# Advancing Equity in the Ontario Structured Psychotherapy (OSP) Program

## Guidance on Developing a Priority Population Approach for Network Lead Organizations

**May 2025**

## A Message from the OSP Health Equity Task Group Chair

On behalf of the Health Equity Task Group (HETG), I am pleased to share with you *Advancing Equity in the Ontario Structured Psychotherapy (OSP) Program: Guidance on Developing a Priority Population Approach for Network Lead Organizations.* This document represents the collective wisdom, experience, and commitment of leaders across the province who are working to ensure that mental health care is equitable and accessible to all Ontarians.

The OSP Health Equity Task Group (HETG) was refreshed in 2024 to help action the recommendations outlined in the 2023 report titled Recommended Health Equity (HE) priorities for the Ontario Structured Psychotherapy program. In response, this guidance was developed to support Network Lead Organizations (NLOs) in indetifying, planning, and implementing strategies to better serve populations facing systemic barriers to quality care.

I would like to thank the members of the HETG for bringing their diverse skills, knowledge, expertise, and deep commitment to equity to this collaborative effort. This guidance would not be possible without your thoughtful contributions. I would also like to acknowledge the PSSP team at CAMH who provided secretariat support to the HETG and played a key role in the development of this guidance. Special thanks as well to the Mental Health and Addictions Centre of Excellence at Ontario Health for their ongoing support and direction, and to all the NLOs who participated in consultations and generously shared their insights, experiences, and local practices.

Advancing equity is not a one-time intiative, but a sustained and evolving process that requires intention, humility, shared responsibility, and accountability. This guidance is intended to support NLOs at all stages, whether they are just beginning work with priority populations or building on existing efforts. It offers a flexible framework, rooted in health equity principles, to help NLOs take meaningful, context-specific action.

By continuing to share learnings, collaborating with communities, and centering those most impacted by inequities, we can collectively build a more inclusive mental health system, with better health outcomes for all Ontarians.

Sincerely,

Aseefa Sarang

Chair, OSP Health Equity Task Group
Executive Director, Across Boundaries

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## Executive Summary

This guidance, developed in partnership with the Ontario Structured Psychotherapy (OSP) Health Equity Task Group, provides practical guidance for Network Lead Organizations (NLOs) to better meet the needs of priority populations within their region. Priority populations are communities who are at a higher risk of poor mental health outcomes, experience additional barriers to accessing services, and/or experience structural marginalization within the healthcare system. Populations identified for OSP include (but are not limited to) the following groups:

- People without access to healthcare benefits and those living on a low income
- People who are Black, Indigenous and other people of colour
- Francophones
- People who identify as 2SLGBTQ+
- People living with disabilities
- People living in remote areas.

This guidance outlines a four-phase process that NLOs can use to develop, implement, and monitor their own priority populations approach. While presented in a linear format, these phases do not need to be completed in order and may be conducted in parallel or revisited as needed, depending on the previous work completed by NLOs, as well as their resources and capacity.

1. **Conducting a Needs Assessment and Selecting a Population of Focus (PoF):**

NLOs begin by identifying regional health needs through developing community profiles, analyzing internal OSP data, and engagement with local partners. This phase supports the selection of one or two initial PoFs using a mix of quantitative data, experiential data, and intersectional considerations.

2. **Assessing Current State and Desired Impact:**

NLOs assess existing capacity, partnerships, and gaps in services to understand their current state. Using a logic model, they define measureable short-, medium-, and long-term outcomes that align with the needs of their selected PoF(s).

3. **Planning and Implementation:**

NLOs develop a workplan outlining tailored activities, roles, and timelines. Activities are co-developed with partners where possible, and are responsive to the unique context of each region.

4. **Progress Monitoring:**

NLOs track outputs and outcomes using both quantitative and qualitative indicators to assess whether their efforts are achieving their desired impacts.

Recognizing that each region has its own unique context, this guidance is not meant to prescribe a one-size-fits-all approach. Instead, it offers a flexible framework and a series of tools that NLOs can adapt to meet the specific needs of the communities that make up their region. Grounded in health equity principles, this approach supports accountability and works towards creating a more inclusive, accessible, and effective program for all Ontarians.

## Glossary

**Eligible Population:** The broadest group of people who meet the clinical inclusion criteria for a clinical service.

**Priority Population:** Smaller sub-groups of the eligible population, identified because they are at higher risk of poor health outcomes, experience additional barriers to access, and/or experience structural marginalization within the healthcare system.

**Population of Focus (PoF):** A specific priority population, a sub-group of a priority population, or a community that intersects across multiple priority populations, that has been identified to receive additional resource allocation for a set amount of time.

**Intersectionality:** The way in which multiple aspects of a person's identity, such as race, gender, class, sexual orientation, disability, etc., intersect and interact to create unique experiences of advantage and disadvantage. First introduced by Kimberlé Crenshaw, intersectionality recognizes that individuals may face overlapping and compounded forms of disadvantage or discrimination that cannot be fully understood through a single-axis lens (eg, race or gender alone). Applying an intersectional lens means considering the complexity of how structural inequities impact mental health outcomes and access to care for people who hold multiple marginalized identities.[1]

**People with Lived and Living Experience (PWLLE):** people who hold experiential knowledge and expertise of living with mental health, substance use, and/or addiction challenges.

**Needs Assessment:** A structured approach to analyzing community needs and service gaps.

**Community Profile:** A data-informed snapshot of a region's demographics and access to the social determinants of health, used to inform decision-making.

**Logic Model:** A visual tool, originating from program planning and evaluation, that outlines a sequence of actions intended to bring about a specific change in a population. This tool links inputs, activities, outputs, and outcomes.

**Inputs:** The resources (eg, funding, staff, partnerships, etc.) invested into PoF-related work.

**Activities:** The specific actions of an intervention implemented to meet the needs of PoF(s).

**Outputs:** The direct products or deliverables of activities (eg, sessions held, resources developed, etc.).

**Outcomes (Short-, Medium-, Long-Term):** The intended changes or impacts resulting from activities, ranging from knowledge to behaviour to population-level health improvements.

**Indicators:** Measures used to track whether activities are achieving the desired outputs and outcomes.

**Progress Monitoring:** An ongoing and systematic process of assessing whether efforts are having the intended impacts. It involves regularly collecting and reviewing data for selected indicators to assess progress, identify challenges, and inform continuous improvement.

**Program Evaluation:** A more in-depth, systematic assessment of a program's value, effectiveness, and impact. It explores not just whether outcomes were achieved, but how and why, to inform decision-making, accountability, and future planning.

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# Advancing Equity in the Ontario Structured Psychotherapy (OSP) Program

### Guidance on Developing a Priority Population Approach for Network Lead Organizations

## Context

The vision of the OSP Program is to make publicly-funded, evidence-based psychotherapy and related approaches available to people across Ontario with depression, anxiety, and anxiety-related conditions. The program's services will be tailored to meet the needs of the populations it serves in communities across the province. This includes ensuring that all Ontarians with these conditions, including priority populations, are able to access the program and experience improved mental health outcomes.

Priority populations within OSP have been identified because these groups have a higher risk of poor mental health outcomes or they experience additional barriers to accessing care. These specific populations include (but are not limited to):

- People without access to healthcare benefits and those living on a low income
- People who are Black, Indigenous and other people of colour
- Francophones
- People who identify as 2SLGBTQ+
- People living with disabilities
- People living in remote areas.

This guidance has been developed in partnership with the OSP Health Equity Task Group with the goal of supporting NLOs in meeting the needs of priority populations within their regions as well as setting out clear accountability expectations.

## Why Priority Populations?

Priority populations are integral to a population health approach that aims to reduce the health gap between those who are the most and least healthy.[2] Health is not evenly distributed across populations, as certain groups experience greater health inequities due to experiences of marginalization and the social determinants of health.[2] As such, a priority population approach within OSP can serve as a mechanism for advancing health equity in program planning and delivery.

It is also critical to consider intersectionality within any priority population approach. Often, approaches focus on a single experience of oppression or disadvantage without adequately capturing the intersectional nature of structural marginalization. Work with priority populations in OSP should be flexible enough to address the needs of those who may fall under multiple priority populations.

Identifying and defining priority populations allows us to better meet the needs of the communities that make up Ontario by:

- Giving us knowledge about the people who live in our communities and the ways in which they may be at greater risk for poor health outcomes[3]

- Allowing us to strategically balance targeted and universal approaches to service delivery[4]
- Allowing program-specific and local-level decisions to maximize the benefit and impact of our services and to meet the needs of our clients[3,4]
- Identifying areas of greatest need for resource allocation[4]
- Operationalizing action on the determinants of health.[4]

Many priority populations have been identified within OSP, and it may not be feasible to meet the needs of all groups simultaneously. The literature also indicates that the designation of a priority population is not necessarily permanent and should be reassessed over time.[5] As such, this guidance proposes that NLOs initially select one or two populations to focus on, with the long-term goal of reassessing needs at regular intervals to ensure no other communities are left behind.

## Language Defining Priority Populations

Terms defining priority populations are often used interchangeably within the literature and in practice. Based on a review of the literature, the following definitions have been developed for use in the context of OSP:

> **Eligible population:** This refers to the broadest group of people who meet the clinical inclusion criteria for the service. For OSP, this would cover "people across Ontario with depression, and anxiety-related conditions."
>
> **Priority population(s):** Smaller subgroups of the eligible population, identified because they are at higher risk for poor health outcomes, experience additional barriers to access, and/or experience structural marginalization within the healthcare system. These have already been identified within the context of OSP and can be found listed above.
>
> **Population(s) of focus (PoF):** This term refers to a specific priority population, a subgroup of a priority population, or a community that intersects across multiple priority populations, that has been identified to receive additional resource allocation for a set amount of time within OSP. For example, an NLO may decide, based on their regional demographic data, to prioritize the creation and promotion of tailored resources that meet the cultural and linguistic needs of newcomers to Canada. PoFs should be re-evaluated regularly to see if other communities are being left behind and require additional resources and care.

