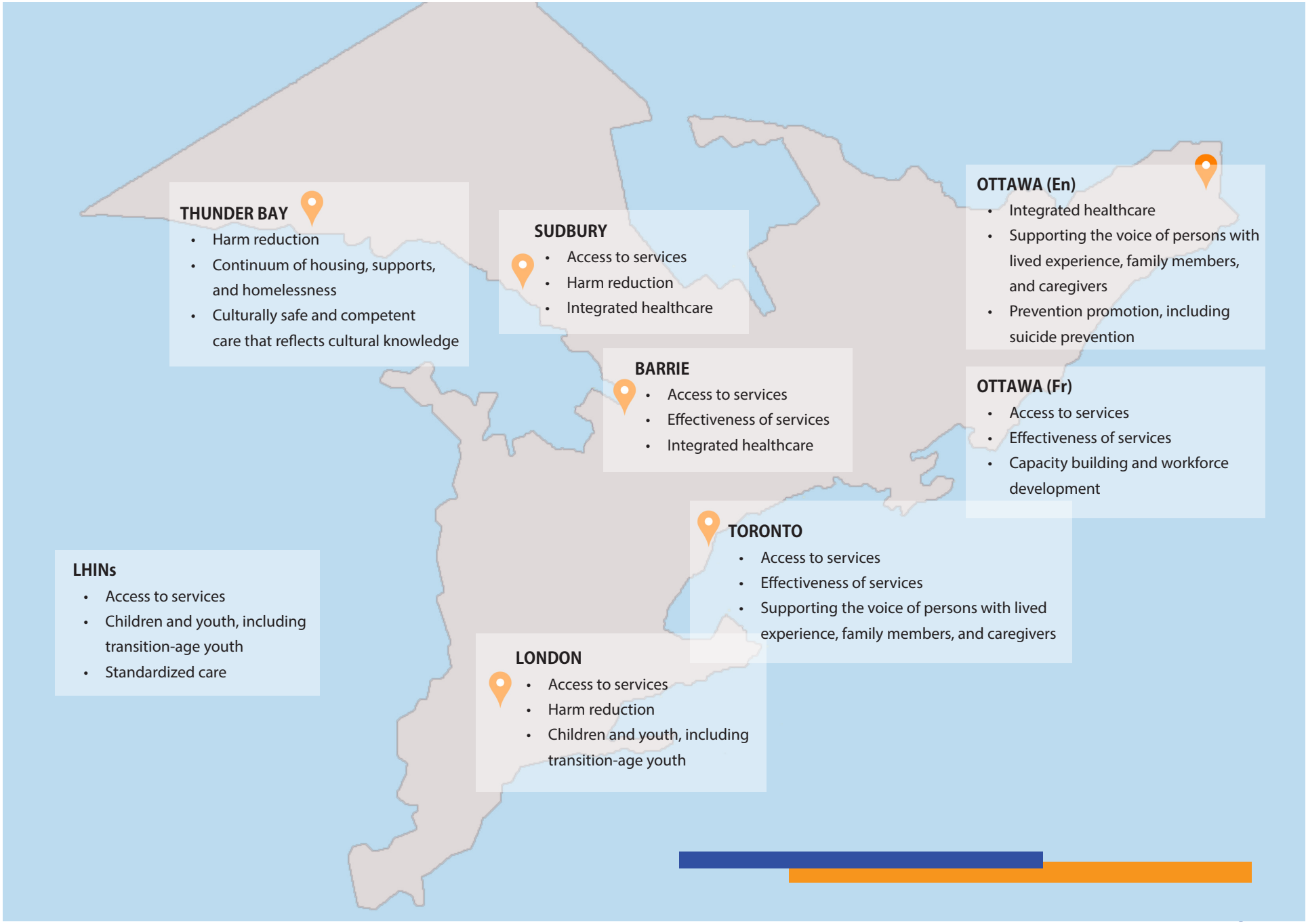
Sharing Together participants identified the evidence they need related to 10 evidence themes:

- **Access to services**
- **Children and youth, including transition-age youth**
- **Continuum of housing and homelessness**
- **Culturally safe and competent care that reflects cultural knowledge**
- **Effectiveness of services**
- **Harm reduction**
- **Integrated healthcare**
- **Prevention and promotion, including suicide prevention**
- **Standardized care**
- **Supporting the voices of persons with lived experience, family members, and caregivers**

Two prioritized evidence needs are identified within each of these 10 themes. For each prioritized evidence need, a summary of why this evidence is needed, and related evidence needs gathered from dialogue participants, is provided in the evidence priority agenda.

Stakeholders also identified capacity building and workforce development needs during their discussions. These are included in the report following the evidence priority agenda.

Prioritized Evidence Themes by Dialogue



Provincial Alignment

The findings of Sharing Together align with and support the objectives of provincial initiatives aimed at improving Ontario's mental health, substance use, and addictions system.

This includes the key recommendations proposed by the Mental Health and Addictions Leadership Advisory Council (the Council),[2] which has issued a series of recommendations, as part of its role to guide government on rolling out Ontario's Comprehensive Mental Health and Addictions Strategy.

For example, participants identified the need to better engage with and consider the expertise of marginalized populations, including those in remote communities and Indigenous peoples, to improve access to culturally safe and appropriate services. This aligns with the Council's focus on health equity considerations to support system transformation.

The Council recommended investing in promotion, prevention, and early intervention efforts, a priority evidence theme identified by Sharing Together participants. In addition, the Council has acknowledged the critical role that people with lived experience, family members and caregivers play in system transformation, also highlighted by Sharing Together participants.

The Council's 2016 report notes that Ontario's Comprehensive Mental Health and Addictions Strategy, ***"...puts people at the center of a strengths-based, high-performing, accessible, equitable and recovery-oriented culturally-appropriate mental health and addictions system."*** [2] (p. 9)

The actions that EENet and other partners will take to address the evidence priority agenda, including providing evidence related to access to services; culturally safe and competent care; effectiveness of services; supporting the voices of persons with lived experience, family members, and caregivers, will directly support the realization of this vision.

Sharing Together also aligns with the goals outlined in the Ministry of Health and Long-term Care's *Patients First: Action Plan for Health Care,* [3] which highlights the need to help people make evidence-informed decisions about their health, improve access to care, and strengthen coordinated and integrated care.

So What?

To move Ontario's mental health, substance use, and addictions evidence priority agenda forward, it will be important to:

1

- improve access to evidence

2

- strengthen connections between stakeholders

3

- help facilitate the use of evidence in system improvement initiatives.

Taking action on the findings of Sharing Together can:

- help service users, family members, and caregivers to better navigate services and supports, and participate in their own recovery;
- equip service providers to offer evidence-based, culturally safe, and trauma-informed care that responds to the needs and feedback of service users;
- help system planners and policymakers make existing services and supports more accessible and effective;
- identify areas and populations that researchers and peer researchers can explore further; and
- validate and integrate cultural knowledge and the voices of lived experience into the system.

THE CO-CREATED EVIDENCE PRIORITY AGENDA

Access to Services

Priority evidence need:

Waitlist management strategies, including effective interim supports for individuals on waitlists.

Related evidence needs include:

- Regional and provincial data on wait times, including a breakdown of wait times based on socio-demographic characteristics (for example, comparing wait times experienced by those with different income levels and ethno-racial backgrounds).
- The impact of wait times on service user experience and outcomes related to mental health, substance use, and addictions, and other needs (such as housing and employment).
- How and where interim supports for individuals on waitlists (such as peer support, non-clinical supports or education) should be offered.

Why this is important for system improvement:

Participants noted that long waitlists act as a barrier to care for those who need mental health, substance use, and addictions services. They indicated that improving access to care will require strategies to address and manage waitlists, and to support individuals on waitlists who require interim supports. These strategies will need to be based on real-time information about wait times. Waitlists also contribute to people seeking services that may not be appropriate, such as through the emergency department, or that are not in the individual's preferred language. Information about waitlists should be shared with service providers so they can help service users access the right services.

Access to Services

Priority evidence need:

How to engage individuals who are hard-to-reach in service delivery (such as those from marginalized populations and rural communities).

Related evidence needs include:

- Effective organizational policies that improve access to services for marginalized populations.
- Alternative methods for service delivery (such as outreach, drop-ins, or after hours) and locations (such as visits in the home or workplace).
- How to create safe spaces that do not stigmatize service users.
- Approaches that increase access to services for individuals in rural communities, such as technology-based service delivery models or approaches that include considerations for transportation.

Why this is important for system improvement:

Participants said it is important to engage hard-to-reach individuals in a meaningful way, as it can increase their access to services. These individuals may include those from marginalized groups such as lesbian, gay, bisexual, transgender, queer, and two-spirited (LGBTQ2S) communities, newcomers, ethno-racial communities, individuals who are experiencing homelessness, and those who require access to services in a language other than English. It may also include those who live in rural communities or areas with limited services. To ensure that these individuals receive the services they need, it is important to identify and address the barriers they face while ensuring services are culturally safe for diverse groups.

Children and Youth, including Transition-Age Youth

Priority evidence need:

Strength-based and trauma-informed interventions for children and youth that integrate mental health, substance use, and addictions.

Related evidence needs include:

- Pathways, processes, and additional tools that will help integrate the delivery of mental health, substance use, and addictions services for children and youth.
- Structures within organizations and at the system level that help integrate mental health, substance use, and addictions services for children and youth.
- Best practices for helping youth develop life skills that will allow them to be independent during adulthood.

Why this is important for system improvement:

Participants noted that current approaches often focus on the individual's deficits or problems rather than their strengths, and do not take an integrated approach. There is a need to identify effective approaches that integrate mental health, substance use, and addictions service delivery. These approaches should be strength-based and trauma-informed, and based on information from children and youth about how they would like to receive services.

Children and Youth, including Transition-Age Youth

Priority evidence need:

How to best support vulnerable and at-risk youth.

Related evidence needs include:

- Approaches that build resiliency and coping skills in youth.
- Alternative approaches to engage youth and provide treatments and supports, other than face-to-face, including using new technologies, such as e-counselling and internet-based interventions.
- Alternatives to mainstream supportive approaches that incorporate cultural beliefs and practices.
- How to create safe spaces for youth, including at first points of access that tend to be trusted by youth (for example, faith groups, youth groups, and schools).
- Approaches that connect youth experiencing similar issues with one another.
- How to optimize the role of family members and other natural supports (such as teachers and faith leaders) in the recovery process, and ensure they have the capacity to provide support to at-risk youth.
- How to increase collaboration between primary care and the children and youth mental health sectors.

