A REVIEW OF EXISTING MENTAL HEALTH COMMUNITY

SERVICES IN THE ST. JOHN'S REGION: GAPS AND RECOMMENDATIONS

by

© Scott Beattie

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Abstract

Since the mid twentieth century, the care and treatment of people with mental illness has moved from primarily institutional settings to the community. Despite great efforts to develop/implement community services to support mental health consumers in the St. John's area, there still remains gaps in service. The Recovery Model was used as the theoretical framework to complete an assessment of existing challenges in the provision of mental health care in the community. This assessment included a comprehensive literature review, consultations with stakeholders and a environmental scan of existing services in the St. John's area. From these processes, there were identified needs for services specific to marginalized groups including those with forensic histories and concurrent disorders. Generalized case management services, home support and peer support were identified as needing expansion. Lack of inter-program collaboration and difficulty with system navigation were also identified as barriers. Recommendations include, 1) provider education in working with specific populations and those groups who are difficult to engage, 2) improving collaboration, eliminating silos and building a service continuum amongst existing programs, 3) increased access to non-traditional services such as home and peer support. Limitations of this project include the lack of consultations with consumers. A consumer voice is essential in a recovery approach to health provision. Both adolescent and geriatric services must also be included in a comprehensive assessment. Advanced nursing competencies that were utilized during this process include clinical practice, research, leadership, consultation and collaboration.

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Mental illness on an international, national and provincial scale is monumental problem. World wide, about one person in one-hundred is considered to have a chronic mental illness (Greenblatt & Norman,1983). The combined prevalence of mood disorders, anxiety disorders, and substance disorders is about 11.1 percent, and about 21 percent of Canadians are affected by a mental illness at some time in their lives (Arboleda-Florez, 2005). Mental health disorders are the leading cause of disability in the U.S. and Canada for ages 15-44 (National Institute of Mental Health, 2009). In Newfoundland and Labrador 11.0% of mental health inpatients had three hospital admissions between 2010-2011 (Canadian Institute for Health Information [CIHI], 2011).

The above statistics and anecdotal observations suggest that despite efforts to develop/implement community services to support mental health consumers in the St. John's area there still remains gaps in service. To learn more about what may be missing, this project was undertaken. This report is comprised of three primary activities, 1) a literature review, 2) consultations with stakeholders, and 3) an environmental scan. Each activity informed the next. For example, The literature review informed the development of the questions asked during the consultations. Key findings from these activities were compiled into a report that also contains recommendations for community mental health services in the St. John's area.

Background and Rationale

In the last fifty years there has been a shift in the management of individuals living with mental health concerns from institutionalization towards deinstitutionalization

or community based treatments (Kelly & McKenna, 2004). Contributing to this trend are concerns as to the ill effects of a prolonged stay within large institutions, the civil rights movements of the 1960's and 1970's (Kelly & McKenna, 2004), and pharmacological advancements. Advocates of deinstitutionalization, argue that higher level psychological needs, such as self-esteem, are not met in the institutional setting (Kelly & McKenna, 2004). Furthermore, institutionalization of the mentally ill is considered a violation of an individual's right to freedom, a public disgrace, and a social disaster (Talley & Coleman, 1992). Pharmacological advances, such as the development of first generation antipsychotics, has helped treat those with mental illness in the community for longer periods of time hence, shortening hospital admission times (Capdevielle, Ritchie, Villebrun, & Boulenger, 2009).

In the 1950's about 63% of mentally ill persons were lodged in psychiatric hospitals and by the early 1970's this had dropped to 33% (Greenblatt & Norman, 1983). The primary psychiatric hospital in Newfoundland housed 1000 people in the 1960's and today has less than 200 beds (Eastern Health, 2007). It is estimated that the number of inpatient beds in Canadian psychiatric hospitals decreased from four beds per 1000 population in 1964 to less than one bed per 1000 population in 1979 (Sealy and Whitehead, 2004). The rapid trend towards deinstitutionalization has led to the immediate dismantling of the psychiatric inpatient system and has posed several challenges related to the lack of planning for community support (Talley & Coleman, 1992). For example community health facilities did not have the adequate supportive and psychiatric health-care services or infrastructure to support this transition or the needs of

this population (e.g., development of coping, social, and self-care skills) (Greenblatt &

Norman, 1983; Talley & Coleman,1992). Suddenly, people who may have spent much of

their lives in institutions were expected to house, clothe and feed themselves with little or

no education and social support networks (Accordino, Porter, & Morse, 2001).These

factors coupled with feelings of stigmatization, victimization, and poor housing reduced

their quality of life and increased difficulty with community living (Kelly & McKenna,

2004).

Integration into community was another challenge facing individuals living with

mental illness during the shift towards deinstitutionalization. A lack of understanding and

compassion for people with a severe mental illness can foster resentment, intolerance,

and negative attitudes within communities (Kelly & McKenna, 2004). In fact these

negative community attitudes were often found to have caused this cohort more problems

than their illness (Accordino, Porter, & Morse, 2001). That is, they found it difficult to

cope with the challenges of their mental illness while trying to live in a community where

they may not be welcomed. Collectively these factors create an environment wherein

those living with a mental illness become marginalized as their mental illness and their

personal circumstances exacerbate each other, making life in the community very

difficult (Johnson & Montgomery, 1999). As a result many are homeless or living in

conditions that are deplorable and dangerous. Some beg for money for food while others

may turn to prostitution. Many turn to street drugs, adding an addiction to their long list

troubles, or end up in the justice system.

Today there are many more outpatient options for those adults suffering from mental illness. New community based approaches to care for this population have been implemented and are making great strides in helping them become healthier, happier members of society. Case management programs, crisis response teams, trauma programs, out-reach organizations, early psychosis intervention programs, housing and employment supportive services are offered with the intent to help those in the community to move forward in their recovery in the community setting (CIH, 2011; Eastern Health, 2007; Stella's Circle, n.d.).

Although there has been an increase in mental health outpatient resources there remains a treatment gap between those that have a mental illness and those who receive treatment. It has been found that the treatment gap for schizophrenia and other psychotic illnesses is as high as 32%, depression 56%, bipolar disorder 50% , and generalized anxiety disorder 57% (Kohn, Saxena, Levav, & Saraceno, 2004). In Newfoundland and Labrador 2009-2010, 11.4% of those discharged from a mental health inpatient stay were readmitted within 30 days;, 13.8% had 2 or more admissions within the year (CIHI, 2011). Although there has been great progress in how those with mental illness are treated in the community, the above statistics indicates there is room for improvement.

The inspiration for this investigation comes from my clinical expertise as a mental health nurse and informal discussions with front line and managerial mental health workers along with consumers of mental health services. The general consensus was that there is something still missing from the existing system that serves adults with mental illness in the community. There is a feeling that some populations of mental health

consumers are not getting best outcomes from existing mental health services in the

metro St. John's area. I have had multiple conversations with referral sources who

express frustration about not being able to find a service for someone who wants help.

These mental health consumers either do not fit admission criteria for existing programs

or they are wait listed for long periods of time. What became glaringly obvious is there

are a group of consumers that do not meet the criteria for any of the current programs and

are essentially left without service. There were varied ideas and suggestions for how to

'fix' the system but it seemed prudent to complete a needs assessment to identify

emerging issues with community mental health services.

This practicum begins with an overview of the goals and objectives of the project

followed by an introduction of the Recovery Model. The Recovery Model provided the

theoretical lens upon which this practicum unfolded. A brief overview of the methods

used throughout the practicum are presented, as well as a literature review, key

stakeholder consultations, and an environmental scan of existing community mental

health services in the St. John's region. It concludes with a discussion of the key findings

that will be presented to Eastern Health along with the advanced nursing competencies.

Goal and Objectives

The goal of this practicum is to complete a needs assessment of adult outpatient

mental health services available in the St. John's region. Based on the findings of the

needs assessment recommendations for practice, research and education will be made to

the executive of Eastern Health's Adult Mental Health and Addictions (MH&A) program.

Key objectives include:

1) To complete a literature review on mental health outpatient services.

2) To consult with key stakeholders in adult mental health outpatient services to identify existing gaps in service.

3) To complete a environmental scan of existing mental health services in the St. John's area.

