The Institute for the
Advancement of Public Policy

FINAL REPORT

Review of the Community Mental Health System

Submitted to:

Department of Health and Community Services
Government of Newfoundland and Labrador

Submitted by:

The Institute for the Advancement of Public Policy, Inc.
St. John's Newfoundland

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Executive Summary

A review of the community mental health system in Newfoundland and Labrador was sponsored by the Department of Health and Community Services ("the Department") and conducted from December, 2001 to May, 2002. The objective of the review was to develop a framework for a community mental health system for the province. The project was undertaken by a team assembled by *The Institute for the Advancement of Public Policy, Inc.* which included a consultant from the Institute for Human Resource Development, *IHRD Group.*

Since December 2001, with the assistance of the Mental Health Co-ordinators across the province, the following activities have been undertaken:

- an inventory of publicly-funded programs and services has been compiled to present the status by region and provincially;
- through a review of documents and interviews with key informants, gaps in the province's community mental health system have been identified;
- trends in mental health service delivery in this and other jurisdictions have been reviewed and compared with the situation in the province; and
- the findings of the consultants were presented in an Information and Discussion Paper that was used as a basis for a series of consultation sessions conducted throughout the province.

This report presents an analysis of the data collected and a framework for a community mental health system.

The major finding is that the existing mental health system is institutionally-based supported by out-dated legislation. While regionalized services have been developed and delivered through Health and Community Services Boards, there has not been a co-ordinated community mental health system established.

Services are fragmented and disconnected; the hospitals serve clients with mental illnesses and persistent mental health concerns while the Regional Health and Community Services Boards primarily serve clients with mental health issues. There is limited consumer

involvement and families have few supports.

In developing the framework for community mental health services in the province, the consultants relied on the principles articulated in Valuing Mental Health. More specifically, the framework emphasises the following directions:

- the Community Resourced-Based Model for the delivery of community mental health services should be implemented;
- services should be regionalized and delivered under plans consistent with the Model;
- priority has to accorded to serving clients with mental illnesses and persistent mental health concerns, which would include children and youth;
- all regions should have the capacity to provide services to clients through inter-disciplinary teams; where professionals cannot be recruited for service within the region, services can be accessed by using tele-health or by having a professional travel to the region;
- consumer participation is to be supported and resources provided to enable consumers to be engaged; in addition, family self-help is to be supported and developed in each region;
- the data bases of Health and Community Services Boards, Integrated Boards and Hospital Boards should be integrated and consistent definitions used to determine service requirements, set standards and monitor performance; and
- the directions of the Framework for Health Promotion should be re-visited and included in the plans for each region.

An Action Plan for the implementation of the framework is found in the report.

Finally, Government must demonstrate leadership and commitment to the framework and implementation of the Action Plan for community mental health services.

Glossary of Terms

For the purposes of this report, the following terms are used to assist the reader:

Community Mental Health	Refers to publicly-funded services delivered by the Regional Services Boards and those community-based non-profit organizations who are delivering services under a contractual arrangement with one of the Boards.
Mental Health -	Refers to an individual's interaction with the context and events of life, critically affected by their life situation, and the amount of support and control the person has in dealing with their circumstances. (adapted from *Valuing Mental Health*, September 2001)
Mental Health Services -	Refers to all publicly-funded mental health services, services based in the institution, out-patient services and services delivered by Regional Health and Community Services Boards.
Mental Illness -	Refers to a medically diagnosable illness that results in the impairment of an individual's thoughts, mood and behaviour. Mental illnesses tend to be episodic or cyclical in nature; a person may have episodes of acute illness, but also long periods of wellness. The mental illness continuum concerns the presence or absence of symptoms of disorder. (adapted from *Valuing Mental Health*, September 2001)
Persistent Mental Health Concerns -	Refers to a situation where an individual whose ability to live independently is at risk due to their mental health concerns.
Primary Care -	Primary care is initial client contact with the health care system for the purpose of assessment, diagnosis and treatment of acute episodic and chronic illness or injury.
Primary Health Care -	Primary health care is essential care (promotive, preventive, curative, rehabilitative and supportive), that is focused on preventing illness and promoting health. Primary health care is both a philosophy of health care and an approach to providing health services. It has been adopted by the World Health Organization and by Canada as the key to enabling people to lead socially and economically productive lives. Clients of primary health care can be individuals, families, groups, communities and populations. The principles of primary health care are accessibility, public participation, health prevention, appropriate technology and intersectoral cooperation. (Canadian Nurses Association - Policy Statement, April 1995).

Introduction

This document the final report of a community mental health review conducted from December 2001-April 2002. The review was sponsored by the Department of Health and Community Services ("the Department") to develop a framework for a community mental health system for the province. The project was undertaken by a team assembled by The Institute for the Advancement of Public Policy, Inc., a consulting firm based in St. John's ("the consultants") which included Colleen Hanrahan, MSW, (Community Development), LL.B. and Rick Morris, MSW (Clinical) of the Institute for Human Resource Development, *IHRD Group*.

The objectives of the review were to:

- develop an inventory of publicly-funded mental health services organized by region in the province,
- determine the extent to which a comprehensive range of services exists,
- examine the level of service accessibility regionally and provincially from both a geographic and a service integration perspective,
- assess the quality of relationships and linkages with other sectors and identify ways to enhance integration, and
- determine resource requirements including, but not limited to, funding in order to enhance and sustain a comprehensive mental health system in the province.

1. Methodology and approach to the review

The approach to this review was developed in accordance with the requirements presented to the consultants by the Department and was approved prior to implementation. The review was conducted over several phases. The Advisory Committee for the development of new legislation intended to repeal and replace the *Mental Health Act* offered comments throughout the process.

Developing an inventory of publicly-funded mental health services

In order to collect information as a baseline to determine the programming that is currently in place throughout the province, an inventory of publicly-funded mental health programs and services was compiled. This information was collected from those directly involved with the programs. The Department, the Mental Health Co-ordinators within the Health and Community Services Boards ("H&CS Boards"), the Integrated Boards and the hospitals with in-patient psychiatric units ("hospitals") were instrumental to the consultants.

A template was developed, approved by the Department and distributed to the Mental Health Co-ordinators to compile information consistently, program by program, under the jurisdiction of the H&CS Boards, the Integrated Boards and the three institutional (hospital) Boards with psychiatric in-patient units. Refer to **Appendix A**. The template assisted the consultants in gathering information respecting the various programs but also helped to identify other relevant information for the review including clients served, gaps in services, and trends.

Each of the Mental Health Co-ordinators was interviewed to discuss the programs in their regions. In most cases, each Mental Health Co-ordinator oversaw the compilation of the information in the template and forwarded the completed summaries to the consultants. Alternately, the information provided was summarized by the consultants in accordance with the template. It was then forwarded to the mental health co-ordinator for verification. A great deal of information was compiled over a period of one month and was synthesized as background for the review.

An inventory consisting of a provincial summary of the mental health programs was then prepared and presented to the Department with the individual templates and supporting documentation. The inventory comprises 50 programs and captures the status of each program

at a particular point in time. As additional programs have been identified by the Mental Health Co-ordinators these have been incorporated in the inventory. Currently, the inventory is in the possession of the Department.

- *Key informant interviews, review of existing documents and scan of selected jurisdictions*

The consultants identified several key local informants to provide an overview of the community mental health system provincially. Among those interviewed were:

- Dr. Ted Callanan, Chief of Psychiatry, School of Medicine, Memorial University of Newfoundland
- Dr. Tom Cantwell, Clinical Chief of Psychiatry, Health Care Corporation of St. John's
- Ms. Debbie Sue Martin, Director of Programs, Department of Health and Community Services
- Ms. Moyra Buchan, Executive Director, Canadian Mental Health Association-Newfoundland and Labrador Division

Further, an interview was conducted with the national executive director of the Canadian Mental Health Association to determine trends and directions in mental health nationally. As the national office is located in Ontario, the national co-ordinator was in the position to comment on trends in that province too.

Several provinces were selected for review of their community mental health systems. These provinces included Saskatchewan, Alberta, and New Brunswick. These provinces have undertaken reforms of their community mental health systems. Key informants from each province were identified and detailed interviews were conducted to gain an understanding of the approaches undertaken in each jurisdiction.

Combined, this research identified information concerning relevant policy directions and approaches that the consultants should consider in identifying possible reforms to the province's

community mental health system. As well, best practices in community mental health systems were identified for consideration. A summary of the key trends is contained in **Appendix B** of this report.

- *Information and Discussion Paper and Consultation Sessions*

Based on the data collected from the initial steps of this review, the consultants presented findings in the form of an Information and Discussion Paper. This document was approved by the Department for use during the next phase of the process, namely consultation with staff of the H&CS Boards, Hospital Boards, Integrated boards, various stakeholders and consumers and their families. Refer to **Appendix C** for the **Information and Discussion Paper**. A series of consultation sessions were organized by region with the assistance of the Mental Health Co-ordinators. These consultations were conducted in all regions in March and April, 2002. Refer to **Appendix D** for a full list of consultation sessions conducted. The professional associations of each occupation involved in the community mental health system were provided with an opportunity to participate in the consultation sessions and/or meet with the consultants and/or provide a brief to outline their particular concerns vis-a-vis the subject matter of the review.

The format of the consultation sessions consisted of a powerpoint presentation summarizing the findings respecting the existing mental health system, presenting the trends in other provinces, and noting the issues arising from that data. The consultants used this process to verify their analysis of the system and to gauge the level of support for, and applicability of, certain directions in other jurisdictions that could be applied to this province. Once the consultations were completed, the Information and Discussion Paper was revised further to information collected through the consultation process.

- *Analysis and Reporting*

The analysis relied on utilization of existing documents provided by the Department and the information collected during the course of the review. The analysis consisted of the following steps:

- the best practices in mental health were applied to identify gaps in the services existing in the province,
- a comparison of trends of reform of the mental health services were compared with the status of mental health services in the province,
- the framework for Community Based Resource Model was used to assess the information collected from the mental health co-ordinators to establish the status of the existing mental health system, region by region, in the province, and
- a framework of social welfare policy, identifying key components essential for a service was applied to assess the existing services and to identify required enhancements to create a framework for a community mental health system.

Reporting included:

- presentation of the inventory of publicly funded mental health services and programs,
- a draft information and discussion paper which was approved for use during the consultation sessions,
- meeting with the Advisory Committee to present the Information and Discussion Paper,
- meetings with officials to debrief on the outcome of the consultation sessions,
- presentation of a draft report,
- submission of the final report.

Limits on the Scope of the Review

The review was limited in several ways that ought to be acknowledged at the outset.

1. The subject of this review is the mental health programs and services within all the Boards. Related programs that have a strong connection with mental health such as addictions, parent-child health or child, youth and family services, have not been considered. As well, the continuing care program that involves nursing staff for example, providing injections to clients with mental illnesses, was not part of the review. There are many other initiatives that are ongoing that could be considered under the umbrella of mental health programming but fall outside the scope of this review.

2. The programs that were reviewed were those that were funded by the Department and/or the Boards under the mental health budgets. Thus, community-based programs and services that are directly or indirectly related to mental health but are funded from other budgets were not within the purview of this review, e.g., Victims' Services.

3. The *Mental Health Act* is the subject of another review led by the Department and was not a matter upon which the consultants have been asked to comment.

4. There were strict limitations on time and resources allocated to the conduct of this review. This project was intended to be a higher level review rather than an exhaustive study . It represents a starting point for further work that will be required to refine and further develop the outcomes of this review.

2.0 Environmental considerations

There are several influences impacting the direction the community mental health system may take in this province. There are two specific initiatives underway within the health sector, independent of this review, that may have an important role to play as to the outcome of this review.

Firstly, the Minister of Health and Community Services conducted a series of health forums in the Fall 2001 as a part of her efforts to achieve change in the health care system. One proposal discussed during these forums was whether to reduce of the number of boards currently responsible for delivery of health services. There has not been a public announcement related to any decisions taken as a result of the health forums. However, any consideration by government to change, if not reduce, the number of health care boards could have an impact on organizational structure(s) required to deliver mental health services in the province.

As discussed in these forums, reform of primary health care system is under active consideration within the Department. **Primary care**, the first level of contact with medical care, is oriented to assessment, diagnosis and treatment of acute, episodic and chronic illness or injury. Services are currently delivered by individual physicians in private practice, consulting with specialists as required. Primary care is oriented to the importance of the role of the physician and the system under which they are operating was the subject of consideration by an advisory committee established by the Minister of Health and Community Services. The advisory committee was formed in response to concerns of physicians respecting primary care delivery, recruitment and retention of physicians, and service gaps. Of interest to this review is that the advisory committee was to advise the Minister on several issues including those related to reform of primary care and primary health care initiatives. Though there was no specific mention of mental health in the committee's terms of reference, it has been assumed that these services will be effected by any reform.

Primary health care refers to health care that targets individuals, families and the community. It is a philosophy of health care embodying principles of accessibility, public participation, health prevention, use of appropriate technology and inter-disciplinary approaches in delivering care. A focus on primary health care will require significant changes in the way health care is to be delivered as well as the role and expectations of physicians.

Primary health care envisions inter-disciplinary networks of professionals, of which a family physician is a member, collaborating to deliver a range of services including health prevention. Whereas the primary care system is now driven by individual client demands, primary health care responds to community defined health service requirements. Services are designed and delivered based on an assessment of regional priorities.

The Department of Health and Community Services has recently established a team to develop a framework for primary health care in this province. At the time this report was written, the team was in the early stages of preparing a framework document for consideration by the Department and stakeholders. Mental health services will form part of the basket of services available within the primary health care framework. This development will be important for the future delivery of community mental health services.

3.1 The delivery of publicly-funded mental health services

Mental health is a topic that is quietly discussed in our society. Mental illness is steeped in stigma. We recognize that persons with physical illnesses need understanding, services and supports. Yet, there appears to be lesser recognition of the needs of persons with mental illnesses. Both physical and mental illnesses can be debilitating for the individual affected. There is potential for both situations to be life threatening. But, as the pain and discomfort of a mental illness is not visible, most people find it difficult to know how to respond. There is a general lack

of understanding of mental illness and a true appreciation of how destructive it can be for those afflicted.

Mental health services in the province have evolved based on responding to circumstances as they developed. Essentially, there is a hospital-based system that is supported by legislative authorities embodied in the *Mental Health Act*, community-based services provided by the H&CS Boards as well as the services provided by the two integrated boards. There are other community-based initiatives, such as self-help organizations, that available inconsistently throughout the regions.

Hospital-based mental health services are those that are primarily targeted to clients with mental illnesses. These services include psychiatric in-patients and out-patient services as well as, to a limited extent, some community-based services. These services also include those services that are based on statutory provisions in the *Mental Health Act* that provide authorization for the state to commit a person to a psychiatric institution for the care and protection of the individual and/or society. Under the common law, this authority has traditionally been vested in the superior courts acting under its inherent jurisdiction, that is, to act in the place of the guardian in the case of minors and persons deemed to be mentally incompetent. Under the Act, this power is delegated to those authorized, namely the hospital to which the person is committed under the legislation is not free to leave the hospital until discharged. Accountability for the exercise of those powers is undertaken by the facilities with the supervision of the Court.

The Regional Health and Community Services Boards ("H&CS Boards") were created in the early to mid-1990s. As part of a national trend to balance the medical services delivered by the hospital boards and, in an effort to encourage and promote self-care, a wellness focus was adopted as the foundation of the H&CS Boards. While the H&CS Boards have a mental health program, they do not exercise , or do not have the legislative authority to exercise the powers and authorities under the *Mental Health Act.*

However, both systems are similar in that they are operating under their respective governing legislative authorities, with independent Boards of Trustees. They are accountable to the Department and they must adhere to the legislation that created them. There are two other Boards that have been created under statutory authorities similar to the hospitals but also have the mandate to deliver community programming similar to the H&CS Boards. These integrated boards are Grenfell Regional Health Services that serves northern Newfoundland, the Labrador Straits and the south coast of Labrador; and Health Labrador Corporation that provides services to Labrador West, the Happy Valley-Goose Bay area and the north coast of Labrador and works in conjunction with three aboriginal health commissions in the region.

3. 2 How the mental health system stands at present and the challenges it faces.

3.2.1 Absence of a Policy Direction for Community Mental Health

Unlike the institutional boards which are guided by the *Mental Health Act* when addressing mental illness, there is no policy direction or plan for the development of community mental health services. Despite this, the four H&CS Boards and the two integrated boards have developed community programming. They have determined their regional priorities and organized them accordingly. Without guidance, the programs and services have developed differently across the province. As a result, there is not a comprehensive system but rather a selection of programming options available that differ by region.

In order to gain an appreciation of the larger picture of how mental health services are delivered provincially, a broad overview of the organization of delivery will be presented for each region.

Grenfell Regional Health Services operates an integrated board using a team approach to the delivery of mental health services. This team includes a psychiatrist, nurses, social workers,

licensed practical nurses, and a psychologist. The team undertakes efforts to be visible in the community and engage in outreach activities. The team targets services to persons with mental illness or persistent mental health concerns. There are strong links running in both directions from hospital based staff and community workers. Given the limited resources and the distances involved in travelling throughout the region, the nurses will not only attend to the specific concerns related to mental health but also address other health issues within the scope of nursing practice and his/her competence. The Mental Health Co-ordinator noted that this ensures there is a client focus. Nurses attempt to be responsive to the client's needs and maximize utilization of health human resources.

Central H&CS Board and the Central West Health Corporation have entered into a resource sharing arrangement to jointly deliver community-based mental health services. Through this arrangement, certain staff from the psychiatric unit at the hospital work in one of two centres that have been established to offer mental health services in the community, namely, the South End Centre for children and youth and #1 Junction, a community-based service for adults. Social work and psychology staff who are employed by the hospital work side-by-side with the staff of the H&CS Board as part of a team. A psychiatrist works closely with the community-based service so there are mutual referrals. The team has representation at case conferences held at the hospital so there is an attempt to co-ordinate activities and put services in place to support clients in the community. While staff indicated that there are issues to be resolved and services are not yet at the level where they ought to be, Central H&CS Board is seen as heading in the right direction.

In Gander, there is a multi-disciplinary group offering services through a community-based site, but this is likely to be returned to the hospital in the near future. Other than the psychiatrist and one psychologist, most work is related to persons with mental health concerns.

The Eastern H&CS Board has a combination of social workers, nurses, psychologists in its mental health program. There are no physicians on staff with the Board. However, there has been a positive working relationship developed with the psychiatrists based in both the Clarenville, Carbonear and Burin hospitals with weekly interdisciplinary case conferencing and mutual referrals. Neither Board has access to an occupational therapist who is able to provide services to clients of the mental health program. As there are no in-patient psychiatric beds in the region, there are recognized limitations on the services that can be provided to persons who are mentally ill or who have persistent mental health concerns in the region.

Health Labrador Corporation ("HLC") provides coordinated services given the unique challenges and limitations presented by the absence of professional resources. There is an emphasis on persons with mental illness and serious mental health concerns. There are two visiting psychiatrists to the region and no in-patient psychiatric beds. There have been difficulties in recruiting psychologists and occupational therapists to the region. In Labrador there is the presence of the beginning of the development of a mental health system to serve the Innu communities of Davis Inlet and Sheshashui. These are well-resourced, in some ways, e.g., psychologists have been recently recruited. The HLC does not have much collaborative relationship with these services.

Western Health Care Corporation has a psychiatric unit based in Corner Brook that serves adults. When the unit discharges clients, out-patient services are available. When referred to the community there is a waiting list in most areas, for example, in Corner Brook it can be up to one year as there is one mental health worker assigned to work with adults. *Western H&CS Board* does not have a direct working relationship with the hospital in the same way the Central H&CS Board operates. There are also 3 beds in the hospital in Stephenville with a psychiatrist to serve clients in the area.

Corner Brook does have a resource in Blomidon Place, a inter-disciplinary centre targeted to children, youth and their families. Programming is sponsored by the Community Mental Health Initiative and funded by several provincial government departments, and H&CS staff work from the Centre. There is an active mental health program operating in Stephenville including a Sexual Abuse Counselling Service (SACS). These services are targeted primarily to those clients with mental health issues. The consulting team was provided with a draft of a mental health services policy paper by the Mental Health Co-ordinator for the H&CS Board so planning is proceeding for the development of mental health services in the region. Although the hospital and H&CS Board services are not formally inter-connected, there appears to be a relationship between staff.

