Health Canada Santé Canada

SHARING THE LEARNING

# The Health Transition Fund

## SYNTHESIS SERIES

## Mental Health

Canada

Our mission is to help the people of Canada maintain and improve their health.

*Health Canada*



This publication may be provided in alternate formats upon request.

For further information or to obtain additional copies, please contact:

Publications
Health Canada
Ottawa, Ontario
K1A 0K9
Tel.: (613) 954-5995
Fax : (613) 941-5366

This document is available on the Health Canada web site: http://www.hc-sc.gc.ca



Cat. H13-6/2002-8
ISBN 0-662-66311-X

SHARING THE LEARNING

# The Health Transition Fund

SYNTHESIS SERIES

## Mental Health

**Elliot M. Goldner MD, MHSc, FRCPC**
Mental Health Evaluation & Community Consultation Unit
Department of Psychiatry, University of British Columbia

# Executive Summary

The Health Transition Fund (HTF), a joint effort between federal, provincial, and territorial governments, was created out of the 1997 federal budget to encourage and support evidence-based decision-making in health care reform. Between 1997 and 2001, the HTF funded approximately 140 different pilot projects and/or evaluation studies across Canada. In order to communicate research evidence from the projects to decision-makers, experts were employed to synthesize the key process and outcome learnings in each of nine theme or focus areas: home care, pharmaceutical issues, primary care/primary health care, integrated service delivery, children's health, Aboriginal health, seniors' health, rural/telehealth, and mental health. This document summarizes the key learnings in the mental health theme area. It has been prepared by Elliot Goldner, MD, MHSc, FRCPC, Director of the Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia.

The HTF supported 24 projects related to the theme of mental health policy and practice. These studies provided an opportunity to examine a series of innovations in mental health practice and allowed a thoughtful investigation of contextual issues germane to the implementation of new mental health services in Canada.

Unique historical features and complex demographic and societal factors have influenced the current landscape of mental health and mental illness across the nation and have helped to shape Canada's mental health policies. Although mental health services in Canada have been highly regarded, there are still prominent challenges in need of attention and creative solutions. In an effort to address some of these challenges, the 24 HTF projects explored various facets of mental health services and investigated innovations applied in the "real world" of Canada's system of health services and supports.

The HTF projects examined a wide range of mental health issues that affect people of all ages and backgrounds. They investigated solutions geared for people living in urban, rural, and remote communities. They pursued novel approaches to the delivery of mental health services while attending to the perspectives of a wide range of stakeholders: people directly affected by mental illness, family members, health providers, administrators, policy-makers, and researchers.

The HTF studies provided evidence supporting the value of new approaches to the delivery of mental health services. Project findings demonstrated:

- the effectiveness of relocating certain mental health services to primary care settings;
- the efficacy of a locally based "re-integration and achievement centre" for clients with chronic mental illness and addictions in a remote community;
- the acceptance by clients, family members, and nurses of home-based services for people with psychotic illnesses;
- the reliability and validity of a new tool that assesses the safety of home environments for people with dementia;
- the improved self-ratings of confidence and skill by primary care physicians who receive brief mental health education;
- the acceptance of an integrated model of service provision by parents of children with autism;

- the quality of life improvements for clients receiving concurrent assertive community treatment and treatment for substance-use disorders;
- the acceptance by parents and children of a brief psycho-educational intervention aimed to prevent affective disorder in the children of depressed parents;
- the acceptance by a wide variety of stakeholders in rural and remote communities of brief educational initiatives addressing the prevention of eating disorders and the treatment of people with these disorders;
- the acceptance by service recipients and providers of the use of "cultural brokers" in the mental health treatment of people of various ethno-cultural backgrounds;
- the acceptance by service recipients of a specialized service for people who have been victims of trauma; and
- the importance of national standardization of mental health information and communication systems to facilitate benefits and minimize risks.

Moreover, the HTF projects provided a valuable set of lessons regarding the implementation of new mental health practices. Taken in sum, the projects shed light upon essential contextual issues that may help to guide advancements in the Canadian mental health system. As a result of the HTF investigators' careful attention to the many variables that facilitated or impeded specific aspects of their project, a series of *critical success factors* has been identified:

- Set measurable goals for all pilot and demonstration projects.
- Realistically appraise the likelihood that pilot and demonstration project goals can be achieved.
- Include appropriate research methods and design characteristics to ensure that pilot and demonstration projects can effectively undertake intended evaluations or test stated hypotheses.
- Before a pilot project starts, ensure there is a commitment (including funding) for ongoing support should the project successfully achieve its goals.
- Before a pilot project starts, ensure all relevant stakeholders commit to a clearly outlined plan to terminate the project if it does not achieve its goals.
- Include a preparatory phase preceding implementation of a new program to prepare stakeholders and foster participation.
- Identify benefits offered to all stakeholders by new programs or projects.
- Promote meaningful participation in a new project by a wide network of stakeholders.
- Establish a knowledgeable and influential advisory group to provide support to project leaders.
- Have project leaders obtain advance start-up funds so that a new program or project begins smoothly.
- Allow for an extended timeline to ensure adequate opportunity for completion of new projects, given unpredictable delays and interruptions inherent in system and service environments.
- Before the project begins, make action plans to address anticipated obstructions.

- Make sure there is effective leadership in place.
- Select staff that are accepted by the key stakeholders.
- Prepare a well-planned and well-executed communication and dissemination plan.

The factors listed above may assist future efforts to implement mental health services in Canada and are also likely to be of use within the broader health care system.

*Health human resources* has been widely acknowledged as the dominant issue facing Canada's health system, and this certainly holds true in the area of mental health. Many of the innovations studied in the current HTF projects – e.g., information and communication technology advances, assessment tools, and educational programs – could potentially support and enhance the capabilities of the mental health workforce. In many instances, these same innovations may improve mental health system accountability, creating a more efficient and effective system, easing pressures, and enhancing the quality of available care. A number of the HTF projects also provide insights into the importance of *effective leadership* as one of the key success factors for implementing new mental health services.

Mental health policy and practice affect a wide variety of stakeholders and require communication and collaboration across sectors. Efforts to bridge sectors are needed at various levels of government and also at the level of day-to-day practice. The HTF projects have investigated integrative and collaborative approaches that may help advances on this front. Further, the current studies acknowledge the importance of grounding decisions in a solid foundation of evidence – a principle that requires continual reaffirmation and commitment.

The 24 HTF projects undertaken between 1997 and 2001 have made a substantial contribution toward a practical knowledge base in mental health policy and practice. They have also served to expand opportunities for people in communities across Canada to develop research skills and expertise; the HTF supported activity by community-based researchers and clinicians and gave them unprecedented opportunity to investigate important questions in mental health policy and practice. As a result, Canadians are entering the new millennium with a deeper and clearer pool of knowledge and resources to improve our approach to mental health and mental illness.

# Preface

In recent years, Canada's health care system has been closely scrutinized with a view to quality improvement and cost-effectiveness. Fiscal pressures and changing demographics are resulting in initiatives to explore how the efficiency of the health care system can be increased while ensuring that high-quality services are affordable and accessible. Within this context, there has been a need for more research-based evidence about which approaches and models of health care have been working and which have not. In response to this requirement for evidence, and on the recommendation of the National Forum on Health, the Health Transition Fund (HTF) was created out of the 1997 federal budget to encourage and support evidence-based decision making in health care reform.

A joint effort between federal, provincial and territorial governments, the HTF funded 141 pilot projects and/or evaluation studies across Canada between 1997 and 2001, for a total cost of $150 million. Of that, $120 million supported provincial and territorial projects and the remaining $30 million funded national-level initiatives. The HTF targeted initiatives in four priority areas: home care, pharmaceutical issues, primary health care, and integrated service delivery. Various other focus areas emerged under the umbrella of the original four themes, including Aboriginal health, rural health/telehealth, seniors' health, mental health, and children's health.

The HTF projects were completed by the spring of 2001. In order to communicate the evidence generated by the projects to decision-makers, experts were employed to synthesize the key process and outcome learnings in each theme area. This document summarizes the key learnings in the mental health theme area. It has been prepared by Elliot Goldner, MD, MHSc, FRCPC, Director of the Mental Health Evaluation & Community Consultation Unit, Department of Psychiatry, University of British Columbia.

## Unique Nature of the HTF Projects

The HTF was quite different from other organizations that fund health-related research in this country, such as the Canadian Institutes for Health Research and its predecessor the Medical Research Council.

- It was a time-limited fund, which meant that projects had to be conceived, funded, implemented, and evaluated all in four years – a very short time in the context of system reform.
- It was policy-driven; policy-makers were involved in the project selection process, and wanted to focus on some of the outstanding issues in the four theme areas in the hope that results would provide evidence or guidance about future policy and program directions.

In order to encourage projects to address issues and produce results that would be relevant to decision-makers, the HTF developed an evaluation framework consisting of six elements (access, quality, integration, health outcomes, cost-effectiveness, and transferability). Each project was required to have an evaluation plan addressing as many of these elements as were relevant. In addition, all HTF projects were required to include a dissemination plan (for which funding was provided) in order to ensure that results were effectively communicated to those best able to make use of them. In addition to these individual dissemination plans, the HTF Secretariat is implementing a national dissemination strategy, of which these synthesis documents are one element. This emphasis on evaluation (systematic learning from the experience of the pilot initiatives) and dissemination (active sharing of results) was unique on this scale.

Most national projects were selected by an inter-governmental committee following an open call for proposals, while provincial/territorial initiatives were brought forward by each individual jurisdiction for bilateral approval with the federal government. At both levels, applications came not just from academics in universities, or researchers in hospital settings, but also from non-traditional groups such as Aboriginal organizations, community groups, and isolated health regions. Groups that had rarely, if ever, thought in terms of research, evidence, evaluation, and dissemination began doing so, and these developments bode well for improved understanding and collaboration among governments, provider organizations, and researchers. The role of federal, provincial, and territorial governments in the selection process ensured that the projects delved into the issues that were of high concern in each jurisdiction. By the same token, there was considerable scope in the range of project topics, and the body of projects was not (and was never intended to be) a definitive examination of each theme.

This unique focus and selection process imparts specific features to the HTF body of projects. The projects that were funded represent good ideas that were put forward; they do not represent a comprehensive picture of all the issues and potential solutions in each of the theme areas. The relatively short time frame meant that many researchers struggled to complete their work on time and the results are preliminary or incomplete; some pilot projects might take a number of years to truly show whether they made a difference. This must be left to others to carry forward and further investigate. Perhaps the greatest value in the large body of HTF projects comes from the lessons we can learn about change management from the researchers' struggles and challenges as they undertook to implement and evaluate new approaches to longstanding health care issues.

# Acknowledgements

The author wishes to thank his colleagues at the University of British Columbia's Mental Health Evaluation & Community Consultation Unit (Mheccu), and in particular, Dr. Julian Somers, for assuming additional responsibilities while this synthesis report was prepared. Carl Lakaski and Dr. Jim Millar of the Federal/Provincial/Territorial Advisory Network on Mental Health kindly reviewed drafts, provided valuable suggestions, and unearthed rare copies of important documents. Dr. Paula Goering, who has been awarded the Canadian Health Services Research Foundation Chair in Mental Health Services Research, and Dr. Alain Lesage, president of the Canadian Academy for Psychiatric Epidemiology, also contributed astute observations and thoughtful suggestions. The author would like to thank the staff of Hollander Analytical Services Ltd. for its skillful assistance in the preparation of this synthesis document. The HTF synthesis series was commissioned by Health Canada and managed by Hollander Analytical Services Ltd. The views expressed herein do not necessarily represent the official policy of federal, provincial or territorial governments.

