

**Home Care and Pharmaceuticals Division,  
Health Policy and Communications Branch,  
Health Canada**

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**Analysis of Interfaces Along the Continuum of Care**

**Technical Report 4:  
Adults Requiring Mental Health Services**

**February 2002**



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Adults Requiring Mental Health Services**

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**February 2002**



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## **EXECUTIVE SUMMARY**

The present study was commissioned by the Federal/Provincial/Territorial Advisory Committee on Health Services' Working Group on Continuing Care. Its purpose was to examine factors and practices that impede or facilitate integrated care for adults with mental health disorders. The study is one of four parallel projects concerned with systems of care relevant to unique populations including seniors, children and people with disabilities. These projects address commonly used health services for each population, how well these services are integrated into a system of service delivery, and how well they are linked to services outside of the health care system.

Data were derived from interviews with key informants in every province and territory representing provincial and territorial governments, regional health authorities, service providers and consumer organizations. A second source of information was focus groups with mental health consumers and family members. Using a structured interview format, 59 individuals participated in telephone interviews with members of the research team.

In general, interview respondents reiterated concerns about Canadian mental health care previously documented through mental health reform/renewal initiatives. In this regard, the study did not necessarily uncover new information on service gaps or inefficiencies. Although understandable, interview data were characterized by a preoccupation with particular shortcoming in the service continuum rather than the mechanisms that promote integrated delivery systems.

Little evidence of fundamental disagreement on needed system improvements among study respondents was observed. The lack of any major divergence in views and opinions expressed at this juncture appears to reflect the common understanding of barriers to appropriate and integrated care that has emerged through comprehensive mental health sector reviews across the country. Differences did emerge, however, with respect to the degree of progress made toward common policy objectives. Regional health authorities and community agencies felt more support and funding was required from provincial governments to achieve the organizational and/or delivery changes envisioned by new policy. Policy-makers at the central level assigned greater significance to the presence of new policy as a mechanism to achieve change. Consumer and family representatives conveyed a more critical view of mental health care systems in keeping with their legitimate "watchdog" and advocacy roles.

Overall findings confirmed that while numerous providers of services and supports to individuals with mental health problems are integral to a comprehensive care continuum, the end result is a large number of interfaces for users to cross. Poor coordination among services can result in significant disruption in service continuity and may fail to keep high need clients engaged in care. This, in the end, leads to higher use of crisis and acute-care services among this client group.

The need to create more integrated systems of care was well recognized among participants and the challenges of achieving this were present in both urban and rural environments and in centralized and decentralized health care systems. Several common themes

emerged which gave rise to specific suggestions that may inform policy development along the continuum of care. The elements considered essential, among study respondents, to achieve improved service integration and better consumer outcomes included:

- consistent policy direction from government leaders and policy-makers;
- inclusive local planning processes and mechanisms;
- ensuring a single point of fiscal and administrative accountability;
- developing the potential for primary care to play a more extensive and central role in mental health care;
- expanding case management capacity;
- greater reliance on technology;
- expanded role for consumer initiatives; and
- more attention to early intervention.

It is recommended that public-sector decision-makers consider these elements in the context of the growing literature on integrated delivery systems.

## **ACKNOWLEDGEMENTS**

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## 1. INTRODUCTION

Mental health disorders affect over one in five Canadians and are associated with significant social and financial costs. Some of these disorders exist in mild forms and can be managed in the general practice setting or may remit without treatment. The present project was concerned with services available to persons with mental health disorders who have complex psychosocial needs. This includes those with serious mental illness, characterized by profound symptoms and marked disability of a chronic nature, and those with less severe conditions but associated with significant functional impairment. These levels of severity affect one in twenty, or 5.4% of the population (US Surgeon General, 1999) and typically require services and supports from multiple providers. The objective of this project was to solicit the views of key individuals across the country regarding factors that promote an integrated continuum of care for adults with mental health disorders. The project was also concerned with links between health care and other sectors and how interfaces along the care continuum might be strengthened.

The outcome of the project is intended to inform policy with respect to potential improvements in access, quality, integration, and cost-effectiveness of mental health care. There are numerous providers of care in the mental health field resulting in a number of interfaces for users to cross. Consumers and families have cited the lack of a smooth transition across these interfaces as a key reason for poor service outcomes (Farrar, 1996). While the need to create more integrated systems of care is well recognized, many changes are required to achieve this. The challenges are present in both urban and rural environments and in centralized and decentralized health care systems.

The input of those involved in the design and delivery of services as well recipients of services was sought on both the factors that impeded and enhance integrated care. Two data sources were used: i) semi-structured telephone interviews with decision-makers, service providers, advocates, and consumers organization representatives; and ii) focus groups with consumers and family members.

Mental health systems across the country are in various stages of reform and/ or renewal and as a result most provinces and territories have undertaken a comprehensive review of their system(s) of care to identify gaps and areas where improvements are needed. Reform efforts have been guided by work commissioned by the Federal/Provincial/ Territorial Advisory Network on Mental Health (ANMH) to identify best practices in mental health reform and strategies for their implementation. This work, completed by the Health System Research Unit of the Clarke Institute of Psychiatry, resulted in the release of three papers (Health Canada, 1997a; 1997b; 1997c). These papers provided a critical look at research relating to best practices in mental health reform, a situational analysis of innovative reform policies, practices, and initiatives in Canada, and a summary and synthesis of findings supporting a checklist of key elements of a reformed system of care.

The best practices checklist provides a mechanism to assess whether a mental health care system is attending to critical issues and processes. The checklist is shown in Appendix A. The project team used the best-practices checklist as a starting point to develop a list of services potentially used by adults with mental health problems. This list (Appendix B) became part of

the interview schedule, allowing respondents to comment on the extent to which the different components were present in their jurisdictions. Despite a coherent sampling frame, the execution of the study did not permit a systematic sampling strategy. As a result, the interview data must be viewed as a sampling of perspectives and local issues, rather than a systematic appraisal of mental health care systems. This limited the extent to which valid comparisons may be drawn between jurisdictions and types of respondents. Rather, the value-added aspect of this study is in the major themes that emerge from the data and in the local examples of innovation to achieve integrated care and good consumer outcomes.

## **2. METHODS**

In total, 54 interviews (with a total of 59 people) and two focus groups were conducted (for a list of the organizations surveyed see Appendix C). Efforts were made to sample several respondents in each province and territory from provincial governments, regional health authorities, service providers, and advocacy and consumer organizations.

### **2.1 Sampling Strategy and Interviews**

The sampling frame applied to each jurisdiction was intended to include at least one respondent from the provincial or territorial government, two from regional health authorities, two from service provider associations and/or agencies, and one from consumer organizations. In larger jurisdictions, an attempt was made to conduct more interviews with regional level respondents. While difficulties were encountered in the execution of the study, primarily because of problems with scheduling and availability, every effort was made to adhere to the original sampling strategy.

The initial list of interview contacts comprised the members of the Federal/Provincial/Territorial Advisory Network on Mental Health (ANMH) and the list of executive directors of the Canadian Mental Health Association divisional offices. The members of the ANMH primarily represent provincial/territorial governments. These individuals are senior decision-makers generally at the assistant deputy minister or executive director level that have responsibility for mental health services. In addition to these lists, each representative on the F/P/T Working Group on Continuing Care was asked to provide key contacts in their province or territory.

Each individual in this initial pool of approximately 40 contacts was sent a letter introducing the study and an invitation to participate in a telephone interview. This letter was followed up one week later by a telephone call and/or email correspondence to arrange an interview date and time. Consenting individuals were contacted at the appointed time by one of three mental health team interviewers. Respondents in Québec were interviewed by a francophone interviewer hired specifically for this component of the study.

Telephone interviews were conducted using a structured interview schedule (English and French versions are shown in Appendices D and E). The interview schedule was derived from the information contained in the request for proposals issued by Health Canada on behalf of the Federal/Provincial/Territorial Advisory Committee on Health Services Working Group on Continuing Care. The interview was refined and revised by the project team on the basis of their experience in the field and on the basis of pilot interviews. Interviews took approximately one hour to complete. Prior to the interview, the service list was faxed to the respondent so that it could be referred to during the interview.

Respondents were asked to forward any recent public policy documents relevant to the study topic and these were consulted in preparation of the final report. They were also asked if they could provide the names of other individuals they considered to be key contacts in their jurisdiction.

Overall, 103 individuals were invited to participate in the study and 54 telephone interviews were conducted with a total of 59 respondents (in a few cases more than one respondent participated), resulting in a response rate of 57%. Those who did not agree to an interview did so primarily because of scheduling problems rather than substantive issues/concerns.

## **2.2 Focus Groups**

Two focus groups were held: one with consumers or recipients of mental health services and one with family members of people receiving mental health services. Six individuals were recruited for the consumer focus group with the help of the Capital Mental Health Association. Questions used to guide discussion in the consumer focus group are shown in Appendix F. The family focus group was organized through the local chapter of the BC Schizophrenia Society and those who agreed to participate were related to individuals who suffered from primarily psychotic disorders. Five family members attended the focus group. Family focus group questions are shown in Appendix G. Both focus groups were held in Victoria, BC. Consumer participants received a \$10 honorarium for their time; family members were not remunerated.

### **3. FINDINGS REGARDING PERCEPTIONS OF WHETHER OR NOT SYSTEMS OF CARE ALREADY EXIST**

Several different perspectives were expressed on whether a “system of care” already exists. These perspectives vary according to the prevailing governance structure, the degree of urbanicity/rurality, and the presence of programs or functions that link services such as case management or case coordination. Compounding this is that the term “system” seems to imply two distinct constructs and its perceived presence or absence can mean different things to different people. The first most common conceptualization is that which equates “system” with coordinated care or effective organization and management of care, irrespective of the number of care components in the continuum. The second view, albeit less widely held, is one that sees “system” as akin to comprehensiveness so that a system is said to exist if all the components of the continuum are present in a geographic area, regardless of the degree of integration.

