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CIHR IRSC

Research Spotlight

Institute of Health Services and Policy Research

Mental Health

Dr Paula Goering

These are exciting times for Canadian mental health and addiction services (MHAS). As a Canadian Health Services Research Foundation (CHSRF)/CIHR Chair in Generating and Disseminating Best Practices in Mental Health and Addictions, and a long-time member of the IHSPR Institute Advisory Board, I have observed first-hand recent developments that bode well for progress in this arena. In the six years of CIHR's and the CADRE program's existence, a lot has happened in training, research and policy to create new opportunities for knowledge generation and translation. Before highlighting some of these developments, I want to describe briefly how MHAS compare to the rest of health care.

There are many similarities in the issues that preoccupy us. Chronic disease management, access for marginalized groups, the gap between what we know and what we do—these are all of concern to MHAS sectors. But there are important differences due to the stigma and discrimination that are still common responses to these illnesses. Levels of unmet need are higher and the services that exist are more fragmented and under-resourced compared with chronic, purely medical disorders. Until recently, MHAS were provided by separate delivery systems. Collaborations with primary care are insufficient. There are unique challenges associated with the infrequent, but unavoidable, use of involuntary hospitalization and treatment for some individuals. There are also strengths: consumer and family involvement in the planning and delivery of recovery-oriented care and a solid evidence base for many interventions. But for the most part, the history and context of the sector are well captured by Romanow's label, "the orphan of health care". Fortunately, decision makers' growing recognition of MHA costs has helped to facilitate new developments in research, education and policy.

Surveys of the priorities of provincial policy makers have helped to put mental health research on the agenda of our national organizations. Statistics Canada's Canadian Community Health Survey – Cycle 1.2 provides the first Canada-wide picture of MHA service needs and use. As discussed in the feature interview between Alain Lesage and Ron Gravel, these data are a rich resource for trainees and researchers; support from CIHR has helped to ensure that they are examined closely. There are planning groups at Health Canada and the Canadian Institute for Health Information contemplating national surveillance and depression outcomes measurement systems with the potential to provide continuing mapping of MHAS performance. A mental health in the workplace initiative is underway that brings decision makers and investigators together to advance our knowledge about how to prevent and treat disability at work.

There are now many more trainees to analyze the data emerging from these initiatives because of CIHR and CHSRF investments in education and capacity building. Support from

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IHSPR and the Institute of Neurosciences, Mental Health and Addiction (INMHA) has given graduate students and post-doctoral trainees more and better options for MHAS stipends and training environments. A CIHR Strategic Training Initiative in Health Research program dedicated to MHAS is profiled in these pages. It has closely linked my chair's program at the Centre for Addiction and Mental Health at the University of Toronto with faculty and students in Quebec, British Columbia and Alberta. An important by-product has been enhanced current and future capacity for interprovincial collaborations.

The Kirby Commission on Mental Illness, Mental Health and Addiction has been studying policy issues since the spring of 2003. Wide consultations with expert witnesses, public hearings, an interim report and the proposal for the establishment of a Canadian Mental Health Commission have generated unprecedented levels of federal/provincial/territorial awareness and interest in systems change. The final report, tabled this May, includes recommendations for more research funding and for the establishment of a national Knowledge Exchange Centre. A planning project funded by IHSPR and INMHA gave Alain Lesage, Elliot Goldner and me the opportunity to gather expert opinion and provide detailed input about how such a centre might function.

New national data sources, more investigators, a higher policy profile and the creation of a Knowledge Exchange Centre all are reasons for optimism about the future, both of MHAS, and research focused on this too-long neglected corner of the health care system. My hope is that the developments profiled in this *Research Spotlight* will translate into better care and quality of life for consumers and their families. Perhaps ten years from now, the label of orphan will no longer apply.

Paula Goering
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Analysis of Canadian Community Health Survey on mental health and well-being

In 2002, Statistics Canada and the CIHR Institutes of Neurosciences, Mental Health and Addiction, Gender and Health and Health Services and Policy Research partnered in a funding competition dedicated to analyzing the Canadian Community Health Survey (CCHS) on mental health and well-being.