# Table of Contents

# 1. Setting the Context

## 1.1 Asylum, Deinstitutionalization, and Community-Based Mental Health Reform

During much of the first century of Canada's nationhood, there were few treatments that could effectively reduce the suffering of people affected by severe mental illness. Following European examples, residential asylums were established to provide safe settings for physical and spiritual care and to shield residents from the harm and peril that commonly befell people with mental illnesses in cities and towns (Burgess, 1898; Deutsch, 1937; Shorter, 1997). A contrary view identifies less humanitarian motivations for asylum development: the segregation of those with mental illness from a society that did not want the discomfort of eccentric behaviour in its midst, and the self-interests of health professionals (Foucault, 1961; Goffman, 1961; Scull, 1989). Whatever motivations may have been in play within Canadian society, a policy of institutionalization led to the proliferation of psychiatric hospitals across the country. This trend continued until the 1960s, when the number of psychiatric beds peaked (see Figure 1, summarizing Quebec data, as an example).

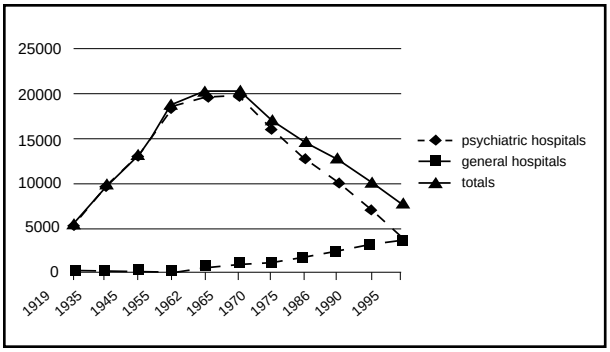


**Figure 1: Psychiatric beds in Quebec**

reproduced with permission from: Lesage et al 2000

Historiographic accounts of Canadian asylums (e.g., Krasnick Warsh, 1989; Shortt, 1986) provide insights to the complex societal and institutional factors that may have led most to be custodial rather than caring (Grob, 1973). These factors included overcrowding, inadequately trained staff, and public disregard for the plight of the mentally ill. Concern regarding the dismal conditions of some psychiatric hospitals, coupled with optimism that accompanied the introduction of new treatments (e.g., antipsychotic medication, psychosocial interventions), later buoyed public support for the policy of *deinstitutionalization*.[1] Figure 1 illustrates the profound downsizing of psychiatric hospitals that has proceeded unabated over recent decades. It also demonstrates that even though general hospitals have provided an increased number of beds for psychiatric care, the total number of psychiatric beds has plummeted.

Deinstitutionalization led to the need to develop adequate services in community settings for people with severe mental illness. Yet in spite of evidence of the profound burden of illness and disability caused by mental disorders (Murray & Lopez, 1996), a system of community-based services and supports that could replace institutional care for people with mental illness has not been adequately developed due to fiscal restraints, competing demands for health budgets, and broad social and environmental factors (Dear & Wolch, 1987; Goetz, McFarland, & Ross, 2000; Grob, 1994; McCubbin & Cohen, 1999; Rachlis & Kushner, 1994; Rochefort, 1997; Simmons, 1990; Torrey, 1996; Torrey & Zdanowicz, 1998).

In recent years, researchers have collected data demonstrating the poor health status of people with mental illness (Alexander, 1996; Newman & Bland, 1987, 1991) and the high proportion of mental illness in the growing homeless populations of Canada's cities (Acorn, 1993; Morrell-Bellai, Goering, &

1. *Deinstitutionalization* refers to the transfer of treatment for people with chronic mental disorders from inpatient psychiatric institutions to community-based facilities emphasizing outpatient care.

Boydell, 2000; Raynault, Battista, Joseph, & Fournier, 1994; Stuart & Arboleda-Florez, 2000). There is also evidence of an influx of the mentally ill to jails (Belcher, 1988; Zapf, Roesch, & Hart, 1996) and high rates of violent criminal victimization of people affected by mental illness (Hiday, Swartz, Swanson, Borum, & Wagner, 1999).

Another grim feature of the Canadian mental health landscape is the toxic co-morbidity that frequently develops when substance-use disorder combines with other mental health problems. Although sometimes described as "dual diagnosis," the combination of substance misuse and severe mental disorder commonly results in the disastrous accumulation of three, four, or more diagnoses – e.g., HIV illness, hepatitis or tuberculosis related to intravenous drug use, liver cirrhosis consequent to chronic alcohol use, and neuro-psychiatric deterioration following acute or chronic use of various substances. Such combinations of mental and physical illness have led to many tragic circumstances across Canada (Davis, 1998; Poulin, Gyorkos, Joseph, Schlech, & Lee, 1992; Stuart & Arboleda-Florez, 2000; Weir, 2001). These circumstances have become evident in urban communities, such as Vancouver's downtown core (home to a large proportion of people with severe mental illness), where a spiraling increase in deaths attributed to illicit drug abuse had become the leading cause of death among 30- to 44-year-olds (Chief Coroner of British Columbia, 1995). Such tragedy also darkens the lives of people in rural and remote communities, as exemplified by the devastatingly high suicide rate of young Inuit people in Nunavut, most of whom have had a history of emotional distress or depression (Isaacs, Keogh, Menard, & Hockin, 1998).

To further put the mental health of Canadians into context, it is important to recognize the ethnocultural diversity that characterizes Canada's population, which is known to have an important and distinctive relationship to the experience of illness and healing (Boone, Minore, Katt, & Kinch, 1997; Kirmayer & Young, 1999; Peters & Demerais, 1997; van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). The impact of anticipated demographic, social, and economic changes on the mental health of Canadians also warrants attention. A substantive change in Canada's demography will soon be felt as a large proportion of the population enters old age; an estimated consequence is a doubling in the prevalence of dementia (Bland, 1998). One demographic characteristic that is unlikely to change is the vast geographical dispersion of Canada's population – the attendant challenges in providing health care across such great distances are felt most acutely by communities in remote areas of the country.

Attempts to improve the Canadian mental health system are not new. Innovations in the delivery of community-based mental health care can be traced back many decades in Canada's history (Pettifor, 1983), with substantial policy-directed efforts to reform the mental health system underway since the 1970s (Mercier & White, 1995; Read & Gehrs, 1997). However, unyielding barriers have often impeded attempts to improve mental health systems (Kendrick, Burns, Garland, Greenwood, & Smith, 2000; Leighton, 1984; Marks & Scott, 1990; McAlpine & Mechanic, 2000; McCubbin & Cohen, 1999; Narrow et al., 2000; Pandiani, Murtaugh. & Pierce, 1996; Roth, Lauber, Crane-Ross, & Clark, 1997). Such barriers are manifold and complex; prominent among them are the following:

- public indifference to the plight of people with mental illness (often fuelled by misinformation, stigmatization, and fear);
- difficulties in mounting political lobbying efforts due to the poverty and disability of people affected by mental illness, and their consequent disadvantage in competing with other groups for limited health care services and supports;
- resistance to system changes by administrators, health professionals, and others who could risk loss of authority, income, or status as a result of

reallocation of resources or restructuring of governance;

- the low status that mental health care has generally been assigned within health care professions (a result, in part, of the relative absence of technological tools associated with mental health care during an era in which technological development has been highlighted); and
- the abundance of ethical dilemmas associated with mental health care that are controversial and actively debated by fractious constituent groups (e.g., compulsory treatment orders, use of psychiatric medications in the treatment of children); attempts to address such important dilemmas will typically slow processes markedly and may hinder definitive action.

In the face of such barriers, it is all the more remarkable that mental health services in Canada have advanced as far as they have over recent decades. Such advancement is demonstrated not only by the availability of improved treatment methods and techniques, but also in the acceptance of enlightened values and treatment philosophies – e.g., increased attention to the rights and preferences of people with mental illness, and greater respect for the contributions of consumers and families to planning, decision-making, and evaluation efforts.

## 1.2 Mental Health Policy and Practice: Evidence and Societal/Cultural Values

Recent decades have seen intensified efforts to adhere to *evidence-based policy and decision-making*, guided by high-quality information, generally derived from well-conducted and well-interpreted research studies (Lomas, 2000). An evidence-based approach has also been highlighted as an important philosophical underpinning for professional mental health practice (Goldner, Abbass, Leverette, & Haslam, 2001). Policy issues are legion and can be categorized into countless divisions and frameworks. Table 1 provides a partial list of policy issues relevant to mental health system reform, drawn from various sources.

**Table 1: Policy Issues Relevant to Mental Health System Reform**

- Rights of consumers and families[a,b,c,f,g,k]
- Continuity of care across time, place, and providers[a,b,e,f,g,h,k]
- Efficiency and rationalized allocation of resources[a,b,f,k]
- Effectiveness of services and supports[a,b,f]
- Acceptability of services to full range of stakeholders[a,b,f,g,h,j]
- Accountability structures[a,b,f,h,i,k]
- Appropriateness of services and ability to meet expected standards[a,f]
- Competence of service providers[a,f]
- Safety and risk minimization[a,f]
- Accessibility of services and supports [a,f,h,j]
- Shift from institutional to community-based programs [b,c,d,e,f,g,j,k]
- Addressing the broad determinants of health [b,c,e,g,i,j]
- Devolving governance to regional authorities [b,c,f,h,k]
- Coordination with other policy and service sectors [b,c,g,h,i,j,k]
- Consumer involvement in shaping policies and practices[b,c,f,g,h,i,j,k]
- Fiscal models and their impact on health services and systems[b,f,h,k]
- Addressing conflict between evidence and values[e]
- Complementary or alternative medicine[e]
- Sharing of information between agencies[e,g]
- Ensuring access to services by people with severe mental illness[f,h]
- Physician funding mechanisms and integration with other mental health service providers[h,k]

[a] Canadian Institute for Health Information (1999)
[b] Health Systems Research Unit (1997b)
[c] Trainor et al. (1992)
[d] Nasir (1994)
[e] Health Canada (1997)
[f] McEwan & Goldner (2001)
[g] Health and Welfare Canada (1988)
[h] Bachrach, Goering, & Wasylenki (1994)
[i] Stephens (1998)
[j] Driscoll (1998)
[k] Gourlay (1998)

A prescient national policy document released by Health and Welfare Canada in 1988, *Mental Health for Canadians: Striking a Balance*, drew attention to the broad determinants of mental health and emphasized the importance of mental health promotion. This perspective was further developed in the Canadian Mental Health Association's (CMHA) *Framework for Support* (Trainor, Pape, & Pomeroy, 1992), which highlighted the importance of services and supports that had traditionally been outside the formal mental health service delivery system. The CMHA envisioned a broadened network of community services and supports that included community housing, meaningful work opportunities, self-help, and family support.

This broadened perspective constituted a paradigm shift that was not readily embraced by the traditional coterie of professional service providers, who were often reluctant to recognize these additional services (e.g., housing and employment opportunities) as equals. Further, acknowledgement of the need for this wider range of services immediately posed the thorny problem of budget allocations by government ministries, often resulting in an endless game of "pass the ball."

A 1992 symposium entitled "An Overview of Canada's Mental Health System" led to the publication of a series of papers edited by Bachrach, Goering, and Wasylenki (1994). The series provided an overview of the unique nature and values of Canada's mental health system, often drawn out through comparisons with its counterpart in the United States (Bachrach, 1994a, 1994b; Beiser & Edwards, 1994; Bigelow & McFarland, 1994; Bigelow, Sladen-Dew, & Russell, 1994; Freeman, 1994; Goering, Wasylenki, & Macnaughton, 1994; Mercier & White, 1994; Wasylenki, Goering, & Macnaughton, 1994). Canadians could certainly feel proud, given the praise from eminent Americans who saw a kinder, gentler mental health system than their own, one that made an earnest attempt to provide universal care to those in need.