4) To prepare a written report entitled, Community Mental Health Services in the St. John's Area: *Challenges and Opportunities* for the executive of Eastern Health's Adult Mental Health and Addictions program.

5) To demonstrate an application of Advanced Nursing Practice Competencies.

The Recovery Model

The Recovery Model as outlined by Jacobson and Greenly (2001) provides the philosophical underpinning for this practicum project. This model takes into consideration the abstract concepts associated with the recovery process and outlines specific strategies to achieve this goal (Jacobson & Greenly, 2001). It is relevant to this practicum given that it's goal is to identify service gaps/needs in our existing system that may be a barrier to recovery. That is, mental health consumers may not be receiving the services they want or need. Recovery by definition is a very difficult concept and can have different meanings for everyone. The Australian Health Ministers' Advisory Council in their document, A national framework for recovery-oriented mental health services defined recovery as "'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (2013a, p.11).

The driving force of this needs assessment has been the idea that a recovery oriented service must be able to adapt to the changing needs of it's consumers (Australian Health Ministers' Advisory Council, 2013b). Hence this needs assessment, at its core, is about gathering information and using it to assist mental health consumers begin and continue on their recovery journey. It is not about finding a cure for a mental illness or suggesting new programs to 'manage the patient'. The purpose of this practicum, through the literature review, has been to identify what consumers report is needed to fully support them in their recovery. And through the consultation process, what service providers identify as essential components of a comprehensive program. In a second document by the Australian Health Ministers' Advisory Council (2013b), they discuss the standards of a recovery oriented mental health system. One standard states that a mental health system actively supports and promotes recovery oriented values through its policies and practices (Australian Health Ministers' Advisory Council, 2013b).

Recovery from mental illness can be described as either an outcome or a process. As an outcome, recovery has been viewed by health care professionals and families of the mentally ill as the person overcoming both the objective and subjective symptoms and disabilities that trouble them and those around them so much (Lefley, 1997). According to the Recovery Model, recovery should be regarded as a process. Deegan (1988) describes the process of recovery as a way in which we approach life and it's daily challenges. She goes on to explain that recovery is not a linear process but about meeting the challenges of the disability and re-establishing a new and valued sense of integrity and purpose within and beyond the limits of the illness (Deegan,1988).

According to this model, as presented by Jacobson & Greenley (2001), there are

both internal and external factors that influence recovery Internal factors include

attitudes, experiences and processes of change in individuals that will impact hope,

healing, empowerment and the social connections of that person. Strategies to instil hope

include helping the consumer to acknowledge and accept that they have a problem,

focusing on one's strengths and commitment to change and celebrating successes.

Healing is not necessarily a complete remission or cure from illness but rather about

assisting someone to understand that they are not the illness and are therefor not defined

by it. Through this process, consumers can regain a sense of self-esteem and begin to

reclaim control over their own life. Empowerment, relates to the sense of helplessness

that many mental health consumers feel about their illness and subsequent treatment. To

empower someone means to help restore their autonomy, courage and responsibility. It is

not only about returning the persons right to choose the health care they receive but also

helping them understand that they are an active participant in their recovery and not just a

passive recipient of treatment. Finally, connections is about maintaining or restoring a

persons connection with society. For some consumers, the only connection they have is

with their health care provider. It is essential for a mental health service to provide or

facilitate opportunities for consumers to develop and maintain connections with others

which will in turn begin to restore hope and healing.

External conditions, as noted by Jacobson & Greenley (2001) are the

"circumstances, events, policies, and practices that may facilitate recovery" (p. 484).

Jacobson & Greenley (2001) discuss that the external conditions that define recovery are

human rights, a positive culture of healing and recovery oriented services. Human rights as it relates to mental illness is described as the elimination of associated stigma and discrimination, promoting and protecting the rights of consumers along with providing equal opportunity and access to mental health resources. A positive culture of healing is regarded as providing a service with a philosophy of inclusion, caring cooperation, empowerment, hope, respect and trust. Examples of this include a consumer voice in care provision and the use of peer support workers as counsellors and care coordinators. Finally, recovery oriented services must include services directed at "symptom relief, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help." (Jacobson & Greenley, p. 484). These services are intended to address the major consequences of mental illness; impairment, dysfunction, disability, and disadvantage.

It is clear that internal and external factors share a reciprocal relationship and it would be impossible to provide a comprehensive service without consideration of both. This needs assessment comes from my personal view that there are many people that are still in need of services and support. The goal is to identify where the needs may lie and with luck, be a catalyst for the provision of new services. I believe the Recovery Model offers a conceptual direction that is appropriate for identifying gaps in existing services. In the review of literature, an emphasis was placed on the voiced needs of consumers and what they prioritize as essential to an outpatient mental health service. This information combined with interviews with key stake holders that work within the existing system, may allow for the emergence of a consumer/clinician partnership. This partnership may,

in turn, begin to change the direction of care provision with an emphasis placed on recovery as a consumer concept rather than a clinician defined one.

Methods

A comprehensive literature review was completed using PubMed, CINAHL, Cochrane Library, and Google Scholar. Key words included: psychiatric outpatient services, gaps in mental health services, admission criteria, transitionary services, best practices, mental health outpatient, step down services and deinstitutionalization. Using materials from Nursing 6660/6661 and the Infection Prevention Control Guidelines' Critical Appraisal Tool Kit (Public Health Agency of Canada (PHAC), 2014), the strength of the articles' were determined. A comprehensive literature review and literature review table can be found in appendix A and B. A synopsis of the literature review is presented below.

In person consultations with key informants were done. This included nurses, social workers, occupational therapists, mental health workers, and peer support workers. Informants included those at the senior executive level, program management level, clinical lead and front line mental health service employees. (see Appendix C)

An environmental scan of approximately 60 community mental health services operated by Eastern Health and other agencies was completed and compiled in a table format (see Appendix D).

Because of the nature of this practicum and to reduce redundancy, all references from the appendices have been compiled into a single list found at the end of this document.

Literature Review

The challenges that impact the recovery of mental health consumers (MHC) include 1) access to resources, 2) socio-demographics, 3) appropriateness of resources and 4) disparities in services.

Access to Resources

Access to resources such as information, social supports, housing, and skills development were key factors that influence the health of MHC. Adding to this are concerns around coordination and collaboration of these services, as MHC needs for specific services merge.

Information. Lack of knowledge about the management of their health as a key concern for MHC. This ranged from general information about their illness to management of prescribed medications (Barbato et al., 2014; Brems, Johnson, Corey, Podunovich, & Burns, 2004; Sunderland & Findlay, 2012), and to physical health issues related to living with a chronic disease. This is concerning given that those living with a with severe persistent mental illness have a life expectancy of 13-30 years shorter than the general population (De Hert et al., 2011) because of a high incidence of chronic illness (e.g., obesity, diabetes mellitus, metabolic syndrome (De Hert et al. 2011; Torres-Gonzalez et al., 2014.). In addition, MHC's are at higher risk for sedentary lifestyle, unhealthy diets, substance use, and are twice as likely to smoke thus, access to information to manage these comorbidities critical (Saddichha, Manjunatha, Ameen, & Akhtar, 2008; Torres-Gonzalez et al., 2014).

MHC often have complex medication regimes the can result in negative physical side effects and lead to chronic disease. For example, some atypical antipsychotics contribute to obesity, metabolic syndrome, and diabetes (De Hert, Schreurs, Vancampfort, & Van Winkel, 2009; Saddichha et al., 2008). Psychotropic medications are also strongly associated with sexual dysfunction and reduced social interaction; a common reason for rejecting medications (Torres-Gonzalez et al., 2014).

Social Supports. A social connection with other consumers, peer support programs, participation in daytime activities, and intimate relationships have all been identified as voiced needs of the MHC (Barbato et al., 2014; Beebe 2010; Brems et al., 2004; Lasalva et al., 2007; Werner, 2012; Zuniga et al., 2013). In fact, between 17% and 75% of individuals living in the community stated they lacked supports such as counselling, medication support, opportunities for social interaction, and help with activities of daily living needed for recovery (Brodbent, Kydd, Sanders, & Vanderpyl, 2008; Pagura, Fotti, Katz, & Sareen, 2009; Sunderland & Findlay, 2012; Urbanoski, Cairney, Bassani, & Rush, 2008). Werner (2012) used the Camberwell Assessment of Need-Patient (CANSAS) and reported that a significant percentage of consumers identified intimate relationships (35.9%), sexual expression (31.6%), and company (24.8%) as unmet needs. Zuniga et al. also used the CANSAS and noted that a significant percentage (19.3%) of MHC identified company and daytime activities (11.8%) as unmet needs.