In some literature, the term "target population" is used to describe specific communities of people.[2,3] This is likely because tailored or *targeted* approaches are often applied when working with these communities. "Target population" should not be used to describe specific communities of people as the term has both military and disempowering connotations.[5] Additionally, it does not adequately capture the systemic nature of injustice and oppression within health care systems and reinforces paternalistic connotations, suggesting that interventions are imposed *on* individuals or communities rather than involving them as equal participants in their own care.

## Methods

To support the development of this guidance, consultation sessions were held with all NLOs and a review of the literature on priority populations was conducted. A summary of the results from the literature review can be found here. NLO consultations provided information on current work with priority populations and PoFs more specifically. Lessons learned have been leveraged in the development of this guidance document and examples from work by NLOs have been included throughout to illustrate application of the guidance.

This guidance builds on values and principles outlined within key equity frameworks including: the First Nations Principles of Ownership, Control, Access and Possession (OCAP®), the Principles of Ethical Métis Research, the National Inuit Strategy on Research, and the Engagement, Governance, Access, and Protection (EGAP) Framework developed by Black communities.

This guidance is also informed by the Exploration, Preparation, Implementation, Sustainment (EPIS) framework, an implementation framework that provides guidance on implementing evidence-based practices in the health and public sectoral systems. NLOs that are interested in doing research as a part of their priority populations work are encouraged to further explore the EPIS framework.

## How to Use This Document

This document has been developed recognizing that all NLOs have begun work to meet the needs of different priority populations and some are further along in this process. This guidance is meant to serve as a collection of tools and resources that NLOs can use to implement their own approach to meet the needs of their PoFs, with an aim to better serve clients in their region overall. This will allow NLOs to tailor their approach to the specific needs present in their region, accounting for their unique circumstances related to time and resources available, and support NLOs in meeting requirements of accountability agreements. It provides a standardized approach to addressing the needs of priority populations across OSP.

The structure of this guidance is intended to support NLOs who have not begun any work with priority populations. It provides a scaffold for the different stages required to successfully implement a priority populations approach. NLOs that are further along in their priority population work can utilize guidance elements that are relevant to their current work.

These stages include:

1. **Needs assessment** – "what are our needs regionally and who is/are our PoF(s)?"
2. **Assessing current state and desired impact** – "what do we want to change (ie, access, treatment experience, etc.)?"
3. **Planning and implementation** – "how are we going to achieve our goals?"
4. **Progress monitoring** – "how do we know we made a difference?"

To further support NLOs in understanding how to apply this guidance, a fictional case study has been included throughout this document. NLOs can download blank versions of all templates used in the case study here.

It is important to note that there is no single correct way to create more equitable experiences for a specific PoF in OSP. This guidance is meant to provide a high-level overview and offers resources that can aid in planning and operationalizing an approach. It is not a strict how-to guide, as different regions and communities, including those with intersectional identities, will require specific approaches. NLOs will have the autonomy to use this guidance to implement an approach that fits their specific context and will enable them to report on what they are doing, why, and the impact they are having.

Additionally, this guidance document is not intended to provide detailed instructions on how to operationalize specific activities that an NLO may want to implement. For example, it does not cover how to work flexibly within Cognitive Behavioural Therapy (CBT) clinical protocols to meet the needs of a specific client group.

Finally, this guidance is meant to complement other equity work happening across OSP, including the work to support French Language Services and the Indigenous Approach program expectations. The stages of this guidance are broad to all priority populations and can be used to support planning, implementation, and monitoring of current or future programmatic equity initiatives within OSP.

# 1. Conducting a Needs Assessment and Selecting Population(s) of Focus

The first stage to advance OSP's priority populations approach at the NLO-level is to select a PoF by conducting a needs assessment. Conducting a needs assessment allows for a systematic and consistent approach to identify the health needs of local communities. Results from a needs assessment can then be used by NLOs to identify regional priorities and resource allocation that will improve health outcomes and reduce inequities for the regional population.[6]

The steps of a needs assessment outlined below will help NLOs select one or more PoFs. Depending on previous work completed at the NLO-level, some of these steps may have already been completed and a PoF selected. Nevertheless, these steps support the standardization of practice across OSP in the selection of PoFs. They can also assist NLOs in working toward the OSP goal of increasing the number of individuals, particularly those from priority populations, receiving services, while ensuring quality care and health equity within OSP.

When selecting a PoF, it is important to underscore intersectionality. This guidance offers an approach to standardize processes, while acknowledging that tension can arise when trying to adopt an intersectional approach. When selecting a PoF, it is critical for NLOs to remain flexible and ensure that they can address the needs of those who fall under multiple priority populations. Individual clients will always have unique experiences, however, if activities can be implemented with intersectionality in mind, it will lead to better outcomes for clients.

The following steps are proposed to conduct a needs assessment so that NLOs can better understand which communities and interest-holders make up their region, and prioritize PoF(s) based on their regional demographics and needs. While organized in a linear way within this document, an NLO may want to approach these steps in a different order or simultaneously. It is also possible that completing one step may lead to needing to revisit a previous one. The steps to conduct a needs assessment are:

1.1 Create or update a community profile
1.2 Analyze NLO-level data
1.3 Identify key Mental Health and Addictions (MHA) or other relevant community interest-holders
1.4 Engage community partners
1.5 Prioritize a PoF.

## 1.1 Create or Update a Community Profile

As a first step, it is recommended that NLOs create or update their community profile to have a better understanding of the sociodemographic and health characteristics of the population within their catchment area. NLOs should generally use publicly available data sources such as StatsCan Census, Ontario Health (OH), Public Health Ontario, etc. (see **Appendix A** for additional resources).

**Callout**

In 2021, PSSP created some community profiles for the newly onboarded NLOs using the 2016 census data. As a more recent census dataset is now available (Census 2021), all NLOs are encouraged to either create their own community profile (if they have not had one previously) or update their existing one with more recent information and additional elements, if applicable.

Reviewing demographic data provides important insight into which priority populations are represented in a region. While not an exhaustive list, NLOs are encouraged to also explore the following demographic elements within their region (see **Appendix A** for possible sources for this information):

- Primary language or language most spoken at home (with special consideration for highlighting the proportion of Francophones)
- The regional French Language Services (FLS) designation
- Income
- Employment status
- Population density (referring to the proportion of the population living in urban compared to rural and remote areas of the region)
- Racial and ethnic identity
- Immigrant status
- Indigenous peoples
- 2SLGBTQ+ identity
- People with disabilities
- Religion or religious identity
- Experiences of hate crimes.

Burden of disease data for priority populations is another source of valuable information. Considering factors such as incidence, prevalence, inequitable access to the social determinants of health, and barriers to accessing care provides additional context needed when selecting a PoF.

Comprehensive and systematic literature reviews are not necessary to gather these data, though a rapid review may be helpful if there is a gap in personal or community experiential knowledge about the mental health needs of different priority populations. **Table 2**, found in **Section 1.5**, can be a useful tool to help map the regional representation of a priority population, as well as additional considerations (such as experiences of health inequities) in selecting a PoF.

In addition to considering regional representation, social determinants of health, and burden of disease, there may be scenarios where intersectional analyses should be considered. Examples of intersectional analysis that may be of interest include:

- Considering groups of people who may identify with multiple priority populations (eg, Afro-Indigenous communities, Francophone newcomers, etc.)
- Assessing representation sub-regionally (eg, determining if racialized communities are disproportionately represented in certain areas of an NLO region, or if people with disabilities are disproportionately represented in certain areas)

- Exploring the specific needs of a subgroup within a priority population (eg, focusing on the needs of Métis communities among Indigenous communities, or considering the needs of Trans- and Gender-diverse communities among 2SLGBTQ+ communities).

Even though intersectional analysis requires considerable skills, time, and resources, it is a necessary component of a priority population approach. Given the reality of limited time and capacity, it is recommended that NLOs first prioritize their PoF(s) before conducting any intersectional analysis. This approach will allow them to gather more information about the intersectional demographics and health needs of their specific PoF(s), facilitating client engagement and activity development. Additional information on practical strategies for intersectional analysis can be found in the Public Health Agency of Canada's report titled How to Integrate Intersectionality Theory in Quantitative Health Equity Analysis.

**Callout**

**Addressing limitations:** all data selection, collection, and analysis, whether quantitative or qualitative, has limitations. Naming these limitations in the needs assessment is best practice and allows for better understanding of challenges, such as limited access to data sources, poor data quality, or limited resourcing.

## 1.2 Analyze Internal (NLO-level) Data

To understand their client base, NLOs should conduct a preliminary analysis of their internal OSP data to gain insight into where over- or under-representations exist in terms of who is **accessing** their service, **attrition** of clients (including the stage at which they are exiting care), client **experiences** of OSP, and the clinical **outcomes** of their clients. These data will also serve as a baseline for monitoring progress (refer to **Section 4**) and understanding whether the desired impacts are achieved.