Also noteworthy is that discussions regarding the integrity of the system take a back seat to concerns regarding service capacity and the complexities of geography and populations to be served. One respondent, representing the advocacy sector in the Yukon, noted that links and interfaces are not the problem –“the real problem is that there is very little to link together.” In essence, it is very hard to talk about a system of care in jurisdictions where there are so many gaps in the continuum. Similarly, the challenges associated with the physical environment and demographics dominate discussions of mental health care systems. In Nunavut, for example, there are 26 separate communities, only three of which are linked electronically, and four official languages. In the Northwest Territories, where locums provide a significant share of general medical practices including mental health care, the quality of care can vary, as can the visiting physicians understanding and knowledge of aboriginal issues.

The above notwithstanding, some general findings emerged. Views about whether a system exists were not strongly related to the affiliation of the interviewee, although there was a tendency among consumer organizations and advocacy groups to appraise the system more critically. The finding in one Maritime province that government sources tend to think in terms of a connected system of care while consumer organizations and service providers often perceive a fragmented system was not uncommon. The term “mental health maze” used by one mental health advocate summed up the difficulties many consumers have navigating existing care systems. This may reflect the discrepancy between planning efforts that strive toward integrated care components and the reality of being on the receiving end of distinct supports and services. However, because an underpinning of reform/renewal has been consumer involvement and intersectoral planning, a consensus has begun to emerge in many jurisdictions as to the system’s shortcoming and needed improvements. This seemingly contributed to the lack of systematic divergence in views found in the present study.

Generally, in large urban centres and where all services are under the authority of a regional health board, there is a stronger perception of a system of care than in less populated regions. Where this perception exists, one finds that there is an availability of a wide array of services and supports, coordinated linkages between service components through sophisticated case management efforts, and a single administrative point of accountability. However, while a system may be assumed to exist because of a more comprehensive set of services and supports in

urban centres, some smaller communities, while lacking most of the key components of an ideal system, may in fact achieve greater integration due to the more manageable size of the clientele and provider network and, by necessity, the multi-functionality role of agency staff. PEI has found that despite fewer specialized services, due to its population size, there is greater familiarity in small communities and a compensatory identification of, and response to, the special needs of individuals.

This differs from views expressed in Alberta where all of the essential service components are said to exist, yet some respondents felt the current organization of services is not an integrated system *per se*. This was said to be related to a number of issues, many of which are in the process of resolution.

#### 4. FINDINGS RELATED TO FINANCING AND RESOURCE ALLOCATION

There was general agreement that the most powerful levers to achieve good mental health care are financial ones. In the remote and sparsely populated regions, major concerns have surfaced regarding the adequacy of mental health funding and the resulting inequities in care. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) (2000) has called for renewed investment in mental health at all levels of government:

*A concerted effort must take place to ensure that a balanced mix of services and support are equally comparably available at similar levels of quality in all regions of the country (p.11).*

In the Northwest Territories one respondent labeled their funding model as “Tarzan funding - swinging from tree to tree”. This reflects the reality that several levels of government, including first nations governments, need to be approached to create a viable funding source to sustain new mental health programs. Major urban centres may be subject to the “heartland/hinterland” phenomena, described by some Ontario service providers, given that mental health funding per capita in downtown Toronto is said to be less than for other areas of the province.

The overwhelming perception of system under-funding dominated discussion of financing and resource allocation. At the regional health authority level, respondents recognized that mental health reform requires more than reconfiguration of current practices and services. The need for provision of increased resources for the mental health sector was at the top of the list in a series of recommendations made by health authorities in BC to the provincial government (Health Association of BC, 2000). In Québec, respondents expressed disappointment that funding did not follow expectations that were created through a mental health forum in 2000 under the previous minister of health. The forum identified priorities and best practices, which created a momentum for change. Significant changes, however, were not realized due to a lack of funds.

Few jurisdictions appear to operate under a true needs-based funding model. Capitation formulas that make adjustments on the basis of demographics alone may result in under-servicing of specific groups such as the mentally ill (Leatt, Pink, & Guerrire, 1998). In most regionalized environments, a separate funding envelope provides funding to health authorities for community mental health services. While this funding is protected in so far as it must be spent on services for mental health clients, it is often not combined with other funding streams to achieve financial and management integration. British Columbia provides separate funding envelopes for community mental health and for acute care with mental health inpatient beds being funded by the latter. Thus, any savings that might be achieved through lower utilization of acute-care services by mental health clients are not transferred to the community side.

The notion of funds following the client was considered by most to be impractical given the way services are organized. Few respondents could name examples where this happens and many questioned the feasibility of such a model. However signs of more flexible funding arrangements were noted. Manitoba’s *Regionalization Act* allows the movement of funds from

hospitals to community services but it was not clear how frequently this has been done. Saskatchewan and BC have a similar provision, a “one-way valve”, which allows regions to move funds from acute care to the community. Ontario’s *Making It Happen*, the policy framework for the delivery of mental health services and supports, identifies innovations in new flexible arrangements to finance individual service plans for shared service clients with multiple needs. Currently, however this only seems to occur within the Ministry of Community and Social Services.

Mental health reform/renewal efforts have been accompanied by targeted funding initiatives, often with the aim of achieving better linkages and partnerships between providers. The Access Project at Riverview Hospital in BC, illustrated the use of patient targeted funding to provide community support for persons ready for discharge from a provincial psychiatric hospital, thus breaking up the backlog occurring with admissions. In Ontario, a funding incentive to facilitate implementation of the Community Treatment Order (CTO) legislation has created new links between the acute-care system and community mental health programs to prevent revolving-door admissions for individuals with serious and persistent mental illness. Forty CTO coordinators are now attached to hospitals to coordinate treatment plans. Other examples of dedicated funding are Manitoba’s Program for Assertive Community Treatment (PACT) which improves client access to multiple services and supports and a specific partnership in Nova Scotia between the Capital area and Dalhousie’s Department of Psychiatry to develop housing options for low-income mentally ill individuals.

As part of their reform/renewal initiatives, provincial and territorial governments have sought to transfer resources from institutional to community care. The proportion of mental health spending invested in community resources has long been advocated by the consumer sector as a key indicator of a progressive mental health system. Newfoundland respondents reported disproportionately high spending in acute care. Ontario is attempting to shift its spending ratio on community and inpatient services to 60/40, which is considered in that province to represent an appropriate balance. New Brunswick is reportedly aiming for a 50-50 funding split. BC currently tracks spending in both sectors as one of its key markers of performance in the mental health service system.

Other issues were raised with respect to financial issues related to drug benefit plans. P.E.I. respondents raised the issue of the cost of psychotropic prescription drugs. Most provinces cover these drugs for mental health clients who are on social assistance but coverage does not extend to many of the working poor. Medication costs can be prohibitive and interfere with compliance, thus leading to deterioration in functioning and an eventual need for social assistance creating a downward spiral. A progressive program in Newfoundland allows persons receiving drug benefits for anti-psychotic medication to retain these benefits for the first six months of employment.

## **5. FINDINGS RELATED TO SERVICE GAPS AND THE ADEQUACY OF SERVICES**

Gaps in the continuum of services exist within the range of publicly funded health care services and within services and supports provided through other sectors. Mental health reform efforts over the past few decades have made significant advances in correcting historical imbalances between hospitals and the community. However, there continue to be serious gaps in community-based services that support those with disabling mental health conditions and allow them to maintain community tenure and achieve a satisfactory quality of life. The range of gaps reported by respondents is extensive. The most common service gaps identified were in the areas of case management, crisis response, psychiatric care, supported housing, rehabilitation services, and income assistance. Adequacy of services was gauged by respondents in terms of service capacity insofar as key services/support components may exist in a given region but be unable to meet the needs of the local population.

### **5.1 Case Management**

Case management was recognized everywhere as a key function that helps consumers access needed services in all sectors and navigate complicated systems. This component of care greatly facilitates access to, and movement between, needed services and supports. Case management exists in some form in most major and small urban centers although providers and consumer representatives in PEI felt it was not a consistent element of care for the mentally ill. Newfoundland contacts described a lack of case management services. Consumer organizations noted that very small and rural communities frequently do not have identified case managers. Saskatchewan respondents described a very strong case management system for persons with serious mental disorders in the province's three largest cities but this did not extend to less populated communities.

Intensive case management or assertive community treatment (ACT) has been advocated as an important element of care for individuals who are high users of mental health services. ACT has been found to reduce the need for hospitalization (Salkever et al., 1999). BC distinguishes ACT from regular case management through five criteria or necessary components: consumer-directed delivery of care, low staff-to-consumer ratio (1:10), assertive outreach, a team approach, and continuous service. While representing a cost-effective approach, the recommended staff/client ratios have limited the number of consumers that can be served through this model. In Ontario where over the last few years there has been dedicated funding for ACT and over 50 ACT teams are in existence, the volume of clients served is still significantly less than those in need. In urban Québec, PACT (Program for Assertive Community Treatment) teams exist, providing intensive community-based services for mental health clients with complex needs who would otherwise be treated in hospital. These teams, based on a US model, were criticized by one respondent who felt that the top-down approach resulted in imposition of models that may be inappropriate for small local systems outside of urban areas.

Even regular case management capacity is inadequate in most areas. The family focus group complained that currently case managers in BC have very large caseloads and cannot give sufficient attention to each case. This perspective was confirmed by regional health authority

personnel, some of who felt the number of case managers could easily be tripled to meet the demand. The Capital Health Region in B.C. has recently disbanded its intensive community support program that provided assertive case management services because the system was becoming too congested. This region has reverted to a standard case management model as a means of increasing capacity.

Good case management can also ensure speedier transfer from acute care to community services. Nova Scotia consumers complained that discharge planning started too late in the hospital stay. The coordination of community supports needed on discharge, when started at the point of admission, can reduce unnecessary days spent in hospital.

## **5.2 Crisis Response**

There are different levels and types of crisis response services. Members of “best practice” working groups in different jurisdictions described the needed range of services including: telephone crisis lines, mobile crisis outreach, walk-in and community crisis stabilization services, and hospital emergency departments. The lack of a range of community based crisis services is believed to account for the high number of hospital emergency room visits. One key policy direction within New Brunswick’s ten-year plan for mental health services was enhancing crisis intervention throughout the province. This was implemented by establishing crisis intervention centers 24 hours/7 days a week in each region.