An important series of documents related to mental health policy and practice, *Best Practices in Mental Health Reform* (Health Systems Research Unit, 1997a; 1997b; 1997c), was commissioned by the Federal/Provincial/Territorial Advisory Network on Mental Health and produced by the Health Systems Research Unit of the University of Toronto's Clarke Institute of Psychiatry (now the Centre for Addiction & Mental Health). Although the term "best practices" occasionally draws criticism (perhaps due to the misperception that it denotes irrefutable superiority and limits exploration of alternatives), it was originally adopted with the goal of recognizing the importance of evidence in implementing practice reforms. Using an evidence-based approach, Goering and her colleagues identified salient policies and practices, producing a theoretical and practice-based context for a list of clinical and system strategies, which has been widely used by policy-makers, planners, and administrators to aid mental health system reform. Reflecting this work, Table 2 provides a partial list of clinical practices in mental health that have been considered to be at the forefront of innovation and quality improvement (Collaborative Working Group on Shared Mental Health Care, 2000; Drake & Mueser, 1996; Health Systems Research Unit, 1997a; Marks & Scott, 1990; Morgan, 1993; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996).

**Table 2: A Partial List of Innovative "Best Practices" in Mental Health Reform**

- Assertive community treatment
- Enhanced case management
- Mobile crisis response
- Home-based mental health services
- Supported employment and psychosocial rehabilitation
- Supported independent living
- Shared and collaborative care: Primary health care and specialized mental health services
- Collaborative family services and supports
- Integrated services for co-morbid disorders
- Promotion of early intervention
- Enhanced information sharing

The level of evidence available to support the effectiveness of practices listed in Table 2 varies considerably, and further effort will be needed to better evaluate their effectiveness and usefulness in various settings. Many of the newer mental health practices have only recently been implemented in Canadian systems; there is a need to share information and experience across the country. It is in the spirit of such examination that many of the current HTF projects were undertaken.

A series of documents was released by the Mental Health Promotion Unit in 1998 as a component of the *National Plan for Promoting Health* (Driscoll, 1998; Gourlay, 1998; Stephens, 1998). The authors provided scholarly reviews of policy issues pertinent to mental health systems in Canada, summarized the various initiatives that were underway in each province and territory, described relevant fiscal and legislative structures, and reviewed findings of the National Population Health Survey with a focus on mental health status. The series called attention to *population health* and *health promotion* perspectives, with far-reaching implications for the conceptualization and delivery of mental health services. We could no longer maintain a myopic viewpoint that saw only those who, by some fluke, found their way into our hospitals and clinics. Instead, our eyes were focused upon the full landscape – viewing not only those with chronic or severe illness, but also the whole population of those who might be affected by mental illness. Along with the dreadful realization that the task was even greater than had previously been imagined came the promise that a shrewd investment of resources might prevent a legion of problems. Like the proverbial stitch in time, one critically positioned mental health initiative might indeed "save nine."

Policy trends in Canada's mental health system during the 1980s and 1990s reflected the need to reallocate resources from formal services to consumer- and family-directed activities and reconfigure patterns of power and influence within the mental health system of services (Trainor, Pape, & Pomeroy, 1997). During the same period, most regions of the country were actively reorganizing health services, shifting governance to regional authorities (Lomas, Woods, & Veenstra, 1997). By the year 2000, policy-makers had focused attention on system accountability.

The Federal/Provincial/Territorial Advisory Network on Mental Health commissioned a report addressing accountability in the mental health system. *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit* was produced by the University of British Columbia's Mental Health Evaluation and Community Consultation Unit (McEwan & Goldner, 2001). Using the *Health Indicators Framework* developed by the Canadian Institute for Health Information (1999), McEwan and Goldner outlined methods to nest the measurement of mental health systems and services within an evidence-based approach. A fundamental principle emphasized by the authors was the importance of tracking system performance in the context of clear policy-related goals and objectives.

Key health research and health services organizations undertook a Canada-wide consultation (Canadian Health Services Research Foundation, 2001) to identify research themes addressing issues that are likely to be most prominent for policy-makers and managers during the current decade. Table 3 lists the primary and secondary themes that emerged as a result of the consultation – each highly relevant to mental health policy and practice. It is notable that one of the primary themes is *improved access for "marginalized" groups*, with explicit attention to people affected by mental illness. This may be interpreted as a signal of increased recognition of the importance of mental health services in the overall landscape of health care.

**Table 3: Themes Identified by the National Consultation on Health Services and Policy Issues (2001)**

PRIMARY THEMES

- Health human resources
- Financing and public expectations
- Governance and accountability
- Driving and managing system change
- Improving quality
- Health care evaluation and technology assessment
- Public advice-seeking in the era of e-health
- Improved access for "marginalized" groups

SECONDARY THEMES

- Primary health care
- Globalization
- Regionalization
- Population health
- Continuum of care and delivery models
- Performance indicators, benchmarks, and outcomes
- Evolving role of informal and voluntary care

Many of the values inherent in Canadian mental health policy – i.e., social justice, societal pluralism, cultural relevance, psychological uniqueness, and social space – have received praise from eminent observers (Bachrach, 1994a; Bachrach 1994b; Torrey, Bigelow, & Sladen-Dew, 1993). The current fiscal pressures that accompany efforts to improve community mental health services constitute an acid test of Canada's commitment to these values and to the long-cherished ideal of universal access to care. Further, the palpable need for better solutions to the substantive mental health problems affecting so many Canadians constitutes an important challenge. In an effort to address this challenge, the HTF projects focused attention upon a series of vital issues prominent in contemporary mental health care and investigated innovative responses implemented in the Canadian environment.

# 2. Overview of the Health Transition Fund Studies

The 24 projects supported by the HTF related to mental health policy and practice are listed in Appendix A. Each is intrinsically related to policy issues described in Tables 1 and 3 of this document, and in combination the 24 projects examined many of the innovative practices listed in Table 2. Three projects focused attention specifically on services to children (SK324, PE421, AB301-9), while others also examined issues relevant to the treatment of young people (NS421, ON321). A substantial number of studies looked at mental health services for older adults (NA221, NA122, QC428) and adults with severe mental illness (QC407, NA149, BC121, QC408, QC434). New approaches to mental health service delivery were investigated, including models that emphasized primary care (AB301-3, NS421, ON321, AB301-10), home-based services (QC407, NA149, BC121), technological advances (QC430, BC423), attention to housing (QC408, QC434), cultural understanding (QC424, AB301-3), prevention (SK423), enhanced case management or consultation (SK329, BC124), and education and service integration (SK324, PE421, QC407, NS421, QC408, QC434, SK327). Some important issues in mental health policy and practice that were *not* studied were those related to supported employment, occupational rehabilitation, and models addressing emergency and crisis response to mental health problems.

# 3. Discussion of Significant/ Relevant Findings

The discussion below highlights some of the central findings associated with the HTF projects. General findings of the studies that are supported by evidence are emphasized in the summary of findings (Table 4).

A number of projects examined service models in urban centres. Results of *8th and 8th Health Centre Proposal for a Formative Evaluation* (AB301-3) suggested that hospitalization for mental illness could be averted by the availability of a centrally located 24-hour integrated community care centre. *Shared Mental Health Care in Primary Health Care Practice* (AB301-10), which examined a model that placed integrated mental health care within urban family physician offices, was associated with improvements in the quality of care. This is a welcome finding given the results of a descriptive study, *Evaluation of Geriatric Psychiatry Outpatient Consultation for Elderly Depressed Patients* (QC428), which examined communication barriers that arose during consultation between primary care physicians and geriatric psychiatrists in traditional models of medical services. *Delivery of Integrated Care for Persons with Severe and Persistent Mental Disorders in Their Home Environment* (QC407) evaluated the integration of treatment for substance-use disorder with services for severe mental illness within an assertive community treatment model in Montréal. A retrospective evaluation of culturally informed services provided by the Edmonton Centre for Survivors of Torture and Trauma (AB301-13) suggested that clients experienced improved physical and mental well-being. Social support was identified as an important determinant of health. In *Development and Evaluation of a Cultural Mental Health Consultation Service* (QC424), interpreters and "cultural brokers" helped overcome barriers to communication and understanding of people from a broad range of ethnocultural backgrounds, including new immigrants and refugees.

Challenges associated with the provision of mental health services to people living in remote regions of Canada were addressed in *Putting in Place an Integrated System for Persons with Severe and Persistent Mental Problems* (QC434). Through establishment of an "achievement centre" in Inukjuak, persons affected by severe mental problems and intellectual disability

**Table 4: Summary of Selected HTF Project Findings**

- Effectiveness of relocating certain mental health services to primary care settings
- Efficacy of a locally based "re-integration and achievement centre" for clients with chronic mental illness and addictions in a remote community
- Acceptance by clients, family members, and nurses of home-based services for people with psychotic illnesses
- Reliability and validity of a new tool that assesses the safety of home environments for people with dementia
- Improved self-ratings of confidence and skill by primary care physicians who receive brief mental health education
- Acceptance of an integrated model of service provision by parents of children with autism
- Quality of life improvements for clients receiving concurrent assertive community treatment and treatment for substance-use disorders
- Acceptance by parents and children of a brief psycho-educational intervention aimed to prevent affective disorder in the children of depressed parents
- Acceptance by a wide variety of stakeholders in rural and remote communities of brief educational initiatives addressing the prevention of eating disorders and treatment of people with these disorders
- Acceptance by service recipients and providers of the use of "cultural brokers" in the mental health treatment of people of various ethnocultural backgrounds
- Acceptance by service recipients of a specialized service for people who have been victims of trauma
- Importance of national standardization of mental health information and communication systems to facilitate benefits and minimize risks

were provided with community-based services and supports, diminishing the need for them to move to distant urban treatment centres. *Eating Disorders Project North* (BC403) sought to help residents of 30 rural and remote communities in British Columbia prevent eating disorders and provide treatment for people affected by them. The study also proposed a theoretical framework that promotes a more comprehensive and integrated approach to prevention, intervention, diagnosis, and therapy, and makes the case for directing a larger proportion of resources to prevention and early intervention.

Up until recently, hospitalization for psychosis was seen to be the safest route for the patient and society. It was believed to be too risky to try to treat psychotic patients at home. But *Home-Based Program for Treatment of Acute Psychosis* (BC121) in Victoria added further weight to previous studies (e.g., Wasylenki, Gehrs, Goering, & Toner, 1997) that showed these patients can be safely managed, stabilized, and returned to a reasonable level of function without the disruption of admission to a psychiatric unit. In BC121, patients were treated by a team of specially trained nurses; the study found that, on average, people receiving the treatment and their respective family members preferred home-based treatment over hospital care. The study also identified organizational factors that serve either to present barriers or facilitate development of such home-based services. A unique aspect of the study was the home-based initiation of Clozapine therapy (a medication that has traditionally been used in hospital settings only) for a number of individuals who received treatment in the course of the project.

*Home Care and People with Psychiatric Disabilities: Needs and Issues* (NA149) undertook a national evaluation of the issue and also evaluated three site-specific pilot programs located in St. John's, Newfoundland; Ottawa, Ontario; and Taber, Alberta. The study concluded that home-based services for people with psychiatric disabilities can provide an effective and cost-efficient model of care deserving of national attention. *Enhanced Case Management Project* (BC124), also addressing home-based services, was able to increase the knowledge, awareness, or confidence of service providers and family caregivers providing home care to non-institutionalized persons with dementia, while *Safety of Persons Suffering from Dementia and Living at Home* (NA122) developed and evaluated tools to assess the safety of elderly people with dementia who are living at home.

Home-based care, which is well-regarded by clients, nurses, and family members, seems to be not only a safe and medically effective model, but also one that has the potential to save the health care system money by an efficient use of resources. However, dedicated funds are required to facilitate implementation. Policy-makers should look for ways to pilot this model, with adequate support and training of the nursing staff in their communities, as this is bound to be a burgeoning area of mental health treatment.