Health Care Corporation of St. John's ("HCCSJ") and the *H&CS Board St. John's Region* deliver mental health services in the St. John's region. There is representation of the latter organization on the Board of Trustees of the HCCSJ. An array of services are delivered by the HCCSJ such as in-patient and out-patient services, a long-term care unit and community-based programs including placements in supported housing, community day programming, and Mill Lane, an occupational rehabilitation program. It has been suggested to the consultants that the community programs should be delivered by the H&CS Board.

With respect to services for adults, there is no direct working level connection for services between the two organizations on a day-to-day basis. Each organization is delivery services within their parameters. The psychiatric units of the HCCSJ and the staff of the H&CS Board are not involved in case conferences or other planning activities for clients of psychiatric units. Children and adolescents are served by the Janeway for in-patients and out-patient services.

The H&CS Board St. John's Region has a four mental health counsellors who are serving adults in Shea Heights, Bell Island, Conception Bay South and the Southern Shore. The mental health counsellors also are responsible for delivering addictions programming. For adolescents, the H&CS Board does have two staff and a manager who deliver services targeted to that

population. The consultants have been advised that there is an ongoing relationship between the staff and that of that of the Janeway Community Mental Health Program through some joint efforts in delivering group sessions.

The H&CS Board has assumed responsibility for several services which were operating under non-profit boards. Among them are:

- ACCESS House, a transition house for clients of psychiatry to return to the community,
- PREP program, a vocational program to assist clients with a mental illness or mental health issue secure employment,
- Crisis Centre, a help-line and drop-in centre for those experiencing mental health issues.

The H&CS Board provides funding to support the operations of several independent non-profit organizations that are providing services to clients with mental illnesses or persistent mental health concerns. These organizations are Stella Burry Corporation, Pleasant Manor and the Pottle Centre. The services these organizations offer will be outlined later in this report.

It should be noted that of the three Hospital Board with designated psychiatric units/beds, the other hospitals have admissions of clients with mental illness or persistent mental health concerns. Therefore, while it appears that are only three regions that provide in-patient care, in reality, there are other hospitals that will admit clients with mental illness/health issues.

3.2.2. Client at the Centre - Who is being served and by whom?

The hospitals and their associated professionals have traditionally served clients with mental illness. As was noted in the Information and Discussion Paper, while there is no accurate means to identify all residents of the province with a mental illness, there have been studies to assist in determining the number of persons who may seek services. The number of clients with

serious mental illnesses was estimated in 1999 to be approximately 13,320 (approximately 3% of the population) of 444,052 who are 15 years+. (Source: Kimberley McEwan and Elliot Goldner, Accountability and Performance Indicators for Mental Health Services and Supports, January 2001) From the information provided from the Newfoundland and Labrador Centre for Health Information respecting actual admissions to hospital for 1995-2000, there were 12,739 persons hospitalized in psychiatric units. According to these statistics, approximately 70% of these clients have one admission to a psychiatric unit. Over the five year period, 15% of these clients have had two admissions while 6% of these persons had at least three (3) admissions to a hospital.

From the data collected for the inventory, the profile of these individuals suggests that they have low education levels, are dependent on income support programs and a high proportion of them are unemployed. These clients are difficult to serve as they face numerous challenges that in turn have an impact on their health status. The hospital system is providing services to persons who are mentally ill and have persistent mental health concerns.

The H&CS Boards are primarily concerned with addressing mental health issues recognizing that some of their clients have a mental illness. The number of persons with mental health issues is difficult to estimate. There may be any number of circumstances for a person to experience a difficulty in coping with an event thereby requiring access to mental health services. The information respecting clients collected for the inventory has been summarized in the supporting documents of the Information and Discussion Paper. The H&CS Boards provided data respecting the clients served. The data compiled is not consistent as there are differing definitions in use, differing time frames, and different ways to determine use (e.g., admissions, visits). The information indicates that there are varying demands for the services. There are several factors that may influence access to services including the availability of staff and priorization of clients where waiting lists are managed. However, there are concerns about the use of waiting list information as it may not be a true indicator of the need for the service. There does not appear to be a common process in place across the regions to manage the waiting lists. (Refer to the

email in **Appendix F**).Thus, there are limitations on the available data respecting the clients served by the H&CS Boards. This point will be discussed later in this report.

The significant point emerging from this discussion is that from the perspective of clients, there is a disconnection within the system. The hospitals serve clients with mental illness or persistent mental health concerns. The hospitals are staffed to respond to the needs of these clients. H&CS Boards do not necessarily serve these clients but this varies by board and by region. Those H&CS Boards that are focussed on serving clients with mental health issues may not have staff with the capacity to address the needs of clients with mental illness. Staff in the institutional boards do not have a full appreciation of the issues related to delivering services in the context of the community. From a client's perspective, this disconnection results in a lack of services or a break in the continuum of services that he/she needs reflecting disjointed service delivery in the province.

3.3.3 Mental Health Programs and Services in the Province

The system of service delivery ought to be co-ordinated in such as way that from a client's perspective, there is ease of access when a service is required. The Clarke Institute of Psychiatry, (the "Clarke Institute") in conjunction with the federal/provincial/territorial officials responsible for mental health, have identified the best practices for policy and programming (Referenced in Kimberley McEwan and Elliot Goldner, Accountability and Performance Indicators for Mental Health Services and Supports, 2001). The best practices highlight services as well as approaches to providing mental health services.

The consultants have assessed the information compiled in the inventory of publicly-funded mental health programs in this province and compared it against the best practices identified by the Clarke Institute. This exercise was undertaken to determine the status of the supports and services available in all regions, and to identify gaps and/or where there are partial

supports and services. The overall conclusion is that while there is evidence of programming across the province, there is a need to enhance the supports and services in all regions.

Supports and Services provided in relationship to Best Practices							
Best Practice Area	Checklist Criteria	St. John's	East	Central	West	Grenfell	Lab
Case Management ACT	array of clinical case management that follows rehabilitation personal strengths and Assertive Community Treatment models	✓ some early intervention services psych rehab program	partial some home visits	partial case management on a case-by-case basis some home visits by PH RN	partial case management on a case-by-case basis	✓ PH RN visits	partial some home visits by Rns
Crisis Response / Emergency Services	continuum of crisis programs to help people using minimally intrusive options	partial some services overuse of police psych unit	no community team hospital is called in emergency no psychiatric beds but there are admissions	good work between police and mental health psych unit	no team but good relationship with police psych unit	✓ good work between police and mental health no psych beds but there are admiss-ions	no team no psych. beds but there are admiss-ions

Housing	variety of housing options available, ranging from supervised community residences to supported housing, with emphasis on supported housing	partial some supported housing	no supported housing	use of personal care homes (service designed for seniors) Ad hoc group formed to address housing needs	✓ CB-Xavier House, a personal care home geared to accept mentally ill clients	no support-ed housing	no support-ed housing
Inpatient Care	Inpatient stays are kept as short as possible; long term stays are placed in alternative care models; physicians and psychiatrists work together	partial psych unit lack of capacity of alternative care and collaboration	partial no psych unit but admissions lack of alternative care and collaboration	partial psych unit lack of alternative care and collaboration	partial psych unit a few in-patient beds in Stephenville Hospital lack of alternative care and collaboration	partial no psych unit but admiss-ion lack of care options	partial no psych unit but admiss-ions lack of care options
Outpatient Care	an array of treatment alternatives, including day treatment and home treatment	✓ no home treatment; services not linked	partial one-one counselling	partial #1 Junction Road and South End sites outreach at other sites	partial Blomidon Place Port aux Basques video conference	partial	partial some use of video

Consumer Initiative	efforts that support mutual aid, skills development and economic development; supported through funding, training, and evaluation	partial not supported	partial	partial some life skills training	Advisory Group in Stephenville Group meets at Blomidon Place	partial	partial
Family Self-help	funding to family groups	partial	partial	partial	partial	partial	partial
Vocational / Educational Supports	supported employment programs in place and studied	✓ employment corporations and Mill Lane	None	None	partial West Lane but no supported employment	some day programs	None

The visual display of the services and programs in place in this province highlights where there are gaps in services or else no services are in existence. There is no one region that can claim to have a fully developed continuum of services in place. This chart does not do justice to reflecting the frustration of clients and family members expressed during the consultation process. Based on the experience related by clients, the lack of co-ordination between the boards is evident as clients attempt to access services within and between regions in the province.

The services that have been highlighted as best practices will be discussed in greater detail in the next section of the report as part of the discussion on a new approach to delivering mental health services is presented.

4. Supporting a Community Mental Health System

The task for the consultants is not to refine an existing plan, but to decipher a set of divergent activities and beliefs and to determine a possible pathway forward to present a conceptual framework for a community mental health system. The key elements needed for such a system are outlined in this section of the report.

A policy framework establishes a set of guiding principles, goals and values often reflected in a vision. It sets the direction for programming and all components are to be consistent with this vision. Based on the policy direction, consideration is given to who is served, the nature of the services provided, the resource requirements and a delivery system. The purpose of this review to provide the basis of such a framework for the community mental health system in this province.

4.1 Adopting a Policy Framework - All heading in the same direction

In any program or system development there must be a shared vision supported by principles to ensure everyone can know the goal and direction in which everyone is heading. The first task is to consider a provincial policy for a community mental health system so leadership can be assumed. The lack of a policy direction and the resultant fragmentation of services has already been recognized by the Department. In an effort to set a provincial vision towards which all the Boards can focus their activities, in 1999, the Canadian Mental Health Association (CMHA) was engaged by the Department to prepare a document of a mental health system for the province. Based on CMHA's research of the subject matter and extensive consultations with a broad group of stakeholders, a direction for the mental health system an approach was outlined.

Valuing Mental Health (September 2001) seeks to set out principles upon which a comprehensive mental health system can be developed. Minister Bettney in her forward noted that the document " provides a foundation for growth and positive influence." At the outset of this

review, the consultants were asked by Departmental officials to use this document in developing a framework for a community mental health system for the province.

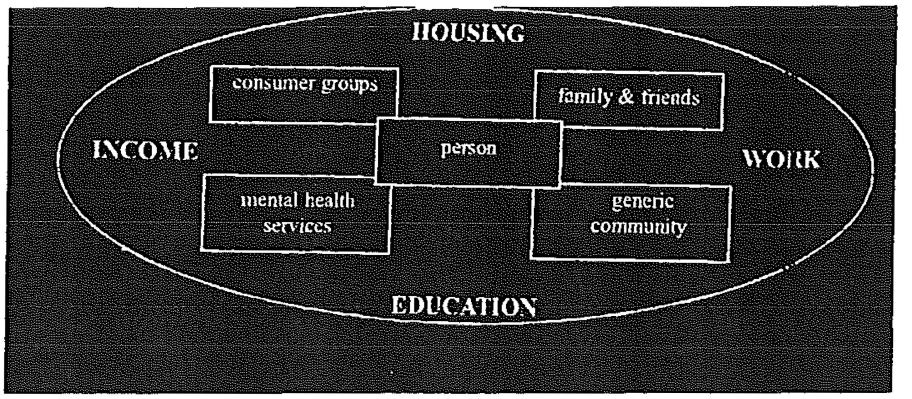
Key to a new system is the acceptance of a policy framework to guide provincial planning and program development. The elements of this framework are as follows:

- Services must be client-centred, not program or provider driven.
- Services must be developed with active consumer involvement and participation.
- Development and enhancement of family and informal supports are integral to the system.
- Services and supports must be available or accessible in all regions to meet client needs.

This document does not reflect official government policy but it does reflect current thinking and trends in mental health.

In a province with scarce resources, **prioritization** among the competing demands for the most effective use of resources must occur. It is the view of the consultants that priority must be to serve those with identified mental illness and / or persistent mental health problems that interfere with their ability to live independently, including children and adolescents. It has been suggested by the Chief Executive Officer of the St. John's Nursing Home Board that the needs of the elderly should be a priority, however, the consultants have not been provided any substantial evidence to make this determination. **Appendix E.** It should be noted that specialized mental health services for the elderly do exist in the province but only in St. John's at present.

Valuing Mental Health advanced the Community Resource Based Model as a means to organize mental health services. As was requested by the Department, this model has been used by the consultants as a guide for the analysis of the existing system and for the development of a community mental health system.



Throughout the consultations, there was general support for the proposed direction embodied in Valuing Mental Health. The document can be used as a basis for a plan to develop a community mental health system for the province. It is in keeping with the policy directions being espoused across the country.

4.2 Components of the Community Resource Based Model (per Valuing Mental Health)

One of the objective established for the review is to devise a framework of-supports that is client centred. Though this review is aimed the community mental health system, the in-patient services delivered through the hospitals cannot be separated from the continuum of services of a mental health system. The system needs to be coordinated in such a way as to accommodate to the needs of the targeted clientele. Those with mental illness or persistent mental health concerns will require a broad range of services to be available in such a way that access is free of organizationally created barriers and is equitable.

- **The Person**

The model has the person at the centre of the framework. Mental health services are organized to accommodate the needs of the client. This is consistent with the principles articulated in the current documents concerning strategic planning generally and in the mental health field in particular. While it is recognized that the contribution of dedicated health care professionals is critical for service delivery and their interests must be considered, the centre of the service must be the client. With this focus, the system can be viewed from the perspective of the client.

- **Client/Consumer and Consumer Initiatives**

The client at the centre of the mental heath system has been self-identified as a "consumer" of services and supports. The role of the consumer has been growing in visibility within the mental health system. Increasingly, there is recognition of the need for participation by those who are the users of the service in planning and developing services. It is the consumer who is the expert on aspects of the system that are working for them and those that are in need of improvement. Consumers have organized groups to have a voice and make their views known. The Consumer Health Promotion Network of Newfoundland and Labrador ("CHANNAL") is a group of mental health consumers organized in this province as an advocacy organization. CHANNAL is being financially supported by the Department and the CMHA.

CHANNAL was formed in the early 1990s. It has a presence in some regions but not all. There have been difficulties in achieving a stable base in all areas. There are differing levels of involvement with CHANNAL by consumers across the province. Through the consultations it appeared that there are varying levels of understanding and appreciation of the organization and how it could be supported by the Boards.

There have been efforts to include participation by consumers in their individual case planning while a client of the hospital. Consumers have been invited to serve on teams focussed on quality improvement initiatives at the hospital or the H&CS Board. It is sometimes viewed as tokenism as consumers feel they are in an inferior position and they perceive they have less power vis-a-vis the professionals. The need for developing new and innovative mechanisms to facilitate meaningful participation by consumers has been identified as a requirement by consumers and service providers alike.

In all the consultations, the difficulties associated with the stigma of mental illness were raised. It is particularly difficult to engage consumers in advocacy efforts, partially because some are not well enough to be involved and also because of the negative views held within the community about mental health issues. To overcome this other provinces' consumer organizations have taken the lead in designing and delivering services to meet the needs of their members. Examples such as the Clubhouse Model, operative in Halifax, that has yet to be funded in this province, provide consumers with opportunities to have an organization that is managed by themselves, with the support of professionals. Through this organization, services are created and delivered by consumers, for consumers. It is through consumer involvement, in a way that is meaningful to consumers, that their need for social inclusion and participation can be addressed. This will involve advocacy efforts related to the development of new services and/or for service enhancements.

Investment and support of consumer initiatives is a critical component for any new framework for community mental health services.

Family & Friends: The Informal Support System

A group that is often forgotten is the family/caregivers of those with a mental illness. The Friends of Schizophrenia Society is one of the few organizations addressing the needs of this group. With a chapter in St. John's and Corner Brook there is some support extended to family members. Both groups are supported by the staff of the hospital in their respective cities. Families who are caring for, or are supporting, their family member who has a mental illness are a group who need services themselves. Family members are coping with situations that present major stress and, in some cases physical danger to themselves. In order to support the person with a mental illness, there must be services and supports created and/or enhanced for the family. The mental health of the family depends on maintaining balance for their members. Finally, the family must have a voice in efforts to plan and deliver mental health programs.

Based on consultations with family members and some the H&CS Boards, it was that acknowledged that there are limited supports for families and that there is a pressing need for resources to be targeted to supporting families. They need opportunities to be educated about the nature of the illness affecting their family member. There is a need to learn about programs and services that can assist their family member and also themselves. The value of families supporting one another has been recognized by the participants. Support from those in similar situations assists in combatting isolation and hopelessness. The consultants have been advised that a member of the group that was brought together for the purposes of the review is interested in establishing a self-help group. The motivation for action was that sharing of experiences during the session held as part of this review was helpful to that person.

Self-help groups cannot develop without assistance from the system and knowledgeable professionals in organization and ongoing support. There is a need for ongoing commitment to promotion, a meeting room, education and basic supports such as transportation for those who do not have means to travel. There must be an investment in extending support for families caring

for a member with a mental illness and/or persistent mental health concern. They are the providers of consistent support to the family member.

- **Generic Community**

There are significant barriers for persons with mental illnesses to receive generic services in the community and to have their needs accommodated, e.g., housing, employment. At the same time, there are organizations within the community that encourage participation and social inclusion in society.

Participation by persons with mental illnesses or persistent mental health issues tends to be problematic. Often these individuals are socially isolated due to their low socio-economic status and/ or as a result of their illness or condition. As a result, their participation in social and recreational activities is limited. Programs to encourage participation is limited to the Pottle Centre in St. John's, a regularly scheduled group meeting in Corner Brook, and various informal programs sponsored by churches and other community organizations.

Often home support services are required to assist with activities of daily living. Due to the regulations governing eligibility, persons with a physical disability or development delay generally qualify whereas a person with a mental illness cannot access home support services. This policy has been criticized as being unethical, discriminatory and one in definite need of revision. Valuing Mental Health refers to the provision of continuing care, which would include home support services, to persons with a mental illness or a persistent mental health concern. Therefore, this is an issue to be addressed in a community mental health program.

The question arises as to what is the nature of the services delivered by the H&CS Boards that are or should be targeted to addressing some of these concerns. To date the emphasis of the H&CS Boards appears to be on establishing one-on-one counselling services for individuals.

There is recognition that there is a major stigma associated with mental illness and mental health and some community education efforts have been undertaken. There has been less emphasis placed on developing self-help groups, mutual aid groups and organizations or developing the capacity of the community to respond to build on its strengths, eg. peer support. There are few, if any, efforts in evidence to advocate for clients in terms of community housing other than on an individual basis. The same is evident for employment. There is limited collaborative contact with other government agencies or community agencies evident.

In Achieving Health for All (Epp, 1986), the Framework for Health Promotion was introduced. Canadians were encouraged to engage in self-care such as exercise and eating a healthy diet as part of a wellness view of health care. There was acknowledgement that there were individuals who needed support to maintain wellness and the Framework of Health Promotion encouraged the development of informal support systems in the community. Further it was recognized that the environment itself presented challenges to well ness and, as such, there must be efforts targeted to creating healthy environments and healthy public policy. These concepts were further developed with respect to mental health in Mental Health for Canadians:Striking the Balance, (Epp, 1988). The challenge of promoting mental health as a key component of wellness was further developed.

The principles underlying these directions were refined and further expanded upon in subsequent policy documents including Strategies for Population Health: Investing in the Health of Canadians, Federal/Provincial/Territorial Advisory Committee on Population Health (September 1994) outlining the determinants of health. These documents served to provide principles as a foundation for the H&CS Boards.

From the data collected throughout the course of this review it is evident that the Framework for Health Promotion provided a guidepost that remains relevant for a community

mental health system. It should be revisited and services reconfigured to reflect and implement these principles in the community mental health system.

In the Minister's Health Forums conducted in Fall 2001, health promotion and wellness strategies were endorsed by participants as a priority for the future direction of health care in the province. This direction has been subsequently supported as being significant for the Strategic Health Plan. Emphasis in this area would be beneficial and support a community mental health system.

- **Mental Health Services**

As mental health services have not been designed in accordance with a planned provincial strategy, they have developed independently within the regions and within the Boards. Hence, there is little consistency in the services delivered, region-by-region, or little communication within and between the regions. According to best practices, there are an array of services that ought to be available. These are described below.

- **Case Management**

There are several aspects to case management including assertive case management. The Health Care Corporation of St. John's (HCCSJ) employs case managers within the institution as do other hospitals and H&CS Boards. In the latter, case management is undertaken on a case-by-case basis as needed but there are few other positions dedicated to fulfill this function. The case managers are employees working to assist clients in accessing services. It is recognized that there are limitations with respect to the extent of their authority and ability to access services beyond their own institutions.

