Running Head: RURAL MENTAL HEALTH SERVICES

Rural Mental Health Services for People with Severe and Persistent Mental Illness: Organization and Effectiveness

By

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A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
For the Degree of
Doctor of Philosophy

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Winnipeg, Manitoba

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FACULTY OF GRADUATE STUDIES
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Acknowledgements

This research has been a large undertaking, and would not have been possible without the support of a number of people and organizations.

First I would like to thank the Advisory Committee, Dr. Cam Mustard, Dr. John O'Neil, Dr. John Walker, and in particular Dr. Leslie Roos, committee Chair. Your mentorship, availability, guidance, patience, support and expertise have been greatly appreciated throughout the long process.

Second, I would like to thank the organizations that provided financial support for the project. Funding was received from:

- The Brandon University Research Committee for a networking grant that laid the foundation for this work;

- Dr. Robert Annis, Director of the Rural Development Institute, who provided financial assistance for fieldwork and support for dissemination of findings at conferences; and

- The National Health Research Development Program, who sponsored this work in part through a National Health PhD Fellowship to Jean Renée Robinson (6607-1786-47)

Assistance was also provided from funding to Dr. Leslie L. Roos through the Canadian Institute for Advanced Research.

Acknowledgements would not be complete without recognizing the contribution of regional health planners, Mental Health Program Managers and their staff, Outreach Workers from Self-Help organizations and, most importantly, the consumers who participated in this study. Your insights are central to the value of this work.

And last, but not least, I would like to thank my husband, Gordon Chester, for his ongoing love, support and personal sacrifice which were instrumental to completion of the thesis.

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List of Abbreviations

ADAM	Anxiety Disorders Association of Manitoba
ADL	Activities of Daily Living
BMHC	Brandon Mental Health Centre
CFS	Child and Family Services
CMHA	Canadian Mental Health Association
CMHW	Community Mental Health Worker
CSU	Crisis Stabilization Unit
CQI	Continuous Quality Improvement
EDC	Employment Development Counselor
EDW	Emergency Duty Worker
EMHC	Eden Mental Health Centre
HSRU	Health System Research Unit
ICM	Intensive Case Management / Manager
MCU	Mobile Crisis Unit
MDAM	Mood Disorders Association of Manitoba
MSS	Manitoba Schizophrenia Society
PSR	Psychosocial Rehabilitation
QLI-MH	Quality of Life Index for Mental Health
QoL	Quality of Life
RHA	Regional Health Authority
SMHC	Selkirk Mental Health Centre
SPMI	Severe and Persistent Mental Illness

Abstract

Background:

Major mental health reforms are being implemented based on efficacious models of community based care. However, these models of care are necessarily adapted to local environments. Rural and remote regions in particular may need to make substantial alterations in programs since model programs have largely been developed in urban environments.

Objectives:

The purpose of this research was to describe adaptations made to service models to suit rural environments, and to examine the effects of adapted service models on individuals who are most affected by changes in service delivery, people with severe and persistent mental illness (SPMI). The first objective was to describe adapted services. Description was based on review of public documents and interviews with key informants in each of the rural Regional Health Authorities (RHA) in Manitoba. The second objective, description of the consumers' perception of service quality (availability, accessibility, acceptability and appropriateness), was assessed through semi-structured interviews with people with SPMI (N=80) in nine rural RHA. The third objective, description of consumers perceived Quality of Life (QoL) under enhanced community-based delivery, was assessed using the Quality of Life Index for Mental Health (Becker, Diamond, & Sainfort, 1993).

Results:

This study found substantial differences between rural RHA in how core services were delivered, and the extent to which new services were established during the period of mental health reform. A number of innovative programs were identified, as well as potential problems with some service delivery methods. These availability of services, and specific methods of

service delivery appear to have a substantial effect on consumer satisfaction with services. New services, such as crisis services, proctor services and social / recreational programs were particularly appreciated. The new services were reported to have assisted in avoiding adverse outcomes, such as suicide, institutionalization or homelessness, as well as promoting health and recovery. Significant differences were found between RHA in QoL scores. The strongest predictor of QoL was the presence of social / recreational programs, which accounted for 87.4% of the variation in weighted QoL. This finding is particularly interesting since social / recreational programs are not core elements of current service models for people with SPMI.

Conclusions:

This study contains important information that will assist service planners in enhancing service delivery. The study may also contribute to revision of current service delivery models if the results are replicated.

Introduction

Since the late 1980s, every Canadian province has undertaken major mental health reforms. These reforms include development of a range of community-based services and downsizing of the acute care sector while increasing consumer participation in all aspects of care. The initiatives that have been implemented are based on efficacious models of community-based care. However, these models of care are necessarily adapted to local or regional environments rather than being a replication of original models. Rural and remote regions in particular may need to make substantial alterations in programs since model programs have largely been developed in urban environments. To date there has been limited description of these modified services, or the effects of these modifications. The purpose of this research is to describe adaptations of model services to suit rural environments and to examine the effects of adapted service models on consumers. The research focuses on people with severe and persistent mental illness (SPMI) as they are often intensive users of services and require a full range of supports. It is anticipated that this group of people will be particularly sensitive to service quality.

Background

The population of provincial psychiatric hospitals across Canada grew until 1948 by which time they had become crowded and custodial accommodations. Under the National Health Grants Program in 1948, funds were made available to extend and improve mental health services. This, in combination with increasingly available pharmacological treatments and growing pressure from civil rights advocates, led to the closure of several psychiatric hospitals in the 1960s and movement in the direction of shorter hospitalizations in acute care hospitals. However, acute care hospitals provided treatment to individuals who were less seriously ill and

had not previously received inpatient care. Many people with SPMI found themselves homeless or incarcerated in jails; others lived in the community with substantial symptoms, unable to function in meaningful social or occupational roles and faced with fragmented services (Goering, Wasylenki, Goering & MacNaughton, 1992). In the 1970s, provincial governments began to fund community mental health programs to meet the needs of people with SPMI but the scope of these services still largely failed to recognize and meet the spectrum of their needs.

Initial deinstitutionalization efforts in both Canada and the United States failed in part because efforts were directed at relocation, with a focus on housing and provision of clinical services. Neither the clinical and housing needs, nor the basic human needs of people with SPMI were being met. Psychiatric institutions, which had functioned as 'total institutions' needed to be replaced with services that considered the full range of needs of people with SPMI (Scott & Dixon, 1995). As pointed out by Kane (Penn & Muesner, 1996), "an array of high quality clinical services does not substitute for shelter, clothing, food, social supports, employment etc." (p. 105).

In response to high readmission rates and the marginal, isolated existence of many individuals with SPMI living in the community, new models of treatment, such as the Training in Community Living model (Penn & Muesner, 1996), were developed. These models considered housing and clinical needs as well as the full range of services and supports necessary to meet the needs of people with SPMI. By 1980, the components of a community support system for people with SPMI had been identified. The components of a community support system include: 1) client identification and outreach, 2) mental health treatment, 3) crisis response services, 4) health and dental services, 5) an array of stable housing alternatives, 6) assistance in obtaining income and support entitlements, 7) peer support, 8) family and community support, 9)

rehabilitation services and 10) protection and advocacy (Solomon, 1992). These components, delivered in a case management framework (Assertive Community Treatment or Intensive Case Management), have demonstrated effectiveness in reducing hospital use and increasing housing stability with moderate effects on symptoms and Quality of Life (QoL) (Solomon, 1992; Scott & Dixon, 1995; Burns & Santos, 1995; Muesner, Bond, Drake & Resnick, 1998).

In 1988 the Manitoba government, like other governments across Canada, began consideration of major changes in the mental health care system. The document *A New Partnership for Mental Health in Manitoba* (Manitoba Health, 1988) identified shortages of community mental health services and fragmentation of care. The document recognized the need for a full range of services. Building on the 1988 policy paper, a consultation paper titled *Building the Future of Mental Health Services in Manitoba* (Manitoba Health, 1992) was released. This document identified those most in need of care as having priority for services, and announced relocation from institutions to the community following development of enhanced community based services. These enhanced services included all the components of a community support system. Specifically, the document made provision for assessment/identification services, acute care treatment, 24 hour mobile crisis intervention services, crisis stabilization services, supportive housing options, self-help and family support, psychosocial rehabilitation (including vocational services), intensive case management, long-term care/treatment capacity and prevention/promotion and public education services.

Since 1992 each of the regions in the Manitoba have moved to develop and implement the elements of this community support system while adapting services to meet their unique needs. Following a move to regional governance in Manitoba, all of the elements were identified as core services (Northern Rural Regionalization Task Force, 1997). This means that each

Regional Health Authority (RHA) must provide the service or provide access to the service. The package of services also appears to be validated by the national *Best Practices* document (Federal / Provincial / Territorial Advisory Network on Mental Health, 1997) that recommends inclusion of these as elements in an effective mental health service system.

To summarize the above information, a specific set of services necessary to the provision of quality community-based services for people with SPMI has been identified, efficacious models have been developed and the documents produced by governments are consistent with best practices. However, the need to adapt these model programs based on geographic, political, socioeconomic and ethnic factors (Bachrach, 1988b; Stroul, 1989) is well known. Program fidelity remains an issue since greater program fidelity produces better outcomes (Scott & Dixon, 1995). Little is known about the ways in which model programs are modified or the effectiveness of these services once they are modified to accommodate local realities.

Adaptations are made based on factors such as availability of personnel and geographic dispersion of the population. A review of the literature in the United States conducted by Lishner, Richardson, Levine and Patrick (1996) found consistent evidence that local health care systems in rural areas fail to adequately address the needs of individuals with disabilities such as mental illness. Lishner et al. point out a number of factors that contribute to service quality in rural areas. Specifically, rural areas may have difficulty attracting and retaining qualified health professionals, resulting in fewer professionals, lower qualifications and greater use of paraprofessionals. In addition, with smaller numbers of people with specific disabilities, provision of specialized services becomes difficult. Professionals need to provide a broad range of services, making it difficult to have expertise in all areas. Further, information that would assist in providing specialized services may also be more difficult to access in rural areas. Fewer

services are available and distance to available services, especially tertiary services, also presents

barriers. Rössler (1999) for instance reports that admissions per thousand population decreases

dramatically as distance to services increases.

It is important to note here that services delivered in rural areas may have advantages as

well as limitations. Smaller numbers of providers and closer networks may create a more

integrated and coordinated service. Further, social networks in rural communities may provide

greater support to people with SPMI. Whatever the direction of influence, it is clear that local

realities are likely to influence the implementation of efficacious models, and that outcomes for

people with SPMI may also differ.

Objectives

The specific objectives of this research are to:

1. Describe adaptations of model mental health programs made to suit the rural environment;

2. Describe consumers' perception of service quality (availability, accessibility, acceptability

    and appropriateness); and

3. Describe consumers perceived QoL under enhanced community-based delivery, and the

    extent to which service delivery characteristics contribute to QoL.

Separate methods are used to achieve each of these objectives. Objective one was

achieved through review of public documents and interviews with key informants in each of the

rural RHA. Objective two was achieved through semi-structured interviews with people with

SPMI in each of the rural RHA. Objective three was examined through interviews with these

same people with SPMI using the Quality of Life Index for Mental Health (Becker, Diamond &

Sainfort, 1993). Since the methods, and literature, for each objective differs, this document is

organized according to the objectives. Relevant literature, methods, results and discussion are

included with each objective. A summary and discussion of the entire project follows the third

objective. Before addressing the objectives however, some discussions about definitions and

ethics that apply to the entire project are required.

Study definitions

This study involves people with SPMI living in rural Manitoba. Due to difficulties in

specifying both "rural" and "severe and persistent mental illness", the use of these concepts for

this study must be delineated. Description of the terms "best practices" and "model services" are

also provided.

Rural

There are no clear parameters for defining "rural" as there is no natural or theoretical

basis for such a definition (Humphreys, 1998). Definitions may use simple geographic location

(Davies, Bromet, Schulz, Dunn & Morgenstern, 1989) or combine this with population density,

distance to services (Yuen, Gerdes & Gonzales, 1996) or even social variables associated with

rural life (Martin Matthews, 1988). Even a single organization, such as Statistics Canada, may

use any of a variety of definitions depending on the context of the study (Statistics Canada,

1997).

This study is being conducted based on service configuration within RHAs, which are in

turn based on a geographic definition. Geography then is a central component of the definition of

rural for this study. Further, since the region is the level of analysis, a definition of rural that is

useful for understanding regional issues is desirable for this study. Of the six definitions used by

Statistics Canada, two are considered useful for conducting such analyses, the Organization for

Economic Cooperation and Development definition and modified Beale Codes (du Plessis,

Beshiri, Bollman & Clemmensen, 2001).

The Organization for Economic Cooperation and Development definition of a rural

region involves the proportion of the regions population living outside rural communities. Rural

communities are defined as communities with less than 150 people per square kilometer. If

applied to the existing health regions in Manitoba, virtually none would qualify as predominantly

rural. For instance, using the Statistics Canada Community Profiles[1], many small towns have a

population density greater than 150 people per square kilometer. Virden, with a population of

3,109 and a land area of 8.57 has a population density of 362.8 people per square kilometer. The

population density for even smaller areas such as Souris (population 1,683 and land area 2.83

square kilometers – 594 people per square kilometer) and Shoal Lake (population 801 and land

area 2.55 square kilometers – 314 people per square kilometer) exceeds the threshold. Given the

geographic context of these regions, and the absurdity of planning "urban" mental health services

for a community of 800 people, this definition does not appear to be useful.

The Modified Beale Codes described by du Plessis et al. (2001) define Metropolitan and

Non-Metropolitan regions, based on the size of settlements within the region and according to

adjacency to metropolitan areas. Using this definition, the City of Winnipeg, with a population of

619,544, would define the Winnipeg RHA as a Mid-sized metropolitan area and the City of

Brandon, with a population 39,716, would define the Brandon RHA as a Non-metropolitan small

city zone. The remaining regions in Manitoba contain settlements of at least 2,500 and less than

19,999 making them Small town zones. It is in this context that rural is defined for the purpose of

this study: rural regions are non-metropolitan regions. The rural regions included in this study

are: Assiniboine, Brandon, Burntwood, Central, Interlake, Nor-Man, North Eastman, Parkland

and South Eastman.

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[1] Population estimates and land areas are based on Community Profiles obtained from the Statistics Canada website. The population is based on 2001 data.

Severe and Persistent Mental Illness

Defining SPMI and identifying the population with SPMI is also problematic. Although it is generally agreed that the definition of SPMI includes diagnosis, duration and disability (Bachrach, 1988a), there are challenges in delineating each of these dimensions. Lack of precision in diagnosis and a wide range of outcomes within a single diagnostic category, levels of disability that fluctuate with the natural course of disorder, and varied domains of disability all complicate definition of SPMI.

In 1987, the National Institutes for Mental Health hosted a consensus conference to develop a definition of SPMI (Bachrach, 1988a). The definition developed by the National Institutes for Mental Health requires an International Classification of Diseases (ninth edition) diagnosis of non-organic psychoses or personality disorder, at least three of nine eligibility criteria for Social Security Disability Insurance and prolonged illness and long-term treatment. However, this definition has not been widely adopted. Further, Social Security Disability Insurance criteria may not be meaningful to service providers or decision-makers outside the United States.

As with the definition of "rural", the definition of SPMI is often specific to a particular study (Schinnar, Rothbard, Kanter & Jung, 1990). In Manitoba, eligibility criteria for the Intensive Case Management (ICM) program was used to provide a basis for a study definition of SPMI. The definition used in this study is very similar to that of the consensus conference and yet is familiar to providers in the regions. Specifically, eligibility criteria for this study are based on eligibility criteria for ICM services in Westman (Westman Region Mental Health Services Manual, 1995). Westman eligibility criteria have been modified to exclude individuals over the age of 64, whose service needs may differ from needs of younger adults, and to include

individuals who are not receiving services. Further, individuals with SPMI but not suitable for

rehabilitation programs due to lack of commitment to rehabilitation goals, continue to be eligible

for this study (Appendix A). It is important to note that program participation is not synonymous

with eligibility for the study. RHA were asked to identify individuals who meet these criteria,

regardless of participation in mental health programs.

Best Practices

The term "best practices" used in this document is based on the description in National

documents. In general "best practices" are "activities and programs that are in keeping with the

best possible evidence about what works" (Health Systems Research Unit [HSRU], 1997a, p ix).

Best Practices in Mental Health Reform is a series of three documents prepared by the HSRU at

the Clarke Institute of Psychiatry for the Federal / Provincial / Territorial Advisory Network on

Mental Health and Health Canada. The first document, titled *Review of Best Practices in Mental*

Health Reform (HSRU, 1997a) was a "critical evidence-based review of the current state of

knowledge about best practices relevant to mental health reform, with a focus on chronic and

severe mental illness" (HSRU, 1997c, p v). The second document, titled *Best Practices in Mental*

Health Reform: Situational Analysis (HSRU, 1997b) described current initiatives in Canada that

provided guidance on how to improve service systems in the direction of best practices. The third

document, *Best Practices in Mental Health Reform: Discussion Paper* (HSRU, 1997c)

synthesized information from the two earlier documents, and created a set of criteria that were

intended to "be used as guidelines for system planning and assessment of performance" (HSRU,

1997c, p v). The document includes a series of recommendations and a checklist of key elements

of a reformed system of care, including both core programs (referred to in this document as

system components) and system strategies referred to in this document as system characteristics).

These documents, and in particular the discussion paper, provide the framework for the description of services in objective one, although some modifications have been made. Unless otherwise indicated, the term *Best Practices* refers to the discussion document (HSRU, 1997c).

Model Services

"Model services" refers to specific models of service delivery that appear in the literature. Specific models are identified in the *Best Practice* documents as being desirable. For instance, the checklist criteria for case management services states "An array of clinical case management programs are in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models. There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders" (HSRU, 1997c, p 11). Clinical case management, rehabilitation, personal strengths and ACT are all models of service delivery.

Two other terms used in this paper require some mention. The first term is "case management". Persons using mental health services have expressed the view that they are not "cases" to be "managed". While the author recognizes that the term can be considered offensive, suitable alternatives have not been identified. As a result, the term is used throughout this paper to refer to a method of service delivery. Similarly, the term "consumer" can be problematic. Again, in the absence of suitable alternatives, the term "consumer" will be used in this paper to refer to people who are, or would be eligible for, mental health services. Neither term is intended to cast people with mental health problems in a negative light.

Ethics

The protocol for this study was approved by both the University of Manitoba Research Ethics Board (Faculty of Medicine) and the Health Information Privacy Committee (formerly the

Manitoba Access and Confidentiality Committee). Approval from the Research Ethics Board was received in May, 2000 with approval from the Health Information Privacy Committee in October, 2000. The Research Ethics Board approved protocol revisions based on Health Information Privacy Committee recommendations in November 2000. Annual approvals were obtained from the Research Ethics Board, with current approval until April 2005.

Regional Health Authorities

In this study, protection must be provided for both consumers and for RHA. Specific provisions for protection of RHA involve approval of the work within the region, use of multiple data sources for collecting information about regional service delivery, plans for addressing discrepancies, providing an opportunity for regional review prior to inclusion in this document and discussion of potentially sensitive areas without attribution of comments to specific regions. Initially, a letter of invitation and a copy of the protocol were sent to the Chief Executive Officer of each rural RHA. The process for approval within regions differed but regional protocols were followed in all cases. Additional information and copies of annual ethical approval were provided as requested.

Multiple data sources were used to collect information in each region. Information from key informant interviews was supplemented by information from a variety of sources including annual reports, websites and brochures collected while in the regions. There were few discrepancies between data sources and, where discrepancies existed, clarification was sought. If discrepancies continued to exist, each perspective was included.

Information from the various sources was synthesized into a description of services in each region. In the fall of 2002 each region was provided with the synthesis and asked to review the synthesis for accuracy. The description was then revised based on feedback from the region.

Checking the information with the region provided an opportunity to correct any misconceptions prior to inclusion of the material in the thesis.

Some potentially sensitive issues were identified in the key informant issues. These issues were excluded from regional descriptions where they might be attributed to specific individuals. These issues were discussed in the synthesis without attributing comments to specific regions, and with recognition that the synthesis often reflected comments made by several people.

Regions are also protected in the analysis of the second and third objectives. The focus for these objectives is on how specific services are delivered. For each analysis, regions are grouped together based on the way service is delivered. The grouping changes for each analysis. For instance, a single region might be grouped in one way based on availability of ICM services and differently based on availability of Mobile Crisis Unit (MCU) or inpatient beds. Consumer satisfaction with services and quality of life is discussed in the context of methods of service delivery rather than by RHA. Further, on request, each region will be provided with specific information on satisfaction with services and reported QoL from consumers in their region. This information will allow regions to obtain direct but confidential information useful for planning.

Consumers

As with any study involving a vulnerable population, protection of people with SPMI is of primary importance. Besides the usual precautions in terms of obtaining informed consent (Appendix B) and protection of data, a number of additional issues must be considered. These issues include protection of identity as a person with SPMI and potential fragility of individuals.

In order to protect the privacy of individuals, the RHA did not identify the population directly to the researcher. RHA were asked to apply the selection criteria to their population. The

selection criteria contain provisions for ensuring that: 1) the individual is mentally competent to give consent for participation; and 2) would not be unduly distressed by an interview. Once the RHA identified eligible individuals, consumers were approached by their case manager and asked to send in a response card identifying that either they are willing to be contacted to hear more about the study or that they do not wish to be contacted (Appendix C). Note that the response card only seeks consent to be contacted, not consent to participate. The card also contained the researchers phone number so potential participants could, if desired, ask questions prior to making a decision. Only consumers who were willing to be contacted provided their name and a contact telephone number. As an additional protection of client identity, the response cards were mailed to the secretary for the Health Information Privacy Committee. Cards were screened before being forwarded to the researcher to ensure that identifying information was only found on cards indicating willingness to be contacted.

Case managers were asked to prompt clients to mail the self-addressed and stamped response card, but would not know whether the client agreed to be contacted, much less whether the client had agreed to participate. In short, the researcher only had contact with individuals who agreed to be contacted and the RHA did not know who participated. A similar protocol for contacting potential participants was used in an earlier study conducted by Prairie Research Associates for Manitoba Health.

To increase client comfort with the interview, clients were invited to have someone they trust present during the interview. Although RHA were asked to exclude consumers who might be unduly distressed by participation, local mental health services were contacted to let them know when interviews were being conducted in the region. Individuals experiencing any distress in the interview were reminded that they could stop the interview at any time. Even in the

absence of evidence of distress, information on local resources was often provided to the participant as a precaution.

Although the interview was not the source of distress, a small number of participants were distressed at the interview. In this instance, consumer needs took priority over completion of the interview. In one case this meant that, after ensuring client safety, the interview was terminated by the researcher.

Data from the interviews is stored in a locked cabinet in a locked room. Names were not attached to interview information and a sheet linking the name and number is maintained separately.

Objective 1 – Adaptations of Mental Health Programs

Introduction

The overall premise of this study is that rural mental health services, while based on efficacious models of service delivery, may differ substantially from the original models. This component of the study is designed to describe adaptations of model mental health programs made to suit the rural environment, and explore possible strengths and limitations of various adaptations.

Methods

Description of the availability of community-based services, structure and functioning of these services and adaptations to suit the rural environment were obtained through review of public documents and interviews with key informants in each of the rural RHAs in Manitoba (Appendix D, Figure 1). Using the key elements of a reformed mental health system of care identified in the *Best Practices* document (HSRU, 1997a), questions were asked about how components of a system of care are delivered (Appendix E). Specific components based on the *Best Practices* document included case management, crisis services, housing, inpatient services, vocational / educational supports, and self-help / family self-help.

Questions were also asked about social / recreational supports and psychiatry / psychology. The former was included as a number of regions provide or support social / recreational opportunities which may influence service satisfaction and QoL for people with SPMI. The latter was included on the basis of interviews with consumers. During these interviews the availability of psychiatry / psychology and the nature of the relationship with these professionals emerged as important. As a result, follow-up questions were asked of the regions about the availability of psychiatry / psychology services.
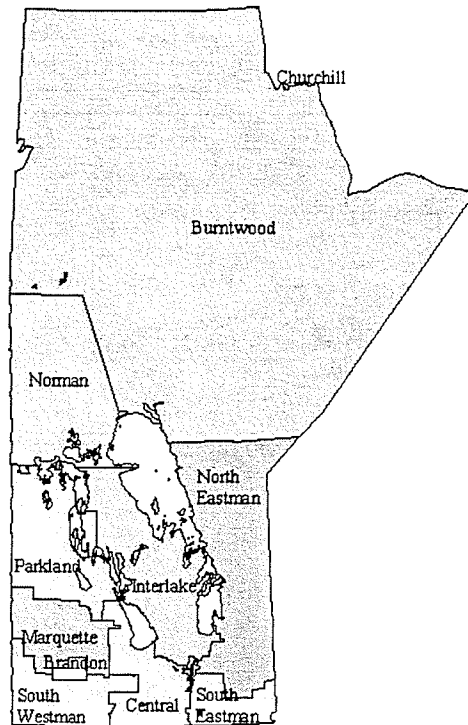
Figure 1: Map of Manitoba rural Regional Health Authorities[2]

In addition to questions about system components, questions were asked about selected characteristics of the system of care. These characteristics provide the context within which key services are delivered. Questions about system characteristics include coverage (size and population of the region, size and distribution of the SPMI population, service provision to First Nations people and extent to which service is obtained out of region), accountability (extent to which the mental health manager is directly responsible for core programs), integration of services (formal or informal linkages between services), budget change (new services established as a result of mental health reform), monitoring / evaluation initiatives, availability of qualified human resources and access to continuing education. An opportunity was also provided for regions to identify unique characteristics of their region that affected service delivery.

Between April and June 2000, the researcher traveled to each of the nine regions to conduct interviews with key informants. Informants were identified by the RHAs based on the necessary expertise to respond to the interview. The mental health program manager was interviewed in each region and, if a number of different managers were responsible for different programs, each was interviewed. For instance, only the Mental Health Manager was interviewed in Assiniboine, but in Brandon, where different managers are responsible for the Adult Community Mental Health, Centre for Adult Psychiatry (inpatient services), Crisis Services, and Psychosocial Rehabilitation Program, all were interviewed. In some instances it was possible to speak with case managers and resource development personnel. Further, since self-help organizations operate independently of regional services, information was collected from or about each of the self-help groups in each region. Interviews with mental health managers were audio taped. Between one and eight interviews were conducted in each region (Appendix D).

Information from key informant interviews was supplemented by information from a variety of sources including annual reports, websites and brochures collected while in the regions. Information from the various sources was synthesized into a description of services in each region. There were few discrepancies between data sources and, where discrepancies existed, clarification was sought. In the circumstance where one informant was in a better position to provide information, information from that person was included. For instance, if the description of services offered by a self-help group differed between the regional manager and the Outreach Worker for that organization, the description provided by the Outreach Worker was included.

In the fall of 2002 each region was provided with a draft description of services. Review for accuracy was requested and, since two years had elapsed between the interviews and

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[2] Marquette and South Westman have since merged to form Assiniboine Regional Health Authority.

preparation of the description, managers were asked to provide updated information on any areas that had changed. The description was then revised based on feedback from the region. Checking the information with the region provided an opportunity to correct any misconceptions prior to inclusion of the material in the thesis. Individual regional descriptions are included as Appendix F.

Model Services and Rural Service Delivery

Objective one is intended to describe how model mental health services are adapted to suit the rural environment. This section synthesizes information from each rural RHA. Methods of service delivery for each of the components of Best Practice services, and selected aspects of Best Practice system characteristics are described. Specific services include: psychiatry / psychology services; case management services; crisis services; inpatient services; housing supports; vocational / educational services; social / recreational services; and self-help / family initiatives. System characteristics include: context of service delivery; accountability; integration / linkages; budget; monitoring / evaluation; human resources; and continuing education. Changes occurring over the period of mental health reform, models for delivery of specific services and the *Best Practice* criteria are also discussed.

This section further includes discussion of potential strengths or challenges posed by specific delivery methods. It should be noted that this discussion was not included in regional descriptions where they might be attributed to specific individuals. Many of the identified issues were shared by more than one region. Description of the issues then represents the authors' synthesis of information from more than one informant.

The reader should also be aware of the limitations of this description. First, each description, and the resulting synthesis, is a simplification of a complex system. Second, the

description does not attend to the full range of mental health or community services available within the RHA. This study focuses on services to the adult population and on direct service delivery. As a result, services provided to children and elderly adults are not discussed. Services directed at the community at large, such as health promotion or community postvention, are also excluded. Third, this description focuses on public services in the specialty mental health sector. For the purposes of this objective, services provided by private counselors or family physicians are not discussed. It should also be acknowledged that mental health services are only one component of a community resource base (Trainor, Pomeroy & Pape, 1993). Description of these other components is beyond the scope of this project. The fourth limitation of this description is the dynamic nature of the health and mental health services system. The descriptions of regional services were obtained, compiled and reviewed by regions for accuracy as of 2002/2003. Where the author is aware of changes subsequent to 2002 these are mentioned, but service changes occurring after the regional review may not be captured.

Finally, it must be acknowledged that questions were not specifically asked about strengths or challenges of specific delivery methods. As a result, the inventory of issues is acknowledged to be incomplete.

System Characteristics

Context of service delivery.

Each region is in some ways unique. Substantial differences exist between regions with respect to the size of the population and area served, and the size and distribution of the population with SPMI. Each of these parameters can influence how services are delivered. For instance, there are inherent differences between delivery of mobile crisis services in the Brandon

RHA, which is very contained, and the Parkland region where 200 km separate major population centers.

Although differences exist, there are also a number of similarities. Statistics Canada (2002b) used data collected at the health region level, mostly through the 1996 Census of Canada, to cluster regions based on social and economic health determinants. The variables considered were extensive and included population change, demographic structure, social status, economic status, ethnicity, aboriginal status, housing, urbanization / metropolitan influence, income inequality and labour market conditions. In the regions studied, Brandon, Burntwood and Nor-Man are unique but North and South Eastman, Interlake and Central were considered to be similar to one another. Assiniboine and Parkland are also considered to be similar to one another.

Regions are arranged in order of size in Table 1. Regions range in size from Brandon, which is essentially a small city, to Burntwood, which covers more than half a million square kilometers. Comparison of size is complicated to some degree by the fact there may be large segments of the region that are uninhabited or that are not served due to isolation of the communities. For instance, one-third of the area of North Eastman is accessible only by air, water or winter roads. Mental health service is not provided in this area. Similarly, a large portion of the Burntwood RHA is uninhabited or has small isolated communities. Again, service is not provided in this area.

Population size has a narrower range, but substantial differences also exist in this area. The size of the population in the largest (Burntwood) and smallest (Brandon) regions is similar. Nor-Man, which has the second largest area, has about half the population of Brandon and Burntwood while Central RHA, a relatively small region, serves twice as many people as Brandon RHA.

Some regions have a sizeable population of Aboriginal people who do not receive mental health services in their communities. The issue of jurisdiction over services for aboriginal people is complicated. Manitoba Health has taken the position that non-insured services for Status Indians resident on reserve are not a provincial responsibility (Burntwood RHA, 2001). With the exception of Nor-Man, where a First Nation community is contiguous with the main population center, RHAs do not usually provide service on reserve. However, all RHAs provide service to First Nations people off reserve.

Interestingly, neither size nor population appears to be a decisive factor in distribution of services. The largest region provides almost no service outside the main population center. In contrast, the second largest region provides weekly, or at minimum bi-monthly, itinerant service to a large number of isolated communities, including Cormorant, Easterville, Moose Lake, Pukatawagan and Snow Lake. The third largest region, like all remaining regions, provides services on a distributed basis through geographically distributing workers. Assiniboine, North and South Eastman provide a particularly distributed service. Central, Interlake and Parkland have concentrations of consumers in the regional population centers, but do provide some service to people with SPMI on a distributed basis. Consumers appear to be distributed in a similar fashion to services. The extent to which service distribution determines distribution of clients, or the converse, is unknown. Distribution of clients and services may also be the result of reciprocal effects. Further, the possibility exists that there are unmet needs in areas where services are not provided.

The proportion of the population with SPMI, and the size of this population, also differs substantially between regions. The distribution will reflect, in part, historic patterns of service delivery. Tataryn, Mustard & Derksen (1994) found that people with SPMI were relatively

evenly distributed across the province at younger ages, but older cohorts tended to aggregate in Brandon and Winnipeg. Both the number of individuals and the proportion of people with SPMI in Brandon reflect this migration. The large number of consumers in Parkland likely reflects repatriation that occurred with the closure of Brandon Mental Health Centre (BMHC). Regions with low populations of SPMI people, such as Burntwood, generally had limited services to support people with intensive needs and / or portions of service delivery were only available out of region. The extent to which historic migration patterns are affected by new services has not been established.

The size of the population with SPMI will also influence service development. Larger client numbers appear to facilitate provision of specialty services while lack of services may lead to migration and continued small numbers of people with SPMI.

Under some circumstances services for people with SPMI may be provided outside a specific region. The *Core Services* document (Northern / Rural Regionalization Task Force, 1997) specifies which services must be provided in the region or made available to residents of the region. By design, out of region inpatient services are used by Assiniboine, North and South Eastman as there are no inpatient beds in these regions. Other services, such as crisis services, may also be based out of another region. Further, individuals living in proximity to larger centers may use some out of region services. For instance, the primary care physician for an individual living in Oak Bank (North Eastman) might be located in Winnipeg and this physician might admit the client to inpatient services in Winnipeg rather than the home region. Self-help services in Winnipeg may also be used by consumers from other regions due to perceived stigma in home communities or greater availability of services. However, most formal mental health services for people with SPMI are provided within their region of residence. People with SPMI often have

limited access to transportation and hence use services within the region. Also, crisis services and community mental health services routinely refer prospective clients back to their home region.

Table 1

Service Delivery Context

Region	Area Sq Km	Pop	SPMI Pop	SPMI Pop per 10,000
Burntwood	534,900	45,000	9	2.0
Nor-Man	72,000	25,000	41	16.4
N. Eastman	35,000	38,621	16	4.1
Assiniboine	30,950	75,000	27	3.6
Interlake	26,000	74,396	50	6.7
Parkland	25,000	43,506	55	12.6
Central	17,433	97,000	53	5.5
S. Eastman	8,000	52,000	26	5.0
Brandon	646	46,888	160	34.1

Accountability.

In the chapter on governance and fiscal strategies, the *Best Practices* document identifies key elements for best practice at a regional and / or local area. The criteria state that "there is a mental health authority in place that: serves as a clear point of responsibility for people with serious mental illness; … has responsibility for planning, organizing and monitoring services and supports, and dispensing funds, and; uses clinical, administrative and fiscal mechanisms to achieve more integrated delivery of care" (p 130). Two aspects of accountability are discussed.

First, accountability to consumers for services and decision-making is discussed. Accountability of specific services to the RHA is also discussed.

Mental health reform began in advance of regionalization of services. Mental Health Advisory Councils were established to facilitate planning, development and implementation of regional[3] service plans. The Advisory Councils were made up of a variety of stakeholders, including consumers and family members. Advisory Councils reported to the Assistant Deputy Minister of Health through the Provincial Mental Health Advisory Council. The Provincial Council again included consumers and self-help organizations but differed from regional councils in that health professions participated on the Provincial Mental Health Advisory Council. Although the Councils were established before the *Best Practices* document, the planning mechanism is consistent with the *Best Practices* recommendation that there be "a free standing mental health reform policy based on an explicit vision that is shared among various stakeholders, including consumers and families" (p 12).

Several Mental Health Advisory Councils dissolved once services were in place. Other regions, including Brandon, Interlake and Parkland, have maintained the Councils. Assiniboine participates on the Brandon Advisory Council. The Brandon and Parkland Council are very active and have good connections to decision-making. For instance, the Council in Parkland reports directly to the RHA Board and the Brandon Council is Chaired by the Vice President of Long-Term and Community Programs. The Interlake Council sees its role as identifying issues and continues to report through the Provincial Council, but does not have direct input into decision-making in the region.

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[3] Many Mental Health Advisory Councils prepared plans based on a single region but others developed plans for a larger area. For example, planning for the West Region included what are now Assiniboine, Brandon, Parkland and Central RHAs.

Regional Health Authorities that no longer have Advisory Councils have developed

alternate means to include consumer and family perspectives in decision-making. For instance,

the Mental Health CQI (Continuous Quality Improvement) team for Assiniboine RHA includes

about 14 stakeholder groups, such as the Addiction Foundation, Family Services, school

divisions, providers and consumers. This group evaluates the region on standards set by the

Canadian Council on Health Services Accreditation and identifies priority areas for

improvement. Some regions include self-help services in monthly team meetings to facilitate

feedback and resolution of any issues that arise. Other regions anticipate that consumer concerns

will be channeled through District Health Advisory Councils, which make recommendations to

the RHA on a range of health issues. The effectiveness of indirect mechanisms for including

consumer and family perspectives is not known. However, direct involvement in decision-

making and high-level reporting relationships are likely to provide the strongest voice.

With the exception of Brandon and Winnipeg RHAs, which were established at the

beginning of the 1998 / 99 fiscal year, RHAs were established in April 1997. Under regional

governance, the role of Manitoba Health changed from direct service delivery to setting

standards and monitoring performance, implementation of outstanding reform initiatives and

supporting RHAs to deliver core services (Manitoba Health, 1999). Manitoba Health also

retained responsibility for funding Selkirk Mental Health Centre (SMHC) as the provincial long-

term care facility and self-help initiatives. RHA assumed direct responsibility for delivery of core

programs and services.

The *Best Practices* document makes two recommendations with respect to accountability

of specific services to the RHA. The recommendations state that "Each region should develop

strong mechanisms … for service integration with clearly designated responsibility for all

aspects of care and sufficient influence to bring together the four solitudes, i.e. Community

Mental Health Programs, Provincial Psychiatric Hospitals, general hospitals and consumer and

family initiatives" (p. v). In Manitoba, neither the consumer and family initiatives nor the

Provincial Psychiatric hospitals are under the jurisdiction of Regional Health Authorities. Both

SMHC and self-help services receive funding directly from the provincial government and Eden

Mental Health Centre (EMHC) is operated by Eden Health Care Services, a non-government

organization. In rural regions that have inpatient beds in general hospitals, the Mental Health

Manager is directly responsible for both community mental health and inpatient services. This

connection facilitates continuity of service as case managers follow their clients before, during

and after hospitalization.

The second recommendation of the *Best Practices* document with respect to

accountability of specific services is that "At the regional / local level one organizational entity

or mental health authority is responsible for mental health care, and is a clear point of

accountability for system performance". With the exception of Brandon RHA, the Mental Health

Program Manager is responsible, directly or indirectly, for all mental health services offered in

the region. In Brandon there are several Mental Health Program Managers who report to a

Coordinator of Mental Health Services. In this case the Coordinator is responsible, directly or

indirectly, for mental health services available in the region.

The services that the Program Manager / Coordinator is directly responsible for differ

greatly between regions (Table 2). Psychiatrists and psychologists are usually hired by, and

responsible to, the Mental Health Program Manager. Case management and proctor services are

also directly responsible to the Mental Health Manager. However, a portion of both psychiatry

and case management in Central are provided under contract to a non-government organization.

Crisis services are directly operated by the RHA in Central, Parkland and South Eastman. South Eastman assumed responsibility for the mobile crisis service in order to ensure continuity of service delivery. The Parkland RHA operates the mobile crisis team out of Dauphin although the Safe House in Swan River is operated by a NGO. Except for Central, where Eden Health Care Services provides inpatient services, the Mental Health Program Manager is responsible for the inpatient unit if there is one.

Although some regions have made specific provisions for housing, the regions do not usually directly operate the housing. Brandon is the exception as it operates a number of residences. Vocational / educational services are operated by the region in Brandon, Central, Interlake and Parkland through Employment Development Counselors (EDC). Social / recreational services are directly operated by the region in Brandon and Parkland. Self-help services in each region are funded directly by Manitoba Health and are not directly responsible to the Mental Health Program Manager.

A number of services, such as crisis services are provided under contract to the region by a non-government organization. These include provision of: a portion of psychiatry and case management in Central; crisis services in Swan River, Brandon and Interlake; inpatient services in Central; housing services in Interlake; the clubhouse in Thompson; and the Support Centres in Interlake. Providers who work for non-government organizations report to their sponsoring organization, such as the Salvation Army, and to the RHA. Although the region does not operate these services, service contracts with these non-government organizations specify what services are to be provided.

Some services are provided outside the region or are accountable to other bodies. For example, crisis and inpatient services for Assiniboine and North Eastman are provided out of

region; SMHC is accountable to Manitoba Health; and self-help services are accountable through their head office also to Manitoba Health. Each of these services has established some understanding with RHA about the services to be provided.

In many cases there is excellent linkage between the mental health program and contracted or out-of-region services. Functionally there may be no difference. However, there is a perception that, in some instances, responsiveness of services decreases as accountability to the Program Manager decreases. For instance, delivery of a contracted service is guided by the values and beliefs of the organization, and may or may not be consistent with best practices as described in national documents. In some cases, differences in the values base places limits on collegiality and results in tension over control of services.

Table 2

Services Directly Responsible to the Program Manager*

Region	Psychiatry / Psychology	Case Management	Crisis	Inpatient	Housing	Vocational / Educational	Social / Recreational	Self-Help
Assiniboine	X	X						
Brandon		X		X	X	X	X	
Burntwood	X	X		X				
Central	X	X	X			X		
Interlake	X	X				X		
Nor-Man	X	X		X				
N. Eastman	X	X						
Parkland	X	X	X	X	X		X	
S. Eastman	X	X	X					

* Note: See text for more detail on categorization.

Integration / Linkages.

The need for integration and coordination of services has been recognized since the early days of deinstitutionalization. Improved integration and continuity of mental health and health related services continues to be identified as a goal. It was recently included as one of five goals in the Mental Health Renewal document in Manitoba (2002). The criteria identified for governance in the *Best Practices* document include use of "clinical, administrative and fiscal mechanisms to achieve more integrated care" (p 130). Mental health managers use a variety of mechanisms to facilitate linkage between services within the program and between the program and external organizations. Linkages between services may be formal or informal, internal or external and can occur at a variety of levels.

Formal linkages exist between Mental Health Program Managers through the Provincial Mental Health Network, which meets quarterly. Formal linkages within regional programs occur in the form of team meetings, which are usually held monthly. These meetings may include contract service providers or representatives from self-help and are useful for sharing information and resolving process issues. Meetings are held more frequently between Psychosocial Rehabilitation (PSR) team members. PSR team meetings often occur weekly and may include housing services and social /recreational services. Close linkages between members of the PSR team are required in order to facilitate provision of an integrated service for consumers with multiple needs. Joint planning meetings are also held around specific topics. For instance, Parkland has a joint education planning committee composed of regional and self-help services that coordinates and collaborates on public education.

Regions that have a limited number of providers tend to have informal linkages while larger organizations have liaison protocols and may even have a designated person in a liaison

role. For instance, in Burntwood a single provider follows the client before, during and after

inpatient treatment while the Centre for Adult Psychiatry has a liaison protocol in place. Case

managers are invited to attend case conferences, but do not provide direct service while the

consumer is an inpatient. SMHC, which has been designated as the long-term care facility for the

province, has a designated liaison person to facilitate linkage with other regions.

Informal linkages occur in a number of ways. For example, RHA may offer space to self-

help for meetings, joint sponsorship of events may occur, staff may move between programs or

offices may be in proximity to those of staff from other programs. On occasion regional staff sit

on committees or boards as citizens. For instance, the Mental Health Program Manager is on the

Board of Directors of the Parkland Mental Health Housing Inc. as a community member rather

than as the Program Manager. Service providers often form informal linkages to facilitate service

delivery for specific clients. Informal linkages are flexible and often strong, but are adversely

affected by staff turnover.

Some barriers to linkage occur with organizations that are not directly accountable to the

Mental Health Program Manager. For instance, information sharing between programs is subject

to individual client consent under the Personal Health Information Act (Government of

Manitoba, 1997) and the Freedom of Information and Personal Privacy Act (Government of

Manitoba, 1997). This appears to be more problematic in some areas than others. In Brandon,

where crisis services are operated by a NGO, every client of the PSR program has an assessment

for crisis potential. Where potential exists for an after-hours crisis, the client and case manager

prepare a crisis plan. The client signs the plan and is provided with a tour of the crisis unit.

Information is provided on what to expect in the event of contact with crisis services and consent

for information sharing is sought. In this instance there are few barriers to communication between regional services and the non-government organization providing crisis services.

Barriers to linkage may also exist for out-of-region services. The extent to which this occurs appears to differ, but can be very problematic. For instance, in South Eastman where a number of services are provided out-of-region, there are no formal links between community mental health staff and the Crisis Stabilization Unit (CSU) in Selkirk, or inpatient services in other regions. Information sharing on inpatient treatment, and referrals back to community mental health are reportedly rare.

Limited linkage with organizations that are external to health appears to limit availability and suitability of some services. For instance, Vocational Rehabilitation Services are delivered by Family services for individuals with a variety of needs, including mental health clients. In many locations the service is not well used by mental health clients. A number of factors may be involved. Community Mental Health Workers (CMHW) may not be familiar enough with the service to refer clients who would benefit or referrals may be inappropriate leading to rejection of the application. Vocational Rehabilitation Services may not be familiar enough with the diverse needs of mental health clients resulting in provision of services that do not meet client needs.

Budget.

Topics related to budget include changes in funding levels, flexibility in funding and protection of funding. The *Best Practices* document recommends "The creation and protection of a separate, single funding envelope that combines various funding streams for the delivery of mental health care is an essential component of system reform." (p. vi). The criteria for evaluation is that "Policy preserves the mental health envelope, prevents losses due to

downsizing institutions, and increases the proportion of funds spent on community care." (p 12).

A single funding envelope is expected to facilitate integration of hospital and community care,

and reallocation of resources from the institutional sector to the community sector. The *Best*

Practices document recommends protection of the funding envelope due to concerns about

reduction in mental health resources. Even strong advocates of regionalization, such as Rachlis

and Kushner (1994), have expressed concern about the vulnerability of mental health and public

heath funding in the absence of such protection.

Budgets were protected during the initial phases of mental health reform, a period of

about three years. When the RHA were established in April 1997, the mental health budget

became part of global RHA budgets. The possibility exists that mental health budgets could

decline in order to resource other RHA programs. However, it appears that mental health has

been considered a priority within each region and budgets have in some cases increased at the

expense of other regional programs. At this point in time, Program Managers do not consider

mental health funding to be at risk.

Flexibility in funding, or rather the ability to move money between programs as needed,

is considered important to accommodate changing client needs. Evaluation criteria outlined in

the *Best Practices* document require that "Diverse funding sources are consolidated into a single

funding envelope that can be used flexibly." (p 12). With the exception of Brandon, each rural

Mental Health Program Manager has control over the mental health budget and is able to move

resources between services in order to meet client needs. The extent to which funds can be

reallocated depends on how many services the Mental Health Program Manager is directly

responsible for. Resources for services that are externally funded, such as self-help services,

would not be available for reallocation. However, some Mental Health Programs have, in effect,

increased funds for self-help. For instance, the Interlake RHA has contributed funding to self-help in order to facilitate delivery of services on a distributed basis throughout the region.

In Brandon RHA, the Program Manager for the PSR program has a budget for the services responsible to her. These resources can be used in a flexible manner to meet client needs. However some services, such as the in-patient service, are responsible to a different Program Manager and are funded separately. While this configuration has the potential to decrease flexibility, the movement of resources between programs is possible. Each of the Program Mangers report to the Mental Health Program Coordinator and the budgets of each Program Manager could be adjusted if indicated.

Overall funding levels for community services changed substantially as a result of mental health reform (Table 3). For instance, Interlake reported that it's mental health budget doubled while Central and Parkland reported that the staff complement doubled. Funds from the closure of BMHC and 65 in-patient beds in Winnipeg were used to develop community resources. The West Region Planning Group, which included Brandon, Central, Marquette, Parkland, and South Westman, collaborated with the Mental Health Advisory Council for these regions to develop plans for needed community services. Funds were allocated to each region to develop or enhance needed services. Funds were also used to develop new in-patient services in Nor-Man and Burntwood. Interlake and Eastman (North and South Eastman were a single region at that point) engaged in a similar exercise. The extent of funding change differs substantially between regions, but was based on plans developed by groups of regions and, at least to some degree, was based on perceived client needs.

With implementation, some regions found themselves under resourced. For instance, professional development resources were part of the existing budgets for some regions and had

Table 3: Change in Services Since Initiation of Mental Health Reform

	Assiniboine	Brandon	Burntwood	Central	Interlake	Nor-Man	N. Eastman	Parkland	S. Eastman
Psychiatry / Psychology			↑ Psychiatry ↑ Psychology	↑ Psychiatry	↑ Psychology	↑ Psychiatry ↑ Psychology	↑ Psychology	↑ Psychiatry ↑ Psychology	↑ Psychology
Case Management		↑ ICM	↑ CMHW	↑ ICM	↑ ICM	↑ CMHW	↑ ICM	↑ ICM	↑ ICM
Proctor	↑	↑	↑	↑	↑	↑	↑	↑	↑
Crisis Services	Access to CSU and MC	CSU and MC	Safe House	Safe House and MC	CSU and MC		Access to CSU and MC	Safe House and MC	MC
In-patient		↓ 15 Beds	↑ 9 Beds			↑ 8 Beds		↑ 10 Beds	
Housing	↓	↑		Housing Coordinator	↑ CMHA			↑	↑
Vocational / Educational		↑ EDC		↑ EDC	↑ EDC			↑ EDC	
Social / Recreational		Support Services	Club	Drop in	Support Centres	Drop in		Club	
Consumer / Family	Available	Available	Available	Available	Available	Available	Available	Available	Available

not been as necessary for others. Once needs emerged in regions that had not historically needed

resources for this purpose, these funds had to come out of the global budget for the mental health

program and could only exist at the expense of other services. Another example of an emerging

need is the case of inpatient beds for South Eastman. Prior to mental health reform, South

Eastman had used inpatient beds in other regions, including Winnipeg. Access to Winnipeg beds

changed substantially following bed closures in Winnipeg. Again, resources to provide these

services in another fashion had not been built into mental health plans. Assiniboine RHA

considers the historic understaffing in community mental health services to have continued under

mental health reform and establishment of the RHA.

Monitoring / Evaluation.

Monitoring and evaluation are recognized as a critical element of system. The *Best*

Practices document criteria suggest there should be "a sufficient, protected evaluation budget" (p

12). The *Best Practices* document further recommends "The setting of explicit, operational goals

and performance indicators within each province [as] a prerequisite for systems change and for

evaluation." (p. vi). Criteria include defining concrete, measurable targets. Specifically "Regular

monitoring of all services and supports is the basis for program and system accountability, and

for continuous quality improvement. Preset goals, performance measures and time lines are

established." (p 12).

At this time, none of the mental health programs has a specific budget for evaluation.

This discussion focuses on evaluation initiatives underway within regions, including

Accreditation, CQI, program monitoring and other initiatives. Accreditation, Continuous Quality

Improvement (CQI) programs and program monitoring are generally integrated processes, with

Accreditation used to identify goals, and CQI used to track progress toward these goals.

Monitoring is used to identify emerging trends while specific initiatives are undertaken to explore issues.

Every RHA has obtained Accreditation through the Canadian Council on Health Services Accreditation, and several have active CQI programs. The Canadian Council on Health Services Accreditation uses the AIM (Achieving Improved Management) standards. The standards for mental health include items in areas such as health promotion, responsiveness, quality of service delivery and outcomes. The Accreditation process involves comparison of performance against these standards and development of recommendations on areas for improvement. Mental health teams are directly involved in the accreditation process and in setting and achieving goals. For instance, the South Eastman team is composed of representatives of each service in the mental health program. The committee meets monthly and reports back to mental health staff during program meetings on progress toward recommendations. Reports are also shared with the region's CQI coordinator who prepares a quarterly report for executive management.

The accreditation teams include program staff but some regions also include a wide variety of other stakeholders. For instance, the Assiniboine mental health team includes several external providers (e.g. Addictions Foundation, Family Services) and consumer representatives. The Parkland team also includes representatives from each of the mental health self-help groups. Some regions, such as South Eastman, invite self-help representatives to team meetings in an effort to identify and address issues.

Monthly statistics, case and file audits, and clinical supervision are used for monitoring. A number of regions have, or are in the process of developing, consumer satisfaction surveys in accordance with Accreditation criteria.

Other *Best Practice* criteria refer to availability and effectiveness of an information system. The criteria state "An information system has common elements for system evaluation (provincial) and local elements for program evaluation (agency level)." (p 12) and "A consumer-centered information system supports decision-making in planning, funding and managing the system." (p 12). In the view of mental health program managers, the Manitoba Mental Health Management Information System does not contain needed information and is not effective in supporting decision-making. The data collected is primarily demographic client data and service information. There is no outcome data. Further, information submitted to Manitoba Health is not readily available for analysis by the regions. Managers reported that evaluation efforts have been hampered by inadequate information. Lack of expertise in evaluation was also considered a barrier.

In addition to the above evaluation efforts, regions have participated in a number of ad hoc projects. Some of these projects include: the Caseload Review project which included all regions and Manitoba Health; a PSR program evaluation (Brandon, Central and Parkland); a study of housing needs (Central); a formal review of mental health services (South Eastman); and use of focus group methodologies to obtain feedback from community members (Marquette).

Human resources.

The Human Resources section of the *Best Practices* document focuses on redeployment of staff from facilities to the community with attention to union and training issues. Redeployment is not discussed directly here, although preparation of health professionals is discussed under "Basic and continuing education" below. A more salient issue in rural areas is the availability of human resources. Shortage of qualified human resources, and specialists in

particular, is routinely identified as a barrier to delivery of health services in rural areas (Bushy, 1994a; Houenstein, 2003; Lischner, Richardson, Levine & Patrick, 1996: Weiss Roberts, Battaglia & Epstein, 1999). Regions were asked about the stability of staffing in the region, and ability to attract qualified applicants for vacancies. These two factors are closely related. Regions with stable staffing have much less difficulty attracting qualified applications than regions with high turnover.

Regions in the southern part of the province, including Assiniboine, Brandon, Central, Interlake, North Eastman, Parkland and South Eastman, have had stable staffing in community mental health programs over time. Each of these regions has been able to attract qualified applicants for vacancies, although the number and quality of applicants diminishes as distance from major centers increases. While not yet problematic, the number and quality of applications has been declining over time with provincial and national shortages of health human resources.

Several Program Managers made a distinction between "qualified applicants" and applications from people who had the necessary skills for the position. Individuals from a variety of disciplines are eligible to apply for positions in the mental health program. Having the necessary skills however requires knowledge of clinical syndromes, mental status assessment, and psychopharmacology as well as knowledge about specific therapies, such as cognitive restructuring therapy. Registered Psychiatric Nurses, who hold about 60 % of CMHW positions in rural areas, have the required knowledge but have been in increasingly short supply. Individuals with a Bachelor of Social Work, who hold about 40 % of CMHW positions in rural areas, have a number of strengths, but do not have these specific content areas. Historically the need for a common knowledge base was addressed through the CORE training modules that

were offered by Manitoba Health and was required of all CMHW. This program is no longer available.

As a result of the independent nature of practice, experience is important in addition to educational qualifications regardless of discipline. As mentioned previously, the number of applications from people with experience has declined over time in all areas and is being experienced to a greater degree for positions that are distant from large population centers.

Several regions benefit, or have benefited, from the presence of BMHC and SMHC. When BMHC closed, positions in Brandon were highly sought after and community mental health programs were able to hire well-qualified applicants. Similarly, Parkland was able to attract people from this same population to fill the new positions in that region. Interlake and North Eastman continue to draw applicants with experience from SMHC.

The two northern regions, Nor-Man and Burntwood, reported high levels of turnover in staffing and difficulty attracting qualified applicants. Nor-Man reported that, over a 10-year period, fourteen staff had been hired to keep four positions filled. The number of applicants, and the level of experience, has declined over time. Burntwood reported particular difficulty in filling positions in isolated areas, such as Lynn Lake. Isolated communities have the most difficulty attracting staff and are likely to have the least skilled workers despite the fact that the scope of practice calls for experienced staff. This challenge is not specific to mental health. Family Services and other health services experience similar challenges in recruiting and retaining staff for isolated areas. Several regions are actively recruiting on an ongoing basis. For instance, Brandon PSR Program staff work with Brandon University, School of Health Studies to facilitate student placements in the program, and with the Brandon School Division to provide students with work experience.

Since the beginning of mental health reform, almost every region has increased the amount of psychiatry services available. However, recruitment of psychiatrists and psychologists has been difficult, even for southern regions. The opening of the inpatient unit in Nor-Man was delayed until a psychiatrist could be recruited. Other regions, such as South Eastman and Burntwood, have had interruptions in availability of psychiatry services.

High turnover and staff shortages have been substantial in crisis services operated by NGO. Staff shortages have resulted in temporary service closures and, in South Eastman, having the region assume responsibility for the service. These shortages are related to wage scales substantially below wages in other positions. Ability to attract and retain crisis staff in South Eastman improved once wages were made comparable to CMHW wages.

The availability of people willing to work as proctors also differs substantially between regions, with some regions reporting difficulty in recruiting proctors, particularly in isolated areas. Proctors are casual employees and the wage is minimal, which often leads to turnover. In many areas the proctor service competes with home care for suitable proctors. Some regions, such as Brandon, have a Resource Developer who coordinates the proctor services and provides orientation to new proctors. Lack of a training program for proctors has been identified as an issue. However, this may be addressed if the recommendations of the Mental Health Education Consortium (discussed below) for a diploma / certificate program are implemented.

Basic and continuing education.

Specialists are rare in rural areas, and access to continuing education and professional networks can pose barriers to maintaining skills (Bushy, 1994b; McDonel, Bond, Salyers, Fekete, Chen & McGrew, 1997; Weiss Roberts et al., 1999). However, delivery of quality services is dependent on the knowledge base. In the words of one Mental Health Program

Manager, "How can you practice using best practice models when you don't know what they are?" There are a number of aspects of education that were explored. These aspects include provision of specialty training, access to continuing education and ongoing professional networks.

Specialty training in Manitoba has occurred primarily through two channels. First, the province invested in a "train-the-trainer" program that provided certification for 10 people as trainers in psychiatric rehabilitation. Four of these individuals work in rural regions. People with this certification are employed in Brandon, Central, Interlake and Parkland. While used to some degree in each region, this avenue has not resulted in large amounts of training. The second channel for providing specialized education was the CORE module training program operated by Manitoba Health. This program was compulsory for CMHW as a means of ensuring that each CMHW had a minimum knowledge base. Each module was an intensive two to three-day course with prior readings and a follow-up assignment. One of these modes was on PSR. Delivery of the CORE modules was discontinued by 2000. In regions such as Parkland where staffing is stable, all or many of the CMHW have taken this course. However, in areas such as Nor-Man with high turnover, few if any people who have had this training remain. Almost all people in ICM or EDC roles have at least the CORE module. ICM and EDC in Brandon also have six to eight days of specialized training. In the regions where the ICM do not have any specialized training, the ICM are using independent study, with or without supervision, as a means to obtain the needed information.

Educational preparation for proctors has also emerged as an issue as this resource has increased in use. In Brandon, the Resource Developer administers the proctor program and is responsible for providing an orientation. Most regions have informal processes for orienting

proctors but consistent information in areas such as interpersonal communication and skills training would be of benefit.