The goal of the competition was to improve the availability of evidence for decision-making in provision of care, program development and support for mental illness and addictions. Seventeen projects were funded in 2003.

One project being undertaken by JoAnne Palin, a doctoral candidate at the University of British Columbia under the supervision of Dr Bruno Zumbo, investigated how self-reported data on primary mental health services utilization in the CCHS compared to service use captured in provincial health insurance records. The preliminary results of the study suggest that utilization as recorded in the administrative data is almost twice as high as that reported in the survey data in British Columbia, and that respondents are more likely to report more recent contacts than distant ones within a 12-month recall period. While the factors contributing to these discrepancies continue to be analysed, the project's findings are intended to help those who design or interpret studies of mental health care utilization to assess potential gaps, limitations and biases associated with either measure.

A second project focused on the prevalence of concurrent substance use and mental disorders, and their impact on health services utilization. A team led by Dr Brian Rush at the Centre for Addiction and Mental Health found that co-occurrence was higher among young men, low-income earners and those unemployed due to a disability. The prevalence of substance abuse problems or dependence among those with mental illness ranged between 16% and 21%; the prevalence of mental illness among those with substance abuse problems or dependence was similar. Overall, 37% of Canadians with either a mental illness or substance dependence sought health care for these conditions in the year prior to the survey. Those with co-occurring disorders were the least likely to report being satisfied with the care they received, and were most likely to report an unmet need for care.

A third project, led by Dr Raymond Tempier at the McGill University Health Centre (now at the University of Saskatchewan), looked at the use of services for common mental health problems by Canadians, and compared the results to those of a recent national survey in Australia. The research team found differences in the prevalence rates of mental disorders between the two countries: Canadians tend to be more anxious than Australians, but Australians are more depressed, drink more alcohol and take more street drugs. Australians also report greater health care service utilization than Canadians for all disorders, except for depression associated with anxiety. The researchers have since used this project as the foundation for a larger CIHR-funded collaboration to examine how Canadian mental health and health care compares with other populations and other health care systems.

For more information on projects funded under this competition, visit http://www.cihr-irsc.gc.ca/e/19277.html.

FEATURE INTERVIEW:

Alain Lesage *interviews* Ron Gravel *about the first national survey on mental health and well-being*

The 2002 cycle of the Canadian Community Health Survey (CCHS 1.2) was the first national survey on mental health. With the support of an expert group and various consultations, Statistics Canada developed the survey in response to important data gaps from research, consumer and policy perspectives. In 2002, CIHR and Statistics Canada partnered on an RFA designed to provide enhanced opportunities for expert analysis of the data collected through this survey.

Dr Alain Lesage is a professor in the Department of Psychiatry at the University of Montreal and vice-chair of the Advisory Board of CIHR's Institute of Neurosciences, Mental Health and Addiction. He obtained his medical degree from Sherbrooke University and completed his psychiatric training within the University of Montreal hospitals network. Alain concentrates his work on the needs of severely mentally ill persons using evaluative, epidemiological and health services approaches, and heads an evaluation unit to support the development of innovative treatments and programs at L-H Lafontaine Hospital and the University of Montreal. He is associate editor for the *Canadian Journal of Psychiatry* and was formerly editor-in-chief of *Santé Mentale au Québec*. Alain participated on the CCHS 1.2 expert committee and as a liaison for the Canadian Academy of Psychiatric Epidemiology.

Ron Gravel is currently the chief of the focus content surveys for the Canadian Community Health Survey at Statistics Canada. Between 2000 and 2004, he was the survey manager of the Canadian Community Health Survey – Cycle 1.2 on mental health and well-being. He was also a senior analyst for the Canadian Forces Mental Health Survey. Following the CCHS 1.2, Ron joined the Public Health Agency of Canada on a special assignment to work with policy analysts on issues pertaining to the CCHS 1.2 data. During his career at Statistics Canada, he has also worked as an analyst on various projects, including the Participation and Activity Limitations Survey and the National Longitudinal Survey on Children and Youth. Ron has also collaborated on various World Health Organization projects.