Why this is important for system improvement:

Children and youth face many barriers to accessing services, especially those who are from marginalized populations or at-risk of mental health, substance use, and additions concerns. They may not want to seek help or access services that are not youth friendly. Participants noted that it's important to understand how and where youth want to access and receive services and the barriers they face (such as transportation). This can be supported by a better understanding of the role of family members and natural supports that may help youth to access services, and how to integrate alternative evidence-based approaches to effectively engage youth.

Continuum of Housing and Homelessness

Priority evidence need:

Effectiveness of different approaches across the continuum of housing and homelessness.

Related evidence needs include:

- Service gaps related to housing models and approaches, particularly in Northern Ontario.
- Supports that help individuals to live more independently, including those with substance use and addictions concerns.

Why this is important for system improvement:

Participants noted that to address the needs of individuals with mental health, substance use, and addictions issues, it is important to identify and address their housing needs. Beyond identifying effective approaches to housing and homelessness, across the lifespan and for different populations, awareness must be raised about the housing supports that are available and those that are missing in different communities.

Continuum of Housing and Homelessness

Priority evidence need:

Transitional housing models and services for different populations.

Related evidence needs include:

- Suitability of transitional housing compared to other models for different needs and populations, including older adults.
- Effective and appropriate short-term and long-term housing approaches for youth
- Effective transitional housing approaches for individuals released from correctional facilities.

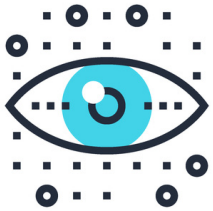
Why this is important for system improvement:

Participants indicated that the effectiveness of the transitional housing model for different populations (for example, youth and individuals who have been released from correctional facilities or hospitals) should be shared to inform and improve service delivery across the system.

Culturally competent and culturally safe care that reflects cultural knowledge

Priority evidence need:

How to provide core services that are accessible, culturally safe, and trauma-informed.



Related evidence needs include:

- How to create culturally safe environments for those seeking and accessing services.
- How to build meaningful relationships and partnerships, including those with Indigenous populations to support traditional healing options in service delivery.
- The impact of cultural sensitivity and cultural safety training for service providers, including the impact on outcomes for those who are receiving services.
- Best practices for incorporating cultural competence into prevention and promotion initiatives, including how to address stigmatizing beliefs in various cultural contexts.
- How to integrate trauma-informed approaches into service delivery.

Why this is important for system improvement:

Participants spoke about the need for services that reflect the needs of different populations, including language preferences. To do this, services and supports must be delivered in accessible, culturally safe environments, where service providers embrace cultural humility and use approaches that are trauma-informed and culturally appropriate. Prevention and promotion initiatives should also incorporate cultural competence.

Culturally competent and culturally safe care that reflects cultural knowledge

Priority evidence need:

How to define culturally safe and culturally competent care in service delivery.

Related evidence needs include:

- Standards and tools to guide and evaluate cultural safety and cultural competency in organizations.
- Outcomes from communities and organizations that have adopted culturally safe and culturally competent care practices.

Why this is important for system improvement:

Participants stated that to provide services and supports that are culturally safe and culturally competent, service providers need to develop a common understanding of cultural safety and competency, along with the capacity to implement these approaches in different settings. Efforts to develop this common understanding of cultural safety and competence should engage elders and representatives from different Indigenous populations, as well as other ethno-cultural and racialized populations, and leverage the outcomes of existing initiatives across Ontario.

Effectiveness of Services

Priority evidence need:

How to define effectiveness of services from the perspective of service users, family members, and caregivers.

Related evidence needs include:

- Experiences of service users navigating the mental health, substance use, and addictions system related to quality of services, transitions between services, and other indicators of effective care (for example, relationships with providers and levels of engagement in one's care).
- How to easily gather and share the information from service user and caregiver perceptions of care tools, so it can be used to improve the quality of services.
- How to gather evidence about the experiences and outcomes of those who are not receiving services.

Why this is important for system improvement:

Participants said that it is crucial to use the expertise of diverse service users, family members, and caregivers, including those who receive French language services, to define and measure the effectiveness of services. Going beyond satisfaction surveys, participants spoke of the need to look at the service user journey, with a focus on system integration, and consider recovery outcomes defined by service users.

Effectiveness of Services

Priority evidence need:

How to address service provider burnout and compassion fatigue at the organizational and system levels.

Related evidence needs include:

- How to measure burnout in service providers.

Why this is important for system improvement:

Participants noted that factors such as workload, emotional demands, and lack of professional development opportunities can all contribute to burnout and compassion fatigue of services providers at both the organizational and system levels. Participants indicated that addressing these issues, in combination with increased resources at the organizational and system level, may lead to more effective service delivery and decreased compassion fatigue.

Harm Reduction

Priority evidence need:

Effective harm reduction approaches for harmful behaviours, substance use, and various types of addictions.

Related evidence needs include:

- Culturally appropriate harm reduction approaches for Indigenous peoples.
- Effectiveness of shelters that allow the use of alcohol and other substances.
- Effectiveness of using safe (or supervised) injection sites for substances other than opioids (for example, crystal methamphetamine).
- Strategies to prevent opioid overdoses, including education on the use of naloxone.
- Guidelines for the use of harm reduction approaches for individuals with process addictions (such as gambling).
- Comparison of the outcomes for residential and community-based settings (for example, drop-in, day programs, and outreach services).
- Comparison of the outcomes for stand-alone methadone clinics and clinics that integrate a variety of services (for example, primary care or mental health services).
- Comparison of methadone and suboxone in different settings (for example, corrections and rural and remote communities).

Why this is important for system improvement:

Participants indicated that evidence is needed on the principles of harm reduction and the effectiveness of the growing range of harm reduction approaches. These approaches aim to reduce harms associated with: (1) the use of substances (such as alcohol, opioids, cannabis, and non-beverage alcohols), (2) other harmful behaviours (such as self-injury), and (3) process addictions (such as problem gambling). They noted that harm reduction approaches are specifically needed for those who live in rural and remote areas, youth, and pregnant women, as well as culturally appropriate approaches for Indigenous peoples. Participants also suggested that evidence can be used to support the integration of harm reduction principles and approaches into new settings (such as primary care and correctional facilities), and for new substances.

Harm Reduction

Priority evidence need:

How to reduce stigma and increase awareness of harm reduction.

Related evidence needs include:

- Common language for service providers to talk about harm reduction, including the differences between harm reduction and prevention approaches.
- Strategies to increase knowledge of harm reduction approaches among family members and caregivers so they can support their loved ones who are involved in or seeking services.
- Resources that increase awareness of harm reduction approaches among police officers and other first responders, as well as primary care providers.

Why this is important for system improvement:

Participants suggested that strategies should be developed to increase understanding and awareness of what harm reduction is, how it is applied, and the evidence of its benefits. Misconceptions and related stigmatizing attitudes can be particularly challenging in smaller, rural areas where privacy concerns can prevent individuals from seeking these services. Stigma reduction strategies could help to increase engagement and support for these services. These strategies should be informed by those who receive these services and tailored to the needs of different groups and cultures.

Integrated Healthcare

Priority evidence need:

Best practices, protocols, and policies that increase collaboration and information sharing between service providers.

Related evidence needs include:

- Approaches that improve transitions between services, organizations, and sectors (for example, from prison to community, youth to adult services, hospital to community, and between community services), including pathways, formal partnerships, referral processes, "warm handoffs", and follow-up policies, based on service users' needs.
- How to increase information sharing between service providers and address privacy regulations, as well as other barriers to information sharing.
- Outcomes of collaborative approaches such as circle of care models, inter-agency outreach services, or sharing of cases between service providers (for example, case conferencing) and various collaborative initiatives (for example, Health Links[4]).

Why this is important for system improvement:

Participants said that genuine collaboration between service providers at the service, organizational, and system level is critical to building an effective system of care. They suggested that collaboration and information sharing is particularly important at points of transition in the system, as well as to support planning across services, sectors, ministries, and jurisdictions.

Integrated Healthcare

Priority evidence need:

Integrated healthcare approaches for rural and underserviced areas, and marginalized populations.

Related evidence needs include:

- Integrated service models and approaches that are accessible and culturally safe, meet the needs of diverse populations, and address the social determinants of health.
- Approaches to integrate primary care, hospital-based care, and community care in underserved areas, and to serve marginalized populations.
- Strategies that help reduce the barriers to integrated care related to geographic service areas.

Why this is important for system improvement:

Participants said that it is important to identify how to use an integrated approach to support underserviced areas and for marginalized populations. To do this, barriers such as geographic service boundaries, transportation issues, and lack of access to services in languages other than English must be addressed. At the same time, culturally safe approaches need to be identified and included in integrated care models to ensure that services meet the needs of diverse groups.

Prevention and promotion, including suicide prevention

Priority evidence need:

Coordinated mental health, substance use, and addictions prevention and promotion strategies, across the lifespan.

Related evidence needs include:

- How to integrate the social determinants of health (for example housing and education) into prevention and promotion approaches to help reduce the need for services.
- How to engage those who may be at-risk, such as youth and isolated older adults, in prevention, promotion, and early identification initiatives.
- Effectiveness of informal supports, such as those found in schools and recreational activities, in promotion, prevention, and early identification initiatives.
- Effective individuals and settings to deliver promotion and prevention approaches (for example, peers, educators, family members, and celebrities.
- Effective integrated or cross-sectoral approaches to prevention.
- Best practices for suicide prevention, including coordinated and trauma-informed approaches to address suicide in Indigenous communities.

Why this is important for system improvement:

Participants spoke of the need to develop a coordinated provincial strategy that builds on existing programs and initiatives to promote mental health and prevent problematic substance use and addictions across the lifespan. This should include approaches that effectively promote positive mental health, and those that help to address issues before they become more serious. A provincial strategy should also make information about evidence-based practices related to prevention and promotion easier to access for caregivers and for those who provide informal support to children and youth.

Prevention and promotion, including suicide prevention

Priority evidence need:

School-based interventions for prevention, promotion, and early intervention (including suicide prevention).

Related evidence needs include:

- Tools for teachers about suicide prevention, including digital approaches to providing support (for example, e-counselling).
- Effectiveness of prevention, promotion and early intervention programs, such as staff supports in schools (for example, social workers) and educational resources.
- The impact of prevention policies and curriculum changes, such as the creation of safe spaces in schools for students from marginalized populations.
- How to engage primary school children in promotion and prevention initiatives, and the impact of peer-led initiatives.