In *Improving Identification, Early Intervention and Outcomes for People with Mental Illness in the Community: A Model for Primary Care Services Integration in the Area of Mental Health* (NS421), four sites in Nova Scotia successfully implemented a shared mental health care model in order to achieve early intervention and improved outcomes for people with mental illness. Investigators reported improved access, decreased waiting times, and a reduced number of visits to emergency rooms. Early identification and intervention were also primary goals identified in two

projects addressing children at risk for mental health problems – *Day Care Consultation Services* (SK329) and *Enhance and Evaluate COPE: A School Based Primary Care Initiative* (AB301-9). Results indicated that the incorporation of specialized programming into schools and pre-school day-care services may produce earlier and more accurate identification of problems and easier access to treatment. *Integrating Services for Families with Affective Disorder* (SK423) evaluated two preventive interventions that sought to minimize the development of psychiatric disorders in children of parents with depressive illness.

*Mental Health On-Line* (BC423) investigated the use of information systems and provided recommendations to enhance information transfer within and across various sectors of the mental health system while protecting the privacy and confidentiality of people affected by mental disorders. The project examined the impact of regionalized governance and identified the importance of having standardized and comparable mental health information across Canada.

The projects led to sustainable changes in the delivery of mental health services in various jurisdictions. In some instances, successful pilot demonstrations led to annualized funding support from decision-makers on the basis of quality improvement and/or cost-effectiveness. Many projects produced new resources such as literature reviews, Web sites, assessment tools, manuals, glossaries, and evaluation frameworks; each of these will facilitate wide dissemination of knowledge.

# 4. Health Human Resources in Mental Health Policy and Practice

In 2001, five national organizations in Canada with responsibilities for health services and research[2] jointly undertook an extensive consultation on the strategic issues facing the health sector, *Listening for Direction* (Canadian Health Services Research Foundation, 2001). Policy-makers, managers, and clinical organizations identified *health human resources* as the dominant issue for the next two to five years.

Canada's health workforce is a precious and superlative resource; many of its professional staff, administrators, programmers, scientists, and specialist workers stand tall among the world's best. Canadians have made major contributions to health sciences research and clinical practice while maintaining a system that strives to provide universal access. However, recent decades have seen this lustrous workforce lose some of its shine. Health workers have expressed growing dissatisfaction; job action is a more common occurrence; and many health professionals are advising young people to pursue alternative careers. Noticeable throughout the health workforce, such disenchantment is certainly seen among mental health workers, who may feel beleaguered and overwhelmed by the dizzying whirl of ideas, ethics, and emotions that are attached to mental health issues. Many mental health workers carry a heavy load and experience substantial work-

2. The organizations were the Advisory Committee on Health Services of the Conference of Federal/ Provincial/Territorial Deputy Ministers of Health; the Canadian Coordinating Office for Health Technology Assessment; the Canadian Health Services Research Foundation; the Canadian Institute for Health Information; and the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

related stress. When pushed to make major changes in their work in accordance with mental health reform, it is not surprising that the response might be negative. Yet in order to implement the shifts that are envisioned in mental health reform initiatives, the workforce will have to undergo substantial redeployment, reconfiguration, and re-skilling (Health Systems Research Unit, 1997c). The mental health workforce includes workers in numerous health professions and disciplines; its rich diversity is often considered to be one of its strengths. However, inter-profession conflict regarding roles and division of labour is prominent and easily ignited by movements to redeploy mental health workers.

Various support and self-help organizations, special interest groups, and government agencies have signalled the need to ensure adequate monitoring and quality control of health workers. Although most health workers aspire to high ethical standards and respond conscientiously to the trust that society confers on them, instances of flagrant harm or abuse have fuelled concerns that some monitoring mechanisms are inadequate. Beyond unusual circumstances of harm and abuse of trust, we must acknowledge a much more common dilemma that arises when the interests of health workers are in conflict with those of their patients/clients. For a simple and frequently encountered example, consider a situation in which work shifts and hours that are most desirable to health workers are undesirable for patients/clients, resulting in poor continuity of care. How is this conflict appropriately resolved? Both groups have legitimate needs and an optimal balance must be achieved. To be in good working order, our mental health system must ensure that its human capital is well nourished and supported. In addition, the system must protect the interests of those receiving care and ensure that adequate mechanisms are in place to guarantee quality care and guard against folly.

Many of the innovations studied in the HTF projects offer promising opportunities to support and enhance the capabilities of the mental health workforce. These include advances such as telehealth technologies, electronic databases, internet resources containing evidence-based information, assessment tools, and educational programs – developments that may ease some of the difficult tasks facing the mental health workforce and encourage recruitment and retention. In many instances, these same innovations may help the mental health system support people affected by mental illness by monitoring the quality of services and assuring system accountability. Thus, many of these innovations are tools to create a more efficient and effective system, easing pressures and improving the quality of care available.

Effective leadership is one of the success factors identified in a number of the HTF projects. Increased attention to the importance of leadership is warranted and has been flagged as an area that is conspicuously neglected within mental health systems (Shore & Vanelli, 2001), an observation that certainly rings true within Canada's system. The inspiration, values, and vision that a capable and respected leadership can infuse are key ingredients to a successful system. In our haste to put together a palatable yet economical spread, we are at risk of eliminating such essential ingredients. With recognition of the importance of leadership, new models, tools, and programs for leadership development are now emerging (e.g., Robbins, Bradley, & Spicer, 2001; Wright, Rowitz, & Merkle, 2001).

The relationship between leadership and system change is worthy of further investigation. Reinharz, Contandriopoulos and Lesage (2000) found, in a study of deinstitutionalization, that a group of health professionals was able to embrace a planned change and transform it into a useful instrument in their efforts to be assigned a central role in the health system and thus consolidate their leadership in the health care sector.

# 5. Cross-Sectoral Implications of Mental Health Policy and Practice

Mental health problems and mental illnesses affect the lives of many people. Further, people in a wide variety of roles have a stake in providing treatment or support, or work to influence some aspect of the mental health system itself. Table 5 presents a lengthy, though not exhaustive, list of interested parties (*stakeholders)*. It is arranged in no particular order, but is meant to acknowledge the vast audience that attends to and influences mental health issues.

How are the multiple rights, needs, and wishes of the various stakeholders adequately represented and balanced? Recently, organizational models that seek to incorporate multiple perspectives have been developed (e.g., Boyce, 2001; Jackson, 2000). Nevertheless, the large number of sectors that would ideally be included and represented in mental health decision-making and practice implementation presents a substantial challenge to governance and integration efforts.

One attempt to solve cross-sectoral challenges has been the establishment of "inter-ministerial" or "inter-agency" committees and task groups. Although these may be of value, they often suffer from their inevitable position as second-rate priorities; when system pressures are high (i.e., most of the time), cross-sectoral efforts are typically put on the back burner and left to smolder.

A unique approach has recently been implemented in British Columbia with the establishment of a Minister of State for Mental Health.[3] This appears to be a direct acknowledgement of the importance of mental health issues within society and provides a prominent office, with a seat in cabinet, to oversee governance and administration of the provincial mental health system.

**Table 5: Mental Health: Interested Groups (Stakeholders)**

- General public
- People directly affected by mental health problems or illnesses
- Families, friends, or colleagues of people directly affected
- Clinicians, health professionals
- Other health workers
- Administrators, managers
- Policy-makers, governors, and decision-makers
- Social workers and others providing social services (including residential and employment-related supports)
- Judiciary, barristers, and solicitors
- Police
- Other workers in the criminal justice system
- Clergy and pastoral services
- Support and self-help agencies and associations
- Volunteer and community support agencies
- Teachers, school counsellors, and others working in schools
- Employers
- Insurance providers
- Policy advocates, lobby groups
- Health industries
- Store owners and other business groups
- Research scientists and research staff
- Journalists, writers, film-makers, artists

More efforts to bridge the distance between sectors are needed. The many perspectives associated with various stakeholder groups and the philosophies that underlie these may conflict. Collaborative models are increasingly being promoted and show substantial promise (Collaborative Working Group on Shared Mental Health Care, 2000; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). As demonstrated by the HTF projects, shared and integrated mental health services provide practical solutions to improve quality and efficiency. Furthermore, they serve to influence

3. The Honourable Gulzar Cheema was appointed British Columbia's Minister of State for Mental Health on June 5, 2001.

each of the collaborators so that respective philosophies are enriched, and accumulated knowledge is expanded and integrated. Although it may be difficult to break the silos and broker such partnerships, these are essential goals to an improved mental health system.

If we are to move toward improved integration, we must also recognize the importance of debate and provide opportunities for cross-sectoral discussion and policy-making. It is critical to maintain a commitment to evidence-based decision-making and put mechanisms in place that protect against political decisions that are contrary to evidence. Although it would be naïve to deny that political factors will continue to play a role in decision-making, a reasonable goal would be to set political decisions firmly within the culture of evidence – i.e., choosing to support evidence-based policy A, B, C, or D. However, evidence to guide many important decisions is still lacking. In order to better inform evidence-based decision-making, there is an urgent need for increased attention to policy-related questions (Macintyre, Chalmers, Horton, & Smith, 2001) and an augmentation of research capacity in this area (Jenkins, 2001).

# 6. Implications for Policy and Practice

With but a few exceptions, the majority of the HTF projects implemented a new practice and simultaneously undertook to study or evaluate some component of the practice or some aspect of the implementation. An important product (i.e., *deliverable* in administrative jargonese) of each project is a set of findings and conclusions that can inform a wide variety of interested groups (i.e., *stakeholders* – more jargonese) about the new practice or about its implementation in the local site. In many instances, innovations in mental health practice that had been found to be promising in other settings were "field-tested" (Figure 2). If the reader might indulge an agricultural analogy, consider the HTF investigators as innovators who have obtained newly bred hybrids that have shown promising results when grown in the distant greenhouses where they were developed. The HTF projects are akin to the important subsequent step ("Field Testing and Local Evaluation" in Figure 2) in which we discover whether these new hybrids will thrive under different conditions, planted in local fields and exposed to the prevailing climatic conditions. Will the crop flourish in Canadian soil and become an important and sustainable source of nourishment? Or will it wither as the result of an unsuitable environment or inclement weather?

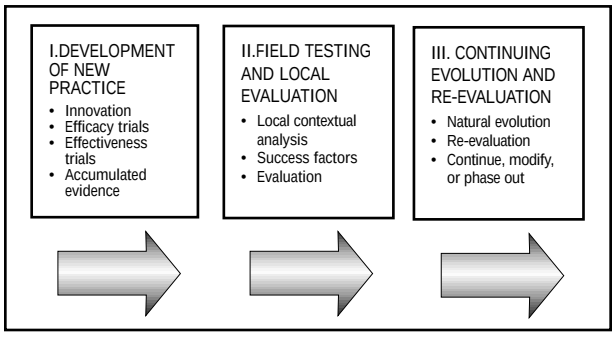


**Figure 2: Steps in the Introduction of New Practices**

Many of these HTF projects have provided a rare and invaluable opportunity to study the activation of new mental health practices in the "real world." The complex processes entailed in implementing such innovations are infrequently considered – yet an improved understanding of the processes that foster or obstruct system change is essential to the success of these initiatives. Taken together, the 24 projects have provided a rich store of knowledge to inform future efforts to implement new service models and facilitate system change. Many of the investigators diligently identified process elements that affected the course of their projects. An examination of the full cluster of projects also provides an opportunity to identify overarching critical success factors. Table 6 is a synthesis of the various factors that helped or blocked new practices and system change.

When taking a few steps back in an attempt to view the overall picture that emerges when the project findings are combined, one image seems very clear – many of the innovations that have been developed in community-based services produce significant benefits for people affected by mental illness and for their families. These models of mental health service that help maintain stable living circumstances and provide support to people in natural and comfortable settings – such as in school, at home, in the offices of family physicians – support the integrity of social networks and minimize disruption and marginalization. Given the oppressive stigma that appears so firmly affixed to mental illness (Crisp, Gelder, Ris, Meltzer, & Rowlands, 2000), approaches that promote healthy social integration and preserve the dignity of individuals and families that experience mental illness are of great importance.