Resources available for continuing education in general, and continuing education for PSR in particular, differ substantially between regions. Due to historic high turnover rates, and sometimes minimally qualified applicants, Nor-Man and Burntwood have had an ongoing need for education. These regions had a specific budget for continuing education prior to mental health reform. This budget was retained under reform. Other regions that historically had easy access to well qualified applicants had not required as much for continuing education. As a result these regions now have very small continuing education budgets and growing needs. For instance, North Eastman RHA has a continuing education budget of about $4000 shared by staff in Mental Health, Home Care, Public Health and Primary Health Care. At the time interview, South Eastman mental health had a continuing education budget of about $750 for seven workers. In Parkland, continuing professional development is at the discretion of the individual service provider.

A number of regions provide a set amount of resources annually for each worker. For instance, Assiniboine allocates $200 to each worker annually while Brandon allocates three days professional development leave and some funds to each worker. Other regions such as Burntwood and Nor-Man have funds that may be requested as opportunities and needs arise. In these situations, or where professional development is at the discretion of the worker, individual workers select their own learning opportunities based on personal interests or emerging caseload needs. Since each CMHW serves a broad range of clients and, since the SPMI population may represent a small fragment of their caseload, PSR may not be identified as a priority for

continuing education. There has been little continuing education in PSR other than Brandon, which has specifically offered some continuing education, and a conference in 2001.

Individual regions have taken various approaches to provision of continuing education. For instance, Nor-Man and North Eastman are providing some staff development through in-service education or speakers, such as self-help, at team meetings.

The Mental Health Education Consortium, which includes Manitoba Health and educational institutions, was recently established to develop a continuum of mental health education programs. Initiatives through this group include development of a proctor-training program at the certificate / diploma level, discussions on ways to ensure that university programs provide the required content for work in mental health, and discussion about ways to facilitate and formalize education in specific topic areas required by people working in mental health. Additionally, the consortium is examining ways to facilitate access to specialized programs.

Professional networks also serve as a means to remain current and provide mutual support. For a period of about three years, rehabilitation staff from Interlake and North Eastman met about once every six weeks to work through new educational material on PSR. The meetings included case discussions and served as an educational forum as well as providing an opportunity to consult with peers. A number of group members have joined individuals from several regions to form the Manitoba Chapter of PSR Canada. This group includes members from Brandon, Central, Interlake, and Parkland. The group works on a variety of projects. For instance, it is currently arranging for speakers for their annual meeting. They are also working on arranging for a PSR expert from Boston University to work with SMHC and to provide public education.

Special considerations.

Some of the challenges experienced by rural regions are shared, but each region also faces unique challenges. These unique challenges represent important aspects of the context in which services are planned and delivered. This section reports specific challenges to service delivery identified by Program Managers. These challenges include: distance; size and source of the client base; heterogeneous population base; and extent of control over services.

Distance is an issue for all rural regions, but was specifically identified as a challenge by Program Mangers in Assiniboine, Burntwood and Nor-Man. Providing services over a wide geographic area, is costly in both human and financial terms. The Program Manager in Assiniboine reports that almost one third of manpower time in the region is spent in travel. The cost of setting up an office and support staff in multiple locations is also substantial. In Nor-Man, which provides service over a very large geographic area, the Program Manager identified that travel to some communities takes three hours one way on poor roads. The travel time limits the frequency with which itinerant services can be provided and consequently, the amount of support that can be provided to clients with high needs. Clients whose needs cannot be met with itinerant service may need to relocate. In Burntwood, which also has large distances to outlying communities, service may be provided by an individual who lives in the community and works for both mental health and family services. However, consumers with needs in excess of what can be provided by this generic worker would need to relocate.

Distance impacts on access to continuing education as well as access to services. The Program Manager from Burntwood identified that having a CMHW attend an education session in Winnipeg involves two days travel time and expenses in addition to the time and cost of the session itself. A short education session can easily cost $1,000 - $2,000 in addition to the

workers time. While the travel time might decrease slightly for more southerly regions, the remainder of the costs would be the same.

A second issue that considerably affects service delivery is the size of the population with SPMI and the source of the client base. The majority of clients for the Brandon PSR program, and a large number of the PSR clients in Parkland, were drawn from inpatients at BMHC. Many of these individuals had been hospitalized for extended periods of time or on multiple occasions. The primary diagnosis was almost exclusively schizophrenia. Similarly, the Interlake PSR program serves a large number of people who have been hospitalized at SMHC and the southern part of Central RHA has a large number of clients who have been hospitalized at EMHC. Each of these regions has a sizeable population of people with SPMI. In contrast, regions that have historically had an out-migration of SPMI clients, such as Assiniboine, Nor-Man, North Eastman and South Eastman, have much smaller populations with SPMI. Further, there will be fewer people with lengthy history of hospitalization. While the differences in available services cannot be directly attributed to the size and source of the client base, it appears that regions with large numbers of clients who have lengthy histories of hospitalization have developed a broad range of services while regions who have experienced out-migration have more difficulty in providing these specialized services for the small and often dispersed individuals that remain in the region. It is possible that the challenges in providing specialty services for small numbers will lead to continued out-migration. However, one mental health manager provided an alternative interpretation, specifically that the more limited numbers of people with SPMI results from lack of services and resulting self-reliance.

Three regions, Central, Parkland and South Eastman, identified that the heterogeneity of the population posed challenges to service delivery. The Parkland RHA is made of several

distinct ethnic groups. A substantial portion of the population is of Ukrainian decent and Ste.

Rose du Lac is a predominantly French area. Language is also an issue in South Eastman where

about 25 % of the population is French speaking. For several of these communities, daily life is

conducted in French. These communities either want or, in the case of individuals who only

speak French, need service provision in French. A need for bilingual service providers

complicates service delivery. For instance, a position that is specified as bilingual may be

difficult to fill. The position may sit vacant or, if a provider who only speaks one language is

hired, a portion of the population will be left without service.

South Eastman and the southern part of Central are home to a large Mennonite

population. The unique language and culture have a substantive influence on services, providers

and practice. Historic and contemporary values of self-reliance in both the French and Mennonite

communities have to some degree influenced both availability and use of services. A culture of

self-reliance influences willingness to access services at the individual level. At the system level

it influences ability to develop mental health services. For instance, perception of need

influenced planning for mental health services under mental health reform and is, in part,

responsible for limited availability of some services in South Eastman.

In regions with larger culturally distinct groups it is imperative for individual workers to

be familiar with, and sensitive to, cultural influences and deport themselves in a manner that is

acceptable to the community. The need for cultural sensitivity may be clear to regional staff in,

for instance, South Eastman, but it may be less clear to staff in services, such as SMHC, which

are outside the region.

Religion is another aspect of culture that complicates service delivery. Choice of

providers, services provided and access can all be influenced by religion. For instance, a social

prohibition exists in Mennonite communities regarding talking about mental health. The view

that mental health problems are the result of how people conduct their lives or failing to connect

sufficiently with God is prevalent. Medications are frowned on. This perspective influences

willingness of Ministers to refer members of the congregation to community mental health

services, ability to offer public education and public awareness of mental health services. In

South Eastman there is a need in many cases for a service or service provider to be sanctioned by

the pastoral association. Although Christian counseling is available through a number of local

churches and private practitioners, there is overt pressure to hire individuals who practice

Christian counseling. CMHW are often specifically asked if they provide Christian counseling or

if they are Christian. The response may determine whether or not the client will accept service

from that provider.

In south Central, Eden Health Care Services is responsible for a wide range of services.

These services are guided by the values and beliefs of the organization and the surrounding

communities. However, since Eden Health Care Services provides inpatient and some vocational

services for the entire region, the service must meet the needs of individuals who are not from

the same faith.

In each of these two examples, there is risk that a portion of the population will not

receive services they consider appropriate. In both cases the services have a mandate to provide

services to people with a variety of backgrounds. Whether a generic service is trying to serve

consumers who would prefer faith-based service, or a faith-based service is trying to serve

consumers not of that faith, delivery of service is, at minimum, problematic. Further, on

occasion, tension over control of services and concern about loss of services has created a

difficult political climate.

Out-of-region services in some cases are not well used by consumers. For instance, the Program Manager for Assiniboine reported that services based in Brandon, such as CSU and MCU, were not well used by consumers living in Assiniboine. The reasons for limited use are not known but may result from lack of visibility. In contrast, North Eastman reports close ties and good use of out-of-region services such as CSU and MCU.

Further, population growth and provision of additional services were identified as issues influencing the service context. South Eastman identified that the population in "bedroom communities" on the border with Winnipeg is growing rapidly with some communities tripling in size. The budget for mental health services has not increased accordingly. The Nor-Man RHA provides services that other RHA do not. Specifically, mental health services are provided on reserve, and the RHA operates an addiction facility. Addiction services are usually the domain of the Addictions Foundation of Manitoba.

System Components

Psychiatry / Psychology.

The extent of psychiatry and psychology services increased substantially in some regions with mental health reform. Prior to mental health reform, regions such as Burntwood, Nor-Man, and Parkland relied on about two days of itinerant service each month. In part because inpatient units were established, each of these regions now has a full-time psychiatrist and Parkland has two psychiatrists. Central also received funding for two psychiatrists, although 1.5 of the two positions was allocated to EMHC.

Several regions experienced limited change. Assiniboine has itinerant service to ten sites once a month. A psychiatrist is part of the PSR team in Brandon. Interlake has 3.5 days of

psychiatry service per week, with a substantial portion of that time allocated to delivery of service throughout the region. North Eastman has a psychiatrist 2.5 days per week.

The extent of available psychiatry service in South Eastman has varied between full-time (1999/2000) and the current 1.5 days per week with some gaps in service. Their review of mental health services identified a need for additional psychiatry time. Central has also identified a need for additional psychiatry services.

The type of service provided by psychiatrists varies depending on the time available. In regions with limited psychiatry time, the psychiatrist provides consultation and support to CMHW, and may provide assessment and prescription of medications. In regions with more psychiatry time, the psychiatrist may provide other treatment as well.

Psychology services increased in all regions except: Assiniboine, which already had a full-time psychologist; Brandon, which uses psychology on a consultation basis; and Central, where the position has been funded but recruitment efforts have failed. Burntwood, Nor-Man and Parkland were each funded for a full-time psychologist. Interlake, North Eastman and South Eastman share a full-time psychologist. Assiniboine and South Eastman identified a need for additional psychology time.

Case management.

Case management is the primary means of delivering community mental health services. Muesner et al. (1998) describe four different models of case management. The first model, Brokering, evolved from deinstitutionalization as a means to provide coordination of care for people with SPMI. The case manager does not deliver services directly but refers clients to needed services and monitors use of those resources. Clinical case management developed next in recognition of the fact that case managers must often provide direct services. Assertive

Community Treatment (ACT) and in particular Intensive Case Management developed later and were intended to meet the specific needs of people with SPMI by providing comprehensive treatment beyond brokering or clinical case management. ACT is provided in the community by a multidisciplinary team, which directly provides all services including assistance with practical supports such as shopping, laundry and transportation.

The specific functions under Clinical Case Management, ICM and ACT differ between models, but there are four specific functions that are shared by all models except the broker model (Anthony, Cohen, Farkas & Cohen, 1988). These functions include: 1) connecting - developing a relationship with the client which provides a basis for work; 2) planning services - identifying what services the client wants / needs and from who; 3) linking - ensuring the client receives needed services; and 4) advocacy - advocating for services that are needed and either do not exist or are inaccessible.

ACT differs from Clinical Case Management in that: caseloads are smaller and shared (10-12 as compared to thirty or more clients); the composition of caseloads is fixed and limited; team meetings are frequent, often daily; service is available on a 24 hour basis rather than during office hours; treatment and rehabilitation occur in the community rather than in an office; client contact occurs every one to three days rather than every one to three months; frequent family contact; and the ACT team assumes responsibility for medication compliance and housing (Santos et al., 1993).

Santos et al. (1993) also discuss differences between urban and rural ACT. Rural ACT: use more help from community volunteers; meet less frequently; are available more limited hours; and see clients less frequently. Responsibility for medications and housing are shared by

staff, consumer and family rather than being the responsibility of staff alone. Rural ACT teams also make more extensive efforts to mobilize community resources.

ICM is similar to ACT except that an individual rather than a team provides services. ICM also differs in that it is not a 24-hour service. In the ICM model, a variety of team members are available for consultation, but a single individual is primarily responsible for developing a close relationship with the client, for direct service provision and for coordinating other services. Employment Development Counselors (EDC) are very similar to ICM. However, the emphasis for EDC is work with clients on employment goals. For all models of case management, a strong relationship between the case manager and the consumer is essential.

Two other models of service delivery are also used for people with SPMI. These models are the Rehabilitation Model and the Personal Strengths Model. The Rehabilitation Model involves assisting clients to achieve their goals in living, learning, working and socializing. Once the client has identified a goal, an assessment is conducted of existing and needed skills and resources specific to the goal. Needed skills and resources are then developed to assist the client to achieve their goal (Anthony, Cohen & Farkas, 1990; Anthony, Cohen Farkas & Gagne, 2002). The Personal Strengths Model assumes that people have the ability to develop their potential and that behaviour is largely a function of available resources. The client is assisted to identify strengths and actively create environments where success can be achieved (Rapp, 1993).

The *Best Practices* document identifies Case Management / ACT as a key element of a system of care. The system should have "an array of clinical case management programs … in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models. There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders" (p 11). The *Best*

Practices document provides detail on the key components of ACT, which include: assertive outreach; continuous, round the clock, time unlimited, individual support; services predominantly provided in the community rather than in an office; and flexible support to meet individual needs. Clinical case management approaches are recommended for clients with less severe problems.

The amount and type of service provided to people with SPMI may differ substantially between regions based on factors such as the model of service delivery in use and caseload size. These factors in turn influence other best practices such as: the range and intensity of services provided; extent of active outreach; work with family and natural supports; and extent of service delivery in the community.

With the exception of Winnipeg, which uses the brokering model, community mental health services in Manitoba use a clinical case management approach. Consumers with SPMI may be served by CMHW when there is no EDC / ICM, or when there is a waiting list for ICM. For instance, in Assiniboine and Nor-Man where there are no EDC / ICM, service is provided to people with SPMI within the Community Mental Health Program. It should be noted that distinctions between models-in-use may not be clear. Based on worker preparation and client needs, individual CMHW may deliver an expanded service more consistent with EDC / ICM models while some EDC / ICM may be performing "practice as usual" even when the language is consistent with ICM models.

CMHW provide comprehensive assessment, consultation, crisis intervention, direct treatment, follow-up, and community education (Manitoba Health, 1993). Treatment may include therapies such as individual or family counseling, assertiveness training, psychotherapy, cognitive-behavioural intervention, relaxation training or supportive counseling. As mentioned

previously, the community mental health program uses a clinical case management approach that

the *Best Practices* document recommends for clients with less severe problems. The caseloads

are much larger for CMHW than for EDC / ICM, limiting the range and intensity of services that

can be provided. For instance, a study of mental health services in Marquette (currently

Assiniboine RHA) reported that the frequency of appointments for individual clients decreased

as caseload size increased (Racher, Ryan-Nicholls, & Robinson, 2000).

Where EDC / ICM are present in the region, a rehabilitation model is usually used.

Depending on the preparation of the provider, elements of the personal strengths or other models

may also be incorporated. EDC / ICM typically have small caseload sizes to allow for more

intensive service. While the services each individual client requires will differ, the range of

services provided under EDC / ICM extends beyond assessment and treatment to include: active

outreach; advocacy; facilitation of social services; assistance with finances and housing; illness

and medication education; medication administration and monitoring; work with families and

natural supports; and assistance with basic needs and instrumental functioning. Services under

this model are usually provided in natural settings in the community rather than in an office.

Mental health managers report that all workers (CMHW and EDC / ICM) provide these

expanded services, but managers also acknowledge that the extent to which CMHW can provide

extended services is limited due to large caseloads.

Outreach involves active follow-up on missed appointments. Under clinical case

management, there is no immediate follow-up when a client misses an appointment. If the client

does not contact to schedule a subsequent appointment, it is presumed that the consumer has

decided services are no longer required. A letter may be sent offering continued or future service

and, if no further contact is received, the case is closed. Under ACT / ICM it is presumed that a

missed appointment may be the result of the client being unable to follow through. The worker

would attempt to contact the client and, if necessary, go to the client home or other places

frequented by the client to ensure the client is safe and well. All regions indicated that, regardless

of the model in use, active follow-up would occur if the worker considered the client at risk for

any reason.

Outreach can also involve maintaining contact with clients who refuse service. In rural

regions, service providers often know individuals with SPMI, even when the potential consumer

refuses services. Several regions reported making regular contact with these individuals to

monitor safety and well being, and to continue to extend an offer of service.

Work with family and other natural supports, including existing community resources, is

an important part of service delivery for clients with SPMI. A substantial number of people with

SPMI live with family members (Pomeroy & Trainor, 1991). Family members are usually the

primary caregivers for people with SPMI and, as a result, need to be included with clients in

planning and working toward goals. Among other things, family members need information on

the illness, assistance with management of problem behaviours, and knowledge of ways to

support clients in achieving their goals. Despite widespread recognition of the importance of

including the family, practice under all three models (CMHW, EDC and ICM) continues to occur

primarily with individuals. Lack of time was often cited as a barrier to enhanced involvement of

families.

Ideally, for people with SPMI, all service is provided in the community. For instance the

ICM may meet the client at the client's home, a bowling alley or coffee shop. Time may also be

spend time looking for housing or employment. Service provision in natural settings allows

greater information on the context of client's lives, and allows for greater transfer of learned

skills. For instance, if a client were seen only in the office, the condition of the residence, or interaction with other people in the household, would not be known. This information is of benefit in assessing functioning and / or safety. Skill teaching in the natural environment also facilitates learning. For instance, cooking skills learned in the client home with the consumer's cooking utensils are more likely to be acquired than cooking skills learned in a cooking lab. Although provision of service in natural environments is desirable, it takes more time than office-based practice. Most regions offer some degree of community-based service, but the emphasis differs substantially. For instance, service in Brandon is provided almost exclusively in the community while service in Nor-Man is primarily provided in one of the offices. The difference appears to be related primarily to the model in use. Service delivery by EDC / ICM is provided almost exclusively in the community while services provided by CMHW are delivered largely in regional offices.

As mentioned previously, a strong relationship between the case manager and the consumer is essential (McDonel et al., 1997). Caseload size has a direct influence on the extent to which these strong relationships can be established. Caseload size differs between CMHW and EDC / ICM. All regions recently participated with Manitoba Health in the Caseload Review Project. The project was designed to review the size and composition of caseloads with attention to urban, rural and northern issues, and recommend guidelines for caseload size (Manitoba Community Mental Health Caseload Review Committee, 2002). Among other findings, the review found that the caseload size and worker functions in specialized programs, such as ICM and EDC, were fairly consistent. For instance, the usual caseload size for an ICM was 19 clients and 16 clients for an EDC. However, caseload size and worker functions varied greatly in the community mental health program. Caseloads in adult community mental health services ranged

from 10 – 103 clients, with an average of 49 clients. The caseload review (Manitoba Community

Mental Health Caseload Review Committee, 2002) further concluded that, with caseloads larger

than 30, CMHW could serve little more than a brokerage function.

In this study, mental health managers reported ICM caseloads as varying from about 18

clients to as many as 25 and, in one case, 35 clients per worker. In some regions, such as

Burntwood, the ICM has a mixed caseload of about 30 clients, 10 – 15 of whom have a SPMI.

Caseloads in regions with no EDC / ICM ranged from 40 – 65 clients. Mental health managers

reported a tension between integrity of ICM programs and demand for the service. In some

regions, such as Parkland, this has meant increased caseload sizes. Other regions, such as

Interlake and North Eastman, maintain the recommended caseload size through waiting lists.

Although CMHW and EDC / ICM provide case management services, some of the other

necessary services can be provided through other channels. For instance, illness and medication

education is increasingly available through self-help services. Proctors (described below) may

also be used to provide care and support above what the CMHW or EDC / ICM can provide.

Two final criteria for services for people with SPMI are: 1) 24-hour service delivery, and

2) services are ongoing and unlimited. Regardless of the model used, none of the regions

provides case management services on a 24-hour basis. However, all regions have made

provisions for after-hours service. The extent of linkage between case managers and after-hours

services differs between regions. Strong linkages between case managers and after-hours

services in some regions mean that continuity of service is available even when the specific

provider is not available.

The expectation that services be "ongoing and unlimited" refers to an ongoing

relationship between the provider and client with intensity of service determined by need, rather

than an arbitrary entitlement to a specific amount of service. Many SPMI clients may need lifelong support in one or more areas. This criterion is particularly relevant in the United States where the number of visits may be limited and where ACT / ICM services, which are expensive, are provided only when clients are exceptionally disabled. This means that the provider might need to change after a certain number of visits or that even small improvements result in being discontinued from a program. All regions in Manitoba provide case management (CMHW and EDC / ICM) on an ongoing basis. Clients are not removed from programs after a certain amount of service. Clients who improve may "graduate" to other services, but are not automatically removed from programs.

Proctor services.

The Proctor Program "provides supportive and developmental programming for individuals who have a significant psychiatric impairment, but who do not require psychiatric treatment in a hospital. The objective of the program is to prepare individuals for as normal a living situation as possible, given the nature and magnitude of their impairment." (Manitoba Health, 1993, p 41). Proctors are paraprofessionals who are hired on a casual basis to provide direct assistance with basic needs and instrumental functioning, skill teaching and socialization objectives. Specific proctor services are dependent upon client goals but may include: assistance with grocery shopping or paying bills; transportation to appointments; assistance in finding housing; employment support; teaching life skills; and providing opportunities for social interaction. Proctor service is requested by the CMHW or EDC / ICM based on a service plan. Service is usually provided on a one-to-one basis. The amount and type of service provided by the proctor is determined based on client goals and needs, and will change over time depending on changes in client goals and needs. The CMHW or EDC / ICM provide supervision for the proctor.

All regions identified proctor services as a valuable component of the mental health program. The extent to which proctor services are available differs substantially between regions based on availability of people interested in working as proctors and the budget available. For instance, the proctor budget for Interlake is $ 120,000 while the proctor budget for North Eastman is about $ 15,000.

Crisis services.

The *Best Practices* document identifies crisis services as a key element of a reformed system of care. The document criteria specify "A continuum of crisis programs are in place to help people resolve crises using minimally intrusive options." (p 11). Crisis services are intended to divert people from inpatient hospitalization. Services may include telephone crisis programs, mobile crisis units, crisis residential services or psychiatric emergency services (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997). Manitoba was one of the few provinces to have developed crisis services when the *Best Practices* document was published in 1997. The Manitoba crisis services were identified as an example of best practice in the *Best Practices in Mental Health Reform: Situational Analysis* (1997b).

Crisis services within Manitoba are organized in a variety of ways (Table 4) and, to some degree, reflect the geographic distribution of the population and anticipated volume of calls. Crisis services can include a crisis line / mobile crisis service and / or a CSU / Safe House. Mobile crisis services generally provide crisis intervention, assessment and referral to community resources for voluntary clients 15 years of age or older who are experiencing an apparent mental health crisis. Some services also provide short-term follow-up.

For each region, crisis calls during the day on weekdays are handled by community mental health services. In the event of an emergency, existing clients of community mental

health services are asked to call their worker directly. If the worker is not available the call is forwarded to a backup, such as the Mental Health Promotion Clinic in Brandon or the Intake Worker in Burntwood, or instructions are left on the voice mail providing instructions for an emergency. Callers who are not presently mental health clients would call the crisis line number and the call would be forwarded, usually to an Intake Worker. Again, a backup or alternate is made available if the Intake Worker is not available.

Means for delivering after-hours crisis services differs greatly between regions (Table 4). Parkland and South Eastman deliver mobile crisis services within their mental health program. In these regions, people working for crisis services are classified similarly to CMHW. Brandon, Central and Interlake contract out their mobile crisis services. The Salvation Army provides crisis services in Brandon and Interlake. In Central, independent providers are paid a retainer for responding to crisis calls. Assiniboine and North Eastman share services located in another region (Brandon and Interlake respectively). Burntwood and Nor-Man have an Emergency Duty Worker who responds to calls from a variety of programs, such as Community Living, Family Services, Home Care, Mental Health and Public Health.

Except for Burntwood, Central and Nor-Man, where crisis workers work alone, providers work in pairs. In areas such as Brandon where providers work in pairs, services are ideally provided in the callers' home or other suitable location. Providers working alone do not provide a mobile service, although they may occasionally conduct an assessment in a safe setting, such as a hospital emergency room.

The number of calls received differs substantially between regions. Burntwood identified that it only receives a few calls each month and Nor-Man averages about 20 calls per month. The number of calls received in southern regions ranges between Central, where there are about 50

calls per month, Assiniboine / Brandon with 320 calls per month and South Eastman with more than 250 calls per month for a single region.

Informants identified a number of issues arising from the different methods of delivering mobile crisis services. These issues include: 1) having different services respond to calls at different times of the day; 2) the need in some cases for multiple calls to make contact; 3) the lack of mobile services in some regions; and 4) challenges related to delivery of a shared crisis service.

As discussed above, community mental health service providers respond to crisis calls during the day during the week. In some regions, a second service provides service in the evening, overnight and on weekends. In other regions the crisis line is managed by a second service in the evening and a third service overnight. In some regions there is no service for periods of time (e.g. overnight or days on weekends). Although there is usually a single phone number for crisis services, there can be as many as three different sets of providers answering the call. This means that a consumer contacting at two points in time, for instance in the afternoon and then again in the evening, would be unknown to the provider responding in the evening and would have to start over. This can be confusing for clients and for agencies, such as the police, when they try to contact crisis services to follow-up. Gaps in service can also cause confusion and pose challenges. For instance, feedback to the mental health program from Royal Canadian Mounted Police and the hospital in South Eastman suggest that a 24-hour service would be beneficial, particularly on weekends.

Having community mental health providers respond to calls during the day from people who are not their clients is also of concern. A sizeable number of callers have not had previous contact with formal mental health services and may not require ongoing follow-up. These

individual are at risk for being assigned to a CMHW. As a result, there is also potential for increased client numbers and caseload sizes.

In some regions, contacting the crisis services can require multiple phone calls. For instance, individuals seeking crisis services in the Pas or Flin Flon call the hospital switchboard, ask for the on-call worker and provide a number where the on-call worker can contact them. The on-call worker is notified and contacts the person in crisis. This can be a cumbersome process for a person who is in crisis. It may take four phone calls before the client is contacted. If the client is calling from a pay phone, the on-call worker will not be able to call back. The region acknowledges this as a limitation imposed by availability of funding and qualified people.

As mentioned previously, some regions do not provide a mobile service and others do not have a mobile service over night. Other regions identified transportation to a CSU or inpatient unit as a critical function of the mobile service. Mobile crisis teams are usually the entry point to a CSU and may facilitate use of this less intensive service. Lack of transportation is an issue for many mental health clients, particularly those with SPMI. Absence of transportation may be a barrier to use of a CSU or inpatient services. While call volume may make it difficult to justify a dedicated mobile service, the service can be made available on an as-needed basis. Specifically, Parkland, whose crisis calls are handled by the in-patient unit over night, will call out experienced staff from the inpatient unit or crisis services to provide a mobile service over night if required.

The final issues related to delivery of mobile crisis services arise from the use of a shared crisis service. As mentioned previously, crisis services in the north are shared between a number of programs, which may include Community Living, Family Services, Home Care, Mental Health and Public Health. Call volume makes it difficult for any of these programs to offer their

own service. The provider then must have expertise in a wide variety of areas. For instance, the orientation provided by Mental Health Services in Nor-Man includes: suicide assessment, mental status assessment, schizophrenia, depression, crisis intervention and the Mental Health Act. Each other program would have their topic areas and legislation for the provider to be familiar with. Further, the proportion of calls related to mental health may be low (e.g. about 10 % in Burntwood). Potential lack of knowledge is addressed at least to some degree by providing a backup. The shared service provider in Nor-Man has a list of CMHW phone numbers and, since the inpatient unit was established in Burntwood, the in-patient unit often handles crisis calls.

A potentially more serious issue, possible conflict between roles, arises from use of a shared service. For instance, a consumer calling the crisis services for mental health reasons may be at risk for having children apprehended by the crisis worker also represents Family Services.

The second component of crisis services is the Safe House / Crisis Stabilization Unit. Both of these services provide short-term 24-hour care to voluntary adult consumers with mental illness or mental health needs that require specialized services for brief personal and / or behavioural difficulties (Canadian Mental Health Association [CMHA], Thompson Region, n.d.). A Safe House is intended to provide a safe and supportive environment, information and referral to community agencies. Crisis Stabilization Units provide short-term intensive care and treatment to voluntary clients who require specialized care in the community but do not require hospitalization. A CSU can provide more intensive service since it is staffed by professionals. Safe Houses are staffed by paraprofessionals. The Safe House / CSU also differ in terms of sponsoring organization. The Safe Houses in Burntwood, Central and Parkland are operated by CMHA while the Salvation Army operates the CSU in Brandon and Interlake.

Several regions, specifically Brandon, Burntwood, Central, Interlake and Parkland, have both a CSU / Safe House and an inpatient unit. In theory, a CSU / Safe House can be complementary to inpatient care. This appears to occur where both services are located in the same town. However, when the services are located at a distance from one another, they appear to serve largely duplicate functions for local populations. For example, Parkland has an inpatient unit in Dauphin and a Safe House in Swan River. People from the Dauphin area would be unlikely to travel two hours to use the Safe House, even if the service were more appropriate, Similarly, a consumer from Swan River would be unlikely to travel to use the inpatient unit unless it was unavoidable.

Due to staffing complement and other reasons, people may be ineligible for service. People are ineligible if they: have a history of unpredictable dangerous behaviour toward others; are at high risk of suicide; have severe physical health problems; or if the primary problem is substance abuse. The client must also be chemical free at referral and the primary reason for requesting service cannot be a crisis in housing. Concern was expressed in one region about the limitations imposed by the mandate. It was felt that some people who would benefit from the service were ineligible.

The CSU in Brandon admits about 22 clients per month and the average length of stay is about five days. The Safe House in Burntwood serves about 80 clients each year and the usual stay is about one week.

One region, South Eastman, does not have either an inpatient unit or a CSU / Safe House. Lack of local beds has posed challenges in terms of access. Depending on availability, services may be provided by a Winnipeg CSU / Safe House or the Selkirk CSU with transportation by the South Eastman crisis service. Locating an available bed can be time consuming and access

depends to some degree on relationships between individual crisis service staff and the CSU /

Safe House. Establishing a CSU was identified as a priority in the service review. Having a CSU

in the region was considered important to keeping people closer to home and natural supports, as

well as reducing time spent by crisis services in arranging placement and transporting clients.

As discussed previously, crisis services are contracted out in a number of regions.

Services provided under contract have experienced particular challenges in terms of recruitment

and retention of staff. High turnover rates and shortages of personnel have led on occasion to

temporary closure of services. South Eastman, which initially contracted out crisis services, was

forced to assume responsibility for the mobile crisis service. Ability to attract and retain staff in

South Eastman crisis services has improved since wages were made comparable to CMHW.

In addition to causing shortages and occasional gaps in service, high turnover makes it

difficult to provide continuity of services. Although some regions have excellent linkages with

non-government organization service providers, having providers within the mental health

program appears to allow greater integration of services and limit potential barriers to

information sharing. Sharing of information between RHA and non-government organizations is

complicated by privacy and confidentiality legislation such as the Personal Health Information

Act (Government of Manitoba, 1997) and the Freedom of Information and Personal Privacy Act

(Government of Manitoba, 1997).

The difference between RHA and non-government organizations in wages also impacts

on the level of qualification and experience among providers of crisis services. Since staff

salaries are far lower in non-government organizations than for positions with the RHA,

experienced staff tend to assume positions with the RHA leaving less experienced staff providing

services to clients in crisis. Concern was expressed about the lack of fit between the experience

level of people providing crisis services and the magnitude of risk inherent in delivery of crisis services.

Table 4

Characteristics of Crisis Services

Region	Delivery Method	Crisis Line	Mobile Service		CSU / Safe House	
			Evening	Overnight	CSU / Safe House	Beds
Assiniboine	Service from Brandon	Y	Y	Y	CSU	Shared with Brandon
Brandon	Contract out	Y	Y	Y	CSU	8
Burntwood	Crisis line Shared service Safe House contracted out	N	N	N	Safe House	4
Central	Contract out	Y	N	N	Safe House	4
Interlake	Contract out	Y	Y	N	CSU	8
N. Eastman	Service from Interlake	Y	Y	N	CSU	Shared with Interlake
Nor-Man	Shared service	Y	Y	Y	None	0
Parkland	MCU Operated directly by region Safe House contracted out	Y	Y	Y	Safe House	4
S. Eastman	Operated directly by region	Y	Y	N	None	0

Inpatient services.

Community-based service delivery is intended to reduce, but not eliminate, inpatient services. Inpatient services are recognized as a necessary component of a continuum of care. A team that is made up of psychiatry, psychology, psychiatric nursing, and social work generally provides inpatient services. Other disciplines, such as Activity Therapy, or a Chaplain may also be included on the team. Inpatient services usually provide assessment, crisis stabilization, treatment and discharge planning.

Historically, inpatient mental health services for non-Winnipeg residents were provided through Brandon, Eden (Central region) or Selkirk (Interlake region) Mental Health Centres. Brandon Mental Health Centre provided inpatient services for what is now Assiniboine, Brandon, north Central and Parkland regions. Eden Mental Health Centre, which is not a provincial facility, provided services to clients from south Central and part of South Eastman. Selkirk Mental Health Centre provided inpatient services to residents of what is now Burntwood, Churchill, North and South Eastman, Interlake and Nor-Man.

The *Building the Future* document identified that BMHC would close, and that the role of SMHC would change. Brandon Mental Health Centre closed in 1998 and, by this time, most long-term residents had been relocated to the community. Acute inpatient units were established in Brandon for children and adolescents; adults; and geriatric clients. Consistent with the *Best Practices* philosophy, the 40-bed adult inpatient unit from BMHC was reduced to 25 beds and was relocated to the Brandon Regional Health Centre in 1998.

The role of the SMHC changed as a result of mental health reform in that it was identified as the provincial resource for long-term care of people with psychiatric disabilities. The forensic unit at SMHC also underwent redevelopment. However, the number of acute and

long-term beds at SMHC was largely unchanged. SMHC continues to provide acute inpatient assessment and treatment for individuals from the catchment area (Eastman and Interlake). SMHC also provides some service to residents of Burntwood, Nor-Man, East Central, Winnipeg, and more recently, Nunavut.

While mental health reform generally involves downsizing of the acute-care sector, regions that had not had local inpatient beds sought to establish such units as a means to provide services closer to home (Table 5). New inpatient beds were established in Burntwood[4], Nor-Man and Parkland. Central also planned for relocation of a portion of their inpatient beds to Portage la Prairie, although this did not take place.

Table 5

In-patient Capacity

Region	Population[5]	Inpatient Beds	Inpatient Beds / 100,000 Pop	CSU / Safe House	Total acute beds / 100,000 Pop
Assiniboine + Brandon	122,388	25	20.4	8	27.0
Burntwood	45,000	10	22.2	4	31.1
Central	97,000	20	20.6	4	24.7
Interlake + N. Eastman	113,017	27	23.9	8	31.0
Nor-Man	25,000	8	32.0	0	32.0
Parkland	43,506	10	23.0	4	32.2
S. Eastman	52,000	0	0	0	0.0

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[4] Prior to mental health reform, Burntwood had one designated mental health bed that enabled involuntary admission and detention until the individual could be transferred. The number of mental health beds increased with mental health reform.

[5] Regional Health Authorities of Manitoba (n.d.)

In addition to closing BMHC and opening smaller units in several regions, CSU / Safe Houses provide additional inpatient capacity. These services, which are discussed above, enhance inpatient options by providing short-term 24-hour care. CSU / Safe Houses exist in Brandon, Burntwood, Central, Interlake and Parkland. Assiniboine and North Eastman use inpatient and CSU services from Brandon and Interlake regions. The only region without direct access to inpatient beds or CSU / Safe House is South Eastman.

At the time of planning for mental health reform, the French-speaking population of South Eastman had good access to St. Boniface Hospital and the Mennonite population had good access to EMHC. As a result, no inpatient beds were planned for South Eastman. A Safe House was proposed but was opposed by people in the local community and was never established. Access to out-of-region inpatient services became more limited after mental health reform. Residents of South Eastman have some access to SMHC. Establishing a CSU is one of the objectives identified in their review of mental health services.

Initial planning for the number of beds per region involved a rough guideline of 20 beds / 100,000 population. In addition to inpatient beds, most regions also established a CSU / Safe House. The combined inpatient capacity differs substantially between regions, ranging from 24.7 to 32.2 beds per 100,000 population (Table 5). The differences may be explained at least in part by minimum numbers required to establish a unit. For instance, it may not be feasible to operate an inpatient unit with fewer than eight beds or CSU / Safe House with fewer than four beds. Consideration of the "appropriate" number of beds per region must also consider that some regions regularly use out-of-region inpatient services. Specifically, regions such as Burntwood and Nor-Man with small inpatient units continue to use SMHC for acute clients who are

aggressive or violent and require more structure and support than can be provided locally.

Residents of north Central also continue to use inpatient services in Winnipeg or Brandon.

Out-of-region service also occurs as a result of service agreements, consumer choice,

provider connections and availability of beds. As mentioned previously, residents of Assiniboine

RHA receive inpatient mental health services from Brandon and residents of North Eastman

receive inpatient services from Interlake on the basis of service agreements. Consumers may

influence the location of admission on the basis of factors such as privacy, culturally appropriate

service, or location of family.

Provider connections may influence the location of inpatient service if the consumer is

using a provider, such as a family physician or psychiatrist, who lives outside the region. For

instance, a resident of Central or Interlake whose physician practices in Winnipeg may be

admitted to a Winnipeg facility rather than the SMHC. Availability of beds also plays a role in

some out-of-region service. For instance, if there are no beds in Winnipeg facilities, a consumer

requiring admission may be transported to Brandon for inpatient services. This latter practice is

problematic as no provisions are made for consumers to be returned to their region upon

discharge. Further, the extent of contact between Brandon inpatient services and follow-up

services is limited. The full extent of out-of-region inpatient service use is unknown, but

Brandon reports that 10 % of their inpatient admissions are from outside Assiniboine and

Brandon RHA.

In addition to out-of-region travel, inpatient mental health services may be provided in

local rural hospitals. Assiniboine, Burntwood, Interlake, Nor-Man, North Eastman, Parkland and

South Eastman identified that they have used, and in most cases continue to use, local hospitals

as the first line resource for inpatient mental health services. Although mental health expertise is

not available in these hospitals, some care can be provided when it is safe for the client. Mental health services are usually provided by the CMHW in collaboration with the physician. Local beds are selected as an option depending acuity and consumer choice. Although some consumers prefer not to be served in their home community, others prefer to be close to home and family, even thought the service is limited. On occasion local hospital beds are also used when there are no inpatient mental health beds available.

Long-term inpatient care can be provided through residential care homes, personal care homes or through Selkirk Mental Health Centre, which is the designated long-term care facility for the province. Residential care homes are discussed below in the section on housing. Depending on age and type of disability, long-term care may also be provided in Personal Care Homes. Both of these options provide long-term care closer to home. However, high-risk populations, such as persons with Substance Induced Persisting Dementia (formerly Korsakoff's disorder) or brain damage related to solvent abuse, are not suitable for acute care, residential care homes or personal care homes. For this small group of high-risk people it is unlikely that even greatly enhanced services would enable community living. Further, due to past actions of these individuals and perceived risk, the community may reject the person. These high-risk consumers require long-term inpatient care in a facility such as SMHC. Clients who are aggressive or sexually inappropriate (e.g. sexual predators) may also require long-term inpatient care. The number of consumers referred to SMHC for long-term care appears low, with some regions identifying no referrals to SMHC and other regions reporting one to three referrals per year. These referrals are often geriatric clients.

It is intended that long-term inpatient services only be provided to those whose needs cannot be met by other alternatives. Consumers referred to SMHC for long-term care receive an

assessment to determine whether there are additional community supports that would assist the consumer to remain in the community. SMHC will not accept the consumer if there are alternatives. While regions agree with the philosophy, they may disagree with SMHC about the suitability of client for community living and resources that should be used. In the event of a disagreement the region may have to retain people in acute care beds for extended periods of time (months) while waiting for placement or develop costly new services. Lack of services for consumers with Acquired Brain Injury was consistently identified as a concern.

As identified in the section on integration / linkage of services, there are potential barriers to linkage between the RHA and organizations that report to other bodies. Because of its' role as a provincial institution, SMHC reports directly to Manitoba Health even though SMHC provides acute inpatient services to the Interlake RHA. These reporting relationships placed some limitations on the scope of planning for mental health reform and decision-making about the role of the facility within the region. The more recent appointment of the former Mental Health Program Manager as Chief Executive Officer for SMHC may provide increased opportunity for joint planning and integrated services.

Housing.

People with SPMI live in a wide range of situations ranging from independent living to living in a 24-hour supervised residence (Table 6). Many people with SPMI also live with family members. Availability of appropriate and affordable housing has been recognized as central to sustaining community living since the early days of deinstitutionalization. The accepted model for supported housing is the "Choose, get, keep" model. This model involves the consumer identifying the living situation in which they would like to live and then providing support to develop the skills needed to be successful in that environment. For instance, a consumer who

wants to live independently but does not have the necessary skills would be assisted to locate an

apartment, and would be provided with support and skill teaching to develop the needed skills.

The *Best Practices* document identifies housing as a key element of a reformed system of

care. The criteria for housing state: "There is a variety housing alternatives available, ranging

from supervised community residences to supported housing, with an emphasis on supported

housing." (p 11). The *Review of Best Practices in Mental Health Reform* (HSRU, 1997a)

identifies critical elements of supported housing as: use of generic housing dispersed widely in

the community; provision of flexible individualized supports which vary in intensity; consumer

choice; assistance in locating and maintaining housing, and; no restrictions on the amount of

time a consumer can remain in the residence. In Manitoba, a full range of housing alternatives

would include competitive housing, supported independent living, and supervised living.

Consumers may obtain housing on the competitive housing market. Competitive housing

offers the greatest range of housing options, from very nice houses to a room in a hotel.

However, competitive housing is difficult to obtain for a variety of reasons. Low vacancy rates,

high housing costs and stigma all impact on availability of housing. There is a shortage of safe

and affordable housing in every region. Affordable housing is particularly difficult to locate in

areas where the economy is growing. Affordable housing can be located in outlying areas but,

unless the consumer has access to transportation, availability of other services in these areas may

be limited. The consumer may be isolated from their case manager, family physician and other

services. Vacancies in subsidized housing available through the Manitoba Housing Authority

(discussed below) also tend to be located in outlying communities.

The terms "supported housing" and "supported independent living" can mean different

things to different people. Support may be provided in a variety of ways, including financial

support for housing, instrumental support to facilitate independent living and advocacy to obtain and maintain housing. All three types of support will be discussed here.

Consumers often have difficulty finding safe affordable housing in the competitive market. High numbers of people with SPMI are on Income Assistance. In Manitoba this means $285 per month is allowed for housing, including utilities. Safe and adequate housing in this price range is rare. Even when consumers share an apartment to keep costs down, there is still a shortage. Consumers, and others on Income Assistance, often find themselves using money allocated for food to obtain any form of housing. Consumers then find themselves relying on resources such as soup kitchens or hampers from local organizations, if these are available, to meet nutritional needs.

The Manitoba Housing Authority provides housing to low-income seniors, families and others at a rate determined as a proportion of income. Manitoba Housing Authority has 13,000 housing units across the province (Manitoba Family Services and Housing, n.d.). Availability of units, and access to these units, differs substantially across the province with most regions reporting insufficient access. There has been no new construction for some time and there is generally a high demand for these units. For instance, North Eastman reported a seven-year waiting list. Even when units are available, consumers may be assigned low priority or may not be eligible. Manitoba Housing does not allow renters with disruptive behaviours (Park, 2002). Even when consumers obtain housing through Manitoba Housing, it may not be suitable. For instance, consumers who reside in elderly persons' housing are required to live like the elderly, regardless of the consumers' age. Park reported that consumers expressed numerous concerns about Manitoba Housing units, including the limitations imposed by housing designed for elderly people.

Stigma is an additional factor that influences availability of units from Manitoba Housing Authority and other landlords. Park (2002) reports numerous complaints are made to the Manitoba Housing Authority about mental health clients. Consumers reported being refused apartments as a result of mental illness. Advocacy is used to address stigma. Case managers may advocate for individual clients with landlords in order to facilitate obtaining or maintaining housing. In some cases the RHA has provided assurances to landlords in order to obtain housing for clients. One region reported that Manitoba Housing, and other landlords, need to be convinced that Mental Health Services will be responsible for any damage before they rent to a mental health client.

In short, there are substantial barriers to obtaining and maintaining affordable housing through both the competitive market and Manitoba Housing Authority. Lack of appropriate housing can have consequences for consumers and for RHA. Consumers may be forced to live with family on an extended basis due to lack of alternatives, may be at risk for admission to a facility and are at risk for reduced QoL. Further, consumers may find themselves unable to remain in, or return to, their community if there is no suitable housing. Lack of suitable housing may also result in mental health facilities being unable to discharge consumers leading to extended length of stay. These potential consequences are confirmed by a recent study of housing needs of mental health consumers in the north part of Central (Park, 2002). The study reports a substantial number of consumers who remained in unsuitable housing for financial reasons. The study also found that extended stays in the Safe House resulting from lack of housing accounted for 193 days stay in 2000 and 349 days in 2001. Prolonged inpatient stays at EMHC for adults awaiting accommodation in 1999/2000 resulted in a total of 542 inpatient days

and an additional ten beds for people with SPMI are fully occupied by people waiting for adequate housing and community supports (Park, 2002).

Several regions have invested in developing affordable housing in collaboration with the non-profit sector. In 1994 Manitoba Health, in collaboration with the Manitoba Housing Authority, set up an organization called Parkland Mental Health Housing Incorporated. This organization purchased a number of properties including a house in Ste. Rose du Lac, four multi-bedroom apartments in Dauphin, a fourplex in Swan River and a three-bedroom house in Swan River. These properties are large, furnished and come equipped with cable. Rent is paid at Income Assistance rates so clients do not have to use the food budget to pay the rent. The South Eastman RHA also worked in partnership with a community group to develop affordable housing. A house with three beds was purchased by a community organization that subsidizes the rent to make it affordable. In Brandon, Brandon Community Welcome has developed 15 suites primarily for people with psychiatric disabilities.

CMHA is involved in housing in several regions. CMHA provides supported housing in 440 House in Brandon, which has five suites, and has rental suites in Burntwood. CMHA also plays a role in providing supported independent living in Brandon and Interlake.

Eden Health Care Services in south Central operate Enns Court Apartments, which offers housing on a subsidized basis for mental health clients and others disadvantaged by finances. It is important to note that some of these initiatives, such as Enns Court apartments and some of the CMHA initiatives, predate mental health reform.

While affordability is a very important component of supportive housing, many consumers with SPMI also need support to develop and maintain independent living skills. Skills such as cooking, cleaning, laundry, shopping, using public transportation, interpersonal skills,

working with landlords, budgeting, and paying bills are all critical to independent living. Each region provides some assistance in meeting these needs through case managers or proctors. The extent to which these supports can be provided depends on caseload size for case manager, and on the size of the proctor budget. Skill teaching may also occur through other avenues, such as the CMHA Ke na now Club in Thompson.

Brandon and south Central provide a few additional options for skill teaching / supported living. In Brandon, the PSR program operates McTavish Manor, a ten-bed facility that is staffed on a 24-hour basis. The PSR Program also has seven apartments that are used for assessment and treatment as well as rehabilitation. The apartments are located in a large complex in Brandon and are used for longer-term individualized support. One of the apartments is used as an office. Staff assists clients in areas such as meal preparation, medication management, money management or home management. Eden Health Care Services in south Central operates Linden Place, a fully supervised residence for eight people. Linden Place provides transition for consumers leaving EMHC and in some cases substitutes for care at EMHC. Consumers usually stay for 18 months to two years. Linden Place offers rehabilitation including life skills training and literacy programs.

If clients cannot be provided with sufficient support to live independently, they may require supervised living. Supervised living can be provided through homes licensed or approved through the Residential Care Licensing Branch of Manitoba Family Services and Housing. Residential Care "is responsible for licensing all residential care facilities which provide care and supervision to individuals who are unable to live independently, including adults with developmental or psychiatric disabilities, or the elderly. The branch ensures that care facilities comply with fire, safety and health standards" (Manitoba Family Services and Housing, n.d.).

Two RHA have assumed direct responsibility for licensing of homes used by mental health clients. The PSR program in Brandon has a Residential Care Coordinator who develops resources and ensures residential care standards are met. In Interlake, CMHA is responsible for licensing and inspecting the approved homes. In other regions, responsibility remains with Manitoba Family and Housing Services. As with subsidized housing, these programs existed prior to reform and in some areas, such as Assiniboine, the number of homes has declined over time.

Residential Care has two kinds of homes, licensed homes and approved homes. Both provide 24-hour supervised living with family or home operators. Licensed homes have more than four but no more than six residents while approved homes have three or fewer residents. Residential care homes do not exist in all regions. Availability is influenced to some degree by willingness of individuals to operate these homes. Burntwood has advertised for home operators but there has been little interest from the community. Distribution of homes within a region is also influenced by interest in operating a home. One region identified that homes were available in an economically depressed area of the region but not in more affluent areas.

The only region that presently has group homes is Parkland. Parkland region has a three-bedroom group home in Swan River and a three-bedroom group home in Dauphin. These homes exist in part due to difficulty in transferring clients to long-term care in SMHC. Until the facility closed following a fire, a seven-bed licensed home was located in Laurier. St. Christopher's Home pre-dated mental health reform and, although located in Parkland, served clients from across Manitoba. The home was isolated and, by virtue of location, access to natural supports was limited. However, the facility did play a role with clients who had high needs and no other resources.

Table 6

Housing Resources

Region	Supported Housing				Residential Care Home	
	Subsidized		Living Skills			
	MHA*	Other	RHA	Other	Approved	Licensed
Assiniboine	Limited		Proctor			✓
Brandon	✓	BCW** CMHA	ICM/Proctor McTavish Manor Amberwood	CMHA	✓	✓
Burntwood	Limited	CMHA	ICM/proctor	CMHA YWCA		
Central	✓	EHCS***	ICM/proctor	EHCS		
Interlake	✓		ICM/proctor	CMHA	✓	
N. Eastman	✓		ICM/proctor		✓	
Nor-Man	Limited		Proctor			
Parkland	✓	PMHHI****	ICM/proctor		✓	
S. Eastman	Limited		ICM/proctor		✓	✓

* Manitoba Housing Authority

** Brandon Community Welcome

*** Eden Health Care Services

** **Parkland Mental Health Housing Incorporated

A number of issues related to housing were identified in the interviews. These issues include: the range of housing alternatives available; debate about what is required; debate about

responsibility for providing housing; the potential for an increase in need for housing; challenges in providing supervised living on a distributed basis; and changes in access related to separation of Health from Family Services.

While all regions have some housing resources, there are a few regions, such as Brandon, Central, Interlake and Parkland, that have made a substantial investment in developing a range of housing alternatives and facilitating access to suitable housing. These also tend to be regions with large populations of people with SPMI and active PSR programs. Other regions, such as North and South Eastman, are in the process of building resources. However, regions without active housing programs identified that there seemed to be limited needs in this area or that housing was a lower priority than other mental health services.

Different stakeholders have different philosophies and different perceptions of need. In keeping with the philosophy of mental health reform, regions have generally shown a preference for supported independent living and, where necessary, supervised community living in a family home. However, other stakeholders consider large staffed group homes as the appropriate living situation for people with SPMI currently in long-term care situations. Depending on perspective, the services that need to be developed could be identified as group homes or community services. Therefore, discussion about the appropriateness of existing resources would be colored by these perceptions and is beyond the scope of this paper.

One program manager pointed out that discussion of housing availability presumes that mental health programs are responsible for housing for people with SPMI. The alternate perspective is that, since many of the people with SPMI have multiple challenges and multi-agency involvement, responsibility for providing access to housing and supports for independent living might best be considered a shared responsibility with other agencies. For instance,

securing housing for an individual with a developmental disability (Family Services) and addictions problem (Addictions Foundation) in addition to mental illness might be the accomplished by any one of the agencies, or through collaboration between agencies.

One mental health manager identified that the need for supported housing can be expected to increase in the future. Many people with SPMI currently live with elderly parents. As these elderly parents become less able to provide support to the consumer, alternate living arrangements may be required.

Challenges were identified in providing supervised living for consumers who are geographically distributed. Even where the number of clients requiring supervised living warrants establishing a supervised residence, these individuals may be widely dispersed. No matter where the residence is located, it is likely that some individuals would have to leave their home community. As a result, the benefits of supervised living need to be balanced against consumer choice about which community they prefer to live in.

The final issue is related to the separation of Health and Family Services under regionalization. Prior to regionalization, the regions were involved in "planning, development and maintenance of community residences, independent and group living programs, foster homes, respite care and day programs" (Manitoba Health, 1994 p 44). Although Brandon and Interlake RHA have directly or indirectly assumed responsibility for licensing residential care homes, other regions reported that separation from Family Services limited access to homes. Ability to exert influence in areas such as frequency of inspection or requirements for programming was also limited by the change. One region anticipated that the RHA would need to develop separate housing resources.

Vocational / Educational supports.

The *Best Practice* criteria for vocational / educational supports states: "There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation" (p 11). Since people with SPMI have a wide range of interests and abilities, the range of supports in the vocational /educational area is also broad. Consumers may have needs in the area of basic literacy, job readiness (e.g. attendance, hygiene, communication skills, and response to supervision), job skills, resume writing and job search, and transitional or supported employment. A variety of organizations, including health and other government organizations, and a variety of community organizations, provide vocational / educational supports to meet these diverse needs.

Brandon, Central, Interlake and Parkland, have designated EDC to meet vocational / educational needs. EDC perform largely the same functions as an ICM, but work primarily with clients whose goals are in the vocational / educational areas. Specific activities depend on the consumer's goals and their existing skills and resources. Activities are designed to fill the gap between existing and needed skills and resources. The specialized services provided by the EDC can involve linking clients with existing resources, directly providing the supports where other resources do not exist, or developing new resources. The emphasis is on assisting the individual to choose, get and keep employment.

Since most of the vocational /educational resources are not operated by Health, a knowledge of diverse programs and resources offered by other government agencies, for instance, Manitoba Education and Training, Manitoba Family Services and Housing, and Human Resources Development Canada, or by community organizations, such as CMHA, self-help services, and Friendship Centres, is needed to facilitate access to appropriate resources. Further,

in the resource development capacity, the EDC may be able to influence existing resources in ways that will enhance the effectiveness of those resources in meeting the needs of people with SPMI. Good working relationships between these stakeholders also facilitates development of new resources. For instance, the EDC in Parkland collaborated with stakeholders such as Federal and Provincial programs and Family Services in development of a pre-employment training program. The program has been very successful with a 100 % placement rate among the last group of graduates (G. Meadows, personal communication, December, 2002). Ideally, the EDC could also establish relationships with local industry to develop and support transitional employment, including addressing issues such as stigma that limit employment options.

In regions with small numbers of people with SPMI, vocational / educational needs are met by ICM or CMHW. The extent to which vocational / educational goals can be pursued depends, at least in part, on caseload size. However, even ICM with recommended caseload sizes may have difficulty providing needed assistance with employment. For instance, when the EDC position in Central was vacant, ICM attempted to provide this service. ICM found that providing supported employment required knowledge of the intricacies of the bureaucracy in Family Services and Human Resources Development Canada. It was difficult for service providers such as ICM, who have multiple roles, to learn how to negotiate the bureaucracy. Development of needed resources would add yet another role and an additional skill set. In short, ICM and CMHW do make efforts to provide some vocational / educational support but the extent of support will be limited. In regions with both EDC and ICM, the EDC may, in addition to their own clients and resource development, provide support for ICM who have clients pursuing vocational / educational goals.

Support for literacy and computer skills, employment readiness, job skills, resume

writing and job search, transitional or supported employment and support of consumer-operated

businesses are offered by a myriad of community and government organizations. It would not be

possible to discuss all the available resources here. However, selected programs that are either

widely available or particularly unique should be noted.

The Vocational Rehabilitation Services Program of Manitoba Family Services and

Housing is designed to provide assistance to adults with disabilities in preparing for, obtaining or

maintaining employment. Services are available in Central, Eastman (North and South Eastman

RHA), Interlake, Nor-Man, Parkland, Thompson (Burntwood RHA) and Westman (Assiniboine

and Brandon RHA). Services include vocational counseling, assessment, vocational planning,

vocational training and support services. Individuals with mental, psychiatric, learning or

physical disabilities are eligible (R. Fortier, personal communication, May 12, 2003). Although

this service is available to mental health clients, most regions complained that the service was

difficult to access and not necessarily appropriate for mental health clients. For instance, the

available services may not meet specific client needs, mental health clients may not be eligible

for services that would be of benefit, or options may be substantially beneath the capability of

eligible consumers. While access has been a problem for some time, the separation of Health and

Family Services appears to have added an additional barrier.

CMHA provides employment services in Brandon, Burntwood and Central. In Brandon

CMHA operates the Re-Store, which sells donated and consigned building supplies. Burntwood

CMHA, through the Ke na now Club, offers an odd-job squad and is considering incorporation

of a work-ordered day into operation of the Club. CMHA Central recently began operating

"Routes to Real Work", a federally funded employment initiative. The initiative involves

provision of supported employment in mainstream work environments and development of

consumer operated businesses.

While each region offers a portion of the range of vocational / educational supports, a full

range of supports is available in Brandon. In addition to the CMHA Re-Store mentioned above,

these supports include: Career Connections, Brandon Community Welcome, Samaritan House,

Ventures, Westman Coalition and Westman Lead. Only Ventures is directly operated by the

region. However, the PSR program is very involved with each of these organizations.

Career Connections is funded through Vocational Rehabilitation Services on a cost

shared basis with the Federal government. This service is for people with disabilities and is not

specific to mental health clients. Clients using this service have access to a job coach who

provides training and support in placements in local businesses, such as Canadian Tire.

Businesses may receive subsidy for the placement, but clients are paid regular wages.

Brandon Community Welcome, a non-profit organization, was established 1986 to

facilitate community living among consumers being discharged from BMHC. Computer training

and workplace health and safety information are some of the educational programs offered.

Brandon Community Welcome established a Transitional Employment Program in 2000. The

program operates a job bank and a service where consumers register for paid casual employment.

Samaritan House, a separate non-profit organization, also provides literacy and computer literacy

programs.

The Ventures program was originally operated out of BMHC and was transferred to the

RHA when BMHC was closed. The Ventures program provides a five-day assessment of work

skills and work readiness skills such as attendance, hygiene, communication skills, and response

to supervision. Once the assessment is complete, clients can participate in skill training. Skill

training is conducted in a variety of settings and is specific to client goals. For instance, if the client's goal is to work as a receptionist then skill training might revolve around computer skills. The Ventures program also has some job placements with the RHA in areas such as courier services. The Ventures program is intended to provide assessment and training rather than serving as a sheltered workshop.