Why this is important for system improvement:

Participants said that schools are an ideal setting for promotion, prevention, and early intervention resources and education aimed at children and youth. They discussed the need for teachers and parents to have access to tools and best practices for supporting students, as well as the need for collaboration between school boards and mental health, substance use, and addictions services. They also highlighted the importance of showing the return on investment for prevention, promotion, and early identification efforts.

Standardized Care

Priority evidence need:

Factors that make standardized care effective, efficient, and appropriate.

Related evidence needs include:

- How and when to use standardized tools (for example, screening) in various settings, such as primary care.
- The impact of standardized care on person-centered care and on access gaps that diverse groups may be facing.

Why this is important for system improvement:

Participants said it is important to determine the elements of standardized care that make it effective, as well as if there are elements of standardized care that compromise person-centered care. They also wanted to better understand how and when to use standardized, evidence-based tools.

Standardized Care

Priority evidence need:

Standardized care pathways (for example, acute care to community or primary care to specialty care).

Related evidence needs include:

A related evidence need identified by participants includes determining the outcomes of current standardized care pathways.

Why this is important for system improvement:

Participants indicated that the development and implementation of standardized care pathways should be evidence-based and supported by a review of outcomes of current care pathways, information provided by organizations, and the experiences of service users, family members and caregivers. They noted that care pathways may need to be adapted to meet the needs of different communities, based on availability of services and take into account barriers to care linked to organizational policies or jurisdictional barriers.

Supporting the Voices of Persons with Lived Experience, Family Members, and Caregivers

Priority evidence need:

How to effectively and meaningfully engage persons with lived experience, family members, and caregivers in decision-making, and outcomes of integrating their experiences in organizational processes and system-level initiatives.

Related evidence needs include:

- How to prioritize and validate lived experience as a form of evidence.
- Barriers to integrating persons with lived experience, family members, and caregivers into decision-making processes, including how to address power differentials between these groups and other stakeholders in the system.
- The impact of having paid positions for persons with lived experience compared to volunteer positions.
- How to recruit and build the capacity of persons with lived experience, family members and caregivers to share their voices in system-level discussions.

Why this is important for system improvement:

Participants said that incorporating the voices of persons with lived experience, family members, and caregivers in decision-making and policy development is a critical part of ongoing efforts to improve services and supports. Participants indicated the need to identify effective structures and processes that allow for meaningful engagement, such as building trust, creating safe spaces for conversations, feedback processes, and the use of advisory groups. It is also important to evaluate and show the impact of these structures and processes for organizations and at the system level.

Supporting the Voices of Persons with Lived Experience, Family Members, and Caregivers

Priority evidence need:

Strategies for service providers to build trust and reduce stigma that are informed by service users.

Participants spoke extensively about peer support models as another approach to building trust and reducing stigma. Related evidence needs include:

- How to structure peer support programs for youth and in rural communities.
- Peer support models that are culturally safe and trauma-informed.
- Criteria for selecting peers for peer-support roles.
- Effective models of support and mentorship for peer support workers.
- Outcomes of peer-based supports and peer-led initiatives, including:
  - comparison with non-peer-led initiatives;
  - impact of peer support on peers and service users;
  - outcomes of initiatives that provide system-navigation support; and
  - regional variations.

Why this is important for system improvement:

Participants indicated the importance of service providers using strategies informed by service users to ensure services are respectful, safe, and equitable and that help to reduce stigma related to accessing and receiving care. They said that it's important to continue to evaluate peer-based and peer-led supports, as well as identify how to structure peer support for different settings and for various populations.

Capacity-building and Workforce Development Needs

In the Sharing Together dialogues, in addition to discussing their evidence needs, some participants spoke of the importance of capacity-building and workforce development to respond to changes at the service and system level, and to provide quality, evidence-based services. They also indicated that resources, supports, and commitment are needed to sustain practice change aimed at system improvement. An example is the need to increase the capacity of family members, caregivers, school staff, service providers, and primary care providers to engage in mental health promotion, prevention, and early identification. Further, there is a need to increase access to training in rural and remote areas, particularly for French language service providers.

Additional capacity building and workforce development needs for specific groups

First responders, including police officers:

- How to respond to people with mental health, substance use, and addictions issues, including the use of trauma-informed approaches.

French language service providers:

- How to provide services for Francophone service users that are culturally competent.

Primary care providers, including family physicians:

- How to identify mental health, substance use, and addiction issues through the use of standardized screening and assessment tools.
- How to connect and refer people to mental health, substance use, and addictions services and supports, such as early psychosis intervention programs.

Service providers who work with youth:

- Approaches for working with youth who are using opioids.
- How to support family members and caregivers during the youth's transition from the youth to the adult sectors.
- How to collect outcome data related to youth engagement in community-based programs.

Youth peer supporters and advocates:

- How to support other youth with mental health, substance use, and addiction issues, including cultural sensitivity training.

Service providers:

- How to work across sectors and use team-based approaches, particularly in rural communities.
- How to use standardized screening and assessment tools.

THE NEXT STEPS

We know that evidence already exists that, if shared and adapted for various populations and settings, would respond to some of the evidence needs identified in this report. This evidence may come from research, cultural knowledge, or the lived experiences of people with mental health, substance use, or addictions concerns, and their families and caregivers, or from the outcomes of current initiatives or practices in Ontario. We also know that evidence may need to be created and collected from various sources to respond to the identified prioritized needs. Stakeholders also spoke of the need for support and guidance on how to move evidence into practice and policy.

EENet and other stakeholders across the province will work together to address the identified evidence needs in Sharing Together. Some of EENet's activities will include:

- Disseminating the final evidence priority agenda and developing targeted knowledge resources that share the Sharing Together findings to engage different stakeholders.
- Sharing evidence priorities with key funders and system planners such as the Ministry of Health and Long-Term Care and the Local Health Integration Networks.
- Connecting with system partners who also engage in knowledge exchange to leverage their support in responding to evidence needs. Conducting a mapping exercise with the EENet Steering Committee, the EENet Persons with Lived Experience and Family Members

- Advisory Panel, the Provincial System Support Program at CAMH, and other actors to identify ongoing work that is relevant to the prioritized evidence needs.

- Bringing together persons with lived experience, family members, caregivers, policymakers, service providers, system planners, members of different ethno-cultural and racialized groups, and other stakeholders for additional dialogues to share existing evidence and co-create new evidence related to the evidence needs.

- Developing evidence briefs and other knowledge resources to synthesize the evidence that already exists and needs to be shared.

As an initial step, the Sharing Together team identified some preliminary knowledge resources related to the evidence needs, which are available on the Sharing Together page of the EENet website.

To move Ontario's mental health, substance use, and addictions evidence priority agenda forward, it will be important to:

1. improve access to evidence;
2. strengthen connections between stakeholders; and
3. help facilitate the use of evidence in system improvement initiatives.

The Sharing Together evidence priority agenda is an opportunity for EENet and interested stakeholders to directly respond to the evidence that stakeholders need to better do their work and navigate the mental health, substance use, and addictions system, in order to support ongoing system transformation.

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APPENDICES

A. Glossary of Terms

Addictions: Addiction is a pattern of substance use or behaviors characterized by "craving, loss of control of amount or frequency of use, compulsion to use, and use despite consequences". In this way, addiction can apply to behaviors such as excessive internet or technology use and problem gambling.[5]

Care pathways: Refers to the deliberate coordination and integration of care that is person-centered and evidence-based.[6]

Continuum: In the context of the report, continuum of housing and homelessness refers to "the range from temporary emergency shelters through transition housing, supportive housing, subsidized housing, market rental housing or market homeownership".[7]

Evidence: Many forms of knowledge, taken together, make up evidence. These forms include research, professional expertise, the lived experience of people and families, and cultural and traditional knowledge. The use of evidence must take into account the local context.[8]

Evidence-based decision making: "A process for making decisions about a program, practice, or policy that is grounded in the best available evidence"[9]

Evidence priority agenda: Identifies areas of opportunity and need that can be addressed by providing access to evidence or creating evidence.

Marginalized populations: "Groups who are marginalized as a result of the social determinants of health, such as sexual orientation, income, race, education, and disability."[10]

Peer support: "Support that is provided by a person with similar lived experience. The various types of peer support fall along a spectrum ranging from informal to formal. Informal peer support occurs when acquaintances with similar experience listen to and support each other. Formal peer support occurs in a structured setting where peer support workers offer the opportunity for a supportive, empowering relationship. The values, principles of practice, and skills apply to all types of peer support and organizations that offer it."[11]

Person with lived experience: "Any person who identifies as having a current or past experience of, mental illness, substance use, or addictions problems, regardless of whether they have a diagnosed condition and/or have received treatment."[12]

Glossary of Terms (continued)

Service user: A person who uses or receives mental health, substance use, and/or addictions services and supports.

Social determinants of health: "The conditions that influence a person's health. They include income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, gender, and culture."[13]

Substance Use: Substance use entails using a licit or illicit substance in a recreational or casual manner with no negative health or social effects.[14]

Transition Aged Youth (TAY): This typically refers to individuals between the ages of 16 and 25, however some have adopted a more flexible definition of TAY by identifying them to be as young as 12 years old. At the level of policy planning and service provision, developmental age is also an important consideration.[15] Also referred to as 'emerging adults' by the Mental Health Commission of Canada.

Transitional housing: "Temporary accommodations for individuals who are homeless or at-risk of being homeless, which are combined with other supports, such as financial assistance and case management, to help them transition to long-term housing and independent living."[16]

B. Sharing Together Process

Step 1. Environmental Scan to Develop Evidence Themes

The Sharing Together team reviewed key documents that provide insight into regional, provincial, and national priorities related to mental health, substance use, and addictions. To identify relevant documents, the Sharing Together team conducted an environmental scan with the help of a CAMH librarian. The search was focused on peer-reviewed, academic literature, as well as grey literature published between 2011 and 2016. The team also put out a call for documents to EENet's Steering Committee, our Persons with Lived Experience and Family Members Advisory Panel, and other EENet partners and stakeholders. Finally, the team used the Health Equity Impact Assessment (HEIA) tool [17] to ensure that our search included documents that outline the priorities of marginalized populations, such as: older adults; individuals with low income; Indigenous populations; faith communities; individuals who identify as lesbian, gay, bisexual, transgender, queer; and individuals living with disabilities.