In most provinces and territories, the full range of crisis services is not available although there is considerable variation on the mix of services available. In the Thunder Bay area, crisis services to smaller communities such as Kenora and Rainy River are primarily telephone lines operated by the CMHA. Mobile crisis teams are in short supply. In rural Quebec, a provider described the lack of structured crisis teams and the failure to avert hospitalization in many acute cases.

In the Yukon, respondents felt that nearly one-third of mental health presentations to hospital emergency could be avoided if there was a 24-hour community based crisis service. Newfoundland contacts indicated that a key needed improvement in adult services was a dedicated emergency response system that includes mobile teams for crisis management, and safe back-up hospital facilities so people in crisis do not have to be incarcerated by the police.

The majority of urban centers have round the clock coverage through community crisis but often have insufficient capacity to meet more than a portion of mental health related emergencies.

## **5.3 Psychiatric Services**

There is a severe shortage of psychiatrists in rural and remote areas and this represents a major barrier to the principle of equitable access in most jurisdictions. Until recently, the Yukon had no inpatient psychiatrist so that all admissions to acute-care for psychiatric problems were assessed and treated by general practitioners. In severe cases, the hospital patient was sometimes sent by taxi with an accompanying nurse to the one part-time outpatient psychiatrist in

Whitehorse. While this may seem extreme, in every jurisdiction, geographically remote communities have very limited access to psychiatrists unless they are willing to travel great distances for appointments. While the situation is mitigated somewhat by the use of tele-psychiatry, there remains a huge gap in the availability of psychiatric care to individuals who live in the North.

In the Northwest Territories, the lack of psychiatric assessment services for mental health conditions relating to earlier traumas associated with residential school experiences among aboriginal people was identified as a major concern. These experiences are thought to underlie much of the addictions problems, family violence and depression in the community. In remote areas of the Maritimes, individuals with mental disorders may have to wait a year after an initial psychiatric contact for a review of symptoms and medication.

In some urban areas, capacity may still be a problem and long waiting times for psychiatric services are identified as a major barrier to care. In Nova Scotia, a number of general practitioners have given up referring to psychiatrists because of length of time before a patient can be seen. Saskatchewan, with only 50 full-time psychiatrists, has a poor psychiatrist/population ratio compared to other provinces and is below levels recommended by the Royal College of Physicians. New Brunswick has attempted to attract and retain psychiatrists through a significant salary boost. Other provinces may have adequate practicing psychiatrists and the problem is more one of how these professionals are distributed throughout the region. Two-thirds of Newfoundland's psychiatrists live in St. John's for instance. In Quebec, the maldistribution problem is compounded by a serious shortage in numbers of psychiatrists and future concerns regarding an aging workforce and further reductions as a result of retirement.

#### **5.4 Supported Housing**

The lack of adequate housing for persons with serious mental illness was a common theme in the discussion of service gaps. Without safe and appropriate housing, these individuals have difficulty achieving stability and quality of life. Mental health housing includes supported housing, residential housing and emergency housing. Supported housing, wherein outreach workers support consumers in their preferred living situation, is the recognized 'best practice'.

Housing shortages are not unique to rural communities. Both Regina and Saskatoon report a serious lack of housing for high need clients as do most other jurisdictions. This shortage causes blockages in acute-care because of the inability to discharge clients who have no stable living arrangement. In the North West Territories, it is not uncommon to have psychiatric stays extended by 90 days because of no available community housing. Acute care backlogs due to a lack of appropriate housing were also reported in Nova Scotia.

In Newfoundland, where respondents felt there were few homeless individuals with severe mental illness due to the fact that the majority of these persons reside with family members, community housing was still identified as a shortage. In fact, there were few jurisdictions where supported housing capacity was not identified as a serious gap.

## **5.5 Rehabilitation**

Rehabilitation programs of all types were considered a critical gap in the service continuum in several jurisdictions. Basic rehabilitation, psychosocial rehabilitation, vocational rehabilitation, and recreation programs were all recognized as supports in the process of helping those with mental illness achieve community integration. An Ontario study participant stressed the role of psychosocial support in preventing the need for re-hospitalization among recently discharged and stabilized patients.

The CMHA participants in the study emphasized the need for services to focus on support for independent living. In this view, the role of the service and support structure is to maximize the way it enhances participation in life as an ordinary citizen. BC's mental health reform initiative identified the need for 2900 new basic rehabilitation and 750 vocational rehabilitation spaces. Only a fraction of these new spaces have been created resulting in a very significant shortage of rehabilitation opportunities for those who require them. The situation is similar in Alberta where almost all respondents identified rehab spaces as a major service gap. Examples were given of structured rehabilitation programs in Calgary, characterized by excessively long wait lists and the need to repeatedly turn people away due to insufficient capacity.

## **5.6 Income Assistance**

People with serious mental illness are often unable to find and maintain full-time employment and require social assistance and/or disability benefits from government. The CMHA's (Trainor, Pomeroy & Pape, 1993) *New Framework for Support* stressed that adequate income is one of the fundamental elements of community life to which every citizen should have access. Unfortunately, many mental health consumers are frequently unaware of their entitlements or may have difficulty accessing assistance through social assistance, disability payments, etc. Focus group participants emphasized this as a major problem for individuals with disabling mental health conditions. These consumers complained that current levels of financial assistance in BC do not provide sufficient income for anything beyond subsistence living.

Respondents in other areas as well noted the income limitations for mental health populations. In Manitoba it was found that over 12% of cases receiving income assistance are for reasons of mental health disability. However, while there have been steady increases in the cost of living, this has not been reflected in the income assistance allowance for nearly 10 years. It was also found that policies related to allowances for essential needs such as telephone and transportation were not uniformly applied across regional areas. Medication coverage for the "working poor" and work incentive amounts have also been longstanding issues affecting people with mental health problems (Manitoba Health, 2001).

## **5.7 Other**

As noted above, many gaps were cited by respondents. Personnel in Nunavut recognize that they may never have adequate trained personnel and a fully diverse service system. For this

jurisdiction, the single largest gap is capacity development. Currently, there is not sufficient funding for needed education and training.

The lack of basic medical care for individuals with serious mental illness has been recognized across the country. Many of the individuals do not have a regular family practitioner and receive only irregular medical attention. Poor access to basic health care, as a result of geography, was raised by respondents in the North West Territories. Unfortunately, the population of persons with severe psychiatric disorders are at higher risk for infectious diseases and other ailments due to self-neglect and living conditions. The potential oversight of physical health problems among mental health clients was also raised in Québec.

Service gaps are largest in the smaller communities, where the population size cannot support a full range of services. For those services that are available somewhere within the region, travel over large distances may be required to access them. Furthermore, there will be times during the winter when services are inaccessible to some clients. Transportation is a big problem for small communities spread over a large geographical region. In Newfoundland, residents who live outside of St. John's may have to travel for several hours to receive mental health services.

Tertiary care facilities do not exist in the territories and residents in need of this level of care need to be sent to facilities outside of their home region. However, as noted by one community development specialist in the area, sending residents out of the region for care runs counter to the aboriginal community's value system.

Finally, human resource problems were highlighted as a major system shortcoming. In Saskatchewan, one impact of the nursing shortage is that many health districts have had to adjust the ratio of nurses to non-professional staff to provide 24-hour coverage on the mental health inpatient units. Interview respondents echoed the nursing shortage concerns documented in the 1999/00 Saskatchewan Mental Health Program Review (Saskatchewan Health, 2000). The Review noted a resurgence in the acceptance and tolerance of the use of physical restraints in the management of individuals in a psychotic state. The interest in closed/locked door facilities is also increasing.

## **5.8 Consensus on the Care Continuum**

There was general agreement among all of those interviewed that the key components in a comprehensive mental health care system should include:

- Case management
- Community mental health outpatient services
- Psychiatry services
- Primary care
- Day hospital/day programs
- Inpatient care: acute and tertiary
- Hospital-based emergency services

- Community based emergency services (crisis lines, mobile crisis outreach, walk-in crisis stabilization)
- Residential care
- Rehabilitation services (psychosocial and vocational)
- Consumer-directed self-help/support groups
- Drug-benefit services
- Supported housing
- Supported employment
- Income assistance
- Transportation services
- Home support

## **6. FINDINGS REGARDING BLOCKAGES AND BARRIERS TO THE EFFECTIVE MOVEMENT OF CLIENTS BETWEEN SERVICE COMPONENTS**

Service configurations and governance situations can create barriers to the seamless movement of clients through the continuum. In Alberta, respondents intimated that there has been some uncertainty regarding the responsibilities for services governed by regional health authorities and those under the jurisdiction of the Alberta Mental Health Board. The process of rationalizing the two systems in the context of reform and ensuring needed input from, and collaboration with, community stakeholders has created significant challenges. In BC, three configurations of mental health services were described: a local structure, a regional structure, and a combination of local and regional structures. Perspectives from those involved in mental health care in rural parts of the province reflected the duplication of effort through unclear boundaries between Community Health Councils and Community Health Services Societies each with their own mental health budget.

The inability for clients to move between service components may be directly related to gaps in any one area of the system. The need for acute-care discharge planning units that ensure the transfer of patient care to a community provider was considered a critical function to ensure smooth transitions. The lack of suitable residential options for clients ready to leave acute care is another prime example of a barrier to effective client movement. There is also difficulty with access to housing given different sets of eligibility criteria across programs. Housing units may give priority to higher functioning individuals and thereby exclude the seriously mentally ill. The issue of narrow program criteria arose with respect to other programs as well. Confusion about where multiple and dual/diagnosis clients fit into existing program structures, for instance, is quite common.

Eligibility is also a concern in the area of home care services. The Canadian Mental Health Association (CMHA) (Parent, Anderson & Neuwelt, 2000) recently published the results of a study to explore issues related to home care for adults with serious mental illness. The study concluded that access to publicly funded home care programs by people with serious mental illness is variable across the country and in many jurisdictions, mental illness is not sufficient to meet eligibility criteria unless it is secondary to a physical condition or developmental delay. Despite the fact that home care can make a significant difference in the lives of people with serious mental illness, the study recorded that the formal home care system does not always address the needs of these clients in a way that is appropriate for their circumstances, and that there is limited awareness by mental health services providers, consumers and their families, as to what home care services are available, from whom, and for what purpose and duration.