If such innovations in mental health services can measurably improve the quality of care received and the quality of life of the recipients – *why does it seem so difficult to effect substantial change to the system*? Decades have come and gone, along with policy-directed reforms that were intended to create a strong network of community-based supports; the years have passed with only small movements forward. Most resources spent in the mental health sector are still devoted to acute hospital admissions, yet the bulk of treatment and support will be needed over the long course of illness that many people face. Clearly, the home-based, school-based, and community-based models of treatment that were implemented in a number of the HTF projects provide appealing

**Table 6: Success Factors – A Synthesis of HTF Findings Related to Practice Implementation**

- Set measurable goals for all pilot and demonstration projects.
- Realistically appraise the likelihood that pilot and demonstration project goals can be achieved.
- Include appropriate research methods and design characteristics to ensure that pilot and demonstration projects can effectively undertake intended evaluations or test stated hypotheses.
- Before a pilot project starts, ensure there is a commitment (including funding) for ongoing support should the project successfully achieve its goals.
- Before a pilot project starts, ensure all relevant stakeholders commit to a clearly outlined plan to terminate the project if it does not achieve its goals.
- Include a preparatory phase preceding implementation of a new program to prepare stakeholders and foster participation.
- Identify benefits offered to all stakeholders by new programs or projects.
- Promote meaningful participation in a new project by a wide network of stakeholders.
- Establish a knowledgeable and influential advisory group to provide support to project leaders.
- Have project leaders obtain advance start-up funds so that a new program or project begins smoothly.
- Allow for an extended timeline to ensure adequate opportunity for completion of new projects, given unpredictable delays and interruptions inherent in system and service environments.
- Before the project begins, make action plans to address anticipated obstructions.
- Make sure there is effective leadership in place.
- Select staff that are accepted by the key stakeholders.
- Prepare a well-planned and well-executed communication and dissemination plan.

alternatives to many of the traditional and prevailing patterns of care, which are too often characterized by frequent emergency room visits, repeated hospitalizations, and missed outpatient appointments.

Theories that examine factors promoting and obstructing change have been developed within diverse disciplines and intellectual frameworks, including organizational theory, economics, psychology, sociology, biology, religious studies, physics, political science, history, and anthropology. Classical organizational theory (e.g., Taylor, 1911; Fayol, 1949) was based on assumptions that human nature leads workers to be lazy and to avoid doing more than the minimum. Contemporary organizational theories no longer adopt such assumptions and work to enhance the inherent strengths of the workforce while attending to environmental factors (e.g., Hammer & Champy, 1993; Lartin-Drake, Curran, & Gillis-Donovan, 1996; Senge, 1990).

The *transtheoretical model*, constructed to shift behaviours that are particularly resistant to change, draws upon social, cognitive, and motivational psychology and is widely used to help individuals with substance-use disorders. The key strategies used in this model, originally developed by Prochaska and DiClemente (1982), have been described by Miller and Rollnick (1991) and are listed in Table 7. Are people who work in the mental health system likely to be supported by strategies such as these when change is undertaken? Do managers, supervisors, and senior clinicians generally respond in this manner in order to support the desired shifts in the system? There is probably a great deal of variability in the system, and the characteristics of the health services environment that facilitate forward change and foster development are worthy of careful study.

Many other frameworks that seek to explain the dynamics of change can be effectively applied to better understand the forces that facilitate or resist change. Kotter (1996) has outlined a comprehensive model for achieving organizational change. A powerful device to effect change is a fiscal strategy that shapes practice patterns and workforce activities by selectively rewarding specific practices and patterns of care. A discussion of a number of fiscal strategies that have been used to create change in the mental health system (including a discussion of some of their drawbacks and limitations) is provided in the *Review of Best Practices in Mental Health Reform* (Health Systems Research Unit, 1997c).

**Table 7: Strategies that Motivate People to Change**

- Give useful advice
- Remove barriers and disincentives to change
- Provide choices
- Decrease the desirability of the current activity
- Demonstrate empathy
- Provide clear feedback
- Help clarify goals (that are realistic and attainable)
- Maintain an attitude of active helping

— adapted from Miller & Rollnick, 1991

Certainly we do not want change only for the sake of change – there is a need for a good measure of constancy and stability in any system (Scott & Marks, 1990). In many circumstances, change can be counter-productive or even destructive. Of particular concern is the "restructuring cure" that is sometimes undertaken at high levels of government. This is characterized by massive reorganization of reporting structures and relationships (e.g., development of new ministries and governance structures) that requires years of realignment of services, employees, and procedures. Such high-level "cures" generally provoke extensive activities and costs that detract from the system's ability to undertake its core mission and often contribute little in the end.

The sweeping changes that attend high-level system reorganization often come in response to dramatic events that have raised public concern and seem to necessitate a response from system governors. Unfortunately, these changes usually do not achieve the desired goal and, instead, often remove parts of the system that had been working well and had been meeting important health service needs.

It is not only high-level system reorganization that warrants careful consideration. Changes that occur at the level of clinical services and treatment programs may seem contrary to logic and likely to diminish rather than enhance available services. We certainly want to avoid wanton destruction of valuable services and resources that have required extensive efforts to build, a desire that is expressed well in a poignant chorus by well-known Canadian songwriter/musician/artist Joni Mitchell:

> *…and don't it always seem to go that you don't know what you got 'til it's gone…*[4]

The HTF projects have provided information on efforts to implement specific mental health service innovations such as home-based care, programs in remote regions, integrated services in urban communities, school-based programs, specialized community services, and information management procedures. As well, the projects have provided important insights into the process of change accompanying efforts to improve mental health services in the Canadian health care environment.

# 7. Conclusions and Recommendations

Health Canada's Health Transition Fund supported 24 projects related to the theme of mental health policy and practice. These studies provided an opportunity to examine a series of innovations in mental health practice and allowed a thoughtful investigation of contextual issues germane to the implementation of new mental health services in Canada.

Unique historical features and complex demographic and societal factors have influenced the current landscape of mental health and mental illness across the nation and have helped to shape Canada's mental health policies. Although mental health services in Canada have been highly regarded, there are still prominent challenges in need of attention and creative solutions. In an effort to address some of these challenges, the 24 HTF projects explored various facets of mental health services and investigated innovations applied in the "real world" of Canada's system of health services and supports.

The HTF projects examined a wide range of mental health issues that affect people of all ages and backgrounds. They investigated solutions geared for people living in urban, rural, and remote communities. They pursued novel approaches to the delivery of mental health services while attending to the perspectives of a wide range of stakeholders: people directly affected by mental illness, family members, health providers, administrators, policy-makers, and researchers.

The HTF studies provided evidence supporting the value of new approaches to the delivery of mental health services. Project findings demonstrated:

- the effectiveness of relocating certain mental health services to primary care settings;

- the efficacy of a locally based "re-integration and achievement centre" for clients with chronic mental illness and addictions in a remote community;
- the acceptance by clients, family members, and nurses of home-based services for people with psychotic illnesses;
- the reliability and validity of a new tool that assesses the safety of home environments for people with dementia;
- the improved self-ratings of confidence and skill by primary care physicians who receive brief mental health education;
- the acceptance of an integrated model of service provision by parents of children with autism;
- the quality of life improvements for clients receiving concurrent assertive community treatment and treatment for substance-use disorders;
- the acceptance by parents and children of a brief psycho-educational intervention aimed to prevent affective disorder in the children of depressed parents;
- the acceptance by a wide variety of stakeholders in rural and remote communities of brief educational initiatives addressing the prevention of eating disorders and the treatment of people with these disorders;
- the acceptance by service recipients and providers of the use of "cultural brokers" in the mental health treatment of people of various ethnocultural backgrounds;
- the acceptance by service recipients of a specialized service for people who have been victims of trauma; and
- the importance of national standardization of mental health information and communication systems to facilitate benefits and minimize risks.

Moreover, the HTF projects provided a valuable set of lessons regarding the implementation of new mental health practices. Taken in sum, the projects shed light upon essential contextual issues that may help to guide advancements in the Canadian mental health system. As a result of the HTF investigators' careful attention to the many variables that facilitated or impeded specific aspects of their project, a series of *critical success factors* has been identified:

- Set measurable goals for all pilot and demonstration projects.
- Realistically appraise the likelihood that pilot and demonstration project goals can be achieved.
- Include appropriate research methods and design characteristics to ensure that pilot and demonstration projects can effectively undertake intended evaluations or test stated hypotheses.
- Before a pilot project starts, ensure there is a commitment (including funding) for ongoing support should the project successfully achieve its goals.
- Before a pilot project starts, ensure all relevant stakeholders commit to a clearly outlined plan to terminate the project if it does not achieve its goals.
- Include a preparatory phase preceding implementation of a new program to prepare stakeholders and foster participation.
- Identify benefits offered to all stakeholders by new programs or projects.
- Promote meaningful participation in a new project by a wide network of stakeholders.

- Establish a knowledgeable and influential advisory group to provide support to project leaders.
- Have project leaders obtain advance start-up funds so that a new program or project begins smoothly.
- Allow for an extended timeline to ensure adequate opportunity for completion of new projects, given unpredictable delays and interruptions inherent in system and service environments.
- Before the project begins, make action plans to address anticipated obstructions.
- Make sure there is effective leadership in place.
- Select staff that are accepted by the key stakeholders.
- Prepare a well-planned and well-executed communication and dissemination plan.

The factors listed above may assist future efforts to implement mental health services in Canada and are also likely to be of use within the broader health care system.

*Health human resources* has been widely acknowledged as the dominant issue facing Canada's health system, and this certainly holds true in the area of mental health. Many of the innovations studied in the current HTF projects – e.g., information and communication technology advances, assessment tools, and educational programs – could potentially support and enhance the capabilities of the mental health workforce. In many instances, these same innovations may improve mental health system accountability, creating a more efficient and effective system, easing pressures, and enhancing the quality of available care. A number of the HTF projects also provide insights into the importance of *effective leadership* as one of the key success factors for implementing new mental health services.

Mental health policy and practice affect a wide variety of stakeholders and require communication and collaboration across sectors. Efforts to bridge sectors are needed at various levels of government and also at the level of day-to-day practice. The HTF projects have investigated integrative and collaborative approaches that may help advances on this front. Further, the current studies acknowledge the importance of grounding decisions in a solid foundation of evidence – a principle that requires continual reaffirmation and commitment.

The 24 HTF projects undertaken between 1997 and 2001 have made a substantial contribution toward a practical knowledge base in mental health policy and practice. They have also served to expand opportunities for people in communities across Canada to develop research skills and expertise; the HTF supported activity by community-based researchers and clinicians and gave them unprecedented opportunity to investigate important questions in mental health policy and practice. As a result, Canadians are entering the new millennium with a deeper and clearer pool of knowledge and resources to improve our approach to mental health and mental illness.

# References


Acorn, S. (1993). Mental and physical health of homeless persons who use emergency shelters in Vancouver. *Hospital and Community Psychiatry, 44*(9), 854-857.

Alexander, R., Jr. (1996). The quality of life of persons with severe emotional disability: A review of empirical studies. *Journal of Health and Social Policy, 7*(4), 9-22.

Bachrach, L.L. (1994a). Deinstitutionalization and service priorities in Canada and the United States. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 3-9). San Francisco: Jossey Bass Inc.

Bachrach, L.L. (1994b). Reflections on mental health service delivery in Canada: One American's view. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 87-95). San Francisco: Jossey Bass Inc.

Bachrach, L.L., Goering, P., & Wasylenki D. (Eds.). (1994). *Mental health care in Canada*, Vol. 61. San Francisco: Jossey Bass Inc.

Beiser, M.R., & Edwards, R.G. (1994). Mental health of immigrants and refugees. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 73-86). San Francisco: Jossey Bass Inc.