AL: The second cycle of the Canadian Community Health Survey (CCHS) provided the first comprehensive data on the mental health and well-being of Canadians. What was the impetus for the focus on mental health and well-being at that time? Were there obstacles to mounting a study of what we might think of as sensitive or stigmatized disorders?

RG: One of the primary objectives of the CCHS is to address data gaps. When the CCHS was initially developed, various stakeholders at the national, provincial and health region level were consulted. At that time, mental health and nutrition were identified as the two most pressing data needs to be addressed in depth in Canada. There had never been any surveys on mental health and mental disorders in Canada that could provide comparable statistics at the provincial and national levels.

There were numerous obstacles facing a study focusing on mental disorders. We designed a comprehensive set of measures to address them. For example, we conducted a privacy impact assessment to evaluate the effects of a survey on individual privacy. We visited provincial and federal privacy commissioners across Canada to discuss potential concerns with the study. There was also qualitative testing with the general population and with people diagnosed with a mental disorder to determine the willingness to participate in such a survey. The reaction when we did our qualitative testing was: "It's about time!"

Overall, the stigma associated with mental health was the major obstacle. Interviewers' main concerns pertained to how respondents would react when asked questions on their mental health status. We added a special interviewer training program that provided support and helped to better understand and "destigmatize" mental health.

AL: In 2002, CIHR and Statistics Canada partnered on an RFA designed to increase the use of the data collected through CCHS 1.2 for decision making. How did this partnership evolve? What were some of the benefits and challenges?

Thanks to the partnership with CIHR, the RFA is certainly a key success of the CCHS 1.2 dissemination activities. CIHR provided a peer review process that added scientific credibility to the analysis of the data, and having a single RFA avoided duplication of the analytical efforts. One of the objectives of the CCHS is to ensure that the survey results are available to all Canadians. Collected data should not simply remain on the shelf; it is important that they be thoroughly analyzed. In that regard, Stats Canada shared the same vision as CIHR on the utilization of quality health data.

The RFA evolved through the strong relationships we had with members of our expert committee, who provided support throughout the development of the survey. The RFA became the next logical step for exploring ways of analyzing the data. The outcome was very positive.

I am particularly pleased with the rapport that we have established with the research community. From the beginning, there was a strong commitment to understanding what the data needs were, as well as how the data would be analyzed. Through ongoing discussions with the various mental health stakeholders, we developed a dissemination

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strategy aimed to provide relevant information to the general population and various targeted audiences, such as policy analysts, decision makers and consumers of mental health services.

One of the "indirect" objectives of the RFA was to obtain feedback to help us plan for the next survey on mental health. Over time, we've received lots of very constructive feedback that guided us. One of the most often reported limitations pertained to the fact that not enough disorders were covered in the survey. It was also felt that the survey should have targeted special populations, such as homeless people and Aboriginal groups, and probed more deeply on topics such as positive mental health, service use, perceived needs and barriers.

One important challenge was making sure that the survey documentation was thorough, as well as easily and readily available to all data users. For the RFA, the CCHS 1.2 data were available through the Statistics Canada Research Data Centres. Although the researchers appreciated having unique controlled access to confidential data, some people were uncomfortable with the procedures associated with working within this kind of environment. Obviously, protecting the confidentiality of any data collected by Statistics Canada is critical. As part of our objective to ensuring adequate access to the data, we appreciate knowing about our researchers' experience. This will guide us in developing strategies to better support them in the future.

As part of our commitments to promote data access, a public use microdata file is available. Although some information was removed or transformed to ensure confidentiality, every effort was made to include on this file detailed information relevant to disorders and service utilization. The final product is an appreciated analytical tool.

AL: Statistics Canada also worked closely with other stakeholders at various stages in the research. Can you highlight some examples of how these collaborations may have influenced or assisted your work?

The list of support that we received from our collaborators is very long. It started with having dedicated individuals on the expert committee. This committee was composed of members from all regions in Canada, with a mix of policy makers, consumers and researchers. Committee members provided feedback and guidance throughout the development of the survey.