Evident in the literature is the lack of formal support networks to enable this population to remain in their homes, such as community health workers, case managers,

counsellors, and mental health workers (Barbato et al., 2014; Brems et al., 2004; Pagura et al., 2009; Sunderland & Findlay, 2012). This lack of supports often delays necessary interventions such as liaising with other agencies or landlords, assisting with appointment attendance or medication changes which can negatively impact MHCs health care outcomes and perceptions of care (Barbato et al., 2014).

Literature suggests that MHC concerns may not be related to the need for more intensive services but rather a different approach to service provision (Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992; Morse et al.,1997 ; Calsyn, Morse, Klinkenberg, Trusty, & Allen, 1998). Such as in home and community based services rather than clinic and office based. Others state that it may be related to a lack of community engagement, stigma, and knowledge (Kohn et al., 2004). This is significant because there is a large community mental health service network in the metro St. John's area yet are still service gaps remain.

Housing. The relationship between mental illness and access to safe affordable housing is clear within the literature. People living with a mental illnesses often face challenges relating to employment and income, thus struggle with maintaining adequate housing (Munn-Rivard, 2014). Inadequate housing can lead to a multitude of stressors that impact coping skills, self-esteem, emotional well-being (Canadian Institute for Health Information [CIHI], 2007), and exacerbation of a mental illness (Munn-Rivard, 2014). Research has shown that 80% of MHC felt that having secure housing is a key factor in preventing hospitalization (Werner, 2012; Brems et al., 2004). Hanson, Houde, McDowell, and Dixon (2007) found that even with case management or assertive

community treatment, the need for housing services was paramount in the recovery of those living with mental health concerns.

Skills: New and Evolving. In order to move towards recovery MHC need essential skills that include maintaining a household (e.g., cooking), vocational rehabilitation (e.g., upgrading), and accessing/maintaining educational opportunities (e.g., college) (Barbato et al., 2014; Hanson et al., 2007; Pagura et al., 2009; Werner, 2012; Zuniga et al., 2013). Of these, vocational rehabilitation was identified 50% of the time as a priority skill (Barbato et al., 2014). Part of tailoring progams focused on daily skills is an awareness that the skill set of MHC is transient (Torres-Gonzalez et al., 2014). Longitudinal research has found that over time health needs of consumers declined yet social needs increased (Lasalva et al., 2007). This may indicate that there is a shift in priority for the MHC; once their higher health needs are met, they identified other areas of importance such as socialization.

Coordination and Collaboration. The literature has shown that problems at program and administrative levels of services related to coordination and collaboration create barriers to those seeking services (Sunderland and Findlay, 2012). Lack of continuity of care, wait times, and choice of provider can negatively impact the mental health consumer (Barbato et al., 2014; Pagura et al., 2009; Raingruber, 2003). Inconsistent staffing, gatekeeping, and compartmentalization of the mental health system was found to hinder the treatment of people with depression and suicidal ideation (Raingruber, 2003). A big concern is that people fail to seek help simply because they do not know where to avail of desired services (Pagura et al., 2009).

Collaboration of services between inpatient and community psychiatric services was noted to improve quality of care such as early intervention, service transition, and decrease wait times (Kisely & Chisholm, 2009; Hansson, Ovretveit, Askerstam, Gustafsson, & Brommels, 2010; Holst & Severinsson, 2003; Mental Health Commission of Canada, 2012). In fact coordination in networks improved mental health services in all themes of the Camberwell Assessment of Needs (CAN) including daytime activities, psychotic symptoms, and interactions with family (Hansson et al., 2010).

Sociodemographics

Age, education and income, gender, and ethnicity were all found to influence the health of MHC.

Age. Although there is some conflicting research, young adults have been shown to have less access to community mental health services, disengage from services earlier, and have more unmet mental health needs (Urbanoski et al., 2008; Zuniga et al., 2013). Reasons cited as to why this is the case include difficulty with attendance, accepting help, developing therapeutic relationships, crafting mutual goals, lower satisfaction with services, and stigmatization (O'Brien, Fahmy, & Singh, 2009). In contrast, Routhier, Leduc, Lesage and Benigeri (2012) found that age did not affect after care service use by consumers recently hospitalized for attempting suicide. These findings question the relationship between age and satisfaction with community health care services warranting more research in this area.

Education and Income. Education levels and income have also been found to impact the need for mental health services. One Canadian survey found that those with

less than 13 years education, were less likely to use mental health services (Tiwari & Wang, 2008). A second Canadian survey reported that individuals with low incomes required more mental health services than those in middle and high income brackets (Urbanoski et al., 2008). Continuity of care is also impacted by income levels. In one study, a housed group had a significantly greater continuity of care of services in comparison to those who were homeless and economically disadvantaged (Fortney et al., 2003). Lasalva et al. (2007) also found that sociodemographics is a significant predictor of consumer rating of needs such as access to services including counselling.

Gender. Gender has also been identified as a predictor of the need for and engagement with community mental health services (Lasalva et al., 2007; Routhier et al., 2012). However evidence remains unclear as to the strength of this relationship. Males with a diagnosis of mental illness and substance abuse were found to use more community services post hospital discharge than females (Routhier et al., 2012). Lasalva et al. (2007) noted that being male was linked to an increase in health and social domains of need. In contrast O'Brien et al. (2009) found, in their review, that gender is not consistently a factor for service engagement. This is interesting because hospitalization rates for women with anxiety disorders, in Canada, are twice as high as those for men (Health Canada, 2002). Women are also 1.5 times as likely to be hospitalized for an attempted suicide than men despite the fact that the suicide rate is almost five times higher with males in Newfoundland and Labrador (Edwards et al., 2008; Health Canada, 2002).

Ethnicity. Research has shown disparities in the use of community mental health services for both immigrant populations along with Canada's Aboriginal populations (O'Brien et al., 2009; Reitmanova & Gustafson, 2009; Tiwari &Wang, 2008; Wilson & Cardwell, 2012).

Reitmanova and Gustafson (2009) investigated the availability of primary mental health care information and services for visible minority immigrants in St. John's, Newfoundland. In a community scan of available services they were unable to find any mental health services specific to immigrants. The Association for New Canadians (ANC) was the only organization providing counselling and group supportive services. Participants reported challenges with obtaining information, language and literacy, mistrust, stigma, wait times, finances, and insensitivity (Reitmanova & Gustafson, 2009).

There is also a body of literature that has examined the mental health of Aboriginal populations in Canada. There are about 1.4 million people who claim aboriginal identity and roughly 4500 of them live in the metro St. John's area (Statistics Canada, 2011). Both the rate of depression and suicide for First Nations people is two times higher than that of the Canadian population (Adelson, 2005; Khan, 2008). It has been found that ethnic minorities and those who live in urban environments have poorer social networks and lower engagement with mental health services (O'Brien et al., 2009). Thus, it is essential that any community based mental health program be sensitive to and educated about the cultural differences and values held by its ethnic and Aboriginal populations.

Appropriateness of Services

Health care workers' priorities sometimes differ from the client's identified needs, including the priority of treatment goals, what needs are met/unmet, and the importance of therapeutic relationships (Brodbent, Kydd, Sanders, & Vanderpyl, 2008; Happell, 2008; Kreyenbuhl, Nossel, & Dixon, 2009; Lasalva et al., 2007; O'Brien et al., 2009; Raingruber, 2003; Werner, 2012). This can lead to an inappropriate use and allocation of services however there is a dearth of literature that examines the inappropriate use of services by MHC. To clarify, MHC's may be getting a service that does not meet or exceeds their actual needs, meanwhile there may be other MHC's waiting for this exact service. Excessive service provision in such a case restricts the availability of resources for those who do have a need for that service. Rosenheck, Neale and Mohamed (2010) investigated consumer responses to being transitioned to a lower intensity service from a high intensity service that traditionally does not discharge. They found that individuals who transitioned required significantly lower crisis interventions and had significantly less symptoms on the Brief Psychiatric Rating Scale (BPRS). Similarly, Hanson et al. (2007) did a comparison of assertive case management (ACM), office based case management (CM) and residential treatment (RES). Findings show that programs offered in each management approach used excessive resources in areas of medication support, counselling, nutrition and activities of daily living (ADL). In fact 18% of RES, 10% of CM, and 4% of ACM consumers were rated as able to function at a lower level of care.