Barriers to the movement of clients between service components can also occur where there is insufficient or incompatible transfer of information. Critical clinical information may not follow the client to a new program due to confidentiality concerns, the lack of mechanisms for electronic linking, or incompatible data systems. One respondent in the Champlain District noted the differences in assessment protocols used in hospitals and community services and the duplication that occurs as a result. Respondents in Alberta expressed frustration over the separate client information systems for the regional health authorities and the Alberta Mental Health

Board. In Charlottetown, it was noted that communication about cases becomes a lower priority when mental health agency staff are overextended with clinical duties.

Impediments to smooth referrals and transitions across service interfaces are sometimes more related to philosophical than practical issues. BC, along with other jurisdictions, suggested that different belief structures regarding the etiology and treatment of mental illness were sometimes a barrier to appropriate client movement. In addition, it was intimated that consumer groups and consumer-run programs are not always perceived as equal partners and thus are sometimes overlooked in the service continuum. This was also reported to apply to non-government community service organizations. To the extent that these programs are seen as “add-ons” they are not able to maximize the role they might have with respect to service continuity. Consumer organizations and advocates also pointed to the continued presence of stigma around severe mental illness among both managers and providers. This stigma, although frequently veiled, creates real barriers to fair access.

Day hospitals and day program are considered an important transitional element in the continuum of services for persons who require intensive support but not necessarily hospitalization. These settings can provide the necessary structure and surveillance for patients recently discharged from acute-care. Day hospitals can begin psychosocial re-entry work with clients and coordinate the transfer to ongoing vocational, rehabilitation and/or recreational programs.

Client movement between programs is impeded when case management services are not available. Case managers coordinate a consumer’s health care, housing, rehabilitation services, vocational training and/or employment. They also address income needs, recreational opportunities and other aspects of personalized care. Because case management often does not exist in smaller communities or does not have sufficient capacity in larger centers, many avoidable barriers to care are experienced by consumers and their families. The Champlain District Mental Health Implementation Task Force is examining the potential for delinking case coordination from case management with the goal of ensuring that the primary responsibility is getting access to different points in the system based on needs.

Clients, living in remote areas, who require transfer from a primary care practitioner to specialty care often face transportation problems. In Ontario, as in other regions, a travel subsidy program exists, but apparently many clients and the referring agent are not aware of this and this imposes further delays in moving from one component of care to another.

Finally, one respondent described the “siege mentality” that has descended on the health care professions due to fiscal restraint, personnel shortages, and major organizational changes through regionalization. This mentality has resulted in a coping style that perseveres with traditional approaches, promotes rigid role definitions and stifles new and creative models of care. This issue was also raised in several jurisdictions where entrenched interests (hospital vs. community; unions; professional associations, etc.) have interfered with needed mental health reform. In Northern communities, the stresses on the system can cause conflict among professionals and contribute to an absence of “good will” that, if present, would enhance communication and coordination among providers.

## **7. FINDINGS RELATED TO INTERFACES BETWEEN COMPONENTS OF THE HEALTH CARE SYSTEM AND WITH SOCIAL AND OTHER SERVICES**

The complex psycho-social needs of people with mental health problems require sound intersectoral linkages. Unfortunately, at present, interfaces between care components for this population are not optimally managed. This was evident in descriptions of the interface between mental health services and primary care physicians and psychiatrists. In the majority of provinces, health care delivery operates within a regionalized structure. Yet, in many jurisdictions, physician services are not regionalized but are managed and funded provincially. Physicians are the largest providers of mental health services. Thus, while regional health authorities oversee the operation of community mental health services, they exert little influence on the provision of medical care and as a result, poor coordination between physicians and other providers occurs. Funding mechanisms and organizational models for the delivery of medical care may contribute to a “sole-provider” mentality, described by a Québec respondent, in which psychiatrists or general practitioners do not attempt to integrate the care they provide with the larger community support network.

Interfaces between acute-care and community care would benefit from improved clinical integration. Respondents noted the increased emphasis on discharge planning for individuals leaving hospital after an admission for major mental disorder. The goal of continuity of care at this interface may break down, however, for a number of reasons. These include a lack of capacity within community programs to provide needed support on discharge, poor communication among providers, lack of transfer of information and records, and a failure to involve the consumer and his/her family in the discharge planning process. The lack of a comprehensive assessment to identify both the clinical and the non-clinical supportive needs of the client may also preclude establishing appropriate referrals/linkages. A very poor interface between the emergency rooms and community agencies was noted. The overcrowding of hospital emergency departments limits the availability of staff to attend to issues of follow-up for mental health cases.

Within the community mental health continuum of services and supports, interfaces were found to be hampered by a lack of functional or administrative integration. Even within a regionalized delivery structure, reports of poorly connected and integrated community agencies were evident. The need for management contracts, joint committees and planning bodies was identified. New Brunswick, being one of the first provinces to adopt regionalization, appears to have achieved structures that promote coordination and integration in the mental health sector.

The problems related to the interface between health and social services were described in the foregoing sections. Family members, in particular, felt that access to social assistance for persons with mental disorders is difficult. The suggestion was made that there is greater understanding of financial issues for the seriously mentally ill when social services and mental health are housed within the same ministry or administration as is the case in PEI and Newfoundland. Other provinces such as BC have committed to improved inter-ministry collaboration but system stakeholders and users feel little progress has been made in this area.

The need to address interfaces with forensic care and with alcohol and drug treatment programs was identified as a priority concern. The latter has been identified as a priority area in

Ontario's implementation plan for mental health reform and B.C.'s recent addictions services task force. In no region, did interview respondents report the presence of a well-integrated approach to caring for people with co-morbid psychiatric and substance use disorders. A recent study to examine best practices for concurrent mental health and substance use disorders was commissioned by Health Canada and conducted by the Health System's Research and Consulting Unit at the Centre for Addiction and Mental Health (2001) in Toronto. The study included a national survey of organizations to develop an inventory of specialized concurrent disorder programs. Thirty-four agencies across the country self-identified as having specialized programs, the majority being in Ontario and Quebec with one or two in BC, Alberta and Saskatchewan. The study concluded that Canada has few integrated treatment programs for this client group and that a very small number of programs adhere to best practice recommendations found in the scientific literature.

Attention to intersectoral issues is a major thrust of Manitoba's mental health renewal. This will involve establishing appropriate links with addictions services, vocational/employment services, housing, income assistance and justice. Quebec respondents noted the successful intersectoral effort among health, employment and community groups to develop regional "services for work integration". These services afford opportunities for adults with mental health related disabilities to re-enter the workforce and facilitate overall community integration.

A definite need for more permeable boundaries across services systems was identified. In addition to more flexible access mechanisms, entry to, and contact with, care systems may be facilitated by consumers' understanding of available services and supports, and their entitlements.

## **8. FINDINGS REGARDING SUGGESTIONS FOR HOW TO IMPROVE SYSTEMS OF CARE**

The following suggestions represent a distillation of the views and ideas expressed by interviewees. Most of the suggested directions are applicable in all jurisdictions although some will have greater relevance in a given province or territory.

### **8.1 Consistent Policy Direction**

The reality of politics in the present era is that changes in leadership occur with some regularity. In several provinces, key informants noted the number of recent changes in health ministers, governing structures, and government and health authority decision-makers. These changes may be seen by stakeholder groups to illustrate instability and to threaten the policy goals outlined in provincial mental health reform announcements. A unified vision accompanied by consistent objectives and direction in the context of changing personnel is considered vital to the pursuit of system improvements in the mental health sector.

### **8.2 Coordinated Planning Mechanisms**

Significant progress has been made in creating coordinated, multi-disciplinary, and multi-sector delivery models to achieve integrated health care. This progress has resulted from inclusive planning processes that address the entire continuum of services and supports. The new model of collaboration, described as community governance, involves a broad range of stakeholders, including those who are not health care professionals, in decision-making. It is noteworthy that in several jurisdictions, provincial policy directives specify expectations at the regional and community level for agency partnerships and coordinated planning and delivery of mental health services. However, these policy requirements do not specify how this should be achieved. As noted by one Québec respondent, however, leaving the strategies to the community agencies themselves has been a good thing and is the reason that innovative coordination networks at the local level have emerged. These networks, of which several examples were cited, are now recognized as representing a key “best-practice” in system strategies to achieve integrated care.

The Mental Health Implementation Task Forces in Ontario illustrate an effective approach to coordinated planning. Nine task forces have been appointed for an 18-month period throughout the province, with the chair of each participating in the provincial task force, which is overseeing common issues. The role of each task force is to involve key stakeholders in the assessment of local needs and the development of feasible and responsive strategies in line with the province’s *Making It Happen* policy framework. This approach ensures that local planning efforts are consistent with current policy direction but tailored to the unique characteristics and circumstances within different regions. The model also allows for information sharing among regions.

Innovative local planning and community governance is also exemplified by Niagara Partners in Service (NPIS), a coalition of community agencies, consumers and families, that have joined together through a shared desire to improve the provision of mental health services in the

region. NPIS has identified the need for a coordinated or centralized access system that would provide information about available services and supports, simplify and facilitate contact with community services and supports, and eliminate redundant assessment procedures. Partners in the coalition have undertaken a process to review models elsewhere and have achieved agreement on the primary functions of a coordinated access system and the general form such a system should take. On finalization of the specifics regarding operations and infrastructure, NPIS will submit a proposal to the Ontario Ministry of Health for funding to implement the system in the Niagara region.

Ontario government officials also conveyed that some local catchment areas are exploring the concept of a “lead agency” as a system design option. Designated lead agencies may fulfill such functions as centralized intake/assessment, first line response through crisis intervention programs, etc. This option is similar to “agency clusters” where services are integrated into a community-based cluster so that roles and functions can be streamlined and avoid duplication of effort.

The Saskatchewan annual Mental Health Program Review is a good example of a continuous quality improvement approach to planning and managing the mental health system of care at the central level. The goal of the Review is to collect and communicate information on mental health programs and services that can be used in planning by health districts, Saskatchewan Health, and other interested groups and agencies. The report acts as a catalyst to identify issues and concerns that affect the delivery of mental health services in that province and highlights positive action and solutions in one district that might be tried in another district. Three annual program reviews have been conducted since the transfer of services to health districts.