We reviewed a total of 51 background documents, which are available on the Sharing Together page of the EENet website.
A content analysis was used to identify evidence needs in these documents, which were then grouped into 21 overarching themes (for example, access to services, problem gambling, and older adults). This step helped to organize the remaining Sharing Together activities.
The list and description of the 21 evidence themes is available in Appendix C.

Step 2. Stakeholder Dialogues

Dialogue Objectives

The aim of the Sharing Together dialogues was to identify and better understand Ontario's evidence needs, from the perspective of stakeholders in various sectors and regions, related to the mental health, substance use, and addictions system, in order to contribute to the development of an evidence priority agenda.

Dialogue Process

The Sharing Together team hosted eight dialogues with stakeholders across the province from January to April 2017. Seven were in-person events in Thunder Bay, Barrie, London, Sudbury, Toronto, and Ottawa. Two took place in Ottawa, in English and French. We hosted an additional dialogue using web conferencing, with representatives from several of the Local Health Integration Networks (LHINs).

We shared our call for participation through:

- EENet's website, e-newsletter, and online community (EENet Connect);
- the EENet Steering Committee;
- the EENet Persons with Lived Experience and Family Member Advisory Panel;
- partner networks; and
- broader CAMH networks.

We encouraged stakeholders to disseminate the invitation to their networks. To help ensure we reached a diverse range of stakeholders, the call for participation was also shared through additional e-newsletters and bulletins, including the Health Equity Council, Rainbow Health Ontario, Primary Health Care Program Network, and the Ontario Health Promotion e-bulletin.

We tracked registrations to help ensure diverse populations would be represented. If numbers were low for certain groups, we personally invited representatives of those groups and their networks, for example persons with lived experience, family members, and caregivers. While each dialogue included individuals from these groups, their representation varied considerably across dialogues and was minimal in some cases. Appendix D shows the specific breakdown of participants at the in-person dialogues.

Everyone who registered for our dialogues received the list of 21 evidence themes that we identified in Step 1 and was asked to complete a pre-dialogue online survey to vote for the top three evidence themes that would be discussed at their local, in-person, or virtual dialogue. This survey aimed to:

- prioritize the evidence themes identified in the environmental scan;
- narrow the focus of the discussion; and
- identify regional variations.

At each in-person dialogue, the Sharing Together team facilitated table discussions to identify participants' evidence needs. These discussions included the three themes selected through the pre-dialogue online survey. To allow for diverse group discussions, seating was pre-assigned, so that each table reflected a mix of stakeholder groups and sectors. Each table discussed the following:

- Issues or topics about which they needed more evidence to better do their work or navigate the system; and
- Evidence needed to advance equity for marginalized populations.

Participants were also asked to provide information, resources, or initiatives that they are aware of that might address the specific evidence needs identified during the discussion.

At the end of their discussion, each table selected their top two evidence needs for each evidence theme based on the following criteria:

- Evidence that would be most helpful to address issues they faced at work or when navigating the system; and
- Evidence they needed to support current priorities in Ontario's mental health, substance use, and addictions system.

Each table then shared their top two evidence needs for each theme with the rest of the dialogue participants. Finally, participants were asked to review the top evidence needs identified by all the tables and to vote using a "dotmocracy prioritization" exercise to identify their top two evidence needs for each theme.

Dialogue Participants

There were 236 participants from nine stakeholder groups representing:

- agency leadership;
- direct service providers;
- family members and caregivers;
- knowledge brokers/implementation staff;
- persons with lived experience;
- policymakers;
- researchers/research staff;
- system planners; and
- others, such as advocates, policy analysts, physicians, students, family workers, program managers, and data specialists.

Participants worked in or were linked to 17 different sectors. The five most represented sectors were community mental health and addictions, hospital mental health and addictions, public health, and research/academia, and other (for example, children's social services, services for individuals with HIV/AIDS, health services for trans people, compassionate care and support services, and services for people experiencing gender-based violence).

Dialogue Analysis

For each dialogue, the Sharing Together team analyzed the top five evidence needs for each theme that participants identified in the "dotmocracy prioritization" exercise. The team also reviewed participants' and facilitators' discussion notes to extract supporting information and add context. Results of our analysis of each dialogue are available on the Sharing Together page of the EENet website.

Step 3. Online Survey

Survey objectives

Based on our analysis of the stakeholder dialogues, we developed an online survey for provincial stakeholders to:

- further prioritize the evidence needs identified during the dialogues; and
- solicit the input of stakeholders who were not able to attend the dialogues.

Survey Process

This survey was developed based on the top five evidence needs for each theme, identified from each of the stakeholder dialogues in Step 2. The Sharing Together team combined similar evidence needs to prevent duplication, as well as the results from different regions so that the survey would better reflect overall provincial priorities. When more context was needed, the team consulted the dialogue participants' and facilitators' discussion notes. The list of evidence needs included in the survey is available in Appendix E.

We sent the survey by email to the same stakeholder groups who received invitations to the dialogues, and asked them to share it with their networks. We shared our call for participation through:

- EENet's website, e-newsletter, and online community (EENet Connect);
- the EENet Steering Committee;
- the EENet Persons with Lived Experience and Family Member Advisory Panel;
- partner networks; and
- broader CAMH networks.

We encouraged stakeholders to disseminate the invitation to their networks.

Survey respondents selected their top two evidence needs in each of the 10 themes that they felt, if addressed, would help them better do their work or navigate the mental health, substance use, and addictions system. The survey gave respondents the opportunity to share additional thoughts and suggestions.

Note: While some dialogue participants identified various needs related to capacity building and workforce development, we did not include these in the survey to keep the focus on evidence needs. These are highlighted separately in the report.

Survey Participants

The survey was completed by 317 stakeholders. Of these, nine were completed in French. Appendix F shows a breakdown of the stakeholder groups, sectors, marginalized populations, and geographical diversity of survey respondents.

Step 4. Creating the Evidence Priority Agenda

The evidence priority agenda is a synthesis of information gathered throughout the Sharing Together process (environmental scan, the stakeholder dialogues, and the online survey). A summary of each evidence need was developed through an analysis and synthesis of stakeholder input from the dialogues.

The draft evidence priority agenda was reviewed by the EENet Steering Committee and the EENet Persons with Lived Experience and Family Members Advisory Panel. The EENet Steering Committee consists of members of provincial and national organizations, persons with lived experience, service providers, system planners, policymakers, and researchers. It was convened in 2011 to guide the work of EENet to strategically align with the system. The EENet Persons with Lived Experience and Family Members Advisory Panel was also convened in 2011. Its members provide their expertise and lived experience as a form of evidence to EENet, and other initiatives that are working to improve Ontario's mental health, substance use, and addictions system.

The evidence priority agenda includes:

- evidence themes (from the environmental scan);
- prioritized evidence themes (from the dialogues);
- priority evidence needs for each of the 10 evidence themes (from the dialogues and survey);
- capacity-building and workforce development needs (from the dialogues); and
- next steps.

Limitations of the Sharing Together Process

While the Sharing Together process aimed to include diverse perspectives, there were some challenges. Because the dialogues were in-person events, we had fewer participants from rural and remote locations. Although there were dialogues held in different parts of the province, it is unlikely that the final evidence priority agenda reflects the full breadth of evidence needs from across Ontario. The Sharing Together process was instead intended to capture a "snapshot" of stakeholder evidence needs from across the province.

Persons with lived experience, family members, and caregivers were also underrepresented at some of the dialogues. Some dialogues only had one individual identify as a person with lived experience, a family member, or a caregiver, while a small number of dialogues included several participants. Also, the only French dialogue took place in Ottawa, and as such, does not capture the perspectives of Francophones living and working in other regions of Ontario.

A few Sharing Together facilitators noted that participants initially had difficulty with the concept of an "evidence need," but that they generally came to a stronger understanding and provided more contributions as the dialogue went on. In addition, a few participants expressed concern related to the pace of the prioritization process at the dialogues. Similarly, survey participants noted that for various reasons it was difficult to prioritize only two evidence needs in cases where more than two needs were important and several needs were related to each other.

In spite of these limitations, feedback from dialogue participants was largely positive. Most indicated that meaningful discussions took place, and many expressed strong interest in hearing about the outcomes in their region and across the province. Importantly, they were interested in the follow-up actions to Sharing Together.

C. Evidence Themes

The following table outlines the evidence themes and a summary of the needs that were identified based on a scan of priority-setting documents for the mental health, substance use, and addictions system. A total of 51 documents were reviewed, which are available on the Sharing Together page of the EENet website. More information on the environmental scan is available in Appendix B.

Evidence theme	Summary of evidence needs identified in the literature
Access to services	• Understanding factors affecting access to care, including equitable access and services for different groups; and • Identifying and implementing coordinated access models and evidence-based tools; monitoring performance and collecting data related to access to services in different communities (such as rural, remote, Indigenous peoples, and linguistic minority groups).
Capacity building and workforce development to improve service delivery	• How to increase knowledge and capacity through education, training, and resources for service providers, primary care clinicians, and public health professionals.
Children and youth, including transition-age youth	• Using evidence to inform collaborative efforts to improve efficiency and effectiveness of child and youth programs, including transitions from one service to another and from youth systems to adult systems, across sectors.
Collection and use of data	• Approaches to better understand trends, with an emphasis on collecting and linking descriptive data, population-level data, and indicators across organizations, geographic boundaries, systems, and sectors.
Continuum of housing and homelessness	• Policies and evidence-based programs pertaining to the housing continuum; • Specific evidence needs related to cost efficiency and prevention strategies and supports; • Developing standardized tools and assessments to match health, housing, and employment resources; and • Positive and negative impacts of different approaches to housing.
Culturally safe and competent care that reflects cultural knowledge	• Evidence-informed interventions that are accessible, holistic, inclusive, culturally safe, and culturally competent; and • How to increase capacity of service providers to provide culturally competent care to diverse groups.
Effectiveness of services	• Program evaluation models, including treatment outcomes and indicators; • Quality improvement approaches; and • Strategies to measure and evaluate the performance of existing programs.