Staff reluctance to discharge people even if they may not need that level of service has also been noted as a factor contributing to this overuse of services (Bromley, Mikesell, Armstrong, & Young, 2014). Reasons contributing to failure to discharge

clients included concerns about clients' future, how to manage disengaged consumers, and confusion about who decides who is to be discharged (Bromley et al., 2014). Werner (2012) suggests that patients are sometimes provided with services because of their availability rather than an actual need. This can lead to situation wherein individuals are linked to available services rather than the appropriate one.

Disparities in Services

There is inconsistency in the literature as to the criteria for allocation of mental health resources. Existing community mental health services such as assertive community treatment and intensive case management tend to be more focused on those living with schizophrenia (Brodbent, et al., 2008; Rosenheck et al., 2010; Zuniga et al., 2013), as opposed to those living with anxiety, depression, or a concurrent disorder (O'Brien et al., 2009). In a recent Canadian study of individuals hospitalized for attempted suicide (Routhier et al., 2012) those with depression had lower rates of contact (56%) with mental health services than those with schizophrenia (77%). This is surprising given that that schizophrenia affects 1% of the population while major depression and anxiety disorders affect between 8% and12% of the population respectively (Health Canada, 2002). It is also true that of those psychiatric admissions, a large percentage (28% or higher) of them are admitted with depression or anxiety related whereas, less than 25% were admitted with schizophrenia (Brems et al., 2004; Thompson et al., 2004). In Newfoundland and Labrador alone there are four times the number of days spent in acute care hospital beds by those with mood and anxiety disorders than those with a psychotic illnesses (Johansen, Sanmartin, & LHAD Research Team, 2011).

Despite the fact that anxiety and depression are a global issues, research indicates that those impacted by these illnesses are not getting the services they need in the community thus disengage from programs (Ruggeri et al., 2007; Routhier et al., 2012). One study of a community based treatment program showed that 49% of participants without a psychotic illness dropped out of the program because of service dissatisfaction whereas, those with a diagnosis of schizophrenia were more likely (in 90% of cases) to stay in the program (Ruggeri et al., 2007). Similarly, people with a diagnosed personality disorder were found to have higher program dropout rates by comparison to those living with schizophrenia (O'Brien et al., 2009). Limited access to treatments for anxiety and depression such as cognitive behavioural therapy (CBT) has been observed at both the provider and system level (Collins, Westra, Dozois, & Burns, 2004). One review of literature, reported that up to 60% of people with anxiety or depression initially present to their family physician (Collins et al., 2004). Because of the physicians lack of experience with mental health conditions, psychotherapy, and reliance on pharmacology, many people go undiagnosed, treated or referred to specialty services.

Evidence also suggests that existing services are inadequate for those who have a concurrent mental health disorder (e.g., psychotic or affective illness) along with a substance dependence problem (Kim, Pfeiffer, Ganoczy, &Valenstein, 2011; Torres-Gonzalez et al., 2014; Urbanoski et al., 2008). Substance abuse was noted to be the most common comorbidity among patients with schizophrenia; only 12.4% of American adults with a dual diagnosis receive treatment for both their mental health and substance issues (Torres-Gonzalez et al.,2014). Noteworthy is the fact that frequent monitoring of those

with a concurrent disorder has been linked to a lower risk of re-hospitialization (Kim et al., 2011).

Summary of Literature

The literature identified several areas in the provision of community mental health care that continue to be less than ideal. Access to services such as chronic disease management, social supports, housing, and skill development are key needs of mental health consumers threaded throughout the literature. These needs are influenced by ones sociodemographic profile and continue to impact not only the needs but also the priorities of mental health consumers. Furthermore there appears to be discrepancy in the allocation of services leaving those living with depression, anxiety and concurrent disorders with limited resources, warranting a different approach to service provision. Adding to this issue is a lack of clarity with MHC regarding where to go for help. Evident in the literature is that community mental health services struggle with maintaining continuity of care and effectively collaborating with other services to optimize care provision for the consumer. The general consensus in the literature is that there continues to be differing priorities between health providers and consumers as to the type of service required. This discrepancy continues to impede the health and well being of MHC.

Consultations

Given that a majority of the research surrounding the needs of mental health consumer's (MHC) took place outside of Newfoundland and Labrador, and even Canada, generalizability is difficult. Newfoundland and Labrador is a unique province with a

unique population and culture. It is essential that we begin to develop an understanding of this population's needs so we may fine tune our services.

Consultations with ten key stakeholders in the field of mental health was done to gain a better understanding of the potential needs of MHC in the St. John's region. Members of a multidisciplinary group were chosen based on their community mental health expertise at various levels of Eastern Health's Mental Health and Addictions programs; including senior (1) and division managers (2), patient care coordinators (1), clinical leaders (4), front line clinical employees(1), and one physician. Participants' health disciplines included nursing, social work, occupational therapy, peer support, and medicine (psychiatry). Each interview lasted between one and two hours. Three three key areas of concern were identified (1) access to services: specialty and general; (2) program collaboration; and (3) psychosocial supports.

Access to Services: Specialty and General

Specialty Services. There was a consensus amongst the stakeholder interviews that a discrepancy exists between the MHC needs and what services (general and specific) are actually being provided in the community. That is, although the majority of this population did receive some type of community services they were not necessarily the 'best fit' for the MHC needs. However, as one stakeholder summarized, "it was the only service available close to what they needed at the time". This was the case for several groups including those with forensic histories (e.g., arson charges, extremely violent, sexual offences), concurrent mental health disorders, personality disorders, sexual orientation concerns, autism, and those with brain injuries.

In the case of those with concurrent disorders, limited service access was attributed to difficulty in treating such complex cases with finite resources and the increased demands for MHC services. Hence, members of this group would often find themselves attending services that were not inclusive of their entire needs. Those with some diagnosed personality disorders face similar challenges. Consultants spoke of the long term need for services of this population coupled with the fact that they can be a very challenging group to work with as an issue. Noteworthy, was the fact that this population have limited service options being that their presentation is dismissed as behaviour rather than illness, which limits their service options in the community.

Stakeholders stated that sexual identity issues was an area where staff lacked the training and skills to properly meet the needs of MHCs. The lack of training amongst staff was also noted with respects to working with the diverse cultural and spiritual needs of those consumers from visible minority groups (e.g., Aboriginal groups).

An unexpected MHC group was identified through the consultations; those living with autism spectrum disorders. Stakeholders reported that they are receiving more referrals to provide services for this population than ever before. This is concerning because most staff have no experience or training in working with this group of people. Individuals living with brain injuries and cognitive impairments were also noted as receiving inadequate services and being referred to mental health programs at an alarming rate. It was explained that although the cause of a brain injury may be physical in nature, the symptoms can often manifest as those of mental illness. As a result medical and mental health programs reject referrals for this population which could leave these

people with no services at all. One solution offered was the implementation of more specialized services that could ease the congestion of the programs admitting this clientele in effort to meeting their needs. Again, as noted previously what is concerning is the lack of success in matching mental health services with the needs for such as complex target group with multiple needs.

Staff need specialized skills to help populations with diverse cultural and emerging health care needs specifically aboriginal groups, sexual identify concerns, forensic histories, autism and brain injuries.

General Services. A common concern of the consultants is that people who need a more general service sometimes "don't fit" under the parameters of a specific program. This has contributed to growing waitlists and problems navigating the system. There was a sense that a programs' criteria sometimes excludes people who do not require a specialized or intensive service but would benefit from services such as medication support and monitoring, appointment reminders, system navigation, and general questions and answers about their health. A generalized case management services was seen as an important alternative to specialized services. This would be comprised of a team of health care providers that would focus on helping MHC manage activities of daily living, navigate community resources, and provide symptom management advise. Consultants proposed that while the diagnostic criteria for such a program should not be too restrictive as to allow the consumer to decide on the level of engagement, if existing programs were to allow admission of people who do not meet its criteria, then the integrity and fidelity of that program may be compromised.