There are a group of clients with a high level of need for support who demand intensive support. The assertive case management model is one which can deliver a range of services and supports to these individuals. A pilot project is underway in St. John's funded under the H&CS Board that provides a range of services, one-on-one, including basic life skills, nutrition, meal preparation and other supports to clients with high level needs. This is an intensive pilot program being tested to determine its effectiveness and potential for development as an established program. The H&CS Board of St. John's entered into a partnership arrangement with Stella Burry Corporation, a non-profit organization with expertise in serving persons who have a history of mental illness, and the H&CS Board, to deliver this project. Preliminary comments by the staff of Stella Burry Corporation about results of the program are positive.

In accordance with the documents reviewed and data collected through the consultation sessions, it is evident that for those clients who have mental illnesses or persistent mental health concerns, co-ordination of supports and services is of critical importance. Based on data respecting hospital admissions, there is a small group of adult clients who have multiple admissions and who place high demand on resources. From the collective knowledge of the professionals in each region, these individuals are known. For co-ordination of supports and services for these clients an approach similar to the Model of Co-ordination of Services for Children and Youth could be employed. This process is currently in place to co-ordinate services for children accessing several services. The hospital boards and H&CS board could design a plan with the client and family and put it in place to ensure supports and services that are required to sustain an adult client in the community are available.

A case manager needs to be assigned to ensure the implementation of the plan. Case managers would be expected to be held accountable for implementing the plans to meet the needs of the clients. It is important to stress that there would be resources required to co-ordinate services and maintain communications with all involved. Case managers are needed in all regions. They would be mandated to work across organizational structures in the interest of the client.

The framework envisages the client at the centre and, given the complexities of the systems it is reasonable to expect that vulnerable clients would need the support of a professional to negotiate and gain access services.

- **Crisis Response/Emergency Services**

There is a crisis phone line operated by the Crisis Centre in St. John's that is intended to serve the province. It has been noted by those in regions outside St. John's that the crisis line is difficult to access in the evening given the competition to secure a long-distance telephone line. Some wondered if it might not be better to have services based in the regions themselves. The history of this service is rooted in consumers' demands to address the problem of mentally ill persons in crisis being housed in the lock-up. For a variety of reasons, the initial expectations of consumers were not realized which has led to questioning of the need for the service as it is currently established.

However, the consultants have concluded that, no matter what the final decision is respecting the Crisis Centre, there is a need for crisis support, such as a crisis line, in each region, where such services do exist at present. This approach will have implications for the Crisis Centre in St. John's whereby existing resources could be redeployed. The St. John's H&CS Board has indicated it is open to developing other options.

With respect to emergency response, in most regions, there is first contact with the hospital. Through the data collection phase the consultants learned that emergency response, especially if the individual is out-of-control, may also involve the police. Police may escort a person to hospital. The police may detain the person until a physician can conduct an assessment to ascertain whether ought to be taken to hospital under the authority of the *Mental Health Act*. The police may have to detain the person under the authority of the *Mental Health Act* in a "safe and comfortable place", in practice the lock-up, if the person is aggressive and/or needs

protection. This latter circumstance has been the source of grave concern for consumers, mental health professionals and advocates as well as the police for some time.

Senior officials of the two police forces in this province participated in the consultation sessions for this review. The police recognize that the lock-ups are not appropriate facilities for persons who are ill, however, for the purposes of the *Mental Health Act* they are often the only facility available in the situation. They would prefer that there could be secure beds in the hospitals in each region to accommodate persons in need of protection and support. They recognize that these individuals should be placed in an environment where they are safe and have access to services they require. Currently, funding has been provided in the 2002 budget and efforts are underway at the HCCSJ to develop a short term stay unit to accommodate clients in this situation. Otherwise, the situation across the province varies region-by-region but few have appropriate accommodations to respond to emergency situations when a client is aggressive and is a danger to themselves or others.

There are two regions where emergency response services are in more advanced states of development. Central West Health Corporation with the Central H&CS Board has developed a protocol with the RCMP to respond to emergencies. To date, the protocol relates only to transportation by ambulance with police back-up, if necessary. Negotiations are ongoing with the RCMP concerning the involvement of a mental health worker in situations where physical safety concerns are present. Also, some private ambulance operators are resistant to participate in transporting mentally ill clients to hospital. In Grenfell region, there is a mental health worker on call 24/7 who is contacted if an emergency arises. The worker travels with the ambulance and has police back-up if needed. Grenfell does not have psychiatric in-patient beds but tries to accommodate the client in any event. However, where the client is aggressive or violent, there is limited capacity to address the situation and they have to rely on sending the client to St. John's, if circumstances permit.

Although there are no inter-disciplinary teams whose task it is to respond to crisis in the community, interest has been expressed within several regions to explore this possibility. There are such emergency response teams operating effectively in other jurisdictions, for example, in Winnipeg a social worker is employed by the police as part of a crisis response initiative. In Toronto, a crisis response team operates in the community and works closely with the police. Further, in efforts to avert a crisis from developing, medications are delivered to clients living in the community on a regular basis, sometimes daily, by workers of the program. (This approach has been used in this province but it is not standard practice.) These models can be considered and the particular circumstances of the regions considered when designing a model for emergency responses and efforts to prevent crises from developing.

The model envisages the client at the centre and these approaches to actively responding to crisis, and trying to prevent such from occurring, must be part of a community mental health system.

- **Inpatient care**

There are approximately 150 acute care beds dedicated to psychiatry in the province. When institutional long-term care and community care beds are considered, there are approximately 275 beds in total in the system. While other regions of the province have hospitals and there are admissions of persons with mental illnesses, there are no other beds designated for psychiatry other than the three hospitals with units, including three (3) beds in Stephenville. The HCCSJ is the provincial referral centre for adult psychiatric care and for children and adolescents although there is no specific unit for the latter group.

Throughout the consultation sessions it has been made clear that although regions outside the St. John's Region are intended to have access to the two facilities, they are perceived to be inaccessible by those outside the region. There was no documentation provided to the consultants

to indicate the extent to which this a problem. The HCCSJ has indicated that 29 % of its admissions are of persons who reside outside the St. John's Region. There have been suggestions from Labrador, Grenfell, Gander regions that there ought to be some capacity in each region to be able to serve directly persons with a mental illness.

There has been questioning of the reasonableness of assuming an admission to the HCCSJ is the most appropriate (with exceptions, e.g., severely ill requiring specialized care).The reality of the life circumstances of an individual is better known within the region. Referring a client to St. John's still requires the staff of the region of origin to provide background information to the staff in St. John's. Further, and importantly, it will up the region to respond to the requirements of the client upon the return home. It is in the region where the client's family and other informal networks exist so services and supports have to be available at that level. Thus it is the supports and services that are available within the regions that are critical. The bigger issue is ensuring there is a level of regional capacity providing a minimal standard of appropriate care. This is in keeping with the Valuing Mental Health document and the configurations found in the other provinces. The consultants do acknowledge that there will have to be further analysis of the requirements of regional facilities and the impact on the HCCSJ if additional in-patients beds are funded in other regions.

With respect to the transition from hospital to the community, difficulties are evident. Co-ordination of services to support the transition between the hospitals and the H&CS Boards is not in place in most regions. For many persons with a mental illness, upon discharge from hospital, there is a need for support immediately. These persons may not be able or willing to search out the resources available to them. Persons with persistent and chronic mental illness are more likely not to have the supports to maintain themselves in the community.

The framework envisages that there will be an ongoing need for effective in-patient hospital services for clients with mental illness. The appropriate resources and location of them

by region should be re-examined to ensure client needs are satisfactorily addressed within the context of the community mental health system.

- **Out-patient Care**

Day programs are associated with hospitals and are designed to enable the clients to make a transition from the hospital to the community and to be supported until settled. As can be seen from the information collected for the inventory these services are partially available across the province. Programs were in place in some regions but discontinued. Another region noted that the existing day program operating from the hospital was not viewed as effective. Its closure is being considered in favour of a program to be delivered from the community. A full range of services as contemplated by the best practices identified by the Clarke Institute is not yet developed in any region.

The framework of a community mental health system would include services to facilitate the transition for the client. There ought to be a bridge period to support the client to re-establish themselves in the community after discharge from hospital. These services will have to encompass a full range of services including those by health care professionals in the home to social activities to services of a case manager who may co-ordinate access to housing and support services.

- **Housing**

The need for stable and secure housing is a basic need for all. Access to affordable housing by persons who are mentally ill is a problem in the province. These clients need housing with a level of support services. There are few supported housing options available across the province. The Stella Burry Corporation, based in St. John's, is well-respected for its expertise in working with persons who are mentally ill. The organization also works with clients who have been

institutionalized either in a psychiatric hospital or correctional facility. It operates several supportive housing facilities and programs to provide services such as assertive case management (pilot), employment and training.

Pleasant Manor, based in St. John's, has been in operation for sixteen (16) years and provides stable housing for persons who are mentally ill along with support services as required. There is a transition program offering accommodation for clients who are supported for up to one year. Nineteen (19) social housing units have been allocated by Newfoundland and Labrador Housing Corporation (NLHC) as long-term accommodation. This partnership appears to be working well, each providing their resources; support to clients is provided by the staff of Pleasant Manor and affordable housing is available through NLHC.

The H&CS St. John's operates ACCESS House, a transition facility for clients who have been discharged from psychiatric units. Support is provided to assist with re-orientation to the community. Otherwise licensed personal care homes often are used to house this clientele. XAVIER House, a personal care home, located in Corner Brook is operated by the Presentation Sisters. In Central Region, from a average of 8% up to 53% of residents of some personal care homes have mental health issues. This program was designed to accommodate seniors but does provide at least of basic level of housing with supports targeted to this clientele. The HCCSJ has operated a housing program in Conception Bay South for some years, however, there are indications that the program may require review as admissions are declining.

Advocates and consumers expressed concern, in this review and others i.e. Inter-departmental Committee on Social Supportive Housing Provincial Study (draft), IHRD Group, 2002 that the personal care homes and long-term alternate care facilities are not appropriate as the sole resources available to mental health consumers.

A report entitled, A Review of Housing and Other Supports for Consumers of Mental Health Services in the Central Newfoundland Region by Educational Planning and Design Associates (2001) discussed best practices in housing for persons with psychiatric disabilities. It was noted that there is a need for a range of housing alternatives, particularly supported housing. This alternative includes accommodations throughout the community, rather than being concentrated in specific locations and supports are available to suit the client's requirements.

The role of NLHC as having a mandate for social housing was re-affirmed by Government in 1998. While it has a portfolio of subsidized rental accommodation, its staff does not have expertise in working with persons who are mentally ill. NLHC has been leading an Inter-Departmental Committee on Social Supportive Housing, and a recent provincial report highlights the need for collaborative efforts to address persons with serious mental health concerns.

There is potential to develop partnerships and collaborative relationships with the staff of the H&CS Boards and others with an interest or stake in working with clients with a mental illness. The development of these relationships will require a investment of time by staff who have a understanding of working in community development and capacity building to identify requirements and bring the resources together to meet the housing needs of those that need to be served.

The framework envisages the client being supported by many systems delivering services and not simply the services of hospitals and community health services. Housing is fundamental as are the individualized supports needed by clients to sustain themselves in the community. Thus there must be consideration given to involving NLHC as well as non-profit organizations as key players in a community mental health system.

- **Vocational/Educational Supports**

Vocational and educational programs are at varying stages across the province. Both the HCCSJ and H&CS Western are operating recycling programs that employ clients with a mental illness. The Pre-Vocational Employment Program (PREP) is a program that was established in the community operating with an independent Board is now part of the St. John's H&CS board. The program is serving clients with mental health issues, some of whom have a diagnosis. Other Departments such as Human Resources and Employment offer programs that service this clientele. This highlights the need for staff involved in community mental health programs to have an awareness of the range of services offered by other organizations that may be accessible to clients with a mental illness.

The framework for a community mental health system must include a means to respond to the full range of needs of the client, including those services that can assist in creating self-reliance and independence. There is a need for knowledge of other programs and services that can be of use to the client even though these are not delivered within the health sector.

- **Income**

For those persons with mental illnesses and persistent mental health issues who have not been able to pursue an education to access employment, or for those who have been unable to continue working, sources of income are social assistance and for those who are eligible, long-term disability pensions. The income levels are seen to be at the lowest levels especially for single adults.

The framework envisages a service being provided, if necessary, to assist clients gain access to a stable source of income through programs such as income support, disability pension

Income support levels have a direct impact on this population, in that they are often forced into environments which are injurious to their independence, health and well-being.

- **Linkages between supports**

Viewing the Community Resources Based Model, it is evident that there are many services required to meet the client's needs. Mental health programs delivered by the health care system are not the only resources required by clients. It is agreed by all stakeholders that at this point there is an absence of a co-ordinated continuum of supports and services within the mental health system. The situation becomes more complex when attempting to involve other agencies, agencies that deliver services that are critical to the well-being of clients with a mental illness.

Service delivery is characterized by barriers to access, limited publicity, and exclusionary eligibility criteria. Services, if accessed, can be suspended or lost upon a relapse and readmission to hospital. Persons who are mentally ill require assistance to access programs, keep those that are secured but also the client needs support to maintain health and wellness in the community. Those with persistent mental illness are the least equipped to interact with a system that is based on serving those who are able to act on their own behalf. While many of these services are not under the jurisdiction of the Department and the Boards, there is an opportunity for improved co-ordination and the development of linkages across the other government departments to expedite access to services. The Case Management Model would assist with this process.

The framework envisages that support would be available to assist clients navigate the bureaucracies and the regulations respecting access to services, services for which there is often demand.

- **Encouraging the Participation of Community-based Organizations (non-profit)**

There is a legitimate role for non-profit organizations that a have special interest and expertise in dealing with persons who are mentally ill. Organizations such as Stella Burry Corporation have developed services to serve the population with innovative approaches that probably would not have been able to have been developed or delivered by the health care boards. Community-based organizations have the capacity to design new approaches to services for clients who have traditionally been, and continue to be, difficult to serve. The H&CS boards have had limited involvement with non-profit, community-based organizations as delivery agents for mental health services, except in St. John's.

Representatives of the Salvation Army participated in the consultation sessions for this review. They expressed an interest in developing services targeted to clients with a mental illness. This is an area in which that organization has demonstrated expertise nationally. There are other opportunities for the Boards to develop additional services in their regions to serve clients that to this point they have been unable to serve. These are valid roles for the boards to play in supporting these organizations. The Framework for Health Promotion and the Strategic Social Plan are supportive of this direction.

It is important that the roles be clearly defined for both the non-profit organization and all parties. All have expertise to contribute and there is potential for learning.
Furthermore, the knowledge and expertise of the these community-based organizations gained through years of involvement in delivering services to persons with mental illness and persistent mental health could be utilized in staff training and development particularly in relation to community development and capacity building.

The framework is consistent with the Strategic Social Plan, a document that Government has supported and is actively advancing. The strategic social plan advances collaboration and partnerships as a desired model of delivering services.

4.3 The foundation of a mental health system

Based on the premise that the Community Resource Based Model will be used as the framework for a community mental health system, there are two essential components that must be considered as underlying the system; legislative authorities and a management information system.

4.3.1 Legislative Authorities

Though the consultants have not been involved in the revision of the *Mental Health Act*, it is important to note the connection between that revision and this review. The Advisory Committee overseeing the revision of the legislation has had an opportunity to comment on the draft final report. It is important to ensure the appropriate instruments are in place to implement a plan and one such instrument is the necessary legislative authority.

The community mental health system has to be linked with those authorities and must be seen as part of the continuum of services for those who are subject to the powers of the *Mental Health Act*. The legal authorities are similar to those exercised to protect those who cannot represent their own interests, such as minors under the *Child, Youth and Family Services Act*. During the preparation of that statute there was the recognition of the need to identify principles under which the system would operate to prevent, to the extent possible, intervention by the state by the removal of the child from the care of the parents. Early intervention services have been built into the system as are support services when the child is returned to the care of the parents. A

similar approach, to provide supports for clients in the community in an effort to maintain health and avoid committal, is required for mental health services.

For a community mental health system to be effective there must a broad view of the continuum of services from early intervention, to providing services to prevent committal, to providing services to ease transition back to the community. The linkage between all the services, including the extreme authorities available under the *Mental Health Act,* must be acknowledged. The objective is to prevent, to the extent possible, the need for the exercise of these authorities. This is the role of an effective community mental health system.

4.3.2 Provincial management information system for mental health

Any plan must identify the clients to be served and their requirements so that resources can be allocated to deliver services. This is fundamental to planning and monitoring for new programs. For the development of a community mental health system there is a need to develop a provincial data base that is integrated using data from all the Boards. The data base should be able to provide baseline information, to measure and evaluate progress, to identify best practices and to set standards. Ideally, the data ought to be computerized and systems compatible with one another to share data for the purposes of contributing to serving clients. Other provinces have recently initiated work on information management, standards setting, and identifying practice indicators.

The hospital based system is founded on the medical model with authority to diagnose being within the scope of practice of physicians, notably psychiatrists for mental illnesses. Diagnoses are conducted by psychiatrists using a categorical classification tool known as DSM-1V. Not all professionals within the hospital system use the DSM-1V tool. The H&CS Boards do not use DSM-1V as a tool to determine the mental health issues being presented by their clients. There is resistence to the application of the DSM-1V assessment tool in H&CS Board settings as

it is viewed as a medicalized model, one that is inappropriate for use in the community. Consistent definitions are not in use across the Boards to determine the nature of the issues presented by clients.

Besides the lack of consistency in assessment tools there are differing systems to record and maintain information. The hospitals maintain their records using a computerized system, Meditech. The information is made available to the Centre for Health Information for provincial planning purposes. Mental health advocates have stated from their perspective that limitations exist with the information that is captured and that a complete picture of client requirements for services is not available.

The Department has supported the development of a computerized data base for use by the H&CS Boards, the Client Referral and Management System (CRMS). The consultants have been advised that it was intended that this system be integrated with that of the Hospital Boards. One region has piloted the CRMS system. Another region has developed its own data base using the Statistical Package for the Social Sciences (SPSS) The CRMS has yet to advance to the point where it includes data on the Mental Health Program. As a result, mental health services program information is not captured with the aid of a computerized information system available to all Boards. The Department is interested in ensuring this system is fast-tracked.

The existing tools for assessment and information management are not compatible or comprehensive enough for the envisioned breadth of services and the desired capture of information. It is will be incumbent on the Department to assume leadership and work with representatives of the Boards and possibly the Newfoundland and Labrador Centre for Health Information, to develop an integrated, comprehensive data base and system for provincial planning purposes for mental health. Other provinces are at various stages of developing information and accountability systems. Perhaps there have been lessons learned to assist this province in developing its information base and other related accountability efforts.

4. 4 Resource Requirements

In order to sustain the framework for community mental health supports, additional resources would be required and some existing resources re-deployed.

4.4.1 Recognition of Informal Supports as Important to Community Mental Health

Informal supports and mechanisms must be nurtured and cultivated as they are central to the care and well-being of persons with mental illnesses and/or who have persistent mental health concerns. If there is to be a client-centred approach with client participation in the design and delivery of a community mental health system, there must be resources committed to developing a solid foundation for consumer organizations. As one example, in 2001-02 CHANNAL has received approximately $60,000 from the Department for a provincial co-ordinator and regional co-ordinators, the latter who work one day per week. Funding has been provided for the development of a provincial consumer network since 1996. Additional funding is required to support similar organizations and to support members in attending and participating in meetings.

Similarly, family support organizations have been formed with assistance from hospital staff and/or H&CS Board staff. In one case, a bereavement group is being supported by a funeral director who provides funds for promotional literature, coffee supplies etc. Again, attendance depends on the ability of the family member to have the means to travel to meetings and events. There are some funds advanced to support a co-ordinator for the Friends of Schizophrenia but otherwise there are limited supports for families.

Both consumer organizations and those groups formed to assist families must be funded, developed and supported throughout the province.

4.4.2 Maximizing Professional Resources by Investment in Continuing Education

It is evident that there are challenges associated with recruiting and retaining health professionals in the mental health field and/or to the Province. This is a constraint that must be acknowledged.