C. Evidence Themes (continued)

Harm reduction	• Efficacy and expansion of harm reduction approaches as well as education and prevention initiatives.
Integrated healthcare	• Innovative and integrated approaches to treating co-occurring conditions (including co-occurrence among mental illnesses, between mental illness and/or substance use, and physical illness); • Approaches to integrate services across settings and sectors, for example, mental health and primary care; and • Impacts on services and client outcomes.
Prevention and promotion, including suicide prevention	• How to develop a common understanding and language of prevention and promotion; • Evidence-informed guiding principles and measurable strategies across sectors; and • How to expand effective interventions across the lifespan and in different settings (for example, workplace).
Nutrition	• Gaps and barriers to a healthy diet; • Dissemination of knowledge to inform policy and increase food literacy; and • Effective models of care to address nutrition and mental health needs.
Older adults	• Clinical services and models of care for older adults; and • Increasing available information to support older adults, particularly related to promotion and prevention.
Opioids	• Evidence-based pain management guidelines for clinical practice and community-based services; and • Education for clients, service providers, and the public to increase awareness.
Problem gambling	• How to implement and evaluate evidence-based prevention and treatment initiatives; and • Increasing awareness of resources and services for problem gambling.
Recovery-focused service delivery	• Development and implementation of best practices across sectors to support recovery models.
Specialty psychiatric hospital services	• Application of data and standards to improve psychiatric services in hospital settings.
Standardized care	• Standardized screening and assessment tools, evidence-based standards, care pathways, and core services.

C. Evidence Themes (continued)

Stigma and discrimination	• Increasing awareness related to stigma; and • Implementing and evaluating existing programs to reduce stigma and discrimination.
Supporting the voice of persons with lived experience, family members, and caregivers	• Building capacity to meaningfully involve persons with lived experience, families, and caregivers in leadership and decision-making to support delivery of appropriate and equitable services and policy, as well as data to identify unique experiences of those who receive services, their families and caregivers.
The intersection of criminal justice and mental health	• Effective interventions to reduce contact with the justice system; • Effective screening, services, treatments, and supports for individuals who are in the justice system; and • Training and education for community mental health agencies and all staff in the criminal justice system.
Trauma-informed care	• Information, services, and guidelines for trauma-informed care for specific populations.

D. In-person Dialogue Participant Demographics

Figure 2. Participants by stakeholder group (participants selected all that apply)

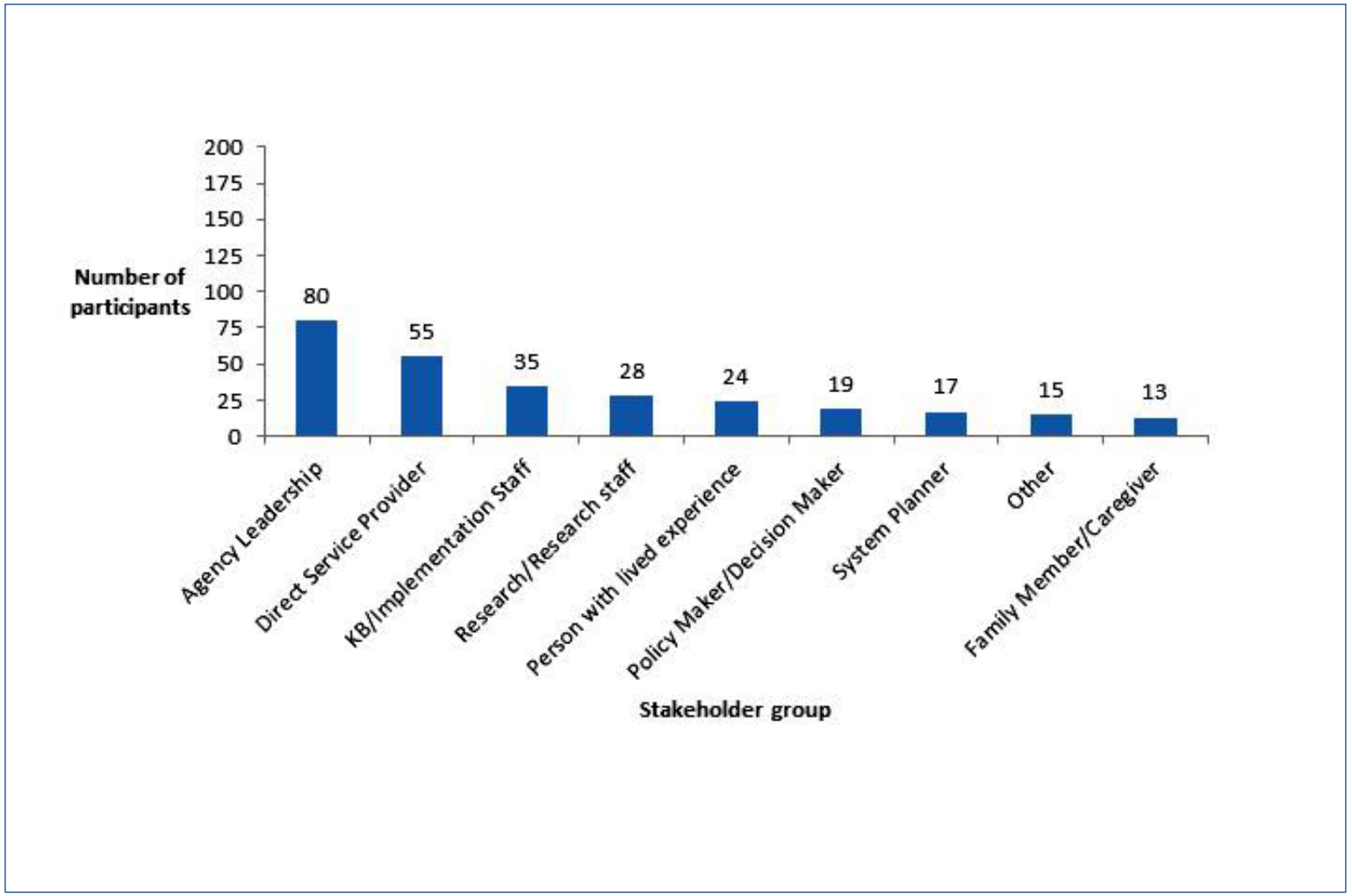


Figure 3. Participants by sector (participants selected all that apply)

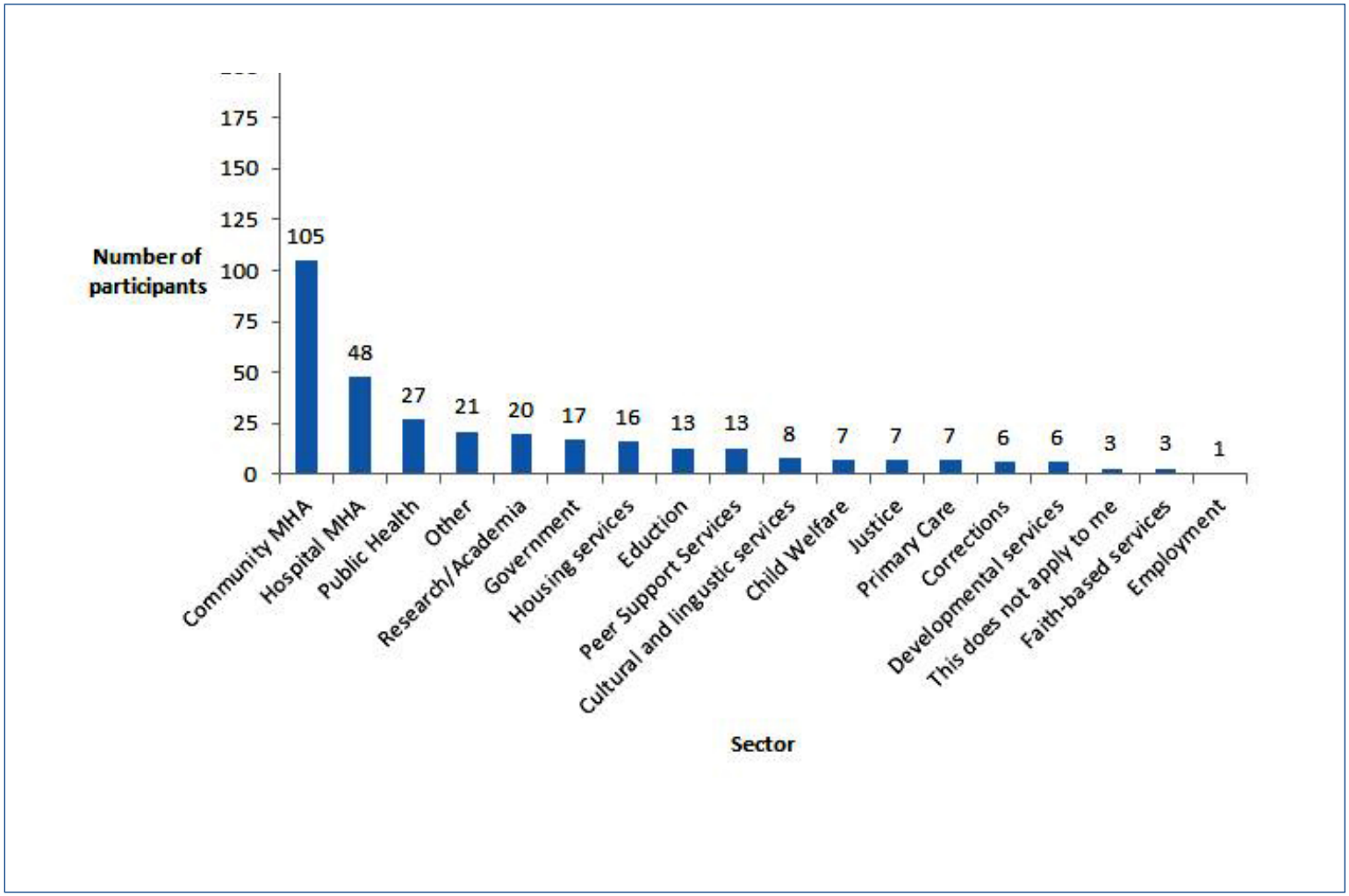


Figure 4. Participants representing marginalized populations (participants selected all that apply)