It is important that any work done considers the full length of a client's journey through OSP, from access to experience to outcomes, as poor care experiences during psychotherapy can lead to negative impacts, such as no change after treatment and increased problems after treatment.[7] This becomes even more critical for priority populations, many of whom have experienced historical and ongoing mistreatment by care providers and as a result have a justified mistrust of health care systems.[8,9,10] In the context of OSP, solely focusing on increasing access for a PoF would not be useful if they have poor experiences while accessing the service (which can contribute to drop out) or if they do not experience an improvement in clinical outcomes. This can have even longer-term systemic consequences where clients do not feel it is safe to re-engage with the mental health care system for other forms of treatment.[10]

In order to make meaningful comparisons between the needs of different communities, it is recommended that NLOs align their data analysis with their community profile and potential monitoring or evaluation measures to track progress, and stratify across the same dimensions where possible.

Other comparisons of interest for NLOs might include:

- Comparing access, attrition, experience, and outcomes of all OSP-identified priority populations to the NLO average to identify potential areas of inequity within OSP's service delivery

- Considering quarterly or annual trends to see how priority populations are changing within OSP over time
- Comparing client data to their regional makeup through geographical mapping to determine if certain groups are over- or underrepresented within their region.

**Callout**

Data for priority populations may have limited sample sizes at the NLO-level, which can impact the ability to draw any meaningful conclusions. Conducting literature scans for a short-list of potential PoFs or engaging with clients might be an option to overcome these data quality challenges. Qualitative data obtained through engaging clients or PWLLE can also be used along with a more robust quantitative analysis to further contextualize why an over- or underrepresentation might exist. More information on meaningful engagement can be found in **Section 3****.**

**OSP West: Using a Geographic Information System to identify PoFs**

OSP West has been using ArcGIS, a Geographic Information System, to better understand their regional service area, including characteristics of clients who access OSP and utilization trends. By connecting client postal codes to the Canada Post Postal Code Conversion File, spatially-referenced program utilization data is linked with census data and other demographic or access data. ArcGIS helps OSP West evaluate assumptions, using quantitative evidence to identify PoFs and understand client distribution and disparities in program representation compared to census representation. Utilizing the results from these analyses allows OSP West to tailor their programming and promotion to ensure equity of access for all, including PoFs that are relevant to each sub-area of their region (eg, Amish, Low-German Mennonite, migrant farmers, refugees, Black, Indigenous, and People of Colour, etc.).

Please refer to **Table 1** below for definitions of different priority populations in the context of OSP, as well as suggestions on how to stratify data sets using OSP Minimum Data Set (MDS) elements. This table is intended to serve as a starting point, as NLOs may have their own data not collected as a part of the MDS, which may be a better fit. They may additionally decide, as a part of their PoF work, to start collecting additional data elements that better relate to their PoF.

**Table 1. Indicator Suggestions for Stratifying OSP-Level Data by Priority Population (using MDS elements)**

| Priority Population | Definition | Sample Data Elements (from MDS 2.2) |
|---|---|---|
| People without access to healthcare benefits | Clients within OSP who do not have access to a private health insurance plan or whose plan does not provide coverage for mental health services. | This information is not currently collected within the MDS. NLOs will need to consider collecting this information if this is a PoF for their region |

| Priority Population | Definition | Sample Data Elements (from MDS 2.2) |
|---|---|---|
| People living on a low income | Clients within OSP who are living on a low income. Low income cut offs can be found through Statistics Canada.*<br><br>*NLOs are encouraged to also consider the living wage within their region. There remains a gap between those who are considered low-income for tax purposes and those who are making less than the actual cost of living in their community. | • Total household income<br>• Number of people household income supports |
| Black, Indigenous, and other people of colour (BIPOC) | Clients within OSP who are Indigenous or otherwise racialized and may have experienced differential treatment on the basis of race, ethnicity, language, culture, religion, etc. Specificity should be used when referring to a particular community instead of using terms like BIPOC, etc.*<br><br>*Note that census data does not adequately capture information about Indigenous people living on reserves. Other data sources, including experiential and community data, should be used to bridge this gap. | • Racial/Ethnic group |
| People who identify as 2SLGBTQ+ | Clients within OSP who identify as a part of sexual and gender-diverse communities.*<br><br>*Gender identity and sexual orientation should be considered separately as much as possible when looking at the demographics and experiences of 2SLGBTQ+ clients. While there are similarities between the experiences of gender-diverse and non-heterosexual people, key structural and political inequities disproportionally affect gender-diverse communities, so it is important to consider them separately. If disaggregated data are not available or sample sizes are too small, consider engaging with gender-diverse people and Trans- and Non-Binary serving organizations for more information on the needs of gender-diverse people accessing OSP. | • Gender identity<br>• Sexual orientation |
| People with disabilities | Clients within OSP who self-identify as a person with a disability. Disability refers to the functional limitations an individual experiences and the barriers they encounter in their environment, including social and physical obstacles that make daily functioning more challenging.*<br><br>*When looking at people with disabilities, it is critical to take into account the spectrum of experiences that exist, including different types of disabilities (ie, physical disabilities, mental health disabilities, learning disabilities, developmental disabilities, etc.). | • Health status<br>• Disability status (new for MDS 2.2) |

| Priority Population | Definition | Sample Data Elements (from MDS 2.2) |
|---|---|---|
| People living in rural and remote areas | Clients within OSP who live outside of population centres (POPCTRs) as defined by Statistics Canada.*<br>*Statistics Canada has also created an Index of Remoteness using census data that can be used to determine population density in a given area. | • City<br>• Postal code |

To support NLOs in understanding how to apply this guidance, a fictional case study has been included throughout this document to demonstrate how they could complete the various steps. This case example is not intended to provide a step-by-step guide for meeting the needs of PoFs; rather, it highlights possible options that could be useful. NLOs will need to balance their capacity and available resources to determine what is feasible within their context.

**Case Study: Getting Started and Looking at the Data**

- After developing a community profile and analyzing their OSP-specific data, an NLO finds that Indigenous communities, Francophone communities, people living on a low income, and people living in rural and remote areas are accessing OSP services at a disproportionately lower rate than expected based on the regional population.
- They also find that all of these groups have higher rates of attrition (dropout) from the program.
- When considering intersectionality, the NLO identifies rural FLS-designated communities as well as rural and remote First Nations communities in their catchment area.
- A rapid scan of the literature shows that people living on a low income and Indigenous people experience higher incidence of mental health challenges. The scan also reveals that Indigenous people are also more likely to be living on a low income.

## 1.3 Identify Key Regional Interest-Holders

To further understand their region, NLOs are encouraged to identify other regional interest-holders that may currently be working to address the needs of priority populations. This exercise helps NLOs understand their community infrastructure, avoid unnecessary duplication of services, and identify potential opportunities to build relationships and partnerships for service delivery, referrals, and more.

These interest-holders might include, but are not limited to, the following:

- Other small, medium or large organizations that deliver MHA services
- Non-profit organizations that advocate for or provide services to different priority populations (not limited to MHA services)
- Local collectives (eg, collectives of people with lived experience of mental health and/or substance use challenges)
- Ontario Health Teams (OHTs)
- Equity staff in OH region
- Public Health Units

- Any preexisting partners (eg, people, organizations, or government officials with whom an NLO may have a preexisting and mutually beneficial relationship).

This stage of the needs assessment does not necessarily involve contacting these interest-holders, especially if there is no preexisting relationship with them. Building relationships takes time, intention, and reciprocity. It is important that NLOs have the capacity and resources to undertake this work meaningfully (see meaningful engagement in **Section 3**). While completing this interest-holder mapping exercise, NLOs should consider how to measure meaningful progress in relationship-building, leveraging preexisting data or resources, if available (see progress monitoring in **Section 4**).

**Callout**

OHTs and equity staff within OH regions are a valuable source of information on different regions. Consider contacting them early to utilize their expertise and leverage previously completed work. See Health Equity Contacts at Ontario Health Regions for contact information.

## 1.4 Engage Community Partners

At this point, NLOs should have a general understanding of their region and a few potential PoFs. It is recommended that NLOs engage with their community partners, including their Service Delivery Sites (SDSs) to share their findings, seek additional context on community needs, and begin prioritizing one or two PoFs.

To support engagement efforts, NLOs are encouraged to consider existing relationships and partners who can support this work. If there are few or no preexisting relationships, building relationships with partners who are closely connected with priority populations will take time and effort. At a minimum, NLOs are strongly encouraged to connect with their OHTs, SDSs, and other OH regional staff who may already be working with priority populations in the region.

**CarePoint Health: An Advisory Panel to Identify Underserved Populations**

As a part of their priority population approach, CarePoint Health convened a Regional Advisory Panel in 2022. Their panel was composed of interest-holders and partners from community, health, mental health, and social service organizations, including all SDSs, three OHTs and OH. The group discussed regional needs, identified underserved demographics and recommended priorities using the following criteria:

1. Impact – population size and need
2. Capacity – ability to support activities for specific populations
3. Strategic alignment with provincial and regional initiatives.

Through these discussions, the Panel recommended the following PoFs for their region and for CarePoint to collaborate with its partners to increase access for:

a) South Asian clients – developing a full pathway in an additional language
b) Black, African, and Caribbean – creating culturally relevant communications
c) Young adults (18 to 29 years) – connecting with postsecondary students.

Community partners may also hold additional expertise about regional trends and changes in community demographics that may not have been captured in the community profile (eg, world events that have contributed to a rapid increase in migration of a certain community into an NLO's region, or a particular community that has been experiencing increased discrimination and hate crime incidence). Conversations with partners can bring deeper discussion and consideration of intersectional experiences or impacts on certain communities. Leveraging this expertise can strengthen an NLO's priority populations approach and foster trust with partners. NLOs may also wish to explore developing new SDSs with their partners as relationships are developed.