Waitlists for program and service entry were identified as an ongoing concern. Program expansion was voiced as a possible solution however with the addition of the above recommended services, this may not be needed. Repeatedly, examples were given of referrals made to multiple programs where the MHC was declined access. This supports the notion that there is a lack of services for those MHC who require generalized services and do not meet the criteria for the existing more specialized programs.

It was also evident in the stakeholders narratives that there is an increasing need for services that address physical health concerns and chronic disease management. For example, although referrals are made for diabetes education these are limited partly because of human and financial constraints. As well, MHC often need additional support and follow up in the community to translate what they have learned into practice. there was unanimous agreement that MHC are stigmatized within the medical system and because of this many do not seek medical care or are denied service because "they're trouble makers".

The consultants spoke of system navigation as a serious barrier for people wanting community services. This issue is not only a consumer barrier but a provider problem. Several consultants voiced that they are unclear about existing services in the metro area and their criteria for admission. In cases such as this a system navigator would be helpful.

Program Collaboration

There is a sense that inter-program collaboration is on the rise within the Mental Health and Addictions program. However, the health care system is not fully prepared to

handle such an approach whereby MHC can transition between services based on their shifting needs, without gaps in service provision. It was suggested that services must work on a continuum where discharge or graduation from a service would make a client eligible for another service.

Stakeholders acknowledged the fact that MHC are starting to advocate more for themselves. While they appreciate this step forward, the reality is that many resources are based on program budgets and are not feasible (eg., more money for a larger apartment, sheltered employment, immediate access to a psychologist). Programs are working with MHC to identify needs and develop plans of action to tailor services. Consultants also report that some programs are taking a evidenced based approach to allocation of resources in effort to meet the priority needs of MHC such as peer support services and physical activity.

Psychosocial Supports

Services such as social and peer support, housing, and home support were identified as essential factors for a community mental health system. Psychosocial supports (peer support and home support) were noted as being inadequate by all consultants. Peer support is available within a small number of Eastern Health programs however the primary organization that offers this service is outside of Eastern Health's authority. The consensus was that a peer support program should reside under Eastern Health so that all MHC could equally avail of this opportunity. These sentiments were the similar in the case of home support services but not for housing.

Housing was identified as a very serious problem within the St. John's area. There were various responses regarding whether the Mental Health and Addictions program should be more involved. Several consultants expressed that other agencies should carry this responsibility. The literature also identified lack of safe affordable housing as a barrier to recovery however, it did not discuss specifically who is responsible. Despite the debate on who should take the lead in this , all consultants agreed that safe, secure housing is essential for recovery from mental illness.

Summary of Consultations

Not only did the consultants identify specific groups in need of improved community services (forensic histories, concurrent disorders, some personality disorders, autism spectrum, those with brain injuries, sexual identity issues and ethnic minorities), they also identified the need for a more generalized service that was able to provide concrete supports to consumers. These included medication and health support, assistance with activities of daily living and system navigation. It was clear that consultants believed that existing services were important but cannot be everything to everyone. Also, waitlists to some community services and the need for service expansion was an identified need. There was also the suggestion that both workers and consumers struggle with navigating the large and somewhat disconnected system. This led to the identification of the need for improved program collaboration as to ease consumer transition and improve service provision. Finally, the consultants identified chronic disease management and psychosocial services such as home and peer support as important factors in recovery and in need of expansion.

Environmental Scan

The community programs fall into two distinctive categories: (1) Eastern Health's services and (2) community agencies (see Appendix E and F). Each category includes the name of the service, the type of service, the length of service provision, and admission criteria.

There are a wide range of services available to the MHC. They range from drop in programs that offer meals, group counselling and socialization, to housing assistance and employment support. A large portion of the agency services operate to meet a necessary and important need such as housing and employment services (e.g., Wiseman Centre and Stella's Circle).

Based on this environmental scan, gaps in Mental Health Consumer's (MHC) services were identified. There seems to be limited collaboration and some duplication of services between Eastern Health and the community agencies. This is evidenced by the availability of employment services from Eastern Health, Stella's Circle, the Salvation Army and others. Some exceptions include Eastern Health partnerships with Stella Burry in housing initiatives and New Hope Community Centre. Collaboration within larger organizations that run multiple programs including Stella Burry and Salvation Army were distinct. These agencies have their own mandates and operate within that capacity. Agencies provide primarily generalized services for MHCs. Limited services exist for people with specific mental health issues. Limited case management services are available with the exception of Stella Burry and the Canadian Mental Health Association (Justice Project). Inadequate continuum of services. With exception of Stella Burry, most

programs are equipped to address a limited number of issues that a MHC may have (e.g., housing, addictions, socialization). Outside of Eastern Health's community services there was an observed lack of nursing expertise as coordinator of care. Stella Burry does employ licensed practical nurses. There are a a small number of nurses, both RN's and NP's that are employed by Eastern Health but work closely with other agencies (eg., New Hope Community Centre). They offer services such as foot care and medical assessment and diagnostics. Lack of services for men. The Wiseman Centre recently transitioned from male only.

Summary of the Report to Eastern Health

A report entitled "Community Mental Health Services in the St. John's Area: Challenges and Opportunities" (see Appendix E) was developed to be presented to Eastern Health's managers and executives. It is essentially a condensed version of this document. It contains an executive summary, introduction and background, discussions of the literature review, consultations and the environmental scan. Finally, gaps or challenges are discussed and recommendations are provided. The key recommendations address areas related to mental health stigma, education, access to resources and service allocation.

Mental health care advocates must take a proactive stance to challenge stigma and misconceptions both within and out of the health care system. Social media campaigns can increase visibility while providing information on system entry and navigation.

In order to address the needs of mental health consumers those delivering mental health services must be well versed in existing treatment modalities and available

resources. Staff need specialized skills to help populations with diverse cultural and emerging health care needs, specifically aboriginal groups, sexual identity concerns, forensic histories, autism and brain injuries. This may be accomplished through the use of educational modules on best practices and/or the expanded use of clinical educators with expertise in this field. Expanded education on chronic disease management for both consumers and providers is essential.

There is a need to reevaluate how mental health consumers can access resources in an efficient manner. Imperative to this is the establishment of system navigator roles/ positions, the expansion of peer and home support programming and to continue working toward eliminating silos and improving service coordination. There needs to be a balance between generalized case management services and access to specialized services. Efforts to deliver non traditional modes of services such as expanded hours of operation, weekends, and in home care will facilitate access to resources.

Evident within the literature review, key stakeholder consultations and the environmental scan was concerns of the duplication of and the transition between services. Efforts to alleviate these issues could include the introduction of a standardized needs assessment tool (e.g. Camberwell Assessment of Need). This will help identify the unique needs of mental health consumers and to provide interventions tailored to the client. Part of this is to ensure that continuity of care is maintained. For example, the discharge or graduation from one service would make a client eligible for another, if they so choose. The success of such an approach requires increased collaboration between in

and outpatient services, as well as developing partnerships between programs so they may come together and identify gaps and duplication of services (e.g. housing).

Advanced Nursing Practice Competencies

This practicum experience has demonstrated advanced nursing competencies in clinical, research, leadership, and consultation and collaboration in accordance with Advanced Nursing Practice: A National Framework (Canadian Nurses Association (CNA), 2008).

Clinical

Within clinical competencies, the advanced practice nurse develops "advanced intervention strategies within a client centred framework for clients, communities and populations" (CNA, 2008, p 22). The purpose of this needs assessment was to make recommendations for service improvement/expansion for a population with mental health needs. Advanced clinical competencies also entail identification of "patterns that have health implications for individuals, families, groups or communities" (CNA, 2008, p.22). This consultation process identified emerging concerns/themes that can be addressed at the systems level and hopefully be the catalyst for the development of a more comprehensive service. Finally, it is also stated that the advanced practice nurse "generates new nursing knowledge and develop new standards of care, programs and policies" (CNA, 2008, p.22). A key purpose of this project was to better understand the needs of our own, unique population so services can be better tailored to meet them.