### **8.3 Single Point of Accountability**

While an inclusive approach is key to the achievement of better mental health systems, so is the need for a single point of accountability. Establishment of one organizational entity or mental health authority at the local/district level responsible for program and fiscal accountability was felt to be a key mechanism to facilitate an integrated care continuum. In many regionalized systems, the point of responsibility has been established in the form of a regional mental health manager or director. However, the scope of responsibility and control was found to vary from region to region. In other jurisdictions, decentralization is relatively new and the functions required of mental health authorities to ensure integrated care approaches are still developing.

The BC Mental Health Monitoring Coalition (2000), representing the BC Schizophrenia Society, the Canadian Mental Health Association – BC Division, and the Mood Disorders Association, has called for consolidation of responsibilities at the regional level wherein mental health leaders are accountable for all parts of the mental health system and act as full participants in planning and decision-making in the region.

## **8.4 Improved Links with Primary Care**

A consensus exists on the need for an expanded role for primary care in the management of persons with mental health disorders. For a large majority of persons with mental health disorders, the first contact with the formal health care system is through the general practitioner. Moreover, general practitioners tend to stay involved with the client over the long-term and as such are key providers in the care continuum. Several provinces, including Saskatchewan, BC, and Manitoba, noted that reviews of the numbers of mental health services provided by fee-for-service primary care physicians have been undertaken. These numbers are very large compared to the number that consult a psychiatrist or receive services through a mental health clinic. The view that mental health care would be greatly improved if there were greater integration between primary care physicians and secondary or specialized services was widespread in the present study.

In 1997 a joint working group of the Canadian Psychiatric Association and the College of Family Physicians published a position paper on shared mental health care (Kates, 1997). The working group stressed the function of primary care as the cornerstone of the health care system and the central role of family physicians as providers of mental health care in almost every community. The aim of the position paper was to suggest three key strategies for collaborative activities between family physicians and psychiatrists. These strategies included: improving communication, new linkages between family physicians, psychiatrists and psychiatric services, and integrating psychiatrists and psychiatric services within primary care settings. This work and shared-care pilot programs helped stimulate many new primary care initiatives across the country.

One of the early innovative models for integrating mental health services with primary care was implemented in the Hamilton-Wentworth region. The program currently involves 87 family physicians serving approximately 185,000 people. This represents just over 30% of physicians in family practice in Hamilton and about one-third of the population of the region. The Hamilton model has been adopted by Calgary and regional health authorities elsewhere and has proven successful in establishing better links with general practitioners. In Calgary's Share Care project, a mobile mental health team visits physicians' offices to see clients and hold case conferences with the physician.

The Simon Fraser Health Region's shared care pilot project in British Columbia began in October 1999. It's goals are to increase the skills and comfort of family physicians in identifying and managing mental health problems and to enhance the position of family practice clinics in the mental health continuum of care by strengthening links with local mental health services. The project has achieved better accessibility to mental health services and improved communication and working relationships between family practitioners, psychiatrists and other mental health providers.

Manitoba's plan for mental health renewal embraces a primary health care model founded on population health principles. These principles which include holistic, community-based strategies and coordinated, integrated approaches underpin the development of new Health Access Centres throughout the province. Three, of the twelve planned centers will be launched in

2001. The centers are designed to promote single entry and access to all related services. This allows people's health needs to be addressed both in the primary care system and intersectorally

Different areas of the country have begun to explore ways to enhance the role of primary care physicians in mental health. Considerably more needs to be done. New initiatives will need to resolve funding differentials between fee-for-service and alternate payment models for physicians and explore ways to remunerate physicians for indirect services such as case conferencing.

### **8.5 Expanded Case Management**

The development of models of case management that have the capacity for good "reach" throughout a region such as New Brunswick's case management program which is delivered by public health nurses throughout the province should be supported. Different models of regular and intensive case management are in place across the country. Some jurisdictions adhere very closely to the ACT models found to achieve good client outcome, as described in the scientific literature. Other areas, for reasons related to excessive demand or cost-constraints, have pursued standard case management or have developed more flexible models of ACT.

The key to effective case management is a clear understanding of the function of this component in the care continuum and to ensure the resources and staff/client ratio support fulfillment of this function. In all jurisdictions, funding for case management could be improved.

### **8.6 Greater Reliance on Technology**

Tele-health was advocated in most jurisdictions as a means of improving care. A partial solution to the lack of specialists in remote areas of the country is tele-psychiatry. Ponoka Hospital is thought by many to lead the way in this area. Other well-developed programs include Sunnybrook Hospital's North Network, the Child and Youth tele-psychiatry program out of Dalhousie University, and the tele-mental health program operated by the Mental Health Evaluation and Community Consultation Unit at UBC. The Canadian Psychiatric Association now has a section of tele-psychiatry and may be conducting a formal inventory of services across the country.

Electronic health records are also considered a beneficial way to promote continuity of care for clients who need to be transferred between regions and providers. While integrated service delivery has been achieved in many communities, there has not been corresponding coordination in the collection, transfer and management of mental health information. The Capital Health Region (CHR) in BC has recently been awarded funding through the Canadian Health Info-Structure Partnerships Program (CHIPPP) to develop a piece of public domain software that can track clients through multiple layers of the health and social system. At present, in the CHR, as soon as a client is referred to a third-party agency, there is a loss of continuity in the record. The new project will develop and implement an important component of the electronic health record for use by small to medium size health and social service delivery agencies that operate at the community level. The resulting software package will be developed

and implemented to meet the general client information, operating, management, and networking requirements of community mental health service agencies in a regional health authority setting.

Online resources are a useful means of connecting consumers to services and supports and improving linkages between providers. The BC Mental Health Resource Guide is an example of an online web directory containing up to date information about mental health resources throughout communities in British Columbia. The Guide includes information about adult mental health centres, child and youth mental health services, hospital psychiatric services, mental health societies and associations, and mental health self-help groups. The Guide is searchable by age, diagnosis, region, and service.

## **8.7 Expanded Consumer-Run Programs**

Consumer advocates argue that the informal component of support for persons with mental illness is a critical component in the overall care continuum. Consumer-driven and consumer-run initiatives, with appropriate financial support, can fill gaps in the community resource base and address needs in the area of peer-counseling, recreation, training, and employment. Such programs, distinct from the formal health care system, represent an important resource to many consumers. The benefits of consumer involvement include reduced hospitalization and use of other health care services, improved social support networks, in addition to increased self-esteem and well-being. While the value of ensuring consumer initiatives have a place in the continuum of care is acknowledged by government decision-makers, adequate financial support has been lacking. Community mental health providers in Quebec noted the vulnerability of consumer run programs due to the absence of secure funding. Very few provinces appear to have a specific line item in their mental health budgets for consumer initiatives. The uncertainties arising from an unstable funding base limit the potential of these programs in the care continuum.

Consumer-run programs are able to go beyond the limits of traditional services and address essential elements of community life, such as work, housing, income, and education, all of which are non-health care components that significantly affect quality of life. Several examples of successful programs that meet these needs were found.

A model program is Ontario's Council of Alternative Businesses, which operate as a consumer run businesses so that employment can be structured to accommodate the needs of clients with mental health related disabilities. This program has been hailed as one which develops a sense of pride and ownership. Calgary's Potential Place Clubhouse, partially funded by the Alberta Mental Health Board, has developed a consumer operated education and employment program which offers pre-employment skills, supported employment and flexible employment options for members.

In Newfoundland, consumer organizations not only see themselves as a key component of the care continuum but also feel they are essential to compensate for the weaknesses in the system through the provision of clubhouses, recreational programs, and many other supports. In this province, there is an entrepreneurial, consumer-run program known as CHANNAL (Community Health Awareness Network of Newfoundland and Labrador), which enables mental health consumers to train and work in an environment that provides a supportive

framework. This provincial network has begun to develop alliances with industries that will allow consumers to enter structured part-time work placements. It also provides assistance to participants in nutrition and other life-skills.

The North Okanagan Peer Outreach/Mutual Support is a program whose day-to-day operations are run entirely by consumers. While the program steering committee includes some mental health professionals, most program decisions are made by consumers. Those attending the program receive training in communication and conflict resolution skills, crisis intervention, and grief management.

The above are just some of the many examples of successful consumer-based programs. Another key role for consumer programs is as brokers of information about the health and social service systems. Such initiatives also have the potential to connect people to care systems and to integrate them to the larger community. This role is an important one in terms of ensuring appropriate access to all services and supports within the care continuum. To realize substantially greater support for consumer programs, such initiatives will need to produce evaluation data that demonstrates intended outcomes are being achieved.

## **8.8 More Attention to Early Intervention**

There is mounting evidence that early intervention and treatment of mental health disorders is associated with better outcomes from a number of perspectives. Evidence also suggests that it is during the first few years of psychotic illness when people experience the greatest decline in functioning, after which deterioration levels off (McGlashan, 1996).

A number of provinces now have early psychosis intervention projects underway and a momentum in this area is building across Canada. The early intervention program run out of the University of Saskatchewan is aimed at preventing deterioration. BC's early psychosis intervention program provides education and resources for mental health providers and families around the province. Alberta has mounted a huge early intervention program that extends beyond psychotic disorders and has been successful at improving coordination between the school system and mental health services. Successful programs were also identified in Halifax and London, Ontario.

Youth with mental health problems in PEI benefit from a program in which a mental health clinician is assigned to a particular school each week to consult with guidance counselors and address potential mental health problems among students. This provides an opportunity for mental health intervention with youth to occur within the school setting and reduces stigma.

Efforts in Manitoba are focused on early intervention for people with mental disorders at all stages of life through articulation of "portals of entry" which may include primary care, schools, day cares, community health centers and welfare agencies. Planners and policy-makers in this jurisdiction are tackling the interface between health care and public health. This type of forward thinking recognizes that these two historically distinct sectors of medicine and public health are becoming increasingly dependent on one another to achieve their goals (Lasker, 1997).

## 9. SUMMARY AND CONCLUSIONS

Adults, for whom mental health problems cause significant disability in terms of day to day functioning can benefit from the assistance of a diverse set of providers. However, this results in there being several interfaces between services for users to cross. Poor coordination among services can result in significant disruption in service continuity and may fail to keep high need clients engaged in care. This in the end leads to higher use of crisis and acute-care services.