The Westman Coalition was established in 1995 through block funding from Manitoba Education and Training in collaboration with Human Resources Development Canada for people with a variety of disabilities. A Vocational Rehabilitation Counselor assesses needs, and assists in resume development and finding employment.

The Westman Lead was established in 2000. This initiative is funded by the National Network for Mental Health and promotes opportunities for self-employment among persons who have experienced mental health problems.

Other employment resources include the Trainex Centre in Central and the Selkirk Support Centre in Interlake.

Trainex Centre is operated by Eden Health Care Services and provides some vocational services under contract to the Central Manitoba RHA. The Trainex Centre is a workshop that is designed to prepare people for, and assist in obtaining, employment. Service at the Trainex Centre is provided to a range of clients including individuals with mental health problems, recent immigrants, recipients of income assistance and other individuals with employment problems. A three-week assessment is followed by development of a vocational plan and skill building at the Centre. There is also a work experience program with community businesses. Assessment services have been well used by the RHA, but access to other services is somewhat limited for

mental health clients. The program is best suited to individuals who have been in long-stay environments.

The Selkirk Support Centre offers a pre-employment program that enhances confidence and provides training in basic work skills. This program links with the "Sunflower Café" at the Selkirk Mental Health Centre, which is a consumer-operated business.

High unemployment and disincentives under Income Assistance create barriers to employment for people with SPMI. Unemployment is high in a number of areas and competition is substantial even for entry-level positions. Interestingly, regions with high unemployment identified that unemployment does not appear to be a particular concern for consumers, possibly because there is less stigma associated with unemployment.

Since a high number of people with SPMI rely on Income Assistance, policies on retention of earned income serve as a disincentive to employment. A consumer working a substantial number of hours would only retain a small amount of that income and would potentially jeopardize disability benefits. Becoming self-supporting would require full-time employment at a minimum of eight dollars per hour. Since most available jobs pay minimum wage, working disadvantages consumers.

Low client numbers were identified as a barrier to establishing EDC. Low caseload numbers and a lack of quick results is another barrier. These factors created pressure on the EDC position in Central. The position was reduced to half time, which resulted in a great deal of staff turnover.

Social / Recreational supports.

Social and recreational supports are recognized as a component of a community support system. People with SPMI are often isolated due to characteristics of the disorder, stigma and

poverty. For these individuals, integration into the community requires support for participation in social and recreational opportunities. The *Best Practices* criteria for social recreation, which is combined with the statement on employment, states "There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation" (p 11).

Social and recreational opportunities that exist within the community and are available to all community members are also available to people with SPMI. Proctors are used to support participation of people with SPMI in these activities. The extent to which support can be provided depends on the extent of proctor resources and the priority attached to social goals.

In some regions, specifically Assiniboine, North and South Eastman, existing community activities are the only resources. Each of the other regions has some provision for social / recreational opportunities for people with SPMI. These options differ substantially in terms of how they are funded and what is offered. The options available in each region, beyond use of proctors, are discussed here in order to illustrate the range of possible configurations.

In Brandon, Community Support Services, CMHA Community Friends and Grey Owl provide social / recreational opportunities. Activity Instructors from Community Support Services, which is part of the PSR program, work with individuals and groups to facilitate initiation and participation in social / recreational opportunities in the community. Community Friends is a program operated by the CMHA. It pairs a client with a volunteer to provide social opportunities. The Grey Owl is the social /recreational part of Brandon Community Welcome. It follows Clubhouse principles and operates as a drop-in centre as well as offering regular events, such as movies, bingo or barbeques. Drop-in centres provide consumers with friendship, support, information and belonging. About 30 people attend the Grey Owl each day. Grey Owl and

Community Friends partner with the PSR Program for some events, such as a fashion show, potluck suppers and a Christmas party.

The Ke Na Now Club, which is operated by CMHA under contract to the Burntwood RHA, provides a day program. The day program includes life-skills training and operates as a drop-in centre. The Club also has a social / recreational program in the evenings. The Club provides transportation to facilitate participation by members. The budget provided to the Club by the region is substantial in comparison to regional support in other regions.

CMHA also offers a consumer driven and operated peer support drop-in program in Portage la Prairie (Central). The program is well attended and provides social and volunteer opportunities for consumers. CMHA also periodically organizes special events or trips to, for instance, Winnipeg. Further, CMHA is present in Winkler one or two days a week to provide social / recreational opportunities. Eden Health Care Services offers the Community Choices Day Program on a mobile basis to provide social, recreational and life skills programs to individuals in residential care settings operated by Eden Health Care Services. Both the drop-in centre and the day program are funded independently of the RHA.

Social / recreational supports in the Interlake region are provided by the Selkirk/Interlake Mental Health Support Centre Inc. under contract to the Interlake RHA. This non-profit organization is run by a Board and operates Support Centres in Ashern, Arborg, Lundar and Selkirk. These Centres provide a safe place for consumers to meet friends, connect to the community and community events, socialize, problem solve, and obtain basic support. Many persons discharged from SMHC begin participation at the Centre as a means to reconnect, or become reoriented to, the community. Each Centre has a lunch program and hosts social events, such as barbeques and Christmas parties. Centres may also offer some unique services. For

instance, the Arborg Support Centre has a Thrift Shop. Proceeds of the Thrift Shop largely cover expenses for the meal. About eight consumers attend the Arborg Support Centre daily on a drop-in basis for movies, games and conversation. The Arborg Support Centre opened in 1996 and the Lundar Support Centre opened in 2002.

At the time of writing, CMHA in Nor-Man had obtained grant funding to establish a drop-in centre in Flin Flon. The centre is expected to operate two days per week. Efforts are being made to establish a similar program in the Pas.

Helping Everyone Reach Out (HERO Club), which was named by the members, was established in Parkland in 1994. The Club is similar to a Clubhouse in that it is member directed but differs in that the emphasis is on social / recreational activity rather than work. Once a month members decide what activities will take place, prepare and distribute a calendar of activities to members. Activities are largely social / recreational but may include some work activities. Work activities might include walking dogs, holding yard sales, or making craft projects for sale. The HERO Club is also involved in fund-raising and educational activities. Members are actively involved in all aspects of operating the Club.

The HERO Club is supported by the region through proctors and a small budget of around $45,000 per year. Separate Clubs operate in Dauphin, Roblin and Swan River. The Swan River HERO Club has about 15-20 active members and the Dauphin Club has 20-25 active members. About 15-20 members would attend a typical recreational activity in Dauphin. On occasion HERO Clubs from various locations in the Parkland region meet for activities.

The Parkland region also supports a summer camp that is available to consumers. The region pays for camp rental and proctor services to operate the camp. Consumers pay a small fee to cover the cost of meals. The camp is well attended.

CMHA also operates a drop in centre in Swan River. The drop in centre provides individual and group support in life skills, budgeting, finding and securing housing, assertiveness training and so forth.

The review of mental health services in South Eastman identified an interest in development of a day program. At the time of writing, CMHA was collaborating with MSS and EMHC to develop a drop-in centre in Steinbach for people with mental illness.

In summary, participation in social / recreational opportunities in the community are supported by Mental Health Services primarily through the use of proctors. Most regions also offer some services, such as drop-in, specifically for people with mental illness. These latter services may be delivered and funded in a variety of ways including direct operation by the region, delivery by a non-government organization under contract to the RHA, or through grant funding.

Self-help / Family self-help.

Self-help groups "draw upon the experience of members to provide support, information, coping skills, problem solving and advocacy. Group members are empowered to take control of their lives, support others, and develop positive attitudes about themselves and their conditions" (HSRU, 1997a, p 74). The *Best Practices* criteria state that: "initiatives are in place that have diverse purposes such as mutual aid, skills training and economic development. Self-help services are supported through funding, consumer leadership training, education of professionals and the public about self-help services, and evaluation using appropriate methods" (p 11).

Although organizations such as the Anxiety Disorders Association of Manitoba (ADAM), CMHA, Mood Disorders Association of Manitoba ([MDAM] formerly the Society for Depression and Manic Depression) and Manitoba Schizophrenia Society (MSS) existed in

Manitoba prior to reform, the organizations were small and were concentrated in Winnipeg. Under mental health reform, the role of self-help organizations in providing mutual aid, and as a vehicle for consumer and community involvement in local and provincial mental health issues, was recognized (Manitoba Health, 1993). Funding was directly provided to these organizations by Manitoba Health to establish services in each region. About $30,000 was allocated to each service in each region and, between 1994 and 1997, offices were established in all rural regions. Since the services were established before regionalization was implemented, the present distribution of resources reflects historic Health and Family Services boundaries. The Westman office, located in Brandon, now serves Assiniboine and Brandon RHA. Services in Eastman are shared between North and South Eastman.

Offices are usually staffed by an Outreach Worker on a part-time basis. Outreach Workers are hired for between 15 (Burntwood) and 30 hours per week. Organizations also rely on volunteer assistance.

As part of the Mental Health Renewal process, a review of self-help policy was initiated. The leadership role of self-help organizations in movement toward a recovery-based mental health system was recognized. The review identified the core self-help functions as: mutual aid and peer support; public education; advocacy; and consumer operated services (other than self-help / support groups) (Mental Health Self Help Policy Review Committee, 2002).

Mutual aid and peer support may be delivered through individual or group support. Most self-help groups offer individual support on a limited basis with the goal of engaging the individual in one of the group sessions or, if needs extend beyond what can be offered, through referral to other agencies. Group support is available through weekly, bi-monthly or monthly meetings in areas of the region where numbers are sufficient to operate a group. For instance, the

MSS in Central regions organizes peer support sessions on a weekly or bi-monthly basis in Portage la Prairie and Winkler with an additional group starting at Headingly jail in January 2002. ADAM also provides a follow up support group for graduates of their education program.

Each of the self-help groups provides education not only to the public, but to consumers, family members and health professionals as well. Public education may be provided through presentations in schools, displays in health offices, health fairs or public presentations. Both ADAM and MSS have well established psychoeducation programs that are offered periodically for consumers and / or family members. For instance ADAM offers two 12-week Cognitive Behavioural Therapy sessions, one for Panic Disorder and the other for social anxiety, while the MSS offers "Eight stages of healing" for family members. Education is also provided to existing health professionals and students in a variety of human services. Further, education may be provided to professionals such as police or clergy, who come into contact with people with mental illness. Education may also be offered to teachers on working with anxious children, staff at SMHC or guards at Stoney Mountain Penitentiary. CMHA provides some public education, primarily in the area of health promotion.

One additional means of providing education to a broad range of audiences was the use of resource libraries. When the self-help services were established in rural regions, most developed a resource library. The logistics of operating these libraries became such that, as part of mental health renewal, a centralized Mental Health Education Resource Centre was established in Winnipeg. This library contains material, such as books, journals, pamphlets, presentation kits and videos, on a wide range of topics related to mental health and mental illness. The Mental Health Education Resource Centre is in the process of establishing a web

catalogue and will mail out material at no cost to Manitoba residents (Mental Health Education

Resource Centre of Manitoba, 2003).

Advocacy involves ensuring a consumer voice in activities relevant to people with mental

illness. This may involve participating as a member of a Mental Health Advisory Committee or a

regional CQI team. It may also involve attending monthly meetings of regional mental health

staff. Other ad hoc groups, such as the Suicide Awareness Committee, may also seek consumer

involvement through the self-help groups.

Consumer-operated services go beyond typical self-help activities to include social and

vocational services. For instance, consumers or self-help groups are involved in the operation of

the Support Centres in Interlake, drop-in program in Central and the Clubhouse in Burntwood.

Self-help groups may also be involved in literacy programs, skills training, and employment

initiatives, including consumer-operated businesses.

While regional offices operate within the parameters of their organizational mandate, it

appears that the extent to which these four elements are attended depends on the Outreach

Worker. For each group, regional offices will have some elements in common as well as some

unique initiatives. The description of each of the self-help groups below will identify general

activities and programs for each organization, as well as noteworthy regional initiatives.

ADAM offers individual and group support and information. New members attend one of

two 12-week Cognitive Behavioural Therapy Programs, one for Panic Disorder and the other for

social anxiety. The sessions include illness education and coping in a peer counseling / mutual

support environment. Follow-up support groups are usually available on a monthly basis for

graduates of the educational session. ADAM also offers information and referral, and public

education, through eight regional offices that cover all ten rural health regions. Offices are

located in South Nor-Man (the Pas); North Nor-Man (Flin Flon); Westman (Brandon); Interlake (Teulon); Parkland (Ethelbert); Central (Winkler); Burntwood (Thompson); and Eastman (Oakbank) (ADAM, n.d.).

The MDAM (formerly Society for Depression and Manic Depression) provides individual and group support, including visitation in hospital; monthly education meetings; public education and workshops for professionals and students; and resource library services (Society for Depression and Manic Depression, n.d.). There are 11 offices, nine of which are in rural areas. These offices are located in Brandon, Dauphin, Flin Flon, Fisher Branch, Oakbank, the Pas, Selkirk Mental Health Centre, Thompson and Winkler.

The MSS offers a number of services, including: individual and family support in areas such as illness management and available supports and services; public education and awareness; and advocacy for a recovery-oriented mental health system. One of the public education initiatives is the "Hearing Voices" workshop, which assists participants to gain some understanding of the experience of hearing voices that are distressing. Centrally, the MSS is also responsible for the Mental Health Education Resource Centre and the Partnership for Consumer Empowerment initiatives.

Nationally the Schizophrenia Society of Canada has tended to be focused primarily on family issues. In contrast, the MSS has worked to become consumer focused with an emphasis on psychosocial rehabilitation and recovery.

CMHA's mandate is to promote mental health and provide service to mental health consumers, their family and friends (CMHA, n.d.). Like other self-help groups, CMHA has been involved in public education, information and referral, and advocacy. CMHA is less involved than the other three groups in peer support, but has been more involved in direct provision of

services. A range of services related to housing, employment and recreation have been provided under contract to some RHAs. Services provided by CMHA under contract to RHA include: the Safe House and the Ke na now Club (social / recreational and employment services) in Burntwood; the supported housing program in Interlake; and the Safe House in Parkland. CMHA is also involved in development or operation of drop-in centres in Central, Interlake, Nor-Man, Parkland and South Eastman. Some social / recreational and skill training opportunities are provided through these drop-in centres. Even when services are not provided under contract to the RHA, RHA may make a financial contribution toward certain activities. For instance, as described below, Interlake provides financial assistance to self-help in order to facilitate service delivery across the region. CMHA's health promotion activities include operation of "I'm Thumbody" a self-esteem program children in grade three, and delivery of presentations / workshops on topics such as anger management, self-esteem, stress management, and relaxation.

Brandon Community Welcome / Grey Owl also provides self-help services to consumers in Brandon and area. Services are funded through fundraising, grant funding and contributions from the RHA. Services provided include housing, education, employment and social / recreational opportunities.

Although exceptions exist, all four self-help groups collaborate extensively with each other, with other community services and with RHA. Self-help services in Central and Eastman developed later than in other regions. This provided opportunities to learn from the experience in other regions. In Central, ADAM, CMHA, MDAM and MSS collaborate on a number of initiatives and share responsibilities for others. For instance, the above groups collaborate with others to offer a yearly consumer retreat at Camp Assiniboia for about 50 people. The groups also collaborate on public health promotion and illness education initiatives. Responsibility for

representing consumers on committees is shared. For instance, ADAM assumes responsibility

for participation in the Mental Health Advisory Committee and the Accreditation Committee

while MSS assumes responsibility for participation on the Suicide Awareness Committee.

Similarly, in Eastman, ADAM, CMHA, MDAM and MSS formed a coalition called the Eastman

Mental Self-Help Service. Each organization maintains a separate identity, but there is a high

degree of collaboration on specific initiatives.

In many cases the self-help groups share office space or travel costs. For instance, in

Central, ADAM and MSS are located in Winkler while CMHA has its offices in Portage la

Prairie. The self-help groups share space so that CMHA can provide service in the south one or

two days a week and ADAM and MSS can provide service in Portage la Prairie. In some cases, a

single individual will serve as the Outreach Worker for two different organizations. For instance,

in the Pas, MDAM and MSS share a single Outreach Worker.

The most common area of collaboration is public education. Self-help organizations often

work with each other, with other community organizations and with RHA to offer educational

sessions. Collaboration with RHA may also involve offering space or other resources. For

instance, in Assiniboine, the RHA worked in partnership with the self-help groups to identify a

theme for each month and provide public education on mental health topics such as mental

health promotion and depression. The RHA provided support by making a site available, and

providing coffee and promotion for the event. Self-help organizations also collaborate with

facilities in and outside health care. For instance, SMHC provides an office onsite and each of

the self-help groups spends a portion of their staff time at SMHC.

Hatfield (1994), as cited in the *Review of Best Practices in Mental Health Reform*

(HSRU, 1997a), reports that almost 60 % of families of the mentally ill are operating as primary

caregivers. In contrast to this level of responsibility, families have historically received no support and were often viewed as contributing to the mental illness. Organized family support, through groups such as the National Alliance for the Mentally Ill, has provided avenues for family self-help and advocacy for consumers. The *Best Practice* criteria for family self-help state that "funding is provided to family groups who also participate in planning and evaluation of care delivery" (p 11).

As mentioned previously, the specific aspects of the mandate that are emphasized in a region depends to some degree on the person hired. In general, the self-help groups provide some information and assistance to family members, but this is peripheral to work with consumers. The MSS however has embraced family services and directly operates family education and support groups, including groups for children. The "Eight stages of healing" group is provided to family members to facilitate successful coping. Following the education sessions, family members may continue to meet as a support group. Family support groups operate monthly in most regions, including Brandon, Central (Portage la Prairie and Winkler), Interlake (Ashern and Selkirk), North Eastman (Oak Bank), Parkland (Dauphin and Swan River), and South Eastman (Steinbach). Residents of Assiniboine region seeking family support can attend meetings in Brandon. Burntwood has had difficulty establishing family supports due to staff turnover. Nor-Man, because of the small numbers of people with SPMI, MSS offers a support group for family members of people with a range of conditions, such as Alzheimer's disease and anxiety disorders.

MSS has developed a support group, "Name that Feeling", for children that focuses on the needs and feelings of children who have a family member with a mental illness. However, this group is not available outside of Winnipeg.

There are a number of issues that arise in discussion about self-help services. Most of these issues arise from the level of funding provided to these organizations.

Through mental health reform, spending on self-help organizations increased from about $50,000 to one million dollars. The funding formula is based membership and financial contributions (fundraising) by self-help organizations. Within each region, each organization is currently eligible for up to $50,000 with a minimum contribution by self-help of 25 %. A portion of the 25 % can be provided by in-kind donations but five to ten percent of the contribution must come from financial contributions. In addition to basic funding, self-help organizations are eligible for support for some direct service activities (N. Koop, personal communication, January 25, 1999).

Each of the self-help services in each region has a budget of about $30,000 to cover all costs, including staff, office, and program costs (such as educational material for consumers, and travel). Outreach workers are usually paid for 30 hours a week although it can be as low as 15 hours per week. In the case of Assiniboine / Brandon and Eastman, 30 hours of service is shared between two regions. Some organizations, in an attempt to accommodate travel, have reduced the available staff time. For instance, the MDAM / MSS Outreach worker in Nor-Man is paid to deliver services for both organizations to the whole region on 32 hours per week. The MSS Outreach worker in Burntwood is hired on a casual basis.

The mandate of self-help organizations (individual and group support, public education, advocacy and direct service delivery) is sizeable in comparison to the resources available. Most regions identified funding levels as a substantial impediment to delivery of service. Limited funding places limits on the extent to which services can be offered, and where those services can be offered.

Initial planning for delivery of self-help services in rural areas did not take travel into account. One manager commented "They discovered when they started doing self-help ... that there was more travel and more expenses and the self-help model was really a city model that was plunked into the rural areas. They worried about things like parking and not travel. Parking is a buck a day anywhere and travel is a hundred bucks a day." This means that, in Burntwood for instance, self-help services are largely limited to the Thompson area. Large distances to the outlying communities, and limited staff hours, mean that travel to a single community could take a whole week of the staff members' time and use substantial financial resources. Travel is costly for southern regions as well since most cover a large geographic area. The distance between Selkirk and Ashern, Steinback and Pine Falls, Dauphin and Swan River is substantial. As mentioned previously, some regions have reduced staff hours in an attempt to offset travel costs.

Limited funding has also, to some extent, led to closure of offices and staff turnover. In turn, office closures and staff turnover can result in gaps in services and decreased visibility in the community.

Outreach Workers are increasingly asked to operate from their home. Increasing operation from home was one of the factors leading to centralization of resource libraries. Work from home has a number of undesirable effects, including: inability of clients or others to drop in; decreased visibility in the community; and decrease in time available for service delivery. The Outreach Worker must travel for every appointment and must spend substantial time in arranging space. Delivery of, for instance, individual support is hampered by operation from home. Volunteers, who often provided reception in the offices, have fewer options for contributing.

Despite the challenges of part-time pay for what is usually full-time work, and a requirement for fundraising, a number of regions have benefited from continuity in staffing and very ambitious efforts on the part of the Outreach Worker. In many other areas, turnover occurs every two or three years. Some areas, notably the north, have ongoing difficulty with turnover in this sector as well.

Recruitment is a challenge and on occasion positions sit vacant, sometimes for extended periods of time. Even where turnover is minimal, it can have detrimental effects on services. Filling a vacancy might take six to eight months during which no programs are offered. Orientation of new staff and re-establishing programs can take up to a year.

Relationships between self-help and RHA are very strong in several areas, but differ between self-help groups, between regions and over time. Historically there were areas where relationships between self-help and RHA were limited, and sometimes strained. For instance, there were reports of confrontational rather than collaborative relationships, duplication of services rather than provision of complementary services, and intentional distance on the part of both groups. The self-help role in advocacy, a perception that effective consumer organizations need to distance themselves from formal services, and perception of threat were factors that were identified. The personalities and philosophies of the individuals involved clearly plays a role. The organizational structure, where self-help reports to a head office in Winnipeg rather than to the RHA, may also be a factor. Concern was expressed that self-help reported to, and took direction from, head office without consideration of regional activities or needs.

It appears that over time many of the above factors have been addressed. For instance, instead of both self-help and RHA providing public education, they often collaborate on delivery of public education. Formal means of linkage, such as attendance at team meetings or

participation on CQI teams, are also beneficial. The Mental Health Self-Help Policy Review (2002) also made recommendations to formalize the relationship between self-help and the RHA. The document recommends that a letter of understanding defining the relationship between the RHA and self-help be developed. The contents would be developed based on self-help consultation, service demands and the community needs assessment. The letter of understanding will include: a description of activities that will be provided; description of how organizations will communicate; and a statement acknowledging the autonomy of the self-help organizations.

Self-help services in the province continue to experience change as new organizations seek funding and as a proposal for a Manitoba Federation of Self-help Organizations[6] is put forward. Discussions in this area are continuing.

Impact of Rural Characteristics on Availability, Accessibility, Acceptability and Appropriateness of Rural Services

Objective one involves description of adaptations of model mental health programs made to suit the rural environment. The preceding section describes model services, ways in which these services are delivered within rural regions in Manitoba and issues related to the options selected. This section discusses ways in which characteristics of the natural, social and economic environment of rural regions influences the way services are delivered, and the impact of these modifications on availability, accessibility, acceptability and appropriateness of specific mental health services. Although the literature frequently views rural areas from a deficit perspective, this section will also attend to areas of strength in rural regions that may affect service delivery.

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[6] Manitoba Health has proposed that ADAM, CMHA, Obsessive / Compulsive MB, MDAM, and MSS form a Federation to increase visibility of consumer organizations, provide economies of scale (e.g. shared reception, bookkeeping, purchasing), new full-time shared positions, and an improved mechanism for connecting with Manitoba Health

It should be noted that rural areas are far from homogenous. The differences between

rural areas may be as great, or greater than differences between rural and urban areas (Bushy,

1994a). However, if one were to attempt a general description, the population of rural areas can

be characterized as geographically dispersed, with lower levels of education, and greater levels

of disability and dependence. Housing shortages, poverty and unemployment are more common

than in urban areas. Rural people highly value independence and self-sufficiency, generally have

closer social networks, and may demonstrate distrust of outsiders. Health services are often

sparse and service providers are often generalists or paraprofessionals rather than being

specialists (Bushy, 1994a; Human and Wasem, 1991; McDonel et al., 1997; Wagenfeld, 2000).

Each of these characteristics exerts an influence on health services.

Challenges

Availability.

Availability of services in rural areas is influenced by the size and dispersion of the

population. Small numbers of people limit the range of services that can be provided, and the

number of locations where services can be provided (Bushy, 1994a; Lischner et al., 1996). In the

specialty mental health sector, this means that only the most common services can be provided

on a distributed basis and the full range of services may not be available even in larger centers.

Insufficient numbers of clients may also mean that providers are hired on a part-time basis,

which leads to difficulty in recruiting and retaining staff, or the provider must fill multiple roles,

which makes it more difficult to be expert in any one area. A limited range of services available

in the region increases dependence on out-of-region resources. Issues of access to, and

coordination with, out-of-region services then emerge as important.

Geographic dispersion of the population compounds challenges related to small numbers. Even when there are sufficient numbers of people in the region to warrant a service, these individuals may be too far apart to establish a service or too far away to make use of the service. For instance, a region may have a sufficient number of people with SPMI to warrant ICM but provision of intensive services is problematic if these individuals are located across a large region. Specialty services are particularly adversely affected.

With the exception of Brandon, which has a sizeable population of people with SPMI living in a relatively contained area, services in all rural regions are affected by small numbers of people with SPMI and / or geographic dispersion. Availability of psychiatry / psychology, case management, crisis services, inpatient services, vocational / educational supports, social / recreational supports and consumer / family initiatives are all affected.

The only component of the system of care that does not seem driven by size and distribution of the population is housing. Availability of housing differs substantially between communities, but appears to be a function of the economic environment rather than geography. Affordable housing is available in communities that are shrinking but is at a premium in communities where there is a growing economic base.

Regions approach challenges related to small numbers and geographic dispersion through: limiting access to services outside larger population centers; providing itinerant services to outlying areas; having generalist providers deliver specialty services; hiring part-time providers in outlying areas; using paraprofessional service providers; or through some combination of these approaches. For instance, ICM services may be provided by CMHW on an itinerant basis with local support from generic health or paraprofessional providers.

Each of the strategies used to address small numbers of consumers and geographic dispersion has benefits and limitations. Limiting service delivery to major centers is consistent with the goals of regionalization, which involves decentralization of common services and centralization of specialized services. Limiting delivery to specific locations allows provision of more specialized services, but means relocation for consumers in outlying areas.

Providing services on a distributed basis means that the cost of delivering services increases and may become prohibitive (Bushy, 1994a). Consumers can remain in their community, but the intensity of service will decrease and the costs of delivery will increase as provider time is used in travel. A shortage of professionals also limits ability to provide services on a distributed basis (Bushy, 1994a). Having a local generalist provider, such as a CMHW, deliver specialty services also enables consumers to remain in their community and helps to contain the cost. However, lack of specialized skills and inability to provide intensive services within a large caseload may reduce the range and quality of services. Care should also be taken when combing roles to ensure that the roles do not conflict. For instance, in areas where a single provider provides crisis services for a range of organizations, the provider may find that their role in child protection for Family Services conflicts with their role as a provider of mental health services. Even a perception of conflict may place consumers at risk.

Hiring part-time specialist providers in outlying areas would enable consumers to remain in their community and would contain costs, but recruitment and retention in part-time positions is problematic and may result in lengthy vacancies. Hiring paraprofessional service providers in the community may be easier than hiring a professional but expertise, or access to education that would provide the expertise, may be limited.

Without sufficient services, people with SPMI, who often need intensive service delivery, may not be able to remain in their home communities. Interestingly, the small numbers and lack of services appears to have a reciprocal effect. Migration to larger centers or out of region may result from lack of services, but out-migration perpetuates low numbers and inability to develop or support a range of services. It is possible that, even with reforms designed to keep people closer to home, regions with a wider range of services will continue to experience in-migration.

Availability of services is also a function of available human resources. The shortage of health human resources in rural areas is well documented and cuts across disciplines (Bushy, 1994a; Houenstien, 2003; Lischner et al., 1996; Weiss Roberts et al., 1999). Shortages of specialists are particularly acute. Merwin, Hinton, Dembling and Stern, (2003) describe a significant shortage of mental health professionals in the United States, with rural areas 4.7 times more likely than urban areas to be designated as having a shortage of mental health professionals.

The degree to which human resource shortages affect a region appears to be directly related to proximity to urban centers. Regions in close proximity to Brandon or Winnipeg have less difficulty recruiting and retaining health human resources than more remote regions. Historic shortages of mental health professionals have been exacerbated by increased numbers of services, such as inpatient beds, available in rural areas and by recent shortages in a number of health professions. Shortages in Burntwood and Nor-Man have increased while other regions that had not experienced challenges have noted difficulty in attracting health human resources. Part-time positions and those with lower wage scales are particularly vulnerable to vacancies. In some cases regions have delayed opening of a service, or temporarily closed services as a

response to shortages of human resources. Sporadic delivery of service may, in some ways, be even more of a problem than absence of services.

Telehealth is often suggested as a means to increase availability of specialist care in rural areas. Telehealth has been found to be acceptable to consumers and provide cost-effective access to specialist services. While telehealth has great potential for improving assessment, making a diagnosis and prescribing treatment, it may have less value in provision of case management or other services for people with SPMI.

Accessibility.

Services that are available in a region may not be accessible for people with SPMI. Transportation within and outside rural communities is central to access (Human & Wasem, 1991; McDonel et al., 1997). Poverty, disability and limited social networks limit travel to out-of-community resources. Resources within the community may also be difficult to access. Lack of public transportation and, where a taxi is available, affordability may pose barriers. Outreach, where the worker attends the client home or where proctors provide transportation, can be used as a strategy to enhance access. However, increased costs and human resource shortages reduce opportunities for outreach.

Weather, road conditions and the normal cycles of rural life also affect access to out-of-community resources. For instance, whether the consumer travels for service or the provider comes to the community to provide service, storms and the condition of roads will influence the frequency and consistency of contact. Obtaining assistance with transportation from other community members is subject to their availability, which may be limited at certain times of the year. In addition to outreach, ensuring that basic supports exist within the community will also

enhance access. For instance, a local proctor or generic service provider may provide basic supports in collaboration with the CMHW or ICM.

Acceptability.

Characteristics of rural people themselves may influence the extent to which a service that is available and accessible is valued and used. A number of authors, including Bushy (1994a), Houenstein (2003), and Human & Wasem (1991) report a tradition of self-care among rural people. Rural people value independence and prefer informal help to professional assistance. Rural areas generally have stronger natural social and family systems, and increased informal helping (McDonel et al., 1997). Where professional assistance is required, generalist care is preferred to specialist care (Houenstein, 2003). While reliance on paraprofessionals and generalists has drawbacks, rural consumers may prefer this method of delivery. Both access and acceptability are improved.

Stigma also plays a role in the preference for generalist providers. Rural communities are known to have a high degree of tolerance of difference (Kane & Ennis, 1996) but there is also sigma against mental disorders (Houenstein, 2003; McDonel et al., 1997). Both of these factors will influence the degree to which service use is perceived as needed and the degree to which services are used. The urban orientation of may providers, and a general mistrust of outsiders (Bushy, 1994a; Human and Wasem, 1991), can also influence acceptability of services. Additionally, lack of choice of providers may affect service use. Use of local generic providers minimizes stigma and may increase opportunities for choice of provider.

Appropriateness.

Appropriateness of services in rural areas is affected by a number of factors, including: availability of training and continuing education; pressure to provide generic services; professional isolation; and lack of evaluation.

Access to basic and continuing education are important concerns, particularly in areas where there is difficulty recruiting and retaining professionals. In these areas, an applicant may be hired even though they lack some of the knowledge required for the position. In this circumstance, basic education is critical to provision of quality services. Also, since the field is evolving rapidly, access to continuing education is required to remain current. Shortages of professionals and higher costs of accessing continuing education opportunities limit ability to ensure that providers are current and have the necessary skills for the work. Further, the extent to which existing educational opportunities attend to issues relevant to rural practice is limited.

Pressure to provide generic services results in providers needing to be current in a variety of areas, or to provide a generic service regardless of the constellation of consumer needs. Limited access to basic and continuing education affects the degree to which skills can be maintained in any one area of specialization, much less several areas. Generic service provision then may involve practice outside areas of expertise and competence, which raises ethical concerns (Weiss Roberts et al., 1999).

Even where there a specialist is hired to provide a specialty service, the numbers of these providers may be very low. For instance, there may be only one ICM or EDC in a region. Isolation and lack of professional networks make it difficult to remain current in a particular field or to consult with colleagues (Lischner et al., 1996). Several authors (Bushy, 1994a; Bushy, 1994b; McDonel et al., 1997; Weiss Roberts et al., 1999) identify professional isolation (defined

as lack of clinical supervision and peer support, limited access to relevant continuing education), the generalist role (leading to loss of specialized skills) and large caseloads as factors affecting recruitment and retention. Again, it appears that shortages of human resources lead to factors that perpetuate shortages of human resources.

Program evaluation, which is critical to ensuring quality services, may occur less frequently in rural areas (McDonel et al. 1997). As with other aspects of service delivery, evaluation suffers from shortages of human resources in general, and specialists in particular. Several regions indicated an interest in additional evaluation, but felt that specialized knowledge and additional human resources were critical to design and conduct of rigorous evaluation.

Opportunities

Consideration of the adequacy of rural services must take into account the extent to which the experience of rural consumers is a result of rural residence, and not a function of rural mental health services. Further, adequacy must consider that different is not synonymous with inferior.

Some of the challenges experienced in rural areas are not specific to rural areas and others are not specific to mental health. For instance, housing shortages and high unemployment are more common in rural areas than in urban areas. These factors lead to migration to larger centers and out of the region regardless of mental health status. Similarly, substantial concern was expressed about the lack of fit between the high level of skill ideally suited to delivery of crisis services and the minimal qualifications of some crisis staff. Low wages often result in minimally qualified individuals making independent decisions in a high-risk environment. Although this issue is important, it is not isolated to rural areas. The same funding arrangements, and the same risks, exist in crisis services operating in urban areas. While these factors must be

acknowledged as problematic, caution must be exercised in making comments about the adequacy of services. Migration based on lack of housing or employment, or risks inherent in use of specific models of delivery of crisis services, are not necessarily a consequence of adapting urban models of service delivery to rural areas.

Best practices as defined by models developed and tested in urban areas that may apply differently, or not at all, in rural areas. For instance, Wagenfeld (2000) identifies that some service models "require such intensive professional involvement that they are patently unsuitable for anything but the most populous urban areas" (p 92). While descriptions of rural services often emphasize absence of resources, there are other ways to consider rural communities. Kane and Ennis (1996) criticize the deficit-based framework and recommend building on community strengths. They recommend using strengths such as strong networks, tolerance for the abnormal, and willingness to extend oneself to develop informal networks to supplement and complement the work of the traditional system. This means that, while rural services may be different, they may be better at meeting the needs of rural consumers than urban models. Further, some of the emerging models of service provision may be ideally suited to the rural environment. For instance, newer models of care for people with SPMI that emphasize individual approaches and supported independent living may be better suited to the rural environment than models emphasizing a continuum of services.

Availability.

Challenges related to small numbers and geographic distribution of the population were discussed earlier. These challenges may lead to use of services in a manner that differs from urban services but may better meet the needs of rural consumers. For instance, geographic dispersion of complementary services is identified earlier as increasing overlap between services.

Specifically, because of distance between the services, geography may be more important than acuity in determining location of inpatient service use in Parkland. Consumers in Swan River are more likely to use the local Safe House and consumers from Dauphin are more likely to use the inpatient beds even though the distant service might be more appropriate. From an urban perspective the overlap in services would probably be viewed as redundancy. In a rural context however, dispersion of the services increases access. The availability of local acute service is increased and the range of available service options also increases.

Lack of alternatives may in some cases facilitate practices consistent with emerging models. For instance, lack of housing alternatives encourages provision of supported independent living that may in turn improve outcomes for consumers and increase community integration.

A tension exists in providing mental health services between providing support and creating dependence. One mental health manager postulated that lack of services was in part responsible for the apparent health of consumers in the region. In the absence of services, consumers, families and communities assume responsibility for meeting needs and finding solutions to challenges. Effectively meeting these challenges may foster a sense of empowerment and facilitate recovery. However, caution must be exercised not to carry this perspective to the extreme. Fostering independence should not be synonymous with abandonment of consumers.

Accessibility.

As previously noted, where it is feasible, accessibility is improved by locating services within communities. Improving access to services within a community can be achieved through provision of services within consumers' homes or through providing transportation to services. Provision of services in consumers' homes or other community locations is consistent with

expectations of ACT models. ICM generally provide the majority of their service within the community. Rural providers appear to be sensitive to issues related to transportation and may use proctors to provide transportation. Transportation may be provided to facilitate attendance at appointments and as a support for independent living. For instance, transportation may be needed to facilitate grocery shopping or participation in the Ke na now Club.

Outreach appears to be facilitated by the small size of communities. Rural service providers are often familiar with local consumers whether or not the consumer is using services. This means that consumers who would benefit from service are, or can be, approached periodically to see how they are managing. Where indicated, an offer of service can be extended. Mental Health Managers in these regions identified that maintaining contact facilitated access for consumers when and if the consumer chose to use it. The ability to provide some degree of monitoring and protection for non-clients may be unique to rural areas.

Although rural regions may not have the same range of services available in larger centers, the small size of provider networks and flexibility in mandates may provide opportunities for more integrated and coordinated care. Referrals and planning are simplified by small numbers of providers who usually know each other. A flat administrative hierarchy, where most service providers report, directly or indirectly, to the mental health program manager, also facilitates coordination of care. Coordination of services with programs outside mental health is also facilitated by flexibility in mandates. Several mental health managers identified that mandates of various organizations are often stretched to ensure that client needs are met. Urban environments, with more hierarchical administrative arrangements, and a larger number of specialized programs, may find it more difficult to provide integration and coordination of care. Further, gaps in service appear more prevalent in urban areas. For instance, a consumer with

mental illness and addictions problems may be refused service by both mental health services and addictions services.

Acceptability.

The value rural people place on self-reliance and the preference for informal sources of support may affect expectations of services. Consumers may be satisfied with, or even prefer, paraprofessional or natural supports and lower levels of intervention. For instance, a consumer may prefer the familiarity and proximity of an inpatient stay at a local hospital even though specialty mental health services are not available. Similarly, a consumer who may benefit in some ways from supervised living might decide that the benefits would not offset the losses resulting from moving to another community for this resource.

While the burdens and expertise of generalist providers must be considered, this preference may offer unique opportunities for providing service in rural areas. Although communities themselves would need to be involved in the decisions, providing assistance to indigenous supports, such as proctors, health unit nurses, physicians and clergy, may be more useful than increasing the number of professionals. Use of indigenous supports would: be consistent with values of independence and informal support; minimize stigma associated with specialty services; maximize the acceptability of services; and provide opportunities for choice. In this instance, use of paraprofessional supports may reflect a superior service. However, evaluation of this premise is needed. Increased use of services and adverse outcomes, such as attempted suicide and manic episodes, have been found for rural residents with bipolar disorder receiving care in the general medical sector (Rost, Owen, Smith, & Smith, 1998).

Overall expectations may also differ between rural and urban residents. For instance, in Winnipeg there was great public concern about overnight closure of an emergency room, even

though another emergency room was in close proximity. In contrast, rural residents accept that obtaining an ambulance involves paging the volunteer ambulance attendants who travel to the equipment and then go out to the location. Acceptable time waiting for an ambulance and time in transport differs substantially between rural and urban residents.

Another example of how different expectations can influence services can be found in vocational services. High unemployment in many areas makes it much more difficult to assist consumers to find and maintain employment. However, precisely because unemployment is so high, there appears to be much less stigma associated with unemployment. Several informants identified that, where unemployment levels were high, paid employment appeared to be less important to consumers. These perspectives influence the orientation of services. For instance, unlike a traditional clubhouse that is centered on a work-ordered day, the Ke na now Club is primarily oriented around social and recreational activities. The orientation of the Club, while different from traditional models, appears to be consistent with the needs and expectations of local consumers.

Appropriateness.

Access to basic and continuing education, pressure to assume a generalist role, professional isolation and lack of evaluation were identified as challenges in the provision of appropriate services. As discussed, the generalist role may provide opportunities as well as challenges. Challenges related to lack of access to education and professional isolation may be reduced as use of communications technology increases. For instance, the ability of providers to use internet sources for information may assist in obtaining current information and identifying resources. Courses, and entire educational programs, are increasingly available through online sources. Professional isolation may be reduced through online opportunities to consult with

colleagues. The extent to which technology can close the gap between rural and urban residents is not known, but there is potential for improvement in this area.

The close social ties in rural communities that pose challenges in terms of privacy also mean that providers have a detailed understanding of the context of peoples' lives and the resources available to them (Wagenfeld, 2000). This increases the likelihood that the individual is viewed from a holistic perspective and that planning is truly geared to the individual client. While urban areas also strive to provide holistic care and individualized service, providing such a service may be facilitated in rural areas.

This section has examined challenges and opportunities that affect delivery of services in rural areas from the perspective of the literature and key informants in rural areas. The following sections will examine consumer perspectives of service quality and will consider the influence of rural services on consumer QoL.

Interim Conclusions, Objective One

The overall premise of this study was that rural mental health services, while based on efficacious models of service delivery, might differ substantially from the original models. Document reviews and interviews with key informants in nine rural health regions found that new services were established in all rural RHA over the period of mental health reform. However, the extent to which new services have been implemented differs between regions. Further, although efforts have been made to address *Best Practices* criteria, rural mental health services are adapted to suit the rural environment. The ways in which services were adapted differed substantially between rural RHA. Possible strengths and limitations of various methods of delivery were described. Assessment of the effect of these adapted services on consumer outcomes.

Selection of Outcome Indicators

In 2001, a synthesis document was prepared for the Federal / Provincial / Territorial Advisory Network on Mental Health by McEwen and Goldner. The document built on the *Best Practices* document and the Canadian Institute for Health Information Health Indicators Framework (Canadian Institute for Health Information, 1999). The synthesis document, titled *Accountability and Performance Indicators for Mental Health Services and Supports* was intended to assist decision-makers in selecting and using indicators for monitoring health system performance. Based on information contained in this synthesis document, two key outcome indicators were selected for examination of the effectiveness of mental health services in rural areas. These outcome indicators were QoL and satisfaction with services.

Identification, Approach and Representativeness of Study Participants

In order to assess consumers' satisfaction with services and QoL, face-to-face interviews were conducted with people with SPMI in each rural region. The identification, approach and representativeness of these individuals is discussed here since the information is relevant to both objective two (service satisfaction) and objective three (QoL).

Study Population

The researcher collaborated with RHAs to define and identify the population, and to develop and implement strategies for conducting the interviews. The target population for objectives two and three (satisfaction with services and QoL) included all people with SPMI living in rural areas. The study definition of SPMI was based on eligibility criteria for the ICM program in Westman (Westman Region Mental Health Services, 1995). The study definition

included all individuals meeting the criteria, regardless of whether the individuals were using services (Appendix A). The eligibility criteria were modified to exclude individuals under the age of 18 and over the age of 64, whose service needs may differ. Potential participants were excluded if they had active psychosis with substantial acting out (were dangerous), had cognitive impairment such that he / she was incapable of participating in the interview or had primary addiction to drugs and / or alcohol (needs may be different). Individuals who were not mentally competent to consent to participation or would be unduly distressed by the interview were also excluded.

This study also did not include First Nations people living in a First Nations community and receiving their services under programs established by the Federal government. The needs of this group and the resources available to them may differ substantially from those of individuals not living in a First Nations community. First Nations people living off reserve and receiving (or eligible for) provincial mental health services were included.

Identification of Study Participants

Potential participants were identified by rural RHA based on the study definition. In order to protect the privacy of these individuals, the RHA did not identify the population directly to the researcher. Program Managers and case managers applied the selection criteria to clients in their program and to potential clients who were not receiving services. The identified population is largely complete. As previously mentioned, mental health service providers in rural areas are often familiar with, and attempt to maintain some contact with, individuals with SPMI who are eligible for service but refuse those services.

The number of eligible people per RHA ranged from 9-160 people. A total population of 435 people was identified by the rural RHA at the time the invitations were made. In all but one

region, the entire identified population was invited to participate. In Brandon, where 160 people were identified as being eligible, a sample was identified for invitation to participate. The RHA, in consultation with the researcher, selected every third person on the list of potential participants. As a result, a total of 53 people from the Brandon RHA were selected for invitation to participate. In total, 328 people with SPMI were invited to participate.

Approach of Potential Participants

The procedure for inviting participants was complex in order to ensure privacy for participants. Response cards were developed for distribution to potential participants, and basic information on the study was prepared for case managers (Appendix C). Program Managers were supplied with information for case managers and the correct number of response cards and stamped, self-addressed envelopes. The Program Manger distributed the materials to relevant case managers and case managers approached potential participants. Potential participants were provided with general information about the study and asked to return the response card identifying that either they were willing to be contacted to hear more about the study or that they did not wish to be contacted (Appendix C). The response card also contained the researchers phone number so that potential participants could, if desired, ask questions prior to making a decision about being contacted. Case managers also followed up to ensure that potential participants had returned the response card. It is important to note that care providers are prompting return of the response card, not seeking consent to participate in the study.

Potential participants who were willing to be contacted provided their name and a contact telephone number and returned the response card in the stamped envelope provided. This protocol ensured that the researcher only had contact with individuals who agreed to be contacted and the RHA did not know who participated. A similar protocol for contacting

potential participants was used in an earlier study conducted by Prairie Research Associates for Manitoba Health.

The stamped envelopes were addressed to the Secretary of the Health Information Privacy Committee. The Secretary screened cards before forwarding them to the researcher in order to ensure that identifying information was only found on cards indicating willingness to be contacted.

Once the researcher received the returned response cards, potential participants were contacted to provide additional information on the study and invite participation. Interviews were scheduled with individuals who agreed to participate. To increase participant comfort with the interview, participants were invited to have someone they trust present during the interview. Participants also selected the location of the interview. As a final precaution to ensure the safety of participants, regional mental health services were contacted to let them know when interviews were being conducted in the region.

A total of 80 face-to-face interviews were conducted across nine rural health regions over the period between December 2000 and September 2002. Informed consent (Appendix B) was obtained prior to each interview. Interviews were often held in participant home, but were also held in locations such as coffee shops and local health offices. Individuals experiencing any distress in the interview were reminded that they could stop the interview at any time. Even in the absence of evidence of distress, information on local resources was often provided to the participant as a precaution. Participants were provided with a ten-dollar honorarium at the conclusion of the interview.

Representativeness

Objective two, exploration of satisfaction with services, uses qualitative methods. Establishing the degree to which participants are representative of the poplulation, and the degree to which the results might be generalized to the large population, is more central to quantitative research. However, since the same participants also participated in the QoL (quantitative) portion of the study, it is important that the representativeness of the participants be discussed.

There are a number of points at which potential participants could be lost or refuse to participate. First, potential participants, who were invited by case managers to return the response card, could decide not to participate or neglect return of the response card. Individuals who indicated that they were willing to be contacted and were provided with additional information on the study could decide not be interviewed. People who agreed to the interview were provided with the full consent form and again had an opportunity to decline participation.

Of the 328 people who were invited, 99 (30.2 %) agreed to be contacted (Table 7). Of these 99 individuals, nine could not be contacted, usually because the listed phone number was not in service. Once contacted, five individuals chose not to participate in an interview. Attempts were made to schedule 85 interviews. Four interviews, all in one region, were not held due to scheduling conflicts. One individual met with the researcher but declined participation after review of the consent form. In total, 80 interviews were conducted. The response rate overall was 24.4 %, although the rate differed substantially between regions.

Table 7

Participation by Consumers in each RHA

Region	Invited to participate	Agreed to be contacted	Agreed to interview	Interview conducted	Response rate (%)
Assiniboine	25	10	9	9	36.0
Brandon	53	8	8	8	15.1
Burntwood	9	4	4	4	44.4
Central	53	18	14	13	24.5
Interlake	50	13	11	11	22.0
Nor-Man	41	13	9	9	22.0
N. Eastman	16	11	10	10	62.5
Parkland	55	19	17	13	23.6
S. Eastman	26	3	3	3	11.5
Total	328	99	85	80	24.4

In order to establish the extent to which respondents were representative of the identified population, each region was asked to provide aggregate information on the potential participants. Specifically, regions were asked to identify: how many males and how many females were invited; how many people were in each of three age categories (under 30, 30-45, and over 45); and how many people were in each of three diagnostic categories (schizophrenia, mood disorders, or other disorder). Characteristics of the invited population are identified in Table 8.

Table 8

Characteristics of People with SPMI in Rural Regions

Region	Pop	Gender		Age Group			Diagnostic Category **		
		M	F	Under 30	30 – 45 years	Over 45	Schizophrenia	Mood	Other
Assiniboine	25	6	19	0	11	14	9	6	11
Brandon	160*	35	18	9	20	24	42	10	1
Burntwood	9	7	2	1	7	1	7	2	1
Central	53	22	31	4	21	28	29	15	15
Interlake	50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nor-Man	41	18	23	4	15	22	21	15	5
N. Eastman	16	6	10	2	10	4	9	4	2
Parkland	55	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
S. Eastman	26	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*A sample of 53 was invited to participate

** Numbers in diagnostic categories is greater than the population as an individual may have more than one diagnosis

Three regions, Interlake, Parkland and South Eastman, did not provide information on the characteristics of the population. None of these regions collected demographic information at the time the population was identified and were unable to retrospectively construct the information.

Further, there appeared to be problems in the approach of potential participants in the Interlake region. At the request of the Program Manager, the researcher met with the case managers and provided information on the study. An opportunity was provided to ask questions and assistance was sought in approaching potential participants. However, after an extended period of time, only four participants had responded. All these individuals resided in Selkirk and

had the same case manager. The mental health supervisor agreed to remind case managers to prompt the identified potential participants, but no additional responses were received. As a result, the mental health supervisor approached local self-help organizations to solicit participation from suitable individuals. These self-help organizations did approach a number of people enabling a much larger and more geographically dispersed participant population from that region. However, self-help organizations do not collect and were unable to provide aggregate information on potential participants.

The age and gender of participants was compared to the invited population to determine whether participants differed substantially on either dimension. Using chi square tests, there were no significant differences between the participants and the invited population with respect to age (chi square – 0.33 with 2 df, p=0.85) or gender (chi square = 0.81 with 1 df, p=0.37).

Comparison on the basis of diagnostic category was more difficult. Although most of the regions provided aggregate information on the diagnostic category for potential participants, the researcher does not have definitive diagnostic information on those who actually participated. It was possible however in all cases to place participants in one of the three diagnostic categories based on self-reported diagnosis or medication and symptom reports. For instance, a participant reporting psychotic symptoms and use of anti-psychotic medication would be placed in the "Schizophrenia or Other Psychotic Disorder" category, while participants reporting mania and use of lithium would be placed in the "Mood Disorder" category. The "Other" category contained people with, for example, Post-Traumatic Stress Disorder and Dissociative Identity Disorder (formerly Multiple Personality Disorder). Using chi square tests, there was no significant difference between the participants and the invited population with respect to diagnosis (chi square – 0.99 with 2 df, p=0.61).

Although there are no statistical differences between the identified population and participants on these areas, substantial caution should be exercised in interpreting the data. The participation rate overall is quite low and there are a number of reasons to be concerned about bias in the results. As noted above, participation rates differed by region and generally were quite low. A Canadian study of people with SPMI (Aubry & Myner, 1996) reported a response rate of 62 %. Previous work in Manitoba investigating consumer perspectives on mental health services had a response rate between 30-39 % (Prairie Research Associates [PRA], 1996). The response rate in this study, which uses the same methodology as the study by PRA, is lower. Even if the rate of participation were similar to the PRA study, the response rate would still be low enough to warrant caution in interpretation.

The main problem with a low response rate is the increased possibility of bias in participation. Respondents could differ on key factors other than age, gender and diagnosis. Bias can occur because of bias in selection, or selective participation. Bias in selection occurs as the population is being identified. In this study, individuals who have the most severe illness may have been more likely to be excluded. Due to concerns about client welfare, regions were able to exclude individuals who would be "unduly distressed" by the interview. Individuals were also excluded on occasion because, in the view of the region, combined mental health and substance abuse problems made it impossible for individuals to participate.

Severity of illness might also result in selective participation. Lack of energy, cognitive problems or high levels of stress or paranoia might influence return of response cards and, in at leas two cases, influenced ability to participate in an interview.

In summary, the participants do not appear to differ from the invited population on age, gender or diagnostic category. However, a low response rate and several potential sources of bias

make it difficult to assert that the participants comprise a representative sample of the

population. Caution must be exercised in making generalizations based on these interviews.

Results must be considered suggestive rather than conclusive.

Objective 2 – Consumers' Perception of Service Quality

Objective one found that efficacious models of service delivery are adapted to suit the rural environment, and that the ways in which services were adapted differed between RHA. A number of possible strengths and limitations of the adapted models were identified. Objective two examines consumers' perception of service quality and the effect of the varied methods of service delivery on consumer satisfaction.

Satisfaction with services in this study includes three dimensions of health systems performance as identified by the Canadian Institute for Health Information (1999). These dimensions include accessibility (e.g. access to services, active outreach), acceptability (e.g. satisfaction with services received, involvement in decision-making) and appropriateness of services (e.g. services delivered in a best practice manner, consumer perception of appropriate service). For the purpose of this section, availability is considered as a component of accessibility of services. The study further includes questions about perceived changes in health status based on new services, as changes in self-reported health status, in addition satisfaction with services, are indicators included in the Canadian Council on Health Services Accreditation standards. Meeting these standards is part of routine accreditation process in RHA.

Methods

Consumer perspectives on service quality were examined through semi-structured interviews with the population described above. Participants were asked which mental health services they had used. For each of these services participants were asked questions about accessibility (e.g. How easy was it for you to get this service?), acceptability (e.g. Were you treated in ways you were satisfied with?) and appropriateness (e.g. Did the service do what you needed it to?). If participants had not used a service, questions were asked about whether they were familiar with the service, and whether the service was something they might benefit from.

In addition to questions about specific services, participants were asked whether they had the services they needed and about the effect of new services (Appendix G).

Interviews averaged 40.5 minutes and ranged in length from 10 minutes to 95 minutes. In two cases, the interview was divided over two separate sessions. Session length was influenced by a number of factors, including extent of service use, tolerance of the participant for being interviewed, and participants' ability to communicate. Participants who used fewer services typically had shorter interviews. Interviews were shorter for individuals who had difficulty concentrating, became restless or found it tiring. Participants who exhibited poverty of speech, which includes affective flattening (face appears immobile and unresponsive with poor eye contact and reduced body language) and alogia (decreased fluency and productivity of speech), also tended to have shorter interviews.

With client consent, interviews about service quality were audio taped. Alternately, notes were made during the interview. Audiotapes and notes were carefully reviewed and participant responses were organized according to system components as described in Objective One. Responses for each system component were examined for themes and for patterns of response that might correspond to ways in which services were provided.

The following represents a summary of participant responses, organized by system components. Although a semi-structured interview was conducted, the content of each interview differs somewhat. For example, psychiatric service is not a specific element of the *Best Practices* document and was not included in the original interview schedule. Since early participants were including psychiatry service in their description, it was routinely included in later interviews. As a result, not all participants responded to each aspect of each area. It is not possible, or appropriate, to use this data to make statistical inferences. Data has been analyzed for themes and

these themes are reported. Observations that appear important but were identified by only a few individuals are also reported, but are identified as such.

Results

Psychiatry

Accessibility.

A large majority of participants reported seeing a psychiatrist, although seven people reported that the psychiatrist was seen on a consultation basis or exclusively during the course of an inpatient stay at a mental health unit. For these individuals the psychiatrist visits occurred over a limited time and the participant is not currently seeing the psychiatrist.

The number of participants reporting using psychiatry services differed between regions, as did the extent of psychiatry services received. Specifically, regions that provided only itinerant service (e.g. Assiniboine and Nor-Man) had fewer people report seeing a psychiatrist than regions with at least one full-time psychiatrist (e.g. Brandon, Burntwood, Interlake). Participants from Assiniboine and Nor-Man regions who did report seeing a psychiatrist tended to report traveling to see an out-of-region psychiatrist, or that service use was temporary or occasional. Participants from South Eastman, whose access to psychiatry service has been intermittent, did not have even an itinerant psychiatrist at the time of the interviews. All participants were traveling to see an out-of-region psychiatrist or had been referred to their family physician. Possibly due to a shortage of psychiatrists outside the Winkler area, about half of the participants living in Central region either traveled to Winkler or an out-of-region psychiatrist for service.

The reported frequency of visits differs between participants and over time for the same individual, presumably based on need and current initiatives. For instance, clients are usually seen more frequently when they are experiencing problems or undergoing medication

adjustments. As a result, it is not possible with these data to make inferences about the influence of psychiatrist availability on frequency of visits.

Availability of psychiatrists can be expected to affect how long it takes to see a psychiatrist and, in some cases, whether there is any access to a psychiatrist. A few people reported waits of six months to see a psychiatrist, but the wait was typically a week or two, which participants felt was reasonable. However, depending on the current problem, participants pointed out that even a short wait could be an issue. For instance, if the individual is experiencing a manic or psychotic episode, a wait of even a few days can be a problem.

In the absence of psychiatrists, other providers, such as CMHW or family physicians, serve consumers. For some participants this was clearly insufficient.

I waited 19 years to see a psychiatrist for my original diagnosis. The [local hospital] did the most that they can, but mostly they pumped me full of tranquilizers and that was not the answer. I needed to be on antipsychotic medication.

Now I have to go to this doctor I don't know and try and explain to him why I'm taking all these pills. Kind of start all over again. He's a general doctor so I'm kind of a little bit scared that if ever I do get sick again, I don't know how much support I would have from [the doctor]… That, I guess, I'm very sad about: that we don't have a psychiatrist here.

Psychiatrist availability also appeared to play a role in ability to offer consumers a choice of provider. Participants living in a region where there was more than one psychiatrist were able to request a different provider while a participant living in a region with itinerant service did not have this option.

Acceptability.

Participants were asked if they felt respected and well treated by the psychiatrist. A few reported that their psychiatrists was rude, bossy or 'in the wrong profession'. However the majority of participants reported feeling respectfully treated and considered themselves partners in decision-making. Included in this group are a small number of people who felt unable to be active in making choices at this time and preferred to have the psychiatrist make choices for them. Participants were satisfied with psychiatrists who listened to them, who they could trust, who understand them and don't push. The strongest endorsement came from a participant who described the power of a positive attitude in assisting recovery.

Like, he always believed I was going to get better. And I thought I was just going to end up being one of the long-term residents [at Selkirk Mental Health Centre], especially after the third admission. I kind of wanted to give up. I though I could never be a good parent to my daughter again. (*now working full-time and has successfully raised her daughter*).

Appropriateness.

Participants were asked what services the psychiatrist provides for them. The question posed difficulty for many participants. Responses such as "he talks to me and asks how things are going" were common. My understanding of this response is that the psychiatrist is conducting an assessment. Based on this understanding, assessment and medications were the most common intervention, and in many cases the only intervention reported. Completion of forms (e.g. for disability coverage, obtaining or maintaining drivers licenses and meeting Review Board requirements) and supportive counseling were mentioned less frequently. Only one of the participants reported psychotherapy (for integration of personalities in Dissociative Identity Disorder) and contracting for safety as services provided by their psychiatrist.