Research

Within the competency of research, the CNA describes a advanced practice nurse (APN) as being able to "identify and implement research-based innovations for

improving client care" (CNA, 2008, p. 23). By completing this literature review and

consultation process, gaps in adult mental health outpatient services have been identified

and recommendations were made that will improve the outcomes of people living with

mental illness in the community. As well, the research competency explains that the APN

should "evaluate current practice at individual and system levels in light of research

findings" (CNA, 2008, p. 24). This project disseminated relevant research and compared

it with current practices along with using the consultation process to identify possible

areas where we can improve.

Leadership

The CNA (2008) describes leadership as advocating for groups in relation to

policy decisions that affect health and quality of life. Advanced practice nurses "identify

gaps in the health-care system and develop partnerships to facilitate and manage

change" (CNA, 2008, p. 24). This practicum was ultimately about identifying the needs

of this group and promoting a change in existing services, so support can be provided and

recovery can proceed. Leadership also entails advocating for and promoting the

importance of health care access, identifying gaps in services and developing partnerships

to facilitate change. By consulting with the above people and programs, partnerships will

be formed. All outpatient programs are working toward the same goal; to improve our

patient's quality of life.

Consultation and Collaboration

Cconsultation and collaboration competencies describe the advanced practice nurse

as being able to consult and collaborate with members of a care team to develop quality

improvement strategies and advocate for changes in health policy (CNA, 2008). Again by

consulting with key stakeholders in the field of mental health, we can work together to

identify resources needed to improve existing services. By presenting these findings to

the Eastern Health executive, the people who are able to implement these changes can be

fully informed.

Limitations and Next Steps

As discussed earlier, this project is not without limitations. The scope of this

project was limited to adult mental health services that are available in the metro St.

John's area. It did not include consumers of services in the investigation. It also did not

include informants from agencies outside of Eastern Health. It is essential that mental

health consumers as well as private sector workers are invited to participate in further

identification of needs and the future direction of community services. As well, both

adolescent and geriatric services were not included in this investigation but most certainly

require their own attention in the decision to allocate services.

Conclusion

This practicum project identified existing challenges in community based adult

mental health service provision in the St. John's area. Using a literature review,

consultations with key informants and a community environmental scan,

recommendations were made to improve service access for these marginalized

individuals. Efforts to improve worker education and program collaboration can make

great strides in eliminating barriers for those seeking service. Access to information,

shorter wait times and ease of system navigation are essential for facilitating recovery. Program expansion and the addition of services for those difficult to engage and support is also recommended. It is important that the next step in this process be to work with consumers of mental health services in identifying what is most important to them.

With the Recovery Model as a conceptual framework to guide future efforts, I am confident that this project will lay the groundwork for developing a more comprehensive and inclusive mental health service.

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Appendix A: Literature Review

Gaps in Community Mental Health Services for Adults:

A Review of Literature

Scott Beattie

009259961

Mental illness on an international, national and provincial scale is monumental

problem. World wide about one person in one-hundred is considered to have a chronic

mental illness (Greenblatt & Norman,1983). The combined prevalence of mood

disorders, anxiety disorders, and substance disorders is about 11.1 percent, and about 21

percent of Canadians are affected by a mental illness at some time in their lives

(Arboleda-Florez, 2005). Mental health disorders are the leading cause of disability in the

U.S. and Canada for ages 15-44 (National Institute of Mental Health, 2009). In

Newfoundland and Labrador 11.0% of mental health patients had three hospital

admissions between 2010-2011 (Canadian Institute for Health Information [CIHI], 2011).

Within the metro St. John's area, Eastern Health primarily provides adult

community mental health services. There are also several agencies such as Stella Burry,

the Canadian Mental Health Association (CMHA), and the Salvation Army that provide

much needed support for this population. Some of these services include counselling,

case management, emergency shelters and housing services as well as home support,

skills training, employment and therapeutic recreation.

Rationale

The inspiration for this literature review comes from my clinical expertise as a

mental health nurse and informal discussions with front line, managerial and consumers

of mental health services. The general consensus was that there is something still

missing from the existing system that serves adults with mental illness in the community.

There is a feeling that some populations of mental health consumers are not benefiting

from existing mental health services in the metro St. John's area. I have had multiple

conversations with referral sources who express frustration about not being able to find a

service program for someone who wants help. These mental health consumers either do

not fit admission criteria for existing programs or they are wait listed for long periods of

time. What became glaringly obvious is there are a group of consumers that do not meet

the criteria for any of the current programs and are essentially left without service. There

were varied ideas and suggestions for how to 'fix' the system but it seemed prudent to

review the existing literature to identify emerging issues with community mental health

services.

This literature review is part one of a needs assessment that examines community

mental health services. From this literature review, issues that impact the health of mental

health consumers will be identified, questions will be developed and key stakeholders

within the system will be approached for their opinions on these issues.

Background

In the last fifty years there has been a shift in the management of individuals

living with mental health concerns from institutionalization towards deinstitutionalization

or community based treatments (Kelly & McKenna, 2004). Contributing to this trend are

concerns as to the ill effects of a prolonged stay within large institutions, concerns

regarding the care of the mentally ill, the civil rights movements of the 1960's and 1970's

(Kelly & McKenna, 2004), and pharmacological advancements. Advocates of

deinstitutionalization, argue that higher level psychological needs, such as self-esteem,

are not met in the institutional setting (Kelly & McKenna, 2004). Furthermore,

institutionalization of the mentally ill is considered a violation of an individual's right to

freedom, a public disgrace, and a social disaster (Talley & Coleman, 1992).

Pharmacological advances, such as the development of first generation antipsychotics,

has helped treat those with mental illness in the community for longer periods of time

hence, shortening hospital admission times (Kelly & McKenna, 2004; Capdevielle,

Ritchie, Villebrun, & Boulenger, 2009).

In the 1950's about 63% of mentally ill persons were lodged in psychiatric

hospitals and by the early 1970's this had dropped to 33% (Greenblatt & Norman, 1983).

The primary psychiatric hospital in Newfoundland housed 1000 people in the 1960's and

today has less than 200 beds (Eastern Health, 2007). It is estimated that the number of

inpatient beds in Canadian psychiatric hospitals decreased from four beds per 1000

population in 1964 to less than one bed per 1000 population in 1979. (Sealy &

Whitehead, 2004). The rapid trend towards deinstitutionalization led to the immediate

dismantling of the psychiatric inpatient system and posed several challenges related to the

lack of planning for community support (Talley & Coleman, 1992). For example

community health facilities did not have the adequate supportive and psychiatric health-

care services or infrastructure to support this transition or the needs of this population

(e.g., development of coping, social, and self-care skills) (Greenblatt, & Norman, 1983;

Talley & Coleman, 1992). Suddenly, people who may have spent much of their lives in

institutions were expected to house, clothe and feed themselves with little or no education

and social support networks (Accordino, Porter, & Morse, 2001). These factors coupled

with feelings of stigmatization, victimization, and poor housing reduced their quality of

life and increased difficulty with community living (Kelly & McKenna, 2004).

Integration in the community was another challenge facing individuals living with mental illness during the shift towards deinstitutionalization. A lack of understanding and compassion for people with a severe mental illness can foster resentment, intolerance, and negative attitudes within communities towards those with a mental illness. (Kelly & McKenna, 2004). In fact these negative community attitudes were often found to have caused this cohort more problems than their illness (Accordino et al., 2001). That is, they found it difficult to cope with the challenges of their mental illness while trying to live in a community where they may not be welcomed. Collectively these factors create an environment wherein those living with a mental illness become marginalized as their mental illness and their personal circumstances exacerbate each other, making life in the community very difficult (Johnson, & Montgomery, 1999). As a result many are homeless or living in conditions that are deplorable and dangerous. Some beg for money for food while others may turn to prostitution. Many turn to street drugs, adding an addiction to their long list troubles, or end up in the justice system.

Today there are many more outpatient options for those adults suffering from mental illness. New community based approaches to care for this population have been implemented and are making great strides in helping them become healthier, happier members of society. Case management programs, crisis response teams, trauma programs, out-reach organizations, early psychosis intervention programs, housing and employment supportive services are offered with the intent to help those in the community to move forward in their recovery in the community setting (Canadian Institute for Health Information [CIHI], 2011; Eastern Health, 2007; Stella's Circle, n.d.).