We also had support from various organizations, including the Centre for Addiction and Mental Health, the Canadian Alliance on Mental Illness and Mental Health, the Canadian Medical Association, the Canadian Mental Health Association, the Canadian Psychiatric Association and the Canadian Psychological Association.

There were several collaborative initiatives established throughout the survey cycle to address many issues, such as evaluating and adapting various instruments to the Canadian context of a population health survey, conducting qualitative testing, developing an interviewer sensitivity training program and acting as media contact when the survey results were officially released.

AL: The release of the survey in September 2003 received a lot of media attention at the time. What were some of the initial insights from the data? Did any new or different insights emerge from the funded research projects?

The objective of that initial report (Statistics Canada, *The Daily*, Wednesday September 3, 2003) was to offer a brief portrait on mental health in Canada. One of the key findings was that approximately 2.6 million Canadians aged 15 and over had reported symptoms consistent with one of the disorders measured (depression, mania, agoraphobia, social phobia, panic disorder), or alcohol or illicit drugs dependence, in the 12 months prior to the interview. This represented 1 out of every 10 Canadians aged 15 and over. Major depression was the most prevalent disorder—affecting 4.5% of the Canadian population. Another important reported finding was that only 32% of those who had feelings and symptoms consistent with the surveyed disorders or substance dependencies had seen or talked to a health professional during the last 12 months. Interestingly, the vast majority of those who had sought care were satisfied with the care received. In fact, 82% of the respondents profiled with a disorder or substance dependency said they were satisfied with the care received.

Quite a few research projects further explored what was initially reported in September 2003. One example was a research project looking at service use and gender; it discovered that women and men who are less anchored to society were more likely to use general medical services for mental health reasons. Other research focused on perceived needs—which is a very important aspect of mental health and access to services. The *Canadian Journal of Psychiatry* (*CJP*) focused on the survey data in its September 2005 issue: many of the published papers resulted from the RFA. This issue is an excellent example of research initiative and collaboration.

The CCHS 1.2 constitutes a very rich set of data; the RFA has ensured that those data are explored through rich analyses using various quantitative techniques. The published articles clearly address important mental health issues that are highly relevant to policy analysts and decision makers. The articles don't necessarily provide complete answers, but their findings can feed into the complex processes associated with policy development and program development.

AL: Are there examples of this research evidence being used to inform decision making?

Analyses focusing on health care access and utilization are certainly getting a lot of attention. As mentioned earlier, the September 2005 issue of the *CJP* offers many examples of how research evidence can be used to inform decision making.

At the national level, the Kirby Commission is finalizing a report on mental illness, mental health and addiction in Canada based on various sources of information, including CCHS 1.2. In an upcoming follow-up report, the Public Health Agency of Canada (PHAC) also relied on the analysis of this data to provide a comprehensive portrait of mental health and mental illness in Canada. This new report will provide key

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information to both the general population as well as to health professionals.

The CCHS 1.2 and the research associated with it have generated additional momentum behind mental health. Many researchers who have already published papers are well networked within the "policy shops" and are providing evidence-based guidance on how mental health services should be developed. In addition, the PHAC is developing a surveillance program of chronic conditions that will include mental health. There is recognition that mental health needs to be measured on a more regular basis.

At Statistics Canada, we just completed consultations across Canada to map out the future topics for the CCHS focus surveys. Mental health has again been identified as a high priority. When exactly the next cycle will be taking place, I can't really tell you. But I'm sure that we won't be waiting twenty years for the next survey!

It's been extraordinary to witness how the data have been analyzed and how the results of that work have become an important reference point in current policy discussions about mental health in this country. I'm particularly happy to hear that the CCHS 1.2 data constitute a critical component of the information required for developing a national strategy on mental health, and for supporting the analytical work towards the establishment of a proposed Canadian Mental Health Commission.