Participants consistently reported that psychiatry services were effective and often cited "getting the right medication" as the best aspect of psychiatry services.

Thanks to the encouragement of [CMHW] and [cousin] and [psychiatrist] I started on new medications. ... And then I kept getting better on medications and, you know something... I'm just so grateful for trying me out with this wonderful medication. I'm just so grateful that they did that for me. Because it's a very expensive medication and I've been on it ... for four years now and it's just, I blossomed from it, you know.

Providers who really listened to clients and who supported clients in making choices about medications were particularly appreciated; even when it took a while for the consumer to chose medication.

The biggest issue in my life was my non-compliance with medication. I never went through a bargaining process with a psychiatrist until about four years ago.... He allowed me to go off my medication and I got sick. Then he allowed me to go off my medication again and I got sick. Then he allowed me to go off my medication again ... . Then I was an involuntary patient for about six months. (*Participant had been non-compliant with meds for many years. Now takes medication regularly and is doing very well*)

Areas for Improvement.

In terms of areas for improvement, participants identified three areas for improvement among psychiatrists and two areas for improvement within the system. Lack of provider time and a focus on medication were each cited by several participants as problematic. Participants made statements such as:

I'm only there for about five minutes, because they're so busy.

Well I wish he wasn't so busy. Sometimes it's hard for him to fit me into his schedule.

I'm out of there within five or ten minutes. He doesn't get into any deeper issues.

It seems like we've only got about half an hour, sometimes only fifteen minutes together.

And once you have a problem you can't cram it all into that fifteen minutes or half an

hour or whatever it is. I think they should allow a bit more time.

All they wanted to do was give you a drug and get you out of there.

The psychiatrist here in town … just wants to work with the drugs. I thought … a

psychiatrist works with a wider range but, … I just feel this area he's covering is very

narrow.

The third recommendation for psychiatrists is that psychiatrists focus on the future and

getting better instead of focusing on the past.

Only a few participants made suggestions on how to improve the system. The first issue

was related to itinerant services provision. The participant pointed out that, while itinerant

services worked reasonably well for routine appointments, it may not work so well for urgent

issues.

When I was in CSU unit, when I had to stay there overnight because I was feeling really

bad, they had to get my pills checked out to make sure that the pills I brought were what

the doctor wanted me to take. And they could never find him, because he was everywhere

[traveling].

The second system issue concerned lack of continuity between inpatient and community

settings. The participant expressed concern about seeing one psychiatrist in the community and

having to deal with someone who doesn't know you once you are admitted to an inpatient

facility.

Psychology

Only four participants reported seeing a psychologist, although it is probable that others saw a psychologist during the course of an inpatient stay. Three of the four people are from a single region that has a full-time psychologist and the fourth saw a private psychologist. Those seeing the regional psychologist were attending group-counseling sessions. This was a new service and generated very little comment.

Case Management

All participants reported currently seeing a CMHW, ICM or EDC. This is not surprising since potential participants were approached initially through the case manager.

Accessibility.

The type of provider (CMHW, ICM or EDC) differs based on region and general availability within each region. Specifically, participants from Assiniboine, Nor-Man and South Eastman were served exclusively by CMHW while participants from Brandon were served exclusively by ICM / EDC. Provider type appears to have a strong influence on frequency of contact and range of services provided. Participants served by a CMHW usually reported being seen about once a month for supportive counseling while participants served by ICM / EDC were usually seen weekly and received a wider range of services. However, there was overlap between the groups. A few CMHW saw participants frequently and provided a wide range of services, and a few ICM / EDC saw clients infrequently and / or provided a more limited range of services.

Participants were asked what the case manager assisted them with. The most commonly provided service was support, meaning that the provider listens, helps solve problems and facilitates coping. The second most common service was assistance with medication. Assistance

with medication might include medication administration, such as administering injectible medication, or medication monitoring. These two types of service account for about one third of services reported by participants. Other commonly reported activities include: liaison with other providers such as the psychiatrist, Public Trustee, Income Security, family physician or family members; arranging and providing support for a proctor; working toward educational or employment goals; assisting in obtaining suitable housing; and assisting with activities of daily living, such as taking a bus, budgeting or managing money. Less frequently mentioned activities included providing information, making referrals, advocacy, transportation to appointments and ongoing monitoring. In addition to the supportive counseling previously mentioned, a number of CMHW were reported to be providing formal counseling and treatment for phobias, panic attacks and trauma issues. A small number of participants also reported that the case manager assisted them through preparation of emergency plans and crisis intervention.

Due to the exploratory nature of the questions, it is not possible to make inferences about the amount of provider time devoted to each of the activities. Similarly, the frequency and range of reported activities could differ substantially if participants were presented with a list to choose from.

Although one participant reported that it was almost impossible to reach his worker, availability and flexibility were often cited as the best aspect of case management services.

I think the availability of it. Whereby, if I have to see my mental health worker twice a week, she's available for that. Um, customarily I see her every three weeks or two weeks. If I'm having a rough time or, if I'm having a crisis, once a week or whatever. Its really good.

The services I have received out here are just wonderful... Do you that... my psychiatric

nurse, she has appointments with me before work - I don't miss any work. You know she

comes to where I work, to the town where I work and I meet her there... She's made it

possible for me to keep working all these years... Seeing someone for psychiatry once

every two weeks, it really would hurt my full-time job... I've just improved so much.

Like, just to give you an idea, before when I worked I had 15 jobs in 15 years... I couldn't

cope with the situation, with the people, with the anxiety of working. Now I can.

Now I have this psychiatric nurse and I feel comfortable with her and I can talk about

anything and she can help me... She can talk me through things and then I see the doctor

when I need to. This to me works very well for me.

Acceptability.

Participant responses to questions about how they were treated by the case manager were

very similar to responses to the same question about psychiatrists. Participants valued providers

who were supportive and understanding, easy to talk to or listened well. A few reported that their

provider was moody or bossy but most felt respectfully treated and as partners in decision-

making.

My worker always makes sure before she does anything that it's alright with me. She will

tell me if she's worried about me. She will tell me if I'm doing really good.

She doesn't like, tell you what to do. She just says "These are your options.", you know,

"Which do you figure?" ... "Are there others?", "Is there anything else you can think

of?" and then she totally asks for your input. She prefers to have your input as to what

you think is going on and what would be good for you. She adapts what she knows to

help you do that.

The same people who chose to let the psychiatrist take charge of decision-making also preferred that the case manager take charge. Participants appreciated providers who listened to them, who they could trust, and don't push. The same issues figured into participants' dissatisfaction. One participant reported that he did not like current worker as she didn't seem to listen or understand. "She almost doesn't seem to believe what I'm telling her." He has difficulty telling worker what is, or isn't, working for him. Interestingly, another participant who had the same worker was very satisfied with her. This suggests that, in at least some cases, the "fit" between provider and client is the critical issue rather than specific provider characteristics.

Appropriateness.

As with psychiatry a majority of participants reported that seeing a case manager did what was needed. There were a few more tentative responses (e.g. that providers were slow in getting around to tasks or not getting to the root of a problem) but there were some very positive comments as well. For instance, one participant came from outside of Manitoba. She had several CMHW in that province and always felt like she was going for no reason. Nothing was accomplished and she never met any goals. Nothing got resolved.

I met a lot of really nice people but we never made any real progress. That's probably why my depression became so deep and so drug resistant. I've tried almost every medication out there, tried ECT [Electroconvulsive Therapy] for six weeks, three times a week and that didn't work. *(still having crises but making steady progress).*

Areas for improvement.

Although participants generally felt that they had greater access to case management than psychiatry services, several participants felt that accessibility could be improved.

She's always in a rush. [worker] is always in a rush. I mean, I know she's really busy. I'm

not trying to criticize her but, for me, I feel like I'm keeping her [away from other things].

Provider knowledge of services available but outside the region was also considered

important. For instance, one participant lives close to Winnipeg and feels he would benefit from

a number of services located in Winnipeg, but worker isn't familiar with those services.

Knowledge of where to obtain specialized services is also important to proper treatment for

individuals with less common problems.

The last suggestion for improvement was a request for more active follow-up on clients.

"[Case manager] hasn't followed up on me since I left hospital. I was depressed January 'till now

and struggling." The participant needed somebody to call her as she was having difficulty

reaching out for help.

Proctor Services

Accessibility.

Roughly half of the participants reported using proctor services at some point. Six of

these individuals had discontinued use of a proctor, primarily because the participant had become

more independent and no longer required the service. Three participants who did not have

proctors did have a support worker through Child and Family Services. The support worker

performs many of the same functions as proctors.

Regional patterns are evident in the distribution of proctor services. Assiniboine region,

where there are no ICM, makes extensive use of proctors. In this instance it is possible that

proctors are used to extend the work of CMHW by enabling clients with higher needs to have

more, although different, provider time. However, Nor-Man, which is similar to Assiniboine in

terms of provider population, did not use proctors in the same way. None of the participants from

Nor-Man reported using proctor services. Participants residing in North and South Eastman, which have small proctor budgets, were less likely than other regions to report receiving proctor services.

The amount of proctor service provided differs based on client needs and goals. Participants reported using as little as one hour a week and as much as 30 hours a week. In some cases, and depending on activities required, the hours might be split over two or more proctors. For instance, one proctor might provide primarily transportation while another might provide support for employment or specific skill teaching. A client may also have more than one proctor in order to provide for service seven days a week. The extent of service provision may also change over time as goals are met or new goals are identified.

The most common type of service provided to participants was assistance with social / recreational goals. Social and recreational goals can be very important in recovery and reducing feelings of isolation. For instance, one participant used to garden but "forgot"' how. The proctor helped her get a garden started.

> Oh she's my joy. Her more than anything. She changed your life. Give me a different outlook on life. Instead of sitting around brooding about your mental illness and the past, there's other things in life. Reading, walking.

Almost everyone who had a proctor reported that the proctor took them out for coffee, to movies, for walks or other outings. It should be noted though that only six people reported social / recreational needs as the sole reason for seeing a proctor. Social / recreational supports were usually provided along with other supports such as assistance with activities of daily living or transportation.

Support for activities of daily living (ADL) and transportation were also very commonly reported services. ADL includes a wide range of activities, such as assistance with basic hygiene, home maintenance (e.g. cleaning, doing dishes), grocery shopping, cooking, laundry, budgeting, paying bills, banking, or using public transportation. The proctor may provide service directly or provide skills teaching. Transportation was provided for appointments (e.g. physician or psychiatrist) as well as banking and grocery shopping.

Other less common activities included assistance with self-administration of medication, assistance in finding housing, monitoring a behavioural program, liaison with external agencies such as the police and supporting employment. Proctors supported employment initiatives through assisting with job search or serving as a job coach.

It should be noted that a single activity can serve a variety of purposes, and that the participant may not have reported all the functions of a particular activity. For example, the participant might report that the proctor takes him or her to the grocery store. The trip may be intended to meet social goals (e.g. increase comfort with being in public), teach money management, develop knowledge of nutrition or simply provide access to a store with a range of products and reasonable prices. The study design does not provide for detailed analysis of the goals of activities, only the activities themselves.

Acceptability.

Although participants were generally satisfied with the manner in which services were provided by psychiatrists and CMHW / ICM, participants unanimously reported satisfaction with proctor services. The satisfaction arises in part because the consumer has at least some control over who the proctor is and what activities are undertaken. As one participant put it "I'm the boss". In some cases the consumer is directly involved in interviewing and selecting a proctor. If

the proctor isn't effective, the consumer, in consultation with the case manager, can "fire" the

proctor and get a different one.

Things didn't go too well between us so now I've got [new proctor]… If it's not going

right then I can talk to my worker and we can decide what to do. And we decided to get

another proctor. And it worked out. Two weeks later I had another one.

Proctors were seen primarily as a support rather than a person in a position of power over

them. Proctors facilitate independence rather than dependence.

Because they don't judge you… and they don't tell you how to run your illness or what's

wrong. They just kind of handle it. You know, give you a taste of the real world every

once in a while. And go and do things. Be your friend, that kind of thing. Yeah, I think

the proctors are one of the best things that a person with schizophrenia could have.

Participants often spoke of the proctor as "a friend" or "like a father". In some

circumstances participants continued to see the proctor as friends after the service was

discontinued. One participant reported that the proctor had given him a used bicycle. This was a

cherished gift and facilitated independent recreation and transportation at least in the summer

months. Participants also appreciated that the proctor paid for outings, such as coffee or a movie.

Covering the cost facilitated social interaction without placing a financial burden on people who

often have very limited means.

Participants also enjoyed the flexibility of the proctor service.

Probably the flexibility as well. Not only with the being able to see you but the flexibility

of the kind of assistance they can offer me. It's great. Like, you know, if I'm having a

crappy day we sit at my place and drink coffee and talk. If I'm having a really good day

we go for a walk, we go grocery shopping.

Appropriateness.

Again, participants were unanimous in their report that the proctor service was working. Some had become more independent and no longer required service. Others had achieved stable housing or better access to community resources. Being able to get to a proper grocery store and have assistance with grocery shopping meant that participants had nutritious food and that there was enough food to last until the end of the month.

Two participants were experiencing particularly dramatic results. One of these participants started with 30 hours of proctor service each week and, at the time of the interview, service use had declined to one hour a week, which was primarily for monitoring. He reports that he learned how to cook, clean his apartment, do laundry, take public transportation, pay his bills and do his banking. He was able to live independently in the community.

My life would have been worse if I didn't have a proctor... I wouldn't be able to get out of the hospital. I didn't know how to cook and clean and I didn't know how to do nothing like get groceries. I'd be lost. Budgeting, money and everything else.

The other particularly dramatic circumstance was a participant who had been in care of one form or another for her whole life. When she was living in the community, she was frequently victimized and had lots of conflict with neighbours. She now has a proctor who provides structure and support. For instance, at the request of the participant, the proctor was in attendance at the interview. The proctor set very gentle limits and created a safe environment for the participant. The proctor was also instrumental in integrating the participant into the community. For example, the proctor made individual contact with members of the church before the participant began attending. The participant now volunteers at the church and receives emotional support from church members. The proctor has also served as a liaison with the police

and the police are now an additional support for the participant. The proctor assisted in finding current housing and housing is now stable.

Areas for improvement.

Despite the positive comments about proctor services, participants identified two areas for improvement. First, not everyone had access to a proctor. A few participants who did not have proctors reported that they requested a proctor but the case manager didn't feel it was needed. It is unclear what factors influenced decision-making, but availability of the resource may be one contributing factor.

The second area for improvement is continuity. Work as a proctor usually involves casual hours and minimal wages. As a result there can be substantial turnover and disruption for consumers.

> I mean, I understand that, in most jobs nowadays, there isn't much continuity. You know, that people don't take a permanent position and work at it for the rest of their lives, but [moan/sigh] three proctors in a year is a bit much for me. It disrupts my structure. I need a lot of structure but I'm always getting to know somebody else to help me. I get frustrated.

Crisis Services - MCU

Accessibility.

About 85 % of the participants knew about crisis services, and about half of these had used the crisis service at some point. Some of the individuals who didn't know about the crisis service didn't think they needed such a service. It is therefore possible that the case manager didn't provide the information because they also thought the person wouldn't need it. However, more than one third of those who didn't know about the service reported that it would have been

helpful. The fact that several participants who feel they would have benefited from crisis services weren't aware of the services suggests that it may be beneficial to provide the information on a routine basis.

Knowledge of crisis service and successful use of the service appears to differ by region. Participants from regions with mobile crisis services, including Brandon, Interlake, Parkland and South Eastman, tended to know about the service, were willing to use the service if needed and tended to have a positive experience with the service. Participants from Assiniboine and North Eastman, regions, which use an out-of-region mobile service, were less likely to know about the service. Participants from regions without mobile service, or in particular regions using a shared after-hours service, often didn't know about it, were reluctant to use it, or experienced problems with the service when they did try to access the service.

Some of the identified barriers to service use were related to personal preferences. For instance participants reported not using the service for fear of being admitted to hospital or because they didn't want to work with someone they didn't know. However, other barriers appeared to be related to the nature of the service itself. In particular, shared after-hours services that required leaving a message and waiting for a call back were problematic. One participant referred to it as "telephone tag". Substantial delays can occur in connecting with the person on call.

> I was very disappointed. I was in an extremely angry state and I phoned the hospital ... was put in touch with mental health and ... three quarters of an hour or so and I heard nothing. And I phoned again and the hospital says "I told him. I'm surprised you haven't heard nothing". And so, after the second attempt it was about another half an hour, so it must have been a good hour and a half from the initial call before anybody called. At

least it would have helped if there was any delays that somebody in this department could have said "So, I hear you're having a problem right now. I'm trying to get ahold of your therapist. Hope to have him in a few minutes".

With the on-call sometimes it doesn't work ... When you phone, that's the time you need it and then the call may not come to you for another hour or two hours.

The nature of the shared service provided in Nor-Man and Burntwood may also pose barriers to consumers. One participant reported being afraid to call crisis services even though she knew that she needed help. Her fear arose because the person who would answer the call was also responsible for Child and Family Services after-hours work. The participant was afraid that making the call would result in her children being apprehended by the very worker she was looking to for help.

Even with a service that participants were familiar with, access can be complicated. Two participants reported developing an emergency plan with the CMHW. The plan is essentially a list of people to call. One participant reported that she just keeps going down the list until she reaches someone. Several numbers are required as there are different numbers to call at different times of the day and different days of the week. In addition, some of the services might not be available at that moment. For instance, during the day during the week she would call her case manager but if he was with another client, she might need to call the hospital or the police. If it were later in the evening she could call the MCU but if the line was busy or they were out on a call, she might try an out-of-region crisis line.

In the absence of knowledge about how to access crisis services, and sometimes even with that knowledge, a number of participants developed their own emergency plans. These plans included actions such as calling their proctor or case manager, going to the Safe House or

going to the emergency room. Some had also obtained the toll-free number for the KLINIC crisis line in Winnipeg. There may be difficulties with each of these plans. For instance, even if the proctor or case manager has provided their home phone number, it is unreasonable to expect that they would be available 24 hours a day. The participant who used the Safe House reported that they really weren't set up to deal with a crisis call and the KLINIC line was reportedly busy at times of the day when the participant needed it most. Further, while the KLINIC staff may be able to deal with immediate issues, they are not well positioned to make referrals or call in other emergency personnel, such as police, if they are required.

Participants who reported frequency of use were about evenly divided between using the service infrequently (e.g. once or twice) and regular use. Individuals in the latter group were likely to report using the service more than once a week, sometimes daily.

Reasons for using the crisis line varied, but the majority of the calls were made because the person was in crisis. The most common activity was arranging and / or providing transportation to a CSU / Safe House or an inpatient unit. In other situations the MCU helped a person settle down or deal with a panic attack. In a few situations the MCU was called to do an assessment at a local hospital and make referrals. A small number of people who used the line were not in crisis at the time but felt a need for someone to listen and provide guidance on how to deal with problems.

Participants appreciated the availability of the service. One reported that the case manager is "almost impossible" to reach, but the crisis line is there. Another participant reported "They're immediate. They're right on the line, they come right out for you, so that helps".

Acceptability.

Although phone lines were occasionally busy and one person reported dissatisfaction at being put "on hold", participants who had used mobile crisis service reported that they were generally satisfied with how they were treated. People who used the service on a regular basis reported that some workers were better, or more qualified, than others. These consumers would purposefully avoid contact with workers they disliked by, for example, waiting to a certain hour to call or hanging up if that worker answered the phone. On occasion this put the consumer at risk. For instance, one participant, who appeared to pose a high risk for suicide, was advised at one point by a crisis worker to go home, light a candle and read her bible. The consumer considered this highly inappropriate advice. She knew she was unsafe and took other measures at the time. Now she will wait, even when at risk, until that person is off shift.

Participants differed in their ideas about the effects of talking to someone they didn't know. One participant found the anonymity provided by the telephone was an asset, but others avoided the crisis services because they didn't want to talk to someone who didn't know them.

Appropriateness.

Participants generally reported that the crisis service was effective. Tentative responses were related to challenges with connecting to after-hours services and certain providers that weren't very helpful. Only one person did not feel the crisis service was effective. This view is likely related to the outcome of the call: involuntary admission to an inpatient facility.

The presence of a crisis service may have effects beyond the immediate population served. One of the participants found it reassuring that the service was there, even though she had not needed to use the service.

Many of the services provided, such as transportation to a CSU / Safe House or helping a client settle down or conducting an assessment at a hospital, require a mobile service. Not all regions provide a mobile service. The design of this study does not permit assessment of the extent to which providing a mobile service facilitates appropriate care, but the issue does emerge as one for which more information would be beneficial. Similarly, the extent to which "listening" can or should be provided is unclear. For one of the participants who made regular use of crisis services, the issue appeared to be loneliness rather than a mental health need. However, it is beyond the scope of this project to determine "appropriate" use of the service.

Areas for improvement.

Participants were asked if they felt that they would be able to get help if they needed it, particularly in a crisis situation. Eighty seven percent of participants felt that they could get help if they were having a problem. The main issues for people who felt they might not be able to get help were: lack of knowledge about crisis services; lack of 24-hour access to crisis services; a desire to call the case manager rather than crisis services; or concerns about the person who answered the phone at MCU.

Barriers also existed based on the nature of some mental disorders. A few of the participants identified that they are unable to reach out for help when they need it most.

The main area suggested for improvement in mobile crisis services was an increase in the number of hours that crisis services are available. Not all regions offer a 24-hour service. Participants didn't seem to be overly concerned that there were different numbers at different times of the day, but wanted 24 hour coverage. Other suggested improvements involved: increased training for staff in hospital emergency rooms; increased staff training to improve skills of less effective workers; and working more with the family.

To speak a little bit more with [my wife] to tell [her] what she has to do, what she has to

understand, what I am going through.

Crisis Stabilization Unit / Safe House

Accessibility.

About 25 % of the participants reported using a CSU or Safe House. All of these people

reported that it was easy to access the services, although one participant, whose area is not served

by a mobile crisis service, identified lack of transportation to the Safe House as problematic.

Stays were generally short, ranging from two days to a week. However there were two

participants who reported very lengthy stays, of more than a year. These stays were in not in the

same Safe House.

Other than Nor-Man, which has neither a CSU nor Safe House, there was no clear pattern

in frequency of use. Some of the participants in each region had used the CSU / Safe House.

About a third of the participants who reported using the service used it only once or twice and an

additional third reported using the service less than five times. The final third reported using the

service on a regular or frequent basis.

The most commonly reported reason for using the CSU / Safe House was for counseling

or someone to talk to. A place of safety, a place where participants obtained relief of stress, and

education / groups were also frequently identified as reasons for using the service. Less common

reasons included medication adjustment, referral to resources, and development of a safety plan

or contracting for safety.

It's a place you can be when you don't function any more in the family. A shelter. ... I

don't want to hurt my children, I don't want to hurt my wife. Not just physically you

know, but mentally. It's a good place to stabilize my emotions, my medications. Stabilize everything. When I feel good again I go back home.

[CSU] allows you to… have some time for inner thought and meditate on yourself for awhile. You have no one around you. You can talk if you want but you don't have to. You can stay in your bedroom just thinking to yourself, reading your materials and stuff like that. So it helps you to get yourself together to move on and make it at home. Also, you get to relax. You have no stress, absolutely no stress. You don't have to worry about dishes, making the bed or anything. It's no stress.

Acceptability.

In general, participants spoke about CSU / Safe Houses in very positive terms.

It was a warm place to be. There's a lot of good people there. And there was just a lot of things to learn. … like anger management, stress management, alcohol addiction… They give them paper (worksheets) and stuff like that on topics that pertain to some of the people that are there, and give them ideas they can use to help cope with their illness.

The people that work there are wonderful people. They listen to you and help you in any way they can.

Participants felt that staff understood their problems and were able to help. In particular, the "normalcy" of the place was appreciated. For instance, being able to talk to the staff while sitting on the back deck having a cigarette and coffee felt very normal. "They made me feel like you were not necessarily ill, which I can get into very easy."

Participants who had used a CSU or Safe House reported that they were satisfied with how they were treated by staff, although a couple reported conflict with one of the staff

members. Unlike the mobile service, this did not seem to pose serious problems. Participants could talk to, and receive assistance from, other staff.

Although participants were generally satisfied with the service, about 25 % of those who had used a CSU / Safe House had complaints about the food and / or beds. In one situation, a poor bed was reported to have aggravated back problems. Also, more than 25 % of those who had used a CSU / Safe House were unhappy with the mandatory bedtime and requirement to remain in bed overnight. In particular people who had difficulty sleeping found this rule problematic. One participant reported that if felt like being in jail or prison. It should be noted that these concerns were not isolated to one facility, or even one type of facility.

So I'm only supposed to have a problem between the time that we're allowed to come downstairs until suppertime? Other than that I'm not supposed to have a problem?

Appropriateness.

Participants reported that their stay at the CSU or Safe House was effective and met their needs. Some of the reported uses did not fit into the stated mandate, but likely met a legitimate need. For instance, one participant, who had no supports at home, stayed at a CSU before and after major surgery. Another participant was leaving an abusive relationship and stayed at a Safe House until housing could be arranged, while others stayed at a CSU or Safe House while waiting for a bed in an inpatient unit, or during transition from an inpatient unit back to the community. However, in a couple of situations, use did not appear to be appropriate. Specifically, one participant reported using the service at the end of the month to supply meals when he ran out of money for food. Another reported staying at the Safe House for an extended period of time to learn basic living skills, such as cooking and cleaning. These skills can usually be taught through other means.

Inpatient Services

Accessibility.

Seventy-five percent of participants reported having been hospitalized for mental health problems at least once. Of these, two thirds had been in a mental health facility within the last 10 years. A small percentage received inpatient treatment for mental health problems, in whole or in part, in a local general hospital.

Participants often reported multiple admissions and for some, the hospitalizations were lengthy. For instance, one participant reported being in a mental health facility for 20 years and two other participants reported 12 year stays. However, some of the participants also reported short stays of a few days or a few weeks. Only three participants reported delays in admission because of lack of beds or difficulty negotiating the admission process.

About 60 % of most recent admissions were reported as 'voluntary', meaning that the person chose to be admitted rather than being committed against his or her will. However, a number reported the admissions as "sort of" voluntary, meaning that they went willingly knowing they would be committed if they didn't agree to go.

The most common reason for admission was reported as being establishing or adjusting medication. Other common reasons for admission were safety, (e.g. suicide risk) and stabilization (e.g. reduce current stressors and build resources). Some of the other services received included: assessment; anger management and coping skills programs; and preparation for community living.

Nine participants reported receiving inpatient mental health services in a local hospital. For some individuals the admission was temporary. In these situations the participant was admitted and referred to mental health services or admitted overnight and transferred to a Safe

House. However, one of the participants reports that the local hospital has successfully replaced inpatient services at a mental health facility.

Acceptability.

More than two thirds of people reported satisfaction with how they were treated and an additional ten percent felt well treated in some ways. The satisfaction rating stands in stark contrast to the comments people made about their treatment in a mental health facility. Several participants, both voluntary and involuntary, reported experiencing coercion and maltreatment. Participants used words and phrases such as "strong arming", "power trip", "like garbage" and "degrading", although one participant remarked that staff were less bossy than they were in the 1960s. Participants were reluctant to "rock the boat" and end up in seclusion or time out.

I did not like (mental health facility). I think it's not a therapeutic place. Um the nurses and staff are just basically downright rude. They're not even a bit nice.

They just force you. If you don't do what they want you stay in pjs all day.

They (staff) would say we have rights. You know you have rights but thing is, I can't practice my rights because I don't know who to contact.

It seemed like every time I opened my mouth I got another shot of something.

Look at them the wrong way and you'll be harassed and abused.

Participants also complained that they did not feel listened to, and reported minimal interaction with nurses and psychiatrists.

They weren't listening to me very well. I told them what was going on but they didn't listen. … My doctor, I tried to tell him the truth about things but he thought I was paranoid and kept giving me more medicine. *(doctor found out years later that these things were true)*

But I found, I could see that the nurses were busy with paperwork and stuff too, but I found there wasn't a lot of interaction between the staff and the patients. Like I really didn't find too many people [staff] there that I could talk to or who would come and mingle with the patients. ... Like they were standing behind the desk and they would not [come and talk to patients].

Three of the participants expressed discomfort with the environment in a mental health facility because of fear of other patients, particularly those exhibiting psychotic symptoms.

I was terrified because the other patients were walking around and behind me sometimes when I was sitting on the couch and I was just terrified.

Sometimes I found that they didn't put the patients on the right wards ... Instead of being admissions they should have gone straight up to the lock-up ... mainly because they were more active or agitated than what I thought would be expected there.

There was strange people in there. People that were, I wasn't nowhere near like they were.

Participants also commented on the physical space and meals. Some appreciated the newer inpatient units for their privacy while others appreciated older facilities for the space and large grounds to go for walks. Some participants felt that food was good while an equal number were unhappy with the quantity or quality of the food. A small number also commented on the availability of activities. Some of the participants found the days very long and felt that they would have benefited from more recreational opportunities.

I guess my biggest complaint would be just the boredom there, because they hardly have any activities, eh. You're just sitting there from one meal to the next. Gets quite boring.

Participants using local hospitals for service reported benefits such as familiar staff and increased ability of family to visit. However, other participants reported that the staff didn't have the time, expertise or comfort level to provide assistance.

There's nothing they can do for you here [at the local hospital]. You go in here and basically all it is, is they probably give you your meds when you're supposed to and you lay on a bed. So what good is that?

Cause they don't like putting you on a medical ward. I requested one time to be put on a medical ward. I'll never do that again. [laughs]. ... I told them "I need to be in hospital, I don't care where I am, I just need to be in a hospital"'. And the nurses, like I swear to God they went like that [back to the wall] around my room. I didn't see any of them the entire time I was in there. I was in there for a week. I saw the doctor but no nurses... The dietary people came in, but no nurses. ... I didn't have anybody to talk with, just the doctor. You were just so isolated it was useless. I mean it was pointless. It was a safe place to be. I mean that was it. And that was what I needed, but on the other hand I might as well, like I have a supportive partner, we might as well put me in a room at home, shut the door and him keep an eye on me. You know. Because at least then I have somebody to talk to.

Appropriateness.

Similar to the reports of satisfaction with services, people generally reported that services were effective. With respect to appropriateness however, comments were more consistent with ratings. Where the service didn't meet participant needs, participants often attributed lack of success to their own inability to participate in treatment or to staff shortages.

The people, I couldn't talk to them, they weren't well enough, the other patients. …

Other than that, there's only staff and staff haven't got much time 'cause they're busy.

Well they were cutting back on staff and we didn't get the one-to-one basis that we really

needed.

Staff should talk to patients rather than sitting in the office. They don't even know how

people are doing. Don't even find out what is wrong.

Perception of effectiveness may also change over time. Two participants reported feeling

differently about hospitalization once they felt better. One participant reported that she came to

respect staff that she felt were hard on her during the inpatient stay.

Housing

Accessibility.

The majority of participants, about 75 %, reported living independently, with or without

supports. The single most common concern was the availability of decent affordable housing.

People regularly expressed concern, and even anger, that the housing rates paid by Income

Assistance were not sufficient to pay for decent housing. A few suggested that Income

Assistance rates would only pay for "slums". For instance, one participant reported having lived

in a building that was subsequently condemned and demolished.

There was rats the size of a small kitten and there was cockroaches. You would go to eat

a meal and the cockroaches, you could see them coming towards your plate. It was just

terrible. And when I wanted to take a bath I had to clean the bathtub out real good and get

all the cockroaches out of there. I went nuts in that place... And at night, there was a

woman there, and she was an extreme alcoholic and she used to walk around the hallways

hollering and screeching. She was drunk when she did that. So I put the, I had help and

we put my closet against the door so she couldn't break in.

Other participants spent more than they could afford on housing or remained in

inappropriate places. For instance, participants reported having very lengthy stays in Safe

Houses, transition housing, or a group home because they could not find affordable housing.

Some stayed with family out of necessity rather than choice. For instance, a number of

participants were in their 30s and still living with their parents. Others only began living

independently in their 50s after their parents died. Still others reported having had living

situations that were largely transient or extremely tenuous. For instance one woman's housing

was based on, and dependent upon her relationships with men.

Even when housing was obtained, some reported difficulty maintaining that housing.

I've been through eight or nine places in the last little while. … Trying to keep the right

kind of housing. It's never been a problem to find housing, it's trying to keep the house.

Some participants were able to share an apartment with someone else and together they

could afford the rent. In both these circumstances the individuals sharing the apartment got along

well together, provided company for one another and divided up tasks based on skills and

preferences. However, not all participants felt comfortable sharing a place, particularly with

someone they didn't know.

Manitoba Housing Authority properties exist in all regions. Rent for these properties are

based on income and are therefore affordable. At least ten of the participants were currently

living in Manitoba Housing properties. Others are on a waiting list, but the wait can be lengthy.

For instance, one participant reported being on a waiting list but being told that he could expect

to wait at least three years. Further, concern was expressed by some of these participants that the elderly, who often occupy these properties, do not mix well with mental health clients.

There's old people and patients from the hospital here. ... They run us down and blame everything on us. It doesn't work old people and mental patients together... I'm getting fed up with staying here but where am I supposed to go? I'm getting fed up with all those old people.

Acceptability.

While many people had experienced problems with obtaining or maintaining appropriate housing at some point, most reported that they satisfied with their current housing situation. It appeared to the writer that expectations for housing were generally very low. For instance, people who experienced lengthy stays in a mental health facility, or who had lived a transient lifestyle were very excited to have stable housing, regardless of the objective quality of that housing. One woman, who lived in a place that was particularly dilapidated and filthy reported that she was "very satisfied" with her housing on the QoL survey.

Appropriateness.

Despite general satisfaction with current housing, regional differences are apparent in the extent to which housing issues are addressed by community mental health services. Participants from Brandon consistently reported receiving assistance in finding housing. Many also received skills training. Skill training was provided through programs, such as the Community Preparation Program, McTavish Manor, Progressive Choices, or through proctor support for independent living. Participants from Parkland also frequently reported having assistance in locating housing and / or living in properties belonging to Parkland Mental Health Housing. In contrast, while

participants from Nor-Man identified housing needs, they did not report any assistance in

obtaining or maintaining housing, or support for independent living.

Vocational / Educational Services

The importance of work was emphasized by a number of participants, despite substantial

disability.

I get through it all by working. I figure working is the best medication there is for a

person to keep active and doing stuff and keeping your mind thinking ... I figure if you

work, everything should look after itself ... I think if I wasn't able to work I'd die inside.

Availability.

About 25 % of participants reported that they were not receiving assistance with

employment at this time but, because of the extent of their disability, were unable consider

employment at this point. About 19 % of the participants reported being independent with

employment. They had been able to find and maintain suitable employment. About half of these

people had received support for employment at some point in the past. Almost 30 % of

participants reported receiving at least some support for employment. However, about 17 % of

respondents reported that they were either making efforts and could use some support, wanted

employment or would be interested in exploring the possibility. This suggests that there is a

sizeable group whose needs are not yet being met.

The three main types of assistance provided included: exploring interests, assistance with

résumé preparation or job search; access to a training or educational program; and support for

educational initiatives, including adult literacy. Assistance with education might include

providing transportation to classes, proctor support in the form of tutoring, or supportive

counseling to manage issues arising from participation in an education program. In a smaller

number of cases, a proctor was serving as a job coach. A job coach provides support and assistance in the workplace while the consumer learns a new job. Even when the participant was independent in employment, the case manager may also have a role in supporting that employment. For instance, scheduling meetings outside work hours may be important to maintain that employment.

Only three of the participants were working full-time. The remainder of the participants who were employed reported working limited hours (e.g. five hours a week). Most reported working as much as they could manage at this point.

Regions appear to differ in the extent to which employment issues were addressed and the means used to meet employment needs. For instance, participants from Brandon and Parkland, regions that have training programs, often used those programs. Regions with ICM / EDC appeared to pay more attention to employment issues than regions without these providers.

Aside from the services that are provided, there are a number of factors that influence interest and participation in employment initiatives. A number of participants expressed concern about Income Assistance rules and about the availability of jobs in the community. Lack of employment opportunities, difficulty competing for the available work and jobs that did not meet their needs made it difficult for some participants to seek employment. Income Assistance rules limit employment to about eight hours a week. After eight hours, documentation must be submitted and money is deducted from the income assistance cheque. This process can feel daunting and can result in delays in obtaining the income assistance cheque. Consumers who have worked in excess of allowed hours reported having to pay back the money.

One factor that appeared to be helping people to participate in employment initiatives was the newer medications. People who had not worked in many years reported that they now had the energy to consider working. One participant who hadn't worked in 25 years said

> I'm looking for work now. Before I didn't want to because I was so dragged out, so tired, so run down with those other older medications. I didn't feel like I wanted to work at that time.

Acceptability.

For some individuals work was stressful, but others found work provided stress relief.

> I can go there and be having problems but once I walk in the door and start working, my problems go away. I'm concentrating on what I'm doing so I forget what's outside that door. And I don't have to face that until I walk out of here.

Some participants appreciated enthusiasm on the part of the case manager, but for other participants enthusiasm made them feel "pushed". This latter group felt that the caseworker was too "forceful" and that the service would be improved by going slower. "I think they believe in me a little too much. That's the problem."

Social / Recreational Programs

Accessibility.

Just over half of the participants reported using some form of social / recreational service. The extent to which the services are used varied widely by region. About 90 % of participants from Assiniboine and Brandon used some form of social / recreational service, while less than 10 % of participants from Nor-Man and South Eastman reported using this type of service. Participants from Nor-Man and South Eastman reported that there was nothing available.

With the exception of Nor-Man and South Eastman, all regions used proctor services to meet social / recreational needs. In addition, Brandon, Burntwood, Interlake and Parkland have programs that follow, to varying degrees, the Clubhouse model (Grey Owl, Ke na now Club, Support Centers, and HERO Club). Central has a part-time drop-in centre and MSS offers a bi-monthly activity in some areas.

Participants using the proctor service to meet social / recreational goals reported that the service provided company and outings, although these activities tended to involve individual rather than group activities such as going for coffee, to the library or shopping. Further description of the proctor service is provided in that section.

Participants using a clubhouse type program reported a variety of reasons for attending. The most common reasons for attending were the peer support, outings and games. People also reported that they got some exercise and information through attendance at the club, and some reported volunteering at the club.

For the clubs in particular, participants identified a number of barriers to attending. Many of these barriers were related to the nature of their illness. People reported having social anxiety or panic attacks, had difficulty attending because of withdrawal related to depression, or experienced paranoia in a group situation. These individuals might benefit more from proctor support, at least until a tolerance for social situations is established. Other barriers to participation in club activities included lack of transportation and stigma. Participants living outside larger centres, and sometimes those living inside larger centres, reported being unable to attend because they couldn't get there. Concerns were raised about stigma that might result from being identified as a consumer or being associated with the club.

Acceptability.

The best aspect of social / recreational services was summed up by one participant as "socializing with others and doing things I like with others." People spoke very positively about the clubs, but there were a couple of factors that influenced whether participants attended or the extent to which they attended. The first such factor is smoking. Smoking was identified as problematic for people who did not smoke, and particularly for people with asthma or allergies. The other factor that influenced attendance was the behaviour of other consumers at the club. Some reported that they were uncomfortable with the mix of people or found certain people disruptive.

> It's not much of a help. You get people in there, there's one lady there that's always yelling, screeching. So I just feel like going home and not going back.

Areas suggested for improvement included extending hours of operation for programs that operated limited hours and increasing the number of activities and outings.

Appropriateness.

Where available, social / recreational programs were considered effective and highly meaningful. In addition to meeting social needs, programs helped people deal with challenges and fostered growth and recovery.

> When I first moved in here [apartment], from sun-up to sun-down, seven days a week, the only time I left the apartment was to go shopping with my dad or to go to my mom and dads. The rest of the time I would stay here [in the apartment] from sun-up to sun-down.

> I get support and good things that I would otherwise never have. I can come here. Even if I'm grumpy the staff helps me settle down. I leave with hope that tomorrow will be better.

It seems like it's a place where you can go to forget that you have an illness, that you're

schizophrenic. A place where you can go and leave it all behind, whatever the day

brought you. You can go in there and say "Hi" to people or watch TV or play games ...

You can kind of amuse yourself for a few hours and feel happy for awhile.

They seem to be encouraging people to do something constructive with their lives and

meaningful and something that is going to benefit society.

It gives meaning to my life.

Even when participants didn't use services, they appreciated that the service was

available if it was needed.

Self-Help

Accessibility.

About eighty percent of participants had heard about self-help services. The extent of

knowledge differed between regions. All the participants in Brandon and Parkland were familiar

with the service while fewer than fifty percent of participants from Assiniboine and Burntwood

knew about the service. However, only a few of those who weren't familiar thought self-help

services were something that they might benefit from.

About two thirds of the people who reported knowing about self-help services had used

the service. People who didn't use the service either felt they could manage on their own or their

needs were being met in other ways. Some of the other ways in which needs were met included

support from family members, church groups or, in one instance, through a separate support

group initiated and maintained by the group.

There were a number of barriers to use. The barriers to use of self-help services were

similar to barriers to participation in social / recreational initiatives. Specifically, the nature of

peoples' illnesses and transportation posed barriers. Participants reported that social anxiety and panic attacks prevented attendance. Transportation was an issue by itself, as well as in combination with illness. For instance, one participant who usually drives to self-help meetings, is least able to undertake the drive when she needs the meeting most. Other barriers included physical space that was inaccessible (e.g. stairs) or lacked washroom facilities.

As mentioned previously, about two thirds of those who had heard of self-help services had used the service at least once. Considerably more participants attended MSS (about 60 %) than either of the other two self-help groups or CMHA. However, the proportions are reasonably consistent with the distribution of probable diagnoses among participants.

The most frequently used aspect of self-help service was peer support, which includes both formal support groups and informal opportunities to provide mutual support. Education about illness and / or medication was also frequently mentioned. Participation in social activities and individual support were also used by some of the participants.

Although a good portion of the participants had heard about self-help services, and a good portion of those who had heard about the service had used the service, considerably fewer had maintained contact with the self-help groups. At the time of the interviews, about forty percent reduced or stopped using the self-help services.

Acceptability.

Participants consistently reported feeling well treated while using the service.

Just the way they treat you. They treat you like a human being instead of just a number...

In [other province] I was a number. I was not a human being. Here I'm like a normal

human being.

The best aspects were reported to be contact with other with similar experience. The ability to talk freely was also mentioned as being valuable.

I like it better than talking to anybody... I don't know, you're freer there and there's more people who are up on the meds... You can talk about them without worrying about what people might think.

However, not all the people who attended peer support groups felt comfortable. Several participants stopped attending because they didn't like the people, didn't feel they had enough in common with other people or had different needs than other group members. Some felt healthier than others and, while one participant felt she might be able to assist other participants, did not have the personal resources (energy) to assist. Another felt largely "dragged down" by the group.

Everybody had so many troubles so that's all you heard. You felt worse when you left the meetings.

There were a number of additional factors that contributed to reduction in participation or quitting. The first was service suspension. When programs closed for the summer, were interrupted by staff changes (including maternity leave), or were frequently cancelled, participants tended to stop attending and not return. The second substantial reason for quitting was stigma. Several people commented on the lack of anonymity in rural areas. Having an open discussion was difficult when everyone knew each other. Further, anonymity was not possible because neighbours who weren't in attendance would know you attended the meetings anyway.

Those type of support groups are not common here because everybody has relatives in this town.

I notice that they put these meetings, it's a small area but everybody knows everybody... and they put [the announcement] in the local paper [for] the open meetings. And I don't

know, I think that's pretty confidential to be putting in open meetings sometimes... that's

the only thing I don't like.

Everybody knows that truck and they see it going down the road and they see it parked in

front of some place. They know it. If they know what's going on there, they know why

I'm there.

Appropriateness.

People who attended groups, educational sessions and social activities generally found

them helpful. Many of those who were no longer using the service also reported that they had

learned new things and benefited from the service, but no longer needed the service.

Family Supports

Families were reported to be a substantial source of support. However, less than 25 % of

participants reported receiving some family support, and one third of these received support from

agencies outside mental health, specifically through Child and Family Services or private

counseling. Of those receiving services within mental health, half received support through case

managers. Case manager support was largely limited to maintaining contact and sharing client

information. Only one participant reported that the case manager provided direct support to the

family. Similarly, one psychiatrist was reported to have provided support for the family. This

support consisted of meeting with a family member on a single occasion.

The majority of family support was provided through the three self-help groups (ADAM,

MDAM and MSS). However, since most participants did not receive any support, the majority

refers to the families of five participants. The families of two of the participants attended support

groups and the remaining three families received information. Participants whose family had

attended an educational session or attended a support group reported that the family members

were better able to understand what the participant was experiencing and that family generally felt that their information needs had been met.

A large portion (about 60 %) of those who reported that family had not received support either had no family, had family who lived out of province, or the participant felt that family members would not be interested. In particular, parents of people who had been ill for a long time were thought not to need family support.

Well I've had this illness since I was 16 and I'm turning 41 now. They're obviously used to me.

While participants generally reported that parents didn't need information or support, participants did feel that there was a need for information for the spouse and / or children. More than ten percent of all the participants indicated that they would like their family to better understand their experience. Participants also felt that family would be able to provide more support if they had a better understanding of what was helpful.

[Husband] might [benefit from information]. To understand what I've got... I feel like he could understand it better.

Talking to my son more about my illness. Um, like anxiety and depression, to explain to him what it's like... you've got to talk to my family.

More family involvement. They totally leave family out. [Service provision] is more individualized. *(Husband is feeling left out and it is causing problems in their relationship)*

A few participants who were divorced or estranged from their children wondered if a better understanding of the illness might have kept the family together.

Although questions were not asked about the extent of mental illness in the family, 16 % of the participants reported serious mental illness among immediate family members and some participants reported several immediate family members with serious mental illness. Illness among family members made it more difficult for family to provide support and often brought additional care-giving responsibilities. For instance, one participant reported that her husband and son both have mental health problems. When she is having difficulty, her husband can't cope with her and they both end up in CSU. If either goes to the CSU then the other person is left with more responsibility than they can manage alone.

At least ten of the participants made references to parenting. Five of the participants were raising small children or had teenagers who had just left home. Parenting represented both a burden and a source of strength. Participants reported that life was more complicated as they tried to, for example: balance their own need for medication with the needs of the baby during pregnancy; ask for needed services knowing that they might lose their children to Child and Family Services; or make suitable arrangements for children at a time they were so ill they were being hospitalized. However, the presence of children, for these participants, increased their determination to get well. Some of the participants reported that they were hospitalized for shorter periods of time after having children because they tried that much harder to get well. There was no opportunity to give up.

Clearly the level of family support is minimal in relation to the reported needs in this area. Attention to the larger family system may be an area for increased involvement. Involvement with the family and providing family support would likely be very beneficial considering the extent of serious mental illness among family members (parents, siblings, spouse and children) and the number of people with SPMI who are actively parenting children.

Other supports

Questions were not specifically asked about what other supports participants might be receiving, but a number of participants included other supports in their description of services. Clearly many more participants may be using these "other" resources. However, information that was provided can offer an illustration of the resources available to consumers and is therefore included.

The most frequently mentioned "other" support was the family physician. About twenty-five percent of participants indicated that their family physician provided services for mental health problems. For a few of the participants, the family physician was the first one to "pick up on it" or was active in managing their mental health in relation to physical health issues, such as pregnancy. Others reported that the family physician monitored blood work (e.g. for lithium levels or blood dyscrasia that may result from certain antipsychotic medications) and / or prescribed medication. In some situations the physician appeared to be managing the disorder alone, but more frequently in collaboration with a psychiatrist. For instance, the participant might see the psychiatrist as little as once a year, if the condition was stable, and see the family physician every three months for monitoring.

Participants were mixed about the acceptability of services provided by physicians. Some participants clearly had very positive experiences, reporting that the physician listened, took the time to sort things out, or would stay and talk as long as required.

He's good. He'll stay with you as long as you want to talk about stuff instead of rushing you out in ten minutes with a prescription.

Other participants reported that the physician was "always in a hurry" and "couldn't possibly understand" during a short visit. A few reported that they actively disliked the family

physician but, due to the small number of providers in rural areas, were unable to change physicians.

The main concern expressed about services provided by the family physician was the extent of knowledge in psychiatry and ability to recognize illness and intervene at an appropriate point.

Family doctors don't understand mental illness, only medical illness. They don't even know what questions to ask.

They're not trained to deal with mental health. He didn't understand until you get real bad. I mean, it's frustrating sometimes with doctors. They don't really understand how rotten you [feel].

My family physician doesn't recognize mania until its time to hospitalize.

The expertise of the family physician was particularly important when lack of access to psychiatry meant that the only resource would be the family physician. One woman, who had seen a psychiatrist for years, was referred to her family physician when the psychiatrist left.

Now I have to go to this doctor I don't know and try and explain to him why I'm taking all these pills. Kind of start all over again. He's a general doctor so I'm kind of a little bit scared that if ever I do get sick again, I don't know how much support I would have from (the doctor)... That I guess I'm very sad about. That we don't have a psychiatrist here.

Other supports that were frequently mentioned were Alcoholics Anonymous, Child and Family Services (CFS), church, family, and police. People that were attending Alcoholics Anonymous reported very regular, almost daily, use. All considered it an important support.

Child and Family Services provided support workers for three of the participants. Support workers are similar to proctors. Services were provided because the participants were unable to

care for their children or home. One person reported that she was very depressed and couldn't get out of bed. Her husband was trying to help but didn't know what to do. Another reported that she wasn't aware of the effect of her illness on the children.

When I was in a depressed state I was like, I couldn't cope, but I didn't want to tell anybody that. I was so scared at the time. … I was worried about me and I didn't, I didn't realize that I wasn't taking proper care of my children, although I wanted to... 'Cause I never dreamed that I wasn't taking care of my family.... There were certain things that I would normally do that I wasn't doing.

Support workers were providing about four hours a day of in-home support. Support included assistance with housework and child-care, as well as getting organized and dealing with situations that arose. The assistance was intended as support rather than direct provision of child-care or home management service.

That's what I needed. Not someone that's going to come in there and take over for me but someone that can show me. And that's what he does. We work together.

CFS support services were also flexible and could be increased if the participant was in hospital.

People that reported church as an important resource identified that church members were welcoming and supportive, and that the church offered social opportunities. While the social environment was warm, for one participant at least, it appeared that the information and advice provided by church members conflicted with the information provided by community mental health. The participant found the conflicting information very confusing. She reported that she doesn't care any more what she has or how it came about, she just wants to get better.

Police were involved with participants in a variety of capacities. For some participants, particularly where there were no mobile crisis services, the police were sent by the crisis services to transport the person to an inpatient facility. In other situations the police were allies in managing difficult situations in the community or even people that could be relied on to come over and talk for a while when the participant was in trouble. One participant was particularly pleased that the police appeared to have more training in the area now, but also felt that there was room for improvement.

Good to see the mounties get a little bit of training in psychiatric … They didn't understand it because they put him (son, who also has a serious mental illness) in jail. Someone that's got a psychiatric problem should be seeing a psychiatric doctor because you're not going to get any help sitting in a jail. You're not responsible for your actions, I guess you might say, when you're in that state of mind, you know. I think it's getting better. I think there's some training which they didn't have then. But there's still lots of improvement could be made.

Only one or two of the participants mentioned some of the other supports. These included: formal services such as a specialized treatment facility, Addiction Foundation of Manitoba, the Public Trustee and a school Guidance Counsellor; Non-government organizations such as a women's shelter, Seniors for Seniors, and Samaritan House; peer support including Emotions Anonymous and a grief group; and a soup kitchen.

Two additional "other" supports were mentioned by only one participant but are worthy of mention because they appeared to be unique or particularly innovative. The first is a peer support group that developed spontaneously among a group of people who had been inpatients at the same facility at the same time. The members of the group developed strong bonds and they

continue to meet and provide peer support and, on occasion, crisis intervention. The participant reported having sent a rather hopeless email to one of the other members. That person contacted the psychiatrist and had a third member go directly to see her. The group has been operating entirely independently for some time. There is interest by other members of the community in joining the group because is so helpful.

The second innovative support was provided to a person who lived in a very rural area. The person needed more frequent support than could be provided by the ICM who lives and works at a distance. The participant did have some good supports in his own community, but they were not able to meet important needs. The ICM now collaborates with, and provides backup for, the local person to ensure that the participant's needs are met. This collaboration has allowed the person to remain in his home community with friends and family.

It appears that there are a number of other natural supports available to consumers. Knowledge of the resources available to clients, and willingness to collaborate with these supports, may ensure that client needs are met, and met in a way that is acceptable to clients.

Have needed services

Participants were asked if they felt they had the services they needed. About 85 % of participants reported that they had the services they needed, but a large number accompanied the 'yes' with a suggestion on how things could be improved or what would be helpful. Some of these suggestions were based on earlier discussions of specific services and have been discussed in detail in the relevant section. For instance, a number of participants expressed concern about frequency and length of visits with a variety of providers. The concerns expressed are discussed in conjunction with the relevant provider. This section discusses the perceived availability of provider time in general, as it appeared to be an issue across provider types.

Accessibility.

Some of the participants discussed how much they valued providers who listened, took the time to understand, and to help. In fact, this appeared to be a major contributor to satisfaction with services. However, several participants expressed concern about the length and / or frequency of visits. Participants who were dissatisfied acknowledged competing demands, such as paperwork or large caseloads, but were clear that their needs were not being met. Concerns were not isolated to a single type of provider. All categories of provider, including psychiatry, psychology, CMHW / ICM, proctor, inpatient staff, self-help and family physician, were identified as not spending enough time with participants.

Several participants reported that access to services had improved over time. Availability of some services, such as psychiatry, increased in several regions, and the level of service in outlying communities often increased. More local service appeared to be very helpful for some participants. For instance, one participant had been traveling to Winnipeg to see a psychiatrist every six months for over 20 years. Once she was able to see a psychiatrist locally she was able to see him more frequently and, as a result of a very effective medication change, has experienced substantial recovery. However, there were a number of participants who continued to experience very limited local access. This number is likely an underestimate because the study design involved approach of consumers through providers. Consumers with the most limited access to providers may well have been excluded from participation.

Transportation is another means by which access can be enhanced. Access to transportation was a key element of access to treatment, participation in self-help, access to social / recreational services and even meeting basic needs. Appointments with, for instance, an out-of-region psychiatrist, attending a peer support group or participating in social activities

offered by a clubhouse are often dependent on transportation. Even transportation within town can be an issue, depending on physical health and weather. Participants who did have access to transportation were clear that the services they were receiving would not be available without transportation. Access may be further limited by cost. People with very limited means may be unable to afford transportation even when it exists. The presence of self-help and social / recreational opportunities is new to most regions. People appear to be benefiting from these services. However, in the absence of means to provide access to these services, they are likely to be underutilized. Proctor services have been used to meet transportation needs for some consumers. However, there appears to be a sizeable number of people for which, for all intents and purposes, services still do not exist.

Acceptability.

Two of the main issues reported by participants that affected acceptability of mental health services were: 1) continuity of service delivery and 2) stigma. Continuity of service provision was identified as being very important. Participants reported that staff turnover was distressing, disruptive, and slowed progress.

To keep changing all the time. I don't know how to explain it, but you get relying on somebody or something and that person is taken away or goes away and you feel lost again.

And I've had about three or five different mental health workers… not so good 'cause once you get used to somebody, It takes me a while to listen to each other, to get used to them before I will talk.

Being with the same people, getting the same person … instead of being, like, dumped on two or three different people … somehow stabilize the people that are doing it instead of

… It's almost like you feel you have to start over because that person doesn't really know you … You build rapport with the one person that was there and all of a sudden they bring in someone new and then you're basically starting over

One of the participants gave an example of how continuity made a difference. People who knew him well were more familiar with his response to medication. They also knew him and that he knew his own body. These people were better able to work as a team, and to work with him, to adjust medications effectively. If any of the providers changed it was a big setback.

Even disruptions for maternity leaves were problematic.

'Cause I have a very difficult time trusting and talking to people. They kept changing so I kept talking and talking. It made a big difference to have the same person. [The provider] was great and the person didn't change, but she was there, then on mat leave for a year, back for a bit then gone [left the region]. It was the same person and she's really nice and good, but it just kept stopping.

Concern was expressed about turnover in psychiatry, community mental health, proctors and self-help services, although turnover appeared particularly high among proctors.

I had eight or nine proctors over a five-year period.

I've been through proctors right and left. They don't stay.

I mean, I understand that, in most jobs nowadays, there isn't much continuity. You know, that people don't take a permanent position and work at it for the rest of their lives, but [moan / sigh] three proctors in a year is a bit much for me. It disrupts my structure. I need a lot of structure but I'm always getting to know somebody else to help me. I get frustrated.

As for the mental health worker, well, I've had a string of them. They've all been good, but I'm getting very frustrated with the lack of continuity.

Turnover in self-help services was also cited as problematic and led to disruptions in programs and participants just stopped going. One participant said that self-help just wasn't helpful at that level of turnover.

Many of the participants described experiencing stigma as a result of having a mental illness. Participants found the treatment they received from others was sometimes very hurtful.

As soon as they find out you have a mental health counsellor, they think you're some kind of psychotic... they don't understand. I'm not sure they want to. I don't think so. Like, I thought maybe if there was more information out there people would understand it more. I gave them a blast last week. I was so tensed up about this and I just told them straight, I said 'Do you think it's funny me having a nervous breakdown and behaving in some ways that I do?' ... I hate being laughed at.

Several people reported that they were reluctant to use services, particularly peer support and social / recreational opportunities offered through mental health services because of stigma. Participants were concerned that use of the service would identify the person as a consumer and expose them to stigma. The size and composition of small communities made it more difficult to attend and maintain anonymity.

People here are afraid to come out and expose their illness. ... They're ashamed to come out. They don't want people to know.

Everybody knows that truck and they see it going down the road and they see it parked in front of some place. They know it. If they know what's going on there, they know why I'm there.

Being a teacher, one of the big concerns was, and it wouldn't be any fault of the mental

health department, but even me walking in there would create comments.

However, there were signs that the degree of stigma may be changing. One of the

participants commented about how public education provided by self-help had been helpful in

reducing stigma and enabling him to respond to stigma. Another participant was taking active

steps to combat stigma.

I have learned that the more open I am about it, the more comfortable other people

around me are about it. Because it's kind of like, you know, the elephant in the room.

People have, like say I was in Brandon (Mental Health Center). Even though I was in

Brandon, people here knew about it... So our family has learned just to take the bull by

the horns and just be comfortable with it.

While the possibility exists that use of community-based mental health services could

pose a risk of stigma to individual consumers, the possibility also exists that the presence of

these services may decrease stigma. In an interesting twist on community integration,

participants from two of the Support Centres reported that people without mental illness have

started to drop by. When the benefits of the Support Centers are sufficient for people without

mental illness to risk being identified, correctly or incorrectly, as a consumer, the environment

would seem to be ripe for true community integration.

Appropriateness.