Belcher, J.R. (1988). Are jails replacing the mental health system for the homeless mentally ill? *Community Mental Health Journal, 24*(3), 185-195.

Bigelow, D.A., & McFarland, B.H. (1994). Financing Canada's mental health services. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 63-72). San Francisco: Jossey Bass Inc.

Bigelow, D.A., Sladen-Dew, N., & Russell, J.S. (1994). Serving severely mentally ill people in a major Canadian city. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 53-62). San Francisco: Jossey Bass Inc.

Bland, R.C. (1998). Psychiatry and the burden of mental illness. *Canadian Journal of Psychiatry, 43*(8), 801-810.

Boone, M., Minore, B., Katt, M., & Kinch, P. (1997). Strength through sharing: Interdisciplinary teamwork in providing health and social services to northern native communities. *Canadian Journal of Community Mental Health, 16*(2), 15-28.

Boyce, R.A. (2001). Organisational governance structures in allied health services: A decade of change. *Australian Health Review, 24*(1), 22-36.

Burgess, T. (1898). A historical sketch of our Canadian institutions for the insane. In *Transactions of the Royal Society of Canada.* Ottawa: Royal Society of Canada.

Canadian Health Services Research Foundation. (2001). *Listening for direction: A national consultation on health services and policy issues*. Ottawa: The Foundation.

Canadian Institute for Health Information. (1999). *National consensus conference on population health indicators: Final report*. Ottawa: The Institute.

Chief Coroner of British Columbia. (1994). *Report of the task force into illicit narcotic overdose deaths in British Columbia*. Victoria: Ministry of Attorney General.

Collaborative Working Group on Shared Mental Health Care. (2000). *Shared mental health care in Canada.* Ottawa: Canadian Psychiatric Association and the College of Physicians and Surgeons.

Crisp, A.H., Gelder, M.G., Ris, S. Meltzer, H.I., & Rowlands, O.J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4-7.

Davis, S. (1998). Injection drug use and HIV infection among the seriously mentally ill: A report from Vancouver. *Canadian Journal of Community Mental Health, 17*(1), 121-127.

Dear, M., & Wolch, J. (1987). *Landscapes of despair: From deinstitutionalization to homelessness*. Princeton: Princeton University Press.

Deutsch, A. (1937). *The mentally ill in America: A history of their care and treatment from colonial times.* New York: Doubleday.

Drake, R.E., & Mueser, K.T. (Eds.). (1996). *Dual diagnosis of major mental illness and substance abuse: New directions for mental health services*. San Francisco: Jossey Bass Inc.

Driscoll, L. (1998). *Mental health policy: A discussion paper*. Ottawa: Health Canada, Mental Health Promotion Unit.

Fayol, H. (1949). *General and industrial management*. London: Pittman.

Foucault, M. (1961). *Madness and civilization: A history of insanity in the age of reason.* New York: Pantheon.

Freeman, Stanley J.J. (1994). An overview of Canada's mental health system. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 11-20). San Francisco: Jossey Bass Inc.

Goering, P., Wasylenki D., & Macnaughton E. (1994). Planning mental health services: Current Canadian initiatives. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 31-40). San Francisco: Jossey Bass Inc.

Goetz, R.R., McFarland, B.H., & Ross, K.V. (2000). Effects of runaway health care costs. *New Directions in Mental Health Service, 85*, 1-3.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates.* New York: Doubleday.

Goldner, E.M., Abbass, A., Leverette, J.S., & Haslam, D.R. (2001). Evidence-based psychiatric practice: Implications for education and continuing professional development (CPA Position Paper). *Canadian Journal of Psychiatry, 46*(5), insert.

Gourlay, D. (1998). *A fiscal and legislative map of Canadian health and mental health systems*. Ottawa: Health Canada, Mental Health Promotion Unit.

Grob, G.N. (1973). *Mental institutions in America: Social policy to 1875*. New York: Free Press.

Grob, G.N. (1994). Mad, homeless, and unwanted: A history of the care of the chronic mentally ill in America. *Psychiatric Clinics of North America, 17*(3), 541-558.

Hammer, M., & Champy, J. (1993). *Reengineering the corporation: A manifesto for business revolution*. New York, Harper Business.

Health and Welfare Canada. (1988). *Mental health for Canadians: Striking a balance*. Ottawa: Ministry of Supply and Services Canada.

Health Canada. (1997). *Canada health action: Building on the legacy*. Volumes I & II, Reports of the National Forum on Health. Ottawa: Health Canada.

Health Systems Research Unit, Clarke Institute of Psychiatry. (1997a). *Best practices in mental health reform: A discussion paper.* Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Health Canada.

Health Systems Research Unit, Clarke Institute of Psychiatry. (1997b). *Best practices in mental health reform: A situational analysis*. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Health Canada.

Health Systems Research Unit, Clarke Institute of Psychiatry. (1997c). *Review of best practices in mental health reform.* Prepared for the Federal/Provincial/ Territorial Advisory Network on Mental Health, Health Canada.

Hiday, V.A., Swartz, M.S., Swanson, J.W., Borum, R., & Wagner, H.R. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric Services, 50*(4), 566-567.

Isaacs, S., Keogh, S., Menard, C., & Hockin, J. (1998). Suicide in the Northwest Territories: A descriptive review. *Chronic Diseases in Canada, 19*(4).

Jackson, S. (2000). A qualitative evaluation of shared leadership barriers, drivers and recommendations. *Journal of Management in Medicine, 14*(3-4), 166-178.

Jenkins, R. (2001). Making psychiatric epidemiology useful: The contribution of epidemiology to government policy. *Acta Psychiatrica Scandinavica, 103*(1), 2-14.

Kendrick, T., Burns, T., Garland, C., Greenwood, N., & Smith, P. (2000). Are specialist mental health services being targeted on the most needy patients? The effects of setting up special services in general practice. *British Journal of General Practice, 50*(451), 121-126.

Kirmayer, L.J., & Young, A. (1999). Culture and context in the evolutionary concept of mental disorder. *Journal of Abnormal Psychology, 108*(3), 446-452.

Kotter, J.P. (1996). *Leading change*. Boston: Harvard Business School Press.

Krasnick Warsh, C. (1989). *Moments of unreason: The practice of Canadian psychiatry and the Homewood Retreat, 1883-1923.* Montréal: McGill-Queen's University Press.

Lartin-Drake, J.M., Curran, C., & Gillis-Donovan, J. (1996). Improving the quality of health services organization structure by reengineering: Circular design and clinical case impact in an academic medical center. *American Journal of Medical Quality, 11*, 151-158.

Leighton, A.H. (1984). Barriers to adequate care for mentally ill people. *Social Science and Medicine, 18*(3), 237-241.

Lesage, A.D., Morissette, R., Fortier, L., Reinharz, D., & Contandriopoulos, A-P. (2000). Downsizing psychiatric hospitals: Needs for care and services of current and discharged long-stay inpatients. *Canadian Journal of Psychiatry, 45* 526-531.

Lomas, J. (2000). Using "linkage and exchange" to move research into policy at a Canadian foundation. *Health Affairs, 19*, 236-240.

Lomas, J., Woods, J., & Veenstra, G. (1997). Devolving authority for health care in Canada's provinces: An introduction to the issues. *Canadian Medical Association Journal, 156*, 371-377.

Macintyre, S., Chalmers, I., Horton, R., & Smith, R. (2001). Using evidence to inform health policy: Case study. *British Medical Journal, 322*(7280), 222-225.

Marks, I.M., & Scott, R.A. (Eds.). (1990). *Mental health care delivery*. Cambridge: Cambridge University Press.

McAlpine, D.D., & Mechanic, D. (2000). Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. *Health Services Research, 35*(1, Part 2), 277-292.

McCubbin, M., & Cohen, D. (1999). A systemic and value-based approach to strategic reform of the mental health system. *Health Care Analysis, 7*(1), 57-77.

McEwan, K., & Goldner, E.M. (2001). *Accountability and performance indicators for mental health services and supports: A resource kit*. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Health Canada.

Mercier C., & White D. (1994). Mental health policy in Québec: Challenges for an integrated system. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 41-52). San Francisco: Jossey Bass Inc.

Mercier, C., & White, D. (1995). [Mental health policies and the transfer of services to the community]. *Sante Mentale Quebec, 20* (1), 17-30.

Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Morgan, S. (1993). *Community mental health: Practical approaches to long-term problems.* London: Chapman & Hall.

Morrell-Bellai, T., Goering, P.N., & Boydell, K.M. (2000). Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing, 21*(6), 581-604.

Murray, C.J.L., & Lopez, A.D. (Eds.). (1996). *The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge: Harvard University Press.

Nasir, H. (1994). *Mental health and health care resource allocation*. Edmonton, AB: Alberta Health.

Narrow, W.E., Regier, D.A., Norquist, G., Rae, D.S., Kennedy, C., & Arons, B. (2000). Mental health service use by Americans with severe mental illnesses. *Social Psychiatry and Psychiatric Epidemiology, 35*(4), 147-155.

Newman, S.C., & Bland, R.C. (1987). Canadian trends in mortality from mental disorders, 1965-1983. *Acta Psychiatrica Scandinavica, 76*(1), 1-7.

Newman, S.C., & Bland, R.C. (1991). Mortality in a cohort of patients with schizophrenia: A record linkage study. *Canadian Journal of Psychiatry, 36*(4), 239-245.

Pandiani, J.A., Murtaugh, M., & Pierce, J. (1996). The mental health care reform debate: A content analysis of position papers. *Journal of Mental Health Administration, 23*(2), 217-225.

Peters, R., & Demerais, L. (1997). Improving mental health services for urban First Nations: Policy issues relevant to health care reform. *Canadian Journal of Community Mental Health, 16*(2), 29-36.

Pettifor, J.L. (1983). Who administered mental health? Fifty years of community mental health services in Alberta. *Canadian Mental Health, 31*(3), 24, 26.

Poulin, C., Gyorkos, T., Joseph, L., Schlech, W., III, & Lee, S. (1992). An epidemic of hepatitis B among injection drug users in a rural area. *Canadian Journal of Public Health, 83*(2), 102-105.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*, 276-288.

Rachlis, M., & Kushner, C. (1994). *Strong medicine: How to save Canada's health care system*. Toronto: HarperCollins.

Raynault, M.F., Battista, R.N., Joseph, L., & Fournier, L. (1994). [Reasons for the hospitalization and length of stay of a homeless population in Montréal]. *Canadian Journal of Public Health, 85*(4), 274-277.

Read, N., & Gehrs, M. (1997). Innovative service redesign and resource reallocation: Responding to political realities, mental health reform and community mental health needs. *Canadian Journal of Nursing Administration, 10*(4), 7-22.

Reinharz, D., Contandriopoulos, A-P., & Lesage, A.D. (2000). Organizational analysis of deinstitutionalization in a psychiatric hospital. *Canadian Journal of Psychiatry, 45*, 539-543.

Robbins, C.J., Bradley, E.H., & Spicer, M. (2001). Developing leadership in healthcare administration: A competency assessment tool. *Journal of Healthcare Management, 46*(3), 188-202.

Rochefort, D.A. (1997). *From poorhouses to homelessness: Policy analysis and mental health care* (2nd ed.). Westport, CT: Auburn House.

Roth, D., Lauber, B.G., Crane-Ross, D., & Clark, J.A. (1997). Impact of state mental health reform on patterns of service delivery. *Community Mental Health Journal, 33*(6), 473-486.

Scott, R.A., & Marks, I.M. (1990). Implementation and overview. In I.M. Marks & R.A. Scott (Eds.), *Mental health care delivery: Innovations, impediments and implementation*. Cambridge: Cambridge University Press.

Scull, A. (1989). *Social order/mental disorder. Anglo-American psychiatry in historical perspective.* Berkeley: University of California Press.