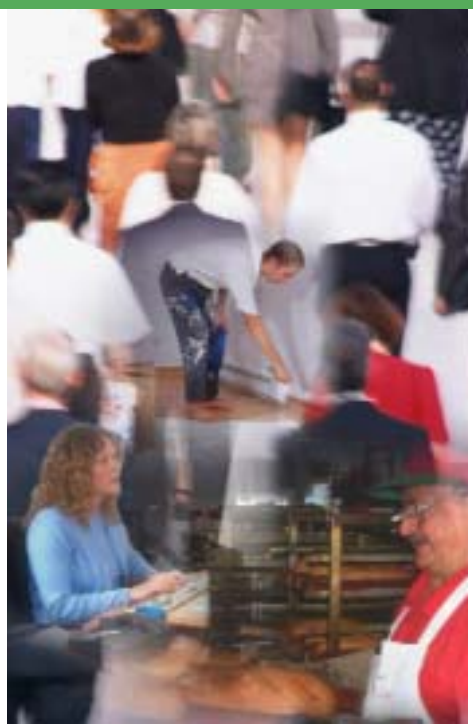
Helping mentally ill individuals find employment

Principal investigator: *Eric Latimer, Douglas Hospital Research Centre, Quebec*
Co-investigators: *Myra Piat, Tania Lecomte, Céline Mercier, Robert Drake and Deborah Becker*

Most people with severe mental illness would like to work in normal job settings and are able to do so, particularly when part-time work options are available. Working has positive effects on self-esteem and quality of life, and can also improve mental health and social functioning. Yet more than three-quarters of people with severe mental illness in Canada remain unemployed.

Traditional approaches to helping people with severe mental illness find meaningful work involve sheltered or transitional employment opportunities that rarely lead to competitive employment. But a radically different approach that places individuals directly into jobs with ongoing support has been shown to result in dramatically improved employment outcomes.

In 2001, Dr Eric Latimer and colleagues received a CIHR Operating Grant to test the effectiveness of this approach, called Individual Placement and Support (IPS), in a randomized study at the Douglas Hospital, a teaching psychiatric hospital in Montreal. IPS had been demonstrated to work in the United States, but this was one of the first programs of its kind in Canada, and the first to undergo a rigorous evaluation.



In IPS, which was developed by co-investigators Robert Drake and Deborah Becker, clients are assigned an employment specialist who is attached to their clinical service and communicates regularly with their case manager or psychiatrist. The specialist helps the client obtain a job that matches their interests and capabilities, helps them to continue in that employment and, if the job is lost, identify what went wrong.

The trial at Douglas Hospital involved 150 adults with severe mental illness, who were randomly assigned to receive either IPS or traditional vocational services. In the first 12 months of the program, 47% of the clients in the IPS group had obtained competitive employment, versus 18% in the control group, and held a greater variety of jobs, including higher-level employment.

However, as Dr Latimer noted, the impact of IPS was not as large as that found in most previous studies. "There are a number of particular circumstances in Quebec which we would expect to reduce the effectiveness of the program, compared to the US," said Dr Latimer. "One is that people with disabilities in Quebec have no economic incentive to work more than a few hours per week, because monthly earnings above $100 are subtracted dollar-for-dollar from their disability cheque. In addition, there can be advantages, such as free public transportation passes, to those who work in traditional, sheltered programs."

What the study has shown is that the IPS model can be successfully implemented in a Canadian setting. It is also clearly more effective than traditional vocational rehabilitation approaches. The main results of the trial have been presented at a number of scientific conferences and will soon be published in a high-impact peer-reviewed journal.

Dr Latimer and the IPS team are now actively engaged in knowledge translation activities aimed at promoting the IPS model more widely in Quebec. They have given presentations to

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clinicians at a number of hospitals across the province and dissemination to professional associations of health care providers and clinical administrators will take place later in the year.

The team continues to discuss what further steps are likely to bring about greater adoption of the IPS model. "This is actually very challenging, as the organization of mental health and vocational services in Quebec, as in most, if not all other provinces, is based on principles that impede implementation of the IPS model," said Dr Latimer. "We are looking forward to participating in a new pan-Canadian project, led by Dr Marc Corbière and Dr Daniel Reinharz, that will investigate, in part, the dynamics that lead to successful implementation of supported employment programs."