**Case Study: Engaging with Interest-Holders**

- The NLO decides to draw on their existing relationships and hosts a meeting to bring together different interest-holders, including representatives from: SDSs, Indigenous-led mental health and social service organizations, the French-language planning entity for their region, the district social services administration board, organizations providing services to low-income individuals and families, the local OHT, and a regional consumer/survivor organization.
    - PWLLE not attending in a professional role and Elders are paid an honorarium for their participation at the meeting.
- The NLO presents their data findings and shares their short-list of potential PoFs to their interest-holders. The attendees then discuss a series of questions in groups with a facilitator to narrow down the list and help establish regional priorities.
- Questions include:
    - Discussing barriers to accessing OSP or other services among potential PoFs
    - Potential for wrap-around supports or services in partnership with OSP
    - Identifying population needs and burden of disease based on attendees' experiential knowledge
    - Notable intersecting identities and experiences for each population group.

## 1.5 Prioritizing a Population(s) of Focus

The final step in selecting one or more PoFs for OSP delivery is to prioritize which population to focus on. There is no correct way to prioritize and it will involve weighing many factors, such as burden of disease, experiences of inequities, available resources, community partnerships or infrastructure, readiness, and more. NLOs can use **Table 2** as a template to organize the information gathered in the previous steps of this needs assessment, helping to identify priority populations with the greatest need for a tailored OSP approach. When considering the dimensions of care, selecting a specific PoF may be justified due to:

- Disproportionate access to OSP
- Increased stigma related to mental health reported among this population
- Increased rates of dropout before treatment completion
- Worse experiences compared to other OSP clients
- Clinical outcomes that demonstrate smaller improvements compared to the program average, etc.

This prioritization exercise also provides an opportunity to consider the intersectional needs of different priority populations. Below are some examples of intersectional needs that NLOs may consider:

- The proportion of newcomers who are Francophone and how their needs differ from those of Francophones who have been here for several generations
- The specific needs of Afro-Indigenous clients within OSP
- The type of adaptations required for 2SLGBTQ+ people with disabilities.

**Case Study: The PoF Selection Process**

- The NLO organizes their findings from the discussion with interest-holders into **Table 2** below.
- After completing the table, NLO leadership realizes that there is a common theme emerging from their engagement sessions. They assess that although Indigenous communities, Francophone communities, and low-income communities each experience unique challenges in accessing appropriate care, these challenges are exacerbated when individuals are also living in rural and remote communities.
- The NLO also realizes that the representation of clients from rural and remote areas is far less than what might be expected based off their regional makeup (rural and remote populations make up 60% of the region, but only 22% of all OSP clients live in rural and remote areas).
- Given that the NLO already has dedicated pathways set up for Indigenous and Francophone clients, they decide to focus on rural and remote communities as their PoF, with plans to integrate activities dedicated to the needs of rural and remote clients into all OSP services, including the Indigenous and Francophone pathways.
- The NLO also plans to integrate considerations for low-income clients into all three streams of priority populations work and plans to revisit adding low-income clients as an additional PoF in the next fiscal year, depending on capacity.

**Table 2. Case Study Example: Mapping Potential PoFs**

| **Priority Population** *Identified through OSP's vision statement or any additional groups that may have been identified by an NLO* | **Burden of Disease and Determinants of Health** *Any relevant data on prevalence, incidence, etc. for a priority population as well as any health inequities experienced by a priority population (generally found through literature searches)* | **Regional Representation** *Data gathered in the community profile on how this priority population is represented in a region* | **NLO-Level Data Considerations** *How this priority population is represented at the NLO-level. Includes indicators related to intake, attrition, experience, and outcomes* | **Intersectional Considerations** *Any additional considerations for this priority population that should be considered* | **Other Considerations** |
|---|---|---|---|---|---|
| Francophone Communities | Francophone communities experience increased barriers to accessing MHA services in French. | In our region, Francophone communities make up 10% of the population, compared to approx. 4% across Ontario. | • Fewer Francophone clients are accessing services than we would expect (Francophone clients make up 5% of all OSP clients, but 10% of the region)<br>• Francophone clients are more likely to drop out of OSP | We are seeing a growing population of Francophone newcomers in our region. | Our NLO currently has a Francophone pathway to ensure clients can access services in French. |
| Indigenous Communities | Indigenous communities disproportionately experience more MHA challenges (due to systemic racism and historical and ongoing impacts of colonialism). | In our region, there are a large number of First Nations communities living on reserve. First Nations people make up 5% of our regional population compared to approx. 1.8% across Ontario. | • Fewer First Nations clients are accessing services than expected<br>• Indigenous clients are more likely to drop out of OSP | Indigenous communities are more likely to experience poverty (due to racism, colonialism, etc.). Additional considerations may be needed for Indigenous clients living on reserve. | Our NLO has partnered with a local Indigenous organization to provide culturally safe services for First Nations clients. |

| **Priority Population**<br>*Identified through OSP's vision statement or any additional groups that may have been identified by an NLO* | **Burden of Disease and Determinants of Health**<br>*Any relevant data on prevalence, incidence, etc. for a priority population as well as any health inequities experienced by a priority population (generally found through literature searches)* | **Regional Representation**<br>*Data gathered in the community profile on how this priority population is represented in a region* | **NLO-Level Data Considerations**<br>- *How this priority population is represented at the NLO-level. Includes indicators related to intake, attrition, experience, and outcomes* | **Intersectional Considerations**<br>*Any additional considerations for this priority population that should be considered* | **Other Considerations** |
|---|---|---|---|---|---|
| People living on a low income | People living on a low income experience more MHA challenges and have more limited access to private MHA services. | In our region, there is a large population of people living on a low income. | • Low-income clients are less likely to access OSP services | Indigenous clients are more likely to also be experiencing poverty. | |
| **People living in rural and remote areas** | **People living in rural and remote areas have increased barriers to accessing MHA services.** | **Our region's geography is 60% rural or remote.** | • **People living in rural and remote areas are less likely to access OSP services (They make up 60% of our region's population, but only 22% of OSP enrolled clients)**<br>• **Clients living in rural and remote areas are more likely to drop out of OSP** | **Many Francophone and Indigenous communities live in rural and remote areas of the region.** | |

## 2. Assessing Current State and Desired Impact

After conducting a needs assessment and identifying one or more PoFs, the next stage is to assess the NLO's tools, resources, and capacity to address the needs of their PoF(s). This is can achieved by developing a plan to implement and monitor activities, using a tool such as a logic model.

### 2.1 Assessing Current State and NLO Resources (Inputs)

Below are some questions that an NLO can use to evaluate their current state:

- "What is our NLO currently doing to meet the needs of the PoF?"
- "What are the current challenges in effectively meeting the needs of the PoF?"
- "Who is currently at the table and who is missing when making decisions about the PoF? How are partners, PWLLE, and clients involved in creating the vision for the service? What ideas are shaping the approach?"

**Callout**

A good place to start when assessing an NLO's current state is to use the Health Equity Maturity Model (HEMM) developed for OSP.

An NLO should also determine the optimal use of available resources to implement and monitor potential activities. Balancing resource usage is crucial to ensure that NLOs can not only implement activities but also measure their progress. If an NLO chooses to create a logic model (described in more detail in **Section 2.3**), they can document their resources as **inputs** within the model.

| **Inputs**: Consider resources needed and what is available |
|---|
| Examples of possible resources to be leveraged:<br>• Staff allocation for all stages of this work, including needs assessment, implementation, and progress monitoring (eg, skillsets, time needed, etc.)<br>• Available funds (eg, consider how existing resources can be used or how one-time funds, if available, can be leveraged)<br>• Physical space or technology for implementing activities (eg, engagement sessions, etc.)<br>• Data sources that are currently available (for assessing baseline and monitoring progress)<br>• New or existing interest-holders that could be engaged<br>• Honoraria for PWLLE engagement<br>• Technology supports<br>• Consultant support<br>• Other organizational supports that are not a part of OSP (eg, data support, etc.)<br>• Student placements |

**Case Study: Assessing Current State**

After identifying their PoF (people living in rural or remote areas), the NLO works to document what they are currently doing to address the needs of people living in rural and remote parts of their region. Based on findings from their intersectional analysis, this includes examining their current Francophone and Indigenous pathway. Using the HEMM, and continuing their consultation with their interest-holders, the NLO identifies the following strengths and gaps:

- They have a few strong partnerships in rural and remote communities, including one SDS
- There are rural and remote areas in their region where they currently do not have any active partnerships
- They have informational products about OSP available in French and in the primary Indigenous language spoken in the region. These products were co-developed with relevant partners as part of other priority population work
- They have a device loan program to improve access to virtual care, but it is currently only operating in the urban area where the NLO is located
- The NLO has one-time, year-end funds available to use toward improving access initiatives.

## 2.2 Identifying Desired Impacts

Once an NLO assesses their current state and identifies their available resources, they should identify the key changes that they aim to achieve through this PoF work (also known as outcomes). These outcomes should ideally encompass all different dimensions of the client's care journey, including access, attrition (at triage, triage to treatment, or during treatment), experiences, and clinical outcomes. Changes may not happen simultaneously, and efforts to achieve the desired impact may need to be phased based on available resources and other factors.