Although there has been an increase in mental health outpatient resources there remains a treatment gap between those that have a mental illness and those who receive treatment. It has been found that the treatment gap for schizophrenia and other psychotic illnesses is as high as 32%, depression 56%, bipolar disorder 50% , and generalized anxiety disorder 57% (Kohn, Saxena, Levav, & Saraceno, 2004). In Newfoundland and Labrador 2009-2010, 11.4% of those discharged from a mental health inpatient stay were readmitted within 30 days;, 13.8% had 2 or more admissions within the year (CIHI, 2011). Although there has been great progress in how those with mental illness are treated in the community, the above statistics indicates there is room for improvement. This literature review provides insights into the needs of this population so that health care providers can tailor health care resources that can address them.

Search Strategy

Literature was found using a key word search of Medline, PubMed, PSYCHINFO, Google Scholar databases for Canadian and world wide articles. Key words used were combinations of "gaps in service", "mental health needs", and "community mental health services". Reference sections of key articles found above were also reviewed for relevant articles. Using materials from Nursing 6660/6661 (2014) and the Infection Prevention Control Guidelines' Critical Appraisal Tool Kit (Public Health Agency of Canada [PHAC], 2014), the articles' strength was determined. Based on this search strategy there were 7 bodies of literature found that explored mental health services in the community. These included; general unmet needs and lack of engagement, consumer perspectives on service fragmentation, consumer versus provider priorities,

sociodemographics, chronic disease management, service disparities and continuity of care.

Unmet Needs/Lack of Engagement

It is apparent from the literature that many people with mental illness who require mental health services are not getting them. This may be because of a lack of availability of services or lack of engagement. Kreyenbuhl, Nossel, and Dixon's (2004), literature review found that up to 50% of people who met the diagnostic criteria for serious mental illness including schizophrenia went without treatment in the previous year. Studies have also shown that between 17% and 75% of individuals living in the community with a mental illness have unmet needs such as counselling, location of services, and in home support (Brodbent, Kydd, Sanders and Vanderpyl, 2008; Sunderland and Findlay, 2012; Pagura, Fotti, Katz and Sareen, 2009; Urbanoski, Cairney, Bassani, & Rush, 2008).The highest percentage of those voicing a need were found in people with concurrent disorders (51%) and depression or anxiety disorders (75%) (Sunderland & Findlay, 2012; Urbanoski et al., 2008). These studies are all limited by their cross sectional retrospective design and some excluded key populations, such as those with personality disorders or psychotic illnesses, that may impact generalizability (Pagura et al., 2009; Urbanoski et al., 2008).

Another factor contributing to the health of individuals living with a mental illness is that some of them are not engaged in their treatment opportunities or do not seek treatment. One study found that 24% of people who attempted suicide in the previous year did not seek mental health services (Pagura et al., 2009). Stigma and lack

of knowledge was noted to be a major contributor to not seeking treatment in a review of

the literature looking at treatment gaps in world- wide community-based mental health

services (Kohn et al., 2004). It is also suggested that fear of mental health system, a bad

previous history with the system, the perception that treatment will not be effective or

people want to solve the problem on their own all contribute to a reluctance to seek

service (Kreyenbuhl et al., 2009).

Fragmentation in Services: Consumers Perspectives

While the above section shows there are unmet needs of mental health consumers,

we do not have a clear picture of what those needs are. At this point it is prudent to

discuss literature that identifies what mental health consumers consider important for

maintaining wellness in the community. This will contribute to the identification of

external circumstances that are barriers to consumer recovery. Key areas noted in the

literature are information, human resources, social support, housing and skills

development, and the shifting needs of the consumer.

Information

Evident in the literature is that mental health consumers want information about

their mental disorder and its management. The scope of this information ranges from

having someone to provide them with more information about their illness to

management of prescribed medications (Barbato et al., 2014 ; Brems, Johnson, Corey,

Podunovich, & Burns 2004; Sunderland & Findlay, 2012). Barbato et al., (2014) in their

retrospective investigation of perceived quality of mental health care found that mental

health consumers had high negative ratings of both illness (29.1%) and medication

(26.1%) information access. Sunderland and Findlay's (2013) Canadian cross sectional

survey, reported that seven percent of individuals identified mental health information has

a need however type of information was not discussed. Despite the large sample size

(n=25113) used in Sunderland and Findlay, 2013 unlike other studies (e.g, Barbato et al.,

2014) individuals with psychosis and personality disorders were excluded thus the

diverse needs of this group was not captured.

Lack of accessible information is not just limited to mental illnesses. It has also

been shown that those with mental illness do not have access to information related to

physical health. Goldberg et al. (2007), in their cross sectional investigation of a group

mental health consumers, with diabetes, found that a significant (p<0.05) proportion of

them received less education on this chronic illness than the control group that did not

have a mental illness. Again, this research is limited by its design and use of self-

reporting.

Human Resources

Another need of mental health consumers threaded throughout the literature is

more community health workers. Community mental health workers are a resource and

the literature suggests there is not enough of them. Consumers have voiced the need for

case managers, access to counsellors and therapy, choice of professional, as well as

mental health workers to come to their homes as being essential to their recovery

(Barbato et al., 2014; Brems et al., 2004; Pagura et al., 2009; Sunderland & Findlay,

2012). Sunderland and Findlay's (2012) cross sectional study, found that counselling was

the most common reported need (12%) but this research excluded some informants based

on diagnosis thus, may not capture a true picture of the needs of this population. In another cross sectional study more than 50% reported that a case manager and someone to come to their home would have been essential resources in preventing their re-hospitalization (Brems et al., 2004).The sample had all had at least one psychiatric admission in the year prior to the study. This report did not discuss its limitations and only frequency distributions are used for analyzing the results. Barbato et al. (2014) found that the inability to choose one's health professional (56%) and wait times (50%) negatively impacted mental health consumers perceptions of care. In a recent report by the Wait Time Alliance (WTA, 2014), despite benchmarks to identify wait times for mental health services, there were no statistics for Canada or Newfoundland. This lack of information is concerning given the fact that access to mental health services has been part of federal and provincial initiatives and that longer wait times for services has been linked to negative health care outcomes (CIHI, 2012).

Access to specialty services was noted to be a limiting factor in Reitmanova and Gustafson's (2009) study in the metro St. John's. They found that some services such as psychology are not publicly funded and thus present a barrier to access. This was limited by small sample and that the environmental scan focused on service access for ethnic minorities thus not generalizable to the larger population.

Social Support

A consensus in the literature is that mental health consumers are not receiving the social support needed their recovery. A social connection with other consumers, participation in daytime activities, and intimate relationships have all been identified as

voiced needs of consumers (Barbato et al., 2014; Beebe, 2010; Brems et al.,2004; Lasalva et al., 2007; Werner, 2012; Zuniga et al., 2013). Beebe's (2010) small descriptive study of problems that people with schizophrenia face living in the community, found that social isolation was common. Social is "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling relationships" (Nicholson, 2009, p. 1346).

Individuals who are socially isolated lose hope and are prevented from moving towards recovery and perceiving their lives as meaningful and purposeful (Copic, Deane, Crowe, & Oades, 2011). Werner (2010), using the Camberwell Assessment of Need-Patient (CANSAS-P), found that a significant percentage of consumers (p < 0.05) reported intimate relationships (35.9%), sexual expression (31.6%) and company (24.8%) as unmet needs. Zuniga et al. (2013) also used the Camberwell Assessment tool to identify unmet needs and found that a significant (p<0.05) percentage (19.3%) identified company and daytime activities (11.8%) as an unmet needs. These three studies are limited in their generalizability because the informants' primary diagnosis was schizophrenia and/or schizoaffactive disorder. Barbato et al. (2014) had broader criteria in their sample of consumers but still found a high percentage (15-26%) of negative opinions with regard to quality of psychosocial interventions of community based programs.

Literature suggests that the above unmet needs may not be related to the need for more intensive services but rather a different approach to service provision. Calsyn et al. (1998) reported on two earlier studies that examined the effectiveness of assertive

community treatment (ACT) teams on improving the social relationships of homeless

mentally ill people (Morse, Calsyn, Allen, Tempelhoff, & Smith,1992; Morse et al.,1997).

The first study found significant difference between sizes of professional networks that

consumers had depending on their treatment intensity but there was no significant

difference in social relations between the groups (Calsyn, et al.,1998; Morse, et al.,1992).