Visit the INMHA website this month for information about funding opportunities, including a new RFA on knowledge translation in mental health and addictions.

http://www.cihr-irsc.gc.ca/e/8602.html

Strategies to improve the care of persons with dementia in rural and remote areas

Principal investigator: *Debra Morgan, Institute of Agricultural Rural and Environmental Health, University of Saskatchewan*
Co-investigators: *Jay Biem, Margaret Crossley, Carl D'Arcy, Andrew Kirk, Norma Stewart, Dorothy Forbes, Lesley McBain, Sheri Harder, Jenny Basran and Vanina Dal Bello-Haas*

Cognitive impairment in aging, including Alzheimer's disease and other types of dementia, affects one in four Canadians over the age of 65, and two out of three Canadians over the age of 85. With our aging population, the prevalence of dementia is expected to double in Canada over the next 30 years.

There is a growing need for specialized dementia services and personnel. For the 24% of seniors living in rural and remote areas, the availability, accessibility and acceptability of such services are critical issues. Many seniors living in small towns and villages have to make numerous trips to various health service providers, which can be costly, time-consuming and stressful.

In 2003, Dr Morgan and her co-investigators were awarded a five-year CIHR New Emerging Team grant with a Cognitive Impairment in Aging focus, for a research project designed to improve the care of people with dementia in rural and remote areas. The team includes expertise in nursing, medicine, neurology, psychology, physical therapy and sociology, and aims to address three main areas: improving the availability of services, improving the accessibility of programs to support caregivers and improving the acceptability of services for people with dementia.

One of the team's core studies was the design, implementation and evaluation of a rural memory clinic in Saskatchewan, aimed at improving access to assessment, diagnosis and management of

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early-stage dementia. Seniors from rural and northern communities can now access streamlined one-day multidisciplinary assessments in a tertiary-care centre in Saskatoon. Videoconferencing, or telehealth, is used before and after the clinic assessment for pre-assessment and follow-up.

During the project's first six months, the team held consultations with care providers in fourteen communities to inform the clinic's design. Dr Morgan and her team viewed these early consultations as critical to the development of successful research partnerships. "Meeting with the local care providers in rural and northern communities allowed us to identify feasibility issues and address them before trying to implement the clinic," said Dr Morgan. "Northern seniors in particular encounter many barriers to accessing services, which are now being investigated in a separate project by one of the team's graduate students."

The outcomes of the clinic for patients, family and local care providers are currently being evaluated, but early indications suggest patients and families are satisfied with the one-stop approach and the use of telehealth. "People seem to be comfortable using telehealth, and appreciate not having to drive so far or so often for appointments," said Dr Morgan.

Other core studies will focus on health services utilization by people with Alzheimer's disease, with a focus on the impact of rural versus urban locations, and the evaluation of a program developed by the Alzheimer Society of Canada to assist nursing homes improve the care provided to individuals with dementia. Many other related projects are also underway, ranging from the development of culturally appropriate assessment tools for cognitive impairment and dementia in older Aboriginal adults, to an evaluation of magnetic resonance spectroscopy in improving the diagnosis and prognosis of cognitive impairment. Many of these studies are being conducted in partnership with decision makers and health care providers in rural and remote Saskatchewan and will provide data for future health planning.

New Emerging Teams are designed to bring together independent investigators to undertake collaborative multidisciplinary research that would not otherwise be possible. The team has now been operating for over two years and, despite the challenges of team research, Dr Morgan says the benefits of working in a multidisciplinary environment are clear. "During our first year of funding, three new co-investigators and six students joined the team; we have presented our work at various conferences; and various team members have successfully applied for external funding," she said. "As our research program continues to develop, we are looking forward to seeing our results reflected in concrete changes for seniors and caregivers in the communities with which we are working."

Providing integrated treatment for dual disorders of mental health and addictions

Astrid Brousselle, University of Montreal, Groupe de recherche sur l'équité d'accès et l'organisation des services de santé de première ligne (GREAS1) and Groupe de recherche interdisciplinaire en santé (GRIS)

Mental health and substance abuse disorders often occur simultaneously. Medical best practices recommend providing integrated treatment for individuals with such a dual diagnosis. An integrated model that accounts for both clinical and organizational factors in providing care has proven to be highly effective, but can be very difficult to implement. Only half to two-thirds of implemented programs succeed in adhering to the model in a way that ensures its effectiveness.