It is useful to organize outcomes into short-, medium-, and long-term. Generally, short- and medium-term outcomes affect individuals, while long-term outcomes occur at the population level (see **Case Study – Identifying Desired Impacts (Outcomes)** below for more details). All outcomes should ultimately tie back to the PoF and not the staff or organization supporting the PoF. While an NLO may select certain outcomes that measure shorter-term staff- and organization-related changes, these should always be linked to outcomes directly related to the PoF, which is the focus of the work. For example, an NLO that selected South Asian communities as their PoF wishes to provide cultural safety training to their clinical staff. The training in itself is not a desired impact, but rather an activity that will be implemented. The desired impacts or outcomes from the training would be improving the care experiences of South Asian clients accessing OSP (as a result of improved cultural safety among clinicians). Session attendance and improvements to clinicians' knowledge and attitudes should be tracked as outputs, but are not considered outcomes as they relate to the clinicians and not the South Asian clients.

**CMHA-YRSS: Working with a Community Partner to Identify Desired Outcomes**

After identifying the Chinese-speaking community as one of their PoFs, CMHA-YRSS worked together with their SDS, Hong Fook Mental Health Association, to identify desired impacts. Their census data, literature review, and initial community feedback all indicated that disparities in access for this PoF were primarily due to practical barriers (eg, knowledge of access and language). Therefore, CMHA and Hong Fook jointly decided to focus on the marketing, referral, and intake domains of the HEMM.

From there, Hong Fook led the translation and cultural adaptation process of the referral form, intake package, and intake process. These activities included an extensive consultation process that involved Chinese-speaking staff, Hong Fook clients, and members of the community to obtain feedback on the documents. The process was staged; materials were first tested by a group of 20 clients, and feedback was then incorporated before the documents were finalized.

Concurrently, CMHA led three focus groups with five different community organizations that serve the Chinese-speaking community. These consultations aimed to obtain input on the client-facing marketing materials and opportunities for collaboration to promote the program across the local community. This collaboration is still ongoing as these organizations continue to share OSP resources with their clients, invite CMHA to participate in community events, and add marketing materials to their client-facing newsletters.

Determining outcomes does not need to be a lengthy or difficult process. Through the needs assessment completed in the first stage, NLOs should already have a sense of the existing gaps for their selected PoFs. Selecting one or two desired outcomes to address these gaps is enough to get started. These outcomes should also align with OSP's overall goal and vision: to ensure that all Ontarians with depression and anxiety-related challenges, including the program's priority populations experiencing inequities, are able to access the program, maintain their participation, experience good quality care, and achieve positive health outcomes.

**Case Study: Identifying Desired Impacts (Outcomes)**

The NLO works to set short-, medium-, and long-term outcomes based on their identified strengths and gaps, and maps them in the table below:

**Table 3. Case Study Example: Mapping Short-, Medium-, and Long-Term Outcomes**

| **Short-Term Outcomes**<br>*Affects knowledge, skills, and attitudes* | **Medium-Term Outcomes**<br>*Affects behaviours* | **Long-Term Outcomes**<br>*Affects big picture and population-level impact* |
|---|---|---|
| • Clients and providers living in rural and remote communities have increased awareness of OSP and how to access the service | • Clients living in rural and remote communities have increased service utilization (access) of OSP<br>• Clients living in rural and remote communities have | • Decreased stigma about accessing mental health services among rural and remote communities<br>• Improved depression and anxiety-related mental |

| **Short-Term Outcomes**<br>*Affects knowledge, skills, and attitudes* | **Medium-Term Outcomes**<br>*Affects behaviours* | **Long-Term Outcomes**<br>*Affects big picture and population-level impact* |
|---|---|---|
| • Clients living in rural and remote communities have improved care experiences in OSP | increased completion of OSP (decreased attrition) | health outcomes for rural and remote communities |

## 2.3 Logic Models

A logic model is a useful tool that can be used to organize an NLO's approach for a given PoF. This tool originated from program evaluation and is often used in program planning, implementation, and progress monitoring. It serves as a visual representation of the logical sequence between the resources, activities and expected results (or changes achieved) in a given project, program, or intervention.[11] Using a logic model can be beneficial because it clearly organizes activities for a PoF and emphasizes how each activity links to an improved health outcome (short-, medium-, or long-term).

The components of a logic model include:[11]

| Component | Description |
|---|---|
| Inputs | The resources that are invested into planning, implementing, and monitoring an intervention. |
| Activities | The specific activities that will be carried out as a part of an intervention. |
| Outputs | The evidence that indicates the direct and tangible result of a completed activity (often a process measure). Outputs are directly within a program's control and will eventually become part of the completed work found in the implementation work plan. |
| Outcomes | The measurable changes for a PoF that would be expected to result from the activities of an intervention. They occur after outputs and are not directly within a program's control. Outcomes are broken down into short-, medium-, and long-term, and are associated with changes in awareness, knowledge, skills, behaviours, and population health outcomes. The tracking of outcomes (using indicators – see row below) will eventually become part of the progress monitoring plan. |
| Indicators | The quantitative or qualitative measures that indicate if an NLO has achieved an output or outcome. |

At this stage, an NLO should have their inputs (available resources) and outcomes (short-, medium-, and long-term changes) identified. As a next step, an NLO can determine what activities they wish to implement as well as plan their outputs as a part of their progress monitoring plan. Developing a logic model is an iterative process. As activities are developed and progress monitoring plans are established, it may be necessary to come back and edit previous components. Additionally, the available resources and the needs of PoFs may change over time, which can be a positive thing, as it means that an intervention has had its intended impact. A logic model should be updated as needed to address different gaps for a given PoF, or new ones developed as new PoFs emerge. NLOs are encouraged to engage their interest-holders in drafting or commenting on their logic model, if feasible.

Logic models allow for great flexibility in design and can be simple or complex. There is no one-size-fits-all approach to logic models. NLOs are encouraged to review additional resources, including Public Health Ontario's Focus On: Logic Models and the State of Michigan's Logic Models: A Beginner's Guide.

**Case Study: Building a Logic Model**

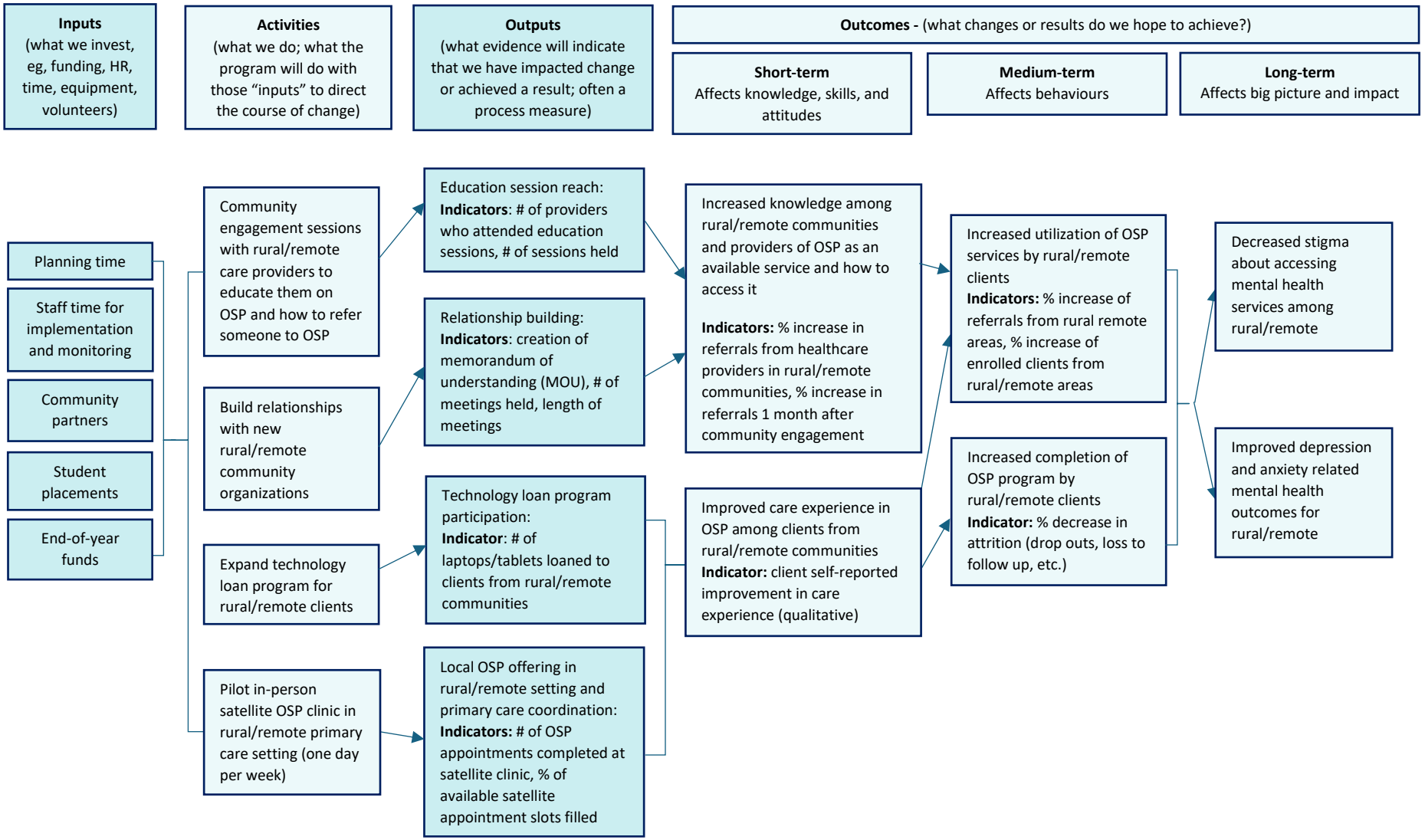
The NLO drafts a logic model (included below) and adds their inputs and outcomes. After getting feedback from their interest-holders, they decide to create a small task group composed of one NLO staff, one staff from their rural SDS, one student supporting this work as a part of their placement, and one staff from a partnering, primary care organization serving rural and remote communities. The task group decides to focus on four main activities:

1. Hosting three community engagement sessions with primary care providers from rural and remote areas of the region to educate them on OSP and how to refer patients to the program. This activity was selected after hearing feedback from another NLO that observed increase in enrollment after implementing similar sessions.
2. Building new reciprocal relationships with community organizations, including Indigenous and Francophone organizations, in rural and remote parts of the region, while focusing on regional areas with no OSP enrollments to date. The task group emphasizes that the goal of these relationship-building activities is to explore whether OSP is the right service for these communities and is not intended to be extractive. The hope is that, over time, new community partners might refer clients to OSP or eventually become SDSs.
3. Expanding the current technology loan program using end-of-year funds to better support clients living in rural and remote areas of the region. The funds will go towards purchasing additional laptops or tablets that clients can borrow and return from primary care offices in their local communities. This would eliminate the need to travel to the large city to borrow devices.
4. Piloting a new satellite clinic in a rural area of the region where several OSP clients are currently accessing services virtually. An OSP clinician will travel one day per week to a local primary care office to provide OSP appointments. This primary care office has been a long-time partner of the NLO and one of its staff members participates in the task group. The NLO and primary care organization have agreed to coordinate family physician appointments with OSP appointments to reduce clients' travel time.

After creating their progress monitoring plan at a later stage, the NLO reviews its logic model and completes the outputs and indicators sections.

**Figure 1. Case Study Example: Logic Model**

Overarching goal: This work aims to reduce inequities related to access, care experiences, and mental health outcomes experienced by priority populations in OSP



# 3. Planning and Implementation

The next stage for an NLO is planning their activities for implementation. The activities that an NLO chooses to implement will be unique to their specific circumstances and PoF(s). While it would be out of scope for this guidance to provide specific guidance on which activities an NLO should plan or how to work flexibly within OSP protocols, NLOs can consult the compiled list of tools and resources below to select activities and support the implementation process. Depending on their stage, NLOs may choose to use only some of these tools. It is recommended that NLOs use a logic model to document their activities and plan their key indicators before starting to implement activities. This will facilitate tracking the achievement of outputs and outcomes at a later stage.

## 3.1 Planning Tools

### Considering Context

As activities are being developed, it is helpful to reflect on and document potential barriers and facilitators that might exist when implementing activities for a PoF. Additionally, consider the inner and outer contexts when identifying these barriers and facilitators (adapted from the EPIS Framework).

| Inner Context Considerations | Outer Context Considerations |
|---|---|
| Examples:<br>• Organizational culture<br>• Leadership & staff capacity and skills<br>• Need for training, directed hiring or other preparatory work that must be done before PoF-specific activities<br>• Fit of new activities into organizational current state | Examples:<br>• Relationships and care pathways between NLOs and SDSs, other community partners, and PWLLE-led organizations<br>• Sociopolitical context<br>• Availability of relevant program materials for PoF |

**Callout**

Listed below are examples of facilitators that can benefit the adaptation of OSP services for PoFs. These were identified through consultations with NLOs:

- Support training with opportunities to apply learnings
- Build relationships before making requests, as relationship building takes time
- Ensure support for racialized and marginalized staff
- Balance the creation of change with the risk of staff burnout
- Co-create approaches with the population groups themselves.

### Engagement

Engagement, relationship building, and co-creation have been identified by several NLOs as levers for successful implementation of priority populations work. When planning activities for a PoF (or prior to planning), an NLO can engage their clients, PWLLE, or community partners. When engaging others, it is important that engagement practices are approached with a goal of building collaborative relationships

and reciprocity, and that PWLLE or clients are compensated appropriately for their expertise, especially within a priority populations context. The Laying the Foundation for Meaningful Engagement Workbook was a resource previously developed for OSP and should be reviewed by NLOs that will be engaging priority populations. Additional resources on meaningful engagement have been compiled and can be found in **Appendix A**.

**Waypoint: Engaging with Indigenous Partners**

Waypoint's OSP program has prioritized meaningful engagement with key Indigenous partner organizations. These partnerships have been critical to the development of Minookmii, a program that weaves together Indigenous Ways of Knowing, cultural interventions, and evidence-based CBT practices to meet the needs of local Indigenous communities. Waypoint's OSP program took the following steps to actualize meaningful engagement with their Indigenous partner organizations:

- Joint reflection on the foundational 11-year relationship between Waypoint and the Indigenous Health Circle
- Collaborative production of a Letter of Relationship and a Wampum Belt Ceremony with Waypoint and Indigenous partners, explicitly delineating principles of reciprocity and mutual respect
- Shared decision-making for funding and creation of an Indigenous Co-Lead role
- Collaborative production of supporting documents and processes for Minookmii, including Indigenous-specific intake and consultation
- Joint participation in bimonthly meetings, including the Indigenous Evaluation Circle (for discussing Minookmii-specific program evaluation efforts).

### Developing a Workplan

A workplan template can be useful for NLOs to plan and operationalize their activities addressing the needs of their PoF(s). NLOs may already use a preferred project management software or a workplan template. This guidance includes a sample template adapted from general quality improvement workplans and informed by the EPIS Framework. Additional resources related to implementation have also been compiled and are available in **Appendix A**.

**CAMH: Planning Activities to Address the Needs of Black Communities**

As a part of their work with priority populations, CAMH identified Black, African, Caribbean communities as one of their PoFs. To better meet the needs of Black clients, they decided to implement the following activities:

1. Training:
    - All staff have completed required training on dismantling anti-Black racism
    - All staff have completed a Culturally Adapted CBT course for the African, Black and Caribbean populations
    - CAMH has hosted a presentation from an SDS working with women from racialized communities on how they provide culturally adapted assessment and CBT.

2. Consultations:
    - Since April 2024, CAMH has engaged an external consultant, Dr Natasha Williams, with expertise in CA-CBT to:
        - Offer ongoing consultation for the team
        - Train the CAMH OSP consultants to eventually offer CA-CBT consultation themselves.
3. External Interest-Holder Engagement:
    - CAMH has been meeting with external interest-holders who work with Black clients to understand aspects of stigma related to mental health within this population. The CAMH team engaged in dialogue about systemic barriers to access care, and discussed ways to improve access, care experience and retention of Black clients
    - CAMH will summarize these discussions and determine the feasibility of additional activities to implement at the NLO-level
    - CAMH has determined community engagement to be an additional priority for the 2025-26 fiscal year.

**Case Study: Preparing for Implementation**

After convening their task group and determining the key activities, the NLO considers the barriers and facilitators that may influence their PoF work. Some of the potential challenges that they identify include:

- Confirming details for the pilot satellite clinic and finalizing an agreement with their community partner prior to implementation. This includes deciding together what additional training and orientation is needed for an OSP clinician to start, and whether current OSP clinicians are able to participate. This will be a long-term goal.
- Developing a tracking process for new indicators not captured in the current system, such as device loan through third parties.
- Considering staffing capacity to ensure implementation plan is moving forward.
- Verifying that new referral pathways are integrated within the existing pathways for Francophone and Indigenous clients.

Using elements from their logic model, the NLO starts to organize the following workplan (**Table 4**) for one of their activities, ensuring all action steps are aligned with their desired outcomes and outputs. Please note that this is a simplified example that does not include all planning considerations that may be required to implement this activity.