Participants reported two areas as having an effect on the appropriateness of services. The

first issue was gender. For many women the gender of the provider was not an issue. However,

for a small number of women, the gender of the provider was critical to effective service

delivery. These women felt that male providers were insensitive to women's issues. Women who

reported a history of abuse felt very uncomfortable meeting alone with male providers,

particularly when meeting with, for example, a male CMHW and a male psychiatrist at the same

time. The women used different strategies to address their concerns, with differing degrees of

success. One woman brought her proctor to meetings with male providers, which increased the

participants' comfort level. However, the participant still felt unable to discuss her concerns or

request a female provider. Another participant did request a female provider and was told that no

female providers were available. Because the participants' needs were not being met, she

stopped seeing the male provider, became ill and was hospitalized after a suicide attempt. After

the hospitalization she was again referred to the same provider. It appears that, for at least some

women, an expressed need for a female provider represents more than a preference. Lack of

attention to these needs may place some consumers at risk.

The second issue that affected the appropriateness of services was religion or faith. Some

of the participants very much appreciated having a Christian provider (individual or

organization). These individuals reported that religion was an important support and felt that a

provider with the same beliefs was better able to understand and assist them. Other participants,

who did not share the providers' beliefs, found references to religion objectionable and

considered the references highly inappropriate. As a consequence these consumers rejected a

service that would have been useful.

He wasn't supposed to be preaching. He's a preacher. I didn't know that. He wasn't

supposed to be preaching anything about God in that group. ... I'm sick and I'm going to

theology school.

The last time I talked to him I was in crisis. He sat down and told me to go home, light a

candle and read my bible.

Other concerns.

There were a number of other factors identified by participants that influenced their lives in important ways. Even though the factors are not related to the organization and delivery of mental health services, the factors do have an effect on the way in which services are delivered. The two most prominent factors were poverty and new medications.

Poverty had a pervasive effect on the lives of many of the participants. In the QoL survey, two thirds of the respondents reported relying in whole or in part on Income assistance. Participants found it difficult to meet basic needs, such as decent housing or enough food to last the month, on Social Assistance rates. Participants reported that Social Assistance does not make provision for common amenities such as a telephone or transportation. Lack of a telephone or transportation limits access to services and other community resources, as well as increasing social isolation. Lack of funds for social / recreational purposes also contributes to social isolation. Financial stress has both direct and indirect effects on mental health services. Financial stress was reported to increase use of services, such as the crisis services, and impede recovery. Beyond the rates themselves, the Income Assistance policies were reported to provide disincentives to work. In particular, participants using newer medications were unable to go off Income assistance because of the high costs of the medication.

Although the mental health service system is not in a position to influence Income assistance rates, sensitivity to the realities of consumers' lives appears important in ensuring that people are able to use existing services and resources. For instance, provision of transportation to enable shopping at more affordable grocery stores, or providing low or no-cost activities were helpful in enabling participants to stretch financial resources and reduce financial stress.

The second factor that impacted on service delivery was use of newer antipsychotic medications such as Clozapine, Risperdal and Olanzapine. These medications were reported to be creating substantial reduction in the negative symptoms of Schizophrenia. This alone appeared to having sometimes-dramatic effects on participants' symptoms, ability to engage in treatment, and ability to resume normal social roles. As these individuals recover, the amount and type of services required has changed.

> I'm looking for work now. Before I didn't want to because I was so dragged out, so tired, so run down with those other older medications. I didn't feel like I wanted to work at that time.

> Thanks to the encouragement of [CMHW] and [cousin] and [psychiatrist] I started on new medications. … And then I kept getting better on medications and, you know something… I'm just so grateful for trying me out with this wonderful medication. I'm just so grateful that they did that for me. Because it's a very expensive medication and I've been on it … for four years now and it's just, I blossomed from it, you know.

Effect of New Services

At the end of the interview, after discussing the services used and the strengths and limitations of each of these services, participants were asked about the effect of the new services in their lives. Specifically, participants were asked to speculate on how their lives might be different in the absence of the new services. A number of participants were unable to respond due to the abstract nature of the question. Others responded simply that the new services made a big difference but were unable to elaborate. However, even simple statements could be very significant. For instance, one participant who demonstrated significant poverty of speech,

reported that "These people help me quite a bit". This was the longest sentence of the whole

interview, suggesting an importance that extends beyond the simple words.

Many of the more articulate participants reported that the new services had a dramatic

effect on their lives. People reported that, in the absence of the new services, they would be dead,

If it wasn't for all the community services out here, I wouldn't be here... I could never

have made it this far without them. Like I tried to commit suicide one time and almost

made it too... so many times sick things have happened that I didn't think I was going to

make it. But with all these supports that I have pulled me through. I'm getting better. I'm

a lot better now

Saved my life, totally. I would have been dead by now. ... I would have committed

suicide. Because they did catch me a couple of times. ... I'm very self-destructive ... and

there was days when I just don't want to go on and the crisis centre got me, talked me out

of it.

in hospital on a long-term basis,

I'd probably be in [long-term inpatient care] if wasn't for a lot of these people helping me.

My life would have been worse if I didn't have a proctor... I wouldn't be able to get out

of the hospital. I didn't know how to cook and clean and I didn't know how to do nothing

like get groceries. I'd be lost. Budgeting, money and everything else.

I'd be in a hell of a lot of trouble, that's for sure. Probably end up in Brandon Mental

Hospital if that was still open. Or an institution or even jail... Changed my life around. It

really did.

in jail,

I'd probably be in Winnipeg in a cell somewhere, or living on the street

on the street,

> I'd probably be on the street or ... I'd be stuck in the mental. Other than that I don't know
>
> what I'd do.

or in situations of risk.

> I'd be right back with the guy that beat the crap out of me any time he feels like it. Like
>
> I'd still be there.

In addition to preventing these adverse outcomes, many participants reported that the new

services enriched their lives,

> There was a time where uh, where the drop-in centre, it was, I would go there from the
>
> time it opened until the time it closed. And I was really hungry and thirsty for some,
>
> some camaraderie and rubbing shoulders with people. You know, just someone to talk to.
>
> Not even to talk to, just someone sitting over there staring at the same screen. ... But now
>
> I've got, I go to the library, I go to the Community Arts Centre. I go to the library once a
>
> month, but now I'm checking out the web so now I go more than once a month. And then
>
> sometimes the Arts Center has a different exhibit, sometimes more than once a month.
>
> When I first started coming here [Support Centre] it was something different than sitting
>
> at home or. At that time I still couldn't concentrate on watching TV or reading. Like those
>
> are all things I had to really work on to get back. At least when you came here though
>
> you could listen to people talking and stuff like that ... And I guess eventually I started
>
> talking to other people.

> They help me out quite a bit. They give me a, they sort of make my world a little better
>
> because they help me out when I'm there. When I need advice or a shoulder to lean on
>
> there's somebody there at the Safe House or at CMHA or whatever. They're positives in

my living because they understand me where other people do not understand me sometimes.

When I was here [home town] before ... I was pretty much on my own, trying to beat the sickness all by myself. There was no HERO Club, there was no hospital ward or anything. I would always end up in Brandon [Mental Health Center]. I was admitted there quite a bit ... It's much better now because when I need a break I can just stay here [local inpatient mental health facility] and everybody welcomes me there and they help me get through my bad spells.

enhanced coping,

I can definitely say I would be on welfare or I would be living with my parents at home with them taking care of me. I know I would be, because all of these things, every single one of them, allow me to live independently... each one of them have given me the support so I can get up and do it myself.

It's nice to get out and meet people who have had similar problems and you know that you're not alone. If they can deal with it, I can deal with it. You know, you can reminisce with them what you went through and what they went through and it makes it easier ... Speak about it and letting them know how you feel, you know, and I think that's good too, rather than keeping it all balled up inside.

and facilitated recovery.

When I met her [ICM] I wasn't going to school, I wasn't working. I wasn't doing things. Now I am. I'm a full time student, full time work, doing all these things ... Like, from the moment I walked into her office it was concentrated on 'Where do you want to work', 'What kinds of dreams do you have'. And she never laughs at the dreams ... Before,

everything revolved around the illness. And I finally feel like now I'm getting beyond that. You know, now I'm making choices ... I make the choices, not the illness. It's not controlling me anymore.

The new services may also have freed up providers to assist other people.

I would be lonelier... I feel I would be too much for my worker to do it all, to meet my needs. I don't think it would be fair to her to have me all alone.

Not all participants lived in areas where new services were provided. Even here, enhanced access to traditional services, such as psychiatry services, made a difference. One participant was happy to have enhanced access to psychiatry but was also acutely aware that earlier access might have substantially altered the course of his life.

I think my quality of life would be a lot better if I had received proper help when I was 18 or 19. I'm 39 years old and I'm thinking about going to university. But if I would have dealt with these issues when I was 18 or 19, I would be in my early 20s going into university.

It is impossible to say how much of the recovery reported by participants would have occurred in the absence of the new services. One participant who was not receiving any new services also reported dramatic effects of services.

If it wasn't for [CMHW] and my doctor, I'd probably put a bullet in my head a long time ago. Between those two and my wife, they've kept me on, alive, so far.

Recovery can occur without any professional assistance. However, since participants were universally positive about the effects of new services it is reasonable to conclude that, aside from recovery that may have occurred in the absence of services, the new and enhanced services are having widespread and sometimes dramatically positive results.

Discussion of Service Satisfaction

For several components of the mental health service system, the description of how services are delivered (Objective One) can be combined with information on satisfaction with services (Objective Two) to suggest which methods are accessible, acceptable and appropriate for people with SPMI, and which methods of service delivery are problematic. This section discusses participant reports of satisfaction with services, in the context of the ways in which services are provided, and identifies what participant reports might suggest for enhancing service quality.

Findings from the first two objectives of this study suggest that:

1. Each region have at least one full-time psychiatrist.

Access to traditional services, such as psychiatry services, has increased with mental health reform. However, access to psychiatry services remain a concern for participants, particularly those who live in regions without access to a full-time psychiatrist. Lack of access had detrimental effects on quality of care and consumer outcomes. While shortages of psychiatrists and challenges of recruiting and retaining psychiatrist in rural areas are recognized, limited access is problematic for consumers.

2. Each region have at least one ICM / EDC with a restricted caseload size that facilitates delivery of an expanded range of services to people with SPMI.

Case management resources were increased, and ICM / EDC were established in several regions. Participants in this study largely confirmed the results of the Caseload Review project (Manitoba Community Mental Health Caseload Review Committee, 2002). Larger caseload size limits the amount of support that can be provided, and the range of services that can be attended to. Regions that only had CMHW paid less attention to issues such as housing and employment.

Reduced intensity and range of service provision limits the extent to which the needs of people with SPMI are met.

3. **Use of proctor services be increased in areas where the service is not routinely available.**

   Proctor services are one of the new services established as part of mental health reform. Participants were highly satisfied with this service. The proctor service appears to be very effective in meeting a range of client needs and goals. The availability and flexibility of the service was greatly appreciated. The service also facilitates consumer control and choice. Further, proctor services have the potential to bridge service gaps. Despite the apparent benefits, the service is not well used in some regions.

4. **Consumers be routinely provided with written information on crisis services, including contact information and backup phone numbers.**

5. **A review be conducted of the various models of crisis service delivery, with particular attention to the effects of: mobile services; 24 hour service delivery, and: use of shared after-hours services.**

6. **CSU / Safe Houses consider the safety and staffing implications of restricting clients to their room at night.**

   The crisis service, which includes mobile crisis services and crisis stabilization or Safe House beds, was also an initiative of mental health reform. Both services were highly valued by participants. However, a substantial number of participants, including those who could have benefited from the service, did not know about them.

   The absence of a mobile service in some regions was problematic, particularly since transportation to a CSU / Safe House was one of the most common activities of the MCU. A

number of substantive concerns were expressed about shared after-hours services in two regions.
These services were difficult to access and, because of multiple mandates, could place
consumers at risk. When a crisis plan and list of resources was prepared in advance, participants
were able to cope with multiple providers delivering crisis services at different times of the day.
However, the need for a 24-hour mobile crisis service was stressed.

Participants were very satisfied with Crisis Stabilization Units and Safe Houses. The
relatively "normal" environment of the house was appreciated. The units were able to provide
safety, support and stabilization. The main concern was rules that restrict clients to their room
overnight. During the night was often a difficult time for participants and being isolated at this
time was problematic.

7. **Inpatient services be the focus of continuing monitoring and quality improvement
    efforts.**

8. **Consumers be provided with choices about alternative resources, such as CSU and Safe
    House programs, when appropriate to the situation.**

Unlike other services, participants were very unhappy with their treatment in inpatient
settings. The services that participants were talking about were fairly recent (within the last ten
years), and most occurred in large provincial facilities. Even when participants were admitted as
voluntary patients, and reported that the inpatient stay was effective, they reported neglect,
maltreatment and coercion. Participants who had glowing comments about other services were
critical of these inpatient services. The high degree of concern suggests that inpatient services
should be the focus of continuing monitoring and quality improvement efforts. There should also
be attention to providing consumers with choices of alternative resources, such as CSU and Safe
House programs, when these are appropriate to the situation. Participants also reported being

fearful of other patients. While inpatient services were acknowledged as a necessary part of the service delivery system, participant comments raise questions about the extent to which philosophies and practices in inpatient facilities are consistent with consumer empowerment and recovery models.

9. **The effects of new housing models on quality and stability of housing for consumers be examined.**

Housing has been an important part of community mental health services since initial efforts at deinstitutionalization. The majority of participants in this study were living independently, with or without supports. Participants were also reasonably satisfied with their current housing. However, there was substantial concern about the availability of affordable housing. Suitable housing at income assistance rates is rare, regardless of region. Clear differences are apparent in the extent to which regions attend to housing issues. Innovative models, such as Parkland Mental Health Housing and semi-independent housing in Brandon, have been developed. Despite an clear need for affordable housing, regional differences in housing initiatives, and the presence of innovative models, this study did not find evidence of differences in satisfaction with housing. However, many participants appeared to be tolerant of what appeared to be inadequate housing. Further investigation with different methodology is required to determine the extent to which new models impact on the quality and stability of housing for consumers.

10. **Discussion of vocational / educational goals be included in the initial assessment and as part of ongoing assessments.**

11. **Effectiveness of various employment initiatives be evaluated on a range of consumer outcomes.**

Meaningful work plays an important role in the lives of consumers, but attention to vocational / educational issues are very limited in some regions. About one in five participants were interested in exploring employment or education, but the topic had not been discussed with their case manager. This suggests substantial room for improvement in the degree to which vocational / educational issues are addressed. A need was identified for specialized expertise in provision of employment services. Several regions have developed unique means of meeting vocational / educational needs. Decisions about what strategies to use would be assisted by additional information on the effectiveness of the various models.

12. Inputs and outcomes of social / recreational programs, such as the HERO Club and Support Centres be investigated and documented.

13. Inpatient programs consider the social / recreational needs of patients.

Social / recreational programs are a relatively new component of service delivery. Availability varies widely across the province. Several regions use proctors to meet social goals, but there are also a number of innovative programs. Programs such as the Parkland HERO Club and Interlake Support Centres, have been able to deliver social / recreational programs on a distributed basis in their respective regions. These inventive programs appear to foster community integration and recovery among people with substantial disability. Social / recreational programs are very well received by consumers. Further, these programs are relatively inexpensive for the regions to operate and may well be providing excellent value for the investment. Further investigation of the inputs and outcomes of these programs would be of benefit, particularly for regions that have not implemented such programs.

The lack of meaningful activity was identified as a deficit even when people were very ill. Participants felt that there was inadequate attention to social / recreational needs in both inpatient facilities and CSU.

14. The fit between consumer needs and services offered by self-help services be examined, in conjunction with assessment of barriers to use, in order to ensure that the services provided are useful to the largest possible number of consumers.

The value of self-help is well established. Self-help services have been very helpful to some individuals but interest in ongoing participation appears limited. Many participants weren't interested in attending and, of the people who did attend, a sizeable number stopped using it. Some participants stopped using the service because they felt they had the information they needed. Others quit because of service interruption. However, a better understanding of the fit between consumer needs, services offered and barriers to use of available services would be of benefit in ensuring that services meet the needs of a broad range of consumers.

15. That service providers routinely investigate the family context of clients, the information needs of the family and the extent to which the family system is a source of support and / or stress.

16. That self-help groups collaborate with other providers to examine the extent to which family information and support needs are, or could be, met.

Family self-help appears to be a particularly neglected service component. Several of the participants had immediate family members who also had a serious mental illness, and several participants were actively parenting young children. Understanding the family context appears to be important in providing the appropriate type and amount of service. Further, referral of family members to appropriate resources requires knowledge of who might need information or support.

Participant feedback suggests that the need for information occurs relatively early in the illness and is of limited benefit in later years.

Participants were perhaps poorly positioned to identify family needs and suggest services that would meet those needs. However, the services that were received appear to have been delivered primarily to parents and siblings, while participants were expressing a need for support for the spouse and children. MSS is the only self-help service that makes efforts to address family needs, and their target population would appear to be largely parents. MSS does offer a group for children, but this group is not offered outside Winnipeg.

17. That family physicians be supported in provision of quality mental health services through greater access to psychiatry consultation.

Working with natural supports in the community is particularly important in rural areas where there are fewer specialized services. Participants frequently identified the family physician as a support, but also complained about lack of expertise in mental health. Rural physicians' practices are very diverse and the extent to which they are able to independently meet the specialized needs of people with SPMI may be limited by the scope of practice. Collaboration with a psychiatrist may increase the knowledge and quality of service provision by family physicians. Further, since the number of family physicians is larger than the number of psychiatrists, consumers would have more choice in providers.

18. That each service proposal, or service evaluation, consider the effect of access to transportation on access to the service, and include or recommend strategies to ensure that service access is not compromised by lack of transportation.

Transportation emerged repeatedly during the course of participant interviews in discussion of a range of services. Lack of access to transportation limited access to treatment,

participation in self-help, access to social / recreational services and even ability to meet basic needs. Whether a health service is brought to the individual or the individual is brought to the service, it appears that transportation must be considered. Active outreach by case managers, use of proctors for transportation or 'bus' service for educational or social / recreational activities all enhance access to service. In the absence of adequate access to transportation, even excellent services will be underutilized and service satisfaction will be jeopardized.

19. Factors contributing to turnover among proctors be reviewed, and a plan developed to address turnover.

20. Strategies to minimize the impact of turnover be implemented.

Turnover was an important concern for participants. Turnover was disruptive and slowed progress. Turnover in proctor positions appears to be particularly problematic for consumers. Addressing determinants of turnover, such as low wages and casual work, or implementing strategies to minimize the effects of turnover, such as broadening the base of support, would be of benefit in enhancing consumer satisfaction.

21. Spiritual assessment, differing in scope depending on the nature of the service, be conducted to facilitate provision of service that is consistent with the values and beliefs of the consumer.

Service providers who shared a common faith with consumers were very important in the recovery of some participants. However, faith-based service provision was a barrier for other participants and in some situations placed the participant in a position of risk. Assessment of the role of faith in understanding of illness, and beliefs about appropriate strategies for intervention, is central to delivery of services that are acceptable and effective. Providers then need to obtain and use this knowledge, regardless of personal belief, to guide practice with that individual.

Limitations

There are a number of observations that should be made about the limitations of this component of the study. First, the sample may not be representative even though the sample did not differ from the population on age, gender or diagnostic category. Steps taken to protect consumer privacy, while necessary, appear to have introduced additional points at which potential participants could be lost. Further, the degree of support by Program Managers and case managers appears to have influenced the numbers of participants and, for Interlake region, possibly the nature of participants. Although the intent is description rather than quantification of issues, caution must be exercised in interpretation.

Second, there are limitations on the depth that can be provided in any particular area. The breadth of the study requires that the depth on any specific topic be limited. However, this broad view offers opportunities to look across the system and at the relationship between several different factors. Further, the breadth of this study provides opportunities to identify topics and relationships that would benefit from more in-depth study.

Third, some of the questions were getting out of the range of ability of participants to answer. Individuals are experts on their own lives and can, even with limited communication skills and a high level of disability, report what services they used, whether they felt the services were helpful, and what they liked best about a particular service. Other questions were outside the direct experience of the participants. For instance, questions about availability of family supports, or the extent to which family supports are needed or used, should be answered by family members. Abstract questions, such as how services could be improved, were more problematic. Few participants provided specific suggestions for improvement. Areas for improvement are largely identified based on areas where participants identified problems.

Similarly, a number of participants were unable to answer questions such as how their life might be different in the absence of new services

Finally, the researchers understanding of phenomena relies on participant understanding about specific interventions. If providers for these same individuals were interviewed, phenomenon might appear quite differently. For instance, one participant reported staying at a Safe House for over a year to learn cooking and cleaning. This would appear to be an inappropriate use of that resource, but there may be other explanations for the stay that the participant was unable to provide. Similarly, a participant report that they did not know about a specific service does not mean that information was not provided. For instance, one participant reported that he didn't have access to information on patient rights when in a Mental Health Center. To the knowledge of the researcher, this information is routinely provided in written for on admission and also posted on bulletin boards in the facility. Therefore, lack of participant knowledge does not necessarily mean that efforts have not been made.

Two other observations should also be made at this point. First, the nature of the health care system, and the broader social system, is dynamic rather than static. Mental health reform can be considered more of a process than an event. As the system continues to evolve and change, some of the issues identified here will have been resolved and others will have emerged as important. For instance, some of the participants found smoking at clubs to be an irritant and barrier to attendance. The province-wide smoking ban that was implemented in 2003 will have alleviated the concerns of this group. However, in all likelihood, the smoking ban will have created a barrier to attendance of others. Other changes that have occurred include opening of inpatient beds in Nor-Man and transfer of responsibility for Crisis Services from non-

government organizations to RHA. As a result, findings at the time of the study will change as the system continues to evolve.

The second observation is that the conduct of interviews may have independently created small changes. When participants did not know about a service, information was provided. Participants who were interested in additional information were provided with contact information. Simply asking about areas and services that a person was not using may have prompted consideration and exploration of the topic with case managers. For instance, an individual who had not been considering employment might decide to initiate discussion with the case manager. In another instance, difficulty in locating the number of a crisis service in the phone book prompted a call to the provider identifying the inaccessibility of the number. In the subsequent phone book, the listing was easier to find. Similarly, the MSS phone number and contact name was provided to people who indicated interest in family support. The researcher then reported interest in family support in the particular geographic area to the MSS, which prompted consideration of a family support group in that area and a family support group has now been established. It is therefore possible that the interviews themselves will have changed the system in small ways.

Interim Conclusions – Objective Two

Objective two was intended to describe consumers' perception of service quality and the effect of the various methods of service delivery on consumer satisfaction. Interviews were conducted with 80 consumers in nine RHA. With the exception of inpatient services, participants were generally satisfied with the services they used, and were particularly satisfied with new services such as the crisis services, proctors and social / recreational initiatives. Participants felt that they had the services they needed and could get help when they needed it. However, some

methods of service delivery appeared to be more satisfactory than others. A number of areas for

improvement were identified and recommendations were made to improve service delivery.

Participants were universally positive about the effects of new services. Participants reported that

the new services had prevented a range of adverse outcomes and facilitated recovery.

Objective 3 – QoL under enhanced community-based delivery

The first two objectives of this study identified substantial differences between model mental health services and the ways in which services were delivered in the rural RHA. There were also differences between RHA in the way services were delivered. Consumers identified that some methods of service delivery were more satisfactory than others. Objective three is designed to describe consumers perceived QoL under enhanced community-based delivery, and the extent to which service delivery characteristics contribute to QoL.

As discussed earlier with Objective two, outcomes of mental health services are the "bottom line" in measuring the effectiveness of a service system (McEwen & Goldner, 1996). Improvements in life expectancy and QoL are the ultimate goal of the health care system (Canadian Health Information Systems Working Group, 1993).

"The most fundamental issue, though, is that system, program, or individual supports should improve the consumer's quality of life, as defined by him or her. This is the touchstone of any real notion of accountability" (CMHA, 1995 as cited in McEwen and Goldner, 2001).

The World Health Organization definition of health as "a complete state of physical, mental, and social well-being and not merely the absence of disease" (WHO, 1975) is very broad. The definition makes reference to a number of domains and acknowledges that the importance of each domain varies between people. In this broad sense, health and QoL can be considered to be similar constructs.

Quality of life then is a multi-dimensional concept. Any instrument attempting to measure QoL must capture the relevant domains and account for individual preferences for specific domains. Domains of Qol usually include biological, psychological, interpersonal, social

and economic experience, but can also include family, living situation, finances, psychiatric symptoms and religion (Atkinson and Zibin, 1996). Depending on the domains chosen, the instrument can measure general QoL or disease specific QoL. Disease specific QoL takes into account the areas of life that are affected by illness. For the purposes of measuring QoL among people with SPMI, there is less of a distinction between general and disease specific instruments, since SPMI has broad impacts on people's lives. For people with chronic disabling conditions, a general QoL perspective is most appropriate, since it accounts not only for direct health outcomes, but also for the potential social and economic effects of disability (Lehman, 1995).

> Severe mental illness ... leads to various deficits in ability to carry out activities of living... such that functional deficits impede social relationships, vocational abilities, recreational opportunities and the ability to access and maintain housing and adequate health care ... Systems of comprehensive care are necessary to support the severely mentally ill to maintain functional ability, to encourage restoration of lost abilities, and to ensure adequate maintenance of the individual in terms of healthcare, social and housing needs" (Kane & Ennis, 1996, p 446).

In order to provide guidance to researchers and policy-makers, a synthesis document was prepared in 1996 by Atkinson and Zibin, which outlines the basic methods of evaluating QoL and instruments that can be used with people with SPMI. Based on the range of domains covered, ability to account for personal preferences among domains good reliability and validity, the Quality of Life Index for Mental Health (Becker, Diamond & Sainfort, 1993) was selected for use in this study.

Methods

Instrument

Quality of life was assessed using the Quality of Life Index for Mental Health (QLI-MH) (Becker et al., 1993). The QLI-MH (Appendix H) has nine domains[7] including: general satisfaction; occupational activities; psychological well being; symptoms; physical health; social relations / support; and activities of daily living (ADL). The instrument has test-retest coefficients of greater than 0.82 on all nine scales. High criterion validity coefficients were obtained when comparing the QLI-MH to other established scales such as the Brief Psychiatric Rating Scale (Becker et al., 1993).

Specific scale scores for the QLI-MH are used to calculate an overall QoL score, which encompasses eight domains. In addition to asking about satisfaction in each domain, the instrument includes questions about the importance of each domain. The relative importance of each domain is then used to calculate weighted QoL. Weighted QoL reflects both satisfaction with a particular domain and the importance of that domain relative to others. For instance, satisfaction with an area judged to be very important would contribute more to weighted QoL than the same level of satisfaction with an aspect judged not important to QoL.

Administration

The instrument was administered during the client interviews described above in objective two. A total of 75 questionnaires were completed and included in this analysis. Five of the people interviewed did not complete the questionnaire for reasons such as difficulty concentrating and researcher concerns about personal safety. Forty-one percent of the participants (N=31) required assistance in completion of the questionnaire. In these situations the

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[7] One of the domains (use of alcohol and other drugs) included in the questionnaire is entered into the data for information and planning, but is not used by this instrument to analyze outcomes. Comparison to instrument norms is not possible as norms were not supplied.

researcher read the questions to the participant and recorded the responses. Reasons for requiring assistance appeared to be related to low literacy levels, limited ability to concentrate, or tremor in the hands.

Procedure

Individual responses were coded as described in the QLI-MH scoring manual, entered into an Excel spreadsheet and then imported into SAS version 8.02 for analysis. Quality of life scores for each domain, as well as unweighted and weighted total scores for the instrument, were calculated as directed in the scoring manual.

The Student t-test statistic was used to compare total and subscale scores with instrument norms for clients in an Assertive Community Treatment Program (PACT). This population is ideal for comparison, since eligibility for the study was based on eligibility criteria for ICM, which is similar to PACT. The bonferroni correction was applied to address the implications of multiple testing. Analysis includes eight domain scores, a weighted and unweighted total score. As a result, the significance level was set at 0.005 (10 X 0.5).

Regional differences in subscale and total QoL scores were examined using one-way Analysis of Variance (PROC ANOVA). Where the ANOVA indicated significant differences between regions, Duncan's Multiple Range test was used to determine which regions were different from others. As with the comparison to instrument norms, the bonferroni correction was used to address multiple testing.

Domains where significant differences were found between regions were further explored through univariate, bivariate and multivariate analysis. Univariate analyses were conducted to ensure that variables met assumptions of normal distribution and homogeneity of variance. Bivariate analyses and multivariate analyses were conducted using multilevel modeling (PROC

MIXED). Multilevel modeling takes into account that participants are not independent of one another, but rather are clustered within regions. PROC MIXED can be used for individual and service system characteristics, and can accommodate both categorical and continuous explanatory variables.

Following the bivariate analyses, separate models were constructed for each of the three outcomes. Variables that demonstrated a relationship to the outcome were entered into a model using forward stepwise selection to create a final model describing factors contributing to the QoL score.

Selection of Service Configuration Variables

The description of regional services and the context of service delivery is beneficial in illustrating the extent to which original models of service delivery are adapted based on regional concerns. In order to analyze the extent to which these differences in methods of delivery influence outcomes, specific elements that may be used for analysis must be defined. The description in Objective One contains a large number of possible variables, but some variables lend themselves more readily to inclusion in analysis. This section discusses which variables will be included in the subsequent analysis, as well as those that must be excluded. Potential variables may be excluded because they do not vary substantially between regions or because the descriptive methodology did not provide for adequate measurement of the concepts.

Variables that do not vary.

There are few differences between regions in a number of areas. Even though a factor may have important implications for outcomes, exploration is not possible in this study if there are no substantive differences between regions. Variables in this category include selected aspects of accountability, monitoring / evaluation, continuity of services, use of medical inpatient

beds, access to long-term care, access to vocational rehabilitation services, use of proctors and availability of self-help services.

While accountability mechanisms vary, all regional mental health managers are directly responsible for, or directly involved with, case management, psychiatry, psychology, proctor, and in-region inpatient services. All self-help organizations are accountable directly to their provincial organization. Therefore it is not possible to explore the implications of different accountability mechanisms in these areas.

The *Best Practices* document recommends a protected mental health budget. Mental health managers indicate that budgets have increased and mental health is seen as a priority in each region. However, none of the regions presently has a protected mental health budget.

None of the regions has a 24-hour mobile crisis line. Community mental health service providers handle crisis calls during the day during the week. Although the specific arrangements and the number of providers over a 24-hour period differ between regions, most have made provision for 24-hour coverage for crisis calls.

Although the extent of engagement in CQI processes differ somewhat, all regions have CQI programs and undergo regular accreditation processes. Therefore, differences between regions on these aspects of monitoring / evaluation is not possible.

All regions use medical beds in acute care hospitals to some extent. This practice continues even with new regional in-patient beds. All regions use Personal Care Home beds to some extent for long-term care, and each region has the same facility (SMHC) for referral of clients for long-term care.

All regions have some access to Vocational Rehabilitation services, although the apparent effectiveness of these services for mental health clients differs somewhat. Although availability

of resources (human and fiscal) differs, all regions use proctors to meet client needs that exceed what case managers can provide.

Finally self-help services have been established in all regions of the province. Again, some differences exist in continuity of service and available human and fiscal resources, but the core self-help services are available in each region. As a result of lack of difference in these areas, the extent of their influence on satisfaction with services or QoL cannot be explored.

Although in-depth exploration is not possible in this study, opportunities may exist for collaborative work with jurisdictions differing from Manitoba RHA on these dimensions.

Variables subject to measurement challenges.

Differences appear to exist between regions in a number of areas, including the size of the regions, population served, distribution of the population, extent of accountability to consumers / families, extent of integration of services, investment in monitoring / evaluation, adequacy of long term care and housing, and models of case management, including specific services provided and use of proctors. Again, each of these areas would provide important information in considering the effects of regional differences on outcomes. Unfortunately measurement challenges make it inappropriate to include these elements as possible explanatory variables in the present analysis.

Regions differ substantially in size and population. However, the actual area of service provision and the size of the population served can differ from geographical size and population of the region in many ways. In some cases, large areas of the region do not receive any service or segments of the population, such as Aboriginal people living on reserve, are not served by regional services. As a result, calculation of the area over which the region provides service and the actual population served requires additional information.

Discussion of the distribution of the population with SPMI is problematic as this methodology used service providers to identify the client population. This study was only able to interview people known to providers. People living inside a particular service area are more likely to be identified and served than those living outside the service area. As a result, there may well be people with equivalent needs who are not served. A more population-based methodology would be required to evaluate ability of services to meet the needs of the population.

Regions appear to differ in the extent to which they value and include consumer / family perspectives. In some cases there are formal bodies, such as a Mental Health Advisory Council, that report directly to RHA management. Some regions are assertive in ensuring consumer involvement in, for example, CQI. Still others do not appear to have any mechanism for involving consumers / families. Examination of the extent to which there is consumer / family participation in planning and evaluating services is beyond the scope of this project.

Integration of services is recognized as critical to service delivery. Rural regions have the potential to provide a more integrated service than urban areas due to fewer services, flexible mandates and providers assuming multiple roles. However, measurement of effectiveness of linkages is beyond the scope of this work. Formal linkages do not ensure integration and absence of formal linkages do not preclude integrated services. A more dedicated analysis of continuity of care using an instrument such as the Alberta Continuity of Services Scale for Mental Health (C. Adair, personal communication, Oct. 30, 2003) would be needed for fully assessing service integration.

This study sought to investigate the effect of specific models of case management on outcomes. Managers were asked about the service model employed. Unfortunately the classification of "in use" models can be problematic and provider activity may not reflect the

model reported by managers. Inclusion of questions on specific tasks did little to clarify "in use" models. Although managers acknowledged that caseload size influences the extent to which specific services could be provided, managers universally reported all identified services were provided to some extent. More in-depth analysis of provider tasks would be of benefit in ascertaining the extent to which specific elements of service provision affect outcomes.

Finally, access to long-term care and adequacy of available housing cannot be assessed by this study. All regions have the same designated long-term care facility, but some regions appear to have more difficulty accessing long-term care than others. Regions show preferences for different types of housing. Housing that one region considers ideal (e.g. group homes) might be considered inappropriate by another. Specific measurement of housing needs is beyond the scope of this project.

While inclusion of these elements in this study is not possible, each of these areas represents a potential area for further study.

Variables amenable to analysis.

The list of factors not suitable for analysis is long, but the list of factors that vary between regions and have sufficient precision for inclusion in analysis is even longer. Factors that can be employed include: size of the SPMI population; availability of services in the region; contracted out services; staff turnover; specific training in psychosocial rehabilitation; continuing professional development in PSR; full-time psychiatry and psychology services; availability of ICM services; caseload size; availability of a CSU / Safe House; availability of mobile crisis services; in-region inpatient beds; specific investment in employment initiatives; specific investment in housing initiatives; and specific investment in social / recreational initiatives. The

nature of these variables is dependent on the nature of the variable and the level of precision

possible with available data (Table 9).

The size of the population with SPMI differs substantially between regions, with a range

of 9 - 160 people and an average of 47 people. The size of the population may influence the

extent to which specialized expertise and services are developed. Availability of services may

also exert an influence on numbers of people with SPMI, as lack of service may result in

migration for services.

Table 9

Regional Characteristics for Analysis of QoL Data

Continuous variables	Categorical variables	Binary variables
Caseload size	Contracted out crisis services	Continuing professional
Size of SPMI population	CSU / Safe house	development in PSR
	Mobile crisis services	Employment initiatives
	Psychology services	Full-time psychiatrist
	Staff training in PSR	Housing initiatives
	Staff turnover	ICM services
		In-region inpatient beds
		Social / recreational initiatives

Although changes occurred in the fall of 2004, crisis services were contracted out in most

regions during the study period. Only two regions directly operated at least a portion of their

crisis services.

Staffing in most regions is stable, but two have substantial problems with staff turnover and a third region has increased levels of turnover. Regions with stable staffing tend to have more and better applicants for available positions. All regions report decreasing quantity and quality of applicants.

The extent to which staff working with people with SPMI have preparation in PSR differs substantially. Seven regions have staff with specific preparation in PSR and staff in one additional region have some preparation in this area. All regions make at least some provision for continuing professional development. However, if the caseload is diverse, or the number of people with SPMI is low, there may be little continuing professional development specific to PSR. Five out of nine regions have offered continuing professional development in PSR.

All regions have at least some access to psychiatry and psychology services. At the time mental health reform began, some regions had as little as two days a month of itinerant psychiatry services. Access to psychiatry services has increased over the period of reform, and five regions now have a full-time psychiatrist. Access to psychology services has been even more limited. Five regions have a full-time psychologist and two have part-time service, but two regions reported no access to psychology services.

Seven rural regions have at least a part-time ICM. Remaining regions rely on CMHW to provide service to people with SPMI. Caseload size differs dramatically, even within ICM. Caseload size overall averages 34 people, with a range from about 18 people to about 60. Caseload size is a determining factor in the extent of service provision. As caseload size increases, the extent and range of services provided decreases.

Five regions offer in-region CSU / Safe House beds. Where in-region crisis beds exist, the number of beds may be four (three regions) or eight (two regions). Most regions have made

provisions for after-hours calls, but not all of these services are available on a mobile basis. Only

four regions have in-region mobile crisis services.

All but three regions have in-region inpatient beds. Where in-region inpatient beds exist,

the number of adult beds ranges from eight to 27. Finally, three regions have direct involvement

in housing initiatives, four have direct involvement in vocational / educational initiatives and

four have direct involvement in social / recreational initiatives.

Individual Characteristics

In addition to the influence of service characteristics, individual client characteristics may

also exert an influence on QoL scores. The W-QLI-MH asks a number of demographic

questions, including: age, gender, education, race, marital status, source of income, living

companions, housing type and satisfaction with living companions and housing type. Continuous

variables, such as age and years of education, and binary variables, such as gender and

satisfaction with housing or living companions, can be included directly in the analysis. Other

variables, such as race, marital status, source of income, living companion and housing type have

been collapsed in order to facilitate analysis. The method by which categories were collapsed is

indicated in Table 10.

Results

Comparison to Instrument Norms

Results in four domains were particularly close to instrument norms (Table 11). These

domains include self-perceived psychological well-being, self-perceived physical health status,

reported level of symptoms and adequacy of financial resources. Five domains, including

weighted and unweighted QoL scores, were significant at the $p > 0.05$ level but were not

significant after application of the bonferroni correction. The only domain that remained

significantly different from instrument norms was social relationships / social support. Study

participants reported substantially higher levels of social support ($p < 0.001$) than the comparison population.

Table 10

Collapsed Demographic Categories for Analysis of QoL Data

Variable	New Categories	Original Categories
Race	64 White	64 Caucasian
	11 Non-white	8 First Nations
		2 Metis
		1 African American
Marital status	36 Never married	36 Never married
	18 Currently married	18 Currently married
	20 Previously married	9 Divorced
		4 Committed relationship
		4 Separated
		3 Spouse deceased
Source of income	49 Income assistance	31 Income assistance
		18 Multiple sources, including SA
	26 No income assistance	6 Money shared by partner
		4 Paid employment
		3 Employment Insurance
		5 Multiple sources (no SA)
		3 Other
		2 Money shared by family
		1 Alimony / child support
		1 Retirement benefits
		1 Veteran Pension
Living companion	40 Alone	40 Alone
	26 Family / friend	12 Significant other / spouse
		5 Parents
		5 Spouse and children
		3 Children
		1 Roomate / friend
	7 Other	7 Other
Housing type	67 Apartment / home	67 Apartment / home
	8 Other	4 Group home
		2 Other
		1 Boarding home
		1 School / college

Table 11

QoL Comparison with Instrument Norms

Domain	Study Mean	Instrument Mean	T-test Statistic	Significance Level	Significance with Bonferroni Correction
ADL	2.21	1.84	2.18	0.05	NS
General satisfaction	1.39	1.00	2.08	0.05	NS
Money	0.56	0.10	1.60		NS
Occupational activities	1.34	0.76	2.06	0.05	NS
Physical health	0.02	0.38	-1.29		NS
Psychological well-being	0.33	0.38	-0.16		NS
Social relations / support	2.17	1.15	4.74	0.001	0.001
Symptoms	1.52	1.45	0.34		NS
Overall QoL score	1.16	0.75	2.33	0.05	NS
Weighted QoL score	1.17	0.98	2.52	0.05	NS

Regional Differences in QoL

Very little difference was noted between regions in participants' ability to provide self-care (ADL), or satisfaction with finances (Table 12). Some differences are apparent in terms of satisfaction with occupational status, level of reported symptoms, general life satisfaction,

satisfaction with social relations and perceived physical health. However, these differences were

not significant once the bonferroni correction is applied. The two areas where significant

differences are found are perceived psychological health (F= 4.81 with 8, 64 df, p< 0.0001) and

QoL, with or without weights (F=4.35 with 8, 63 df, p< 0.0003; F=4.20 with 8, 63 df, p<0.0004

respectively). In this analysis, regional differences explain 37.5 % of the variation in

psychological health status and 34.8-35.6 % of the variation in overall QoL.

Table 12

Regional Differences in QoL Scores

Domain	F Value	Significance Level	Significance with Bonferroni Correction
ADL	0.49	0.86	NS
Money	1.11	0.37	NS
Occupational activities	2.22	0.04	NS
General satisfaction	2.28	0.03	NS
Symptoms	2.39	0.03	NS
Social relations / support	2.73	0.01	NS
Physical health	2.92	0.007	NS
Unweighed QoL score	4.20	0.0004	0.0004
Weighted QoL Score	4.35	0.0003	0.0003
Psychological well-being	4.81	0.0001	0.0001

A post-hoc Duncans' Multiple Range Test was conducted to determine which regions

differed from one another. The test suggests that there are three separate groups. Regions with a

common bar are not significantly different from one another (p > 0.05). Regional differences for

weighted QoL (Table 13) are very similar to differences for unweighted QoL. Rank order differs

only slightly for perceived psychological health scores.

Table 13

Regional Differences in Weighted QoL

Region	Mean		
Burntwood	1.97		
Brandon	1.88		
Interlake	1.60		
Parkland	1.45		
North Eastman	1.24		
Assiniboine	1.13		
South Eastman	0.57		
Central	0.36		
Nor-Man	0.32		

Underlying health status within each region provides a potential explanation for

differences in QoL. Using health status rankings developed by the Manitoba Centre for Health

Policy for each region, there does not appear to be a relationship between usual health status for

each region and the participants' reported QoL (Figure 2).

Univariate Analyses

Univariate analyses were conducted for variables describing characteristics of individuals

and service system characteristics. Frequency counts were obtained for categorical variables, and

means were calculated for continuous variables. Continuous variables were examined to

determine whether they were normally distributed. Only two continuous variables, those

describing caseload size and size of the SPMI population, violated the assumption of normality.

Log transformations were successful in returning these distributions to normal. Transformed

variables were used instead of the original variables in the remaining analysis.
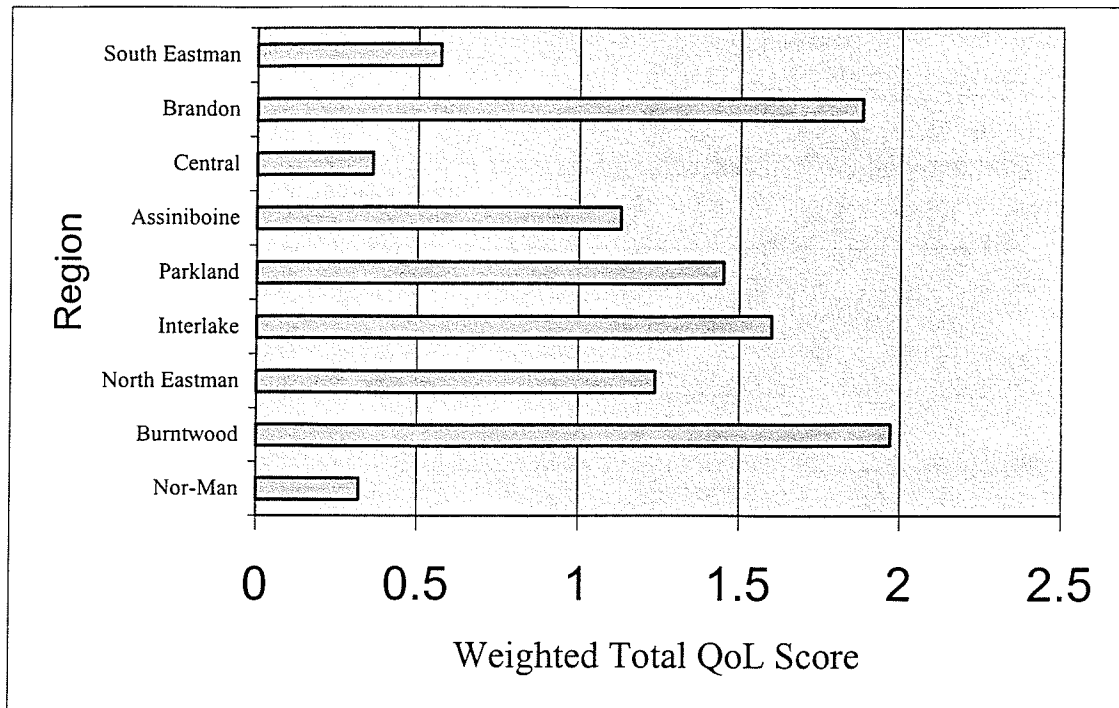
Figure 2. Overall quality of life scores in descending order of health status[8].

Bivariate Analyses

Service system characteristics.

Multilevel modeling was used to compare scores for each of three outcomes

(psychological health, weighted and unweighted QoL) using service system characteristics as

explanatory variables. The majority of the system characteristics did not have any apparent

ability to predict QoL scores (Table 14). A small number of system characteristics, namely

continuing professional development in PSR, housing initiatives, crisis beds and an in-region

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[8] Health Status is measured by age and sex adjusted premature mortality rates (deaths per thousand population). Regions at the top have the higher overall health status (lower premature mortality rates) than regions at the bottom of the figure. Higher total weighted QoL score indicates higher QoL.

psychiatrist, demonstrated a relationship with at least one of the outcomes. While the number of tests performed introduce the possibility that the finding may have occurred by chance alone, the extent to which these elements predict is quite substantial in comparison to the significance level. For example, the effect of housing initiatives on weighted QoL is marginally significant at $p <$ 0.04 but presence of housing initiatives explains 43 % of the variation in QoL scores.

Only one service system characteristic demonstrated a strong relationship with QoL outcomes, the presence of social / recreational programs. The presence of social / recreational programs predicted fully 92.6 % of the variation in unweighted QoL between regions, 87.4 % of weighted QoL and 81.2 % of the variation in self-perceived psychological health.

Individual characteristics.

Individual characteristics appear to exert a negligible effect on QoL scores (Table 15). Only one characteristic, living companions, achieved significance, and only on one of the outcomes. Individuals living alone had lower self-reported psychological health than individuals living with family or friends. Individuals with "other" living companions (e.g. board and room or residential care home) had the highest self-reported psychological health. However, due to the number of tests, this finding may have occurred based on chance alone.

Multivariate Analysis

Multilevel modeling was also used to conduct the multivariate analysis. Variables identified as significantly related to weighted QoL were entered into a model to determine the extent to which additional explanatory variables would add to ability to predict weighted QoL. Inclusion of housing initiatives and continuing professional development in PSR increased the explanatory power of the model to 93.8 % of the variation, although only the presence of social / recreational programs remained significant.

Table 14

Effects of Service Characteristics on QoL Scores

	Unweighted QoL	Weighted QoL	Psychological Health
Caseload Size	NS	NS	NS
Cont. Prof. Development	0.03	0.03	NS
Control over crisis services	NS	NS	NS
Employment initiatives	NS	NS	NS
Housing Initiatives	0.03	0.04	0.04
ICM	NS	NS	NS
In-region CSU / Safe House	NS	NS	NS
In-region inpatient beds	NS	NS	NS
In-region Psychiatrist	NS	NS	0.03
Mobile Crisis Services	NS	NS	NS
Number Crisis Beds	NS	NS	0.03
Number Inpatient	NS	NS	NS
PSR Training	NS	NS	NS
Psychology Services	NS	NS	NS
Size of SPMI Population	NS	NS	NS
Soc/Recreational Initiatives	0.0002	0.0004	0.0005
Staff Turnover	NS	NS	NS

Table 15

Impact of Individual Characteristics on QoL Scores

	Unweighted QoL	Weighted QoL	Psychological Health
Age	NS	NS	NS
Gender	NS	NS	NS
Education	NS	NS	NS
Race	NS	NS	NS
Marital Status	NS	NS	NS
Source of Income	NS	NS	NS
Type of Housing	NS	NS	NS
Has Desired Housing	NS	NS	NS
Living Companions	NS	NS	0.005
Has Desired Living Companions	NS	NS	NS

The same process was used to develop a model for unweighted QoL and self-reported psychological health. The portion of the variation in unweighted QoL increased to 98.6% when continuing professional development and housing initiatives were added to social / recreational programs in the model. As with weighted QoL, only social / recreational programs remained significant in the final model.

The model for psychological health differed somewhat since additional factors, including one individual characteristic, were identified as predictors of self-reported psychological health. Forward selection was used to add new variables in decending order of significance. Variables were removed if they lost significance with the addition of new variables. The final, and most

parsimonious model explained 88.7 % of the variation and included two factors: presence of

social / recreational programs (p < 0.0001) and having living companions (p < 0.0021).

Quality of Life Discussion

This objective was intended to describe QoL among people with SPMI living in rural

RHA, and to identify factors that contribute to QoL. There are three main findings. The first is

that people with SPMI in rural Manitoba, with one key exception, experience the same level of

QoL as a similar referent population used to develop norms for the instrument. Study participants

reported significantly higher QoL in the area of social relations / support than the instrument

norm. This finding on its own does not suggest what factors might lead to higher QoL in this

domain, but finding higher QoL among people with SPMI living in rural Manitoba RHA is

encouraging.

Second, there is substantial variation in QoL between RHA, but these differences did not

appear to arise from regional differences in the participant population or underlying health status

in each region. The similarity between regions on participants' scores in most domains is

particularly interesting since a large number of factors, such as historic lack of service in rural

areas and possible selective migration out of region, have the potential to create regional

differences in the study population. Participants in each of the regions were similar to one

another on factors such as ability to provide self-care, level of reported symptoms, occupational

activities and other factors that might contribute to QoL Regional differences do not appear to be

explained by inclusion of different participant populations in each region.

In these analyses, individual characteristics had almost no relationship to QoL scores. In

contrast, three service system characteristics - presence of social / recreational programs,

involvement in housing initiatives, and continuing professional development in PSR - predicted

as much as 98% of the variation in QoL scores.

The most important finding was the degree to which availability of social / recreational

programs influenced QoL for people with SPMI. This factor alone explained almost 90% of the

variation in weighted QoL. The magnitude of impact is striking on it's own, but is particularly so

because none of the contemporary models of service delivery for people with SPMI focuses on

social / recreation programs. Clubhouse models emphasize the work-ordered day while

psychiatric rehabilitation focuses on education, housing and employment. The components of a

Community Support System and PACT (Program for Assertive Community Treatment)

programs both attempt to address the full range of needs of people with SPMI. However, none of

these programs includes social / recreational components. Controlled research on ACT and ICM

demonstrate that these models reduce time in the hospital and improve housing stability,

especially among patients who are high service users; these models however have demonstrated

little effect on social functioning (Muesner et al., 1998; Burns & Santos, 1995; Solomon, 1992;

Scott & Dixon, 1995).

Programs that address social / recreational needs are rare. Services that are designed to

meet social needs and can be delivered in rural areas are even more unusual. It is intriguing that

more than one of Manitoba's rural RHA has elected to include social / recreational programming

as a legitimate component of service delivery. The means by which these RHAs deliver

programs differs, offering several options for meeting social / recreational needs. More detailed

examination of these programs would be of benefit in understanding the contribution that is

being made to consumer QoL and how these benefits might be extended to consumers in other

areas.

While the effect of social / recreational programs on QoL appears dramatic, the findings could also be viewed as restating the obvious. The determinants of health literature has long held that factors such as social support are more important than health services, and that system level factors are much more important than individual characteristics in determining health. As obvious as the finding might seem from a population health perspective, this philosophy has not yet influenced models of community support for people with SPMI. While more detailed study and replication is required, it is possible that modifications could be made to traditional models that would facilitate improvement in the area of social functioning for people with SPMI.

A number of limitations should also be mentioned. Even though the study included similar people in each region, the possibility of bias in participant selection and participation could limit ability to generalize to the broader population. Several limitations also occur as a consequence of the use of the Wisconsin Quality of Life Index for Mental Health. First, although the instrument was specifically designed for the SPMI population, the complex nature of the survey and required literacy level made it difficult for many clients to complete the survey. In many instances the researcher read the questions and often needed to break down the questions. For instance, most items had a seven-point scale for response that might range from very satisfied to very unsatisfied. The researcher would ask if the participant was satisfied or unsatisfied and, once a response had been provided, ask if the person was mildly, moderately or very (un)satisfied. While the survey instructions acknowledge that assistance may be required, fully 41 % of participants required assistance. This suggests that the instrument may be unsuitable for use as a mail-in survey with this population.

A second limitation of the survey was the abstract nature of some questions. Concrete thinking was evident in response to two particular questions. The first question asks the person to

rate their health on a scale of one to ten with one meaning life is as bad as it could be and ten

meaning life was as good as it could be. The second question asks how hopeful the respondent is

that they will reach their desired QoL. Some of the participants had difficulty understanding the

questions, probably due to difficulty with abstract thinking. Responses given were inconsistent

with other responses in the survey. In some cases the researcher attempted to clarify responses

with the participant but since clarification was not available to all participants, the direct client

response was entered. Fortunately, neither of these questions contributed to the QoL scores.

The final limitation of the instrument is related to the previous two concerns. The

instrument represents a substantial burden on respondents because of complexity. It also includes

items, such as the section on alcohol and drug use, that are not included in the scoring. Further,

the inclusion of the weights virtually doubles the length of the survey. Given the negligible

differences between results based on the weighted and unweighted scores, the instrument was

unduly burdensome for participants.

Interim Conclusions – Objective Three

Objective three was intended to describe consumers' perceived QoL under enhanced

community-based service delivery, and the extent to which service delivery characteristics

contribute to QoL. Participants across regions were very similar to one another, and to

instrument norms. However, there were substantial differences between regions in QoL scores.

These differences were not explained by underlying health status in the RHA, or by individual

characteristics. Service characteristics, specifically the presence of social / recreational programs,

housing initiatives and continuing professional development in PSR, had a substantial and

positive effect on QoL scores. Social / recreational initiatives alone explained 87.4% of the

variation in weighted QoL.

Limitations

The main limitations of this study relate to characteristics of the study population, potential bias in participation, and the breadth of the study. Research involving people with psychiatric disabilities can be problematic because the very nature of disorder can lead to memory problems or influence participant perception of events. When the research specifically focuses on people with severe mental illness, the risk that reports will be incomplete or inaccurate increases. Care must be taken in interviews to understand the extent to which psychiatric disability might influence responses. In this study, participants were often open about their diagnosis or memory problems. For instance, participants would report a diagnosis of paranoid schizophrenia or say that they couldn't answer particular questions because of memory problems. Other participants declined to answer some questions, reporting that they wouldn't be able to say since they were experiencing a good deal of paranoia at the time. The researcher was also in a position to consider specific responses in the light of other responses. For instance, reports of poor treatment from an individual who had positive comments about other services were less likely to arise from paranoia than the same comments from people who consistently reported being badly treated or persecuted. The researcher was also able to ask additional questions about particular experiences. For instance, in one situation the participant reported a particularly bizarre event. Supplemental questions were asked about whether such events had occurred at other times or in other situations. There was only one interview where the person was experiencing pronounced paranoia. Very little usable information was obtained from that interview. While attention to the ability of respondents to accurately report their experience is important, it is a burden that is not placed on participants in other studies. Given the prevalence of mental illness in the population, people with paranoia and memory impairment regularly

participate in other work without examination of their ability to report. Further, failure to include people with these symptoms in a study on mental health services probably represents a larger risk to validity than unrecognized bias in reporting.

Aside from the effect that specific symptoms have on reporting, there is a substantial risk that people with the most severe illness are least able to participate. This risk is particularly problematic when the study is focusing on the extent to which needs of people with severe disability are met, as non-participants may be the most vulnerable to service deficits. The protocol took as many steps as possible to facilitate participation, and many of the participants in this study demonstrated substantial disability. However, the characteristics of non-participants cannot be known and this limitation must be recognized. As noted above, this limitation is not exclusive to people with mental illness, but could be a problem for any study on severe illness.

The scope of the work also creates limitations. In an effort to look broadly at the service system, the depth that can be provided in any one area is limited. However, the broad overview has identified a large number of areas where further, more in-depth, studies would be of benefit.

Readers should note that regional differences in availability of specific services or QoL scores do not infer quality beyond the domains studied. Each region has strengths and limitations. Depending on the outcome selected, the results might look very different. For instance, the extent to which the components studied were available was limited in Nor-Man, and Nor-Man had lower QoL scores than other regions. However, Nor-Man is the only RHA that provides services to First Nations people on reserve. The Nor-Man RHA is also the only region to be directly involved in provision of substance abuse services. Further, efforts are made to deliver mental health services on a distributed basis, despite serving a very large region. Even though these services do not appear to contribute directly to QoL scores, each of these attributes

contributes to the quality of service delivery in the region. Again, use of different outcomes might well have produced different results.

Overall Discussion and Conclusion

This is a large study with several components. This project had three objectives. Each of these objectives is designed to contribute to our understanding of the underlying questions: what do model services look like when adapted to the rural environment, and how do these adapted models work for consumers.

The first objective described *Best Practice* services and ways in which rural RHA deliver these services. Challenges and opportunities based on rural characteristics are identified, as well as possible risks and benefits of the strategies used. Findings from objective one suggest that, while rural service models attempt to use the underlying principles of traditional models, the product delivered may bear little resemblance to the traditional models. In addition to adapting traditional models, a number of truly unique programs have been developed.

The second objective used consumer interviews in nine rural RHA to describe consumers' perception of service quality (availability, accessibility, acceptability and appropriateness). In general, participants were very happy with the extent to which services had changed since the beginning of mental health reform. Access to a number of traditional services, such as psychiatry and case management services, increased; other traditional services which had not previously been available, such as inpatient beds, were established in several regions, and; new services, such as crisis services, proctor services, self-help services, social / recreational programs were established in several regions.

Increased access to traditional services was appreciated, but access was still limited in some areas. The extent to which regions have implemented new services differs widely.

Participants in areas with new services found these services very valuable and often reported dramatic changes in their lives based on the new services. However, some methods of service delivery were clearly more effective than others. The discussion section from objective two makes a number of recommendations, including areas for further research.

Objective three uses a standardized survey instrument to describe consumers perceived QoL under enhanced community-based delivery. The results suggest that service system factors are much more important than individual factors in explaining QoL, and that the presence of housing initiatives, continuing professional development in PSR and, in particular, social / recreational programs have a dramatic and positive impact on consumer QoL.

These findings are important because of the size of the population in rural areas, the numbers of people using mental health services, and the level of disability experienced by people with mental illness. First, a sizeable number of people live in rural environments. Depending on the definition used, in 1996 about 31.4 % of the population of Canada lives in predominantly rural regions (Bollman, 2004). Studies differ on the question of whether mental health problems are more, or less, prevalent in rural areas. However, the sheer number of people living in rural areas and the prevalence of mental illness and mental health service use (Martens et al., 2004), make availability and quality of mental health services in rural areas very important.