Ms Astrid Brousselle is the recipient of a Fellowship Award (jointly funded by GREAS1 and CIHR) and of a CIHR Operating Grant for research that will ultimately analyse how well two different types of integrated services work in practice in Quebec. As a first step, she wanted to see how some of the challenges of implementing integrated treatment might be addressed. Ms Brousselle and colleagues at the Douglas Hospital Research Centre and the University of Montreal looked at what the scientific literature, including the professional and the organizational literatures, had to say about integration and identified points of convergence. The resulting conceptual model suggests that integrated treatment models may be more adaptable to particular contexts and individuals than previously thought. It can also be used to identify the key factors necessary for success, as well as to test how well new models of practice might work.

The model has been presented at Canadian and international conferences and is currently in publication. Later this year, Ms Brousselle will analyse two different models of integration in order to identify the factors that facilitate or hinder implementation of integrated services.

Easing the transition: implementing a care model from hospital to community

Principal investigator: *Cheryl Forchuk, University of Western Ontario*
Co-investigators: *William Reynolds, Elsabeth Jensen, Mary-Lou Martin, Siobhan Sharkey, Susan Ouseley, Pat Sealy, Georgiana Beal*

Over the last decade, Canada, like many other Western countries, has experienced continued change and reform in the mental health care sector. One significant shift has been towards providing long-term care in the community, rather than in psychiatric hospitals. But the transition from hospital to community is complex and can be challenging for individuals and the health care system.

In a 2002 study supported by CHSRF, Dr Cheryl Forchuk and colleagues demonstrated the effectiveness of a transitional discharge model (TDM) of care to help people with a chronic mental illness move from hospital to community living. The most important elements of this model are peer support from former clients of the mental health care system and an overlap of hospital and community staff while the individual transitions. In this study, which involved 26 tertiary care psychiatric wards (13 intervention, 13 control) the average length of stay of individuals was reduced by 116 days for intervention subjects, resulting in a cost saving of over $12 million.

However, Dr Forchuk and her colleagues noticed that the extent to which the model was effectively implemented varied. The team successfully applied for funding through the CIHR Knowledge Translation Strategies for Health Research competition to test a knowledge translation framework, based on findings from the earlier study, in implementing the model in other psychiatric wards. The elements of the framework include enhancing staff participation, creating a supportive ward environment, meeting specific educational needs and supporting managers throughout the change process.

At the same time as the 2002 study was underway, a collaborative research team was evaluating the TDM in Scotland. This independent pilot project found that individuals from participating wards were two times less likely to be re-admitted than control subjects five months after their discharge. The Scottish team similarly decided to undertake an evaluation of knowledge integration strategies.

This convergence created an obvious opportunity for collaboration, and in 2004, the joint Canadian-European team received a CIHR International Opportunity Program grant for a wider project to compare the findings of knowledge translation strategies across different cultures. According to Dr Forchuk, how much adaptation of the model is required to integrate it into practice in other parts of the world is unknown, but it will obviously need to fit within a variety of health care systems and models of care. "The community view of mental health and mental health care also varies, according to the norms of different societies," said Dr Forchuk. "The focus of this research partnership will be on sharing learnings each team has in their own country and collaborating to problem solve. The grant was very important in allowing us to do site visits and developing a proposal that is sensitive to the needs of each country." Hospitals, community and team members from Canada, Scotland, England, Ireland, Portugal and Estonia are now involved in the project.

Both grants are still in progress, but early findings suggest that strategies to support the integration of knowledge into practice and increase health care providers' skills and abilities to implement evidence-informed interventions include support from others and support of policy, practice and education. In general, active engagement and participation by staff, the psychiatric institution, clients and the community throughout the implementation process appear to be critical.