Seaburn, D.B., Lorenz, A.D., Gunn, W.B., Jr., Gawinski, B.A., & Mauksch, L.B. (Eds.). (1996). *Models of collaboration.* Oakland: HarperCollins.

Senge, P.M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York, Doubleday.

Shore, M.F., & Vanelli, M. (2001). Leadership. In J.A. Talbott & R.E. Hales (Eds.), *Textbook of administrative psychiatry: New concepts for a changing behavioral health system* (2nd ed., pp. 43-51). Washington, DC: American Psychiatric Publishing Inc.

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac.* New York: Wiley.

Shortt, S. (1986). *Victorian lunacy: Richard M. Bucke and the practice of late nineteenth century psychiatry*. Cambridge: Cambridge University Press.

Simmons, H.G. (1990). *Unbalanced: Mental health policy in Ontario, 1930-1989*. Toronto: Wall & Thompson.

Stephens, T. (1998). *Population mental health in Canada*. Ottawa: Health Canada, Mental Health Promotion Unit.

Stuart, H.L., & Arboleda-Florez, J. (2000). Homeless shelter users in the postdeinstitutionalization era. *Canadian Journal of Psychiatry, 45*(1), 55-62.

Taylor, F.W. (1911). *Scientific management*. New York: Harper & Row.

Torrey, E.F. (1996). *Out of the shadows: Confronting America's mental illness crisis*. New York: Wiley.

Torrey, E.F., Bigelow, D.A., & Sladen-Dew, N. (1993). *Quality and cost of services for individuals with serious mental illnesses in British Columbia compared with the United States*. Paper presented at the annual meeting of the National Alliance for the Mentally Ill, Miami, FL.

Torrey, E.F., & Zdanowicz, M. (1998, August 4). Why deinstitutionalization turned deadly. *Wall Street Journal*.

Trainor, J., Pape, B., & Pomeroy E. (1992). *Framework for support*. Toronto: Canadian Mental Health Association.

Trainor, J., Pape, B., & Pomeroy, E. (1997). Critical challenges for mental health policy. *Canadian Review of Social Policy, 39*.

van Uchelen, C.P., Davidson, S.F., Quressette, S.V., Brasfield, C.R., & Demerais, L.H. (1997). What makes us strong: Urban aboriginal perspectives on wellness and strength. *Canadian Journal of Community Mental Health, 16*(2), 37-50.

Wasylenki, D., Gehrs, M., Goering, P., & Toner, B. (1997). A home-based treatment program for the treatment of acute psychosis. *Community Mental Health, 33*, 151-162.

Wasylenki, D., Goering, P., & Macnaughton, E. (1994). Planning mental health services: Background and key issues. In L.L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental health care in Canada*, Vol. 61 (pp. 21-29). San Francisco: Jossey Bass Inc.

Weir, E. (2001). Inhalant use and addiction in Canada. *Canadian Medical Association Journal, 164*(3), 397.

Wright, K., Rowitz, L., & Merkle, A. (2001). A conceptual model for leadership development. *Journal of Public Health Management Practice, 7*(4), 60-66.

Zapf, P.A., Roesch, R., & Hart, S.D. (1996). An examination of the relationship of homelessness to mental disorder, criminal behaviour, and health care in a pretrial jail population. *Canadian Journal of Psychiatry, 41*(7), 435-440.

# Appendix A: List of HTF Projects Relevant to Mental Health

This appendix provides summary information on the HTF projects which were reviewed in the preparation of this document. For further information, please refer to the HTF website (www.hc-sc.gc.ca/htf-fass).

**(NA122) Safety of Persons Suffering from Dementia and Living at Home**

**Recipient: CLSC Côte-des-Neiges, Montréal**

**Contribution: $178,035**

This project developed and validated a questionnaire to evaluate risks to elderly people suffering from dementia and living at home. The questionnaire aimed to identify and reduce risks by assessing appropriate interventions and the impact of counselling the informal caregiver. The questionnaire was developed in two versions (short and long) and in two languages (English and French) through pilot work in urban, semi-urban, and rural settings in Alberta, British Columbia, and Quebec. Health care practitioners who had referred patients to the project were asked to review their patients' questionnaires. The response rate from practitioners was over 50 per cent in Quebec, only 15 per cent in Alberta, and zero in British Columbia. The authors feel that this tool can be used in all provinces to provide a structured assessment interview, particularly on first meeting with a patient who has dementia and is living at home.

**(NA149) Home Care and People with Psychiatric Disabilities: Needs and Issues**

**Recipient: Canadian Mental Health Association, Toronto**

**Contribution: $204,900**

This national study explored the issue of how adults with serious mental illness (not including Alzheimer's) in Canada might benefit from publicly funded home care services. The project conducted a national evaluation of the accessibility, appropriateness, and effectiveness of existing home care services for adults with serious mental illness by reviewing completed surveys from 77 branches of the CMHA and 140 home care organizations, comments from patients and families in 13 cross-Canada focus group sessions, and information from face-to-face interviews with 142 key stakeholders. Concurrently, site-specific pilot programs were developed, implemented, and evaluated in Taber, Ottawa, and St. John's, showing that there is a variety of ways to integrate mental health and home care. The report recommends a series of changes to policy and practice that would relieve the "revolving door syndrome" of the mentally ill cycling in and out of hospital: making admission planning to home care part of hospital discharge planning, providing more support to caregivers and home care staff, and undertaking intensive case management. The report also makes the case for improving the integration of home care and mental health services in all parts of Canada.

**(NA221) Benzodiazepine Use in the Elderly**

**Recipient: Association of Canadian Medical Colleges**

**Contribution: $618,455**

This national project tested the feasibility of a Canada-wide drug utilization review as well as a continuing medical education (CME) component for primary care physicians concerning appropriate benzodiazepine prescribing. The inappropriate prescribing of benzodiazepines in the elderly has been well documented. All eight provinces with medical schools have adopted their own approach to the issue. Ontario and Quebec were able to identify physicians with potentially inappropriate patterns of prescribing and to tailor education efforts to these individuals on a confidential basis. Interventions in the provinces included seminars, the mailing of written material, and patient education handouts. Four provinces also used academic detailing. Two provinces used interactive small-group CME. The thrust of the initiative in all locations was non-coercive and educational. At the time of reporting, follow-up analysis had been completed only in Newfoundland and Ontario; Newfoundland showed no major change in group prescribing data, and Ontario showed a very modest decline in individual prescriptions to seniors.

**(AB301) Alberta Primary Health Care Project**

**Recipient: Alberta Health and Wellness**

**Contribution: $11,112,759 – 27 Studies**

This report is a meta-analysis of the 27 Alberta evaluation and demonstration programs. The projects addressed primary health care through six key strategies: rural/remote access, illness prevention and health promotion through community development, early intervention and education, system restructuring, integrated service delivery, quality improvement, and community health centre models. Findings from these projects contribute, in various degrees, to an understanding of the six national dimensions of primary health care. Some projects found that existing methods of payment to physicians discourage them from participating in interdisciplinary and multidisciplinary activity. Many projects exemplified successful integrated service delivery and resulted in improved continuity of care. Others revealed a need for greater information sharing among providers, clients, public agencies, and administrators. Yet others emphasized the importance and benefit of early intervention and public awareness strategies. Rural projects demonstrated successful alternative strategies for advancing primary health care such as telehealth, "settlement nurses," remote health teams, and immunization schedule monitoring. All projects completed individual reports and are accompanied by fact sheets and summaries.

**(AB301-3) 8th and 8th Health Centre Proposal for a Formative Evaluation**

The operations at Calgary's 8th and 8th Health Centre, a downtown facility offering 24-hour urgent medical care as well as mental health, public health, continuing care services, and community liaison, were evaluated with the goals of improving the centre and, depending on the results, exploring the possibility of developing other similar centres in the region. The study found that the centre's services were used by a considerable number of individuals who neither work nor reside in the downtown core. The main reasons for visiting the centre included its location, convenience, clients' satisfaction with services and staff, short waiting times, and possibly the users' lack of a family physician. The study also suggested that when urgent care is incorporated into a health centre model, the continuity of care may be compromised.

**(AB301-9) Enhance and Evaluate COPE (Community Outreach in Pediatrics/Psychiatry and Education Program): A School-Based Primary Care Initiative**

This project looked at how to enhance and evaluate a school-based mental health program that identifies and diagnoses children with mental health problems. As well, the project investigated relationships between medical and school personnel and investigated the extent to which families were knowledgeable about their children's mental health. The project's ultimate goal was to reduce long-term social and health problems associated with the late identification of mental health problems. The study resulted in an earlier, more accurate, and more comprehensive diagnosis of children's emotional, behavioural, and learning difficulties. It also was found that the fee-for-service funding structure actively discourages physicians from working in school-based settings.

**(AB301-10) Shared Mental Health Care in Primary Care Practice**

This project sought to develop better links between family physicians and mental health providers (psychiatrists, psychologists, and nurses) by facilitating the delivery of mental health care in family physicians' offices. Mental health care was shared among three psychiatrists, 24 family physicians, three mental health nurses, and one psychologist. The study found that participating family physicians were more effective and confident in dealing with mental health issues and were better able to recognize, diagnose, and treat patients with mental health problems. They also spent more time counselling patients and seemed to prescribe psychotropic medications more appropriately. Patients also were satisfied, saying they appreciated the convenience, accessibility, and lack of mental health stigma when treated in their doctor's office.

**(AB301-13) Evaluation of Edmonton Centre for Survivors of Torture and Trauma (ECSTT)**

This project retrospectively evaluated services provided by the Edmonton Centre for Survivors of Torture and Trauma (ECSTT). The centre, which opened in 1994, assesses the needs of refugee immigrants who have suffered torture and trauma and provides referrals to appropriate services. The ECSTT also maintains an on-site therapist, coordinates children's and women's programs, and

trains lay counsellors. The study found that, overall, clients were happy with the support services and experienced improved mental and physical well-being. One of the key successes, especially for the Somali women, was the opportunity to meet others of the same ethnic origin, to speak their first language, and to share feelings of loneliness. Learning new skills – including speaking English, sewing, and using computers – was an important motivator to continue attending classes.

**(BC121) Home-Based Program for Treatment of Acute Psychosis**

**Recipient: Capital Health Region**

**Contribution: $187,000**

This 10-month trial sought to determine whether home care for acutely psychotic patients is an efficient and cost-effective alternative to hospitalization. In the experiment, 10 nurses working in a regional health setting received training that enabled them to manage 37 acute care episodes in private homes. Only three clients required a brief hospitalization or readmission. In a departure from conventional practice, five patients initiated Clozapine therapy in the home. No home support or social work staff beyond that ordinarily available to clients was found to be required. Although operating cost savings were modest, such programs avoid capital costs for additional psychiatric beds. Six months after the project was completed, the Capital Health Region announced funding for a permanent, expanded service based on this model.

**(BC124) Enhanced Case Management Project**

**Recipient: Upper Island/Central Coast Community Health Services Society**

**Contribution: $126,623**

This initiative sought to boost the knowledge and confidence of service providers and family caregivers who support non-institutionalized persons with dementia. The project developed and delivered a series of education and on-site sessions to home support workers, case managers, and home support supervisors. After training, case managers increased the time spent with family caregivers. All members of the support team benefited from an experimental, dedicated case management position at a local hospital to screen, manage, and discharge patients with dementia. Researchers found that more home support workers than expected were interested in the program. Participants said their knowledge, confidence, and team pride "immeasurably increased" as a result of this project.

**(BC403) Eating Disorders Project North (EDPN)**

**Recipient: Northern Interior Health Unit**

**Contribution: $277,870**

This 18-month project sought to help physicians and residents of rural and remote communities better prevent and treat eating disorders close to home. It involved 30 communities and 385 participants. Organizers convened a committee of regional advisers on a monthly basis, used surveys to investigate community needs and resources, and then prepared and offered a variety of multi-day training sessions on prevention, intervention, and therapy. The study suggests a theoretical framework that could be integrated into a provincial/federal policy on eating disorders. The framework describes and promotes a more comprehensive and integrated approach to prevention, intervention, therapy, and diagnosis, and it makes the case for more resources for treating eating disorders.