The population for this study was limited to people with SPMI and the SPMI population represents only a small portion of the total rural population. However, because of the diverse needs of this group, they are likely to be the most sensitive to service quality. Service systems that are able to meet the needs of the most disabled individuals should be able to meet the needs of individuals who require assistance in fewer areas. Therefore the findings of this study have relevance beyond the population studied.

The study is also relevant to a range of stakeholders, and may benefit individual with mental illness and their families, decision-makers in and outside RHA, and the academic community. This work provided an opportunity for participants to have their voices heard and to contribute to our understanding of rural mental health service delivery. In making this contribution, participants may have experienced some measure of empowerment as they participate in improving service delivery for themselves and others (Wallerstein, 1992). Family members, who are often left to fill the gaps in services, could also benefit if, as recommended, support for families is improved.

The study findings will assist decision-makers in identifying both strengths and limitations of their current methods of service delivery. The study also provides a basis for discussion with other regions about the merits of various approaches and identification of ways to improve existing services. Further, the study acknowledges the specific investment and innovation of rural decision-makers in working to tailor traditional models to meeting the needs of consumers.

Last, but not least, the study has raised academic questions about the extent to which current models address the full range of consumer needs and has identified potential strategies to meet these needs. A number of issues have been identified as areas for further research. Data from this study could also provide a baseline against which subsequent work could be compared.

A number of issues arose from the methodologies that have implications for future research, and for ongoing service evaluations in organizations. First, use of survey methodology, even surveys designed for people with SPMI, may not be appropriate for use with this population. Almost half of the participants in this study required assistance to complete the survey. In conjunction with Accreditation standards, many organizations are developing, or have

developed, service satisfaction surveys. If study participants were any indication, survey methods would achieve minimal participation from individuals whose perspective is particularly valuable in assessing how well the organization is meeting client needs.

The second methodological issue is the striking difference between rating scales and participant comments. Rating scales are often preferred for service evaluation because of the ease in data collection and analysis. However, participant rating of satisfaction with at least one service was far removed from their comments. Relying on a rating alone would have produced very different, and inaccurate, account of the performance of that service.

The final methodological issue is that the alternative to surveys and rating scales, namely interviews, is also problematic. Numerous challenges were experienced in contacting individuals who did not have phones, and appointments that were made sometimes needed to be rescheduled as the participant forgot about the interview. The logistics and cost of arranging interviews across large geographic areas was also problematic. However, the most important concern when using interviews is interviewer skill. The interviewer in this study has many years of experience working with this population. That experience was central to maintaining interviewer safety, facilitating participant comfort and even understanding or being able to clarify participant comments. Use of, for instance, undergraduate students to conduct interviews could place both interviewer and participant at risk, and also may yield less useful information.

This study represents an initial effort to describe the ways in which model services are provided to people with SPMI living in rural areas. The study found that mental health service models are substantially modified to suit the rural environment, but the way in which modifications are made differs between regions. These diverse approaches provide opportunities to examine the effectiveness of each new model. Consumer reports on satisfaction with services

and QoL suggest that it is possible to provide a full range of high quality mental health services in rural areas. Consumers believe that these services have helped avoid adverse outcomes and improve quality of life.

The results of this study extend beyond provision of services to people with SPMI, since people with less disability will also have access to the services they need. The results of this study also extend beyond rural areas. Rural services are different than urban services, but different does not mean inferior. Some rural areas have expanded original models of service delivery in ways that contribute substantially to consumer QoL. These modifications may in turn enhance existing models for consumers, regardless of rural or urban residence.

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Appendices

Appendix A - Study Definition of Severe and Persistent Mental Illness

1. 18 – 64 years of age

2. Experiencing a severe and persistent psychiatric illness

3. Demonstrated functional impairment(s) in two or more of the following:

   - living skills
   - social behaviour
   - support system
   - employment
   - economic stability

4. Recent use of services including one or more of:

   - intensive psychiatric treatment
   - structured residential care
   - extensive contact with mental health services

OR

   Service refusal despite demonstrated need for intensive service

5. Multiplicity of needs which may include:

   - being prone to crisis
   - having difficulty successfully using services
   - being at risk of homelessness

Exclude individuals with:

   - active psychosis with substantial acting out
   - cognitive impairment such that the individual is incapable of participating in the interview
   - primary addiction to drugs and/or alcohol

Also exclude individuals who:

   - are not mentally competent to consent to participation
   - would be <u>unduly distressed</u> by the interview

Appendix B - Consent to Participate

UNIVERSITY OF MANITOBA   FACULTY OF MEDICINE   750 Bannatyne Avenue
Department of Community Health Sciences   Winnipeg, Manitoba
Canada R3E 0W3

Fax: (204) 789-3905

CONSENT TO PARTICIPATE

Topic: Community based mental health services in rural areas: Organization and Effectiveness

Researcher: Ms. Renée Robinson, RPN, BScMH, MSc (Community Health)
PhD Student, Community Health Sciences, University of Manitoba

You are being asked to participate in a study. Please take your time, read this form and ask any questions you might have. If you do not understand any part of this form, please ask Ms. Robinson to explain. You may also talk to friends or family before you decide.

Purpose of this study:
This interview is intended to find out how you think mental health services are working in your area. You are being asked to take part because you are using, or have used, these services. All people using services such as Intensive Case Management will be asked to participate. About 100 people from across Manitoba will be interviewed.

The purpose of this study is to find out how organization of services affects clients' health and quality of life, as well as how organization affects use of services. This research is being done because health planners, such as Regional Health Authorities, need to know how community based mental health services work in rural areas.

Study procedures:
Agreeing to participate in this study means you agree to be interviewed. The interview will be taped only if you agree to it. Questions will be asked about your quality of life and opinions about services. The interview will take about one hour. You can stop the interview or take a break at any time. You can also bring someone you trust with you to the interview if you want to.

Risks and benefits:
By participating in this study you will be assisting Ms. Robinson to describe how organization of services affects use of services and quality of life for clients. This information is of interest to health planners and may result in improved services in your area. This information may also help health planners in other areas improve their services. There are no known risks to participating in this study.

Payment for participation:
Following the interview you will be given $10 to thank you for helping with this work.

Confidentiality:
Unless you tell someone, the only person who will know if you participated or not is Ms. Robinson. Information collected in this study may be published or presented in public forums, but your name will not be used. Records that contain your identity will be treated as confidential according to the Personal Health Information Act of Manitoba. A small amount of anonymous, grouped data will be supplied to the designers of a research questionnaire included in this study. This standard practice of sharing research data poses no risk to you.

All tapes and questionnaires will be destroyed after seven years. Tapes and questionnaires will also be destroyed if you decide to withdraw from the study.

Voluntary participation/withdrawal from the study:
You do not have to participate in this study. You can refuse to participate or withdraw from the study at any time. The services you receive will not be affected by your decision about participating.

Questions:
You are free to ask any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study, you can contact Ms. Renee Robinson collect at (.   . For questions about your rights as a research participant you may contact the University of Manitoba Faculty of Medicine Research Ethics Board at 1 800 432 1960 extension 3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all your questions.

Statement of consent:
I have read this consent form. I have had the opportunity to discuss this research study with Ms. Robinson and have had my questions answered. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation is voluntary and that I can choose to withdraw at any time. I freely agree to participate in this study.

I understand that information regarding my personal identity will be kept confidential. By signing this consent form I have not given up any of the legal rights that I have as a participant in a study.

Participant Name: _____

Participant Signature: _____

Date of Signature: _____

Person explaining the consent form: _____

Signature of person explaining the consent form: _____

Date of Signature: _____

Revised March 27, 2000

Appendix C - Response card

RESPONSE CARD

I understand that Renee Robinson is doing a study to find out how people think mental health services are working in rural areas. I know she would like to talk to me about being interviewed for the study. I am being asked to allow Renee Robinson to contact me to tell me more about the study.

I understand that my privacy is being protected. The Regional Health Authority did not give out my name. Renee Robinson does not know who has been invited and she will not know who I am unless I agree to be contacted.

I understand that the services I receive will not be affected by my decision about being contacted. A staff member in the region has asked me to mail this card to the address on the envelope, but does not know if I agreed to be contacted.

I understand that I can contact Renee Robinson collect at if want to ask questions before agreeing to be contacted.

I AM AGREEING TO BE CONTACTED ONLY. AFTER HEARING ABOUT THE STUDY I CAN MAKE A DECISION ABOUT WHETHER OR NOT I WANT TO BE INTERVIEWED.

Please check <u>one</u> of the following and mail this form back in the addressed and stamped envelope supplied.

☐   I can be contacted at _____ (phone number where I can be reached). My first name is _____. The best time to reach me is _____.

☐   I do not wish to be contacted

Thank you.

Appendix D – Service Configuration Information Sources

Interviews

Assiniboine

Carnegie, D., Program Director, Mental Health

Brandon

Done, A., Program Supervisor, Crisis Services

Fitzsimmons, M., Program Manager, Psychosocial Rehabilitation

Hayes, A., Program Manager, Adult Community Mental Health

Kowalchuk, D., Outreach Worker – Westman Region, MSS

Leflar, B., Outreach Worker – Westman Region, MDAM

Nichol, M., Outreach Worker – Westman Region, ADAM

Styles, L., Program Manager, Centre for Adult Psychiatry

White, B., Resource Developer

Burntwood

Barbara, Outreach Worker – Burntwood Region, ADAM

Suzanne Garbutt, ICM / CMHW

Franklin, S., Director Health Programs

Thomas-Franklin, C., Outreach Worker – Burntwood Region, MSS

Central

Asham, W., Supervisor, Crisis Services

Chappelaz, C., Outreach Worker – Central Region, MDAM

Goerz, E., Chief Executive Officer, Eden Health Care Services

McVety, B., Community Mental Health

Pauch, W., Regional Director of Mental Health Services

Smith, S., Outreach Worker – Central Region, ADAM

Titchkosky, C., Outreach Worker – Central Region, MSS

Interlake

Hradowy, D., Outreach Worker – Interlake, MSS

Nattrass, K., District Director, Southwest

Tarnopolski, P., Mental Health Program Manager

Sielski, B., Outreach Worker – Interlake, ADAM

Krahenbil, C., Outreach Worker – Interlake, MDAM

Nor-Man

Gannon, G., Nor-Man CMHA

Harris, D., Nurse Manager / Clinical Supervisor

Pearn, J., Regional Program Manager, Mental Health

Shewchuk, N., Outreach Worker – Nor-Man, MDAM / MSS

Spear, S., Outreach Worker – Nor-Man, ADAM

North Eastman

Berg, G., Eastman CMHA

Bissonnette, S., Mental Health Manager (current)

Dyck, R., Outreach Worker – Eastman, MDAM

Orvis, M., Mental Health Manager (previous)

Parkland

Gessner, E., Outreach Worker – Parkland, MSS

Meadows, G., Director of Mental Health Services

Rehaluk, A., Outreach Worker – Parkland, ADAM

Snitka, E., Outreach Worker – Parkland, MDAM

South Eastman

Berg, G., Eastman CMHA

Dyck, R., Outreach Worker – Eastman, ADAM / MDAM

Williams, A., Mental Health Program Manager

Other

Ek, N., Member, Mental Health Education Consortium

Fortier, R. Director, Emergency Social Services, Manitoba Family Services and Housing

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Documents

Annual Reports

	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01
Manitoba Health	X	X	X	X	X	X	X	X	X
Brandon						X	X	X	X
Burntwood									X
Central Interlake						X	X		
Marquette						X	X	X	X
Norman						X	X		
North Eastman						X			X
Parkland						X	X	X	
South Eastman								X	X
South Westman						X	X	X	

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Appendix E - Questions for Regional Health Authorities

System Components

According to the Best Practices in Mental Health Reform: Discussion Paper (Health Systems Research Unit, 1997) which was prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, the following services are key elements of a reformed system of care. Please tell me how each of the following services are provided in this region.

Psychiatry / Psychology. Availability, EFT, changes over time.

Case management. Availability of ICM / EDC (established?), model used, caseload size, specific services (advocacy, facilitation of social services, assistance with finances and housing, illness and medication education, medication administration and monitoring, symptom management, assistance with basic needs and instrumental functioning. Active outreach. Service in the community. Work with natural supports. Use of proctors.

Crisis services. When established. 24-hour coverage. Mobile service. Crisis stabilization or safe house.

Inpatient services. If new, when established. Number of beds. Use of medical beds in local hospitals. Long-term care (including Residential Care homes and Personal Care Homes).

Housing. Availability of housing. Use of Manitoba Housing Authority, Residential Care homes, group homes, supported housing.

Vocational / Educational supports. – EDC, Vocational Rehabilitation, Job skills, transitional employment.

Social / Recreational supports. Availability, use of proctors. Other.

Consumer / Family support. When established, groups active, services offered.

System Characteristics

Coverage. Where service is provided (theoretical and actual), service on reserve, service within region.

Accountability. Reporting relationships for above components.

Integration. Linkages between services.

Budget change. New services, funding changes under mental health reform, protected funding.

Monitoring / Evaluation. Budget, accreditation, CQI, other.

Human resources. Recruitment and retention, qualifications.

Continuing education. Training in PSR, CORE module, continuing education.

Special considerations. Factors unique to the region that affect service delivery.

Appendix F - Regional Descriptions

Assiniboine

Marquette and South Westman operated as two separate regions from the formation of

Regional Health Authorities in 1997 until September 2002. Although the regions were separate

during most of the study period, the two are described together in this document. Marquette and

South Westman have reasonably similar populations, shared the same Mental Health Program

Manager, and had similar service configurations. Where differences exist, they are noted.

System Characteristics

Context of Service Delivery

The Assiniboine RHA covers an area of 30,950 square kilometers and serves a population

of 75,500 people (Regional Health Authorities of Manitoba, 2000). About 27 consumers with

SPMI live in the region.

Clients in Assiniboine are geographically distributed throughout the region rather than

being concentrated in specific areas. Clients close to regional boundaries may receive some

services from other regions. This would include people from Assiniboine receiving services in

other regions and people from other regions receiving services in Assiniboine. Further, some

individuals living in Brandon continue to receive services in Assiniboine as they have

established relationships with providers in these areas. The numbers of clients being served in

this fashion is minimal, and would be particularly small for clients with SPMI.

Community mental health services are not provided to First Nations people on reserve.

However, services are provided to this population off reserve.

Accountability

Historically, Assiniboine and Brandon were both part of the Westman Health and Social

Services region. The two Regional Health Authorities (RHA) continue to operate a number of

services on a shared basis. Shared services include inpatient care at the Centre for Adult

Psychiatry, psychiatry services, crisis stabilization and mobile crisis services. These services are

funded through the Brandon Regional Health Authority, but are indirectly accountable to

Assiniboine RHA through a service agreement.

Marquette and South Westman shared a single Mental Health Program Manager who has

continued in this role under the Assiniboine RHA. Community Mental Health Workers

(CMHW), Proctors, psychiatry services and the psychologist are directly responsible to the

Program Manager, although Proctors are supervised by the CMHW. Self-help initiatives are

funded separately from the region and have no direct accountability to Assiniboine. However,

the mandate of the self-help services located in Brandon includes both regions. Vocational

Rehabilitation Services, which provides employment skills training, reports to Family Services.

Assiniboine RHA does not have a Mental Health Advisory Council. However, consumers

and other stakeholders do participate in CQI (Continuous Quality Improvement) teams.

Integration / Linkages

A planning committee, consisting of the mental health program managers from both

regions, provides direct administrative links between intra- and extra-regional services. Mental

Health Services has administrative linkages with other regional structures, such as Public Health

and Family Services, with mental health services in other regions through the provincial network

of regional managers (Provincial Mental Health Network), and with program specialists at the

mental health directorate. There are also client-specific linkages between regional programs and

services in other regions.

Sharing of information between Brandon and Assiniboine is complicated by privacy and

confidentiality legislation such as the Personal Health Information Act (1997) and the Freedom

of Information and Personal Privacy Act (1997). Information from Crisis Services can be shared with community mental health services with client consent. Joint planning is regularly conducted within a collaborative services framework with client consent.

There are formal mechanisms in place to provide linkages between community mental health services in Assiniboine and the Centre for Adult Psychiatry, which provides acute inpatient treatment. Despite formal linkages, Assiniboine continues to experience some challenges in providing continuity of service delivery. In 1998 the Marquette RHA initiated a study of consumer perspectives of mental health services used following discharge from inpatient services (Racher, Ryan-Nichols, & Robinson, 2000). The study made suggestions for improvement and provided a vehicle for discussion of issues. The region has also attempted to foster linkages through activities such as inviting Brandon-based facilities to share information about their programs.

Vocational Rehabilitation Services provides on-site services in Assiniboine. There have been some challenges in linking clients to Vocational Rehabilitation Services, possibly due to lack of knowledge about the program on the part of CMHW. Efforts are underway to improve knowledge and develop working relationships between staff in the different programs.

Budget

Historically, Brandon and Assiniboine were a single region. They became three separate regions as of April 1, 1997 when the Regional Health Authorities were formed. Marquette and South Westman amalgamated in 2002. These changes in structure make it difficult to describe the extent to which funding has changed over the period of mental health reform. Further, some services, such as crisis services and inpatient services are provided to Assiniboine on a contract basis with funding flowing through Brandon RHA. What is now Assiniboine RHA did obtain a

small amount of funding upon closure of Brandon Mental Health Centre but generally the only increase in budget has been a small amount for proctor services. Proctor services were administered on a tri-regional basis until April 1, 2002. The region considers the historic understaffing in community mental health services to have continued under mental health reform and establishment of the RHA.

Monitoring / Evaluation

Neither Marquette nor South Westman had a specific budget for monitoring and evaluation. This has not changed as a result of the amalgamation. A CQI team is in place. This team is made up of about 14 stakeholder groups, including providers, such as the Addictions Foundation of Manitoba, and consumers, such as self-help representatives. The group evaluates the region on the criteria established by the Canadian Council of Health Services Accreditation AIM (Achieving Improved Measurement) standards. These standards include items in areas such as responsiveness, quality of service delivery and quality of work-life as well as items specific to mental health services.

Marquette and South Westman each underwent an accreditation process in 2001. The next Accreditation will be for the Assiniboine region and will occur in 2004. As previously mentioned, Marquette initiated an evaluation of health services use following discharge from inpatient services. This information was used to improve services and has stimulated interest in grass-roots involvement in service planning. A series of focus groups has also been held by the Marquette region to receive input from community members. In addition to the above initiatives, the Assiniboine region participated in the Caseload Review with Manitoba Health and other RHAs.

Human Resources

Marquette and South Westman have routinely had a choice of good quality applicants for community mental health positions, although the numbers of applicants decreases as the distance from Brandon increases. There has been some difficulty in attracting psychiatric nurses, but the regions have been able to hire, for example, Social Workers with specialized training. Staffing has been quite stable in the regions with minimal turnover.

Basic and Continuing Education

Other than CMHW who took the CORE modules in the past, there has been no training in psychiatric rehabilitation. There is no ongoing education on this particular topic as the population represents a small fragment of a CMHW caseload. Each worker has $200 per year for professional development and makes independent choices about what to attend. This means that it is important for applicants for CMHW positions to be well prepared educationally, if not experientially, prior to application. An undergraduate degree is considered to be the entry to practice.

Special Considerations

Like other rural regions, geography creates challenges in staffing. Provision of services to a dispersed population is very costly. Almost one third of manpower time in Assiniboine is spent in travel. The cost of setting up an office and support staff in multiple locations is also substantial. The region is understaffed.

Services located in Brandon, such as crisis stabilization and mobile crisis services, are not necessarily well used by CMHW or clients in the Assiniboine region. Brandon-based services are not as visible in rural areas and there is a perception that these services are not a rural support. Ongoing efforts are being made to increase knowledge about, and use of, these programs.

System Components

Psychiatry / Psychology

Adult mental health clients in the Assiniboine region receive itinerant service from one of three psychiatrists operating out of Brandon. Services are provided in ten sites on a monthly basis. In addition to providing assessment, consultation and treatment, the psychiatrists provide consultation and support for CMHW and professionals from other agencies. While it would be preferable to have a psychiatrist working exclusively in the Assiniboine region, psychiatric consultation has been sufficiently available.

Assiniboine RHA has one full-time psychologist who operates out of Neepawa. The psychologist provided itinerant services to the three other health offices in the former Marquette region. This service is now available to South Westman as well. Additional psychology support would be preferred.

Case Management

There are 10 adult CMHW in the Assiniboine region. They provide crisis intervention, counseling to individuals and families, follow-up and medication monitoring in a clinical case management framework. Intensive Case Management (ICM) and Employment Development Counselors (EDC) are available in Brandon but are not available in the Assiniboine region. Services for people with Severe and Persistent Mental Illness (SPMI) are provided within the caseload of CMHW who each have a caseload of about 60 active clients. CMHW provide clinical case management, focusing on psychosocial counseling. Services include direct assistance with symptom management, limited medication administration and monitoring, and illness education. Because of caseload size, the CMHW may not be able to provide all services in the depth required by some clients. Assistance with basic needs and instrumental functioning,

which would ideally be provided for by ICM, are provided through a proctor, whose services are initiated by the CMHW.

Clients are seen in the community or in regional sub-offices. In order to reduce travel time, proctors may be used to provide transportation for the client to regional sub-offices. CMHW have some opportunity to work with the broader client system but tend to be more focused on the individual. The extent of outreach is determined by client need. Active follow-up of missed appointments occurs for clients with SPMI.

Crisis Services

Crisis calls are handled by Community Mental Health Services during the day on weekdays. Mobile crisis services are offered through Brandon in the evenings, overnight, on weekends and holidays (see description in Brandon). Between community mental health services and the Mobile Crisis Unit (MCU), crisis services are available on a 24-hour basis. Good relationships exist between crisis services and the Assiniboine region. Crisis services are not well used in rural areas, possibly due to being seen as a Brandon service rather than a rural service. Distance may also be an issue. Crisis services have been making an effort to work with rural regions to develop more of a presence outside Brandon. Education might also be of benefit to facilitate use of this service.

Inpatient Services

The first line resource for inpatient care is the local rural hospital. While mental health expertise is not available in these hospitals, some care can be provided when it is safe for the client. The Centre for Adult Psychiatry in Brandon is used as an inpatient resource based on urgency and acuity as well as consumer choice. Some consumers prefer not to be served in their home community but, on occasion, there are no beds available at CAP.

There are no group homes in the Assiniboine region but there are two licensed

Residential Care homes where long-term residential care can be provided. The total number of

licensed homes represents more than a 50% decrease in this type of service as there were five

such residences in 1997.

The Assiniboine region has access to McTavish Manor, a staffed group home in Brandon,

but there is a waiting list based on a priority list and need. On rare occasions clients have been

placed out-of-region in private residential care. The services of Selkirk Mental Health Centre

have not been required.

Housing

Other than the Residential Care licensed homes, the housing available for people with

SPMI is the same as what is available to other community residents. Some subsidized housing is

available from Manitoba Housing, but it is very limited. People with SPMI usually live

independently though some live with their families. In general, availability of appropriate

housing has not been identified as a problem. There may be some needs for supervised living

but, as the individuals who would benefit are widely dispersed geographically, some individuals

would need to relocate to other communities. The benefits of supervised living would have to be

balanced against consumer choices about which community they choose to live in.

Vocational / Educational Supports

There are no specific vocational / educational supports located in either region. As

mentioned, there are no Employment Development Counselors. Vocational Rehabilitation

Services, which are operated by Family Services, are located in the region and have a mandate to

serve mental health clients but to date they have not been well used. CMHW are not familiar

with this program or means to access the program. More recently, community mental health

program staff has been appointed to sit on a joint planning and service delivery committee with

Family Services to ensure collaborative practice, particularly for those with dual diagnoses

(developmental disability and mental disorder).

Social / Recreational Supports

A day program operated out of Hamiota (Marquette) until December 2001 when it was

discontinued. It was felt that the program duplicated the Services for Seniors program which was

already operating in the community. Further, by the time the program was discontinued,

participants had become a cohesive group and they continue to meet independent of a formal

helper network. The region provides accommodation and makes meals available to facilitate

maintenance of this network.

Proctor services are used to reduce isolation and to facilitate participation in local events

and recreational activities. The Assiniboine RHA has about 50 proctor agreements for between

four and 10 hours of services per week.

Consumer Initiatives / Family Self-Help

Self-help resources are located in Brandon but are intended to serve both the Assiniboine

and Brandon regions. Contact between the self-help groups and the Marquette / South Westman

regions was limited until 1999. The only consumer support groups operating in either region

were offered by MDAM (Mood Disorders Association of Manitoba) in Virden and Neepawa.

Since 1999 the role of self-help has expanded. Marquette RHA, and later South

Westman, set up a theme for each month, and displays for public health offices to correspond

with those themes. The RHA worked in partnership with the self-help groups to provide public

education on mental health topics such as mental health promotion and depression. For instance,

during Depression Month, MDAM offered four public presentations, two in Marquette and two

in South Westman. The RHA provides support for the self-help groups by providing a site, coffee and promotion for the event.

Initiatives have largely focused on education. Mutual aid, individual and family support is provided out of offices in Brandon for ADAM and MSS. The MDAM currently operates support groups in several locations in the region, including Deloraine, Killarney, Shoal Lake, Souris and Virden.

Future Goals

The Assiniboine RHA is working to improve knowledge of, and use of, services located in Brandon. Increased partnership and accountability is expected to facilitate increased service use.

Brandon

System Characteristics

Context of Service Delivery

The Brandon Regional Health Authority serves the City of Brandon and two outlying municipalities. The RHA has a population of 46,888 (Regional Health Authorities of Manitoba, 2000). The City of Brandon is the second largest city in the province of Manitoba. It serves as a referral center for many health services. For mental health in particular, there is substantial joint planning and some services are operated on a joint basis with the Assiniboine RHA.

Based on availability of services, patterns of travel for commerce and employment, and relative anonymity in a larger center, Brandon often provides services to individuals from outside the region. However, the extent to which people with SPMI travel for service is minimal. The Psychosocial Rehabilitation (PSR) Program is operated in Brandon only.

The Psychosocial Rehabilitation Program serves about 160 people in one or more of their services, which include ICM, EDC[9], Ventures (a vocational assessment and training facility), Mental Health Promotion Clinic, Community Support Services and residential services. Adult Community Mental Health serves about 12 individuals who could be considered SPMI, although these individuals would have fewer needs than those in the PSR program.

Accountability

The Program Manager for the Psychosocial Rehabilitation Program is directly responsible for ICM, EDC, the Resource Developer, Residential Care Coordinator, Proctors, Community Support Services, Mental Health Promotion Clinic, Ventures and some housing. The Program Manager reports to the Coordinator of Mental Health Services. In addition to the Psychosocial Rehabilitation Program, the Coordinator is responsible for community and

inpatient mental health services for children, adults and the elderly. The Coordinator is indirectly

responsible for crisis services, which are operated by the Salvation Army on a contract basis.

Consumer self-help and psychiatry services are not directly responsible to either the

Program Manager or the Coordinator. Self-help services are funded by the province and report to

Manitoba Health through their respective head offices. Most psychiatrists, like other physicians

in the Brandon RHA are in private practice or combine private practice with contract work for

the RHA. Those under contract to the RHA report to the Chief of Staff.

There are also a number of community organizations providing service to the SPMI

population, such as the Brandon Community Welcome, Brandon Friendship Centre, CMHA and

Samaritan House. These organizations provide social opportunities, literacy and life skills

programs but are outside the formal health care system.

Integration / Linkages

PSR Program staff work closely together and have weekly meetings to share information.

The program also works closely with inpatient services, crisis services, consumer, and

community organizations. The Centre for Adult Psychiatry, which provides inpatient services,

invites case managers to attend conferences. Crisis services are linked at both the planning level

and the client level. Every client has an assessment for crisis potential. The client and the case

manager prepare a crisis plan if there is potential for an after-hours crisis. The client signs the

plan and is provided with a tour of the crisis unit. Information on what to expect in the event of

contact with crisis services is also provided.

The PSR Program periodically offers space to consumer groups to facilitate linkage. The

PSR Program, through the Mental Health Promotion Clinic, coordinates health promotion

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[9] Note: ICM and EDC both perform case management services. Service focus determines the type of case manager selected. The description of Brandon services will use the term case manager to refer to ICM and EDC.

activities with consumer organizations. They jointly sponsor community education initiatives.

Linkages with the MSS are particularly strong since this is the group most relevant to the PSR

client population. CMHA, which operates vocational and housing programs, is also closely

linked to the PSR program. Consumer groups such as ADAM and Adults Molested as Children

have stronger links with the Adult Community Mental Health Program on the basis of their client

population. Good linkages exist between PSR program staff and community agencies such as

Samaritan House, employment agencies, and Brandon Community Welcome.

Integration is also achieved through the Mental Health Advisory Council. The Council

meets quarterly and is Chaired by the Vice President of Long-Term and Community Programs

for the Brandon RHA. The committee is composed of a wide range of stakeholders including

Program Managers from Assiniboine and Brandon RHA, consumer representatives, a Chaplain

and the Friendship Centre. Council members collaborate on issues such as lobbying for bus

passes for mental health consumers.

Administrative linkages with other regional structures, such as Public Health and Family

Services, and with program specialists from Manitoba Health occur through the Coordinator of

Mental Health Services. Linkage between mental health Program Managers within the region

occurs through the Mental Health Coordinator and through monthly meetings. Program

Managers in each region link though the provincial network of regional managers (Provincial

Mental Health Network),

Budget

The budget for mental health services in Brandon has experienced substantial change as a

result of mental health reform and regionalization. The budget for Brandon Mental Health Centre

(BMHC) was reallocated to community services as the Centre was downsized and eventually

closed. Not all of the money remained in the Brandon RHA as funds were provided to Central,

Parkland, Marquette and South Westman to develop or enhance their community-based services.

Funds were also used to develop new inpatient services in other regions. Under regionalization

the PSR Program has its own budget. Having a specific budget allows shifting of funds within

the program to meet client needs. Funding for mental health services was protected for a period

of time but is now part of the global budget for the RHA.

Monitoring / Evaluation

Brandon RHA went through an accreditation process and received accreditation in 2000

and has a CQI program in place. There is no budget for ongoing evaluation but the mental health

program is committed to evaluation. The PSR Program has undertaken a number of specific

evaluation initiatives. The PSR Program worked with Manitoba Health and two other RHAs

(Central and Parkland) to design and conduct an external evaluation of program operation, client

satisfaction, family, and community satisfaction. The report was completed and provided to

Program Managers in 2001. Work on identifying performance indicators and clinical outcome

indicators, including client satisfaction, is under way.

Human Resources

The PSR Program has had no difficulty in filling vacancies with qualified staff. Brandon

positions were highly sought after in the closure of BMHC, and most of the staff transferred into

the program when BMHC closed. Active planning to meet future staffing needs is under way.

For instance, PSR Program staff work with Brandon University, School of Health Studies to

facilitate student placements in the program, and with the Brandon School Division to provide

students with work experience.

Basic and Continuing Education

The Program Manager of the Psychosocial Rehabilitation Program has been certified by Boston University to provide training in psychiatric rehabilitation. In addition to the CORE module on psychosocial rehabilitation, ICM and EDC staff received eight days training in psychiatric rehabilitation. Other staff received a six to eight day training session. The Program Manager also worked with vocational and residential services to implement a psychiatric rehabilitation model using principles of skill teaching and skill programming. Some continuing education is provided in the area of psychiatric rehabilitation. Inservice programming has been developed to meet the educational needs of proctors.

Adult CMHW took the CORE Modules training program when it was available. Psychiatric rehabilitation was one of the required modules. Although the CORE Modules are no longer available, stable staffing in the region has meant that most CMHW have taken the module.

The Brandon RHA offers up to three days educational leave per year. The RHA provides some funds for each professional staff member for continuing education. Staff can also access continuing education funds through the Manitoba Nurses' Union. Individual staff members determine what educational opportunities to pursue based on their caseload and interests.

Special Considerations

Brandon is unique in terms of geography, client population, range of health professionals and services available, and separation between Adult Community Mental Health and PSR programs. With the exception of Burntwood that covers an extremely large area, the average area of a rural RHA is about 31,000 square kilometers. Brandon is a city with a population similar to other RHAs. Brandon is urban in many respects but, due to its relatively small population,

dependence on agriculture and role as a regional referral center, it is also rural. In this light, Brandon might best be described as a rural city.

When the PSR Program was established in Brandon, its' clients included individuals who were living in the community but had limited support. However, the majority of clients were drawn from inpatients at BMHC. Many of these individuals had been hospitalized for extended periods of time or on multiple occasions. The primary diagnosis was almost exclusively schizophrenia. However, the constellation of clients in the Brandon PSR program is changing. The program has started to serve younger clients who have not been institutionalized and is able to provide earlier intervention. At present about 90% of clients have a diagnosis of schizophrenia or mood disorder.

PSR program has a wide range of health professionals in a variety of roles. The disciplines include Activity Instructors, Occupational Therapists, Physicians, Psychiatrists, Registered Psychiatric Nurses and Social Workers. The larger client population allows for specialized expertise and services. Further, the larger size of the city facilitates recruitment of a variety of disciplines.

In Brandon the Adult Community Mental Health program is separate from the PSR program. While both program managers work out of the same location and report to the same individual, the separation has had implications for access to some services. For instance, Adult Community Mental Health clients with mild to moderate needs who would potentially benefit from PSR services have had limited access to some services, such ICM or EDC. More recently, through partnership between programs, access to components within the PSR program has improved. Referral to the PSR program continues to be difficult as the program was filled with BMHC clients as soon as it opened. Turnover in PSR clients has been slow.

System Components

Psychiatry / Psychology

A psychiatrist and a physician are members of the PSR Program team. They provide

regular follow-up and consultation. Physical health concerns are addressed by the client's family

physician. Psychology services are available on a consultation basis.

Case Management

The PSR program, which includes case management services, was established in

September1994 when outpatient services from BMHC were transferred to regional mental health

services[10]. The program currently provides case management to about 160 consumers using one

or more of their services.

As previously mentioned, the majority of clients of the PSR program came from the

BMHC inpatient population. Some of these individuals are in service on the basis of provisions

under the Mental Health Act (1998). A small number receive service under a Certificate of

Leave. The Certificate of Leave is intended to provide treatment that is less restrictive and less

intrusive than being detained in a facility. The individual must attend appointments with a

designated service provider and comply with the treatment plan described in the Certificate in

order to remain in the community. Individuals who have been found Not Criminally Responsible

under the criminal code may also receive ICM services. This applies to three individuals in the

PSR Program. These clients must also adhere to specific requirements, such as residing at a

specific location, not contacting certain individuals, or refraining from alcohol. A substantial

majority of the clients participate in the program on a voluntary basis.

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[10] Note: Until April of 1997, the area that is now the Brandon RHA was part of the Westman Region and was administered by Manitoba Health through a Regional Director.

The PSR Program is very client-centered, and reflects both a rehabilitation model and a personal strengths model. It attempts to balance rehabilitation and treatment as the two are seen as complementary approaches. For instance, program staff have found that newer atypical anti-psychotic medications provide a better treatment response. Changing clients to atypical medications has enabled the clients to experience recovery and participate more fully in rehabilitation.

ICM "provide assertive, long-term case management services which assist individuals to be satisfied and successful in the living, learning, working and social environments of their choice" (Brandon RHA, 2000). A wide range of services is available, but the services a specific client receives depend on the clients' goals. Incoming clients are assigned a case manager who works with the individual to identify goals. Intervention occurs in the domains of living, learning, working and socializing as well as symptom and medication management. Assistance with basic needs and instrumental functioning may be provided directly by the ICM or by a proctor.

ICM have a caseload of 15 – 20 clients. Virtually all of the work is conducted in the community. For instance the ICM may meet the client at the client's home, a bowling alley or coffee shop. Time may also be spend time looking for housing or employment. Missed appointments are actively followed up. Depending on the client's wishes, and the involvement of the family, education is also conducted with the client's family and friends. Many individuals have lost touch with their family. In this instance the ICM encourages reconnection. Over time consumers appear to be increasingly engaged with families.

The Mental Health Promotion Clinic was established in 1996. The Clinic administers depot medication as well as monitoring health status, providing health education and health

promotion services. The number of clients served by the Clinic has declined as clients have switched to newer medications. About 40 clients currently use this service.

The Resource Developer administers the Proctor Program. This involves hiring and orienting proctors, primarily around boundary issues. To date the program has had the ability to be selective in hiring of proctors. Proctors work in partnership with clients and case managers/ CMHW to assist individuals to develop and maintain skills required to be successful in the community. Each service plan is specific to the individual. Plans are flexible and are reviewed by the ICM / EDC / CMHW in consultation with the Resource Developer once every three months. The number of weekly proctor hours can increase or decrease depending on goals. Clinical supervision for proctors is provided by the ICM / EDC / CMHW.

Proctor services were originally provided to clients who had been institutionalized, or those who were particularly marginalized in the community. Over time, proctor services have changed and are now provided to clients who have not experienced lengthy hospitalizations. The goal of the service is to enhance quality of life and connect the client to services in the community. For instance, the proctor may assist with grocery shopping, paying bills, or transportation to medical appointments. Services also include finding housing, teaching new skills, scheduling skills, monitoring and providing structure.

Planning for the proctor service assumed that the need for service would decline over time. In practice, the need for service in many cases increased as consumers began to recover and began to pursue goals.

Clients in the PSR program have made progress. However, none of the clients have yet "graduated" from the program. Many may need lifelong support in one or more aspects of life. However, clients may be asked to leave the program if they are not willing to work on

rehabilitation goals. For instance, if the client is addicted to inhaling solvents and is not willing to stop, the program cannot provide treatment and the individual may be asked to leave the program.

Adult Community Mental Health clients differ from PSR clients in that most (about 60%) have never used inpatient services and may never use them. Although some of these individuals would benefit from access to ICM services these services cannot be provided within the Adult Community Mental Health Program. CMHW have caseloads of 60 – 70 clients. This means they provide assessment and treatment, and make sure that housing and financial needs are met. However, the CMHW may not be able to provide intensive services or a full range of services. For instance, concentrated individual case management, including skill development, coping skills, problem solving and stress management are difficult to provide with a caseload this size. Proctors have been used to meet some of these needs, but funding limits use of proctors to some extent.

More recently, Adult Community Mental Health program secured funding for an enhanced community mental health service that is intended to specifically address skill development needs of people with SPMI. The enhanced community mental health service uses a group format to teach functional living skills in areas such as stress and coping, problem solving, interpersonal and social skills. Further, through use of a shared service model, community mental health clients might also have an EDC, attend the Mental Health Promotion Clinic or use the Community Support Services. Decisions about services are driven by client needs rather than being specific to programs.

Adult CMHW practice using both a rehabilitation model and a recovery model. The program offers the services of a multi-disciplinary team, including psychiatry, psychology,

psychiatric nursing and social work. Services tend to be office-based although the extent of office practice depends on the worker and the clients needs. Missed appointments may be followed up with a phone call or a letter, depending on the circumstances and how the missed appointment is interpreted. Work with family and friends may occur. As with the PSR program, after-hours service is provided by crisis services.

Crisis Services

The Salvation Army, under contract to the Brandon Regional Health Authority, operates crisis services for Brandon and Assiniboine RHA. The crisis services consist of a Mobile Crisis Unit (MCU), which was established in October of 1995, and a Crisis Stabilization Unit (CSU) that opened in the spring of 1997.

The Mobile Crisis Unit operates evenings, overnight, and 24-hours on weekends and holidays. During regular office hours, clients contact their worker directly. The Mental Health Promotion Clinic serves as backup for case managers if case managers are not available. Intake provides backup for CMHW if they are not available. For a period of six months, the MCU provided mobile crisis services on a 24-hour basis. While there was support in principle for the expansion, funding for the additional 0.9 EFT was not available and the MCU again operates on an after-hours basis.

The MCU provides crisis intervention, assessment, short-term follow-up, and referral to community resources. MCU staff provide telephone services or, ideally, meet with callers in their home or other suitable location. The MCU serves about 320 clients per month.

The Crisis Stabilization Unit operates on a 24-hour basis and has eight beds exclusively for adults. It provides assessment, treatment and discharge planning. Individuals who require a secure environment, such as those who are at high risk of suicide, have demonstrated violent

behaviour or have severe physical health problems, are not eligible for service. The team

includes nurses and an activity worker. Psychiatric consultation is also available. The CSU

admits about 22 clients per month and the average length of stay is about five days.

As mentioned previously, there are close working relationships at both a planning level

and a client service level with Adult Community Mental Health and the PSR program. For

instance, both Adult Community Mental Health and the PSR program engage in joint planning

with MCU, particularly for clients who use the crisis services on a regular basis. Crisis services

shares information with these programs about clients who have called the MCU.

Prior to establishment of crisis services, the PSR program had a small number of shared

service plans in place with Emergency Department at Brandon Regional Health Centre. A plan

might still be developed if a client were using the Emergency department on a regular basis.

However, there are more services available now and there does not appear to be an ongoing need

for coordinating service with the Emergency department.

Inpatient Services

The Centre for Adult Psychiatry is a 25-bed inpatient unit at Brandon Regional Health

Centre. It was opened in 1998 and replaced the 40-bed Short Term Assessment and Treatment

unit at BMHC. CAP provides inpatient services to Brandon and Assiniboine regions, as well as

providing some service to other regions. Ten percent of admissions are from outside the Brandon

and Assiniboine regions.

Eight psychiatrists have admitting privileges at CAP. Other team members include

Activity Workers, an Occupational Therapist, Psychiatric Nurses, a Psychologist, Nurses and a

Social Worker. The Centre provides assessment, crisis stabilization, treatment and discharge

planning. The average length of stay is 15.3 days although most clients are admitted for shorter

periods. Barriers exist for discharging some clients. Clients can be inpatients at CAP for

extended periods of time if they are waiting for a long-term bed at Selkirk Mental Health Centre

(SMHC). CAP is one of the primary users of residential options such as McTavish Manor and

Amberwood Village.

Two additional services offered by CAP are emergency room consultation and

transitional programming. Psychiatric nurses from CAP are called to provide psychiatric

consultation in the emergency room at the Brandon Regional Health Centre. Psychiatric nurses

provide assessment and make recommendations that expedite admission or alleviate

inappropriate admission. Maintaining knowledge of community resources for referral facilitates

linkages between inpatient staff and community programs.

Transitional programming allows discharged patients to continue to attend programs such

as the coping skills program or group counseling. Maintaining this connection provides a bridge

to community services, provides care in the least restrictive environment and provides feedback

to professionals about appropriateness of discharge decisions.

Housing

A range of housing options is available in Brandon, including housing operated by the

PSR Program. The Program operates McTavish Manor, a ten-bed facility that is staffed on a 24-

hour basis. The PSR Program also operates a block of seven apartments that are used for

assessment and treatment as well as rehabilitation. The apartments are located in a large complex

in Brandon and are used for longer-term individualized support. One of the apartments is used as

an office. Staff assists clients in areas such as meal preparation, medication management, money

management or home management.

The PSR program has a Residential Care Coordinator who develops residential care resources and ensures residential care standards are met. There are four licensed homes with more than four but no more than six residents. There are also a number of approved homes (about nine) with three or fewer residents. These settings provide 24-hour supervised living with family or home operators.

At one point, the PSR program had 80 people in supported housing of some sort. The PSR program has clients in all five high-rise properties operated by the Manitoba Housing Authority. A number of clients also live in Manitoba Housing Authority properties throughout the city.

Non-profit organizations also provide some housing to people with psychiatric disabilities. Brandon Community Welcome has six suites and Armstrong place, which was built in 1995, has nine suites. These suites are primarily for people with psychiatric disabilities. CMHA provides supported housing in 440 House, which has five suites and provides itinerant support for about 35 individuals to facilitate independent living. Further, CMHA provides advocacy for social housing and has a housing facilitator who assists clients in finding places in the competitive market.

The major housing challenges have been related to cost. Although many consumers share an apartment in order to minimize costs, there continues to be a shortage of safe, affordable housing. Smaller units and units accessible to people with physical disabilities are particularly scarce. The Manitoba Housing Authority has also placed limits on the number of people with psychiatric disabilities who can reside in specific properties. The RHA is collaborating with Family Service and Housing, and the Manitoba Housing Authority to develop an integrated supported housing strategy.

Vocational / Educational Supports

Clients in the PSR program have varied interests and abilities, ranging from basic literacy to assistance with resume writing and job search. A range of options exists, both inside and outside of health services, to meet these diverse client needs. The PSR program has Employment Development Counselors and operates the Ventures program to assist clients in meeting vocational goals. Employment Development Counselors provide case management with an emphasis on assisting the individual to choose, get and keep employment. EDC was established in 1995.

The Ventures program was originally operated out of BMHC and was transferred to the RHA when BMHC was closed. The Ventures program provides a five-day assessment of work skills and work readiness skills such as attendance, hygiene, communication skills, and response to supervision. Once the assessment is complete, clients can participate in skill training. Skill training is conducted in a variety of settings and is specific to client goals. For instance, if the client's goal is to work as a receptionist then skill training might revolve around computer skills. The Ventures program also has some job placements with the RHA in areas such as courier services. The Ventures program is intended to provide assessment and training rather than serving as a sheltered workshop.

The PSR program has good linkages with several organizations in Brandon that provide vocational supports to individuals with SPMI. This provides continuity of service delivery. PSR clients make good use of community vocational resources. These resources include Career Connections, CMHA Re-Store, Brandon Community Welcome, Samaritan House, Westman Coalition and Westman Lead.

Career Connections is funded through Vocational Rehabilitation Services on a cost

shared basis with the Federal government. This service is for people with disabilities and is not

specific to mental health clients. Clients using this service have access to a job coach who

provides training and support in placements in local businesses, such as Canadian Tire.

Businesses may receive subsidy for the placement, but clients are paid regular wages.

The CMHA operates the Re-Store, which sells donated and consigned building supplies.

The Re-Store provides employment and income for people with mental illness. Samaritan House,

a separate non-profit organization, provides literacy and computer literacy programs.

Brandon Community Welcome was established 1986 to facilitate community living

among consumers being discharged from BMHC. Computer training and workplace health and

safety information are some of the educational programs offered. Brandon Community Welcome

established a Transitional Employment Program in 2000. The program operates a job bank and a

service where consumers register for paid casual employment.

The Westman Coalition was established in 1995 through block funding from Manitoba

Education and Training in collaboration with Human Resources Development Canada for people

with a variety of disabilities. The Coalition is co-located with City of Brandon Social Services

but also provides services in the rural areas. A Vocational Rehabilitation Counselor assesses

needs, and assists in resume development and finding employment.

The Westman Lead was established in 2000. This initiative is funded by the National

Network for Mental Health and promotes opportunities for self-employment among persons who

have experienced mental health problems.

Social / Recreational Supports

In addition to opportunities available to all members of the community, social / recreational supports are provided to people with SPMI through Community Support Services, CMHA Community Friends, Grey Owl and Proctors. Activity Instructors from Community Support Services work with individuals and groups to facilitate participation in social / recreational opportunities in the community. Proctors may also be used to facilitate social involvement.

Community Friends is a program operated by the CMHA. It pairs a client with a volunteer to provide social opportunities. The Grey Owl is the social /recreational part of Brandon Community Welcome. It follows Clubhouse principles and operates as a drop-in center as well as offering regular events, such as movies, bingo or barbeques. About 30 people attend the Grey Owl each day. Grey Owl and Community Friends partner with the PSR Program for some events, such as a fashion show, potluck suppers and a Christmas party.

Consumer Initiatives / Family Self-Help

A number of consumer organizations exist in Brandon, including ADAM (Anxiety Disorder Association of Manitoba), CMHA (Canadian Mental Health Association), Brandon Community Welcome, MDAM (Mood Disorders Association of Manitoba) and MSS (Manitoba Schizophrenia Society). ADAM, MDAM and MSS are engaged in public education and have resource libraries. Each organization has about 0.75 EFT to provide service to Brandon and Assiniboine regions. Staffing in these programs has been relatively stable with staff turnover every two or three years. MDAM and MSS had offices until 2001 and have operated out of the staff persons' home since that time. The groups work well together.

ADAM is involved in advocacy by participating on Assiniboine and Brandon RHA committees. ADAM also provides two 12-week Cognitive Behavioral Therapy Programs, one for Panic Disorder and the other for social anxiety. Graduates may attend a support group once per month. Groups are held in Brandon but are well attended by people from the Assiniboine region.

The MDAM provides individual support and peer support groups. MDAM also provides consumer education on specific topics based on requests.

The MSS provides individual and group education and support to people with schizophrenia and their families. There is a weekly ladies group and a group for men. A family group meets on a monthly basis. On occasion MSS and the PSR program, through the Mental Health Promotion Clinic, partner in offering education in the community.

As previously mentioned, Brandon Community Welcome / Grey Owl provides housing, education, employment and social / recreational opportunities. CMHA also provides some housing, employment and social / recreational services. In addition, CMHA is involved in mental health promotion through programs such as I'm Thumbody, public education and advocacy in areas such as social housing and poverty.

Future Goals

The PSR Program has made a concerted effort to evaluate the effectiveness of atypical anti-psychotic medications for each client. Newer medications have had a positive effect on negative symptoms of schizophrenia and on cognitive deficits. Although some clients have had to return to injectable medication due to non-compliance, the total number of individuals receiving their medication in injectable form has decreased from 95 to 37.

The PSR Program continues to evolve as gaps are identified. Plans are developed and implemented to address those gaps. For instance, planning for the Transitional Employment Program was started in June of 1999 when ICM and EDC identified a gap in employment opportunities. They met with the Westman Coalition and then worked with Brandon Community Welcome to develop the Transitional Employment Program.

Burntwood

System Characteristics

Context of Service Delivery

Burntwood Regional Health Authority covers an area of 543,900 square kilometers and serves a population of 45,000. The region is sparsely populated with great distances between communities. Some of the communities are linked by rail or road, but many can only be reached by air. The economy is primarily resource-based (mining, hydro-electric development, forestry, commercial fishing, trapping). Unemployment and poverty rates are high (Burntwood RHA, 2001).

The population with SPMI is low, about nine people, and is concentrated in the city of Thompson. People with SPMI tend to move from outlying areas to Thompson or Winnipeg due to lack of services in outlying areas.

The majority of services provided to people with mental health problems are provided within the region. Thompson is the third largest city in Manitoba and, due to great geographic distance to other large centers, people with mental health problems usually receive mental health services within the region. This is particularly true for people with SPMI.

The RHA does not usually provide services on reserve as the Medical Services Branch is mandated to provide these services. The RHA does provide service to First Nations people who access services off reserve. Some service to First Nations residents is also provided out of region as Medical Services Branch offers treatment in either Burntwood or Winnipeg.

Accountability

The Mental Health Manager is directly responsible for the Community Mental Health program and the Community Mental Health Consultation Team, which includes nursing, occupational therapy, social work, psychiatry and psychology services for the inpatient unit. The

team also provides consultation to the Community Mental Health program. Crisis services are provided on a shared basis between Mental Health, Home Care and Family Services.

CMHA provides the Safe House and Ke Na Now Club (day program, vocational / educational supports) under contract to the RHA. Consumer organizations such as CMHA, MSS, ADAM and MDAM are funded by the province and are not directly accountable to the RHA. There is no Mental Health Advisory Committee. It is anticipated that input on mental health issues will come through the District Health Advisory Council.

Integration / Linkages

Due to the small number of providers, linkages between programs are very close and continuity of care is facilitated. For instance, the CMHW provides direct service to their clients in the hospital. Community Mental Health services also appears to have good linkages with the Safe House, Ke Na Now Club and psychiatry services. Linkages with self-help services vary, depending on the person in the position and whether there is a person in the position. The region provides support to the ADAM staff person. The CMHW directly negotiates housing and vocational / educational prospects with community members. Linkages extend beyond referral as the different groups are usually involved in joint planning. Agencies work together and mandates are relaxed to some extent to meet client needs. However, building and maintaining linkages is an ongoing task due to frequent staff turnover.

Regional staff report good linkages with Selkirk Mental Health Centre. Administrative linkages with other regional structures, such as Public Health and Family Services, and with program specialists from Manitoba Health occur through the Mental Health Manager. Program managers from each RHA link though the provincial network of regional managers (Provincial Mental Health Network),

Budget

Funding for mental health has increased as a result of mental health reform. Prior to 1992 Burntwood had four adult CMHW. Three additional adult CMHW were hired in 1996. Funding was also obtained for a full-time psychiatrist and a full-time psychologist. A new ten-bed inpatient unit was established as a result of mental health reform. This represented an increase of nine beds. Funding has also been received for specialized programs, such as the safe house and Ke Na Now Club. Although not in the RHA budget, self-help services are now available in the region.

Monitoring / Evaluation

There is no specific budget for evaluation of mental health services. The Burntwood RHA conducts monitoring / evaluation through the Accreditation team. The region received Accreditation in 2001. Some monitoring occurs at the program level through case audits, file reviews and consumer satisfaction surveys. The RHA was also a participant in the provincial Caseload Review project. Further program evaluation projects are not planned at this time.

Human Resources

Unlike other regions, most of the staff in Mental Health transferred from Family Services at a time when the two were a single organization. Very few of these individuals came with specific experience in mental health service delivery. Education, was provided through the CORE modules to ensure a consistent knowledge base.

Hiring patterns changed when the RHA was established and current applicants often lack experience. The experience CMHW obtain in Burntwood is excellent due to the breadth of their practice: individuals often come on a temporary basis to obtain this experience. Once workers have experience they become very marketable and are recruited by other regions. Staffing is

particularly problematic in outlying areas such as Lynn Lake and Leaf Rapids. These isolated

communities have the most difficulty attracting staff and are likely to have the least skilled

workers despite the fact that the scope of practice calls for experienced staff. This challenge is

not specific to mental health. Family Services and other health services experience similar

challenges in recruiting and retaining staff. The current shortages of nurses and psychiatric

nurses also influences availability of professionals.

Basic and Continuing Education

Historically CMHW took the CORE Modules Training Program, which included a two-

day module on psychiatric rehabilitation. High turnover of staff results in an ongoing need for

this education but Manitoba Health no longer offers the CORE Modules Training Program.

Fortunately, two staff members have preparation in psychiatric rehabilitation and Mental Health

Services does have a specific budget for continuing education. To date, follow up education on

the topic of psychiatric rehabilitation has not been made available to CMHW.

Special Considerations

Distance, staff turnover and resources present special challenges in this region. The

population of Burntwood is largely concentrated in the City of Thompson and outlying

communities are widely dispersed. As a result, most services are concentrated in the city. Even

itinerant service delivery to outlying communities is very difficult to provide due to large

distances between communities. For instance, it may take three or more hours to travel from

Thompson to an outlying community. As a result, a service provider, such as a psychiatrist or

self-help group staff member, would have to spend an entire day to attend a single community.

Further, population size does not support delivery of specialty services, such as mental health

services, in outlying areas.

Due to the small size of the population in isolated communities, a generic worker provides both mental health and family services. Practicing in this dual role presents unique challenges as the two roles may be in conflict. For instance, if the worker has apprehended the children as a Family Services worker, it is difficult for that worker to engage the family to address their mental health needs.

Frequent turnover of staff as well as the entry qualifications and experience of new staff results in substantial ongoing educational needs. The need for specialized basic education in psychiatric rehabilitation and ongoing education in the field must be balanced with a number of other competing priorities. Further, due to distance, the cost of continuing education is substantial in terms of human and fiscal resources. For example, attendance at an education session in Winnipeg involves two days travel time and expenses in addition to the time and cost of the session itself. A short education session can easily cost $1,000 - $2,000 in addition to the workers time.

Frequent turnover of Community Mental Health staff also results in a continuous process of developing connections between mental health service providers in the region, with other programs in the region, and between services in Thompson and individual communities. High turnover of generic workers further complicates development and maintenance of working relationships.

System Components

Psychiatry / Psychology

Until 1996, psychiatry services were provided as an itinerant service out of Selkirk Mental Health Centre. A psychiatrist would come to Thompson once a month for about two days. From 1996 until June of 2001 the Burntwood RHA had a full-time psychiatrist who provided service to both inpatient and outpatient clients. A full-time psychiatrist was hired in

September 2002, with use of itinerant, but more frequent, service provided by SMHC in the interim. During that period, psychiatric services were provided for three days per week, with access to telehealth for a half day per week. The region hired a full-time psychologist in November of 2002.

Case Management

Case management within the city of Thompson is provided by Community Mental Health Services. A multi-disciplinary team using a clinical case management model provides these services. A single provider delivers ongoing service to the client but can access other services, such as psychology.

The CMHW provides supportive counseling and assistance with housing, finances, symptom management, medication monitoring, facilitating access to social services and illness education as required. If the client requires additional support, the CMHW can request a proctor for the client. Proctors provide assistance with such tasks as grocery shopping, cooking, and taking clients to appointments as well as providing opportunities for social interaction and life skills teaching.

CMHW have a mixed caseload of about 35 people. In 1999 clients with SPMI were transferred to a single worker. This worker has a somewhat smaller, although still mixed, caseload of about 30 clients, 10-15 of whom have a SPMI. This worker also provides clinical case management and works with the natural support network and existing community resources such as the Ke Na Now Club. Clients are usually seen in the community. The goal is improvement in client quality of life. There is active follow-up of missed appointments based on need.

Limited service is available outside the City of Thompson. One generic worker provides child / adolescent services out of Lynn Lake with itinerant service to Leaf Rapids and South Indian Lake. One generic mental health worker in Gillam provides both adult Mental Health and Child and Family services. An itinerant child / adolescent worker provides service in Wabowden. The workers provide as much support as possible in the local area, but if clients require specialized services they must relocate. Usually clients relocate to Thompson. The number of generic workers declined when the RHA was established in 1997 and Health and Family Services became separate. Other communities do not have any local service.

Crisis Services

During regular business hours, crisis calls are handled by Community Mental Health services either through the individuals CMHW or, if the caller is not an existing client, through an intake worker. If the caller requires urgent service, they may be seen in the Emergency department at the Thompson General Hospital.

As mentioned previously, prior to establishment of the Burntwood RHA, Health Services and Family Services operated as a single entity. Under this integrated service, after hours calls went to an Emergency Duty Worker (EDW) who handled crisis calls for Mental Health, Home Care and Family Services. The on-call contract workers provided crisis intervention and suicide intervention but only about 10% of the calls were mental health clients. If there were mental health concerns the client was referred depending on needs. A low-risk client would be referred to Community Mental Health services while a high-risk client would be taken to the Emergency Department at the Thompson General Hospital. A client presenting at Emergency was seen by the attending physician and, if necessary, admitted to the one designated mental health bed in the hospital. The role of the EDW has changed with the separation of Health and Family Services

and the opening of the inpatient unit. The EDW now has very few mental health calls. Most after hours calls would go directly to the Thompson General Hospital Emergency and be assessed by the Psychiatric Nurse from the inpatient unit.

There is no crisis line for the Burntwood RHA since the volume of potential calls would not warrant such a line. The Emergency department at the Thompson General Hospital handled crisis calls from the time Health and Family Services became separate until the inpatient unit was established in 2000. The inpatient unit has handled crisis calls since it was established. The inpatient unit also handles after-hours calls from workers in outlying areas. Mobile services, where a team would go out to conduct an assessment, are not available.

The Canadian Mental Health Association established a four-bed Safe House in the fall of 1995. The Safe House provides a place to go for a person in psychosocial crisis but is "a step down" from hospitalization. It does not provide service to individuals: whose primary reason for crisis is substance abuse; who are not chemical free; who have a history of unpredictable behaviour; who are at high risk for suicide; who have severe physical health problems; or whose primary reason for crisis is housing. Occupancy rates are about 60% and the Safe House serves about 80 residents each year. Clients can be referred by Community Mental Health, by the hospital other professionals or, if the client is known to the Safe House, by self-referral. Individuals can stay for up to three weeks but usually stay for about one week. The Safe House provides support and linkage with resources.