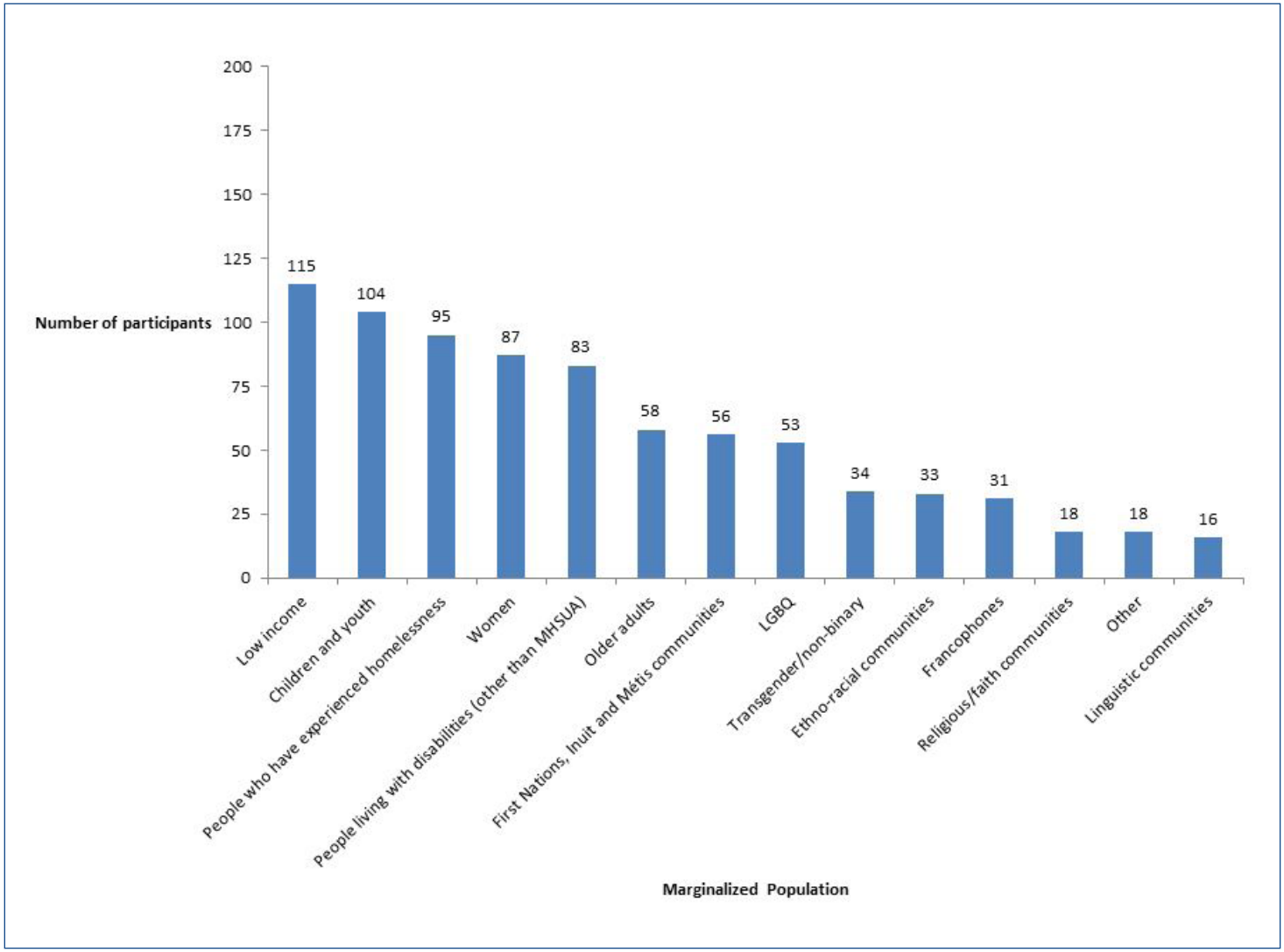
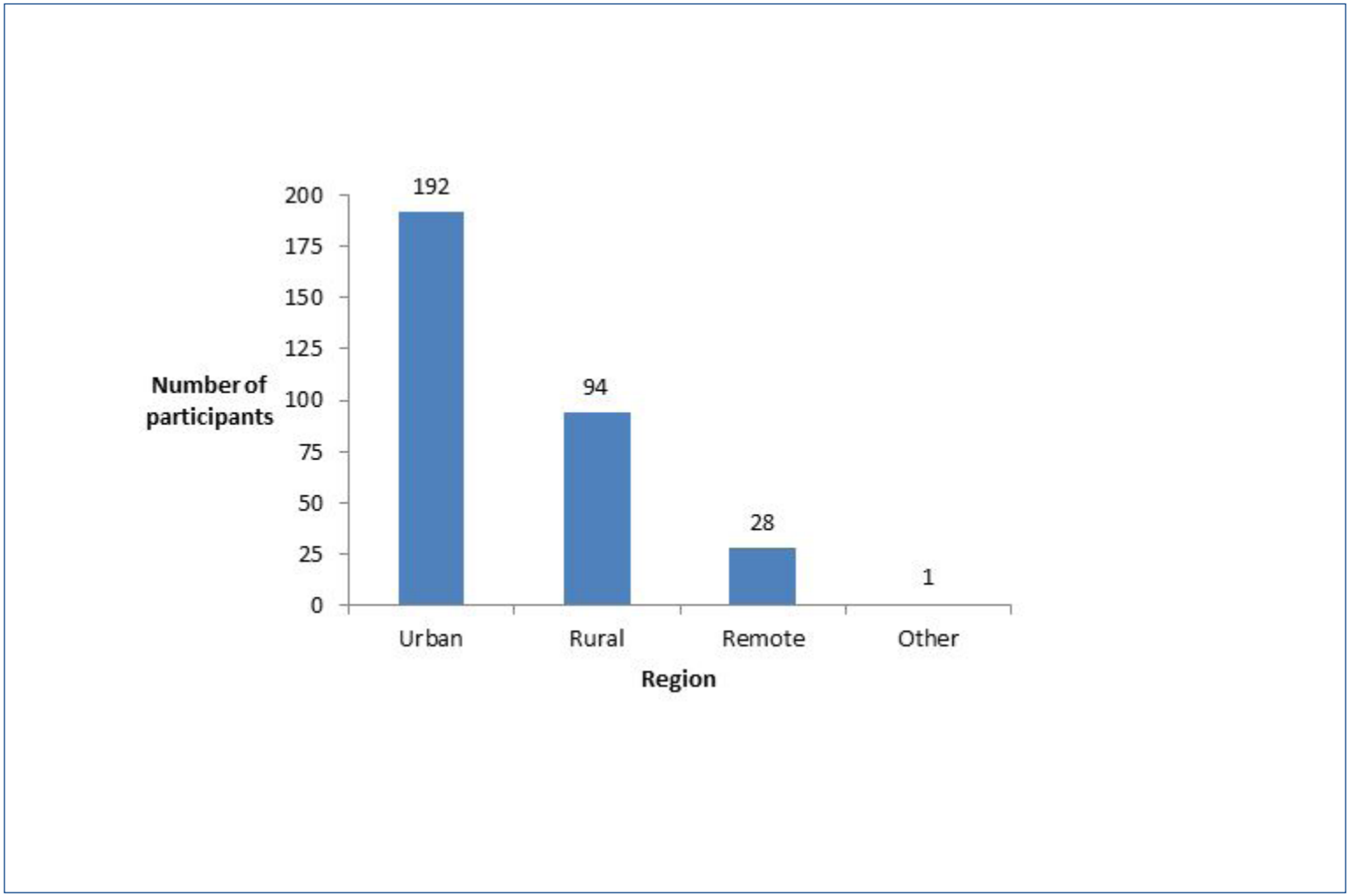


Figure 5. Participants from urban, rural, and remote regions (participants selected all that apply)



E. Sharing Together Online Survey

Welcome!

Welcome to the Sharing Together online survey! This survey is for anyone who would like to have a say in co-creating an evidence priority agenda for Ontario's mental health, substance use, and addictions system.

Even if you already participated in one of the Sharing Together dialogues, you are welcome to provide more feedback here. If you were not able to attend, this is your chance to contribute.

What is Sharing Together?

Sharing Together is an initiative of the Evidence Exchange Network (EENet) that aims to identify the priority evidence needs of diverse stakeholders and sectors across Ontario's mental health, substance use, and addictions system. Through Sharing Together, EENet is facilitating the co-creation of an evidence priority agenda, which will outline areas of opportunity and need, which can be supported by access to and use of evidence. The results of this process will allow EENet and potential partners to make evidence in these areas more accessible to stakeholders of the system.

What has already happened?

Earlier this year, EENet hosted eight Sharing Together in-person and online dialogues across Ontario with stakeholders in multiple sectors. Participants included service providers, system planners, persons with lived experience, Local Health Integration Network planners, and caregivers. At each dialogue, participants identified specific evidence needs that would help them better do their work or navigate the system.

How does this survey fit into the larger Sharing Together process?

This survey gives you the opportunity to further prioritize the evidence needs already identified. It asks you to review statements describing those evidence needs already identified during the dialogues and let us know which ones you feel are a priority. The survey also asks you to provide additional feedback and share information about your role in the system. It should take approximately 10-15 minutes to complete.

Staff in the Provincial System Support Program at CAMH will analyze the data and use the survey results to develop an evidence priority agenda for Ontario's mental health, substance use, and addictions system. Most importantly, it will help us respond to your evidence needs.

Your participation is voluntary. If you have any questions about this survey, please contact **Angela.Yip@camh.ca or Alexandra.Harrison@camh.ca.**

If you agree to participate, please click on the 'Next' button below to get started.

Thanks for agreeing to participate! You will be shown 10 pages with statements describing evidence needs identified by stakeholders during the Sharing Together dialogues. The statements are grouped into the 10 themes that were identified and discussed in the dialogues:

- Access to services
- Children and youth, including transition-age youth
- Continuum of housing and homelessness
- Culturally safe and competent care that reflects cultural knowledge
- Effectiveness of services
- Harm reduction
- Integrated healthcare
- Prevention and promotion, including suicide prevention
- Standardization of care
- Supporting the voice of persons with lived experience and caregivers

We would like you to identify which are your top evidence needs, based on what will help you to better do your work or navigate the system. You will be asked to select up to two statements per theme.

Note that some themes contain more evidence needs than others, due to the varied discussions that took place at each of the dialogues. You will have an opportunity to provide additional thoughts or suggestions on evidence priorities later in the survey.

These are the evidence needs for this theme that emerged from the dialogues. Please select up to two evidence needs that you feel are priorities in Ontario's mental health, substance use and addictions system. [limit to 2]

1. From your perspective, evidence is most needed on:
   - ☐ Evidence need 1
   - ☐ Evidence need 2
   - ☐ Evidence need 3
   - ☐ Evidence need 4
   - ☐ Evidence need 5
   - ☐ None of these evidence needs are priorities.

Please share any additional thoughts or suggestions on evidence priorities here?

Background information

1. Which stakeholder group best represents you? (choose all that apply)
2. What sector do you work in? (choose all that apply)
3. Which type of community/communities are you based in for your work or receive services from? (choose all that apply)
4. Do you have expertise on the issues affecting the following populations (based on lived experience, work experience or both)?
5. In which Local Health Integration Network (LHIN) area do you primarily work or receive services from?
   (To find out which you are in, click here.)