Ideally, the experience of the mental client should be one of a single coordinated pathway of care where there are smooth referrals and seamless transfers between care components including primary and secondary care, acute and community care, health and social services, health and criminal justice systems, health and education systems, and health and housing services.

Participants in this project reiterated concerns about Canadian mental health care previously documented in earlier reports and, in this regard, the study has not necessarily uncovered new information on service gaps or inefficiencies. No evidence of fundamental disagreement on needed system improvements among study respondents was observed. The lack of any major divergence in views and opinions expressed at this juncture is a reflection the common understanding of barriers to appropriate and integrated care that has emerged through comprehensive mental health sector reviews across the country. What did differ was assessment of the degree of progress made toward common policy objectives. Regional health authorities and community agencies felt more support and funding was required from provincial governments to achieve the organizational and or delivery changes envisioned by new policy. Policy-makers at the central level saw the presence of new policy to guide change as a significant achievement in and of itself. The notion of bridge funding as a means of overcoming administrative constraints to implement new policy was promoted as an effective mechanism.

Representatives from consumer organizations and consumer advocates were somewhat more critical of the care system than those involved in the planning and delivery of mental health services. This role of “watchdog” helps to keep system reforms on track and relevant to the needs of users. A clear distinction could be seen in the views of those in rural versus urban communities. The lack of basic services and supports in remote regions is regrettable and represents an urgent need for more innovative strategies. The very significant gaps in these communities overshadowed discussions of system interfaces.

The findings noted in the previous chapter represent a distillation of perspectives and suggestions from a large number of key individuals in the mental health field. The authors acknowledge certain limitations in the report. First, despite a reasonably structured interview protocol, respondents tended to focus on particular shortcomings in the service continuum rather than on mechanisms which promote integrated systems. Second, while system issues and possible solutions were enumerated, the scope of the project did not permit a detailed discussion concerning the complexities in these areas. A full analysis of these issues may need to be explored through other means. These concerns notwithstanding, the identified directions have the potential to improve service quality and client outcomes through addressing gaps in one or more

care components, improving links between different care components, and enhancing overall care planning.

The study results have provided a series of directions, which hold promise for improved service integration and better consumer outcomes. These include:

- Consistent policy direction from government leaders and policy-makers;
- Inclusive local planning processes and mechanisms;
- Ensuring a single point of fiscal and administrative accountability;
- Developing the potential for primary care to play a more extensive and central role in mental health care;
- Expanding case management capacity;
- Greater reliance on technology;
- Expanded role for consumer initiatives; and
- More attention to early intervention.

These suggestions should be considered in relation to the following key elements of an integrated delivery system as defined by Leggat and Leatt (1997):

- A focus on population health needs;
- Service capacity matched to population's needs;
- Coordinated and integrated care across the continuum;
- Information systems to link patients and providers across the continuum of care;
- Information available to stakeholders on cost, quality outcomes, and patient satisfaction;
- Financial incentives/organizational structure used to align governance, management, and providers in support of shared objectives;
- Continuously improves care provided; and
- Inclusive/participatory approach to ensure community's health objectives are met.

Ensuring these elements are in place can be a challenge in any governance model. It is all too easy to identify shortcomings in mental health care systems. The current priority must be close examination and active management of the interfaces between the different components that make up a comprehensive mental health care system. Significant progress in this area is being made in several health districts where solid alliances among all stakeholders are evident. The degree of commitment, leadership and funding provided at the political level appears to be a strong inducement for renewed efforts to improve mental health care system(s) in a region. When a clear policy framework for mental health care accompanies this, as is the case in many provinces and territories, it creates an impetus and context for local planning and for attaining local solutions.

That the identified service gaps and inefficiencies in the planning and delivery of mental health care continue in many jurisdictions represents a source of frustration among stewards, providers, and users of that care. This frustration, however, has not contributed to a prevailing sense of pessimism. Rather, its presence has helped to stimulate change. In fact, the vision outlined by the Canadian Alliance on Mental Illness and Mental Health (2000) sees, by the year

2005, *an appropriately funded, integrated, accessible system that provides the continuum of care that is supported by research, an information base, as well as public and professional education* (p.30). There is recognition that much has been learned from mental health reform initiatives throughout the country and these lessons can contribute to continued renewal of the system. At present, mental health consumers, their families, advocates and organizations which represent them are positioned to hold the formal care system accountable for achieving needed changes and for ensuring improvements in the quality of life for those compromised by serious mental illness.

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# **APPENDICES**



**APPENDIX A**  
**Checklist of key elements of a reformed system of care: Core programs\***

Best Practice Area	Checklist Criteria
Case Management/ACT	<p>An array of clinical case management programs are in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models.</p> <p>There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders.</p>
Crisis Response/ Emergency Services	<p>A continuum of crisis programs is in place to help people resolve crises using minimally intrusive options.</p>
Housing	<p>There is a variety of housing alternatives available, ranging from supervised community residences to supported housing, with emphasis on supported housing.</p> <p>Housing needs of the homeless mentally ill are addressed.</p>
Inpatient/outpatient care	<p>Inpatient stays are kept as short as possible without harming patient outcomes.</p> <p>An array of treatment alternatives to inpatient hospitalization is available, including day hospitalization and home treatment.</p> <p>Long stay patients in provincial psychiatric hospitals are moved into alternative care models in the community.</p> <p>Service delivery models link family physicians with mental health specialists.</p>
Consumer initiatives	<p>Consumer initiatives are in place that have diverse purposes such as mutual aid, skills training and economic development.</p> <p>Consumer initiatives are supported through funding, consumer leadership training, education of professionals and the public about consumer initiatives, and evaluation using appropriate methods.</p>
Family self-help	<p>Funding is provided to family groups who also participate in planning and evaluation of care delivery.</p>
Vocational/educational supports	<p>There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation.</p>

Reprinted from: Health Systems Research Unit, Clarke Institute of Psychiatry. (1997). *Best Practices in Mental Health Reform: Discussion Paper*. Ottawa: Health Canada.

**APPENDIX A (cont'd)**  
**Checklist of key elements of a reformed system of care: System strategies**

Best Practice Area	Checklist Criteria
Policy	<p>There is a freestanding mental health reform policy based on an explicit vision that is shared among various stakeholders, including consumers and families.</p> <p>There is a planned strategy for implementing policy.</p> <p>Policy preserves the mental health envelope, prevents losses due to downsizing institutions, and increases the proportion of funds spent on community care.</p> <p>Policy defines concrete, measurable targets for reform.</p>
Monitoring and Evaluation	<p>Regular monitoring of all services and supports is the basis for program and system accountability, and for continuous quality improvement.</p> <p>Preset goals, performance measures and time lines are established.</p> <p>An information system has common elements for system evaluation (provincial) and local elements for program evaluation (agency level).</p> <p>There is a sufficient, protected evaluation budget.</p>
Governance and Funding	<p>At the regional/local level one organizational entity or mental health authority is responsible for mental health care, and is a clear point of accountability for system performance.</p> <p>The authority uses clinical, administrative and fiscal mechanisms to promote cost containment, transfer resources from institutional to community care, implement best practices and increase accountability.</p> <p>Diverse funding sources are consolidated into a single funding envelope that can be used flexibly.</p> <p>Funding allocations to a region or local area are linked with unique characteristics and needs of residents.</p> <p>A consumer-centred information system supports decision-making in planning, funding and managing the system.</p> <p>Administration of mental health care is connected with the broader health system and with generic services.</p>
Human Resources	<p>A detailed labour strategy is in place to facilitate redeployment of staff.</p> <p>Strategies enhance consumer involvement as providers and educators.</p>

Reprinted from: Health Systems Research Unit, Clarke Institute of Psychiatry. (1997). *Best Practices in Mental Health Reform: Discussion Paper*. Ottawa: Health Canada.

**APPENDIX B**  
**List of Services Potentially Used by Persons with Mental Disorders**

	Available?			Adequate Capacity?
	Yes	No	Should be	
<i>Publicly funded health services</i>				
Case Management - Assertive Case Management - Standard Case Management				
Outpatient Services - Clinic (Community Mental Health Centre or Hospital Psychiatry Outpatient Dept)				
Outpatient - Psychiatrist Services (FFS)				
Outpatient - Psychiatric care through GP				
Outpatient - Day Program/Day Hospital				
Inpatient- Acute Care				
Inpatient - Tertiary Care				
Emergency Services (crisis lines, mobile crisis outreach, walk-in crisis stabilization, community crisis stabilization, hospital based emergency psychiatric services)				
Residential Care - MH Boarding Homes, Respite Care				
Consumer-run programs (recreational, etc)				
Drug Benefit Plan				
<i>Social/Other services</i>				
Supported Housing				
Rehabilitation: Vocational/Educational Programs				
Supported Employment				
Social Assistance				
Transportation				



## APPENDIX C

### List of Organizations Interviewed for the Mental Health Component of the Project

Region	Organization	Number of Interviews	Number of People Interviewed
<b>British Columbia</b>	1. Capital Health Region	1	1
	2. Office of the Provincial Mental Health Advocate	1	1
	3. Ministry of Health, Adult Mental Health Division		
	4. Health Association of BC, Service Provider Association	1	1
	5. BC Schizophrenia Society		
	6. Kootenay Boundary Community Health Services Society (CHSS), Mental Health Services	1	2
	7. Canadian Mental Health Association, BC Division	1	3
		1	1
	<b>Total for British Columbia</b>	<b>7</b>	<b>10</b>
<b>Alberta</b>	1. Children's Hospital, Mental Health and Child Development Programs	1	1
	2. Regional Health Authority, Calgary	1	1
	3. Canadian Mental Health Association, Alberta Division	1	1
	4. Alberta Health and Wellness, Population Health Strategies		
	5. Calgary Association of Self Help	1	1
	6. Regional Health Authority, Fort McMurray	1	1
		1	1
	<b>Total for Alberta</b>	<b>6</b>	<b>6</b>
<b>Saskatchewan</b>	1. Saskatchewan Health, Community Care Branch	1	1
	2. Saskatchewan Mental Health Services, Adult Therapies		
	3. Canadian Mental Health Association, Saskatchewan Division	1	1
	4. Schizophrenia Society of Saskatchewan		
		1	1
	<b>Total for Saskatchewan</b>	<b>4</b>	<b>4</b>
<b>Manitoba</b>	1. Government Health Programs	1	1
	2. Regional Health Authority, Winnipeg, Community Mental Health Programs	1	1
	3. Manitoba Schizophrenia Society	1	1
	<b>Total for Manitoba</b>	<b>3</b>	<b>3</b>