The Safe House has been forced to close for periods of time due to lack of staff or lack of funding. The maximum length of closure was about two weeks when there was no funding. Funding is more secure now but the Safe House has had to close over night or for 24 hours if

there was no staff available. Staff are usually lay people and there is frequent turnover of staff in this organization.

Inpatient Services

A new ten-bed inpatient unit opened in the Thompson General Hospital in March 2000. Prior to this time, inpatient care was provided in the one designated mental health bed. Under the Mental Health Act, the designated bed was essential to be able to detain the person on an involuntary basis or to use seclusion for disturbed behaviour. The service provided a safe physical place but did not provide specific services. Regular hospital staff provided patient supervision only. The CMHW provided mental health services in collaboration with the physician. Clients were typically maintained in the mental health bed for three to four days until they were stable and then were transferred to a bed in a general medicine ward. SMHC continues to assist with violent / aggressive inpatients that require more structure and support than can be provided in a small unit.

Selkirk Mental Health Centre provides long-term inpatient care to people whose needs cannot be met by community services. The Burntwood region has been able to maintain most people within the region but high-risk populations, such as persons with Substance Induced Persisting Dementia (formerly Korsakoff's disorder) or brain damage related to solvent abuse, are not suitable for either acute care or a personal care home. For this small group of high-risk people it is unlikely that even greatly enhanced services would enable community living. Further, due to past actions of these individuals and perceived risk, the community may reject the person. The transfer of these high-risk clients to long-term care in SMHC was, and remains, a challenge.

Housing

The RHA does not directly provide any housing for mental health clients. Mental health clients are housed in a variety of living situations including private apartments and supervised living. People that can be supported to live in apartments (with or without proctor support) are usually housed in apartments. Some housing is available to people with mental health needs in an apartment complex operated by CMHA. The Manitoba Housing Authority also has properties in Thompson although people with mental health concerns have limited access. Manitoba Housing (and other landlords) need to be convinced that crises will be tended to and that Mental Health Services will be responsible for any damage before they rent to a mental health client.

A number of clients require supervised living since they do not have the necessary skills to live independently, even with proctor support. The RHA has advertised for Residential Care homes but there has been very little interest from community members in sharing their home with a mental health client. On occasion supervised living for female clients is provided at the YWCA. Clients may also be housed on a short-term basis at the Safe House if necessary. Skill development for independent living is provided through the YWCA or through the Ke Na Now Club.

Provision of housing in the region is complicated by a high turnover of clients, many of whom have multiple problems. An individual with mental health problems, substance abuse problems and social service problems may require housing, but the responsibility for providing housing does not lie exclusively with Mental Health Services. High turnover of clients means that finding accommodation is an ongoing concern.

Housing initiatives were identified as important under mental health reform. Resources to date have been allocated, based on regional priorities, to independent living, a 24-hour Safe

House and the Ke Na Now Club rather than housing. More housing options, such as Residential

Care homes and a group home, need to be developed for people requiring supervised living.

Vocational / Educational Supports

In addition to the Safe House, the CMHA operates the Ke Na Now Club. The Ke Na

Now Club, which was established in the spring of 1995, follows the principles of a Clubhouse,

but is not traditional in that it does not center on a work-ordered day. Work does not appear to be

as central to a persons' identity when employment in the community is low. Employment in

some communities is as low as two to 10%.

The Club is member (consumer) driven organization and members have a strong voice in

decision-making. There are formal linkages between the Club and Community Mental Health if

the client accesses the service through Community Mental Health. To date the Club has not

focused on vocational services, but hopes to move in this direction. The Club operates an "Odd

Jobs Squad" that undertakes a variety of tasks such as lawn maintenance.

The Thompson Supported Employment Program is available for people with physical,

psychiatric or developmental disabilities. A shared program is required as the suitable population

in any one group was not large enough to support a program on an ongoing basis. The program

provides assistance in obtaining employment and supporting individuals in the workplace

through, for example, a job coach. The CMHA also provide vocational services to a small

number of clients as part of individual goals for treatment.

Social / Recreational Supports

Ke Na Now Club also provides a day program. The day program includes life-skills

training and operates as a drop-in centre. The Club also has a social / recreational program in the

evenings. The Club provides transportation to facilitate participation by members.

Consumer Initiatives / Family Self-Help

ADAM, MSS and CMHA currently provide services in Thompson. The MDAM

Outreach Worker position is vacant. Self-help services are largely limited to the Thompson area.

Due to large distances to the outlying communities, and limited staff hours, travel to a single

community could take a whole week of the staff members' time and use substantial financial

resources. Outlying communities are supplied with literature on request.

ADAM was established in 1997 and has been a stable program. The Outreach Worker is

hired for 15 hours per week and provides education for the public and for professionals. For

instance, the Outreach Worker is currently offering educational sessions for teachers on working

with anxious children. ADAM has a resource library and offers two 12-week Cognitive

Behavioural Therapy programs (one for panic disorder and one for social anxiety). ADAM

usually offers a graduate group to provide ongoing support. There has been little interest in

Thompson and a group has not been established. However, graduates of individual courses often

form relationships and continue to provide mutual support outside of established groups.

The CMHA provides health promotion through programs such as "I'm Thumbody" and

participates with ADAM in public awareness initiatives such as Mental Illness Awareness Week.

The CMHA also operates the Safe House and Ke Na Now Club.

MSS offers Hearing Voices workshops and some public education. A limited amount of

individual support is also provided. As with ADAM, the Outreach Worker operates out of her

home. This limits the extent to which certain services, such as individual support, can be

provided. Services are also limited due to the Outreach Worker being hired on a casual basis.

Self-help services in Burntwood experience substantial challenges in providing continuity

of programming due to lack of visibility and difficulty in recruiting and retaining staff. These

organizations typically operate out of the Outreach Workers home and do not have visibility

within the community. With the exception of ADAM, whose staff person is a consumer and

long-term resident of the community, there has been difficulty recruiting and retaining qualified

people to Outreach positions. The positions are part-time and subject to turnover. Filling a

vacancy might take months during which no programs are offered.

Future Goals

Regional staff indicated that there are a number of areas where they would like to

improve services. These areas include increased involvement of First Nations residents in service

planning, reorienting the Ke Na Now Club to a work-ordered day, and stabilizing consumer self-

help. First nations residents receive services but have no input into those services. Mental Health

Services is attempting to build relationship with communities one at a time, but this is a long-

term project.

Consideration has been given to reorienting the Clubhouse to a work-ordered day to

facilitate progress on employment goals. Consideration has also been given to merging consumer

initiatives, such as ADAM, MDAM and MSS, to enable hiring of full-time staff out of a single

office. This would facilitate hiring and would provide program stability.

Central

System Characteristics

Context of Service Delivery

The Regional Health Authority of Central Manitoba serves a population of 97,000 people

and covers an area of 17,443 square kilometers (RHAs of Manitoba, 2000). Central region has

two large concentrations of population and multiple very small populations. Services for people

with SPMI are technically provided across the region, but in reality services are provided almost

exclusively in either Portage la Prairie or Winkler due to difficulty in providing intensive

services on a geographically distributed basis. Clients in need of intensive services tend to

relocate to one of these two centers. There are about 53 people with SPMI living in Central

region, not counting those receiving services from Eden Health Care Services.

As with other regions, mental health services are not provided on reserve. Services are

provided to First Nations people who access services off reserve.

Although some clients choose to access services outside the region due to concerns about

stigma, or established relationships with providers formerly serving Central region, most of the

services provided to people with SPMI are provided within the region. This is due in part to

transportation problems experienced by people with SPMI that limit access to out-of-region

services. A small amount of service for people with SPMI is obtained out of region. For instance,

has placed a small number of clients in need of residential care in facilities outside the region.

Accountability

The Regional Director of Mental Health Services is directly responsible for crisis

services. The Regional director is also directly responsible for a portion of the psychiatry

services, case management and vocational services. The remainder of the psychiatry services,

case management, and vocational services are provided under contract by Eden Health Care

Services, a non-government faith-based organization. Eden Health Care Services also provides inpatient services at Eden Mental Health Centre and supported housing under contract with the RHA. Consumer self-help is independently operated and funded.

The Mental Health Advisory Council, which had been established to facilitate service planning under mental health reform, is no longer in operation. The original task of the committee had been completed and other avenues were established to ensure consumer perspectives were included in planning.

Integration / Linkages

Intensive Case Management services operated by the region and those operated by Eden Health Care Services are coordinated with psychiatric services and vocational supports. Some linkages also exist with crisis services. For instance, if indicated, the ICM and client develop a crisis care plan and share the plan with after-hours service providers. However, the extent of information sharing between ICM and crisis services is limited to some degree by privacy and confidentiality legislation.

Consumer self-help, specifically CMHA, was established in Central region prior to mental health reform and has been somewhat independent of regional services. More recently CMHA and other self-help representatives have been invited to attend monthly provider meetings to facilitate information exchange. The region also makes space available to self-help groups to facilitate service provision in Portage la Prairie. Self-help services are co-located at the corporate offices of Eden Health Care Services in downtown Winkler.

Linkage with services provided by Eden Health Care Services is somewhat challenging at an administrative level due to differences in perspectives on how service should be provided. However, linkages between direct service providers reporting to the Regional Manager and those

reporting to Eden Health Care Services, including EMHC, have been good. Staff work well together and try to be inclusive of each other.

Administrative linkages with other regional structures, such as Public Health and Family Services, with mental health services in other regions through the provincial network of regional managers (Provincial Mental Health Network), and with program specialists at the mental health directorate are through the Regional Director of Mental Health Services.

Budget

Funding for mental health services in Central region has increased substantially under mental health reform. In 1992 there were 7.7 CMHW positions and now community services has 17.7 EFT (equivalent full-time) staff, 11 of which provide service to adult clients. Two additional psychiatrist positions were funded and proctor service budgets were enhanced. Crisis services were also established. Also, although not part of the RHA budget, self-help services are now available in the region.

Funding for new mental health services was protected for a period of three years. Subsequently, under regionalization, all programs have been funded from the RHA global budget. Self-help continues to receive its funding provincially.

Monitoring / Evaluation

There is no specific budget for monitoring / evaluation of mental health programs. After regionalization, like other regions, Central participated in an accreditation process and received accreditation in 1999. A CQI program is in place using AIM standards (Achieving Improved Measurement). Regional management is interested in evaluation and has participated in some specific initiatives but has no ongoing evaluation plan. Specific initiatives include: development of a consumer satisfaction instrument as recommended by the accreditation; evaluation of

psychosocial rehabilitation services in collaboration with the Mental Health Branch, Brandon and Parkland regions; an assessment of housing needs; and participation in the Caseload Review project with Manitoba Health and the other RHAs. It is expected that participation in each of these initiatives will stimulate thinking about practice and facilitate excellence in planning and service delivery.

Evaluation efforts have been hampered by inadequate information. Information on mental health clients and services provided to those clients is submitted by the region to Manitoba Health but is not available for analysis by the region. The region is considering their information needs in developing a plan for ongoing monitoring and evaluation.

Human Resources

There has been minimal turnover in staff, and Central region has been able to attract sufficient qualified staff for available positions, including term positions. Notable exceptions have been psychiatry and psychology. Although there is a psychologist at Eden Mental Health Centre, the region does not have a psychologist and has no access to psychological testing. There has also been difficulty in recruiting and retaining psychiatrists to work in the region. The region participated in a Manitoba Health physician training initiative designed to improve the number of psychiatrists outside of Winnipeg and Brandon. Under the initiative, physicians were provided with training in psychiatry. Both physicians from Central region taking part in the initiative now specialize in child psychiatry. There continues to be a shortage of psychiatrists for adult clients.

The number of staff has generally been sufficient for the population served. However, greater flexibility allowing staffing where it is needed for the time it is needed would be of benefit. The ability to tailor existing services so they work better together would also be desirable.

Basic and Continuing Education

Two CMHW were provided with extended preparation in psychiatric rehabilitation (10 full days training). Psychosocial rehabilitation was also taught as a module in the CORE Modules Training Program that was offered by Manitoba Health. Although this program is no longer offered, stable staffing in the region has meant that both ICM have had some exposure to education on the topic. Continuing education is a growing need for all mental health workers, particularly in the absence of the CORE Modules Training Program. Regional management has recognized this as an issue and a continuing education plan is in development.

Special Considerations

There are a number of challenges unique to Central region, including the faith-based nature of a substantial segment of the service delivery, distinct populations with differing needs, and numbers and distribution of the SPMI population. Eden Health Care Services is generally responsible for inpatient services for Central region[11]. Eden Health Care Services also provides outpatient services, housing, and employment services for residents of the two municipalities surrounding Winkler. Delivery of these services is guided by the values and beliefs of the organization, and may not be consistent with best practices as described in national documents. Differences in the values base also places some limits on collegiality. Further, on occasion, tension over control of services and concern about loss of services creates a difficult political climate.

Regional planning is complicated by the heterogeneity of the population. The population in the two large centers differs substantially, and the needs of each population also differ. Anecdotal information suggests that people in the northern part of the region are healthier, more

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[11] Eden Health Care Services reports to a Mennonite Churches Board that represents synods from several regions. This means that clients from other regions are also served by Eden Health Care Services.

independent and better able to articulate their needs than people in the southern part of the region.

There are few people with SPMI in the region generally and in particular in the northern part of the region. While the cause of the low numbers is unknown, it is possible that this is related to historical lack of access to inpatient services. Consumers have been maintained in the community and appear to have less disability as a result. In part because of low numbers and in part because of the distribution of population, provision of services outside large centers is very difficult.

System Components

Psychiatry / Psychology

Historically, psychiatric consultation was provided under contract by Eden Mental Health Centre (EMHC) or by an itinerant psychiatrist from Winnipeg. Under mental health reform, Central region was funded for two additional psychiatrists. One and one half of these two positions were assigned to EMHC. At present, one psychiatrist provides consultation three days a month for all adult clients (adult acute, rehabilitation and psychogeriatric programs) in the northern part of the province, and one day per month in the southern part of the region.

Case Management

Intensive Case Management services are provided directly by regional services in the north and through Eden Health Care Services in the south. Intensive Case Management services in Portage la Prairie were initiated in the fall of 1993. Two staff members are specifically identified as ICM. Each worker serves approximately 25 people with SPMI. Workers practice using a rehabilitation model. They provide assistance with symptom management, administration and monitoring of medications, illness education, advocacy and facilitation of social services. Assistance with basic needs and instrumental functioning is also provided either directly or by

proctors who are supervised by the CMHW. Active outreach, such as follow-up of missed appointments occurs, depending upon knowledge of the individual and their patterns of behaviour. Service is generally provided in the community and tends to be focused on the individual client rather than the client support network. ICM services provided by Eden Health Care Services are largely the same, although practice in this setting is more facility-based.

To some degree, ICM work in isolation. A variety of team members are available for consultation but this has not yet translated into team-based service delivery. Team-building efforts have been identified as a priority for the region. ICM services are available during regular hours during the week, with crisis services providing coverage in the evenings and on weekends.

Eden Health Care Services provides case management to clients in the south part of the region. There are no identified ICM. However, there has been an attempt to reduce caseload size for workers providing service to the SPMI population. Also, since Eden Health Care Services provides an integrated service including housing, employment training and social / recreational options, the need for intensive case management may be reduced.

Crisis Services

Crisis services in Central region include a crisis line and a Safe House. The crisis line, known as Mobile Crisis Services, differs substantially from mobile crisis services in other regions. Planning for Mobile Crisis Services involved consideration of a variety of funding mechanisms that would ensure adequate service without promoting over-servicing. The result was a service operated on a contract basis. Providers are paid a retainer for providing the service, rather than fee-for-service. The planning also involved consideration of historic patterns of calls to after-hours services. Since almost 97% of calls were handled by phone, the service was established as a crisis line rather than a mobile crisis service. Service providers work alone rather

than in pairs and are actively discouraged from going out to calls. If it is necessary to meet with a caller, the service provider meets with the person at a safe location, often a hospital emergency room. In the event that the caller is at risk of injuring self or others, police are called to provide transportation.

Mobile Crisis Services were established in January of 1999, with phone lines in both Portage and Winkler. There are no offices. The service operates after office hours during the week and 24 hours on weekends and holidays. Calls to Mobile Crisis Services are forwarded to an on-call Crisis Worker. Crisis Workers are all professionals with other positions in the region. Additional training is provided. Again in contrast to other regions, there has been virtually no turnover in staffing for this service. The service receives approximately 50 calls per month.

The Karen Devine Safe House was established in 1996. The Safe House is "a residential setting where adults with mental health problems can go when they need to work things out in a safe, supportive and caring environment." (Central Manitoba RHA, n.d.). The Safe House provides a supportive environment, information and access to community services. A maximum of four guests can stay at the Safe House at any one time, and stays are usually limited to between five and seven days. ICM may work with clients staying at the Safe House. People who present a risk of self-harm or violence, are intoxicated, have outstanding criminal charges or severe physical or mental problems cannot use the Safe House.

The safe house uses a peer support model with para-professionals hired on a casual basis when there are people in the house. Staff members have empowerment training and mechanisms are in place to provide feedback on the experience. The service appears to be very acceptable to consumers and consumer organizations.

Inpatient Services

Plans for inpatient services for Central region included beds at EMHC and in Portage la Prairie. Using a ratio of about 20 beds per 100,000 population, it was determined that the region had enough beds but that they should be redistributed with EMHC keeping 12 acute beds and transferring eight acute beds to a new unit at Portage District General Hospital. Redistribution of the beds was very contentious and there was insufficient political will to ensure redistribution. An inpatient unit was built at the Portage District Hospital but was never opened due to difficulty in recruiting psychiatry. Subsequently, the unit developed problems with mold and opening was delayed further while the problem was rectified. The RHA requested a group of stakeholders to make recommendations about the future of the unit. After an extensive consultation process and review of new service models the group recommended that the role of EMHC within the region be clarified, and their capacity to provide acute inpatient service in an atmosphere not constrained by religious beliefs or practices be reviewed.

Eden Mental Health Centre is a 40-bed inpatient facility with 20 beds allocated for acute clients. Ten beds are allocated to psychogeriatric clients and the remaining 10 are allocated to rehabilitation clients. The facility is located in Winkler and is operated by Eden Health Care Services. The facility provides inpatient services to the Central Manitoba RHA under contract. People who consider EMHC inappropriate receive inpatient services in Brandon or Winnipeg.

Clients requiring long-term supervised care are placed in residential care homes, personal care homes or at Eden Mental Health Centre. On rare occasions consumers have been placed at a residential care home out of region or at SMHC. There are only a few residential care homes in the region and no group homes.

One population with a need for long-term inpatient care is people with an acquired brain injury. This is a small population making it difficult to support comprehensive services. Some of these individuals have been placed in personal care homes even though they do not meet the age criteria. Eden Mental Health Centre uses some of its beds for relatively long-stay clients.

Housing

As with other areas of service delivery, availability of housing differs between the north and the south areas of the region. A range of supported housing options is operated by Eden Health Care Services in the south. These services, which predate mental health reform, include a fully supervised residence for eight people and an apartment complex. The residence, Linden Place, provides transition for consumers leaving EMHC and in some cases substitutes for care at EMHC. Consumers usually stay for 18 months to two years. Linden Place offers rehabilitation including life skills training and literacy programs. The apartment complex, Enns Court Apartments, offers housing on a subsidized basis for mental health clients and those disadvantaged by finances. This housing is an important resource in an area where industry is growing and affordable housing is limited.

Consumers in the north historically lived with families or independently. The population of this part of the region has not changed substantially. The type of housing available to individual consumers depends upon their income and cycles in vacancy rates. In Portage la Prairie, supported housing has not been developed specifically for people with SPMI. However, Portage la Prairie does have a sizable number of subsidized housing units. These Manitoba Housing Authority properties were initially designed as elderly persons housing. The housing units often offer meal programs and are close to public transportation. However, in order for a person to live in these buildings they must adhere to rules for elderly persons' housing. This

means that consumers are not allowed visitors except family, no late nights and no noise. Individuals who are potentially disruptive are also not eligible to stay in these units.

Until recently, locating suitable accommodations for clients in the north was not a problem. With growing industry and declining vacancy rates housing has become more of a concern. The north recently devoted part of a position to developing supported housing. The first task of the Housing Facilitator was to conduct a housing needs assessment for the northern part of Central region. The report (Park, 2002) documents several barriers to obtaining and maintaining housing. It also reports limited availability of appropriate and affordable housing. Limited availability results in some clients remaining at the Safe House or in hospital for extended periods of time while waiting for suitable accommodation, or living in substandard accommodations. There is also some need for supervised living accommodations.

Housing does not appear to be a problem in small towns and villages. In areas where people have been moving away, good quality housing can sometimes be obtained for minimal cost. However, these small towns may not have any services. Residence in small towns is therefore dependent upon factors other than availability and cost of housing.

Vocational / Educational Supports

Eden Health Care Services provides some vocational services under contract to the Central Manitoba RHA. These services are not new. Service is provided at the Trainex Centre, a workshop that is designed to prepare people for, and assist in obtaining, employment. Service at the Trainex Centre is provided to a range of clients including individuals with mental health problems, recent immigrants, recipients of social allowance and other individuals with employment problems. A three-week assessment is followed by development of a vocational plan and skill building at the Centre. There is also a work experience program with community

businesses. Assessment services have been well used by the RHA, but access to other services is somewhat limited for mental health clients. The program is best suited to individuals who have been in long-stay environments.

Employment Development Services were established as a reform initiative. Relatively low caseload numbers and lack of quick results created pressure on the position. It was reduced to a half-time position, which resulted in a great deal of staff turnover. Intensive Case Managers attempted to provide this service when the EDC position was vacant. However, providing supported employment requires knowledge of the intricacies of the bureaucracy at Human Resources Development Canada. It takes time and effort to learn how to negotiate the bureaucracy making it difficult for service providers such as ICM, who have multiple roles, to develop the expertise. Further, existing resources were only suitable to job-ready clients. Pre-employment services that address hygiene, coping skills and job skills were not available.

The half-time EDC position has now been combined with the half-time housing facilitator position to create a full-time position. In addition to facilitating housing, this person is expected to provide supported employment and to network with other agencies providing vocational and educational supports in the area. This individual works with the two ICM as a team to provide services to people with SPMI.

CMHA recently began operating "Routes to Real Work", a federally funded employment initiative separate from regional services. The initiative involves provision of supported employment in mainstream work environments and development of consumer operated businesses. CMHA and regional staff work as a team. CMHA works with the EDC and ICM with some clients, and partners on development work.

Social / Recreational Supports

In Portage la Prairie, CMHA offers a consumer driven and operated peer support drop-in program. The program is well attended and provides social and volunteer opportunities for consumers. CMHA also periodically organizes special events or trips to, for instance, Winnipeg. Further, CMHA is present in Winkler one or two days a week to provide social / recreational opportunities.

Eden Health Care Services offers the Community Choices Day Program on a mobile basis to provide social, recreational and life skills programs to individuals in residential care settings operated by Eden Health Care Services. The program was established in 1996 but to date has not received funding.

Consumer Initiatives / Family Self-Help

Compared to other regions, self-help services were slow to be established in Central region. The delay offered an opportunity to benefit from the experience of other regions and to consider a variety of models. As a result, ADAM, CMHA, MDAM and MSS collaborate on a number of initiatives and share responsibilities for others. For instance, the above groups collaborate with others to offer a yearly consumer retreat at Camp Assiniboia for about 50 people. The groups also collaborate on public health promotion and illness education initiatives. Responsibility for representing consumers on committees is shared. For instance, ADAM assumes responsibility for participation in the Mental Health Advisory Committee and the Accreditation Committee while MSS assumes responsibility for participation on the Suicide Awareness Committee. Each group provides referral to community resources and most have a resource library.

ADAM and MSS are co-located with the corporate offices of Eden Health Care Services in downtown Winkler. CMHA, which existed in Central region prior to mental health reform, expanded its offices in Portage la Prairie. The self-help groups share space so that CMHA can provide service in the south one or two days a week and ADAM and MSS can provide service in Portage la Prairie.

Each organization also offers specific services. ADAM offers two 12-week Cognitive Behavioural Therapy programs, one for Panic Disorder and the other for social anxiety, and operates a peer support group for graduates. The ADAM Outreach Worker is a member of the region's Accreditation Committee and the Mental Health Advisory Committee. CMHA participates in regional mental health committees, provides a quarterly newsletter, operates a drop-in program and supported employment.

MDAM primarily offers individual and family education and support at this time but plans to establish peer support. There is no resource library since the Outreach Worker is home based. There is a resource library available at the MDAM main office in Winnipeg. The Outreach Worker attends monthly Mental Health Team meetings. The current Worker has been in the position since the summer of 2003. Prior to this, the position was vacant for six months.

MSS offers education for professionals such as health professionals, police and corrections staff at the jail in Headingly. Peer support groups are offered weekly or bi-monthly in Portage la Prairie and Winkler with an additional group starting at Headingly jail in January, 2003. Family support groups are held monthly in Portage la Prairie and an eight-week family psychoeducational program will be offered in January.

Outreach Workers for ADAM, MDAM and MSS each work about 30 hours per week and need to include fundraising in their responsibilities. Funding for self-help services has been an

issue. The current level of funding limits the ability of these groups to provide services and be a resource to other providers. There has been minimal turnover in staff for ADAM and MSS.

Future Goals

The Central Manitoba RHA identified several goals on the basis of feedback from the 1999 accreditation. The goals include: 1) making services more user and family friendly; 2) increasing integration of empowerment and recovery models in service delivery; and 3) improving collaboration with consumer organizations.

Families provide information to facilitate service planning but are often information is not shared with them. Inclusion of the broader client system in provision of services would enhance knowledge and skills of family members and independence of consumers.

Services for people with SPMI currently reflect the rehabilitation model. Use of a personal strengths model would be more consistent with consumer empowerment and recovery. Services are gradually moving in this direction but reorientation is an ongoing process.

Historically CMHA operated somewhat in isolation of regional services. Initiatives have been implemented to increase knowledge of regional staff about consumer organizations. For example regional staff attended a consumer conference as observers rather than as participants. Initiatives have also been implemented to increase collaborative service planning. For instance, all self-help groups regularly attend monthly staff meetings to share information and stimulate discussion.

Interlake

System Characteristics

Context of Service Delivery

The Interlake Regional Health Authority covers an area of 26,000 square kilometers and serves a population of 74,396. About 50 people with SPMI live in the community in the Interlake region. As with most other regions, mental health services are not provided on reserve but are available to aboriginal people off reserve.

The Selkirk Mental Health Centre, a provincial psychiatric hospital and the designated long-stay facility for the province is located within the region. As a result, a substantial number of people with SPMI are concentrated in Selkirk. However, people with SPMI are located throughout the region. Some specialized services are available only in Selkirk but others, such as EDC, operate as regional services. CMHW are located in all areas of the region.

Availability of community resources, such as housing, recreation and employment, and community based crisis intervention services that would meet the needs of people with SPMI was limited prior to mental health reform. Individuals who could not be supported by the Community Mental Health program would often relocate to Winnipeg for service. Increased availability of community-based services has enabled more consumers to remain in the Interlake region. Further, clients living in the Interlake region but seeking services in Winnipeg are usually referred back to Interlake. As a result, most service to the SPMI population is provided within the region. In fact, many areas now look to Interlake to provide services not available in their regions.

Accountability

The Mental Health Program Manager is directly responsible for all community based mental health services including the Adult Mental Health and Psychososcial Rehabilitation

Programs, psychiatry and psychology services, and the Proctor Program. The Mental Health

Program Manager is also responsible for services provided on a contract basis by Non-

Government Organizations, including the crisis services, supported housing and residential care

services, and the support centers.

Funding for crisis services flows through the Interlake RHA to Salvation Army Crisis

Services. Although the budget is determined by, and provided by, Manitoba Health, crisis

services are accountable to the Interlake RHA for meeting community needs. Housing services

are provided by CMHA under contract to the Interlake RHA.

As with other regions, self-help services are funded directly by the province. However,

these services are also accountable to the region for services. Selkirk Mental Health Centre

reports directly to Manitoba Health.

The Interlake region has an active Mental Health Advisory Council. The original

mandate of this group was to assist in planning reform. Although the Council is not part of the

formal structure of the Interlake RHA, it serves a monitoring function and raises issues of

concern. This body also provides a consumer and family voice at the Provincial Mental Health

Advisory Council.

Administrative linkages with other regional structures, such as Public Health, Home Care

and Family Services occur through the Mental Health Program Manager. Mental Health Services

works to promote shared ownership of responsibility for individuals who don't clearly meet the

mandate of any program. Flexibility in mandates facilitates meeting client needs. Program

managers in each region link though the provincial network of regional managers (Provincial

Mental Health Network),

Integration / Linkages

ICM, EDC and the Resource Developer work closely together as the PSR unit. Psychiatrists and Psychologists are not members of the team but consultation services are available. The PSR unit also shares clients with, and works closely with, the supported housing program and social / recreational programs. Meetings are held at minimum on a quarterly basis.

Regional mental health services are linked to SMHC through a variety of mechanisms. The Mental Health Program Manager attends program planning meetings of the short-term and long-term treatment programs, rehabilitation program and extended care. CMHW provide information to SMHC on their clients if they are admitted. CMHW also attend planning and pre-discharge planning for their clients. Further, SMHC has a liaison worker to facilitate linkage with the regions SMHC provides service to. Further, there is some sharing of human resources with SMHC. SMHC staff are periodically seconded to work in community programs and some of the SMHC medical staff provide psychiatry and psychology services to the Interlake RHA on a contract basis.

Linkage between Community Mental Health Services and Crisis Services work effectively through a liaison protocol. CMHW / ICM and crisis services communicate about clients under the Personal Health Information Act provisions for sharing of need to know information. The Program Manager meets with crisis services on a quarterly basis to discuss budget and program objectives. Meetings are also held to work collaboratively on specific issues, such as implementing an emergency proctor service.

The self-help organizations in the region have good linkages with each other. The extent of linkages with Community Mental Health services differs depending on individuals in particular locations.

Budget

The budget for mental health services in Interlake virtually doubled with mental health reform. Roughly three million dollars from the closure of acute care beds in Winnipeg was allocated to Interlake, North and South Eastman. A substantial portion of this money was allocated to crisis services, EDC, housing, PSR, support centres and self-help services. Outpatient services from SMHC, and staff that had been providing those services, were transferred to the Interlake RHA. The Interlake RHA also acquired staff from the SMHC School of Psychiatric Nursing when the School closed. The Interlake RHA spends about $120,000.00 each year for proctor services. The Interlake RHA has also contributed funding to self-help in order to facilitate delivery of services on a distributed basis throughout the region.

The budget for mental health services is not protected. Money has been reallocated within mental health programs, such as moving money from crisis services to proctor services but, with one exception, the resources have not been reduced. About $20,000 of proctor funding was redistributed to Brandon and Parklands after funding for the Additional Care and Support Program ended.

Monitoring / Evaluation

There is no specific budget for monitoring and evaluation. The region received Accreditation in 1998 and 2001. The Mental Health Planning Team addresses continuing improvement and accreditation surveys. The region also anticipated an evaluation of crisis services funded by the Provincial government. To date this evaluation has not taken place.

Human Resources

There has been minimal turnover in staffing in regional mental health programs and in the PSR program. Key people have been retained. To date mental health programs have been able to attract qualified applicants and have been able to draw experienced staff from SMHC.

In contrast, the crisis service has experienced substantial difficulty in recruiting and retaining qualified staff. The Crisis Unit was closed temporarily in 2000 due to staffing shortages. Instability in staffing results in large part from salary rates substantially below rates offered by other employers.

Basic and Continuing Education

The mental health program has invested substantially in education in PSR. Between 1999 and 2001, practitioners in Interlake and North Eastman collaborated with CMHA and the Support Centres to offer peer training in PSR. The meetings included case discussions and presentations on psychosocial rehabilitation and served as an educational forum as well as providing an opportunity to consult with peers. Some of the CMHW / ICM from Interlake were instrumental in organizing a Manitoba chapter of the International Association of Psycho-Social Rehabilitation. The Resource Developer / ICM is certified to provide overview training in Psychiatric Rehabilitation on the basis of attending a training for trainers course.

Special Considerations

Mental health service delivery in the Interlake region is affected by a number of factors specific to the region. These factors include the timing of reform initiatives, strength of the Mental Health Advisory Council and influences resulting from the presence of a provincial mental health facility.

The planning of mental health reform initiatives for Interlake and Eastman began in September 1993 and continued until 1995. This was later than some of the other regions and provided an opportunity to learn from others experiences.

The Mental Health Advisory Council in Interlake is one of the most successful in the province and has had a substantive influence on mental health services in the region. The success is due in part to the efforts of a Resource Developer who invested heavily in supporting consumer and family involvement in these groups. There are a number of opportunities for consumers to participate in an advisory capacity in the region.

The presence of SMHC continues to influence community services in many ways. Some of these influences include: 1) a tolerance of difference in the town of Selkirk related to SMHC being a major employer, and; 2) acquisition of consumers from other regions. Consumers who have had lengthy hospitalizations at SMHC can become disconnected from families and social support networks in their home regions. Also, where needed services are not available in the home region, consumers remain in the Selkirk area. Although this acquisition appears to be comfortable both for consumers and community members, the extent to which a single community can absorb and provide service to the population with existing resources is uncertain.

System Components

Psychiatry / Psychology

Two psychiatrists from SMHC each provide one half-day of psychiatric services per week on a contract basis to the Triple S area (Selkirk/St. Andrews and St. Clements). The rest of the region is served by a half time (0.5 EFT) Psychiatrist who travels to the four districts in the Interlake.

A 0.33 EFT Psychologist based in Selkirk travels to the rest of the Interlake to provide service and consultation to Adult Mental Health programs.

Case Management

Case management for SPMI clients is provided by ICM (1.25 EFT) and a full-time EDC who has a separate full caseload. Each EFT serves 15-20 clients. ICM was established in 1994 / 95 and EDC was established in 1997. Both use the Boston University Rehabilitation Model as a basis but the EDC program integrates components of other models, such as the "Choose, get, keep" model. ICM / EDC services include advocacy, facilitation of social services, direct assistance with symptom management, crisis intervention, skill teaching and resource development, administration and monitoring of medication, medication and illness education, assistance with basic needs and instrumental functioning in the context of a long-term clinical relationship. Assistance is also provided in meeting housing and social / recreational needs. Active outreach and service provision in the client's natural environment is characteristic. A major component of ICM/EDC work is the inclusion of family in the clients system and working with the family and any natural supports the client identifies.

A further 25 people meet criteria for PSR programs but are maintained on Community Mental Health caseloads while on the PSR waiting list. Adult Community Mental Health caseloads often exceed ninety clients. These clients would have less intensive outreach. Other services would be provided but not in the same depth. In this instance, proctors are used to provide assistance with basic needs and instrumental functioning.

The Mental Health Program believes that caseload size is critical to provision of a quality service for people with SPMI. Efforts have been made to protect the integrity of the program by limiting the number of clients on ICM / EDC caseloads. This has resulted in satisfaction by providers and minimal turnover. This in turn has allowed practitioners to increase their skills within the rehabilitation model.

Crisis Services

The Salvation Army provides crisis services, including mobile crisis and crisis stabilization services, to the Interlake RHA. The service was established in 1996 and operates out of Selkirk. This unit also provides service to the North Eastman RHA.

Case managers are responsible for crisis response during business hours. After hours services are provided by the mobile crisis service which will respond to calls and travel anywhere in the Interlake or North Eastman region. The mobile crisis team provides crisis intervention, assessment, and makes recommendations for service. The service operates from 2:00 P.M. to 2:00 A.M. weekdays and 8:00 A.M. to 2:00 A.M. on weekends. The overlap between hours of CMHW and crisis services is designed to facilitate continuity of care by offering an opportunity for information exchange. During the overnight hours (2:00 A.M. to 8:00 A.M.) the phone line is answered by the CSU but there is no mobile service.

The Crisis Stabilization Unit has eight beds and is a 24-hour service. It provides assessment, treatment and discharge planning for individuals with an emotional or psychiatric crisis. Individuals who require a secure environment, such as those who are at high risk of suicide, have demonstrated violent behaviour or have severe physical health problems, are not eligible for service. Staffing the CSU has posed problems at times and, at one point, was closed for a week due to staff shortages. Staffing was not a problem at the time of interview. Proctor services have been provided when an individual was in General Hospital and a crisis bed was not available. However, this is not appropriate if the persons is under an order for a Psychiatric Examination under the Mental Health Act.

Inpatient Services

Inpatient services have not changed in the Interlake RHA as the SMHC is located within the region. Inpatient psychiatric services are provided at SMHC or, depending on the suitability of the placement, in local hospitals. SMHC provides "short term and acute inpatient mental health services to Manitoba residents of the Interlake, North Eastman, South Eastman, Burntwood, Nor-Man and Churchill Regions" (SMHC, 2002). SMHC has 261 inpatient beds, 27 of which are designated for short term and acute services.

SMHC has an Extended Treatment and Rehabilitation Program and is the designated long-term inpatient treatment facility for the province. This program provides services to individuals whose needs cannot be met through other services. SMHC also provides a Community Preparation Program and Forensic Rehabilitation Program. Clients in the Forensic Rehabilitation Program receive treatment by virtue of their legal status.

Long-term residential care is also provided in approved homes, which are 24-hour supervised residences. These residences are part of the CMHA Housing program and are described below.

Housing

Housing supports are provided by CMHA under contract to the Interlake RHA. Services include approved homes and supported independent living. CMHA is responsible for licensing and inspecting the approved homes. Approved homes provide 24-hour care to three or fewer residents in a family setting. Many of these homes existed prior to reform and are concentrated in the Selkirk area. Efforts are being made to increase availability of approved homes in other locations. The Mental Health Advisory Council has identified that there is a major difficulty with housing in the Interlake. Approved homes are not considered the environment of choice for a

number of people with SPMI. A need has been identified for alternative housing such as group homes or increased support for independent living.

Supported independent living is based on the "Choose, get, keep" model. Consumers are provided with itinerant support to facilitate living in the environment of choice. Examples of support include, assistance with paying bills, skill teaching for home maintenance, cooking, acquiring resources (dishes, linen etc.), as well as learning interpersonal skills needed to live in community.

Housing within Income Security rates ($285 per month for rent) is limited in Selkirk. On occasion two people will live together and share the rent. However, some of these individuals would prefer to live independently and sharing an apartment may not be their environment of choice.

The Manitoba Housing Authority in the Selkirk area has made it possible for consumers to live in Elderly Persons' Housing by reducing the age limit. A number of clients live in two Manitoba Housing Authority apartment buildings. Further, the Housing Authority partnered with the Interlake RHA to develop a supported community residence. This residence is a single-family dwelling where two consumers live independently. While the home situation is ideal, and a model the region aspires to, there have been some difficulties with this situation. For instance, the landlord required that CMHA be the official tenant and that CMHA have insurance against damage.

Robinson Place Apartments is another living environment available to consumers in Selkirk. The Selkirk and District Support Centre collaborated with CMHA to offer housing in the apartment block to people with mental illness and to people with low income at the Manitoba Housing rate (25% of income). The apartments are large and have a separate bedroom. A Board

with consumer representation operates the Apartments. About 50% of the tenants are people with a mental illness. The initiative has been extremely successful in terms of reducing stigma and promoting living satisfaction for all the tenants.

In planning for mental health reform, a conscious decision was made to keep residential care settings small. Some debate exists about whether a Level 5 group home with 24-hour staffing would enable discharge of some clients currently residing at SMHC. This debate has not been resolved.

Vocational / Educational Supports

The Interlake region has a full-time EDC who provides vocational / educational supports for people with SPMI. The EDC is located in Selkirk but provides service to the entire region. This individual links clients with existing resources. For instance, the EDC will assist clients to find employment or arrange for education programs that already exist in the community. The EDC also facilitates access to Vocational Rehabilitation Services, which provide assessment, training and support to individuals with disabilities, including those with psychiatric disabilities.

The Selkirk Support Centre is currently offering a pre-employment program that enhances confidence and provides training in basic work skills. This program links with the "Sunflower Café" at the Selkirk Mental Health Centre, which is a consumer-operated business.

Social / Recreational Supports

Social / recreational supports in the Interlake region are provided by the Selkirk/Interlake Mental Health Support Centre Inc. under contract to the Interlake RHA. This non-profit organization is run by a board and operates Support Centers in Ashern, Arborg, Lundar and Selkirk. These Centres provide a safe place for consumers to meet friends, connect to the community and community events, socialize, problem solve, and obtain basic support. Many

persons discharged from SMHC begin participation at the Centre as a means to reconnect, or

become reoriented to, the community. Each Centre has a lunch program and hosts social events,

such as barbeques and Christmas parties. Centres may also offer some unique services. For

instance, the Arborg Support Centre has a Thrift Shop. Proceeds of the Thrift Shop largely cover

expenses for the meal. About eight consumers attend the Arborg Support Centre daily on a drop-

in basis for movies, games and conversation. The Arborg Support Centre opened in 1996 and the

Lundar Support Centre opened in 2002.

Consumer Initiatives / Family Self-Help

The self-help groups have a very strong presence at SMHC. An office is provided on-site

by SMHC and each organization spends a portion of their time at that site to connect with

patients and their families.

CMHA provides a number of services in the Interlake region, including housing supports,

advocacy, and public education. The organization participates in regional and provincial

committees, and collaborates with others to stage some social events. The organization does not

have an active role in self-help although consumers are represented on their Board of Directors.

Delivery of self-help services across the region was facilitated by a strategic decision to

locate the offices "anywhere but Selkirk". Experiences in other regions suggested that services

tended to meet local needs before regional needs and, since resources are limited, location of

self-help outside the major center was critical. This year, in each quadrant of the region, the self-

help organizations have collaborated to offer a series of workshops to the public on topics such

as anger management, stress management and mental health awareness.

ADAM, MDAM and MSS all have good relationships with one another and at one time

shared office space. Over time the organizations began to function as home-based organizations

so that resources could be used for travel and services rather than "bricks and mortar". These organizations collaborate on a number of events, including social events. All three have resource libraries and participate in public education, including health fairs, schools and workplaces. Each Outreach Worker is hired for about 30 hours per week. There has been minimal turnover in Outreach Worker positions.

ADAM was established in 1994 and operates out of Teulon. The Outreach Worker has been in the position since it was established. Public education is offered as well as education of staffing facilities such as SMHC and Stoney Mountain Penitentiary. Advocacy is offered through participation on the Mental Health Planning Committee and Accreditation Committee for the Interlake RHA. ADAM offers two 12-week Cognitive Behavioural Therapy Programs. Graduates of these programs participate in a mutual support group. Information is provided to families to assist them to support the person with an anxiety disorder.

The MDAM Outreach Worker participates on the Regional Mental Health Planning Committee and the Mental Health Advisory Council. Individual and group support is provided to consumers. Groups include education and peer support. These groups currently operate in Ashern, Lundar, Selkirk and Stonewall. About four of the 30 hours per week are allocated to work with inpatients at SMHC to create linkages and facilitate transition to community living. Family support is limited at this time. There has been very little turnover in this position.

The MSS Outreach worker has also been consistent over time. The MSS provides support to consumers and families, individually and in groups. Consumer groups currently operate twice per month in Gimli, Selkirk, Stonewall and the Stoney Mountain Penitentiary. Family groups are held monthly in Ashern and Selkirk.

Nor-Man

System Characteristics

Context of Service Delivery

The Nor-Man region is distributed over 72,000 square kilometers and is second only to

Burntwood in size. The Nor-Man RHA serves a population of 25,000 (Regional Health

Authorities of Manitoba, 2000). There are two main population centers and a number of outlying

communities. People with SPMI are located throughout the region. Community Mental Health

Services has offices in the Pas and Flin Flon. Itinerant services are provided to outlying

communities, including Cormorant, Cranberry Portage, Easterville, Grand Rapids, Moose Lake,

Pukatawagan, Snow Lake and Wanless. Itinerant service is also provided to Sherridon as needed.

CMHW visit these communities weekly or bi-monthly. There are about 27 people in the Nor-

Man region with SPMI.

Nor-Man differs from other regions with respect to providing services to First Nations

people on reserve. Nor-Man has been flexible about providing service on reserve and workers

have established good relationships with federal service providers. Health services were

supposed to be transferred to local community control under health transfer agreements between

the Federal government and First Nations communities. Community Mental Health will continue

to provide service until the transfer has taken place.

The region is relatively isolated so most service to consumers with SPMI would be

provided within the region. The region does provide some service to people from outside the

region since Creighton, Saskatchewan is contiguous with Flin Flon. However, service boundaries

are respected as much as possible.

Accountability

CMHW for children, adults and elderly adults report to the Mental Health Program

Manager. In order to provide supervision in both of the main settlement areas, there is also a

Nurse Manager/Clinical Supervisor. Psychiatry and psychology services, and the Nor-Man adult

acute care psychiatric inpatient unit at the Pas Health Complex, are also accountable to the

Mental Health Program Manager.

Crisis services are provided on a shared basis between Mental Health, Family Services,

Public Health, Community Living and Home Care. As with other regions, self-help services are

accountable through their provincial body to Manitoba Health. There are no specific housing,

vocational / educational or social / recreational services that report to Mental Health Services.

Integration / Linkages

Linkages between Mental Health Services and the crisis services are informal. If CMHW

have a client they feel is, or may be, in need of on-call services, they leave information for the

on-call worker to be used if required. In the event that on-call service is provided, crisis work is

documented and forwarded to the CMHW. Consumer organizations participate on the Regional

Mental Health Advisory Council, although the Advisory council is not currently active.

Due in part to the small number of individuals involved, close working relationships exist

with other health and social services. These services are co-located and individuals know each

other well. Familiarity and a value on maintaining positive working relationships facilitate

discussion and resolution of concerns. Mandates are somewhat flexible in meeting needs.

Linkages with other departments are not as close, but the size of the community means that

people know each other personally. Traditionally, monthly meetings were held with decision-

makers on reserve to coordinate services. However, these meetings were on hold at the time of

writing (April 2003) due to a vacancy in the Nurse Manager / Clinical Supervisor position.

Administrative linkages with program specialists from Manitoba Health occur through

the Mental Health Program Manager. Program managers in each region link though the

provincial network of regional managers (Provincial Mental Health Network),

Budget

The budget for the Nor-Man region was increased as a result of mental health reform to

include two new positions: a Child and Adolescent Mental Health Worker and an adult CMHW.

A new eight-bed inpatient unit was established and, although not in the RHA budget, self-help is

now available in the region. In addition, proctor services have been better used since the region

assumed responsibility for the program.

Monitoring / Evaluation

Although there is no specific budget for evaluation, the Nor-Man region has participated

in some specific initiatives. These initiatives include an ongoing satisfaction survey instituted in

2000 (overall, responses indicate satisfaction with services). The Nor-Man region obtained

accreditation in 2002. Some monitoring takes place through preparation of monthly statistics,

however, the existing Mental Health Management Information System is difficult to use for

monitoring. There is interest in monitoring outcomes and program evaluation. Specific expertise

would be of benefit in designing such an evaluation.

Human Resources

Until recently the Nor-Man region had been able to attract CMHW. New CMHW usually

had the required qualifications but often had minimal experience. In addition, depending on

discipline, staff may not be familiar with medications and may not have experience in

conducting mental status exams. It has become increasingly difficult to attract qualified

applicants. Turnover has always been a concern. In the Pas over a ten-year period fourteen staff

were hired to keep four positions filled.

Challenges in attracting a psychiatrist delayed opening of the inpatient unit. The region

has a full-time psychologist. Turnover has not been a problem with these positions.

Basic and Continuing Education

As a result of turnover, only one of the CMHW has taken the CORE module on

psychosocial rehabilitation. Funds are available for conference or continuing education travel.

Individuals who attend these events bring information back and share it with co-workers. The

Mental Health Program also attempts to offer staff development on a monthly basis. This might

include bringing speakers in or having local groups, such as self-help groups, provide

information.

CMHW in the Nor-Man region provide a wide range of services and as a consequence

continuing education needs are also diverse. There has not been any continuing education in the

area of psychosocial rehabilitation.

Special Considerations

While travel time and cost of travel is an issue for all rural RHAs, it is exaggerated in a

region the size of Nor-Man. Travel to some communities takes three hours one way on poor

roads. These constraints limit the frequency with which itinerant services can be provided. There

are no proctors to provide support in isolated communities. Clients whose needs cannot be met

with weekly or bi-monthly visits may need to relocate.

Nor-Man is also unique with respect to the size of the SPMI population, and the large

First Nations population. Some regions, such as Parkland repatriated a large number of people

with SPMI when BMHC closed. Nor-Man did not have a large influx of clients. Rather, there is a tendency for consumers who leave the region for services to remain in the new location. Some choose not to return and others cannot return to the region, as services necessary to support that individual are not available. For instance, even if proctor services were available in isolated communities, the proctor budget is limited and could not support intensive service. As a result, the population of people with SPMI is relatively small.

Nor-Man has a large First Nations population. Community Mental Health services are available to the population but are not well used. The region would prefer that CMHW were more representative of the population, but have had difficulty in attracting First Nations workers.

Finally, Nor-Man is unique in the range of clients it provides service to. Flexible mandates and lack of other services may result in Community Mental Health providing services to clients who might be better served by other agencies. For instance, there are high rates of Fetal Alcohol Syndrome / Fetal Alcohol Effects in the region and limited services for this population. As a result of a need for service and lack of resources, these individuals may be included on Community Mental Health caseloads. Similarly, the RHA has assumed responsibility for Rosaire House Addiction Centre that provides inpatient alcohol and drug abuse treatment. The Addiction Foundation of Manitoba generally provides addictions treatment.

System Components

Psychiatry / Psychology

Historically, Nor-Man had two days per month of psychiatry consultation. Some of the consultation was provided on-site and some was provided by telephone. A full-time psychiatrist was hired in the summer of 2000. He continues to live in the community and provides service to mental health clients and the inpatient unit.

A full-time psychologist was recruited starting in September 1998. Prior to 1998, psychology services were provided on an itinerant basis from Winnipeg.

Case Management

ICM is not offered in Nor-Man. People with SPMI are included on the caseload of CMHW. The adult program in Nor-Man includes four CMHW in the Pas and three in Flin Flon. CMHW have a caseload of 40-65 active clients. Caseloads are reviewed on a routine basis and inactive cases are closed. The program uses a clinical case management model although some elements of psychiatric rehabilitation and personal strengths may be incorporated depending on client needs and the workers' preparation. A half-time occupational therapist was available until 1999, but the region has been unable to fill the position since that time.

CMHW provide depot medications and medication monitoring (depending on worker preparation), direct assistance with symptom management, illness and medication education with clients and their families, advocacy and facilitation of social services. Assistance is not usually provided with housing or finances.

Community Mental Health services are not usually provided in client homes. Work with client families is somewhat limited. Active outreach is provided if the worker considers active follow-up to be necessary.

Proctors provide assistance with basic needs and instrumental functioning with supervision by the CMHW. Proctors may also provide some skill training and are particularly good at developing relationships with clients who are difficult to establish relationships with, such as people who have paranoid schizophrenia. Skill training is usually provided in the natural environment. Proctors are also used for social / recreational goals. The proctor program existed prior to reform but, since it was administered out of Winnipeg, it was difficult to access. Use of

proctors has increased since the region assumed responsibility for the program. However, there is a shortage of proctors and the proctor-training program no longer exists.

Crisis Services

Prior to mental health reform, CMHW provided after-hours on-call duty. Since 1992 crisis services have been provided on a shared basis between Mental Health, Family Services, Public Health, Community Living and Home Care. About 20 calls per month come from mental health clients. During the day during the week crisis calls are handled by Community Mental Health.

Individuals seeking crisis services call the hospital switchboard in the Pas or Flin Flon, ask for the on-call worker and provide a number where the on-call worker can contact them. The on-call worker is notified and contacts the person in crisis. Assessments may be conducted at the Royal Canadian Mounted Police station, hospital or in the callers' home. Police backup is requested as needed. Counseling and practical advice is provided. If the person in crisis is not safe they are admitted to the hospital.

Individuals providing after-hours services may or may not have a professional designation related to one of the sponsoring programs. Prior to assuming on-call duties, workers are provided with an orientation that includes education on suicide assessment, mental status assessment, schizophrenia, depression, crisis intervention and the Mental Health Act. On-call workers also have contact information for CMHW as backup. CMHW may also contact clients they have concerns about over the weekend just to check in. The provision of crisis services was not changed as a result of opening the inpatient unit. The region has been satisfied with the functioning of the service.

Inpatient Services

An eight-bed inpatient unit was established at the Pas Health Complex in February of 2001. Prior to 2001, inpatient service was provided in the general hospital. If a secure environment was required, the police would detain the individual until transfer to SMHC or, once an inpatient unit was established in Thompson, the Thompson inpatient mental health unit. CMHW provided follow-up care to clients when they return to the region.

Provision of mental health services within the general hospital was offered on a collaborative basis between Community Mental Health services and the attending physician. The CMHW usually conducted an assessment and provided recommendations, including medication recommendations, to the physician. The CMHW continued to provide service for clients in the General Hospital and following discharge.

Since the establishment of inpatient beds in the Pas inpatient staff provide the majority of inpatient service. CMHW participate in client conferences and provide follow-up care when the individual is discharged. There is no crisis stabilization unit or safe house.

People with a need for long-term inpatient care may be placed in a Personal Care Home if age and behaviour are amenable to this type of placement. Others, such as those with brain injury who cannot be maintained in the community, are transferred to SMHC. Three people were transferred to SMHC in 2002 for long-term rehabilitation. The referral process has worked well.

Housing

Some housing is available for people with limited financial resources from the Manitoba Housing Authority. There are no Residential Care homes, respite or transition homes for mental health clients. Consumers usually rely on family or use what is available in the community. There is very little available housing in the Pas or Flin Flon. Many consumers have exhausted

the resources of family and friends and, if a client is evicted, there is no place to go. In this situation, though not usually part to the CMHW role, the worker may advocate for the client and negotiate with people to try and locate housing.

Vocational / Educational Supports

Vocational Rehabilitation services are available in the region but this service is not well used by mental health clients. There are no substantive connections between Vocational Rehabilitation Services and Community Mental Health services.

There is no EDC, supported employment or transitional employment offered by mental health services. Consideration has been given to developing a drop-in center that would serve a social function initially and work initiatives would be introduced gradually. However, the number of individuals that would be served may not warrant development of a program. Further, due to high unemployment in the region, and in the outlying communities in particular, clients may not consider vocational or educational activities necessary.

Social / Recreational Supports

CMHA has recently obtained grant funding to establish a drop-in center in Flin Flon. The center operates two days per week. Efforts are being made to establish a similar program in the Pas. Other than this, there are no social / recreational activities beyond what is available to the general public. Consideration has been given to development of a day program based out of the inpatient unit in the Pas to meet the needs of clients with SPMI. However, staff shortages have been a barrier to implementation.

Consumer Initiatives / Family Self-Help

ADAM, CMHA, MDAM and MSS are active in the Nor-Man region. Offices are located in the Pas with itinerant service to Flin Flon. For each group, staff time is split between the Pas

and Flin Flon. Some adjustments may be made to available time as well. For instance, some staff time is sacrificed to pay for travel between sites since the budget does not include travel. The MDAM / MSS Outreach worker has 32 hours per week to fill both roles in both areas.

The MSS office in Nor-Man was established in 1994 and was one of the first in the province to be established outside Winnipeg. A single worker has held this position since it was established. The other self-help groups have had substantial turnover and some difficulty recruiting to the positions.

All four groups participate in public education and each has a resource library. Self-help provides advocacy through participation on the regional Mental Health Advisory Committee but are not involved in regional CQI committees. ADAM and CMHA share office space in the Pas. MDAM and MSS share a single Outreach Worker, whose office is next door. The office location is called the Mental Health Self Help Resource Centre. The groups have collaborated on some initiatives, but hope to improve collaboration efforts. Relationships between consumer groups and the region are positive although the strength of the relationship has varied over time on the basis of staff changes. While the efforts are seen as complementary rather than duplication, the region also provides public education.

The ADAM Outreach Worker position is divided into the Pas and Flin Flon, each of which has 15 hours a week. The Outreach Worker is active in the Pas although there has been some turnover in the position. The position in Flin Flon is vacant and there have been challenges in recruiting. The Worker in the Pas provides service to that area and, on request, has provided some service on reserve. For instance, the community of Pukatawagan brought in the MDAM and ADAM Outreach Workers to provide an education session. Education has also been provided in Grand Rapids. ADAM offers two Cognitive Behavioural Therapy Programs, one for

Panic Disorder and the other for social anxiety. There is no graduate group operating in Nor-

Man. Some individual support is provided although the goal is to engage the individual in one of

the group sessions or, if needs extend beyond what can be offered through MDAM, referral to

other agencies. Public education is also part of the Outreach Worker role.

CMHA offers a number of health promotion activities, such as workshops on stress

management and relaxation. CMHA also provides individual support or education to consumers

or family members as needs are identified. A drop-in center was recently established two days

per week in Flin Flon and an attempt is being made to establish a similar program in the Pas.

The MDAM / MSS Outreach Worker offers public education through participation in

health fairs and staging depression screening as well as education in the jail and schools. Support

is also provided to clergy. A weekly peer support group is held. To date, consumers with

depression and those with schizophrenia have participated in a single group. The Worker plans to

form two groups in January, 2003 to better address the specific needs of client groups. The

MDAM / MSS Outreach Worker has collaborated with CMHA to provide information and

support to family members. Unlike other family support initiatives offered by MSS, this group is

open to families who have a range of concerns including Alzheimer's and Anxiety Disorders.

Future Goals

Building capacity for delivery of proctor services in outlying communities is a goal that

the region is pursuing. Collaboration with home care is being considered as a means to offer this

service in more communities.

North Eastman

System Characteristics

Context of Service Delivery

The North Eastman Regional Health Authority spans an area of 35,000 square kilometers and provides service to a population of 38, 621 people (Regional Health Authorities of Manitoba, 2000). The economy includes farming, mining, forestry, electric power and a significant tourism industry. The region is characterized by cultural diversity. One third of the region is accessible only by air, water or winter road and the RHA does not provide service in that area. The RHA also does not provide service on reserve although aboriginal people may access mental health services off reserve. The estimated population with SPMI in the region is 16 –20 people.

CMHW are distributed throughout the region and people with SPMI are similarly distributed, although there is a concentration of SPMI consumers in the Beausejour area. Some services, such as crisis and inpatient services are received from Selkirk, but most services are received within the region. Consumers in areas, such as Oak Bank, that border Winnipeg may use some Winnipeg services. For instance, an individual might be referred by their family physician to a psychiatrist or inpatient unit in Winnipeg. The family physician might also be located in Winnipeg. In some circumstances the individual would receive some service in Winnipeg but for services such as ICM the individual would be referred back to North Eastman. Individuals from North Eastman attempting to access Winnipeg crisis services would be redirected to the crisis services located in Selkirk. The Salvation Army Crisis Services although located in Selkirk, are contracted to provide services to both the Interlake and the North Eastman Regions.