Clients who are mentally ill and those with mental health issues rely, first and foremost upon their family physician for support, referrals and medications. It is the presence of the 400 family physicians throughout the province that makes them the first line of service. In theory, the family physicians are the gatekeepers for accessing psychiatrists who are considered to be consultants who can recommend a course of treatment and support the family physicians. Psychiatrists are finding that they are following clients who could be followed by family physicians thus there is an issue respecting the appropriate use of these resources. This situation presents an opportunity for a solution to be developed within the effort to advance primary health care reform.

There are 45 psychiatrists, 31 of whom are based in St. John's. In regions outside St. John's there was frustration raised by participants about the perceived need for additional psychiatrists. There are varying estimates of the number of psychiatrists needed per the population in use in different provinces. These range from 1:8400[1] (Royal College of Physicians and Surgeons, 1998), 1:11,995 (New Brunswick, 1999), 1: 8379 (Saskatchewan, 1993-94). Applying these numbers in this province, based on a population of 530,000 would mean the range is from a low of 44 to a high of 64 psychiatrists. Designating a ratio is the part of the work of the Physicians Human Resource Planning Committee whose work is not finalized.

[1]The ratio is based on 1 full-time equivalent (FTE) psychiatrist, not one person. The FTE is determined by a calculation based on salary and other considerations.

Notwithstanding this, the reality of recruitment and retention is a continual issue. Labrador has not been able to recruit a psychiatrist clients are served by visiting psychiatrists. Gander's psychiatrist is relieved on weekends by psychiatrists from St. John's who alternate visits on weekends. According to the Clinical Chief of Psychiatry at the HCCSJ this is a challenge, not only for this province, but elsewhere in the country. Due the fact that there are not enough medical school graduates to meet current demands and, fewer graduates are choosing psychiatry as a specialty, it is becoming increasingly more difficult to recruit psychiatrists to the province. Recognizing the challenges being faced in recruiting and retaining professionals such as psychiatrists, it is important that maximize use be made of existing opportunities to use these professionals as specialists.

The Canadian Psychiatric Association has produced a document outlining a shared care approach that has been supported by the Canadian Medical Association. There are at least two impediments to the full implementation of the shared care protocol that inhibit most effective use of specialists in psychiatry. Firstly, family physicians need to be supported through ongoing continuing education in psychiatry particularly respecting pharmaceuticals. Secondly, the fee schedule of the Medical Care Plan (MCP) may be proving to discourage family physicians to follow clients with mental illness/mental health issues. This latter point was noted by an official of MCP but was not discussed with representatives of the family physicians.

During the consultations, there were several persons who raised the issue of orientation to mental illness and mental health for all professionals. There were concerns raised by stakeholders that general practitioners need continuing education to be kept up-to-date concerning the latest advances in psychiatry. Social workers were seen as requiring orientation and continuing education above the degree program to fully understand the requirements of persons with a mental illness or a persistent mental health concern. This also applies to psychologists and occupational therapists. The Association of Registered Nurses of Newfoundland and Labrador submitted a brief to the consultants indicating psychiatry is a

specialty area of practice. A brief outlining the roles nurses may play in community mental health was submitted for consideration. (Refer to **Appendix G**).

Orientation to current issues in mental health and continuing education must be a key component built into the system for all professionals particularly if a community mental health system is to deliver the services demanded by best practices.

4.4.3 Increasing reliance on inter-disciplinary teams

From the summary of human health resources compiled for the inventory of services it is apparent that the hospitals with psychiatric units are those more likely to have the full complement of professionals required for the presence of inter-disciplinary approaches, but not always. This is important as all the professions bring a different competency to the treatment and management of chronic mental illnesses and mental health issues.

Once a primary health care model is implemented, services will be delivered by inter-disciplinary teams. This will require that H&CS Boards access to health human resources of differing specialities if they are to effectively serve clients with mental illness. There is an inconsistent pattern of the types of professionals present by region. In the H&CS Boards, there is a predominance of social workers. While social workers bring one perspective and knowledge base there is a need for the knowledge and skills of nurses, psychologists, physicians, psychiatrists and occupational therapists. The consultants have not been able to determine why the social work profession has a relatively stronger presence in the H&CS Board but one explanation may be their relative availability as compared with other professions.

For example, in the St. John's H&CS Board the workers in mental health program are all social workers. Western H&CS Board has the equivalent of 13 social workers, 5.4 psychologists,

0.75 of an occupational therapist position, and no nurses. These regions are the weakest in terms of relationship with the hospital system and hence are limited in their ability to respond to clients with mental illness or persistent mental health concerns. The Eastern H&CS Board has 11 social workers, 4 nurses and 2 psychologists and is marginally better off given the close working relationship with the hospitals. The other Boards are involved in differing levels with systems that are working as co-ordinated teams although each has limitations.

The resource sharing arrangement between the H&CS Board and the hospital serving the Central West region has enabled the creation of an inter-disciplinary team with access to professionals with competencies in the specialties required to serve persons who are mentally ill. At this point, the hospital is still perceived as being ultimately responsible for these clients in a crisis. There have been excellent examples provided to the consultants of the joint services and supports planning activities undertaken by the staff of both Boards, working with the client and family, to enable clients to return to the community after discharge from hospital The staff recognize there are improvements needed but they are moving in a direction that supports working with the hospital to serve persons who are mentally ill in the community.

It is suggested that all the regions move toward having all disciplines either available to them, i.e., working in the region, or accessible, i.e., by video-conference/audio-conference by way of reasonable travel, to form the basis of an inter-disciplinary team.

4.4.4 Use of Tele-Health

It is apparent to the consultants that there is a requirement to have access to the resources of all the professions to all regions, and at times to small areas within regions. It is recognized that it may not be possible to have all represented in the regions. There is a means to access these resources via tele-medicine, both video-conferencing and audio-conferencing. This province has a well-developed tele-health system that is continuously improving. All regions have access to

these services. There have been pilot projects undertaken demonstrating this as an effective means of delivering services in this field. For example, persons in Labrador have been assessed under the *Mental Health Act*, via video-conference by a psychiatrist based in St. John's. There are issues with the use of the technology, among them, the need for education about the uses of the technology, the need to raise public awareness of the availability and benefits of these facilities and facilitating participation by physicians through adjusting the MCP fee schedule.

It is suggested that this method be more widely used for tele-psychiatry and related applications (e.g., professional continuing education, staff meetings) where professional resources are not available within a region.

4.4.5 Re-focussing efforts aimed to raise the profile of mental health

Promoting the importance of mental health and de-mystifying mental illness is a role the H&CS Boards are well positioned to undertake. The profile of mental health to one's overall health is in need of targeted efforts to raises its importance in the public view. It is evident that the staff of the H&CS Boards understand this is a need to be addressed. While efforts to assist individuals are good, there could be broader benefits to all if activities of the H&CS Boards are re-focussed on the original vision and directed toward implementing the Framework For Health Promotion.

The role of the professional in this circumstance is as a community developer. This is a very different role than professionals whose practice approach is clinical in nature and who respond to individual clients who seek their services that are delivered in a professional office setting. Community development involves working with people in the community to assess community needs, identifying priorities and developing a plan or strategy based on the capacity of the community. The goal is to empower those involved to assume responsibility for the program/project with the support of the professional. It is a model that fits with initiatives to support consumer participation and control of services. Professionals are not delivering services to

individual clients, but with people from a community of interest, both for themselves and also for the larger community.

There are certain skills possessed by many professionals that are essential for this activity, eg. facilitation skills, community education. There appears to be an assumption that as professionals may have these skills, it is sufficient to say that the H&CS Boards are engaged in community development. Community development is an area of specialty with its own knowledge base and competencies. There are diploma and degree programs in community development. Additional competencies are acquired through the specialized programs focussed on community development and building community capacity.

It is suggested that an investment is needed in orientation and continuing education for the professional staff who are to be engaged in delivering the community mental health program from the perspective of community development.

4.5 Delivery

A co-ordinated continuum of supports and services to provide care to the ill, whether physically or mentally ill, would be consistent with the philosophy of ensuring services are available to those clients who need the service in the community. To differentiate between the type of illness, physical or mental, runs the danger of further perpetuating the stigma of mental illness. The current divide between the hospital and the H&CS Boards in terms of who they serve must be eroded. There is also a need to build stronger partnership arrangements between these formal service providers and non-profit organizations and consumer groups. The sense of "we" - "they" could forever divide. Thus, the challenge is to build a system based on working together for a common goal.

In terms of recommending the optimal system to deliver supports and services, the consultants have identified potential delivery mechanisms. These are several considerations and perspectives to be acknowledged. There are strengths and challenges associated with each of the options presented. These alternatives are presented to highlight the possibilities though one option is supported.

1. Establish an independent commission to oversee the development of a community mental health system.

This option suggests the establishment of an independent body or commission to assume leadership for the implementation of the policy direction and framework for a community mental health system. A commission would have control of all provincial resources to support implementation of the framework. In New Brunswick, such a commission was established a time-limited mandate for 10 years to reform the mental health system. After the time expired, the services were transferred to regional boards. This model worked well in New Brunswick where there were resources committed to the Commission. The source of their funding was from savings diverted from deferred capital expenditures to build a hospital for the mentally ill and institutional programming. This model was advanced by the Waterford Foundation as a means to implement a community mental health system in this province.

The consultants believe that though this is a good option with much to recommend it, but the current environment does not support the establishment of another entity board structure when the Department, through the Minister's Health Forum may be contemplating consolidation of existing boards. More importantly, this option perpetuates mental illness as separate from the holistic view of health and well-being.

The next two options consider the possibility of favouring delivery by the institution or the H&CS Board. As was noted by the Clarke Institute in its Best Practices Review, it does not matter which delivers so long as the functions are achieved.

2. Place responsibility for the delivery of all community mental health services under the hospital boards

The hospitals have expertise in addressing the medical needs of persons with mental illness and persistent mental health problems; by extension, they can expand their expertise to all clients. The hospital staff have an understanding of the supports and services required by clients in the community and some experience in working within this system.

Though the hospitals have an appreciation of the supports and services required by clients in the community and have made some efforts to deliver community-based supports and services, this is not their focus or generally part of their mandates. The cost of delivery through the hospitals will be higher than through community-based delivery systems.

The complaint often articulated against the hospital-based system, is that there among conflicting priorities, notably for funding, mental health services do not receive the same level of commitment as opposed to, for example, diagnostic equipment for cancer. Further, in past de-institutionalization efforts, it has been argued that savings are diverted internally to maintain the hospital and do not fund the establishment of new services in the community.

The consultants do not view this option as an acceptable solution.

3. Place responsibility for the delivery of all community mental health services under the H&CS Boards.

The national trend supports community-based delivery of mental health supports and services. The H&CS Boards have a presence in the community and have services and supports partially in place. They have some experience in dealing with clients with mental health issues.

However, the H&CS Board staff have not developed the expertise (with some exceptions) to deal with clients with mental illness living in the community and others with persistent mental

health concerns. In mental health, the H&CS Boards have not fully developed collaborative relationships with community-based organizations which it must do to effectively deliver community mental health services.

The consultants have determined that except for the two integrated boards, neither the hospital boards nor the H&CS Boards are positioned to deliver all community mental health services and supports. The continuation of the "we" vs. "they" has resulted in narrow organizational mandates, with few links, that do not operate well for those clients with mental illness or persistent mental health concerns. As a result, clients have been lost between the systems.

The consultants cannot support this option.

4. The community mental health system should by structured regionally with services delivered on a co-ordinated basis in the community.

This approach supposes that each region has differing needs and that the delivery system should be based on the distinct needs of each region in the province. The strengths and challenges of the existing integrated boards model, as well as the Central West region, could be used in developing models for consideration in the province. This approach builds on the strengths of both systems with the expertise of both Boards that can be directed to the clientele and prioritized. It fosters integration and collaboration of all mental health personnel in a region. A range of supports and services can be developed using an inter-disciplinary approach to serve clients with mental illness and persistent mental health concerns in the community.

There is, at present, no one board with full responsibility for co-ordination of mental health services. This approach will require additional resources and efforts directed to coordinate and to collaborate service delivery between organizations with very different cultures and orientations to

client service. There will be a need to consider the implications of bringing two systems together.

This is the recommended option.

5.0 Opportunities for Making the Transition towards a Co-ordinated Community Mental Health System

Based on the research conducted during this review, the consultants conclude that the best options operating at the moment in the province are those in place in Grenfell and Central West regions. Though not yet perfected, these models are seen as being headed in the right direction. Through ensuring access to resources of the professional services an inter-disciplinary team each region can provide supports and services within that region. This must be supported with active consumer and family involvement and concerted efforts to raise the profile of mental health. These are consistent with the principles of primary health care and the vision embodied in Valuing Mental Health.

As for resource implications, the first phase of the implementation of this framework must be the development of regional plans to determine how best to implement the components of this community mental health system to reflect regional realities. Decisions must be made concerning the organization to be supported in the region. The proposed system is estimated to require an investment of approximately $6.2 M (See **Appendix H** for details). The resource requirements have been developed based on the assumption that the community resource based model will be introduced and services based best practices introduced in each region. It is envisaged that the existing staff would be maintained though some staff may be re-assigned. This investment would be phased in to allow for the regions to proceed with planning, engage in orientation of staff and hire community development specialists. The next phases would see introduction of services and supports based on the requirements of the regions.

It is also recommended that there be consideration given by government to amending the policy that authorizes home support for clients with a physical disability and clients with a developmental delay but does not include clients with a mental illness. As noted above, the Valuing Mental Health document does contemplate the extension of continuing care, which includes home support services. Based on research that has been conducted by the Canadian Mental Health Association, the requirement for home support will vary by the particular circumstances of a client and can range from a few hours per week to 40+ hours per week in extreme cases. Based on the existing home support program rates, assuming there is an average of 200 clients per year requiring 7-8 hours of service per week, a potential budget of $747,000 has been developed. This a notational budget, dependent upon a policy change by government and a budget for this client group.

There will be a requirement for the immediate investment in consumer organizations and family self-help to provide the needed supports. As well, there will be a requirement for orientation of staff in mental illness and mental health. Finally, efforts to implement the Framework for Health Promotion will require an investment in orientation and continuing education in community development for the staff who will be responsible for implementing these efforts. Funds will have to dedicated to this effort.

- **Securing Commitment for a Community Mental Health System**

Throughout the course of the data collection, both for the inventory and the during the consultation sessions, there was a recurrent questioning of the level of commitment by Government to support a community mental health system. This questioning involved Government's preparedness to publicly accord the same level of interest to the mental health system as it does to physical health and Government's willingness to invest in, and commit resources to. developing and sustaining a community mental health system in the province.

These are particularly important issues for those who have been connected with the mental health system as professionals, consumers and their family members. Given the lack of appreciation and understanding of mental health issues generally, and mental illness more specifically, there has been relatively less priority placed by Government for services.

Budgetary commitments reflect this reality. In this province, of a $1.5 billion health and community services budget, approximately 4.3% to 6% is committed to mental health services. The consultants have estimated that 80%-85% of this province's mental health budget is committed to the institutional sector versus the Health and Community Services Boards. In other provinces, the percentage spent on mental health ranges from approximately 9% to 11%[2] of the health care budget and, in provinces that have introduced reforms to the mental health system, the portion allocated to the institutional versus the community is more balanced.

Through reorganization of the Department in 1998-99 in an effort to move away from a program driven approach towards a system based on lines of business, the mental health division was eliminated. Though there has been funding for a position of mental health consultant, it has remained unfilled since 1999. As a consequence, there is no point of contact for those needing information or guidance for example, on policy directions, on best practices. This is perceived by participants to be a major gap in leadership.

Conclusion

In order for a community mental health system to be effective, it must be supported by Government in every way. This system will require a shift in thinking and a shift in approaches to service delivery. It will not be readily accepted by all stakeholders, but this must be faced as the

[2] These estimates must be viewed with caution as it unclear whether the same types of services are being included in the calculations.

existing fragmented approach has serious weaknesses to the detriment of the clients and potential clients it is designed to serve.

First and foremost, there must be commitment to the acceptance of the framework with development of a co-ordinated community mental health system at the highest levels. There must be political commitment to this objective to ensure it is seen as a common goal. Leadership must be exercised by the Department based on that commitment. Existing resources must be realigned and additional resources committed to this goal. Collaboration and planning will be key.

Actions required

Vision

- Establishing a vision to guide the mental health system is essential to ensure the Department, the Boards and stakeholders are moving in the same direction.

- From the consultation sessions, it is evident that there is support for the broad principles articulated in Valuing Mental Health. The principles must be confirmed by the Department as those that can be supported as it advances the community mental health system.

- Efforts ought to be undertaken by the Department to revise the document (e,g., prioritization of the clienteles to be served) and endorsement by Government sought for the policy direction articulated in the document.

Leadership

- The Department must assign a person to assume leadership of, and responsibility for, the development and implementation of a co-ordinated community mental health system on a regional basis.

- The person ought to be a recognized champion within the field. This person must also have the capacity to enable champions within the regions to emerge.

Defining the Clientele and their Requirements

- The Department must assume authority and responsibility for developing a data base for provincial and regional planning purposes.

- The Department must assume leadership for the process of engaging the Boards and other stakeholders in defining the requirements and establishing a plan for its implementation.

- All activities must involve, to the greatest extent possible, consumers and families in creating a community mental health system.

Supporting a Co-ordinated Continuum of Mental Health Services

- The Department ought to assume responsibility for the development of consistent approach to planning and service development across the province. To the extent possible there ought to be a full range of services available within each region.

- Leadership by the Department will be critical particularly where there are other departments and agencies involved, e.g., the police forces and emergency response services, to ensure consistency with the provincial policy direction. In this way, there can be consistent policies developed across the province in relationship to services that are essential to maintaining client's in the community.

- The various boards within a region will have to develop a regional plan, consistent with the provincial direction, to determine the organization of services within their region.

- Existing resources ought to be deployed/re-deployed to respond to the priority needs of clients with mental illness or persistent mental health concerns, e.g., Crisis Centre staff to assertive case management/crisis response teams/help line.

- Efforts should be undertaken to incorporate ongoing monitoring and evaluation in the community mental health system so that improvements and adjustments can be undertaken as required.

Resources

- An investment must be made to resource consumer and family self-help organizations as they require support to facilitate participation in the mental health system.

- Home support policies should be reviewed to include persons with mental illnesses and/or persistent mental health concerns.

- A full range of professional services should be available to all regions. If it is not possible to recruit a professional there may be other means to access the resource either by the use of tele-health or reasonable travel.

- There must be orientation and continuing education of staff to provide an appreciation of mental illness and mental health issues and to implement the Framework for Health Promotion.

- All parties should be encouraged to facilitate use of inter-disciplinary approaches.

- Resources are to be maximized. Every effort should be taken to use the tele-health system to allow services to be within the region. Clients should be able to avail of informal supports available to him/her in their home regions.

Delivery Mechanisms

- There needs to be a prescriptive approach to developing models of delivery across the province. At the same time, there must be flexibility to maximize the strengths in the regions. Specific accountabilities must be defined for each board within each region.

- Participation by consumers and families in designing services as well as the delivery are to be integral parts of the community mental health system.

- To the greatest extent possible, there ought to be efforts to engage community-based organizations with particular expertise, to participate in the delivery of aspects of the mental health programs.

Appendix A

Community Mental Health Services
Program Inventory

Region:

Nature of Organization: □ Regional HC&S Board □ Integrated Board □ Hospital
□ Community organization □ Facility designated under Act

Program Name:	
Program Goals:	
Desired/Demonstrated Outcomes:	
Client profile: **Clients with mental illness /DSM IV diagnosis** ▸ # of clients per year ▸ age range of clients ▸ socio-economic status ▸ % of clients with complex needs/hard to serve	
Client profile: **Clients with mental health issues** ▸ # of clients per year ▸ age range of clients ▸ socio-economic status ▸ % of clients with complex needs/hard to serve	

Nature and range of services provided:	Emergency Services: ☐ individual (assessment, counselling, therapy) ☐ family (assessment, counselling, therapy) ☐ group(self-help, support group) ☐ health promotion ☐ advocacy ☐ other services (e.g., ECT, day programmes)	
HR complement:	social workers nurses primary care physicians psychiatrists psychologists occupational therapists residential workers outreach workers Other (specify)	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Utilization trends: • range of issues • # of clients by issue (mental illness vs. mental health problem) • waiting list • alternative services • gaps		
Consumer/Family participation: • mechanisms • access to mechanism • level of participation		
Links to other Services: • provision of information • referrals by staff		

Performance measures: • existence of standards • models in use	
Evaluations/Reviews of services: • Identify by author & date	
Program Budget: • overall estimate • administration vs. service providers	
Budgetary trends/issues:	
Informant: **Contact Information:**	

Date completed:_____

APPENDIX B
TREND ANALYSIS

1.0 INTRODUCTION

We interviewed a select group of key informants, and reviewed a limited number of reviews and reports, with respect to identifying the general trends in community mental health in Canada. Provinces of particular interest were Saskatchewan, Alberta, New Brunswick, and Ontario, with some national perspectives.