Thank you for completing this survey and helping EENet to co-create an evidence priority agenda for Ontario!

Please remember to share the link with your networks! This survey closes on Friday August 11th, 2017.

For more information, next steps and resources on the regional evidence priorities identified at the dialogues, visit http://www.eenet.ca/initiative/sharing-together#about or contact Angela Yip at **angela.yip@camh.ca** or Alexandra Harrison at a**lexandra.harrison@camh.ca.**

Please click 'Done' to complete the survey.

Evidence Needs in the survey:

Access to Services

- ☐ How to engage individuals in service delivery who are hard to reach (such as those from marginalized populations and rural communities)
- ☐ Barriers to access for marginalized groups, rural and remote communities, and Francophone populations
- ☐ Core components of effective transitions and how to adapt these for different communities and populations for better access to services
- ☐ Effectiveness of virtual care to enhance access to services
- ☐ How to improve access to services for individuals with more than one service need
- ☐ Effective service delivery models with centralized access and central intake
- ☐ Use of standardized demographic indicators to support access to appropriate services
- ☐ System navigation models that support service users and families to access care
- ☐ Unmet service needs, and regional and provincial waitlist data
- ☐ Waitlist management strategies, including effective interim supports for individuals on waitlists

Children and Youth, including Transition-Aged Youth

- ☐ Effective access pathways for youth, including formal processes and tools
- ☐ Developmentally-appropriate services for transition-age youth
- ☐ How to balance the needs of youth with lived experience with those of their families/caregivers
- ☐ How to best support vulnerable and at-risk youth, including youth in northern communities
- ☐ How to increase coordination and collaboration between youth-serving and primary care providers
- ☐ Strength-based and trauma-informed interventions for children and youth that integrate mental health, substance use, and addictions

Continuum of Housing and Homelessness

- ☐ Local needs related to housing models and services, including data on available housing stock
- ☐ Effectiveness of different approaches across the continuum of housing and homelessness
- ☐ Standards for different housing models, including shelters
- ☐ Transitional housing models and services for different populations

Culturally competent and safe care

- ☐ How to define culturally safe and culturally competent care in service delivery
- ☐ Cultural safety standards and common assessment tools to measure cultural competence in organizations
- ☐ How to provide core services that are accessible, culturally safe, and trauma-informed
- ☐ How to build awareness of existing local resources to support cultural competence

Effectiveness of Services

- ☐ Core competencies related to providing person-centered care
- ☐ Data-sharing models between services
- ☐ How to address service provider burnout and compassion fatigue at organizational and system levels
- ☐ How to define effectiveness of services from the perspective of service users, families, and caregivers
- ☐ How to make current perception of care tools easier to access, use, and share
- ☐ Outcomes of current services offered in French in Ontario

Harm Reduction

- ☐ Approaches for treating opioid dependence in rural and remote communities
- ☐ Culturally appropriate harm reduction approaches
- ☐ How to integrate harm reduction approaches into the corrections and justice systems
- ☐ Outcomes of local harm reduction programs and services, including who is accessing available services
- ☐ Safe consumption sites for substances other than opioids
- ☐ Spectrum of effective harm reduction approaches for harmful behaviours (for example, self-injury), substance use, and other types of addictions (for example, problem gambling)
- ☐ How to reduce stigma and increase awareness around harm reduction

Integrated Health Care Services

- ☐ Approaches for developing integrated service hubs
- ☐ Best practices, protocols, and policies that increase collaboration and information sharing between service providers
- ☐ Components of integrated referral systems and in what settings they are most effective
- ☐ Core elements of integrated health services
- ☐ How to effectively integrate health care and non-health care services
- ☐ Impact of integrated team functioning on service delivery and quality of care
- ☐ Integrated health care approaches for rural, underserviced areas, and marginalized populations
- ☐ Outcomes of current integrated healthcare systems in Ontario

Prevention and Promotion, including suicide prevention

- ☐ Coordinated mental health, substance use, and addictions prevention and promotion strategies, across the lifespan
- ☐ Early identification and intervention best practices to encourage earlier access to services
- ☐ Factors related to increasing resilience in marginalized populations
- ☐ Outcomes of current mental health prevention, promotion, and early intervention programs and educational resources
- ☐ School-based interventions for prevention, promotion, and early intervention (including suicide prevention)
- ☐ Service delivery models for integrated mental health and addictions prevention and promotion

Supporting the voice of persons with lived experience

- ☐ Barriers to integrating the voice of lived experience into service delivery and policy development
- ☐ Community-based research models that can effectively inform policy and include peer researchers
- ☐ How to effectively and meaningfully engage persons with lived experience, family members, and caregivers in decision making
- ☐ Outcomes of integrating persons with lived experiences, families, and caregivers in organizational processes and system-level initiatives
- ☐ Peer support models and other strategies informed by service users that build trust, and address stigma
- ☐ How to increase awareness of the different pathways to recovery

Standardized Care

- ☐ Factors that make standardized care effective, efficient, and appropriate
- ☐ How to effectively implement standardized, structured psychotherapy across Ontario
- ☐ Standard indicators and measurement criteria for service and system level data, supported by a central data platform
- ☐ Standardized care pathways (for example, acute care to community or primary care to specialty)

F. Demographics of Online Survey Respondents

Figure 6. Participants by stakeholder group (participants selected all that apply)

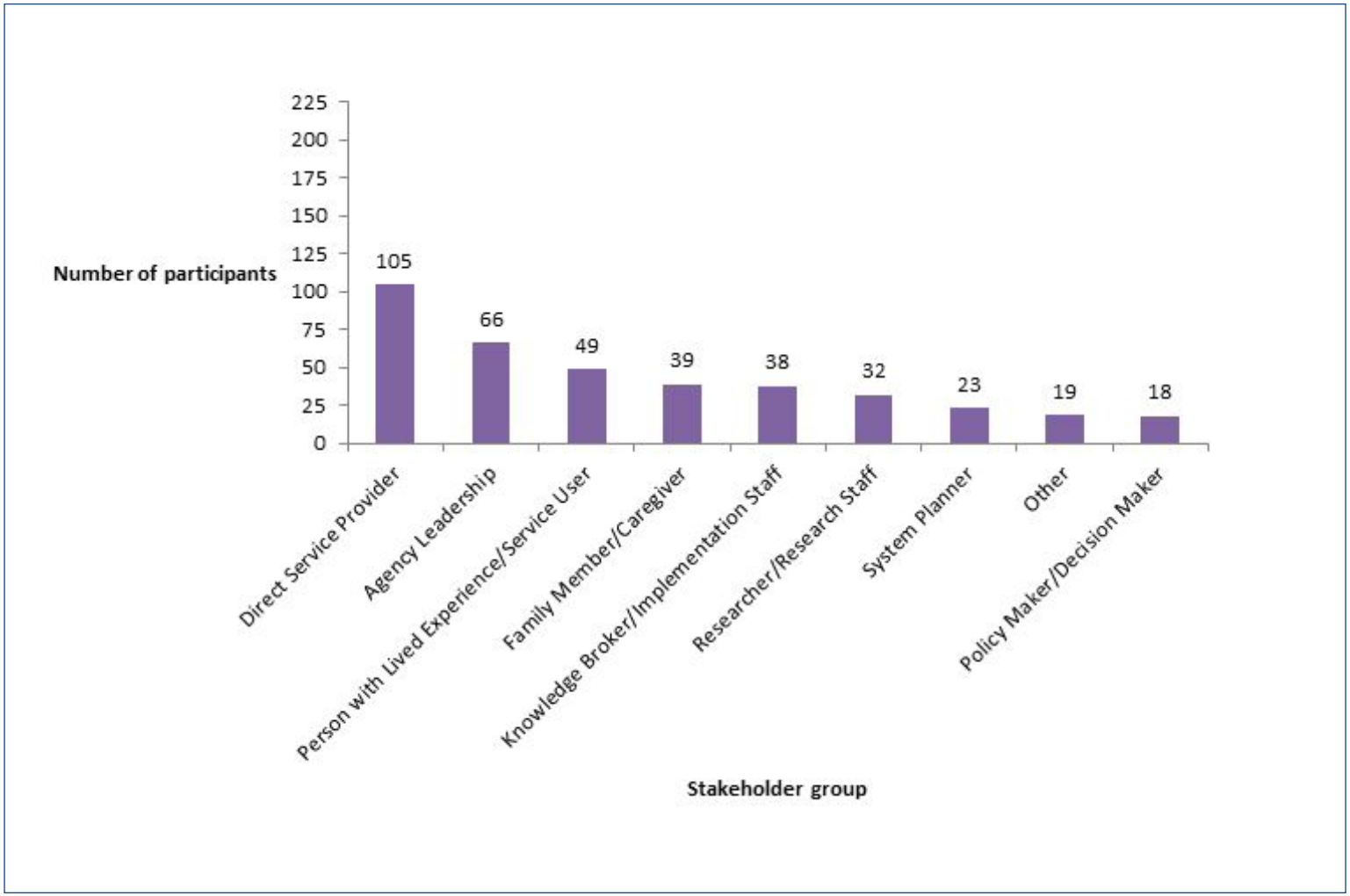


Figure 7. Participants by sector (participants selected all that apply)