<b>Region</b>	<b>Organization</b>	<b>Number of Interviews</b>	<b>Number of People Interviewed</b>
<b>Ontario</b>	1. Ontario Ministry of Health, Integration Policy Planning Division, Mental Health and Rehabilitation Reform Branch	1	2
	2. Ontario Federation of Community Mental Health Programs	1	
	3. Centre for Addiction and Mental Health, Clarke Site, Health Systems Research and Consulting Unit	1	1
	4. Schizophrenia Society of Ontario	1	1
	5. Health and Long-Term Care, Mental Health Implementation Task Force	1	
	6. Canadian Mental Health Association, Ontario	1	
			1
			1
			1
	<b>Total for Ontario</b>	<b>6</b>	<b>7</b>
<b>Québec</b>	1. Community Agency	1	1
	2. Psychiatrist in Rural Regional Hospital and Outreach Program	1	1
	3. Regional Board, Mental Health Services Planning	1	
	4. Ministry of Health and Social Services	1	1
	5. Community Mental Health Organization	1	
	6. Association for Psychosocial Rehabilitation	1	1
			1
			1
	<b>Total for Québec</b>	<b>6</b>	<b>6</b>
<b>New Brunswick</b>	1. Department of Health and Wellness, Fredericton, Community Mental Health	1	1
	2. Department of Health and Wellness, Adult Services	1	1
	3. Department of Health and Wellness, Moncton, Community Mental Health	1	1
	4. Department of Health and Wellness, Central Office	1	1
			1
	<b>Total for New Brunswick</b>	<b>4</b>	<b>4</b>
<b>Prince Edward Island</b>	1. Department of Health and Social Services, Child, Family and Community Services	1	1
	2. Department of Health and Social Services	1	1
	3. Acute Care and Mental Health, Queen's Region Health	1	1
	<b>Total for Prince Edward Island</b>	<b>3</b>	<b>3</b>
<b>Nova Scotia</b>	1. Department of Health, Health Services Branch, Mental Health Services	1	1
	2. Mental Health Program, Social Work	1	
	3. Service Provider, Psychiatry Department, Dalhousie University	1	1
			1
	<b>Total for Nova Scotia</b>	<b>3</b>	<b>3</b>

<b>Region</b>	<b>Organization</b>	<b>Number of Interviews</b>	<b>Number of People Interviewed</b>
<b>Newfoundland</b>	1. Canadian Mental Health Association, Newfoundland	1	1
	2. Department of Health, Program Development		
	3. Community Health Board	1	1
	4. Independent Living Resource Centre	1	1
	5. Emmanuel House (Residential Program)	1	1
	6. Schizophrenia Society of Newfoundland	1	1
	<b>Total for Newfoundland</b>	<b>6</b>	<b>6</b>
<b>Yukon</b>	1. Health and Social Services, Mental Health Services	1	1
	2. Whitehorse General Hospital, Clinical Care		
	3. Second Opinion Society	1	1
	4. Mental Health Expert	1	1
	<b>Total for Yukon</b>	<b>4</b>	<b>4</b>
<b>Northwest Territories</b>	1. Department of Health and Social Services, Community Wellness	1	2
	<b>Total for Northwest Territories</b>	<b>1</b>	<b>2</b>
<b>Nunavut</b>	1. Department of Health and Social Services Unit, Adult Services, Social Services Unit	1	1
	<b>Total for Nunavut</b>	<b>1</b>	<b>1</b>
	<b>Grand Total</b>	<b>54</b>	<b>59</b>



**APPENDIX D**  
**Interfaces along the Continuum of Care Project**  
**Adults with Mental Health Disorders Research Team**  
**Interview Schedule**

Respondent Name: \_\_\_\_\_ Date \_\_\_\_\_

Organization: \_\_\_\_\_ Region: \_\_\_\_\_

***1. Components of the service continuum***

You will have received a list of service and support entities that may be used by adults with mental health disorders.

- Could you please indicate which of these services are available and commonly used by adults with mental health problems in your jurisdiction. If they are available, is there adequate system capacity?
- For services that are not available in your jurisdiction at present, please indicate whether you feel that they should be available (publicly funded) in a fully integrated system of care.
- Are there services/supports that should be on this list.

***2. Service gaps***

- Within the range of services provided to adults with mental health disorders (noted in question 1), do you feel that there are gaps either in the availability of these services or the extent to which they are utilized? Please explain.

***3. Access to care***

- How do adults with mental health disorders typically enter the care delivery system? e.g., primary care, emergency depts, police referrals, community mental health clinics, social service agencies (welfare).

***4. Extent of integration of services within the health care continuum***

The following questions relate to the how community mental health services noted above interact with other major components of the health care system such as acute care hospitals, fee-for-service physicians (GPs and psychiatrists).

- Given entry points noted above, how well are clients referred/linked to the mental health sector?
- To what extent do you think that the mental health sector is well integrated with the broader health care system? Specifically:

- To what extent is it integrated with the primary care system? Can it be assumed that patients receiving mental health care through a general practitioner are receiving adequate care for physical health? For patients who are not under the care of a GP, how are their physical health needs being met?
- To what extent is it integrated with the acute-care system?
- To what extent is it integrated with prevention/early Intervention programs in schools and or the workplace?
- What are your thoughts on what would need to be done to achieve an integrated continuum, or system, of care that maximizes the available resources to achieve better care and better health outcomes for adults with mental health disorders?

#### ***5. Barriers to integration within the service system***

- Within the range of services provided to adults with mental health problems, are there any barriers to the integration of care services into a system of care that permits easy movement of clients between types and sites of service?
- Please identify the two or three most important barriers (probe if necessary ).

#### ***6. Consumer-run initiatives***

- To what extent are consumer/family self-help or other consumer-run initiatives funded by the formal health care system and what role do these services play in the overall continuum of care? Are these services well integrated with other components of mental health care?

#### ***7. Movement of clients and funds within the health care continuum***

- Within the range of services provided to adults with mental health disorders noted in question 1, is it possible for funders or service providers to move funding from one type of service to another in response to client needs?
- To what extent does money follow the client, e.g., if more clients are looked after at home than in residential care are facility funds shifted to community care? Please comment on the feasibility of this within the current system of care.

#### ***8. Cost-effectiveness***

Are there any impediments to providing appropriate care in the most cost-effective and appropriate setting by the most appropriate provider? If so what are these barriers?

- Are the inefficiencies in service provision? - How effective are we at matching client need to resource intensity of the service? What strategies are used to achieve this?

***9. Interfaces, links and coordination with services outside of the health care system***

The next questions are concerned with the extent to which the mental health sector is well integrated with the social services system. Specifically:

- To what extent is it integrated with services outside the health system such as social assistance, housing, transportation and education?
- To what extent are there still barriers to access to, and movement of clients between, types and sites of service?

***10. Overall coordination/integration***

Considering the larger health and social service system and the system of care for mental health clients what are your thoughts on what would need to be done to achieve an overall continuum, or system of care for (population) which maximizes the available use of resources to achieve better care and better health outcomes?

- What policy initiatives do you feel would strengthen the interface and level of integration or coordination between the mental health sector and other components of the broader health and social service system?
- Are any of these initiatives underway in your jurisdiction? Have they been successful. If not, why not?

***11. Context***

Finally, are there any contextual changes that have occurred in your jurisdiction that have enhanced or impeded coordination of care for adults with mental health problems?

- policy initiatives
- socio/economic conditions
- other

## List of Services Potentially Used by Persons with Mental Disorders

	Available?			Adequate Capacity?
	Yes	No	Should be	
<i>Publicly funded health services</i>				
Case Management - Assertive Case Management - Standard Case Management				
Outpatient Services - Clinic (Community Mental Health Centre or Hospital Psychiatry Outpatient Dept)				
Outpatient - Psychiatrist Services (FFS)				
Outpatient - Psychiatric care through GP				
Outpatient - Day Program/Day Hospital				
Inpatient- Acute Care				
Inpatient - Tertiary Care				
Emergency Services (crisis lines, mobile crisis outreach, walk-in crisis stabilization, community crisis stabilization, hospital based emergency psychiatric services)				
Residential Care - MH Boarding Homes, Respite Care				
Consumer-run programs (recreational, etc)				
Drug Benefit Plan				
<i>Social/Other services</i>				
Supported Housing				
Rehabilitation: Vocational/Educational Programs				
Supported Employment				
Social Assistance				
Transportation				

**Appendix E:**  
**Projet relatif aux interfaces du continuum des soins de santé**  
**Équipe de recherche — Adultes ayant des problèmes de santé mentale**  
**Plan de l'entrevue**

Nom du participant : \_\_\_\_\_ Date : \_\_\_\_\_

Organisme : \_\_\_\_\_ Région : \_\_\_\_\_

**1. Éléments du continuum de services**

Vous avez reçu une liste des services et des groupes de soutien (Annexe 1) auxquels ont accès les adultes ayant des problèmes de santé mentale.

§ Pouvez-vous préciser lesquels de ces services sont offerts dans votre province ou votre territoire et souvent utilisés par les adultes ayant des problèmes de santé mentale? La capacité du système de santé permet-elle d'offrir adéquatement ces services?

§ Dans le cas des services qui ne sont pas offerts pour l'instant dans votre province ou votre territoire (avec un financement de l'État), pensez-vous qu'ils devraient être offerts par un système de soins de santé entièrement unifié?

§ D'autres services ou mesures de soutien devraient-ils figurer sur la liste?

**2. Lacunes des services**

§ En ce qui concerne la gamme de services offerts aux adultes ayant des problèmes de santé mentale (voir la question 1), croyez-vous que l'accessibilité de ces services ou l'ampleur de leur utilisation comportent des lacunes? Expliquez.