**(BC423) Mental Health On-line: A Case for Information Management**

**Recipient: University of British Columbia**

**Contribution: $251,250**

This project provided an in-depth, broad-based look at the multitude of issues surrounding information management in the mental health context in British Columbia. Information management encompasses the information itself, the management of process, the dissemination of information, and the management of technology. The report discusses issues of exchanging information among various users as well as among the client and family, to improve services to those with mental health concerns. It also examines criminal justice issues and issues of confidentiality and potential breaches of privacy. The report recommends the active involvement of people affected by mental illness in planning and developing information management systems, as well as more federal funding for an infrastructure of collaborative activities.

**(NS421) Enhancing the Care of People with Mental Illnesses in the Community: A Model for Primary Care Service Integration in the Area of Mental Health**

**Recipient: The Nova Scotia Hospital**

**Contribution: $397,200**

This project piloted a "Shared Care" model of mental health delivery to improve identification, early intervention, access to appropriate services, and outcomes. The Shared Care model deployed mental health workers and psychiatrists in primary care settings at four sites in Nova Scotia: an inner-city community health centre, an urban family medicine centre, a rural family practice, and a comparison site. Each intervention site had three FTE family physicians on salary and a receptionist, psychiatrist, and mental health worker. The comparison site had fee-for-service physicians. A total of 241 patients gave written consent to participate in the research. The evaluation found that patients at the intervention sites received improved access to appropriate mental health services: decreased waiting times, reduced visits to emergency, more referrals for mental health consultations at their own site, and high rates of patient satisfaction. The patients' mental health outcomes were improved, and there was improved collaboration and communication between health care providers.

**(ON321) Mental Disorders in Primary Care**

**Recipient: Centre for Addiction and Mental Health, Toronto**

**Contribution: $195,294**

This study investigated whether a special mental health training binder and workshop could improve primary care physicians' confidence and skill at recognizing, diagnosing, managing, and treating common mental health disorders. The training materials were developed by the World Health Organization Division of Mental Health and Programme of Substance Abuse, and the study found that focus groups preferred the content over drug-company sponsored materials. A total of 2,548 physicians in three settings was selected to receive the materials: binders, pre-test questionnaires, and an invitation to the CME credit workshop. The study evaluated two groups of doctors: those who returned the pre-test questionnaire and attended the workshop, and those who received the materials and did the questionnaires but did not attend the workshop. Physicians in both groups reported an increased confidence and skill in recognizing and treating depression and anxiety, but there was no difference between those who simply read the binder and those who attended the workshop. For substance abuse, however, those who attended the workshop reported an increase in confidence, whereas those who simply read the binder did not.

**(PE421) Autism Integration Project**

**Recipient: Prince Edward Island Department of Health and Social Services**

**Contribution: $171,831**

This two-year initiative aimed to improve treatment services for children with autism and their families by reducing dependency on out-of-province agencies and the need for long-term interventions. The project established a parent/professional committee to oversee the integration of services and train an autism program specialist. The project also set up a rotating autism clinic that brought together pediatric services, child psychology specialists, speech/language services, occupational therapists, and autism program specialists. Researchers concluded that the new model reduced parental stress and improved service delivery. Parents said that their children's physical, mental, social, and language skills improved. However, they also said the responsibilities of training and supervising in-home workers was extremely demanding.

**(QC407) Delivery of Integrated Care for Persons with Severe and Persistent Mental Disorders in Their Home Environment**

**Recipient: Douglas Hospital Research Centre**

**Contribution: $174,311**

Since September 1997, the Douglas Hospital, a psychiatric hospital in Montréal, has had a team of workers using the ACT (assertive community treatment) model, developed in the United States to treat in their own milieu patients who are suffering from severe mental health problems and who are difficult to treat in conventional settings. This project added to the ACT model a dimension of combating substance abuse in this population. Integrating the services helped address the needs of people who would otherwise be excluded from drug and alcohol treatment because of their mental health problems and excluded from mental health programs because

of their substance abuse. The researchers conclude that it is possible to transfer the ACT model from the United States to Canada, despite differences in their health systems. The evaluation of the project demonstrates a significant effect on quality of life for patients, although the project did not succeed in significantly reducing substance abuse. Overall, cost savings were approximately $4,000 per year per patient.

**(QC408) Integrated and Multisectoral Community Support for Persons with Severe and Persistent Mental Health Problems: New Start Housing**

**Recipient: Les Habitations Nouveau Départ**

**Contribution: $900,000**

This project evaluated the effectiveness of a project called Habitations Nouveau Départ (HND), an initiative designed to assist people with mental health problems address their housing and social integration needs. Clients were assigned to receive services in three ways: through Habitations Nouveau Départ, through community outreach from the Pierre-Janet Hospital, or through a combination of the two. The groups were then compared to see whether the HND program was more effective than the support offered through the hospital. Effectiveness was measured by the effects on the participants' mental health and by their use of other community services. The report concludes that support for adequate housing is an important part of the services offered to people with mental health problems.

**(QC424) Development and Evaluation of a Cultural Mental Health Consultation Service**

**Recipient: Sir Mortimer B. Davis Jewish General Hospital**

**Contribution: $449,676**

This project involved the development and evaluation of cultural consultation services in the field of mental health in three hospitals in Montréal, including a children's hospital. The goal was to improve access to culturally appropriate mental health services for patients from a range of cultural backgrounds, including immigrants, refugees, various ethnocultural groups, and First Nations and Inuit patients. One of the sites offered only consultation to other practitioners; the others provided treatment as well. They all used the services of interpreters and "cultural brokers" to overcome the barriers to communication. The evaluation showed that a culturally sensitive intervention improved assessment and treatment. The project also developed a database of community resources and a Web site with links to other sites related to cultural competence.

**(QC428) Evaluation of Geriatric Psychiatry Outpatient Consultation for Elderly Depressed Patients: Perspectives of the Patient and Family, Referring Physician, and Consultant**

**Recipient: St. Mary's Hospital Centre**

**Contribution: $35,013**

This study, carried out in the geriatric clinic of a Montréal hospital, provides information concerning what happens when a primary care physician refers a patient for a consultation with a geriatric psychiatrist. The current emphasis in Quebec on community-based health care (*le virage ambulatoire*) calls for hospital resources to play a consulting role; however, the researchers' literature search found no effective model of this interaction for geriatric patients. The geriatric consultation process included the views of the patient and family, the referring physician, and the consulting psychiatrist. Although most patients and primary care physicians were satisfied, there was only moderate agreement among primary care physicians and consultants as to the type of consultation requested, the reason for consultation, and the responsibility for further treatment. The report highlights some of the problems encountered in the consultation process and suggests simple ways to improve communication and thus improve patient care.

**(QC430) Info-Santé CLSC: Pilot Project for Telephone Intervention in the Area of Mental Health**

**Recipient: Centre hospitalier Pierre-Janet, Hull, Québec**

**Contribution: $225,143**

This project resulted in the development of 28 protocols to assist nurses answering a telephone help-line (Info-santé) to respond to callers with mental health concerns. The protocols addressed a variety of problems for a diverse clientele. Nurses received two days of training, and both the training and the protocols were well received. However, although nurses were able to answer most health-related questions, they felt ill-equipped in regard to mental health because their training was found to be too

general and did not cover the specific problems they encountered. The researchers note that two days of training is insufficient and that it should be followed by supervision over three months to allow nurses to integrate theory into their practice. Both the protocols (in English and French) and the training are available to other CLSCs. The authors note that a telephone call to a nurse costs about one fifth of the cost of a visit to the emergency department.

**(QC434) Putting in Place an Integrated System for Persons with Severe and Persistent Mental Health Problems**

**Recipient: Régie régionale de la santé et des services sociaux de Nunavik, Kuujjuaq, Québec**

**Contribution: $488,238**

This pilot project tackled growing psychosocial problems and high suicide rates in Nunavik by housing, supporting, and employing people suffering from severe and chronic mental health problems who might otherwise be sent to Montréal. The project's integrated approach built on pre-implementation work: preparing communities, spelling out objectives and procedures, and clarifying accountability. During the nine months of the centre's operation, 12 clients were served and achieved greater independence. The majority managed to deal effectively with their addictions problems; only one client was hospitalized during the program. As a result of this project, there is now a new resource in Inukjuak, and the study concludes that the materials developed by the project might be useful in other isolated communities.

**(SK324) An Evaluation of Integrated Services for Families of Aggressive School-Aged Children**

**Recipient: Battlefords Health District**

**Contribution: $171,600**

This project provided mental health services to aggressive school-aged children by moving those services from institutions to schools, homes, and the community. In doing so, it hoped to integrate services and reach children who are traditionally overlooked. The study involved 13 children from "multi-problem" families; the majority were of First Nations ancestry, male, and living in single-parent families or extended families. Most lived in lower-income households, all exhibited aggressive or defiant behaviour, and many were felt to be at risk for criminal conduct. Mental health professionals and social workers involved teachers, school administrators, and families, and services were provided after-hours and in a variety of non-conventional settings. A qualitative review of the data concluded that 10 of the 13 children experienced a positive change in their behaviour, but these results could not be confirmed in a quantitative review.

**(SK327) Survivor Services Program: Pilot Project Proposal for an Integrated Service Delivery Model with Adult Survivors of Childhood Sexual Abuse**

**Recipient: Tamara's House Services for Sexual Abuse Survivors Inc.**

**Contribution: $151,000**

In this project, Saskatoon's Tamara House, a non-profit, community-based, drop-in healing centre for female survivors of sexual abuse, conducted an evaluation of three non-conventional healing therapies: aroma-massage, a massage using oils and music; Reiki, the stimulation of meridian points to release energy blockages; and psychodramatic bodywork, an emotional-release therapy. Nearly half the participants also continued to receive therapeutic support from counsellors or self-help groups. Qualitative and quantitative data were collected from external evaluators, practitioners, and the participants. The women who participated in the study were enthusiastic about all three alternative therapies.

**(SK329) Day Care Consultation Services**

**Recipient: Saskatoon District Health**

**Contribution: $140,000**

This project aimed to overcome traditional barriers to mental health services for 112 at-risk pre-school-aged children in day-care settings. It also set out to increase the skills and knowledge of 91 child-care workers in dealing with children who exhibit aggressive or non-compliant behaviour. The project hired two full-time behavioural consultants, who provided assessments, referrals, support, and workshops for families and community staff. In addition, a group of community stakeholders met monthly to monitor and provide feedback to the team. Evaluation of the project suggested that these children, their families, and child-care workers benefited from the project. The children's behaviour improved, they received better access to services, and staff said that they learned much. Over half of the parent respondents said they

learned better ways of dealing with their children's behaviour at home. Overall, the model fit those in child-care centres better than it did those in family-care homes or infant centres.

**(SK423) Integrating Services for Families with Affective Disorder: Implementing and Evaluating a Preventive Intervention Program in Saskatchewan**

**Recipient: Prince Albert Health District**

**Contribution: $127,750**

Children of depressed parents are at a significant risk of developing psychiatric disorders in childhood or adolescence. This study implemented and evaluated two preventive intervention strategies and modified them for use in the Prince Albert Health District. The intervention was either a series of family meetings with a clinician about depression issues and family functioning or a lecture that covered similar material but did not include the child or family discussion. The evaluation found that brief, family-based intervention was satisfying and helpful to the patient and family. Up to six months after the completion of the project, 94 per cent of depressed patients and 78 per cent of spouses were moderately to extremely satisfied with both the lecture and the clinician intervention. The researchers found no significant difference between the outcomes of the lecture group or the clinician-facilitated group.