Accountability

The Mental Health Manager for North Eastman RHA is directly responsible for ICM / CMHW, proctor, psychiatry and psychology services. The Manager is also responsible to develop and maintain linkages with crisis services provided by the Salvation Army located in Selkirk, and self-help services which are funded directly by Manitoba Health. Vocational Rehabilitation services, other branches of Government, including Family Services and the Manitoba Housing Authority, operate employment services and provide housing. The region no longer has a Regional Mental Health Advisory Committee. However, an attempt is made to maintain a consumer voice on the District Health Advisory Committee. The Mental Health Program also includes consumers on an ad hoc basis on issues such as accreditation.

Integration / Linkages

The CMHW / ICM have monthly team meetings. Self-help services attend these meetings as does a representative of the Salvation Army Crisis services, often the program manager or supervisor. The psychiatrist and psychologist are notified of team meetings but attend on a sporadic basis due to time constraints resulting from provision of services in three regions. There are other relatively informal links between case managers and the Salvation Army crisis services. A liaison meeting is held at the Salvation Army CSU about once per month, depending on whether there are consumers from North Eastman on the Unit. Also, a CMHW who lives in Selkirk provides liaison with the unit on a regular basis to address any issues that arise. Consumers from North Eastman who have been admitted to the Unit are referred to the case manager for follow-up. If the consumer is known to be a client of mental health services in North Eastman, the CSU will contact and speak with the worker directly for information sharing. With

client consent, CMHW provide crisis staff with history information, assist with admission, and serve as escorts when extra support is required.

Administrative linkages with other regional structures, such as Public Health and Family Services are through the Mental Health Manager. The Mental Health Manager also provides linkages with mental health services in other regions through the provincial network of regional managers (Provincial Mental Health Network), and with program specialists at the mental health directorate.

Budget

As a result of mental health reform, the budget for mental health services increased by 0.5 EFT ICM and the proctor budget increased. The budget for psychiatric consultation was increased, although this increase was provided largely to the child / adolescent and elderly population. Although not in the North Eastman budget, crisis services are available to the region and self-help services operate within the region.

The budget for mental health is not protected but mental health is considered a priority in the region. The region is interested in increasing funding for mental health services in order to assist consumers with mental health problems as well as those with mental disorder diagnoses.

Monitoring / Evaluation

The North Eastman RHA received accreditation in 2000 and is in the process of preparing for a second accreditation in June 2003. Strategic plans, with ongoing prioritized action plans, accreditation activities, primary health care planning, and achieving board goals are all linked together. There is no specific budget for monitoring or evaluation of mental health services. The mental health program expects to conduct client satisfaction surveys in 2003. The region was also involved in the provincial Caseload Review project.

Human Resources

Staffing in the North Eastman RHA has been stable. To date the region has not had any difficulty attracting significant numbers of applicants. Proximity to Winnipeg and the option of commuting has meant that the region is able to hire qualified staff. Further, it was possible to hire staff specifically prepared for the ICM position.

Basic and Continuing Education

As mentioned previously, the ICM has specific preparation in Psychiatric Rehabilitation. For a period of about three years, rehabilitation staff from Interlake and North Eastman met about once every six weeks to work through new educational material on PSR. The meetings included case discussions and served as an educational forum as well as providing an opportunity to consult with peers. Participation in these meetings was considered particularly valuable since workers practice very independently. The group has not met this year. Both the ICM and the Mental Health Program Manager are members of PSR Manitoba.

Due to stable staffing, CMHW will have taken the CORE Module on Psychiatric Rehabilitation. Funds for continuing education are limited (about $4000) and are shared between Mental Health, Home Care, Public Health and Primary Health Care. A number of inservices are offered which may or may not be related to PSR.

Special Considerations

North Eastman differs from other regions with respect to the proportion of the population with SPMI, and ties to services in another region. The population with SPMI is low in North Eastman. Reasons for the low numbers are unclear but may be due in part to limited availability of supported housing.

Historic patterns of mental health service use, and current patterns of travel for commerce, employment and services, have resulted in close ties between North Eastman and services in Selkirk and Winnipeg. Travel outside the region to access mental health services remains a barrier for most people.

System Components

Psychiatry / Psychology

A consulting psychiatrist is available in the North Eastman region a half-time basis (0.5 EFT). The psychiatrist provides consultation to CMHW in the Adult program. The region has separate contracts for psychiatric services for their Child and Adolescent Program and the Geriatric Psychiatry Program. The psychologist for North Eastman is shared among three regions (Interlake, South Eastman & North Eastman), thus is available on a 0.3 EFT basis. The position is funded by Manitoba Health and reports to the University of Manitoba, Dept. of Clinical Health Psychology.

Case Management

An Intensive Case Manager was hired on a half-time basis (0.5 EFT) in 1996 / 97. The position was increased to full-time in 2001. Practice is based on a combination of Rehabilitation and Personal Strengths models. Almost all work with these clients is conducted in the community. Active follow-up of missed appointments and work with a range of community supports, including family and self-help support, is provided. As a result of the caseload review, the region implemented the recommended caseload ratios (19 clients for an ICM) and established waiting lists.

Individuals who would benefit from ICM but cannot be accommodated in the caseload of the ICM, three people at the time of interview, are served by CMHW. CMHW provide assessment, treatment, assistance with basic needs are met, symptom management, medication

monitoring and follow-up as well as attending to finances. However, Community Mental Health clients would not have the intensive contact and depth of service provided by ICM. CMHW have caseloads of 50 or more active clients. CMHW are able to consult with the ICM and have access to proctors to provide additional support.

The ICM also provides medication monitoring and assistance with finances. Further, the ICM provides illness education in collaboration with the self-help groups and, either directly or indirectly through proctors, provides assistance with basic needs and instrumental functioning. Advocacy and facilitation of social services is also part of the role.

The region has experienced some challenges in using proctors to provide service. The budget for proctor services is less than $15,000 per year. In addition, mental health competes with other programs, such as home care, for suitable proctors. The region would also like to expand the ICM position and hire a resource developer.

Crisis Services

The Salvation Army provides crisis services, including mobile crisis and crisis stabilization services, to the North Eastman RHA. The service was established in 1996 and operates out of Selkirk in the Interlake region. A letter of understanding between the two regions states that the crisis services are available to both regions. Funding for crisis services flows from Manitoba Health through the Interlake RHA.

Case managers are responsible for crisis response during business hours. After hours services are provided by the mobile crisis service which will respond to calls and travel anywhere in the Interlake or North Eastman region. The mobile crisis team provides crisis intervention, assessment, makes recommendations for treatment/service, and provides short term follow up to ensure service linkages have in fact been established. The service operates from

2:00 P.M. to 2:00 A.M. weekdays and 8:00 A.M. to 2:00 A.M. on weekends. The overlap

between hours of CMHW and crisis services is designed to facilitate continuity of care by

offering an opportunity for referral and information exchange. During the overnight hours (2:00

A.M. to 8:00 A.M.) the phone line is answered by the CSU but there is no mobile service. Crisis

services are well used by North Eastman residents.

The Crisis Stabilization Unit has eight beds and is a 24-hour service. It provides

assessment, short-term intense treatment and discharge planning for individuals with an

emotional, mental health or psychiatric crisis. Individuals must be voluntary admissions.

Individuals who require a secure environment, such as those who are at high risk of suicide and

are unable to contract for safety during admission to the unit, have demonstrated violent

behaviour or have severe physical health problems, are not eligible for service. Staffing the CSU

has posed problems at times and, at one point, was closed for a week due to staff shortages.

Staffing was not a problem at the time of interview.

Inpatient Services

There are no designated inpatient beds in North Eastman. Short-term care may be

provided in a local hospital with support from the CMHW on occasion. SMHC is the designated

psychiatric facility for admissions of North Eastman residents and the majority of inpatient care

is provided by SMHC. However, beds in other regions, for example Winnipeg or Brandon, may

be used when beds are not available in Selkirk Consumers requiring long-term inpatient care are

admitted to SMHC and their regional file is closed.

Individuals admitted to SMHC may remain in Selkirk or may relocate to Winnipeg after

discharge. This migration is not limited to mental health clients and is based on availability of

services as well as limited access to educational, vocational, social and recreational resources in

rural areas. This pattern may account for the low numbers of people with SPMI living in North

Eastman.

Housing

As of fall 2002, North Eastman had three clients living in Approved Homes administered

by Family Services. There are no group homes. Other housing alternatives, such as a Mental

Health Supported Housing Program, have not been developed due to the small population of

SPMI in the region and apparent lack of demand. Most people with SPMI live with families or

look for room and board situations. As of fall 2002, North Eastman had two clients on a waiting

list for residential placement and a waiting list of two potential home operators.

The need for housing is expected to increase in the future. A number of clients with

SPMI are living with elderly parents. These clients will eventually require residential care. There

is limited availability of Manitoba Housing Authority properties as there is currently a seven-

year waiting list. Further, through the separation of Health and Family Services, Health will need

to develop its own housing options. Family Services has allowed existing mental health clients to

remain in their homes (approved for Community Living clients), but new clients are not eligible

for these spaces. The RHA has submitted a proposal for additional staffing to support

development of a housing program.

Vocational / Educational Supports

The ICM also provides employment development for ICM clients. As with other services,

low numbers of SPMI clients make it difficult to justify specialized staffing. The region would

like to have a full-time EDC providing assistance to all Community Mental Health clients. Some

connections exist with Vocational Rehabilitation Services based on stability of staffing and

proximity of offices. More formal linkages would be of benefit.

Social / Recreational Supports

There are no formal social / recreational supports. Proctors are used to address social / recreational needs and goals.

Consumer Initiatives / Family Self-Help

Eastman Mental Self-Help Service is a coalition of ADAM, CMHA, MDAM and MSS. Each organization maintains a separate identity, but there is a high degree of collaboration on specific initiatives. Eastman Mental Self-Help Service was established in Oak Bank as a service for Eastman. Once RHA were established, the service was shared between North and South Eastman. In 2002 a decision was made to establish offices in each of the two regions to provide greater visibility within the region. Currently CMHA and MSS operate out of Oak Bank (North Eastman). ADAM and MDAM operate out of offices in Steinbach (South Eastman). The organizations continue to collaborate extensively, particularly on educational initiatives. Outreach Workers are each hired for about 30 hours per week and split this time between North and South Eastman. A portion of the 15 hours per week allocated to each region is used in travel.

CMHA provides public education, primarily in the area of health promotion. For instance, presentations are offered on stress and self-esteem. CMHA also offers a six to eight week program on anger management. CMHA attends monthly mental health team meetings in both North and South Eastman. CMHA is collaborating with MSS and EMHC to develop a drop-in center in Steinbach for people with mental illness. Individual support is provided and a support group for caregivers is currently being offered. This group is available to caregivers of individuals with a wide range of health challenges, including mental illness. There has been minimal turnover in the position, but there was a vacancy of about six months between the current and previous worker.

The MDAM Outreach Worker provides public education in areas such as depression and suicide as well as making presentations to schools and, for instance, bereavement groups. The Worker participates in Community Mental Health services' monthly team meetings. Two peer support groups operate in each region. Groups are offered in St.Pierre and Steinbach for South Eastman; Beausejour and Lac du Bonnet in North Eastman.

The MSS Outreach Worker offers presentations on schizophrenia and psychosis for a range of audiences including high school students and health professionals. The "Hearing Voices" workshop is particularly useful for professionals. The Outreach worker attends monthly mental health team meetings in North and South Eastman, as well as serving on a number of working committees. For instance, the Worker is a member of the North Eastman wellness committee, which is currently offering stress workshops and a South Eastman committee working to develop a drop-in center. Family self-help has been particularly successful. Groups meet monthly in Oak Bank and Steinbach. Consumer support groups also meet monthly and are held in Steinbach and Beausejour. Resource materials are available but have recently been relocated to the Wellness Resource Centre. The Centre has staff so it is more accessible. Staffing has been quite stable but there was a six-month gap between the original and current MSS Outreach Worker.

Parkland

System Characteristics

Context of Service Delivery

The Parkland Regional Health Authority spans an area of 25,000 square kilometers and serves a population of 43, 506. The region has two main population centers, Dauphin and Swan River. People with SPMI are largely concentrated these two centers, although support is provided outside these centers. About 55 people in the region have SPMI.

Like most other regions, mental health services are not provided on reserve but are provided to First Nations people off reserve. Some First Nations communities are served by West Region Mental Health Services, which are operated by the West Region Tribal Council.

Parkland offers a full range of services and most people with SPMI receive their services within the region however, based on geography, some people may prefer to receive services in Brandon. For instance, an individual living in Ste. Rose du Lac would be closer to the Brandon CSU than to the Safe House in Swan River. The service options available in Brandon may also lead some individuals to relocate to Brandon.

Accountability

The Director of Mental Health Services is directly responsible for ICM, EDC, proctor, and crisis and inpatient services. The Director is also directly responsible for psychiatry / psychology and some social / recreational services. Crisis services in Swan River are provided by CMHA under contract to the RHA. Housing services are managed by Parkland Mental Health Housing Incorporated, which is an independent organization.

Manitoba Health provides funding for self-help services. Funding is provided directly to the head offices in Winnipeg and distributed through those offices.

Parkland region has an active Mental Health Advisory Council. Council membership includes representatives of self-help organizations, consumers, a school division, the Dauphin Friendship Centre and the Parkland RHA Vice President of Community Health. The Mental Health Advisory Committee meets at least quarterly and reports directly to the Board of the Parkland Regional Health Authority.

Integration / Linkages

Good linkages exist between services directly accountable to the Director of Mental Health Services. The crisis services are located in the Dauphin Community Health offices and are operated by CMHW – Crisis. A deliberate one-hour overlap in staff hours is provided to facilitate communication between crisis and other services. Crisis service staff also participate in weekly intake meetings. CMHW / ICM / EDC continue to see their clients when they are in hospital and there is good information sharing between programs.

Linkages with CMHA crisis services in Swan River pose some challenges due to confidentiality issues. Client consent is required to share information. Inability to share information creates barriers to joint planning and provides an opportunity for some clients to "shop" for the answer they want. However the current CMHA manager is very willing to work collaboratively.

Regional and self-help services share responsibility for education initiatives. For instance, activities for events such as mental health week and mental illness week are coordinated through a joint education committee. Regional services and self-help services also make referrals to one another. Further, self-help groups are represented on the Mental Health Advisory Council.

Housing services are operated by an independent organization. The Director of Mental Health Services sits on the Board of Directors of the Parkland Mental Health Housing

Incorporated. However, the Director sits as a private citizen rather than in a formal capacity. The

Board functions largely as a landlord for mental health clients.

Administrative linkages with other regional structures, such as Public Health and Family

Services, and with program specialists from Manitoba Health occur through the Director of

Mental Health Services. Program managers in each region link though the provincial network of

regional managers (Provincial Mental Health Network),

Budget

Funding for the Parkland region increased substantially under mental health reform.

Additional funds were received for the proctor program, housing program, mobile crisis services

in Dauphin, crisis services in Swan River, a 10-bed inpatient unit, social / recreational programs

and increased staffing. Increased staff included two EDC and three ICM. Although not part of

the regional budget, self-help services are now available in the region. With the addition of

proctors, staffing more than doubled,

Monitoring / Evaluation

There is no specific budget for monitoring / evaluation. The Regional Director monitors

statistics on client numbers and services provided. These are largely input and process statistics

rather than capturing outcomes. The region received Accreditation in 2001 and has a CQI team.

The mental health CQI team operates differently from other CQI teams in the region in that

people external to the service are included. For instance, CMHA, ADAM and MDAM all

participate on the team. Parkland region has also participated in some specific evaluative

initiatives, such as: a review of the PSR program in Brandon, Central and Parkland regions

funded by Manitoba Health; and the provincial Caseload Review Project also supported by

Manitoba Health.

Human Resources

Staffing in the Parkland region has been quite stable. New staffing under mental health reform was made up of experienced staff from BMHC. ICM / EDC have had specific training in Psychosocial Rehabilitation.

Historically there has not been any difficulty attracting well-qualified applicants but this has become more difficult over time. Psychiatric nurses are in short supply and fewer Social Workers have been applying. For instance, until recently it would be reasonable to expect 20 well-qualified applicants for a CMHW position in Swan River. At present the same position would be likely to attract only eight qualified applicants and only three with experience.

Basic and Continuing Education

Stable staffing in the region has meant that all CMHW have taken the CORE module on Psychosocial Rehabilitation. Continuing education in the field of psychosocial rehabilitation is at the discretion of the individual practitioner.

Special Considerations

The Parkland region was actively involved in planning for the closure of BMHC. As part of the closure, consumers were asked where they wished to live and a number of former residents of the Parkland region were repatriated to the region. As a result, the number of people with SPMI living in Parkland is somewhat higher than for other rural regions.

The Parkland RHA is made of several distinct ethnic groups. A substantial portion of the population is of Ukrainian decent and Ste. Rose du Lac is a predominantly French area. One CMHW in Ste. Rose du Lac speaks French and several CMHW in the rest of the region speak Ukrainian. However, there is little demand for service in other languages, even among the elderly.

System Components

Psychiatry / Psychology

The Parkland Region recruited a full time psychiatrist in April, 1998, and has had two EFT psychiatrists for some time. Prior to 1998 itinerant psychiatrists served the region for two or three days per month. A full time psychologist has been available since 2001.

Case Management

ICM / EDC has been available in the region since 1994. These workers practice using a psychosocial rehabilitation model and have caseloads that range in size from 18-25 clients. One of the challenges the program faces is maintaining the integrity of the program while addressing the demand for service. ICM / EDC provide advocacy, facilitation of social services, assistance with finances and housing, illness and medication education, medication monitoring and assistance with symptom management. Assistance with basic needs and instrumental functioning may be provided directly by the ICM / EDC or by proctors.

Proctors are used extensively to provide support to individuals with SPMI. Proctors provide services such as: direct skill teaching; assistance with transportation; employment support; and facilitation of participation in social / recreational opportunities. The Parkland RHA currently has 109 proctor contracts.

The majority of service to people with SPMI is provided in the community. Some work is conducted with natural supports but the focus is usually on the individual client. The extent of assertive outreach is dependent on the assessment of the worker. Consumers are encouraged to assume responsibility but if necessary workers provide follow up.

Crisis Services

Crisis services in the Parkland region were established in September of 1996. These services include mobile crisis services operating out of Dauphin and a Safe House in Swan River.

The Mobile crisis service is located in the Dauphin Community Health Office and provides service to the whole region. During business hours, crisis calls go directly to the Community Mental Health Intake worker. From 3:30 P.M. to 11:30 P.M. crisis calls go to the crisis service. The inpatient unit provides backup for both Community Mental Health Intake and the evening crisis service. Over night (11:30 P.M. – 8:00 A.M.) and during the day on weekends the inpatient unit receives crisis calls directly. If mobile service is needed overnight or on weekends, inpatient staff can call out a local CMHW or the crisis staff. A single phone number is provided for crisis services with calls being forwarded to intake, crisis services or the inpatient unit as needed.

CMHA operates a four-bed Safe House in Swan River. The Safe House was originally established as a CSU but was converted into a Safe House in 2001. This is a 24-hour facility with four beds.

Ideally the inpatient unit and the Safe House would complement each other and less acute clients would use the Safe House. In reality, due to the distance between Swan River and Dauphin, services are provided largely on the basis of locality. Residents of South Parkland rarely use the Safe House and residents of the Swan Valley generally use the Safe House unless inpatient care is absolutely required. Residents of the southern part of Parkland who do not meet criteria for admission may travel to the Brandon CSU as it is closer. For instance, Swan River is almost three times further from McCreary than Brandon. Distance is also a factor in maintaining

connections to family supports. In Swan River the consumer from McCreary would be three

hours away from family supports and the usual CMHW.

Transportation is an issue for all consumers. The mobile crisis service plays an important

role in facilitating access to inpatient or Safe House services by providing transportation.

Inpatient Services

The Parkland Adult Psychiatry Unit, a 10-bed psychiatric inpatient unit, opened in April

1998 at the Dauphin Regional Health Centre. The unit provides inpatient service to adults from

across the region. Specialized inpatient services for children and the elderly are provided in

Brandon under contract with the Brandon RHA. Prior to establishing the inpatient unit,

consumers who were voluntary and preferred local service were served in medical beds in local

hospitals. This occurs less frequently now that inpatient services are available, but it does still

occur.

Selkirk Mental Health Centre is the designated provincial resource for long-term mental

health care. Parkland region refers one or two clients to SMHC each year. These individuals,

who are often psychogeriatric clients, are usually aggressive or sexually inappropriate and cannot

be managed in the community. These clients are also not suitable for Personal Care Homes. The

wait for placement at SMHC has been lengthy and the services provided by the region while

waiting for placement have been costly. For instance, one client remained on the inpatient unit

for seven months while waiting for placement in SMHC. The region also invested $100,000 per

year for a staffed group home in Swan River to meet the needs of long-term clients who might be

better served at SMHC.

Housing

A range of housing options exists in the Parkland region, including supported independent living, approved and licensed homes. Consumers are supported in a variety of independent living situations ranging from hotels to nice apartments and homes. Proctors and ICM provide supports for independent living.

Housing was specifically included in planning for mental health reform in Parkland. Challenges had been identified in finding affordable housing. Further, landlords were reluctant to rent to people with SPMI. In 1994 Manitoba Health, in collaboration with the Manitoba Housing Authority, set up an organization called Parkland Mental Health Housing Incorporated. This organization purchased a number of properties including a house in Ste. Rose du Lac, four multi-bedroom apartments in Dauphin, a fourplex in Swan River and a three-bedroom house in Swan River. These properties are large, furnished and come equipped with cable. Rent is paid at Income Assistance rates so clients do not have to use the food budget to pay the rent. The number of units appears to be sufficient although some challenges remain. For instance, residential areas can be some distance from grocery stores, banks and other services: transportation can be an issue.

Parkland region has a three-bedroom group home in Swan River and a three-bedroom group home in Dauphin. The region also has two or three approved homes in Dauphin. A seven-bed licensed home was located in Laurier. The licensed home, St. Christopher's Home, pre-dated mental health reform and served clients from across Manitoba. The home was isolated and, by virtue of location, access to natural supports was limited. The facility did play a role with clients who had high needs and no other resources. A fire in the facility resulted in closure.

Vocational / Educational Supports

Employment Development Counseling was established in Parkland region in the winter of 1996. The EDC functions as an ICM but works with clients whose goals are heavily focused on employment. In addition to direct work with clients, EDC is also involved in resource development. For instance, EDC collaborated with stakeholders such as Federal and Provincial programs and Family Services in development of a pre-employment training program. The program has been very successful with a 100% placement rate among the last group of graduates. works with clients toward employment and other goals. EDC also collaborate extensively with Vocational Rehabilitation Services.

Finding competitive employment has been challenging for consumers in the Parkland region. Unemployment is high and competition is substantial even for entry-level positions. Further, there are systemic disincentives to employment. For instance, to achieve the same benefits as Income Assistance provides, the individual would have to make at least eight dollars per hour. Since most employment options pay minimum wage, there is little value in working more than casual shifts. Also, since unemployment is high, there does not appear to be a stigma associated with unemployment.

Social / Recreational Supports

Helping Everyone Reach Out (HERO Club), which was named by the members, was established in 1994. The Club is similar to a clubhouse in that it is member directed but differs in that the emphasis is on social / recreational activity rather than work. Once a month members decide what activities will take place, prepare and distribute a calendar of activities to members. Activities include some work activities. Work activities might include walking dogs, holding

yard sales, or making craft projects for sale. The HERO Club is also involved in fund-raising and educational activities. Members are actively involved in all aspects of operating the Club.

The HERO Club is supported by the region through proctors and a small budget of around $45,000 per year. Separate Clubs operate in Dauphin, Roblin and Swan River. The Swan River HERO Club has about 15-20 active members and the Dauphin Club has 20-25 active members. About 15-20 members would attend a typical recreational activity in Dauphin. On occasion HERO Clubs from various locations in the Parkland region meet for activities.

The Parkland region also supports a summer camp that is available to consumers. The region pays for camp rental and proctor services to operate the camp. Consumers pay a small fee to cover the cost of meals. The camp is well attended.

CMHA also operates a drop in center in Swan River. The drop in center provides individual and group support in life skills, budgeting, finding and securing housing, assertiveness training and so forth.

Consumer Initiatives / Family Self-Help

As mentioned previously, CMHA operates a safe house under contract to the RHA. The CMHA provides some social / recreational activities and skill training through the Swan River drop-in center. Public education, and health promotion activities are also offered.

ADAM was established in the Parkland region in 1997. The Outreach Worker provides service to the entire region on 25 hours per week. ADAM provides public education in the form of presentations and workshops as well as distribution of pamphlets. The Outreach Worker attends CQI Team meetings and participates in the shared education committee. ADAM has an extensive resource library and offers two 12-week Cognitive Behavioural Therapy programs, one

for Panic Disorder and the other for social anxiety. A graduate group meets bi-monthly to provide peer support.

The MDAM Outreach Worker is hired for 24 hours per week and is heavily involved in presentations in schools and for teachers. For instance three half-day presentations were recently provided to the Brandon University Northern Teaching Education Program. Presentations on health promotion topics such as self-esteem are also offered. The Worker sits on the regional Mental Health Advisory Council, Accreditation Committee and Mental Health Promotion Committee. Two peer support groups and one family support group meet in Dauphin: the depression group meets weekly, the bipolar disorder group meets every two weeks and the family group meets monthly. The Outreach Worker also travels to Swan River once a month. A peer support group meets in Swan River weekly, but this group operates independently. Individual support is also provided, for example, the Outreach Worker visits the inpatient unit on request or by referral. MDAM has an extensive resource library. Turnover in the Outreach Worker position has been minimal.

MSS provides public education on schizophrenia and participates in the Mental Health Promotion Committee. The "Hearing Voices" workshop is also offered. Further, the Outreach Worker periodically attends the HERO club to identify educational topics of interest to consumers. A family group meets monthly in Dauphin and an eight-week family psychoeducation program called "Eight stages of healing" is being offered in Swan River. The Outreach worker has some resources but generally refers individuals to the extensive library at MSS in Winnipeg. Support to consumers includes individual support and peer support provided to inpatient in the inpatient unit. The service operates 30 hours per week and has had stable staffing since it was established in 1996.

Future Goals

There is no suitable service within the Parkland region for people who have brain injuries. The RHA would like to have an appropriate resource for this client population.

South Eastman

System Characteristics

Context of Service Delivery

The South Eastman RHA is distributed over an area of 8,000 square kilometers and

serves a population of 52,000 (Regional Health Authorities of Manitoba, 2000). Some services,

such as inpatient beds and crisis stabilization, are not available in South Eastman and must be

obtained from Central, Interlake or Winnipeg regions. Consumers with persistent psychosis who

are hospitalized in Winnipeg hospitals, SMHC or EMHC may not be able to return to their

region if they require services that are not available in South Eastman. As a result of migration

for service, the population of people with SPMI living in South Eastman is small. About 26

people with SPMI are distributed throughout the region with extensive proctor support.

In addition to migration for services that are not available in South Eastman, proximity to

Winnipeg also facilitates out-of-region service provision. For instance, a consumer whose family

physician is in Winnipeg may be referred to psychiatrists and psychiatric inpatient units in

Winnipeg. Consumers may also choose to access self-help services in the Winnipeg region.

However, individuals living in South Eastman who are seeking community mental health

services in Winnipeg would usually be referred back to their region. As with other regions,

mental health services are not provided on reserve. Services are provided to First Nations people

off reserve.

Accountability

The Mental Health Program Manager is directly responsible for CMHW, crisis services,

ICM, proctors, psychiatry and psychology services. South Eastman does not have inpatient beds.

As with other regions, self-help services are funded directly by Manitoba Health but have

responsibility for provision of specific services in the region. Vocational Rehabilitation Services is operated by Family Services. The region no longer has a Mental Health Advisory Committee.

Integration / Linkages

Linkages exist between members of the mental health team, which includes CMHW, mobile crisis services, the psychiatrist and psychologist. The psychiatrist and psychologist meet regularly with staff and with the Mental Health Manager. The psychologist also attends staff meetings, which are held every two months, and team-building events. The crisis team links with the CSU as need of service arises but there is no formal linkage. Linkage with inpatient services occurs between physicians only. There is no direct contact between regional mental health services once a client has been accepted for a bed outside the region. Regional staff do not participate in discharge planning. Information on inpatient treatment, such as a discharge summary or a referral to provide follow-up are rare. Self-help Outreach Workers may attend team meetings. There are limited contacts between regional staff and Vocational Rehabilitation Services.

Administrative linkages with other regional structures, such as Public Health and Family Services, and with program specialists from Manitoba Health occur through the Mental Health Program Manager. Program managers in each region link though the provincial network of regional managers (Provincial Mental Health Network),

Budget

The budget for mental health services in South Eastman has changed very little with mental health reform. The original budget for Eastman was small and, under regionalization, was further reduced by being divided between North and South Eastman.

A small amount of proctor funding, about $15,000, was obtained in 1992 and was increased by $15,000 in 2001. The region received funding in 2002 for 1.8 EFT ICM, 1 EFT Intake/Urgent Care Worker and 1 EFT Resource Developer. The addition of these staff has been significant for the program. Self-help services are now available but were not part of the regional budget. South Eastman does not have a crisis stabilization unit, inpatient beds, safe house, supported housing, or EDC.

The budget for mental health services is not protected but the region, rather than taking money out of the program, has had to increase funding to provide essential services. Specifically, crisis services were originally provided by a NGO. The difference in wages between the NGO and regional services resulted in high turnover and vacancies. The region assumed responsibility for the services and equalized wages by taking money out of the global budget.

Monitoring / Evaluation

There is no specific budget for monitoring or evaluation in the mental health program. There is a very active CQI program in South Eastman. There is a full-time staff that coordinates the overall program for the RHA. Individual programs, such as mental health services, are required to have their own CQI program. The mental health program has a CQI committee represented by each component of the program. The committee meets monthly and reports back to mental health staff during program meetings. Reports are also shared with the CQI program coordinator who prepares quarterly reports for executive management of the RHA. The region achieved Accreditation in 2000.

Monitoring by the Mental Health Program Manager occurs on a routine basis through clinical supervision and evaluation of staff. Staff meetings, which include psychiatry, psychology and agencies such as self-help, provide a forum for issues to be identified and addressed. In 1999

the region also undertook a formal review of mental health services in comparison to other

regions, including present programs, organization and structure.

Human Resources

South Eastman has relatively stable staffing in the Community Mental Health program.

As mentioned previously, high turnover and vacancy rates were characteristic of the crisis

services until the region assumed responsibility for the program and wage scales improved.

Applicants for positions possess the required qualifications but may not have the specific skills

needed. For instance, individuals with a Bachelor of Social Work are eligible to apply for

positions but may not have expertise in areas such as clinical syndromes, mental status

assessment, and psychopharmacology or specific therapies, such as cognitive restructuring

therapy. Historically the need for specific knowledge was met through the CORE modules,

which are no longer available. Self-study under the supervision of the Mental Health Program

Manager has been used to address knowledge and skill gaps. At present the Resource Developer,

among other tasks, facilitates inservice education including education in PSR for the ICM.

Basic and Continuing Education

Only one of the adult CMHW has taken the CORE module on psychosocial

rehabilitation. Lack of financial resources limits the extent to which the region can support

continuing education. The annual budget for education for seven workers is about $750. Even if

the financial resources were available, there are few educational programs suitable for use by

CMHW. As a result of limited resources, continuing education occurs primarily through the

efforts of individual workers to read journals or attend workshops. Professional development was

identified as a priority in the formal review of mental health services. Provision of quality

service, including best practice models, depends on knowledge of those models. A Resource

Developer position was recently established. This individual provides or facilitates inservice education and has been providing direct supervision of independent learning on PSR by the ICM.

Special Considerations

A number of areas are unique in South Eastman. Language and cultural issues are prominent among them. Language is an issue since about 25% of the population is French speaking and, for several communities, daily life is conducted in French. These communities either want or, in the case of individuals who only speak French, need service provision in French. A need for bilingual service providers complicates service delivery. For instance, self-help services have designated the staff position as bilingual so that education, counseling and other services can be provided in French or English. However, it has been difficult to recruit bilingual staff. The result may be a service provider who speaks only French attempting to provide some service in English or the position may sit vacant. A requirement for bilingual service providers similarly complicates recruitment to regional positions.

The South Eastman region is also home to a large Mennonite population. Their unique language and culture have a substantive influence on services, providers and practice. It is imperative that regional services work closely with the pastoral association. It is also imperative for individual workers to be familiar with, and sensitive to, cultural influences and deport themselves in a manner that is acceptable to the community. Certain language and certain topics have to be avoided. For example, statements such as "Oh my God!" or mention of feces or urine when speaking with staff in a personal care home would be considered offensive and unacceptable. While the need for cultural sensitivity is clear to regional staff, it may not be as clear to staff in services, such as SMHC, which are outside the region.

Service delivery is affected by a substantial demand for Christian counseling and a need

in many cases for a service or service provider to be sanctioned by the pastoral association.

Although Christian counseling is available through a number of local churches and private

practitioners, there is overt pressure to hire individuals who practice Christian counseling.

CMHW are often specifically asked if they provide Christian counseling or if they are Christian.

The response may determine whether or not the client will accept service from that provider.

This poses a dilemma when the program has a mandate to provide services to people with a

variety of backgrounds. These dilemmas extend beyond clinical work to areas such as public

presentations. Offering a public presentation can be problematic if the Pastoral Association does

not specifically sanction it.

Historic and contemporary values of self-reliance in both the French and Mennonite

communities have to some degree influenced both availability and use of services. A culture of

self-reliance influences willingness to access services at the individual level. At the system level

it influences ability to develop mental health services. For instance, perception of need

influenced planning for mental health services under mental health reform and is, in part,

responsible for limited availability of some services in the region.

A social prohibition also exists regarding talking about mental health. The view that

mental health problems are the result of how people conduct their lives or failing to connect

sufficiently with God is prevalent. Medications are frowned on. This perspective influences

willingness of Ministers to refer to Community Mental Health and public awareness of available

mental health services in the region. Even development of a brochure describing mental health

services can be controversial.

A final consideration is the impact of population growth. The population in "bedroom communities" on the border with Winnipeg is growing rapidly with some communities tripling in size. The population of the region as a whole grew by 12% from 1986 to 1996. The budget for mental health services has not increased accordingly.

System Components

Psychiatry / Psychology

Availability of psychiatric consultation has varied over time. The region had a full-time psychiatrist from November 1999 until May of 2000. The position has been vacant for periods of time while recruitment efforts were under way. The adult program currently has 1.5 days per week of psychiatry services. The review of mental health services identified a need for more psychiatry time.

A psychologist has been available in South Eastman since 1997. The position is shared between Interlake, North and South Eastman. South Eastman receives one day per week, although most of that time is provided to the Child and Adolescent Program. Based on available time, service is largely limited to testing. The review of services also identified a need for more psychology time and this was a priority area.

Case Management

Until 2002, there were no ICM or EDC in South Eastman. Case management was provided within a CMHW caseload of about 60 clients using a clinical case management model. People with SPMI were distributed between CMHW in order to balance workloads. Assignment of clients was also based on location, gender and language preference of the client. This method of assignment increased travel but offered important choices to clients.

Each CMHW has different skills and an attempt was made to capitalize on these strengths. For instance, a CMHW with strengths in systems and family would have a different

caseload than the CMHW with experience in forensic mental health. This assignment was intended to provide specialized service to clients and enhance the work satisfaction of CMHW. Workers were able to build depth in a particular area without needing to be "everything to everybody".

CMHW provide the full range of services to clients. Services provided include advocacy and facilitation of social services. Assistance with basic needs and instrumental functioning is provided through proctors. The intensity of service delivery depends on the size and composition of the caseload. As caseloads increase, the amount of service that can be provided to an individual client decreases.

South Eastman has now established 1.8 EFT ICM. These two individuals have assumed responsibility primarily for clients in the residential care program. The ICM practice out of Steinbach, as most of the SPMI clients live in that area. The full-time ICM has a caseload of 35 clients and the 0.8 ICM has a caseload of 22. ICM provide the same services as CMHW but are able to provide more intensive service and to provide support in areas such as recreation. Proctor hours have increased as a result of identifying needs in this area.

Community Mental Health services are shifting from office-based practice to service in the community. Work with natural supports, such as family and friends, is limited but does occur, particularly in rural areas where proctors are not available. Assertive outreach is provided if a need for active follow-up is identified. Practice for ICM is almost exclusively in the community. ICM have more opportunities for work with natural supports and for assertive outreach.

The proctor service was established in 1992 and is seen as particularly valuable. Proctors are used to provide additional supervision or daily contact to high needs clients in order to

maintain the client in the community. Before the budget was increased in 2002, the proctor program had four proctors providing support to nine high needs clients. Available funds limited the number of people that could be served by the program. The Resource Developer is now responsible for proctors and for proctor training.

Crisis Services

As with other regions, Crisis services are provided by Community Mental Health services, usually the Intake Worker, during business hours. After hours crisis services were established in 1995 and were originally operated by a NGO. Low wages for program staff led to high staff turnover and difficulty recruiting. The service was forced to close on occasion due to lack of staff. The RHA assumed responsibility for the service in 2000 and the service is now formally attached to the Mental Health program. Ability to attract and retain staff has improved since wages were made comparable to CMHW wages.

Mobile crisis service has 3.5 EFT staff, and staff work in pairs. The service is operated out of the Community Mental Health offices in Steinbach. The service responds to the entire geographic region and operates from 4:00 P.M. to 1:00 A.M. The start time enables liaison with Community Mental Health, family physician, Family Services or other agencies. The service also gained access to psychiatry services once it became part of the mental health program.

The mobile crisis service is not available over night or during the day on weekends. Feedback from the Royal Canadian Mounted Police and the hospital suggests that a 24-hour service would be beneficial, particularly on the weekends. Expansion of the service to respond to children would also be of benefit. However, the service is very busy with the existing mandate. In a four-month period between January and April 2000 the service responded to over one thousand calls and made 169 home visits.

South Eastman does not have a Crisis Stabilization Unit or Safe House. Depending on availability, these services may be provided by a Winnipeg CSU / Safe House or the Selkirk CSU with transportation by the South Eastman crisis service. Locating an available bed can be time consuming for the South Eastman crisis service. Access depends to some degree on relationships between individual crisis service staff and the CSU / Safe House. This posed particular challenges in times of high turnover in the mobile crisis services. Individuals may self-refer to a CSU /Safe House although these facilities usually prefer prior assessment. The mobile service is the usual route for entry to a CSU / Safe House. Establishing a CSU was identified as a priority in the service review. Having a CSU in the region was seen as keeping people closer to home and natural supports, as well as reducing time spent by crisis services in arranging placement and transporting clients.

Inpatient Services

South Eastman does not have inpatient mental health services within the region. Historically, the French-speaking population sought service at the St. Boniface hospital and the Mennonite population sought service at EMHC. In both cases the service was consistent with the cultural and language needs of consumers. Accessing these services has become increasingly difficult, particularly since the closure of mental health beds in Winnipeg.

Depending on client needs and preferences, inpatient services may be provided in local hospitals. In these circumstances the diagnosis would likely reflect a non-mental health condition such as stress or high blood pressure. The extent of this practice is unknown as the diagnoses may not be accurate. Consumers do not receive active treatment in local hospitals but are provided with a temporary safe haven.

South Eastman has some access to SMHC but consumers are often reluctant to be admitted there. This service is therefore used primarily for involuntary clients. Some family physicians make private arrangements with colleagues to admit clients at EMHC. Again, the South Eastman region does not have access to information on the extent to which South Eastman residents use EMHC.

There are no long-term inpatient beds in South Eastman. Long-term residential placement is provided within South Eastman or the client is referred to SMHC.

Housing

Independent living can be provided through the competitive housing market or through the Manitoba Housing Authority. Competitive housing is scarce and costly. Proximity to Winnipeg, a growing economy and relatively affluent community all contribute to low vacancy rates and housing costs well above social allowance rates. Affordable housing can be located in more rural areas but, unless the consumer has access to transportation, service in these areas may be limited. The consumer may be isolated from their CMHW, family physician and other programs. Some housing is available through the Manitoba Housing Authority, although these vacancies also tend to be located in outlying communities.

Housing for individuals requiring supervised living is provided through the Office of Residential Care. At the present time there are 19 clients living in approved homes or licensed homes. Residential care homes are clustered in the St. Anne area, possibly due to historic economic hardship in that area and greater receptivity to operating a home. Very few residential care homes exist in more affluent areas of the region. The Resource Developer is responsible for training people who operate residential care homes.

Lack of housing has created some barriers to repatriating South Eastman residents who left for service in South Central (Winkler) or Winnipeg. The South Eastman RHA worked in partnership with a community group to develop supported housing. A house with three beds has been opened. It is not an approved home. Rather, the community organization subsidizes the rent to make it affordable.

Vocational / Educational Supports

The majority of vocational / educational supports in the region are provided by ICM or CMHW. Clients with employment challenges, including those who are unemployed, have lost jobs, are on stress leave from work, don't want to work or can't find employment, are all supported by CMHW through counseling.

Vocational Rehabilitation services are technically available for skill training but these services are not well used by mental health clients. The Vocational Rehabilitation service used by South Eastman is shared with, and located in, North Eastman. The service is operated by Family Services and serves a variety of client populations. This is a limited resource and, even when access is obtained, the resource may not meet the needs of mental health clients. For instance, program options for mental health clients may be substantially beneath the capability of consumers and there may be limited access to specific services that would be suitable. Vocational Rehabilitation services are not accountable to the RHA and negotiating more suitable services is difficult for CMHW with large caseloads. Ideally the region would like an EDC who could develop relationships with existing resources that would facilitate delivery in a manner suitable for the range of client needs. The EDC could also build bridges with some of the many industries to establish and support transitional employment. Building bridges with employers would include addressing issues such as stigma that limit employment options.

Social / Recreational Supports

There are no specific social / recreational opportunities other than those available to the community at large. The review of services identified an interest in development of a day program. As mentioned below, CMHA is collaborating with MSS and EMHC to develop a drop-in center in Steinbach for people with mental illness.

Consumer Initiatives / Family Self-Help

Eastman Mental Self-Help Service is a coalition of ADAM, CMHA, MDAM and MSS. Each organization maintains a separate identity, but there is a high degree of collaboration on specific initiatives. Eastman Mental Self-Help Service was established in Oak Bank as a service for Eastman. Once RHA were established, the service was shared between North and South Eastman. In 2002 a decision was made to establish offices in each of the two regions to provide greater visibility within the region. Currently CMHA and MSS operate out of Oak Bank (North Eastman). ADAM and MDAM operate out of offices in Steinbach (South Eastman). The organizations continue to collaborate extensively, particularly on educational initiatives. Outreach Workers are each hired for about 30 hours per week and split this time between North and South Eastman. A portion of the 15 hours per week allocated to each region is used in travel.

CMHA provides public education, primarily in the area of health promotion. For instance, presentations are offered on stress and self-esteem. CMHA also offers a six to eight week program on anger management. CMHA attends monthly mental health team meetings in both North and South Eastman. CMHA is collaborating with MSS and EMHC to develop a drop-in center in Steinbach for people with mental illness. Individual support is provided and a support group for caregivers is currently being offered. This group is available to caregivers of individuals with a wide range of health challenges, including mental illness. There has been

minimal turnover in the position, but there was a vacancy of about six months between the current and prior workers.

The MDAM Outreach Worker provides public education in areas such as depression and suicide as well as making presentations to schools and, for instance, bereavement groups. The Worker participates in Community Mental Health services' monthly team meetings. Two peer support groups operate in each region. Groups are offered in St.Pierre and Steinbach for South Eastman; Beausejour and Lac du Bonnet in North Eastman.

The MDAM Outreach Worker also provides service to South Eastman for ADAM. Two 12-week cognitive behavioural programs are offered, one for individuals with Panic Disorders and the other for individuals with social anxiety. Although there is often a group for graduates of the education program, there is no graduate group in South Eastman at this time.

The MSS Outreach Worker offers presentations on schizophrenia and psychosis for a range of audiences including high school students and health professionals. The "Hearing Voices" workshop is particularly useful for professionals. The Outreach worker attends monthly mental health team meetings in North and South Eastman, as well as serving on a number of working committees. For instance, the Worker is a member of the North Eastman wellness committee which is currently offering stress workshops and a South Eastman committee working to develop a drop-in centre. Family self-help has been particularly successful. Groups meet monthly in Oak Bank and Steinbach. Consumer support groups also meet monthly and are held in Steinbach and Beausejour. Resource materials are available but have recently been relocated to the Wellness Resource Centre. The Centre has staff so it is more accessible. Staffing has been quite stable but there was a six-month gap between the original and current MSS Outreach Worker.

Future Goals

The Mental Health Program Manager has invested substantial effort in meeting mental health service needs in the region. Proposals have been submitted in an attempt to increase the available psychology service, develop transitional housing and increase staffing. Advocacy has occurred for increased access to education, increased mental health content in specific educational programs, and shared care models of practice with primary care physicians. In addition to identifying a number of strengths in the region, the report of the Mental Health Service Review Team identified a number of gaps. A number of specific objectives were identified. These objectives relate to: 1) increasing funding for mental health as a proportion of the regional budget; 2) recruitment and retention of a psychologist; 3) development of a CSU; 4) establishing an urgent care worker; and 5) increasing resources for professional development. These areas represent goals for mental health services in South Eastman.

Appendix G – Service Quality Interview Schedule

As discussed, I am here to ask about your impression of services you have used. There are no right or wrong answers. I am interested in <u>your</u> impression of the services.

Could you tell me which health services you have used in the last few years?

> Psychiatry / Psychology
>
> Case management
>
> Proctor
>
> Crisis services (MCU and CSU / Safe House)
>
> Inpatient services - check voluntary status
>
> Vocational / Educational supports
>
> Social / Recreational supports
>
> Self-help / Family self-help

For each service used ask:

Access

> How did you find out about this service?
>
> Was it easy to get in? For example, did it take a long time?
>
> What kinds of things does [the service] help you with?

Acceptability

Do you feel well treated? For example, do you feel that you have choices and make decisions about the plans?

Appropriateness

> Did it do what you needed it to do?

What is the best aspect of this service?

Are there ways in which this service could be improved?

If services are not mentioned, ask if the participant has heard of the service.

Yes - Have you used the service?

Yes - Ask questions above.

No - What factors influenced the decision not to use the service.

No - Provide information on the service. Ask whether the service is something the participant might use.

Do you feel you have all the services you need? If no, are there services you feel would be helpful to you?

Do you feel that you can get help when you need it?

Did service providers in different programs work together to help you?

Some of these services are new to your area (list new services in that region). How do you feel these new services have affected you?

Thank you for sharing your opinion about services.

Appendix H – Quality of Life Index for Mental Health©

Wisconsin Quality of Life
Client Questionnaire
Wisconsin Quality of Life Associates
University of Wisconsin - Madison

Your Name:_____ ID #:_____

Date of Completion: ___/___/___   Location:_____

Directions: We are interested in your views and feelings. The questions in this booklet ask for your opinions about the quality of your life. When you answer each question please indicate the response which most closely reflects your opinion.

You are the person who knows best how you feel about these questions. If you would like someone to help you in filling out this questionnaire, and a friend or family member is not available, please contact a staff member to assist you.

Note: if this form was filled out by someone other than you, please

indicate who helped: _____

Relationship to you: _____

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BACKGROUND INFORMATION

What is your date of birth? _____

....

You are? ___ Male ___ Female

....

What is your highest grade completed: _____

....

What is your current relationship/marital status?

☐ Single/Never Married   ☐ Committed relationship

☐ Married   ☐ Separated

☐ Divorced   ☐ Spouse deceased

How many times have you been married? _____

....

What is the source of your income? (Check all that apply)

☐ Paid employment   ☐ Unemployment compensation

☐ Social Security Disability Income (SSDI)   ☐ Retirement, investment or savings

     or Supplemental Security Income (SSI)   ☐ Alimony or child support

☐ Veterans disability or pension benefits   ☐ Money shared by your spouse/partner

☐ General assistance   ☐ Money from your family

☐ AFDC   ☐ Other source: _____

....

What is your racial/ethnic background? (Check all that apply)

☐ American Indian/Native American   ☐ Hispanic/Latino

☐ Asian   ☐ White

☐ African American   ☐ Other, specify: _____

....

During the past month, you lived: (Check all that apply)

☐ alone   ☐ with parents

☐ with roommate/friend   ☐ with significant other/spouse

☐ with children   ☐ with other, please specify: _____

....

Who would you like to live with? (Check all that apply)

☐ alone   ☐ with parents

☐ friend/roommate   ☐ with significant other/spouse

☐ with children   ☐ other, please specify; _____

....

During the past month, you lived primarily: (Check one)

☐ in an apartment/home   ☐ at school/college

☐ in a boarding home   ☐ in an institution (i.e. hospital or nursing home)

☐ in an group home or halfway house   ☐ in jail/prison

☐ homeless   ☐ other, please specify: _____

Where would you like to live? (Choose one)

- ☐ in an apartment/home
- ☐ in a boarding home
- ☐ in an group home or halfway house
- ☐ homeless

- ☐ at school/college
- ☐ in an institution (i.e. hospital or nursing home)
- ☐ in jail/prison
- ☐ other, please specify:_____

SATISFACTION LEVEL

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the way you spend your time?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you when you are alone?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your housing?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your neighborhood as a place to live in?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with the food you eat?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with the clothing you wear?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with the mental health services you use?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your access to transportation?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your sex life?	☐	☐	☐	☐	☐	☐	☐

We have asked how satisfied you are with different parts of your life. Now we would like to know how important each of these aspects of your life are.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important to you is the way you spend your time?	☐	☐	☐	☐	☐
How important is it to feel comfortable when alone?	☐	☐	☐	☐	☐
How important is your housing?	☐	☐	☐	☐	☐
How important is your neighborhood as a place to live in?	☐	☐	☐	☐	☐
How important to you is the food you eat?	☐	☐	☐	☐	☐
How important to you is the clothing you wear?	☐	☐	☐	☐	☐
How important to you are the mental health services you use?	☐	☐	☐	☐	☐
How important to you is your access to transportation?	☐	☐	☐	☐	☐
How important to you is your sex life?	☐	☐	☐	☐	☐

OCCUPATIONAL ACTIVITIES

During the **past month**, you have: (Check one)

- ☐ been working/studying or doing housework in your usual manner
- ☐ been working/studying or doing housework but less often than you did before
- ☐ stopped working/studying or doing housework compared to what you did before

....

About how many hours a week do you work or go to school?   Hours per week = _____

....

What is your main activity? (Check one).

- ☐ Paid employment
- ☐ Volunteer or unpaid work
- ☐ School
- ☐ Treatment/rehabilitation program ☐ Other
- ☐ Craft/leisure time/hobbies
- ☐ No structured activity

....

How satisfied or dissatisfied are you with the main activities that you do?

- ☐ Very dissatisfied
- ☐ Kind of dissatisfied
- ☐ Kind of satisfied
- ☐ Very satisfied

....

Do you feel that you are engaged in activities: (Choose one)

- ☐ Less than you would like   ☐ More than you would like   ☐ As much as you want

....

What would you like to have as your main activity?

- ☐ Paid employment
- ☐ Volunteer or unpaid work
- ☐ School
- ☐ Treatment/rehabilitation program   ☐ Other
- ☐ Craft/leisure time/hobbies
- ☐ No structured activity

PSYCHOLOGICAL WELL-BEING

Now we would like to know how you feel about things in your life. For each of the following questions, check the boxes that best describe how you have felt in the **past month**.

YES	NO	
☐	☐	Pleased about having accomplished something?
☐	☐	Very lonely or remote from other people?
☐	☐	Bored?
☐	☐	That things went your way?
☐	☐	So restless that you couldn't sit long in a chair?
☐	☐	Proud because someone complimented you on something you had done?
☐	☐	Upset because someone criticized you?
☐	☐	Particularly excited or interested in something?
☐	☐	Depressed or very unhappy?
☐	☐	On top of the world?

In the **past month**, would you say that your mental health has been:

☐ Poor   ☐ Fair   ☐ Good   ☐ Very Good ☐ Excellent

SYMPTOMS/OUTLOOK

During the **past month**, you have: (Check one)

☐ generally felt calm and positive in outlook

☐ been having some periods of anxiety or depression

☐ generally been confused, frightened, anxious or depressed

There are many aspects of emotional distress including feelings of depression, anxiety, hearing voices, etc. In the **past month**, how much distress have these symptoms caused you?

☐ Not at all   ☐ A little   ☐ Some   ☐ A moderate amout   ☐ A lot

In the **past month**:	Never	Occa-sionally	Frequently	Most of the time	Constantly
How much have they interfered with your daily life?	☐	☐	☐	☐	☐
Have you felt like killing yourself?	☐	☐	☐	☐	☐
Have you felt like harming others?	☐	☐	☐	☐	☐

PHYSICAL HEALTH

In the **past month**, you would best describe your physical health as:

☐ Poor   ☐ Fair   ☐ Good   ☐ Very Good   ☐ Excellent

How do you feel about your physical health?

☐ Very dissatisfied   ☐ Neither satisfied or dissatisfied   ☐ Very satisfied

☐ Moderately dissatisfied   ☐ A little satisfied

☐ A little dissatisfied   ☐ Moderately satisfied

How important to you is your physical health?

☐ Not at all important   ☐ Moderately important   ☐ Extremely important

☐ Slightly important   ☐ Very important

Are you currently taking psychiatric medications?   ☐ Yes   ☐ No

If you are currently taking psychiatric medications, do you take them as prescribed?

☐ Never   ☐ Sometimes   ☐ Always

☐ Very infrequently   ☐ Quite often

If you are currently taking psychiatric medications, do you have side effects from them?

☐ None   ☐ Slight   ☐ Mild   ☐ Moderate   ☐ Severe

If you take medications for mental health problems, do you feel the medication helps control your symptoms?

☐ Not at all   ☐ Some   ☐ A fair amount   ☐ Quite a bit   ☐ Eliminates all symptoms

How do you feel about taking your psychiatric medications?

☐ Very happy   ☐ Okay   ☐ Neutral   ☐ Mildly unhappy   ☐ Very unhappy

ALCOHOL & OTHER DRUGS

Over the **past month**, have you drank any alcohol?

☐ Yes ☐ No

If yes, on how many days have you had any alcohol to drink?_____
(number of days)

What do you think about your alcohol use? (Check one)

☐ It is a big problem ☐ Not a problem

☐ It is a minor problem ☐ It helps a little

Over the **past month**, have you used any street drugs (cocaine, marijuana, heroine, LSD, etc.)?

☐ Yes ☐ No

If yes, on how many days have you used any street drugs? _____
(number of days)

How do you think about your drug use? (Check one)

☐ It is a big problem ☐ Not a problem

☐ It is a minor problem ☐ It helps a little

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the number of friends you have?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with how you get along with your friends?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your relationship with your family? ☐ **No family**	☐	☐	☐	☐	☐	☐	☐
If you live with others, how satisfied or dissatisfied are you with the people you live? ☐ **Live alone**	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with how you get along with other people?	☐	☐	☐	☐	☐	☐	☐
How many people do you count as your friends?	☐ none	☐ 1-2	☐ 3-5	☐ over 5			

IMPORTANCE LEVEL

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important is it to have an adequate number of friends?	☐	☐	☐	☐	☐
How important is it to get along with your friends?	☐	☐	☐	☐	☐
How important are family relationships?	☐	☐	☐	☐	☐
If you live with others, how important are the people with whom you live?	☐	☐	☐	☐	☐
How important is it to get along with others?	☐	☐	☐	☐	☐

During the **past month**, you have (check one):

☐ been having good relationships with others and receiving support from family and friends

☐ been receiving only moderate support from family and friends

☐ had infrequent support from family and friends or only when absolutely necessary

MONEY

Are you paid for working or attending school?　☐ Yes ☐ No

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How do you feel about the amount of money you have?	☐	☐	☐	☐	☐	☐	☐
How satisfied are you about the amount of control you have over your money?	☐	☐	☐	☐	☐	☐	☐

	Not at all important	Slightly important	Rather important	Very important	Extremely important
How important to you is money?	☐	☐	☐	☐	☐
How important is it to you to have control over your money?	☐	☐	☐	☐	☐

How often does lack of money keep you from doing what you want to do?

☐ Never ☐ Sometimes ☐ Frequently

ACTIVITIES OF DAILY LIVING

Below are activities that you may have participated in recently. Please check YES or NO to indicate whether you have done the activity in the **past month**.

YES	NO	
☐	☐	Gone shopping
☐	☐	Gone to a restaurant or coffee shop
☐	☐	Prepared a meal
☐	☐	Gone for a ride in a bus or car
☐	☐	Done the laundry
☐	☐	Cleaned the room/apartment/home

During the **past month** you:

☐ have been able to do most things on your own (such as shopping, getting around town, etc.)

☐ have needed some help in getting things done

☐ have had trouble getting tasks done, even with help

In the **past month**, how often have you had any problems with personal grooming (e.g. taking showers, brushing your teeth)?

☐ Never ☐ Sometimes ☐ Frequently ☐ Almost always

GOAL ATTAINMENT

What did you hope to accomplish as a result of your mental health treatment? Please write below up to 3 goals:

Goal 1: _____ ___ —

 How important is this goal to you?

  ☐ Not very important ☐ Somewhat important ☐ Extremely important

 To what extent have you achieved this goal?

  ☐ Not at all ☐ Somewhat ☐ Completely

Goal 2: _____

 How important is this goal to you?

  ☐ Not very important ☐ Somewhat important ☐ Extremely important

 To what extent have you achieved this goal?

  ☐ Not at all ☐ Somewhat ☐ Completely

Goal 3: _____

 How important is this goal to you?

  ☐ Not very important ☐ Somewhat important ☐ Extremely important

 To what extend have you achieved this goal?

  ☐ Not at all ☐ Somewhat   ☐ Completely

Below are activities that you may have participated in recently. Please check Yes or No to indicate whether you have done the activity in the **past month**.

YES	NO		YES	NO	
☐	☐	Gone for a walk	☐	☐	Gone to a social group
☐	☐	Gone to a movie or play	☐	☐	Read a magazine or newspaper
☐	☐	Watched TV	☐	☐	Gone to church
☐	☐	Played cards	☐	☐	Listened to a radio
☐	☐	Played a sport	☐	☐	Gone to a library

Please check the box below to indicate how you feel about your quality of life during the **past month.**
Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST QUALITY ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **HIGHEST QUALITY**
1 2 3 4 5 6 7 8 9 10

If your quality of life is less than you hope for, how hopeful are you that you will eventually achieve your desired quality of life?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very

How much control do you feel you have over the important areas of your life?
☐ None ☐ Some ☐ A moderate amount ☐ A great amount

Which of the following factors do you think are most important in determining your quality of life?	Not important	Slightly important	Mildly important	Moderately important	Extremely important
Work, school or other occupational activities	☐	☐	☐	☐	☐
Your feelings about yourself	☐	☐	☐	☐	☐
Your physical health	☐	☐	☐	☐	☐
Friends, family, people you spend time with	☐	☐	☐	☐	☐
Having enough money	☐	☐	☐	☐	☐
Ability to take care of yourself	☐	☐	☐	☐	☐
Psychological symptoms	☐	☐	☐	☐	☐
Other, please specify:	☐	☐	☐	☐	☐

Is there anything else you would like us to know?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of Wisconsin-Madison, 610 Langdon Street, 325 Lowell Hall, Madison, WI 53703 Telephone: 608/263-3287 or 1/800/442-4617 E-Mail: marion.becker@mail.admin.wisc.edu