2.0 CONCEPTUAL FRAMEWORK

Most provinces have a solid framework, with clear values and guiding principles for services including accessibility, person-centred, community-based, a broad service range, self-sufficiency, coordination, accountability. Saskatchewan and New Brunswick have designed their delivery according to CMHA's Framework of Support Model.

3.0 DELIVERY MECHANISM

3.1 Authority

There has been a separate authority established at some point in both Alberta and New Brunswick. In New Brunswick, all of the mental health monies were brought into one envelope, with a separate commission put in place with a mandate to direct shift to community delivery. This commission moved directly into the Ministry of Health at the halfway point of its mandate, and service delivery is now set to devolve to regions as that mandate ends.

New Brunswick has both a Mental Health Act and a Mental Health Services Act. Saskatchewan has a mental health director with responsibility for overseeing these acts.

In several provinces, the government devolved most service to regions and retained responsibility for standards.

3.2 Locus of Service

There has been a clear trend to move service away from institutions and into the community. In New Brunswick , community mental health services increased about fourfold over the past ten years. The percentage of community mental health services of the overall mental health budget is increasing, and was described as being in the 30-50%

percent range in most provinces. These figures need to be viewed with some caution, as there are no standard common measures in use.

3.3 Rural Service Delivery

All of the provinces we consulted have regional mental health facilities, with a multi-disciplinary group of professionals, and either access to or responsibility for an in-patient unit. In New

Brunswick, for example, there are a number of regional clinics which serve "cities" of 10,000 population or so, and which also serve as centralized supports for more rural services. In Saskatchewan, there are mental health professionals in 32 separate districts and 91 sites, under a belief that persons should be able to access mental health services within one hour of their home. There are recent tele-psychiatry advances in New Brunswick, Alberta and Saskatchewan, extending to ER-ER consultation and admissions.

3.4 Nature of Services

Core Services

Tertiary Care- all provinces have moved to serve persons with long-term mental health / mental illness increasingly in the community. There has been a range of success in developing a receptive community system, with appropriate housing and other supports.

Short-term In-patient Care- other provinces maintain a regional capacity to provide in-patient services to persons requiring such intervention.

Assertive Case Management- each of the provinces polled uses this approach to address persons with serious mental illness. The goal of case management is to work with clients to ensure integrated approaches, to prevent and manage crises, to support adequate housing and other daily living supports, and to develop natural supports.

Community Clinics- there is generally regional capacity in day clinics, with either in-patient services or access to beds in regional hospitals. These clinics provide direct service in the region they serve, and also serve as hubs for more rural services.

Newer Innovations

Court Diversion Program- this program in Saskatchewan and Ontario attempts to keep persons with mental illness out of court and prison and re-direct them to appropriate resources.

Tele-psychiatry Services- as mentioned previously, significant advancements are being seen in this area.

Early Psychosis Programs- these programs attempt to provide effective intervention and case management services to persons likely to require long-term care.

Mental health - justice partnerships in treating batterers and sex offenders.

Physician - Psychiatrist collaboration- there are initiatives being piloted in several jurisdictions to enhance the relationship between these doctor groups, in particular for appropriate use of the latter by the former.

4.0 RELATIONSHIPS

4.1 Between Government and Boards

The primary role of government in other provinces is in funding, setting and monitoring standards, monitoring and evaluating services. Regions are responsible for direct service delivery. This relationship is evolving, and in New Brunswick and Alberta, mental health authorities are now devolving to the regions, after having single envelope or protected envelope approaches. .

4.2 Between Institutions and the Community

In Saskatchewan and New Brunswick, there are significant formal links between institutional and community systems. For example, in Regina, there is a community nurse situated in the hospital to enhance community re-integration. In New Brunswick there is a liaison nurse who visits in-patient units daily and who assist in discharge planning.

4.3 In Cases of Emergencies

In New Brunswick all of the regions have at least 24 hour on-call services, handled by professionals, and four of eight have an emergency mental health nurse for 16 hours per day. There are on-call community workers who will assist in securing services and accommodations for persons deemed to not require psychiatric admission.

In Alberta, there is a good relationship described between mental health workers and the police. CMHA reports that the RCMP are developing new programs. The general sense is that these links are improving across the country but require significant effort to nurture and maintain.

4.4 Role of Community Groups

In some regions, community groups play a significant role in mental health service delivery, particularly around issues such as employment, shelter and longer-term housing, rehabilitation, training and life skills / recreation. Housing is noted as a huge gap, caused in the main by the lack of federal government investment in social housing, and resulting in additional strain on the other parts of the mental health system and other systems.

In Saskatchewan, a private, non-profit group operates supported housing projects with close links to health staff for treatment supports. There is also a system of Approved Homes, where private operators take in up to five persons with long-term mental health concerns. The former is the mode of choice for the government, but the former is offered in recognition that some (mostly older) persons who have been cared for in institutions may prefer larger communal environments.

4.5 Role of Consumer / Family Groups

Consumers and consumer groups are involved to some degree in decisions about their own care and mental health service delivery generally. This can come in several forms, including:

- advisory committees to formal service delivery structures;
- as members of study panels or task forces;
- as informants in specific reviews or evaluations of service;
- as peer helpers;
- as advocates.

Some provinces provide significant support to consumers' groups. New Brunswick invests over 1 million per year in support of consumer and family groups and another $400,000 for CMHA services. Saskatchewan has a regional rehabilitation council in each of its health regions- consumers and advocates are on these councils. Ontario has recently cut back some on funding community supports. There is little evidence of a meaningful role for consumers in service governance.

5.0 HUMAN RESOURCES

5.1 Role of Psychiatrists

Psychiatrists tend to be either primary providers (mix of fee for service and salary) or consultants. Alberta and New Brunswick are described as having adequate levels of psychiatrists, with at least one in each regional facility working with a multi-disciplinary team. Recruitment is identified in some other areas i.e. Nova Scotia, as quite problematic.

5.2 Role of Nurses

In Saskatchewan, Alberta and New Brunswick, nurses trained in mental health are the most utilized professional group. They serve as managers, day clinic and outreach staff, discharge planners, and in some instances as admitting screeners.

5.3 Role of Social Workers / Psychologists

Social Workers and psychologists are present in each of the regional facilities / clinics in Saskatchewan, Alberta, Ontario, and New Brunswick. There appear to be more social workers in place at a sub-regional level, except for in New Brunswick, where about one quarter of mental health staff are from each of these two professions.

5.4 Other Roles

New Brunswick has identified a role for a human services counsellor, mostly comprised of institutional staff displaced through a shift to community, who have received advanced training. General practitioners provide a significant amount of mental health services in Alberta and Saskatchewan, especially in rural areas.

6.0 BUDGETS

6.1 Ratio of Institutional to Community Budgets

The budget practices of the provinces are all unique. Further, some provinces separate out

programs among several departments while others do not. Thus any numbers may not necessarily reflect identical program responsibilities or activities, but likely do reflect trends.

In Saskatchewan, community mental health represents 46% of overall mental health services ($36 million of $78 million). This percentage has steadily risen over the past ten years. Funding there is delivered under a one- way valve agreement, which ensures any new or redirected funds are put into the community. Several regions have invested more money than transferred from government. Regions have been less efficient, more likely than government itself to carry deficits.

In Alberta the estimate of investment in community mental health services is about 44% of total mental health budgets. As with Saskatchewan, this number has been increasing throughout the 1990's. Children's mental health services in particular are increasing This province, interestingly, accounts for mental health spending under MCP, which is about 18% of all mental health spending.

In New Brunswick, the shift in funding has resulted in a shift from 75% tertiary care and 25% primary / community care, to the reverse today. On their own, the regional CMHC's in New Brunswick receive about 44% of all mental health spending in the province (about $23 million of $53 million) Even with these estimates, the key informant from this province estimated that only about 50% of all monies taken out of the institutional system found their way into the community.

Appendix C
Glossary of Terms

For the purposes of this report, the following terms are used to assist the reader:

Community Mental Health	Refers to publicly-funded services delivered by the Regional Services Boards and those community-based non-profit organizations who are delivering services under a contractual arrangement with one of the Boards.
Mental Health -	Refers to an individual's interaction with the context and events of life, critically affected by their life situation, and the amount of support and control the person has in dealing with their circumstances. (adapted from *Valuing Mental Health*, September 2001)
Mental Health Services -	Refers to all publicly-funded mental health services, services based in the institution, out-patient services and services delivered by Regional Health and Community Services Boards.
Mental Illness -	Refers to a medically diagnosable illness that results in the impairment of an individual's thoughts, mood and behaviour. Mental illnesses tend to be episodic or cyclical in nature; a person may have episodes of acute illness, but also long periods of wellness. The mental illness continuum concerns the presence or absence of symptoms of disorder. (adapted from *Valuing Mental Health*, September 2001)
Persistent Mental Health Concerns -	Refers to a situation where an individual whose ability to live independently is at risk due to their mental health concerns.
Primary Care -	Primary care is initial client contact with the health care system for the purpose of assessment, diagnosis and treatment of acute episodic and chronic illness or injury.
Primary Health Care -	Primary health care is essential care (promotive, preventive, curative, rehabilitative and supportive), that is focused on preventing illness and promoting health. Primary health care is both a philosophy of health care and an approach to providing health services. It has been adopted by the World Health Organization and by Canada as the key to enabling people to lead socially and economically productive lives. Clients of primary health care can be individuals, families, groups, communities and populations. The principles of primary health care are accessibility, public participation, health prevention, appropriate technology and intersectoral cooperation. (Canadian Nurses Association - Policy Statement, April 1995).

Community Mental Health Review
Discussion Paper

Background and Purpose of this Paper

This *Discussion Paper* represents an integral part of a review of the community mental health system in Newfoundland and Labrador. The review is sponsored by the Department of Health and Community Services (" the Department") in an effort to develop a framework for a community mental health system for the province. The project is being undertaken by The Institute for the Advancement of Public Policy, a consulting firm based in St. John's.

Since December 2001, with the assistance of the Mental Health Co-ordinators across the province, the following activities have been undertaken:

- an inventory of programs and services has been compiled to present the status by region and provincially;
- gaps in the province's community mental health system have been identified with a preliminary assessment developed;
- trends in mental health service delivery in this and other jurisdictions have been reviewed.

The purpose of this paper is to present the findings of these research efforts to those with a stake in the community mental health system including clients and their families, service providers, policy and program developers and the public. Further, this paper will be used in a series of sessions to be conducted across the province to gain comments respecting the community mental health system as it currently exists and also to determine the level of interest and support for its proposed future direction. There are possibilities and opportunities to develop a system which can respond to the needs of those who are in need of an effective community mental health system for their health and well-being.

Overview of findings

Policy framework

- Regionalization of mental health services to the Regional Community Health and Services Board proceeded as part of an effort to incorporate prevention and the principles underlying the Framework for Health Promotion into the health care delivery system.

Clients

- The clients of the community mental health system are persons diagnosed with mental illness and those with mental health issues. While there is no accurate means to identify all residents of the province with a mental illness, there have been studies to assist with determining the number of persons who may seek services. The number of clients with **serious mental illnesses** was estimated in 1999 to be approximately 13,320 (approximately 3% of the population) of 444,052 who are 15 years+.

- The number of clients with mental health issues is difficult to estimate. Those with mental illnesses may also have mental health issues. Based on the data collected for inventory, it is apparent that there are inconsistent methods of classification in use. The Regional Health and Community Services Boards are maintaining mental health program statistics manually. The reliability of the data is questionable given that there is no consistent classification system in use and there are inconsistent time frames for reporting. Refer to **Appendix C-1.**

Services

- Services for clients with mental illness are predominately provided through the institutions, through both in-patient and out-patient services. The provincial tertiary care centre is the Health Care Corporation of St. John's. There are mental health units in the Central Newfoundland Regional Health Care Centre in Grand Falls-Windsor and Western Memorial Regional Hospital in Corner Brook.

- There are approximately 150 acute care beds dedicated to psychiatry in the province. Considering institutional long-term care and community care beds considered, there are approximately 275 beds in total in the system. While other regions of the province have hospitals and there are admissions of persons with mental illnesses, there are no other beds designated for psychiatry other than the three hospital referenced.

- The four (4) Regional Health and Community Services Boards and the two (2) integrated boards deliver community mental health services. Though there are exceptions, the primary focus of the services delivered by these Boards to those clients with mental health issues. Many of the mental health programs delivered by the Regional Community Health Boards do not have the resource capacity to respond to the needs of clients with mental illnesses.

- On a community level, approximately 400 general practitioners play a significant role in providing ongoing services to those with mental illness. They act as gatekeepers to the approximately 45 psychiatrists in the province, the majority of whom, approximately 30, are based in St. John's. The distribution of health human resources by region of the province is contained in **Appendix C-2.**

- Community mental health services are delivered by mental health workers, overwhelmingly social workers, many of whom also have responsibility for the addictions program. There is a predominance of social workers employed in these roles with fewer numbers of nurses and psychologists.

- Regional Health and Community Services Boards, except for Central West where there is a resource-sharing arrangement with the hospital, do not have a physician or psychiatrist on staff associated with the community mental health program. Several Boards lack a professional staff member whose specialty is psychology, either through a decision to hire other specialties and/or due to difficulties in recruiting and retention. Several Boards do not have access to services of an occupational therapist.

- There are only two regions which have an emergency response team in place to address the requirements of those in mental health crisis. The regions are Grenfell Regional Health Services Board and the Central West Regional Health and Community Services Board in Grand Falls-Windsor. There

are parts of those regions, due to distance and other considerations, that are not serviced by the team as effectively.

- Persons with a mental illness in crisis, due to the lack of services and circumstances of the case, may find themselves in the care of the police. In St. John's, in 2001 there were approximately 350 persons held in the lock-up pending an assessment by a psychiatrist. As for Corner Brook, the estimate is 50-60 persons in a year. In 2001, the RCMP responded to 1169 complaints that arose from persons that were considered to fall under the *Mental Health Act*. Not all persons were held in the lock-up. They could have been transported to hospital, detained until a physician arrived to conduct an assessment or detained until the weather could allow safe transport to hospital.

- Predominately, community mental health services of the Board are delivered to clients on a one-to-one basis. There are activities targeted to health promotion and education. There is emphasis on community education. There is relatively less activity in group work and/or community capacity building.

- Client participation in the services delivered by the Boards is in accordance with traditional methods of planning services. There is a consumer led organization, CHANNAL, that is a network to encourage consumer participation and advocacy. Self-help organizations for consumers and/or their families primarily meet in St. John's and Corner Brook. These supports are not consistently available throughout the province.

- Based on best practices in the field of mental health, this province has gaps within the existing system. Refer to **Appendix C-3** for an overview of services in place in relationship to best practices.

- Services for children and adolescents are few to non existent in certain regions. The regions with specialized services for children and youth include St. John's, Central West and Western Regions.

- Clients with mental illnesses are discharged from hospital into the community without appropriate supportive services - stable housing, home support services, opportunities for recreation, socialization and employment - which results in re-admissions. Refer to **Appendix C-4** for a summary of gaps.

- A supportive service that are delivered to the clients in the community, assertive case-management, is being piloted in St. John's. Throughout the province there are some services that are out-reach services where practitioners visit clients with a mental illness, e.g., to administer injections.

- The stigma of mental illness and mental health issues remains. There are intangible barriers to be overcome by clients seeking services, e.g., many will not avail of services in their community or region to avoid being seen using the service.

Delivery

- Services of family physicians are delivered in the community. Psychiatrists may be based in the community and there are some who are hospital based..

- Delivery of services is concentrated within the institutional sector or the Regional Health and Community Services Boards. There are a very few non-profit organizations who are delivering services on behalf of the Boards under service agreements.

- The role of the non-profit organization does not have prominence although there are many advantages to their participation, particularly in building support within the community, advocacy on mental health issues that the Boards cannot address due to conflict of interest, and eroding the stigma of mental illness.

- Services delivered for and by consumers are limited. Models such the consumer directed Clubhouse, based on the principles of rehabilitation are not in existence in the province though there have been efforts undertaken to advance it.

Financing

- The resource allocations as determined by budgets indicate that though there has been an effort to introduce regionalization of services, over 80 % of funds remain within the institutions. Refer to **Appendix C-5.**

Trends

The consultants proceeded by reviewing the literature and discussions with staff of the Department of Health and Community Services, Dr. Ted Callanan, Chief of Psychiatry, Memorial University of Newfoundland, Dr. Tom Cantwell, Clinical Chief of Psychiatry, Health Care Corporation of St. John's, and Moyra Buchan, Executive Director, Canadian Mental Health Association.

It was determined by the consultants that several Canadian were of interest as to the reforms that occurred over the past decade vis-a-vis mental health namely, Saskatchewan, Ontario, Alberta and New Brunswick. Refer to **Appendix C-6** for a summary of the information gathered through consultations with officials in these provinces comparing the information with the situation in this province.

Key observations

- Most provinces have a solid policy framework with clear values and guiding principles for services including:
  - accessibility,
  - person-centred,
  - community-based delivery,
  - a broad service range of services,
  - self-sufficiency,
  - coordination, and
  - accountability.

- Provinces have approached implementation of a new regime in varying ways; some have created independent authorities to drive the new agenda. These agencies are being incorporated in the regional systems of health delivery.

- Governments maintain the role for policy development and setting standards. The regional system has responsibility for delivery with budgets allocated by the province, some with protected amounts for mental health services. There is a trend toward determining standards of service is underway.

- Involvement of consumers in decision-making about their own care and the system generally has gained momentum. Resources are diverted to consumer organizations to support their activities.

- There is a clear trend away from service delivery from institutions toward community-based delivery. Inter-disciplinary groups of professionals are favoured. Community clinics provide direct service in the region they serve, and also serve as hubs for more rural services

- All officials consulted indicate that the provinces have moved to serve persons with long-term mental health/mental illness increasingly in the community.

- There are recent tele-psychiatry advances in New Brunswick, Alberta and Saskatchewan, extending to ER-ER consultation and admissions.

- The percentage of community mental health services of the overall mental health budget is increasing, and was described as being in the 30-50% percent range in most provinces. These figures need to be viewed with some caution, as there are no standard common measures in use.

Discussion Points

The purpose of this paper is intended to:

- verify the findings,
- identify gaps not recognized, and
- gauge the degree of support for differing types of delivery mechanisms in use elsewhere and their applicability to this province.

The views of stakeholders are being sought. The feedback received by the consultants will be used to develop a framework for community mental health services in the province.

Underlying Policy Direction to be affirmed

The existing system has evolved from one that was established under a policy established over 30 years ago supported by legislative authorities enacted in 1971. The system has developed without a vision for the 21st century or a reconsideration of the strengths and challenges facing the province. There are gaps in the system and resources are allocated on the basis of maintaining institutions. At the same time regionalization of services

has proceeded but without a clear picture of where the community mental health system ought to be heading.

This review presents an opportunity to examine trends in the context of what is occurring in the field of mental health in the province.

At the outset of this project the consultants became aware of the publication, "*Valuing Mental Health*", a document developed by the Canadian Mental Health Association, Newfoundland and Labrador Division, sponsored by the Department of Health and Community Services. This document reflects the input of a broad based, consultative process into which there was input by stakeholders throughout the system.

In order to proceed with this discussion, guiding principles contained in "*Valuing Mental Health*" (refer to pp. 11-12 of the document) have been summarized for purposes of discussion. These are that a community mental health system should:

- be person-centred and participatory,
- be accessible and user friendly,
- be community-based,
- offer a comprehensive continuum,
- be appropriate and co-ordinated,
- be collaborative in nature,
- be sensitive to regional and community needs,
- be efficient and accountable.

The principles and framework for the development of a provincial policy for mental health were accepted by the consultants as a foundation for this review. Though the forward includes a letter from the Minister indicating that the approach to developing the document is supported by the Department, it has not been accepted by Government as provincial policy. There must be an acceptance of a policy direction to guide the implementation of a new delivery system.