**3. Accès aux soins de santé**

§ Comment s'établit habituellement le lien entre les adultes ayant des troubles de santé mentale et le système de prestations de soins de santé? P. ex., soins primaires, services d'urgence, police, clinique communautaire de santé mentale, organismes de services sociaux (aide sociale).

**4. Ampleur de l'intégration des services dans le continuum des soins de santé**

Les questions suivantes concernent la façon dont les services communautaires en santé mentale mentionnés ci-dessus interagissent avec les autres principaux éléments du système de soins de santé, comme les hôpitaux de soins actifs et les médecins qui sont rémunérés à l'acte (omnipraticiens et psychiatres).

§ Compte tenu des éléments fournis ci-dessus, croyez-vous que l'aiguillage des clients vers le secteur de la santé mentale est adéquat?

§ D'après vous, à quel point le secteur de la santé mentale est-il intégré au système de soins de santé en général? Précisez.

§ À quel point est-il intégré au système de soins primaires? A-t-on raison de croire que les patients qui reçoivent des soins de santé mentale dispensés par un omnipraticien reçoivent des soins adéquats en ce qui concerne leur santé physique? En ce qui

concerne les patients qui ne sont pas suivis par un omnipraticien, comment répond-on à leurs besoins en matière de santé physique?

§ Dans quelle mesure le secteur de la santé mentale est-il intégré au système de soins actifs? À quel point est-il intégré aux programmes de prévention et d'intervention précoce dans les écoles et (ou) dans les lieux de travail?

§ À votre avis, que devrait-on faire afin d'en arriver à un continuum ou à un système intégré de soins de santé qui maximiserait l'utilisation possible des ressources, ce qui nous permettrait d'offrir de meilleurs soins de santé aux adultes ayant des problèmes de santé mentale, et d'obtenir de meilleurs résultats en matière de santé auprès de ces personnes?

### **5. Obstacles à l'intégration au sein du système de prestation de services**

§ Compte tenu de la gamme de services offerts aux adultes ayant des problèmes de santé mentale qui figurent à la question 1, existe-t-il des obstacles à l'intégration des services de soins de santé en un système de soins qui permettrait aux clients de passer facilement d'un type de services à un autre, et d'un emplacement à un autre?

§ Veuillez préciser les deux ou trois obstacles les plus importants (approfondir au besoin — voir l'annexe B).

### **6. Initiatives dirigées par le client**

§ Dans quelle mesure les initiatives qui supposent des efforts personnels de la part de la famille ou du client, ou d'autres initiatives dirigées par les clients, sont-elles financées par le système officiel de soins de santé, et quel rôle jouent ces services dans le continuum général de soins de santé? Ces services sont-ils bien intégrés aux autres composantes des soins de santé mentale?

### **7. Déplacement des clients et du financement à l'intérieur du continuum des soins de santé**

§ Compte tenu de la gamme de services offerts aux adultes ayant des problèmes de santé mentale qui figurent à la question 1, les bailleurs de fonds ou les fournisseurs de services peuvent-ils déplacer du financement d'un type de service à un autre afin de répondre aux besoins des clients?

§ À quel point l'argent suit-il le client? P. ex., si un plus grand nombre de clients reçoivent des soins à domicile plutôt qu'en établissement, le financement destiné aux installations est-il transféré au système de soins communautaires? Veuillez commenter et préciser si cette façon de faire est possible dans le système actuel de soins de santé.

### **8. Rentabilité**

Existe-t-il des obstacles qui nous empêchent de fournir des soins adéquats de la façon la plus rentable et la plus appropriée possible, et par l'entremise du fournisseur qui convient le plus? Dans l'affirmative, quels sont-ils?

§ La prestation des services est-elle parfois inefficace? À quel point réussissons-nous à faire correspondre les besoins des clients au niveau d'intensité des ressources du service? Quelle stratégie utilisons-nous afin d'y parvenir?

### **9. Interfaces, liens et coordination avec les services extérieurs au système de soins de santé**

Les prochaines questions ont trait à la mesure dans laquelle le secteur de la santé mentale est intégré au système de services sociaux. Plus particulièrement :

- § À quel point est-il intégré aux services extérieurs au système de santé, comme l'aide sociale, l'aide au logement, les services de transport et l'éducation?
- § À quel point les clients ont-ils encore de la difficulté à accéder à certains types de services et à certains emplacements, et à passer d'un type de services à un autre, et d'un emplacement à un autre?

### **10. Coordination/intégration générales**

Si l'on tient compte du système de services sociaux et de santé en général et du système de soins de santé destinés aux personnes ayant des problèmes de santé mentale, quelle mesure devons-nous prendre, à votre avis, pour en arriver à un continuum, ou système, unifié de soins de santé destinés aux (groupe démographique) qui maximiserait l'utilisation possible des ressources, ce qui nous permettrait d'offrir de meilleurs soins de santé et d'obtenir de meilleurs résultats en matière de santé?

- § À votre avis, quelles initiatives en matière de politique renforceraient les rapports et le degré d'intégration qui existent entre le secteur de la santé mentale et les autres éléments du système général de services sociaux et de santé?
- § Certaines de ces initiatives sont-elles actuellement en cours dans votre province ou votre territoire? Ont-elles donné des résultats? Sinon, pourquoi?

### **11. Contexte**

Enfin, y a-t-il eu des changements contextuels dans votre province ou votre territoire qui ont amélioré ou compliqué la coordination des soins destinés aux adultes ayant des problèmes de santé mentale?

- § initiatives en matière de politique
- § conditions socioéconomiques
- § autres

## Liste de services que les personnes ayant des problèmes de santé mentale peuvent utiliser

	Accessible?			Capacité adéquate?
	Oui	Non	Devraient l'être	
<i>Services de santé financés par l'État</i>				
Prise en charge - Prise en charge dynamique - Prise en charge ordinaire				
Services ambulatoires — clinique (centre communautaire de santé mentale ou service hospitalier de consultations externes en psychiatrie)				
Services ambulatoires — services d'un psychiatre (rémunération à l'acte)				
Services ambulatoires — soins psychiatriques prodigués par un omnipraticien				
Services ambulatoires — programme de jour/hôpital de jour				
Hospitalisation — soins aigus				
Hospitalisation — soins tertiaires				
Services d'urgence (lignes d'écoute téléphonique, services itinérants d'interventions d'urgence, stabilisation d'une situation d'urgence en clinique sans rendez-vous, stabilisation d'une situation d'urgence en milieu communautaire, service psychiatrique d'urgence en milieu hospitalier)				
Soins en résidence — pension en santé mentale, soins de relève				
Programmes dirigés par les clients (récréatifs, etc.)				
Assurance-médicaments				
<i>Services sociaux et autres services</i>				
Aide au logement				
Réadaptation : programmes de formation professionnelle et programmes éducatifs				
Aide à l'emploi				
Aide sociale				
Services de transport				

## **Appendix F: Consumer Focus Group Questions**

### **Questions for Focus Groups for the Analysis of Interfaces Along the Continuum of Care Project for People Receiving Services**

#### **PREAMBLE**

Thank you for agreeing to participate in this focus group. The focus group is part of a large national study funded by Health Canada. We would like to obtain your views regarding the services that are available for [population]. Your input is very important because it will help to identify the strengths and weaknesses of the services currently available to [population] from the perspective of people receiving services. Your input will be used to inform decision makers about what is working well, and what needs some improvement, from the perspective of people receiving health related services.

Participation in this focus group is totally voluntary. You can choose not to participate in the focus group or not to answer any specific questions. No individually identifiable data will be included in the report of this focus group. Your responses will be anonymous.

#### **QUESTIONS**

1. What services are you currently receiving?
2. What are the two or three best things about the services you are currently receiving?
3. What are the two or three areas that need the most improvement with respect to the services you are currently receiving?
4. Do you feel that you are receiving the services that you need? That is, are there services that you feel you need which are not currently available because:
  - the services do not exist
  - there are long waiting lines to access service
  - the services are not affordable
  - other?
5. If you need a range of services, how are those services arranged and coordinated? That is:
  - do you have to try to access services directly?
  - is there someone who helps to coordinate services? If so, who does this coordination?

6. Are there any existing program, financial or other rules or policies which you feel get in the way of you receiving the best possible care?
7. What are the top three or four suggestions you have for improving how care services are provided to:
  - you as an individual?
  - [population] in general?
8. If you were in charge of providing health services to [population] and were given new funding, how would you spend the money to improve the system?

## **Appendix G: Family Focus Group Questions**

### **Generic Questions for Focus Groups for the Analysis of Interfaces Along the Continuum of Care Project for Family Members of People Receiving Care Services**

#### **PREAMBLE**

Thank you for agreeing to participate in this focus group. The focus group is part of a large national study funded by Health Canada. We would like to obtain your views regarding the services that are available for [population]. Your input is very important because it will help to identify the strengths and weaknesses of the services currently available to [population] from the perspective of family members of people receiving care services. Your input will be used to inform decision makers about what is working well, and what needs some improvement from the perspective of family members of people receiving services.

Participation in this focus group is totally voluntary. You can choose not to participate in the focus group or not to answer any specific questions. No individually identifiable data will be included in the report of this focus group. Your responses will be anonymous.

#### **QUESTIONS**

1. What services is your family member currently receiving?
2. What are the two or three best things about the services your family member is currently receiving?
3. What are the two or three areas that need the most improvement with respect to the services your family member is currently receiving?
4. Do you feel that your family member is receiving the services that he/she needs? That is, are there services that you feel your family member needs which are not currently available because:
  - the services do not exist
  - there are long waiting lines to access service
  - the services are not affordable
  - other?

5. If your family member needs a range of services, how are those services arranged and coordinated? That is:
  - do you or your family member have to try to access services directly?
  - is there someone who helps to coordinate services? If so, who does this coordination?
6. Are there any existing program, financial or other rules or policies which you feel get in the way of your family member receiving the best possible care?
7. What are the top three or four suggestions you have for improving how care services are provided to:
  - your family member as an individual?
  - [population] in general?
8. If you were in charge of providing health services to [population] and were given new funding, how would you spend the money to improve the system?