The RAMHPS Program: Increasing capacity in mental health research

The Research in Addictions and Mental Health Policy and Services (RAMHPS) Program, a CIHR Strategic Training Initiative in Health Research (STIHR), is dedicated to increasing the number and quality of researchers who specialize in addictions and mental health services and policy research. The brainchild of three senior researchers—Elliot Goldner, Paula Goering and Alain Lesage—RAMHPS was created in order to respond to the profound burden of disease and suffering associated with mental illness and addiction in Canada, and the recognition that universities have previously had limited capacity to provide relevant graduate-level training.

RAMHPS training is provided through the collaboration of a number of Canadian centres of expertise: the Faculty of Health Sciences at Simon Fraser University; the Faculties of Medicine at the University of British Columbia, University of Montreal and McGill University; the Departments of Psychiatry and Community Health Sciences at the University of Calgary; and the Health Systems Research and Consulting Unit within the Centre for Addiction and Mental Health and University of Toronto. A core feature of the program is a transdisciplinary, national network of expertise that trainees can access through individualized mentorship, an annual institute, monthly videoconference seminars and hands-on research and policy practica. The program provides a unique opportunity for trainees to gain knowledge and research skills within an established network of academic leaders and peers whose expertise covers a broad range of relevant research experience.

In the first three years of the program, RAMHPS funded 24 highly qualified PhD students and post-doctoral fellows. Trainees come from a wide variety of disciplines, including psychiatry, nursing, public health, psychology, family medicine, epidemiology, social work, health administration, health economics, sociology and political science.

Dr Marc Corbière, now an Assistant Professor (CIHR New Investigator and Michael Smith Foundation for Health Research Scholar) at the Institute of Health Promotion Research at the University of British Columbia, was in the first cohort of trainees in 2003. For him, the most important aspect of the program was the opportunity to work with research leaders such as Elliot Goldner, Paula Goering and Alain Lesage, the key RAMHPS mentors, as well as the broader networking possibilities with researchers in other provinces. "These networks led directly to the development of a new, pan-Canadian project to look at supported employment program implementation for individuals with mental health problems," said Dr Corbière. "This project, which involves team members I met through the RAMHPS program, was recently awarded funding for three years from CIHR."

Dr Aline Drapeau, who entered the RAMHPS program as a post-doctoral fellow in psychiatry, also noted the benefit of an increased network of potential collaborators. In addition, she identified important learnings related to skills and attitudes. "When I first joined RAMHPS, I had already accumulated several years of experience in mental health research, but the program has widened my perspective and contributed to refining my research orientation and thinking," said Dr Drapeau. She also appreciated having access to the expertise of the mentors, and observing how experts interact with each other. "In that respect, the RAMHPS mentors act as role models for me as I develop my own research career."

For Catherine Vallée, a current PhD trainee, the appeal of RAMHPS was its transdisciplinary focus. With a background in occupational therapy, and an interest in recovery-oriented work programs for people with schizophrenia, Catherine had difficulties finding a program within her rehabilitation field that allowed a mental health focus. "It was a pretty lonely planet," she said. "Courses were always relevant by proxy, but were not tackling issues of mental health policy or services directly." RAMHPS gave Catherine access to knowledgeable mentors in the field, but also to students and researchers with similar interests, and diverse, inspiring perspectives. Catherine will spend the second year as a RAMHPS trainee focusing on increasing her skills in quantitative methods, which will include a summer practicum with a public health agency on developing indicators for mental health issues.

Both Dr Corbière and Dr Drapeau view the RAMHPS experience as a factor in their later success in applying for salary awards. Dr Drapeau is currently completing her post-doctoral research and will soon take up a research position at the Centre de recherche Fernand-Seguin in Quebec. Dr Corbière is now a mentor himself in two other related STIHRs, the Work Disability Prevention program at the University of Sherbrooke, and the Partnering in Community Health Research program at the University of British Columbia.

CIHR's Strategic Training Initiative in Health Research (STIHR) is designed to build capacity within Canada's health research community and develop the next generation of bright, creative researchers. Through the STIHR, CIHR, with partners in government, voluntary and private sectors, competitively funds individual strategic training programs to support research trainees. Close to ninety training programs have been funded since the launch of the STIHR competition in 2001.

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