Clients

It is evident that there is a need for a consistent method of data collection and classification of clients to be used within the institutions and the community health system. There is also a requirement for a means to collect data through computerized data systems. The data must be able to be used by both systems to follow clients from one system (hospital) to the other (community) while recognizing there may be concerns re privacy and confidentiality to be addressed.

The hospital system appears to have a good data base and sense of who they are serving. Upon discharge there may be follow-up with out-patient programs. After the client leaves the service there is no automatic referral to community health services. Perhaps one of the most important aspect of this is that for persons with mental illnesses, in particular, there is a need for supportive services in the community (housing, home support, social activities, recreational activities, employment) to prevent admission/readmission to

institutions. Linkages with other systems are critical for the client to be sustained in the community.

For follow-up and co-ordination of services for those with chronic mental illnesses, a suggestion has been to use a process similar to the Individual Support Services Plan (ISSP). This process is currently in place to co-ordinate services for children accessing several services. It is believed that clients with a mental illness are known to providers and could be identified. Between the institution and community health boards a plan could be developed with the client and family to ensure services required to sustain them in the community are put in place. This process, or other options such as case management, may be an option for consideration in the regions.

Whereas it is relatively easy for the institutions to identify clients, this has proven be not so easy for the community health boards. There is a computerized data base for client information being developed for the Boards. This has not advanced to include the mental health program yet. The consultants have heard conflicting views on the system. The point was raised that the Mental Health Co-ordinators have not been involved in designing the data requirements. This involvement must occur and become a priority to ensure establishment of a useful and effective system. The clientele and client needs must be ascertained with a common classification of conditions across all Boards within community health boards system. It is important that the information system is compatible with that of the hospital system.

Throughout the review the question has been who are the clients served by the institutions and who are the clients served by the community health boards?

- **What is your view of the clientele of the Boards?**
- **How can the Boards ensure the data collected for all clients is recorded and classified consistently?**

Delivering Mental Health Services within the Community Health System

It is evident that though efforts have been undertaken in this province to change the delivery of mental health services, this has not resulted in a continuum of services. "Ownership" of clients with mental illness seems to remain with the institutional sector whereas those with mental health issues may be served by the community health boards. Clients with both a mental illness and a mental health issue may be clients of both systems. Clients must rely on both systems to work together to ensure services are provided in a seamless manner. This does not appear to be occurring.

The system remains effectively split between institutions which serve clients with mental illness and the community boards that are predominately serving those with mental health issues (possibly serving some of the former group). There are relatively few services that are co-ordinated between the institutions and community boards. There does not appear to be co-ordination across the community health board system. Unfortunately, the clients are discharged from hospital with out-patient services, if available, and then depending on the region in which they reside, they may be on their own other than with their family physician.

Despite the shift to move services to the community, an effective community mental health service has not been developed. For whatever the reason, services are not co-ordinated within and across health systems under the jurisdiction of the same department of government. It is also important that services from other systems be accessed under the jurisdiction of departments or agencies that have no direct connection with health.

This situation is further complicated, or perhaps assisted, by a trend across Canada favouring reform of primary care. Along with consideration of reform of primary care is a move toward primary health care models and is under consideration in this province. The design of the system is not yet complete. It is assumed that mental health, as part of a holistic view of health, will be an integral part of the reform.

Therefore, the framework for a new community health system is being developed in an atmosphere of change. However, there are certain key aspects that can be discussed to highlight the direction that the stakeholders which to see the system move.

In other provinces that have focussed on the mental health system, there have been deliberate strategies undertaken to ensure the principles of developing community based services are developed. Resources have been deliberately placed in the community while institutions are not expanded. This has been accomplished by:

- the provincial departments of health overseeing a plan diverting resources from the institutional sector in favour of the community, or
- alternately, establishment of a commission tasked to oversee the implementation of such a plan within a defined time horizon after which time a commission has been disbanned.

How can mental health services be enhanced at the community level across this province?

- **Which authority should be responsible for providing what services?**
- **How can the necessary supportive services be accessed to assist the clients of the mental health system?**
- **How can consumers actively participate in the planning and delivery of mental health services in the province? What mechanisms can be created to ensure effective input by consumers?**

The views of stakeholders are sought respecting these issues.

Financing Community Mental Health Services

Newfoundland and Labrador has a system of global budgeting whereby a transfer of funds is provided by government, through the Department of Health and Community Services to the individual boards. The Boards, institutional or community, allocate resources within their budgets based on their regional priorities. As such, allocation of resources for community mental health services have to compete with other priorities within the region. For institutional boards it may be that cardiac surgery or investment in new diagnostic equipment are the priorities. For community health boards it may be child protection or home support services

for the disabled. In any case, the question is how are mental health services positioned to compete among the priorities?

In those provinces that have implemented a plan for a new mental health system, based on past experiences, it was decided that a pro-active stance should be adopted for mental health. There were deliberate decisions made to support the plan with reallocation of resources in favour of mental health. Strategies were developed to divert resources to the community at the expense of institutions. Budgets were protected for mental health services. The percentage of the health budget that is targeted to mental health services is closer to a balance than is evident in this province.

What is the best means to resource a new community mental health system?

- **Is having a protected budget for mental health a good idea? Why? Why not?**
- **How can the support services that are needed be accessed or created when they are not the responsibility of the health care system, e.g.,housing, support services, employment opportunities ?**

Stakeholders' views on these issues are sought.

APPENDIX C-1

Summary of Data Re Clients - Mental Illnesses and Mental Health Issues[1]
Regional Health and Community Services Boards, Institutional Boards and Integrated Boards

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
St. John's Region			
Health and Community Services Board Mental Health & Addictions Counsellors	(Clients may have a mental illness. Clients in crisis referred to HCC.)	Counsellors average 15-25 active clients per month / 4 counsellors	varies by area - Average 5 clients/5 months
ACCESS House	19 17 n/a	-	4-5 persons/3 months
PREP Centre	Average 25 per month	-	-
Crisis Centre	? ? ?	Telephone calls Apr 01-Dec01 Apr 00-Mar.01 5933 5125 (10 mos.) Avg.659 mo. Avg. 512 mo. Walk-ins Apr 01-Dec 01 Apr 00-Mar. 01 353 384 (10 mos.) Avg. 39 mo. Avg. 38.4 mo.	-

[1]Data provided by Mental Health Co-ordinators and/or program staff. Data is not consistently reported as Boards collect data in accordance with the classification systems in use at the board. Not all Boards have computerized data collection systems; some data collection is undertaken manually. Not all data was provided using the same time horizons. Given these factors, data is of questionable reliablity.

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Youth and Family Services	20	180	There is a waiting list.
Services delivered by Non-Profit Sector Funded, in whole or part by Health and Community Services Board			
Pleasant Manor	23 23 23 (98 clients served over 16 yrs.)	-	1 on waiting list but sometimes as high as 6-7
Pottle Centre	200 members	-	No waiting list
Stella Burry Corp. Emmanuel House	73 (residents and former residents)	150 (residents and former residents)	1-2 months
Naomi Centre	16	175	n/a
Carew Lodge & Resource Centre	50	10	Waiting list for social housing.
Community Support (pilot)	13	8	-

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Employment and Education Program	35	100	For pre-employment group No waiting list for individual counselling.
Institutional-St. John's Health Care Corporation 232 beds/150 acute care estimates St. Clare's Mercy Hospital - Acute Care (3 West)	18 beds open 300 admissions per year	-	Reviewed weekly. Emergencies take priority.
Waterford West 1A/3A	52 beds (10-15 usu. closed West 1A) 2001 2000 1A 144 discharges 1A 352 discharges 3A 455 discharges 3A 412 discharges	-	No waiting list. All either urgent or emergent.

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Waterford 3A/ECT	26 beds Apr - Sept 2001 184 admissions 81 patients 911 treatments ECT 93 patients 1259 treatments	-	No waiting list. Demand is high.
General Hospital	25 beds open 340 patients 279 patients	-	3-8 patients/2 weeks elective admissions
Janeway	2000-01 1999-00 90 in-patients 83 in-patients 43 day patients 49 day patients 241 out-patients 719 out-patients 447 new referrals 450 new referrals		2000-01 449 new referrals 68 urgent cases 545 elective 6-8 wk. urgent/4 mo. elective 1999-00 450 new referrals 54 urgent 536 elective 4 wk urgent/6-8 mos. elective
Forensic	110 130	20% of admissions fit to stand trial and do not have a mental illness/All clients of these have mental health issues.	-
Psychiatric Rehabilitation	23 beds 18 adm. 15 adm. 14 adm. 15 discharges 12 discharges 15 discharges 96% occ. rate 82% occ. rate 90% occ. rate	-	No waiting list. Demand is high.
Geriatric Psychiatry Assessment/Treatment	2000-01 1999-00 138 142	-	n/a

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Janeway Community Mental Health	Unknown.	2000-01 1999-00 1289 1285	387 (139 individual/family therapy; 248 group therapy)
Bridge program (pilot)	170 since opened in June 2000 Based on demand to date, projected clientele estimated 340	10%	psychiatric consultation 2.5 months where team is required-24 hrs
Early Psychosis	Since April 2001, 72 assessed with 42 accepted ito the program. Based on experience to date, projected clientele of 70 clients by April 2002.	-	No waiting period.
Ambulatory Care	No statistics available on number of clients.		Walk-in services -1 hr.
Recreation Therapy Program	100% of patients in the program/all in-patients		n/a
Out Patient Occupational Therapy, Vocational Rehabilitation	110 90	-	No waiting list for past 2 yrs.
L.A. Miller Centre, Geriatric Psychiatry Day Hospital	2000-01 / 1999-2000 833 community visits / 723 community visits 923 clinic office visits / 944 clinic office visits 75 day hospital patients / 73 day hospital pts. 2654 days of attendance / 2965 days attendence	-	n/a
Developmental Disability	15 15	-	No waiting list currently.
Geriatrics - Long-term care-North 2A	25 beds (10 residential/15 transitional) 2001 / 2000 16 discharges / 24 admissions 5 deaths / 14 discharges 10 deaths 1 transfer	-	Short waiting list at times dependent on number of patients in transition. Long waiting list if transfers to units on 3A.

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Geriatrics - Long-term care- North 3A	25 beds 2001 / 2000 3 admissions / 1 admission 3 discharges / 1 discharge 2 deaths / 3 deaths 3 transfers in / 3 transfers in 1 transfer out / 1 transfer out	-	In 2001- wait list ranged from 8-14 persons. Majority are in transitional beds on North 2A.
Rendezvous	110 clients per month	-	-
Community Care	241(max accommodated is 267)	-	No waiting list. There has not been a waiting list for 10 yrs.
Family Care	40 beds plus 5 beds kept for emergencies	-	Avg 2 persons; usu. Due to home suitability
Meeting Place	93	-	Current waiting list is 15 persons, avg. is 6-7 persons
Mill Lane	126 per yr.	-	2001- 24 persons 2000- 45 persons

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Terrace Clinic	Clients Per Year DSM 1Vdiagnosis - Psychiatry 8400 100% - Psychology 2400 85% - Social Work 250 65%	Mental Health Issues - 15% 35%	Waiting list Psychiatry 1-6 months Psychology 4 months Social Work 3 months
Community Support Program	150 clients at a time/2000 visits per year	All have major mental health issues	No waiting list
Clinical Sexology	Year 2001 30 clients with DSM1V diagnosis	Year 2001 30 clients with mental health issues	-
Family Violence Program	Year 2001 150 clients seen / 80% with DSM 1V diagnosis	Year 2001 20% without a DSM 1V diagnosis	Waiting list 4 months
Psychiatric Rehabilitation Team-	110 clients seen at a time/3000 visits per year	All clients have major mental illnesses	No waiting list at present though one is anticipated
LeMarchant House	175 clients at one time/4000+ visits per year 70% with DSM 1V diagnosis	30% of clients with mental health issues	Two month waiting list

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Addictions Program	450 referrals per year/1000 visits 100% with DSM 1V diagnosis	All clients have major illnesses	No current waiting list

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Eastern Region **Health and Community Services Board** Mental Health Services		2000-01 1999-00 5056 4494 (NB. Some clients may have mental illnesses)	Varies by area Clarenville 40 Bonavista 5 Whitbourne 68 Trinity-Conception 57 Placentia 6 Holyrood 12 Burin 68
Institutional-Peninsulas Health Care Corporation GB Cross Hospital	Out-patients April 01-Feb 02 2000-01 1115 1341 (NB Clients could have mental illness and/or mental health issues)		n/a
Burin Peninsula Hospital	Out-patients 2000-01 1999-00 1698 142 (NB Clients could have mental illness and/or mental health issues)		2 weeks

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Central Region **Health and Community Services Board** Community Mental Health	2000-01 Adults: Seen by psychiatrist 354/seen by H&CS 59 Children & Youth: Seen by psychiatrist 101 / seen by H&CS 48	2000-01 **Grand Falls Windsor** adults: average 92 per month children & youth: average 54 per month **South Coast** Average 38 clients per month **Springdale** Average 49 clients per month **Lewisporte** Average 36 clients per month	2000-01 **Grand Falls Windsor** adults: average 14 persons children & youth: average 5 persons (NB school strike reduced referrals) **South Coast** Average 0 persons per month **Springdale** Average 0 persons per month **Lewisporte** Average 0 persons per month
Institutional Central West Health Care Corporation- acute care unit/ Psychology & Social Work	20 beds 2000-01 1999-00 234 in-patients 340 in-patients 84% occ. rate 84% occ. rate		
Central East Health Care Institutions Board - out-patient services	Psychiatrists - out-patient services	Out-patient services - SW, RN and psychologist 500 clients seen over past 3 years. Low case load of clients for maintenance of chronic illness.	40 persons relates to team of SW, RN and psychologist

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Western Region **Health & Community Services Board** Adult Mental Health	-	2000-01 1999-00 79 active 55 active 57 referrals 28 referrals	2000-01- 63 persons 1999-00 -25 persons
Blomidon Place	-	2000-01 180 referred 219 seen 18 Justice referrals	2001 - 6 months - 38 persons 2000- 4.5 months 1999 - 4.1 months
Sexual Abuse Community Services (SACs)	-	1999-2000 1998-99 133 active 155 active	7 persons (current)
Bay St. George Mental Health Program	-	2000-01 1999-00 226 active 184 active 157 referrals 113 referrals	2000-01 28 persons 1999-00 41 persons
Bonne Bay Mental Health Services	-	2000-01 27 active 46 referrals	5 persons (10 current)
Burgeo Mental Health Services	-	2000-01 1999-00 26 active 22active 46 referrals 31 referrals	2000-01 9 persons 1999-00 9 persons
Deer Lake Mental Health Services	-	2000-01 1999-00 60 active 45 active 75 referrals 60 referrals	2000-01 35 persons 1999-00 22 persons

Region / Program	Clients with Mental Illness 2001 2000 1999	Clients with Mental Health Issues 2001 2000 1999	Waiting List
Port-aux-Basques Mental Health Services	-	2000-01 1999-00 42 active 90 active 68 referrals 65 referrals	2000-01 7 persons
Port Saunders Mental Health Services	-	2000-01 1999-00 44 active 34 active 76 referrals 34 referrals	2000-01 24 persons 1999-00 9 persons
West Lane	2000-01 1999-00 31 participated 14 participated 20 referrals 20 referrals		2000-01 7 persons 1999-00 7 persons
Institutional-Western Health Care Corporation Acute care unit/ Psychology & Social Work	23 beds 92% readmission rate 425-450 clients per year -records not computerized but experience shows 70% diagnosis/30% could be supported in community with appropriate resources Psychologist - 103 clients in 2001 Social Worker caseload n/a		
Sir Thomas Roddick Hospital	3 bed unit - satisfies demand Short-term intervention protocol in effect		
Region / Program	**Clients with Mental Illness** **2001 2000 1999**	**Clients with Mental Health Issues** **2001 2000 1999**	**Waiting List**

Grenfell Regional Health Services (Integrated Board) Mental Health Program	Of the 158 patients seen by the staff physician, 15% have a DSMIV diagnosis.	Forteau 90 cases including families Flower's Cove-Roddicton - 129cases St. Anthony - 60 out-patients - day programme in transition	n/a
Health Labrador Corporation (Integrated Board) Mental Health Program	Labrador City - In 2000-01, the visiting psychiatrist saw an average of 60 patients per visit Happy Valley-Goose Bay - Visiting psychiatrist has a caseload of 16 Coastal Labrador - In a relative stable period, 51 cases of intervention were under the Mental Health Act were addressed.	Labrador City - In 2001, on average 140 clients per month Happy Valley-Goose Bay, in 2001 there were 198 clients seen/2000 209 clients Coastal Labrador - During the same period, 44 clients seen	n/a n/a n/a

Appendix C-2
Provincial Summary
Mental Health Resources by Region

Region	Professional Staffing -(Estimate)[1] Regional Health & Community Services Boards & Institutions						
	SW	RN	GP	Psychiatrist	Psychologist	OT	Other
St. John's							
-H&CS	4	-	-	-	-	-	
-ACCESS House	-	-	-	-	-	-	1.0 counsellor 1.5 life skills coach 1.0 cook 2.8 domestic workers (after hrs.)
-PREP	-	-	-	-	-	-	1.0 vocational counsellor 1.0 life skills ins
-Crisis Centre	4	3	-	-	-	-	1.0 LPN 1.0 Manager (unfilled)
-Youth & Family Services	2	-	-	-	-	-	-
TOTAL	10	3	-	-	-	-	1.0 counsellor 2.5 life skills 1.0 LPN 2.8 domestics 1.0 cook

[1]Staffing numbers are rounded as reporting by regions was in accordance with resource allocations (FTE and shared resources) not by persons. Inconsistent reporting across regions; For example, figures may not include the Mental Health Co-ordinator or administrative support. Also job titles may vary across regions.

	SW	RN	GP	Psychiatrist	Psychologist	OT	Other
Non-profit organizations							
- Pleasant Manor	-	-	-	-	-	-	1 program director part-time life skills coach
- Pottle Centre	-	-	-	-	-	-	1co-ordinator/ administrator 1 part-time administrator summer students
- Stella Burry Corp	7	-	-	-	-	-	1 Ex. Director/2 program co-ordinators 6 SW / 1 employment/education counsellor/10 residential wkrs/ 1 outreach wkrs/ 2 relief counsellors/2 life skills/ part-time contract staff including consumers/ part-time maintenance/ administrative staff

	SW	RN	GP	Psychiatrist	Psychologist	OT	Other
Total	7	-	-	-	-	-	3 program directors 1.5 administrator 10 community home support wkrs 7 residential wkrs 3 outreach wkrs 2 relief counsellors . 5 life skills

HCCSJ See attached (Information provided by Mental Health co-ordinator)	29	148	9.5	29	25.1	15	116 Licensed Practice Nurses 3 Nurse Practitioners Clinical Associates (same as GPs) 19 Case Managers 16.5 Psychiatric Therapy Aides 1.4 Occupational Therapy Assistants Recreation Therapist (same as Recreation Specialist) 1 Pharmacist 1 Pastoral Care (shared) 1 Dietician (shared with other programs) 1 Special Care Coordinator 1 CP Coordinator 10 Nurse Coordinators 7 Recreation Specialists 8.5 Recreation Workers
Region Total	**47**	**152**	**9.5**	**29**	**9.5**	**15**	**186.4**

Region	Social Workers	Registered Nurses	General Practitioners	Psychiatrist	Psychologists	Occupational Therapists	Other
HCC SJ*	29 Social Workers (3 more are Case Managers) See below.	148 Nurses	9.5 General Practitioners to cover 12 units	29 Psychiatrists assigned to or cover units. See below.	9.5 Psychologists (includes one vacancy) to cover 12 units. Another 15.6 Psychologists in various outpatient settings which includes one Sexologist and one vacancy. So, 13.6 actually working as Psychologists.	15 OTs.	116 Licensed Practice Nurses 3 Nurse Practitioners Clinical Associates (same as GPs) 19 Case Managers 16.5 Psychiatric Therapy Aides 1.4 Occupational Therapy Assistants Recreation Therapist (same as Recreation Specialist) 1 Pharmacist 1 Pastoral Care (shared) 1 Dietician (shared with other programs) 1 Special Care Coordinator 1 CP Coordinator 10 Nurse Coordinators 7 Recreation Specialists 8.5 Recreation Workers
Total	**29**	**148**	**9.5**	**29**	**25.1 (23.1 actually working)**	**15**	**186.4**

* Includes all inpatient and outpatient psychiatric services of the Health Care Corporation of St. John's from Child Health to Seniors Care.