**Table 4. Case Study: Workplan Example***

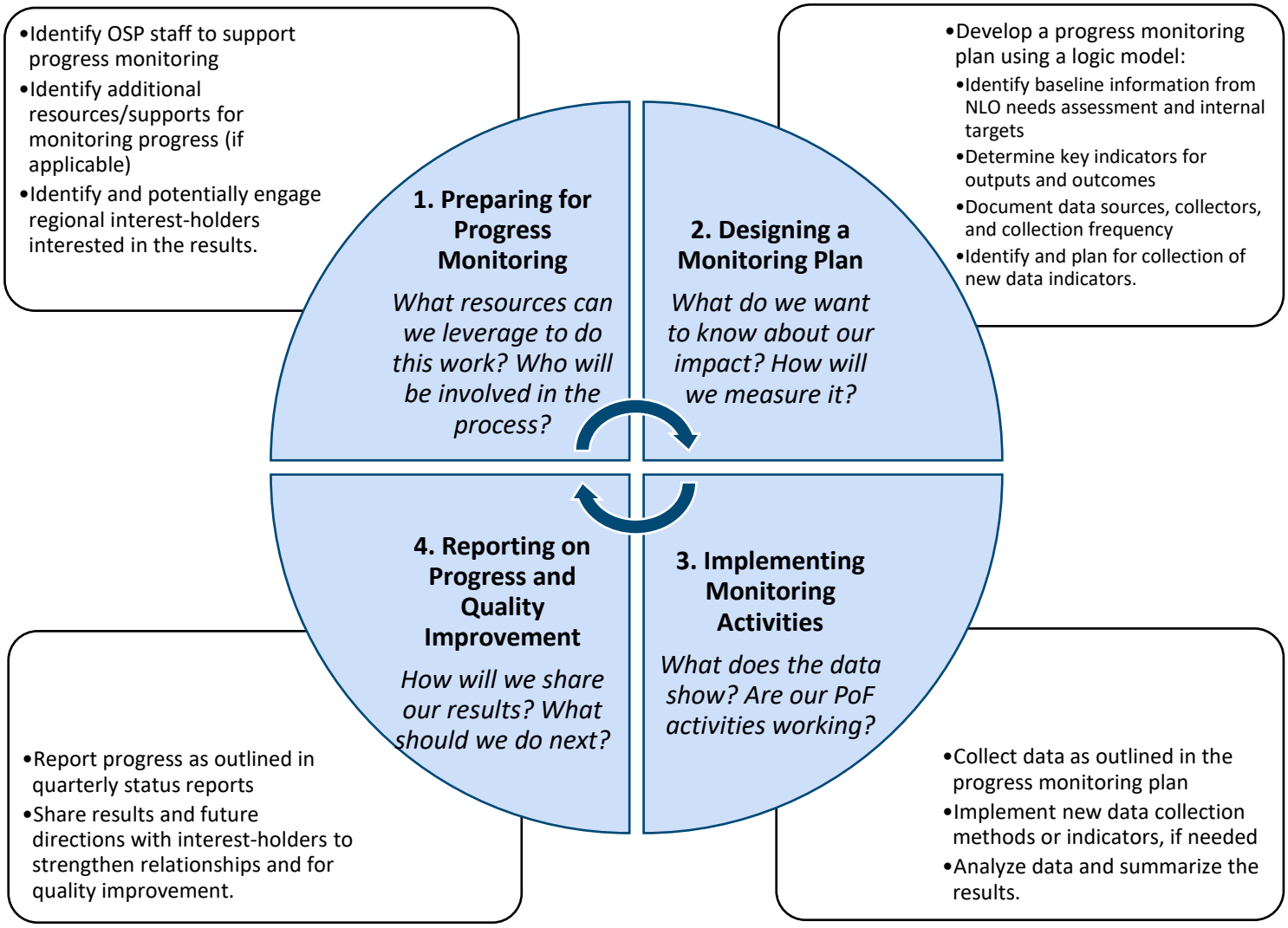
| **Activity to be Implemented** *Describe each element of the work that will be part of the PoF approach* | **Action Steps Required** *What needs to be done to implement this activity?* | **Resources Required** *How much time and funding are required? What knowledge and skills are required?* | **Risks & Mitigation** *What barriers to implementation may arise? How might these be addressed?* | **Date of Anticipated Completion** | **Person(s) Responsible** *Who is best positioned to lead this piece of work?* | **Logic Model Outputs** *How do we know we have achieved what we set out to do? Start thinking of the indicators that measure progress.* |
|---|---|---|---|---|---|---|
| 6-month Pilot satellite OSP clinic in partnership with primary care partner beginning in Q1 of FY 2025/26. | Schedule weekly meetings between the NLO and SDS to plan for moving the pilot ahead | Time from NLO and SDS leadership and support staff | Scheduling conflicts – meetings to be rescheduled or matters moved forward by email as needed. | Beginning Week of January 20th | Amara and Joseph to lead/attend all meetings with Kate as back-up when unavailable. Asha to schedule take minutes. | Track # of meetings, decisions made at meetings and action items completed. |
| | Joint budget and agreement for the pilot | Resources contributed in-kind by both partners – staff time (admin, clinician) | Potential for insurance premiums to change; finding current clinician with ability / willingness to travel 1 day/week; need for additional training / orientation. | Mid-February draft; End of February Finalized; March – implement and orientation | Joseph to lead drafting of budget and agreement. Amara and leadership at SDS to review and approve. | Agreement and budget finalized. |
| | OSP satellite clinic launched | Clinician time and travel costs | Any challenges noted above may affect launch timeline. | April 2025 | OSP travelling clinician | Track # of appointments and % of available appointment slots filled. |

*Similar planning would be included in the workplan for the other activities.

## 4. Progress Monitoring

As resources, outcomes, activities, outputs, and indicators are identified and documented within the implementation work plan and logic model, an NLO should start to formalize a plan for progress monitoring. Progress monitoring is a systematic process that is used to track if a project, program, or other initiative has made a difference and how big of a difference was made. It occurs periodically and is ongoing throughout the entire project. It is less resource-intensive and provides more limited insights compared to other types of assessments such as program evaluation or research.[12]

**Figure 2. Phases of the Progress Monitoring Process**




Planning for progress monitoring begins early, in parallel with earlier stages previously described in this document (ie, PoF selection, identifying desired impacts, logic model building, and workplan development). When deciding what data to use to measure changes in the selected outcomes and indicators, NLOs can leverage existing data gathered through their needs assessment to create a baseline. Establishing a baseline allows the NLO to explore how their implementation activities with

their selected PoF has affected outcomes related to access, attrition, improved mental health, and PoF client experiences. For example, if an NLO selected a PoF partly due to underrepresentation in services based on data obtained through the MDS, they should refer back to the same MDS elements to track change.

If the selected indicators for monitoring are not currently collected as a part of the MDS, an NLO may wish to collect this information separately. This additional data collection could be included in the referral or intake package, or in client satisfaction or perception of care surveys. It does not necessarily require a new data collection mechanism or tool. When developing new data collection elements or updating existing ones (that are not a part of the MDS), all elements should be designed to allow for stratification of findings by priority population group. This is especially important for client experience surveys, which often do not collect demographic information and are not linked to client profiles to preserve anonymity.

Some NLOs may be interested in going beyond progress monitoring to conduct a more formal program evaluation. While progress monitoring allows for continuous quality improvement, evaluation allows for NLOs to delve deeper into understanding the value and impact of their PoF work. A brief introduction to program evaluation is included in **Appendix B**.

**Table 5** below highlights sample indicators that NLOs can use to monitor their progress in meeting the needs of their PoF(s). These indicators are meant as a starting point and may not be relevant for every PoF and NLO context.

**Table 5. Examples of Indicators for Progress Monitoring**

| Area | Quantitative | Qualitative |
|---|---|---|
| Access to OSP services | • # of referrals*<br>• # of assessments*<br>• # of enrolments*<br><br>*demographic data may be available at different points in time depending on the data collection processes at each NLO | • Client narrative on what dimensions of access apply to their experiences trying to access OSP services |
| Awareness of OSP | • # of social media posts, impressions, engagements<br>• # of inquiries about OSP from community<br>• % increase in referrals<br>• # of registrations | • Client or provider perspective on how they became aware of OSP services |
| Attrition | • % of client drop outs/lost to contact<br>• % of clients with exit disposition as complete | • Reasons for dropping out of OSP<br>• Facilitators and barriers to remaining in program |
| Care Experiences | • % of clients indicating satisfaction with services including cultural safety | • Open ended feedback obtained |

| Area | Quantitative | Qualitative |
|---|---|---|
| Clinical outcomes | • % recovered<br>• % reliably improved<br>• Missing data for different PoFs | • Open ended feedback from clients regarding how they are feeling, change they have experienced |
| Relationship building (organizational/system level) | • # of meetings<br>• # of collaborative agreements | • Quality of collaborations and engagements between partners |
| Engagement (of PWLLE) | • # of engagement contacts | • Open ended feedback obtained |
| Staff competence | • # of trainings completed | • Staff feedback on the quality of training, skills learned |

**Case Study: Progress Monitoring**

Now that the NLO has determined their PoF activities and has started developing their workplan, they start developing a progress monitoring plan. Considering the outputs and outcomes in their logic model, they identify key indicators that will allow them to track progress and map them into **Table 6** below. Having previously ensured that they had enough resources for effective progress monitoring, the NLO plans to formally review their data and report on progress quarterly, aligning with their quarterly status reporting. They also plan to report back on their progress annually to their interest-holders. The NLO recognizes that at some point, their PoF work may lead to more equitable rates of access and retention in rural and remote parts of their region. At that point, their PoF activities may become a regular part of their operations and monitoring for OSP, and the NLO plans to consider identifying a different PoF.

**Table 6. Case Study: Progress Monitoring Plan Example**

| **Outputs or outcomes** *Listed from logic model* | **Indicators** | **Data Source** | **Person Responsible** | **Frequency of Data Collection** | **Baseline** | **Target** *Can be external or internal to the organization* |
|---|---|---|---|---|---|---|
| Output: Education session reach | • # of providers who attended sessions<br>• # of sessions held | Participant / attendee lists | Communications lead | Quarterly | N/A | Host three sessions with 40 providers by March 31 2026 |
| Output: Relationship building | • Creation of MOU<br>• # of meetings held<br>• Length of meetings held | Meeting minutes | Engagement lead | Annually | Formalized relationships with two local providers | Develop relationship with two new organizations by March 31 2026 |
| Output: Technology loan program participation | • # of tablets /laptops loaned to clients from rural and remote communities | NLO admin data<br>Client postal code | Admin staff | Monthly | 10% of all technology loans go to clients living in rural and remote areas | 25% of all technology loans go to clients living in rural and remote areas by March 31 2026 |
| Output: OSP satellite clinic service delivery | • # of appointments completed at satellite clinic<br>• % of available satellite appointment slots filled | NLO admin data | Admin staff | Monthly | N/A | 80% of all appointment slots are filled each week at the satellite clinic |
| Outcome: Increased utilization of OSP services by rural / remote clients | • % increase of referrals from rural and remote areas<br>• % increase of enrolments from rural and remote areas | MDS:<br>Referrals<br>Enrolments<br>Client postal code | Clinical lead | Monthly | 22% of enrolments come from rural and remote areas | 44% of enrolments come from rural and remote areas by Mar 31 2026 |

## 5. Conclusion

This guidance is designed to support NLOs in taking concrete, informed steps towards advancing equity within the OSP program. By offering a flexible, phased approach, it recognizes the diverse starting points, capacities, and community contexts across the province. The goal is not to prescribe a one-size-fits-all solution, but to provide a structured yet adaptable path for identifying and addressing the needs of populations facing barriers to care.