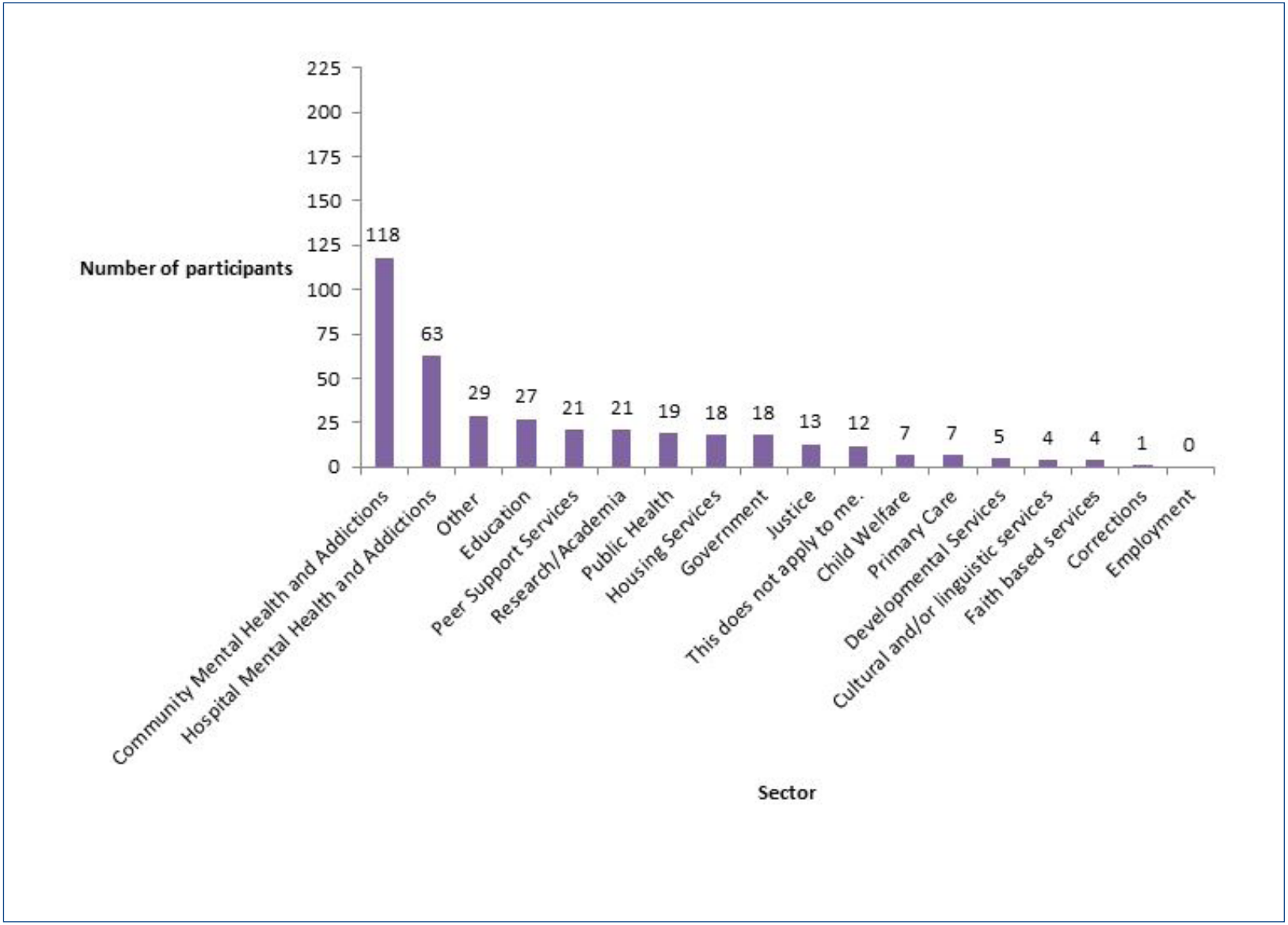


Figure 8. Participants representing marginalized populations (participants selected all that apply)

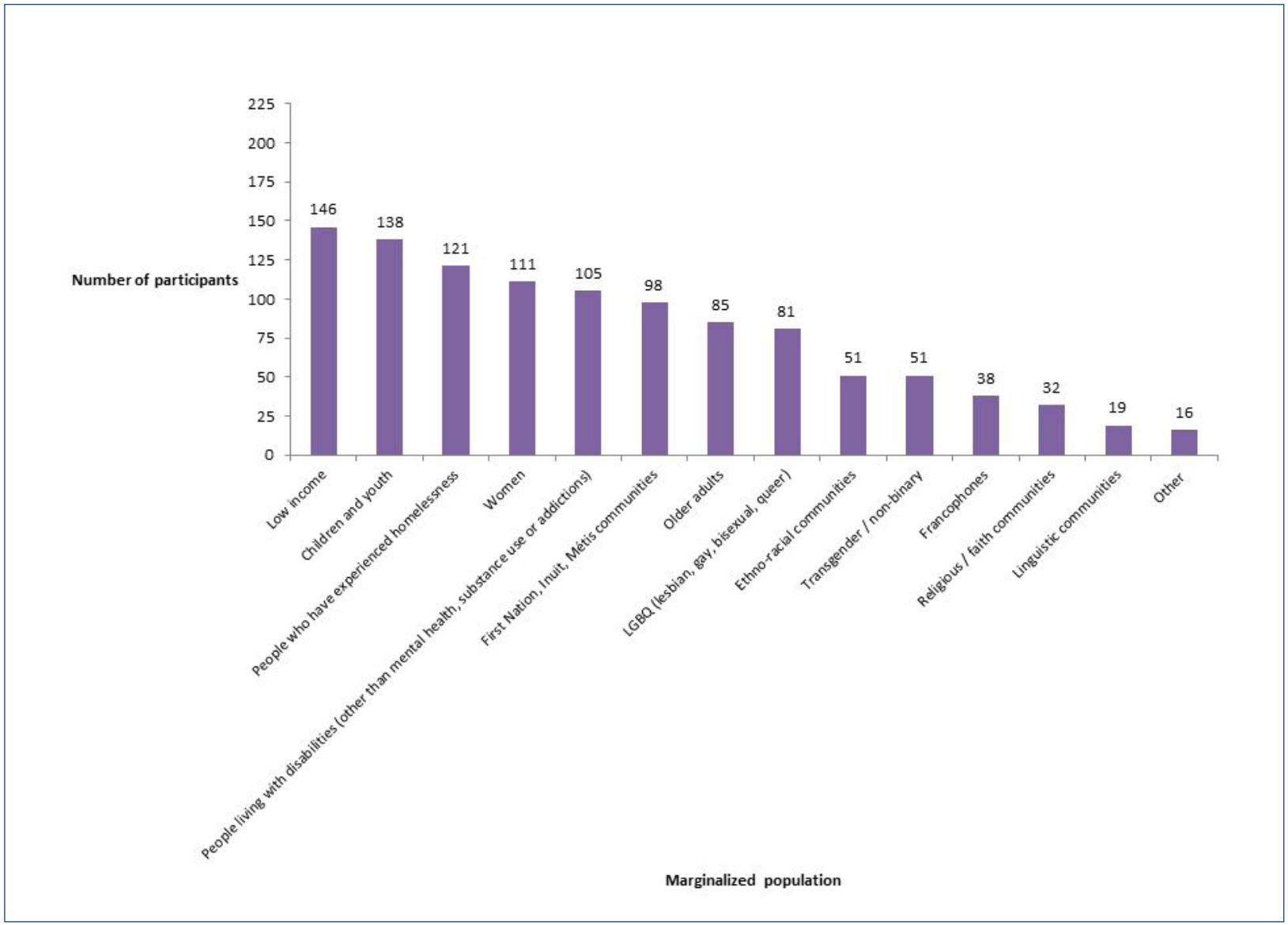


Figure 9. Participants from urban, rural, remote regions (participants selected all that apply

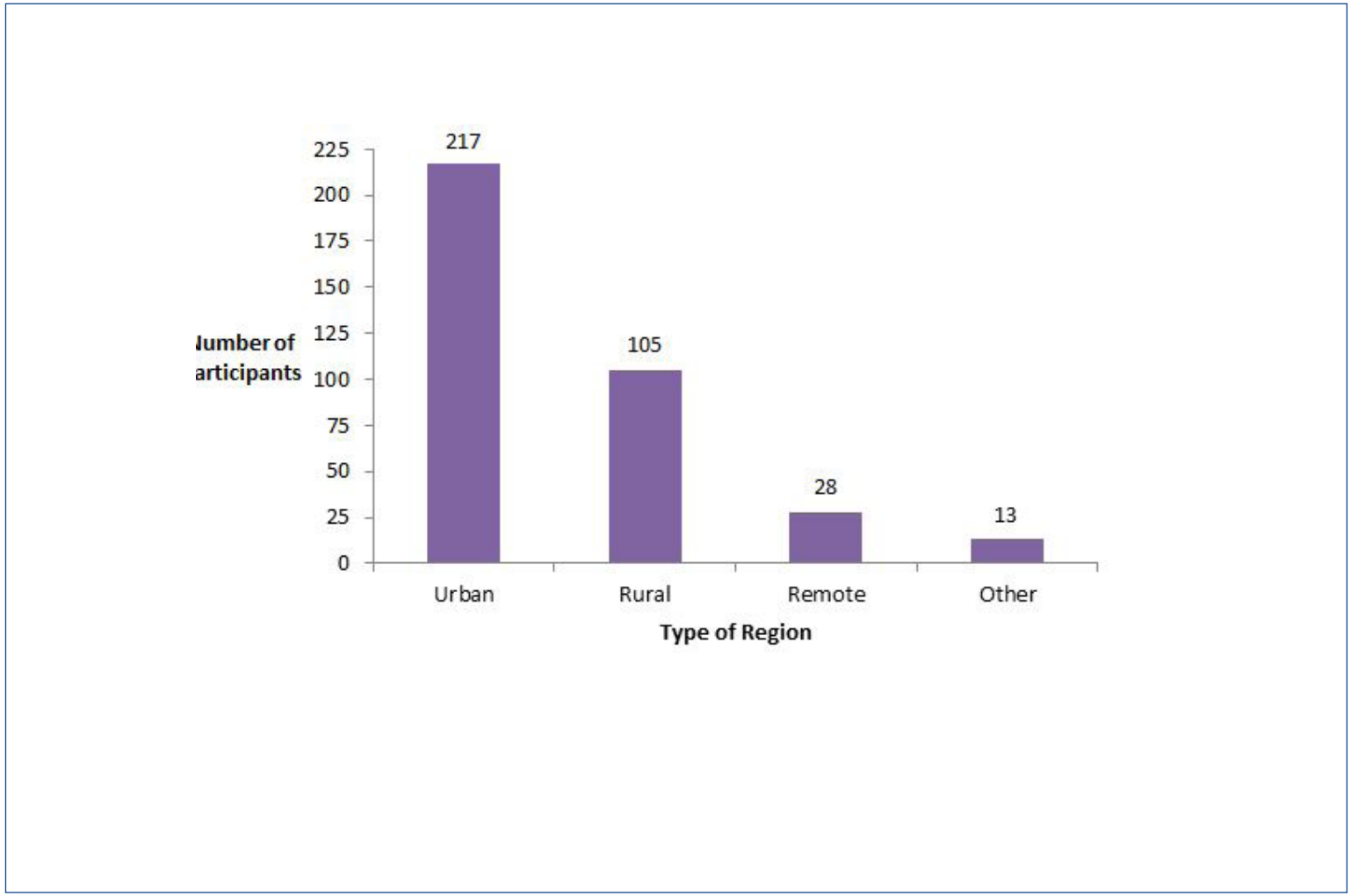


Figure 10. Participants by Local Health Integration Network (LHIN)