Psychiatrists

Child Mental Health (16 years of age and under)
4 Psychiatrists (plus Dr. Anne Porter, Adolescent Psychiatrist, has admitting privileges).

Adolescent / Adult / Seniors Mental Health (over the age of 16 years)
25 Psychiatrists to provide coverage as follows:

19 - Acute Care (5 units, 3 sites, currently 111 beds)
1 - Psychiatric Rehabilitation (23 beds)
1 (shared with acute care) - Forensic (17 beds)
1 (shared with Child Health) - Adolescent
4 - Seniors
1 - Clinical Chief
1 - Chair of Psychiatry

Consultant Psychiatrists (no admitting privileges, no bed coverage)
3 Psychiatrists

Case Managers

These 19 staff are in several different programs: Family Care, Community Care, Psychiatric Rehabilitation Team, etc., and offer different services. The breakdown in terms of professional designation is:

11 Registered Nurses
2 Licensed Practical Nurses
3 Social Workers
1 Pastoral Care
1 Occupational Therapist
1 Psychologist (vacant)

	SW	RN	GP	Psychiatrist	Psychologist	OT	Other
Eastern							
-H&CS	11	4	-	-	2		-
Avalon HCIB							
- Carbonear				1			
PHCC							
- G.B. Cross	1	-	5	2	-		-
-Burin Health Centre	1	-	4	2	-	2(with other duties)	-
Region Total	**13**	**4**	**9**	**5**	**2**	**2**	**-**
Central							
-H&CS*	7	3	-	4 + locum	3	-	3 admin staff
-CWHC unit (Grand Falls-Windsor)	20%	12	-	2 consultants	1consultant	-	4 LPN 1 rec therapist wkr 1clerical
CEHCIB (Gander)	1.75	1	-	1 out-patient 2 visiting relief	1	-	-
Region Total	**9.95**	**16**	**-**	**3** **2 visiting**	**5**	**-**	**4 LPN** **1 rec therapist wrkr** **4 admin** **1 clerical**

	SW	RN	GP	Psychiatrist	Psychologist	OT	Other
Western							
-H&CS	13	-	-	-	5.4	.75	1 OT aide
-WHCC	2 shared	16.4	10-12 GP s private	3 - 1 CrBrook 1Stephenville	1.6	.25	shared- dietician pastoral care
Region Total	**15**	**16.4**	**10-12**	**3**	**7**	**1**	1 OT aide shared- dietician pastoral care
Grenfell							
-GRHS	1	4	6	1	1 NB. Position not funded by Province	-	2 LPN (psych.)
Region Total	**1**	**4**	**6**	**1**	**1**	-	**2 LPN (psych.)**
Labrador							
-HLC	6	4	-	2 visiting	1(unable to recruit)	1 not able to recruit	Adolescent worker -NCB funding
Region Total	**6**	**4**	-	**2 visiting**	**1**	**1**	**1**

Grand Total (Estimate)* *NB This number is ever changing, influenced by the movement of professionals within the system and the relative success of recruiters.	89.95	200.4	36.5 (Some Family GP s)	41 + 1 consultant + 4 visiting	232.5 + 1 consultant NB. Several positions vacant due to difficulty in recruiting)	2+	Hospital 3 NP 1 Clinical Associate 122 LPN 19 case mgrs 16.5 psychiatric therapy aides 2.4+ OT asst. 2 + Rec. specialists 1 pharmacist 2 pastoral care (shared) 2+ dietician 1 special care co-ordinator 1 CP co-ordinator 10 nurse co-ordinator 8.5 rec wrkrs Community[2] 1 Ex. Director 5.5 program directors/mgr 2.0 counsellor 5.0 life skills coach 1 + LPN 10 community home support wkrs 10 residential wkrs 3 outreach wkrs 2 relief counsellors 1.0 cook 2.8 domestics workers (after hrs.)

[2] Estimates only. Job titles may vary for similar roles across the regions.

Appendix C - 3 Supports and Services provided in relationship to Best Practices							
Best Practice Area	Checklist Criteria	St. John's	East	Central	West	Grenfell	Lab
Case Management- ACT	array of clinical case management that follows rehabilitation personal strengths and Assertive Community Treatment models	✓ some early intervention services psych rehab program	partial some home visits	partial case management on a case-by-case basis some home visits by PH RN	partial case management on a case-by-case basis	✓ PH RN visits	partial some home visits by Rns
Crisis Response / Emergency Services	continuum of crisis programs to help people using minimally intrusive options	partial some services overuse of police psych unit	no community team hospital is called in emergency no psychiatric beds but there are admissions	good work between police and mental health psych unit	no team but good relationship with police psych unit	✓ good work between police and mental health no psych beds but there are admiss-ions	no team no psych. beds but there are admiss-ions
Outpatient Care	an array of treatment alternatives, including day treatment and home treatment	✓ no home treatment ; services not linked	partial one-one counselling	partial #1 Junction Road and South End sites outraach at other sites	partial Blomidon Place Port aux Basques video conference	partial	partial some use of video
Consumer Initiative	efforts that support mutual aid, skills development and economic development; supported through funding, training, and evaluation	partial not supported	partial	partial some life skills training	Advisory Group in Stephenville Group meets at Blomidon Place	partial	partial
Family Self-help	funding to family groups	partial	partial	partial	partial	partial	partial
Vocational / Educational Supports	supported employment programs in place and studied	✓ employment corporations and Mill Lane	None	None	partial West Lane but no supported employment	some day programs	None

Appendix C-4
Mental Health Review-Gap Analysis
(Using the Community Resource Base Model contained in Valuing Mental Health)

Consumer Groups • CHANNAL is active in several regions but not funded or supported well • there is some consumer education in some regions • there is some representation of consumers in advisory capacity but rarely in design and not in governance of services	Housing • there is a general lack of housing supports • almost no home support • little supported housing • mental health consumers have not been a priority group • often sub-standard housing, especially for persons with mental illness	*Family and Friends* • culture of support in the province still exists but is eroding (e.g. out-migration) • some evidence of family support groups (i.e. Friends of Schizophrenics) • some efforts to engage them but not consistent and not as a priority • informal system is not recognized or supported • little community capacity building
Income • general lower socio-economic status, especially rural • high rate of income support among persons with mental illness • social assistance rates and policies insufficient to meet needs	**PERSON** • not engaged in care design or delivery • system not person-centred • rural persons have few options and must travel great distances	Work • increasing emphasis on employment programs for persons on income support • some sheltered work environments and some employment corporations, in larger centres • disincentives remain
Mental Health Services • there is a crisis orientation • there is no continuum of service and poor inter-service links generally • there are qualified and well regarded services in several regions, but not enough of them • few community development approaches • significant limitations in rural areas • general disproportion of resources in institutions-resources are not where the people are	Education • public education about mental illness and mental health is poor • training for those working with persons with mental health / mental illness concerns is not consistent • there is some educational support provided to consumers and families in some regions • consumers are not generally involved in providing education	*Generic Community* • family physicians provide a large amount of front-line mental health care • there has not been an increase in community supports to coincide with de-institutionalization • disparate availability of community resources (lack in rural areas)

Appendix C-5
Provincial Summary
Mental Health Budgets by Region
(Estimate)[3]

Region	Community Health & Services Board	Institutions	Total
St. John's ▸ NGOs	1,547,199 1,817,500[4]	29,320,913	32,685,612
Eastern	1,000,000	?	1,000,000
Central ▸ Grand Falls-Windsor ▸ Gander	572,852	 1,119,000 Unknown (staffing and overhead)	1,691,852+
Western	1,255,501	1,418,000	2,673,501
Grenfell	298,915	138,233	437,148
Labrador (Integrated)		626,644	626,644
TOTAL	**6,491,967 est.**	**32,622,790 + est.**	**39,114,757 + est.**

[3]Estimate only. Not all costs related to mental health services were captured.

[4]Reflects operating budgets some of which are publicly funded but the figure also includes funds received from private sources, e.g., United Church of Canada, service organizations.

Appendix C-6

Comparison of trends in mental health services with status in Newfoundland and Labrador

Recent Canadian Trends in Community Mental Health	Present Circumstance in Terms of Mental Health Services in Newfoundland and Labrador
Conceptual framework in policy which supports accessible, coordinated, person-centred approaches, delivered increasingly in the community and which support self-sufficiency with accountability	Draft policy framework which, as in other provinces, is based upon CMHA Community Resource Base Model
Authority for reform assured through protected budgets and / or separate, time limited, organizational structures i.e. commissions, boards. Governments responsible for ***standards,*** though development is slow in most provinces	Authority shared among several independent groups, with few formal links. No standards in place or anticipated, limited capacity within the Department to assume this responsibility.
Significant Increases in community delivery of services over the past ten years, to about 40-45% of total budgets	Estimated 15-20% of mental health budgets allocated to community efforts
Core range of multi-disciplinary mental health services (i.e. in-patient services, out-patient clinics, case management) available on a regional level	Lack of capacity to address serious mental health problems in several regions
Rural services in strategic locations, delivered by trained professionals (usually nurses), well linked to a regional centre, through tele-communications	Existence of social work staff in most areas, though specific training and experience in mental health is questioned; some piloted use of technology
Partnerships and clear formal links between institutions and the community service system; seamless service	Lack of partnership
Emergency Services based on a regional approach (i.e. secure beds and trained staff available)	Some good examples of coordinated effort (i.e. Central), significant lack of emergency services or protocols in some regions
Strong community involvement, particularly in housing, training and rehabilitation, employment and life skills. Lack of adequate housing is a considerable concern across the country, due to an absence of federal government investment in social housing	Most community involvement is in and around St. John's; very few housing initiatives for this population; policy which does not recognize mental illness as a criteria for home support
Significant investment in consumer and advocacy groups	Little investment in consumer and advocacy groups
Psychiatric and psychological services available on a regional basis; nurses , and to a lesser degree social workers as primary service deliverers	Lack of regional capacity in terms of psychiatric and psychological services; social workers and to a lesser degree nurses as primary service deliverers

APPENDIX D

Consultation Sessions
Community Mental Health Review

Labrador Region

- Health Labrador Corporation - Staff
- Consumers
- Labrador Inuit Health Commission
- Innu Nation
- Nurse Manager- Nain
- Community Organizations

Grenfell Region

- Grenfell Regional Health Services - Staff
- Grenfell Regional Health Services - Community Stakeholders
- CHANNAL

Western Region

- Health and Community Services Board-Western Region Staff
- Health and Community Services Board Community Stakeholders, Consumers and Families
- Western Memorial Hospital - Psychiatry program - Staff
- Friends of Schizophrenia

Central Region

- Health and Community Services Board-Central West Region - Staff
- Central Newfoundland Regional Hospital - Psychiatry program staff
- Health and Community Services Board-Central West Region - Community Stakeholders
- CHANNAL
- Health and Community Services Board-Central West Region - Clients
- Health and Community Services Board-Central East Region - Staff
- Health and Community Services Board-Central East Region - Community Stakeholders

Eastern Region

- Health and Community Services Board-Eastern Region - Staff
- GB Cross Hospital - Staff
- Burin Hospital - Staff and Stakeholders
- Health and Community Services Board-Eastern Region - Community Stakeholders and Consumers

St. John's Region

- Health and Community Services Board-St. John's Region - Staff
- Health and Community Services Board-St. John's Region - Community Stakeholders
- Health Care Corporation of St. John's - Staff
- Health Care Corporation of St. John's - Psychiatrists
- Friends of Schizophrenia
- CHANNAL

Provincial Organizations and Associations as well as their Representatives

- Association of Registered Nurses of Newfoundland and Labrador
- Newfoundland and Labrador Association of Social Workers
- Association of Newfoundland Psychologists
- Newfoundland and Labrador Occupational Therapists Association
- Canadian Mental Health Association - Newfoundland and Labrador District
- Chief Superintendent Gerry Lynch, Royal Canadian Mounted Police
- Deputy Chief Browne, Royal Newfoundland Constabulary
- Marvin McNutt, Department of Justice
- Clara Rendell, Corrections Canada
- Dr. Cathi Bradbury, Medical Care Commission

APPENDIX E

Letter from Alan Bradley, Chief Executive Officer St. John's Nursing Home Board

St. John's Nursing Home Board

Office of the Chief Executive Officer

March 28, 2002

Mr. Rick Morris *(e-mail: c/o ihrd@thezone.net)*
President
Institute for Human Resource Development
321 Hamilton Avenue
St. John's, NF A1E 1K1

Ms. Colleen Hanrahan *(e-mail: abbhan@thezone.net)*
The Institute for the Advancement of Public Policy
P. O. Box 23005
Churchill Square Post Office
St. John's, NF A1B 4J9

Dear Mr. Morris and Ms. Hanrahan:

Thank you for the opportunity to participate in the discussions relative to your review of mental health services for this province. It appears to be a very comprehensive project and you seem to be taking a very detailed approach to reviewing the significant issues. No doubt, you will be preparing a report with far-reaching implications and recommendations. I have taken the liberty of preparing some notes which list some of the issues relative to our particular mandate under the following headings:

- mental health issues in nursing homes;
- services in place;
- gaps facing seniors relative to mental health; and
- Other information.

Also, as I stated during our meeting, I will be attending the Symposium focused on mental health issues in long-term care in late April in Ontario. I believe that as we approach a growth in the elderly population, we need to be prepared to address the mental health issues of this target group. I would be happy to share the initiatives of this group, who will take a national approach to the issue. Please advise if this is of any assistance to you and I will prepare appropriate information for you upon my return. In the meantime, I do have some preliminary information on the purpose and intent of the actual review and would appreciate the opportunity to discuss those with you at a suitable time. Again, thank you for the opportunity to participate in the meeting last week. I look forward to further discussions and follow up.

Yours sincerely,

Allan Bradley

Allan Bradley
Chief Executive Officer

AB/pf

10 Escasoni Place, St. John's, NF, A1A 3R6 *TELEPHONE: 709-570-2380* *FAX: 709-570-2313*

Report on
Canadian Invitational Symposium on Gaps in Mental Health Services for Seniors in Long-term Care Facilities
Prepared by Allan Bradley, St. John's Newfoundland - May, 2002

Background:

Recent studies have estimate that approximately 80% of nursing home residents suffer from psychiatric disorders. Dementias, such as Alzheimer's disease, affect many of these residents and may result in problem behaviors, which include verbal and physical aggression, agitation, pacing, and wandering, among others.

In terms of service to address these Mental Health Issues, one study based in Ontario, more than 80% of nursing homes receive five hours or less per month of psychiatric care and almost 40% of nursing homes receive no direct psychiatric consultation. It is believed by many that the need for an appropriate range of mental health services for seniors in long-term care settings substantially outweighs the system's current capacity to provide these much-needed services. Serious challenges and service delivery issues must be addressed for older people who have mental illness and reside in long-term care settings. In addition, the entire area of mental wellness needs to be addressed.

The objective of this symposium was to create a collaborative venue between providers, consumers, and other stakeholders, in order to develop new initiatives that will address these issues.

Process:
The process for this symposium was conducted by Jacqueline Pelletier, a trained facilitator in the use of 'open space'. This method of facilitation was used to identify issues and develop an action plan amongst approximately 90 persons from across Canada. Approximately 50 issues were identified amongst participants as being crucial to the analysis of this particular target population within the long-term care sector. These issues were grouped into the following action planning themes:

1. Education,
2. Human Resources,
3. Advocacy / Public Awareness,
4. Coalition,
5. Needs of special populations / ethno-cultural populations and persons with disabilities,
6. Research,
7. Assessment / treatment,
8. Environment and programs to promote mental health, and
9. Family education and support.

An action plan and working group has been created around each of those topics. One of the more pivotal actions is the formation of a coalition that will develop innovative approaches, act as a coordinating body to the working groups and help facilitate specific initiatives. The Canadian Academy of Geriatric Psychiatry will continue to act as a lead for this initiative and will provide the impetus required to move the process forward.

Conclusion:

The members of the symposium represented many leadership fields in the area of seniors and long-term care from across the country. There was a commitment by all members present to continue the work required to ensure that this important initiative continues to ensure that there are appropriate policies, programs and services that are suitable for this target population. All participants agreed to the implementation of the coalition and subsequent action plans. In addition, there was agreement to forward a letter to the federal and provincial ministers responsible for seniors. The purpose of the letter was to increase the awareness and response to mental health issues facing seniors and to make these issues priority and provide opportunities for working together.

APPENDIX F

E-MAIL from Genevieve Corbin
Health and Community Services Board - Central West Region

chanrahan

From: Genny Corbin <GenevieveCorbin@mail.gov.nf.ca>
To: <chanrahan@nfld.net>
Sent: April 10, 2002 12:01 PM
Subject: Re: Thank-you for your assistance in arrangingtheconsultations

I am very concerned about the insertion of waitlistings as an indicator - there is data on only one piece of the region and the other piece is that the process for waitilistings is signficantly differenet across regions so we are not comparing the same things - how a waitlist is derived impacts what the numbers look like - with the exception of high risk situations allll of our clinets wait for services and some tof them for several months depending on urgency - the other point being that prior to the development and implemenation of our current delivery structure (when services were hospital based) the waitlists were in excess of 300 (more than six months) - in short waitlists do not necessarily reflect demand and while they are an indication of unmet demand we cannot just assume that it is a resouce issue - it can and often is a process issue. It is an interesting fact that when waitlists have been studied signficant duplication has been found to exist - it is as well an interesting fact that after a certain period on time the client is no longer moitvated - we manage our wiatlists which means that we are in constant contact and are constantly revising the list because the client has been referred for services but does not want the service (this is not uncommon); because the concern of the clinet was more situational and the situation abates before we can formlly engage the client and the list goes on - i could speak for hours on waitlisting processes and the fallibilities which go with it -) in short i do not think they can be put in a report given that there has been no formal review of waitlisting processes - it will set up a fallacy -

On another note - for your information Homewood in Guelph - Mental Health and Addictions - 519 824 - 1827 (fax) ; 519- 824- 1010 (telphone) are piloting video conferencing in I think Balise - the profession of assessment and consultation services to remote areas - that is one porject amongst many I might add - very innovated organization (private for profit as well as public accountability structure) - gen

APPENDIX G

Brief
Association of Registered Nurses of Newfoundland and Labrador

ASSOCIATION OF REGISTERED NURSES OF NEWFOUNDLAND AND LABRADOR

ARNNL House, 55 Military Road, P.O. Box 6116, St. John's, Newfoundland, Canada A1C 5X8
Telephone (709) 753-6040 Facsimile (709) 753-4940 Toll Free 1-800-563-3200 Web site: www.arnn.nf.ca

Association of Registered Nurses of Newfoundland and Labrador .

Abstract submitted to The Institute for Advancement of Public Policy
Review of Provincial Mental Health Services Consultation

April 10, 2002

The Association of Registered Nurses of Newfoundland and Labrador is a 6000 member professional organization whose vision is " Healthy People in Newfoundland and Labrador". In pursuit of this vision ARNNL exists so that there will be excellence in nursing, public protection, quality health care, and healthy public policy. ARNNL welcomes this opportunity to provide input into the development of a provincial policy framework to address mental health issues and services for the people of Newfoundland and Labrador.

ARNNL believes that Registered Nurses are a valuable resource who significantly contribute to the attainment of population mental health. However this resource is currently underutilized. In particular there is shortage of psychiatric and mental health nurses in the community. We believe that better utilization of nursing human resources could improve clients' access to community based mental health care throughout the province. Clients are perceived in this brief as individuals, family, groups, and/or communities.

Current registration data indicates that only 4.4% of all nurses (n=264) employed in this province work in mental health nursing practice. Further examination of the distribution between institutional and community based services reveals that only 1.2% or 33 nurses provide mental health services to the community, with almost 70% of this group located in the St. John's area. Although the total number of people in communities requiring mental health services is unknown, available statistics on the number of clients with severe mental illness indicates that there is a minimal ratio of 1 mental health community based nurse per 400 clients. If the provincial government and health boards expanded the number of mental health nurses in community settings client services could be improved.