While the work may look different across regions, the shared commitment to reducing disparities, centering lived experience, and promoting meaningful change remains constant. By building on exisiting strengths and moving forward with intention, NLOs can help ensure that high-quality, inclusive mental health care is accessible to all who need it.

## References


1. Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, University of Chicago Legal Forum: Vol. 1989: Iss. 1, Article 8. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8
2. National Collaborating Centre for Determinants of Health. (2013). Let's talk: Universal and targeted approaches to health equity. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. https://nccdh.ca/resources/entry/lets-talk-universal-and-targeted-approaches
3. Middlesex-London Health Unit. (2012). Identifying Priority Populations: Process, Recommendations, and Next Steps London, Ontario: Carina Rodgers. https://www.healthunit.com/uploads/identifying-priority-populations.pdf
4. Public Health Ontario. (2015). Focus On: A Proportionate Approach to Priority Populations. https://www.publichealthontario.ca/-/media/documents/F/2015/focus-on-priority-populations.pdf
5. Ontario Agency for Health Protection and Promotion (Public Health Ontario), Tyler I., Hassen N. (2015). Priority populations project: understanding and identifying priority populations for public health in Ontario. Toronto, ON: Queen's Printer for Ontario. https://www.publichealthontario.ca/-/media/documents/P/2015/priority-populations-technical.pdf
6. Quality Improvement & Innovation Partnership. (2009). Needs Assessment Resource Guide. https://www.hqontario.ca/portals/0/Documents/qi/qi-rg-needs-assessment-0901-en.pdf
7. Vybíral, Z., Ogles, B. M., Řiháček, T., Urbancová, B., & Gocieková, V. (2023). Negative experiences in psychotherapy from clients' perspective: A qualitative meta-analysis. Psychotherapy Research, 34(3), 279–292. https://doi.org/10.1080/10503307.2023.2226813
8. Faber, S.C., Khanna Roy, A., Michaels, T.I., Williams, M.T. (2023). The Weaponization of Medicine: Early Psychosis in the Black Community and the Need for Racially Informed Mental Health Care. https://doi.org/10.3389/fpsyt.2023.1098292
9. Veltman, A., La Rose, T., Chaimowitz, G. (2023). Mental Health Care for People Who Identify as Two Spirit, Lesbian, Gay, Bisexual, Transgender, and (or) Queer (2SLGBTQ+). https://www.cpa-apc.org/wp-content/uploads/CPA1195727_English.pdf
10. Dawkins, B., Renwick, C., Ensor, T., Shinkins, B., Jayne, D., Meads, D. (2021). What Factors Affect Patients' Ability to Access Healthcare? An Overview of Systematic Reviews. https://doi.org/10.1111/tmi.13651
11. Public Health Ontario. (2016). Focus On: Logic Models: A Planning and Evaluation Tool. https://www.publichealthontario.ca/-/media/documents/F/2016/focus-on-logic-model.pdf
12. Hall, J. (2022). Monitoring. Better Evaluation. https://www.betterevaluation.org/methods-approaches/themes/monitoring
13. Global Evaluation Initiative. (n.d.). What is evaluation? BetterEvaluation. https://www.betterevaluation.org/getting-started/what-evaluation
14. Kusek, J., Rist, R. (2004). Ten Steps to a Results-Based Monitoring and Evaluation System. The International Bank for Reconstruction and Development. The World Bank. https://documents1.worldbank.org/curated/en/638011468766181874/pdf/296720PAPER0100steps.pdf
15. US Centres for Disease Control and Prevention (CDC). (2024). CDC Program Evaluation Framework. CDC. Retrieved at. https://www.cdc.gov/evaluation/php/evaluation-framework/index.html

# Appendix

## Appendix A: Additional Resources

**Needs Assessment Resources:**

- Needs Assessment Resource Guide
  - An in-depth resource created by the Quality Improvement and Innovation Partnership on how to conduct needs assessments (in the context of Family Health Teams).
- Census Program Data Viewer Dashboard
  - A dashboard created by Statistics Canada that allows for quick mapping of key census data elements.
- 2021 Census List of Geographies, Ontario
  - Profiles of census areas by Statistics Canada containing information on age, education, ethnocultural and religious diversity, housing, immigration, income, language, etc.
- Canada's Action Plan on Combatting Hate
  - The Government of Canada's first action plan outlining concrete measures to prevent and address hate.

**Engagement Resources:**

- Laying the Foundation for Meaningful Engagement Workshop Slides
  - A slide deck developed for the OSP's Meaningful Engagement Workshop held in 2022. These slides accompany the workbook.
- Two-Way Street? A Critical Look at Patient and Family Engagement
  - The pre-workshop reading material that is referenced in the slides and the workbook.
- How to Plan Your Next Engagement Session
  - A "quick-start guide" previously developed for OSP that outlines how to plan a meaningful engagement session.
- Equity in Engagement Framework
  - A framework developed by Cancer Care Ontario and Ontario Health outlining how to promote equitable engagement practices.
- Guidelines for Enhancing the Engagement of People with Lived Experience Across the HSJCC Network
  - A framework developed by the Provincial Human Services and Justice Coordinating Committee. It provides practical strategies for improving engagement and outlines the history of the psychiatric consumer/survivor movements and the prisoners' rights movements in Canada.
- Self-Evaluation Tool for Action in Partnership
  - A self-evaluation tool developed by the Canada Research Chair in Community Approaches and Health Inequalities that can be used to identify strengths and weaknesses of a partnerships and areas for improvement.
- Let's Talk: Redistributing Power to Advance Health Equity
  - A resource developed by the National Collaborating Centre for Determinants of Health that outlines the need to focus on power as a root cause of health inequities, as well as strategies on how the redistribution of power can be integrated into practice.

**Implementation resources:**

- Equity-Focused Ideas to Improve Client Access and Experience
  - A good starting point for quick things that an NLO can do to improve client access and experience. These suggestions are not tailored to any specific PoF.

- A Practical Guide to Equity, Diversity, and Inclusion in Hiring and Onboarding
    - A resource previously developed for OSP that includes considerations for getting around HR challenges, as well as hiring and retention challenges.
- Evidence Brief: Professional Interpretation in Psychotherapy
    - An evidence brief prepared for OSP which outlines the evidence on how interpretation services affect the delivery of psychotherapy.

**Progress Monitoring Resources:**

- Monitoring
    - An introductory resource on monitoring activities, projects, programs, and policies.
- What is Performance Measurement?
    - A resource that outlines key processes for performance measurement, as well as outlines common challenges and solutions.
- Rainbow Framework
    - A framework that can be used to support monitoring and evaluation activities.

**Logic Model Resources:**

- Logic Models: A Tool for Effective Program Planning, Collaboration, and Monitoring
    - An introductory resource to logic models that describes how to develop them and how they can be used to improve policy and practice.
- Logic Model Workbook
    - A comprehensive workbook on how to develop a logic model.
- Creating Program Logic Models
    - A resource that outlines how to use a theory of change to develop a program logic model.

**Developing Indicators Resources:**

- Developing Evaluation Indicators
    - A resource developed by the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention that describes what indicators are and how to develop them.
- How to Design Indicators
    - A resource developed by TradeMark East Africa that provides additional information on the definition, type, development process, quality assessment and baseline and target establishment of indicators.
- Indicators
    - A resource developed by Intrac for Civil Society that describes how to frame quantitative and qualitative indicators well.

**Program Evaluation Resources:**

- Better Evaluation
    - A website containing a repository of tools and resources for program evaluation.
- Eval Academy
    - A website with resources on conducting program evaluation.

## Appendix B: Introduction to Program Evaluation

Some NLOs already conducting activities related to their PoFs may be interested in program evaluation. While progress monitoring allows for continuous quality improvement, evaluation allows for NLOs to delve deeper into understanding the value and impact of their PoF work.

Program evaluation is "any systematic process to judge merit, worth or significance by combining evidence and values".[13] Although similar to progress monitoring, program evaluation elicits more in-depth questions about the value of an initiative. It can leverage performance results to understand intervention effectiveness, and further explores the reasons for achieving intended and unintended outcomes, causal contributions of activities to results, implementation processes, lessons learned, and recommendations for improvement.[14]

Traditional evaluations are discrete and larger than progress monitoring deliverables; however, different types of evaluations are conducted at different points in a program. Program evaluation is also a cyclical process that is often learning-focused and can provide richer quantitative and qualitative data and insights, though it may be more resource-intensive than progress monitoring depending on the scope. Ideally, progress monitoring and evaluation should be used together, forming a system where one mechanism learns from the results of the other. Additional resources on program evaluation can be found in **Appendix A**.

The stages in the program evaluation process include:[15]

| Program Evaluation Process | Possible Tasks |
|---|---|
| Assess Context | • Evaluability, needs, readiness, or capacity assessment<br>• Identify current and ideal state |
| Describe the Program | • Building a theory of change<br>• Systems mapping<br>• Interest-holder mapping |
| Focus the Evaluation Questions and Design | • Designing an evaluation plan |
| Gather Credible Evidence | • Advanced data analysis<br>• Regular data collection and analysis system beyond minimum requirements |
| Generate and Support Conclusions | • Variety in reporting products (eg., reports, dashboards) |
| Act on Findings | • Knowledge translation or mobilization<br>• Continuous system of learning |