ARNNL believes that psychiatric and mental health nursing is a special area of practice. Mental health nursing practice involves the promotion of mental health, the prevention of mental illness, and the care of clients experiencing mental health problems and mental illness throughout the lifespan (Canadian Federation of Mental Health Nurses, 1993). To do this nurses use a holistic approach incorporating nursing knowledge, critical thinking and the research process to facilitate self-help and practitioner facilitated care for clients with mental illness and issues. The mental health nurse uses a holistic approach to

client care which requires understanding the relationship between the physical, emotional, mental, spiritual, cultural, and social aspects of the client's needs. Mental health nurses can provide a wide variety of interventions depending on the clients they are serving and the practice setting such as:

- Responding to rapidly changing situations for example self-harm and assault behavior,
- de-briefing after a crisis'
- providing individual and group therapies for clients dealing with grief, depression, stress, parenting challenges, low self esteem, and childhood sexual abuse,
- case management for individuals and families dealing with severe and persistent mental illness,
- chairing and participating in community boards and committees involved in advocacy, education, service delivery, and community development,
- planning and offering education for clients,
- providing home assessment,
- coordinating and linking the health care service needs of clients.

ARNNL believes that there is opportunity to expand the role of nurses in community mental health through the promotion of post basic education. Continuing educational opportunities such as; those offered by distance in other provinces, in the Nurse Practitioner- Primary Health Care program, through the Canadian Nursing Association certification course, and in Memorial University's non-theses Masters of Nursing and in the proposed Nurse Practitioner program, with a mental health specialty. The provincial government must work cooperatively with educational institutions and health boards to ensure that accessible continuing education programs in mental health are available and promoted for registered nurses wishing to pursue a career in community based mental health nursing.

ARNNL believes that mental health nurses can provide leadership in mental health care reform. Client needs can best be met through a Primary Health Care model. This model advocates for the full range of essential services at the community level. Primary Health Care can help close the gap between institutional care and community services and between urban and rural distribution of psychiatry services. Advanced technology in telecommunications should also be better utilized to support care as close to home as possible. Community based mental health nurses can provide leadership in this process as they; understand and function within a primary health care model, are situated in communities throughout the province, are often available 24 hours/day seven days a week, are familiar with information technology, can provide the full range of health care services, believe in collaboration and the importance of interdisciplinary teams, and have the trust of the people and communities.

Conclusions/Recommendations

ARNNL commends the provincial government for commissioning a review of mental health services in our province. We also commend the Institute for the Advancement of Public Policy for providing ARNNL with an opportunity to contribute to this process. It is in this spirit that ARNNL recommends that:

- The provincial government seriously reflect upon the findings of this review and make necessary revisions to improve the quality and accessibility of care that clients with mental health issues and illness can obtain.
- The number of registered nurses employed in community mental health be increased.
- The health boards and educational institutions work cooperatively to ensure that continuing educational opportunities in mental health are available for community based nurses around the province.
- Mental health care service delivery be structured within a primary health care framework utilizing telecommunications as appropriate to allow quality home based care.

APPENDIX H

Estimated Resource Requirements

APPENDIX H

Resource Requirements
Community Mental Health Review
By Region

Assumptions:

- The endorsement of the model proposed in Valuing Mental Health, 2001, CMHA, and notably that consumers will be served as close to home as possible, within reason.
- There will be an investment in consumer-led organizations. Assumes ongoing support for CHANNAL with expansion to all regions. Budget would also include costs of meeting attendance. Initial start -up may require an up-front investment that will not be an ongoing expense item. Special services such as Clubhouse or Drop-in Centres would be funded project by project so are no included in these estimates.
- There will be an investment in family self-help organizations. Assumes involvement of staff of regional Boards and funds to organize and develop informal supports, including assistance to attend meetings.
- There will be the establishment of inter-disciplinary teams in all regions, either by recruitment of human health professionals and/or reliance on tele-health with reasonable travel. Assumes basic inter-disciplinary resources available in, or to, all regions. See attached chart for detail. This may be modified depending on the arrangements negotiated in each region.
- The form of delivery will be based on the requirements and circumstances of the region. Models may include resource-sharing arrangements, memorandums of understanding, integration of mental health services within regions.
- Health promotion will be a significant responsibility involving an orientation to community organization and development, including capacity building.
- Assumes team-building, education of staff re advances in mental health field and community development skills training for H&CS staff. Estimate includes materials, supplies and equipment as well as fees of training personnel.
- Estimates relate to operating budget only. Facilities for secure beds in ER departments to avoid a police lockup.
- Tele-health requirements have been estimated with the assistance of TETRA. It is recognized that the existing infrastructure will be used at the outset. There will be a requirement for orientation and support as the system is not in wide usage at the moment in the community mental health program.

ASSUMPTIONS

Implementation would be phased in over say, a three year period.

Year One

- Regional plans developed to deliver community mental health in accordance with COMMUNITY MENTAL HEALTH FRAMEWORK. Regional capacity to meet best practice standards determined within regions.
- Staff orientation to plan.
- Department to lead development of community mental health information management system across all Boards
- Community development specialists recruited.
- Consumer organizations provided with funding and support.
- Family self-help initiated.
- Community response to include teams responsible for emergency response, community-based assertive case management teams, and help-line for each region.
- Linkage established with RCMP/RNC and other stakeholders to address emergency response planning, including planning for secure beds in regions.
- Linkages with NLHC, HRE and HRDC established to develop supports in all regions.
- Orientation of staff respecting use of tele-health.

Year Two

- Community response teams and facilities established.
- Day programmes enhanced or introduced.
- Community-based programming for supporting consumer organizations enhanced.
- Family self-help organized and supported throughout all regions.
- Increased efforts aimed at community education re mental health.
- Monitoring of progress vis-a-vis the framework and regional plan.

Year Three

- Existing programs enhanced.
- Tele-health sites expanded, as required.
- Consumer organizations supported and sustained throughout the province.
- Family self-help supported.
- Monitoring of progress vis-a-vis the framework and regional plan.

Estimated Resources Requirements for Enhanced Mental Health Services by Region

Budget Item	Estimate by Region						
	St. John's	Eastern	Central	Western	Grenfell	Labrador	Total
Consumer Organization	$70,000	$35,000	$35,000	$35,000	$35,000	$40,000	**$250,000**
Family Support	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000	**$300,000**
Health Human Resources	$577,928	$1,153,991	$1,013,258	$1,017,725	$479,796	$673,660	**$4,916,358**
Tele-health	$35,000	$35,000	$35,000	$35,000	$35,000	$35,000	**$210,000**
Travel	$30,000	$45,000	$39,000	$39,000	$18,000	$27,000	**$198,000**
Staff Orientation	$75,000	$75,000	$65,000	$65,000	$30,000	$45,000	**$355,000**
Totals	**$837,928**	**$1,393,991**	**$1,237,258**	**$1,241,725**	**$647,796**	**$870,660**	$6,229,358

June 4, 2002

Projected Cost of Human Resource

Needs for Enhanced Mental Health Services

May 15, 2002

Region	Service	Human Resource Requirements					Other Salary	Total
		Psychiatric RN FTEs	Psychiatric RNs Cost	Social Worker FTEs	Social Worker Cost	Occupational Therapy FTEs	Cost & Fringe	Salary Costs
St. John's	Community Development Specialists	2.0	$97,126	2.0	$104,000		$60,338	$261,464
	Community Based Case Management	3.0	funding from	4.0			$0	$0
	Help Line Staff		crisis centre				$0	$0
	Crisis Response Team (Additional Salary Costs for Case Mgmt Team)						$55,000	$55,000
	Day Program	2.0	$97,126	2.0	$104,000		$60,338	$261,464
	Subtotal	**7.0**	**$194,252**	**8.0**	**$208,000**	**0.0**	**$175,676**	**$577,928**
Eastern	Community Development Specialists (3)	3.0	$145,690				$43,707	$189,397
	Community Based Case Management (3 teams)	3.0	$145,690	3.0	$156,000		$90,507	$392,197
	Help Line Staff (from St. John's)						$0	$0
	Crisis Response Team (Additional Salary Costs for Case Mgmt Team)	na	na	na	na		$45,000	$45,000
	Day Program (3 Programs for region)	3.0	$145,690	3.0	$156,000		$90,507	$392,197
	Occupational Therapists (2 for Region)					2.0	$31,200	$135,200
	Subtotal	**9.0**	**$437,070**	**6.0**	**$312,000**	**2.0**	**$300,921**	**$1,153,991**
Central	Community Development Specialists	3.0	$145,690				$43,707	$189,397
	Community Based Case Management	2.0	$97,126	2.0	$104,000		$60,338	$261,464
	Help Line Staff (GFIs Inpatient Unit)						$0	$0
	Crisis Response Team (additonal salary cost for case mgmt team)						$35,000	$35,000
	Day Program (3 Programs)	3.0	$145,690	3.0	$156,000		$90,507	$392,197
	Occupational Therapist (1 Central West, 1 Central East)					2.0	$31,200	$135,200
	Subtotal	**8.0**	**$388,506**	**5.0**	**$260,000**	**2.0**	**$280,752**	**$1,013,258**
Western	Community Development Specialists	2.0	$97,126	1.0	$52,000		$44,738	$193,864
	Community Based Case Management	2.0	$97,126	2.0	$104,000		$60,338	$261,464
	Help Line Staff (Western Memorial Inpatient Unit)						$0	$0

	Crisis Response Team (aditional salary cost for case mgmt team)						$35,000	$35,000
	Day Program (3 Programs)	3.0	$145,690	3.0	$156,000		$90,507	$392,197
	Occupational Therapist					2.0	$31,200	$135,200
	Subtotal	**7.0**	**$339,942**	**6.0**	**$312,000**	**2.0**	**$281,783**	**$1,017,725**
Grenfell	Community Development Specialists	1.0	$48,563	1.0	$52,000		$30,169	$130,732
	Community Based Case Management	1.0	$48,563	1.0	$52,000		$30,169	$130,732
	Help Line Staff						$0	$0
	Crisis Response Team (additional salary cost for case mgmt team)						$20,000	$20,000
	Day Program (1 Day Program)	1.0	$48,563	1.0	$52,000		$30,169	$130,732
	Occupational Therapists					1.0	$15,600	$67,600
	Subtotal	**3.0**	**$145,689**	**3.0**	**$156,000**	**1.0**	**$126,107**	**$479,796**
Labrador	Community Development Specialists (1 Coast and G. Bay, 1 LabW)	1.0	$48,563	1.0	$52,000		$30,169	$130,732
	Community Based Case Management (Coast, Goose Bay, Lab West)	2.0	$97,126	1.0	$52,000		$44,738	$193,864
	Help Line Staff						$0	$0
	Crisis Response Team (additional salary items for case mgmt team)						$20,000	$20,000
	Day Program (2 Day Program) - Lab East, Lab West	2.0	$97,126	2.0	$104,000		$60,338	$261,464
	Occupational Therapist					1.0	$15,600	$67,600
	Subtotal	**5.0**	**$242,815**	**4.0**	**$208,000**	**1.0**	**$170,845**	**$673,660**
	TOTAL	**39.0**	**$1,748,274**	**32.0**	**$1,456,000**	**8.0**	**$1,296,082**	**$4,916,356**

Notes:

1. Other salary costs of 30% represents 20% for employers fringe and 10% for other salary costs such as overtime, shift differential, leave, etc.
2. Additional salary costs for crisis response team is calculated at $5000 per FTE for standby, callback, and overtime.

Assumptions
Potential Expenditures for Home Support Services

- Home support services are available to clients with a physical disability or developmental delay. The program is currently not accessible to clients with a mental illness. A policy change will be required before funds can be budgeted and committed..

- The estimated cost of introducing home support services is based on a conservative estimate using program rates as of June 1, 2002 and applying a blended rate of self-managed care with services provided by an agency.

- Based on a study conducted by the Canadian Mental Health Association, estimates of the level of home support could vary from 2-3 hours per week to over 40 hours per week. The level of service will depend on the circumstances of the individual client.

- To establish a notational budget, an estimate of 200 clients who could access 8-9 hours per week was used.

- If a full continuum is implemented, it is possible that the need for home support services could be minimized as there would be a full range of supports in place in the community.

- For purposes of this exercise, the notational budget has been submitted at a low estimate. Officials of the Department overseeing this review have proposed that this budget be based on providing home support services to 200 clients at the maximum ceiling which could amount to an annual budget requirement of an estimated $6,000,000.

Community Support - Mental Health Program

Budget Item	Estimate by Region						
	St. John's	Eastern	Central	Western	Grenfell	Labrador	Total
Clients	90	20	30	30	15	15	**200**
Costs	$336,000	$75,000	$112,000	$112,000	$56,000	$56,000	**$747,000**

Provides for 8 hours support per week at an average hourly rate of $9.00/hour. Authority to provide home support for mental health clients does not exist under current policy, therefore, policy changes are required.

June 4, 2002

TETRA Services

TETRA brings two decades of providing consultation, customer support and service in the areas of telehealth, distance education and corporate activities. TETRA's success and sustainability is attributable to the belief that good customer service, reliability and interoperability are top priority. "Hand holding" and providing ongoing support ensures that the clients of TETRA have good experiences when establishing networks and using the services it provides.

Skilled staff, knowledgeable in technologies and their applications, provides and supports service. Standards and Procedures are in place to ensure that all consumers receive the best possible service and that issues are resolved in a professional, efficient and effective manner.

Tetra brokers video and audio network linkages between various agencies throughout the province, leveraging existing network infrastructure for connectivity. This infrastructure, coupled with existing technologies, is able to support tele-psychiatry applications.

Video costs -$100.00 per site per hour
Audio costs - $25.00 per site per hour
In consultation with clients TETRA prefers to meet with potential new groups and assess their specific needs and recommend a "best fit" model.

NOTE: In other jurisdictions there is evidence that funds are identified and dedicated through provincial Departments of Health for networking, applications, and human resources associated with Telehealth.

Issues to consider for sites with no infrastructure at present:

1. Accessibility to required telecommunications may be a significant challenge.

2. Assuming accessibility to telecommunications is possible, the associated costs are as follows:

   Networking - $25,000 per year

   End Equipment - $25,000 per unit.

Current Provincial Video Networks

TETRA has provided consultation, training, orientation and support to the commissioning of the various networks in the province. The networks and capabilities within the province is an ever changing and expanding environment, as funds and needs are identified.

A communities based IP network project (Burgeo Broadcasting Integrated Communities) for video conference solutions is currently underway in the communities of Ramea, Grey River, Francois, Grand Bruit, and Burgeo.

Western Health Care Board, (Corner Brook and Port aux Basques region) has a "wireless community model" IP network. Western Health also expanded this IP model to include the community of Stephenville.

Central East Health Care, Gander region has extended IP services to three rural sites, Fogo Island, Twillingate and Brookfield. This board also includes a multi-point IP videoconference capability within its region.

Central West Health Care Board, a regional neighbor to Central East Health Care Board, is in the process of inviting tenders for the provision of IP video conference capabilities to five of its regional institutions located in the communities of Grand Falls / Windsor, Baie Verte, Springdale Harbour Breton and Buchans.

TETRA, in an effort to expand the provincial IP outreach, has established a "network to network link" with the Provincial College System (College of the North Atlantic) that connects the various IP sites noted above to an existing College IP network. Each of the colleges' eighteen locations has IP video capabilities that are now accessible through TETRA and available to each of the other video locations.

TETRA, through a Health Canada initiative, has taken advantage of the network linkage with the College of the North Atlantic to add two hospital sites within the Peninsulas Health Care Board, namely the communities of Clarenville and Bonavista to the provincial IP video networking scene.

An Industry Canada Smart Communities Program has enabled twenty communities throughout the north, in Labrador, to join the ranks of the community based IP networking communities, connected through TETRA.

The Provincial Government of Newfoundland and Labrador has recently invested in network connectivity to the TETRA facilities.

TETRA is currently introducing a large scale, service bureau class multi-point IP and dial access video conferencing bridge to its network infrastructure. The result of the aforementioned network links to TETRA, identifies this centre as the corner stone for IP video networking applications within the province. Individual networks are able to protect the integrity of their private network and through TETRA expand their video capability provincially, nationally, and worldwide, on an as need basis.

Tetra Services
Prepared by TETRA

Video Cost Estimate

Region	St. John's	Eastern	Central	Western	Grenfell	Labrador
Communications *based on urban vs. rural placement	$15,000/yr	$25,000	$25,000	$25,000	No cost associated until Oct. 2003	No cost associated until Oct. 2003
End equipment *$15,000-$25,000 per year based on complexity of application	TETRA, Janeway, CNS	James Paton, Twillingate, Fogo, Brookfield Clarenville & Bonavista health sites	No end equipment currently available	Western Memorial, Stephenville, Port aux Basques	Curtis Memorial, Forteau, Charlottetown, Port Hope Simpson, St. Lewis, Mary's Harbour	Melville Hospital, Nain, Hopedale, Davis Inlet, Makovik, Postville, Rigolet, Lab. City, Churchill Falls, Sheshatshui, Cartwright, Black Tickle
Hourly rate	$100/hr/site	$100/hr/site	$100/hr/site	$100/hr/site	No cost associated until Oct. 2003	No cost associated until Oct. 2003

*Activity based on per hour
*Based on using existing networks.
*New sites/locations would have associated costs and requirements.
* CONA and other sites access based on institutional appropriate use guidelines.

TETRA Support Services

Requirements Analysis: Assessment and documentation of the functional requirements of the users and service providers.

Design: The design of the facilities and network infrastructure at sites, as well as the design of the initial healthcare and health education services to be implemented.

Implementation: The installation and commissioning of the facilities, as well as the appropriate training and orientation of all service providers.

Maintenance Support Program (Associated cost negotiated on site by site basis)

TETRA is a research and development facility established to facilitate the use of information technology and telecommunications to urban, remote and isolated areas. Therefore a maintenance support program must consider the barriers of distance and establish mechanisms to ensure that the end user is provided with a reasonable level of service, whether they reside in urban or remote geographic areas.

A "Help Line" telephone number is posted on all equipment. Problems of any nature, are reported by end users or site facilitators, via this line, to TETRA support staff. Each call is routed internally to a systems operator, IT specialist or technologist, depending on the nature of the problem. TETRA support staff coordinate trouble resolution activities. For example, resolution may involve direct intervention by the local telecommunications provider or step by step assistance to staff at remote site to isolate the problem. Resolution of the problems are verified by standard remote troubleshooting procedures and all activities are recorded electronically in a systems trouble log.

TETRA utilizes a "black box" replacement system to address end equipment failures and coordinates all shipping, handling and inventory control for the equipment deployed in each partner location. A complete and current electronic record is maintained on all equipment, including the technical status.

TETRA Scheduling Services

TETRA offers a complete scheduling solution for all networked resources, including audiconferencing and videoconferencing services. TETRA provides over 12,000 hours of audioconferencing programs a year and upwards of 2,400 hours of videoconferencing through various mediums. TETRA has developed a unique scheduling package, which includes a database for billing and statistical information. Requests for service may be booked by voice, e-mail, or through the Internet.
http://www.med.mun.ca/telemed/schedule.htm

TETRA Help Desk Model (Cost determined by user need)

A typical Help Desk access is made available through toll free voice call (The Help Desk is currently staffed 12 hours per day, 5 days per week), supplementary services include voice mail, and e-mail and on call personnel.

NOTE: Schedule of HR coverage reflective of client needs.

TETRA Help Desk incorporates resources to respond to any type of reported *system problem*, providing accurate referrals and answers in a timely manner. The Help Desk's primary focus is to return the workstation or site to full operation as soon as possible.

A *system problem* is defined as any type of hardware, software or telecommunications failure.

The client, guided by instructions provided by a *Support Specialist*, can often identify and /or resolve problems over the telephone. Clients are instructed to provide the Help Desk, with the following information

- Site Location
- Description of the problem
- Description of the activity that was interrupted

- System messages, indicators evident

Trouble Reports - All communications with the Help Desk is recorded in an electronic Trouble Log including client contact, nature of problem, action taken and resolution. Each trouble report has an associated Trouble Ticket Identification Number. All trouble Tickets are stored in a database for statistical analysis.

Sample Application: CHILD TELE-PSYCHIATRY

The Child Tele-Psychiatry Project was launched on September 24, 1996 to determine if children with mental health problems could be effectively assessed at a distance by child psychiatrists utilizing state-of-the art video conferencing system. This study was unique as it was the first to compare a child psychiatrist's assessment of a patient conducted over video conferencing to an assessment made over a face-to-face interview. The diagnosis and treatment recommendations made over the video conferencing system were almost identical to those made face-to-face. The evaluation in the project included satisfaction surveys of the psychiatrists, patients and families, as well as cost analysis.

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