The second study also found significant differences in professional networks but no

significant differences in social networks (Calsyn et al., 1998; Morse et al., 1992).

Although this is only a single investigation, and it is limited in its generalizability, it does

indicate that even with increased service intensity, there is still a areas in provision that

need improvement. This may suggest that despite adequate concrete services, social

supports may be lacking. This is significant to this needs assessment because although

there is a large community mental health service network in the metro St. John's area,

there are still service gaps.

Housing

The relationship between mental illness and access to safe affordable housing is

multidimensional . A homeless person or someone with inadequate housing can

experience a multitude of stressors that impact coping skills, self-esteem, and emotional

well-being (Canadian Institute for Health Information [CIHI], 2007). Over long periods,

these stressors can negatively impact a person's mental health. As periods of

homelessness increase, emergent mental health problems often worsen (Munn-Rivard,

2014). People with preexisting mental illnesses often face many challenges with regards

to employment and income and thus, struggle with maintaining adequate housing (Munn-Rivard, 2014).

The literature shows that mental health consumers report housing as essential for wellness and recovery (Brems et al., 2004; Hanson, Houde, McDowell, & Dixon, 2007; Pahwa et al., 2014; Werner, 2012). In fact, one cross sectional investigation found that more than 80% of mental health consumers indicated accommodations as a need (Werner, 2012). Brems et al. (2004) noted that more than 50% of respondents, reported that secure place to live may have prevented a hospitalization.. Another larger retrospective study found that even with case management or assertive community treatment, there was still a need for housing services (Hanson et al., 2007). Although these three studies shed light on significance of housing on the health of consumers they are limited by their reliance on self-report data that may not be accurate. Furthermore , cross sectional studies capture a "snap shot" of what are the issues facing consumers at one particular point in their lives thus may not provide a complete picture of the entirety of the issues related to housing. Retrospective studies are open to recall basis and like cross sectional studies findings may not hold true in the context of one's existing social cultural environment.

Skills

Skills training for mental health consumers has been identified in the literature as a growing need for this population. Skills is a subjective term and may range from learning simple activities of daily living to employment support or postsecondary education. Voiced needs of consumers include learning household skills (e.g., cooking), vocational rehabilitation (e.g., upgrading), and supported educational opportunities (e.g.,

college) (Barbato et al., 2014; Hanson et al., 2007; Pagura et al., 2009; Werner, 2012; Zuniga et al., 2013).

In a quality assessment of mental health care, consumers reported more than half the time that vocational rehabilitation was the most important intervention by mental health care providers (Barbato et al., 2014). Similarly, Hanson, et al. (2007) also found that people in community mental health programs identified needs in supported education and vocational services. Unfortunately, specific needs in these areas were not discussed. From personal experience, I have noted that consumers have identified educational opportunities assistance with funding and classroom support as important needs. Hanson et al's research may be more generalizable to the St. John's population because it was a larger Canadian study whereas Barbato et al.'s was a smaller convenience sample in Italy. Both however are limited by their retrospective, self-report design.

Shifting Needs

The needs of mental health consumers do change over the life span. That is, the community needs of a 25 year old person, newly diagnosed with schizophrenia in 2014 may be different than those in 2024. This would also be the case for someone who has been working toward recovery and may not require a specific service yet but wants the option to avail of a service if needed. Lasalva et al.'s (2007) longitudinal study found on four year follow up, that despite the fact that there were decreases in unmet health needs of consumers there was a significant increase in unmet social needs. This may indicate that there is a shift in priority for the mental health consumer; once their higher health needs are met, they identified other areas of importance such as socialization. Although

this study had strength in its longitudinal design, the authors report that they were unable to identify which components of care had the most impact on changes in need (Lasalva et al.). Torres-Gonzalez et al. (2014) in their review of literature, support that unmet needs change over time. They recommend the use of needs assessments as an essential tool to identify what is important to the client in developing meaning in one's life. Needs assessments are not used by community mental health programs in the metro St. John's area.

Rosenheck, Neale and Mohamed (2010) investigated mental health consumers transitioning from high to low intensity case management and found that those who transitioned successfully had a significantly lower proportion of crisis interventions and significantly higher family education and support. Transitioned participants had lower symptoms, higher quality of life, higher quality of family relationships and less contact with case managers. Although it is difficult to make inferences because the authors did not collect base line data on their participants' service contacts, it certainly does bring into question changing needs of consumers and the factors that facilitate recovery.

From this overview it is quite evident that there is a large body of research that attempts to identify what mental health consumers believe is important to their recovery. Some key needs have been identified by mental health consumers that must be investigated more fully in order to provide them with a comprehensive community service. These include increased opportunities of socialization and relationship building, peer support, improved access to information and available treatments and services, in home services rather than office based, and improved access to educational and

vocational opportunities. Health providers should recognize that relatively inexpensive

resources may be exactly what are needed for individuals to receive the support and

caring to prevent (re)hospitalization (Rohland, Rohrer, & Richards, 2000). It is also

prudent to be aware that people's priorities will change over time as will their perceived

needs.

Client versus Community Health Care Worker Priorities

There is evidence that while most people working in community with mental

health consumers wish to assist their clients with recovery, worker priorities and their

client's perceived needs may be at odds. It is clear from the literature that there are

different perspectives how needs are assessed, what are the priority treatment goals, what

needs are met/unmet, and the importance of therapeutic relationships (Brodbent et al.,

2008; Happell, 2008; Kreyenbuhl et al., 2009; Lasalva et al., 2007; O'Brien, Fahmy, &

Singh, 2009; Raingruber, 2003; Werner, 2012).

Brodbent et al. (2008) found that clinician rating of needs correlated with Global

Assessment of Functioning (GAF), while the mental health consumers' identification of

needs was based on their perception of their illness and their perceived control over it.

Werner (2012) in a cross sectional Israeli study reported that although patients reported a

higher number of unmet needs (e.g., socialization, intimacy and housing) mental health

workers reported a higher number of met needs. This study suggested that the mental

health worker may assume the consumers' needs are met because they are getting

community services (Werner, 2012). Both of these studies were similar in that the

majority of participants had a diagnosis of schizophrenia however; this limits

generalizability to other mental health consumer diagnosis.

In contrast to Werner (2012), Lasalva et al. (2007) noted that mental health

consumer rating of needs was significantly related to GAF. Lasalva et al. (2007) also

reported that staff-rated needs of consumers had not changed over the four years but at

the patient level, the health domain showed a significant reduction in met needs. As noted

in a previous section, mental health consumers had more focus on social needs while

health care providers focus on clinical.

Disengagement in mental health services has been explored in two literature

reviews (Kreyenbuhlet et al., 2009; O'Brien et al., 2009). There is a consensus that

mental health workers approaches to care such as the formation of shared goals and plans

of care with the MHC can impact service engagement such as appointment attendance

(Kreyenbuhl et al., 2009; O'Brien et al., 2009). Mental health consumers stated that the

creation of a therapeutic alliance is a priority in treatment goals and that staff

relationships and peer support is more important than medications (Happell, 2008). The

importance of medications in their treatment was acknowledged but only when the

physician listened to their concerns. In a small qualitative investigation on gaps in service

for those with depression and suicidal ideation (SI) it also was noted that a lack of holistic

care and personal interaction caused a negative perception of the care consumers were

receiving (Raingruber, 2003). Consumer and provider collaboration is necessary and

imperative when identifying the needs of those with mental health concerns (Werner,

2012).

Appropriateness of Services

There is a dearth of literature that examines the inappropriate use of services by mental health consumers. This is not to infer that mental health consumers are using services inappropriately but rather people may be getting a service that does not meet or exceeds what is needed. Excessive service provision for someone who does not need that level of care restricts the availability of resources for those who do have a need. Rosenheck et al. (2010) investigated consumer responses to being transitioned to a lower intensity service from a high intensity service that traditionally does not discharge. They found that individuals who transitioned required significantly lower crisis interventions and had significantly less symptoms on the Brief Psychiatric Rating Scale (BPRS). This study limited in its lack of base line data but does suggest that a closer look at who is using and who actually needs an intensive service is warranted (Rosenheck et al., 2010). Simarily, Hanson et al. (2007) did a comparison of assertive case management (ACM), office based case management (CM) and residential treatment (RES). Findings show that programs offered in each management approach used excessive resources in areas of medication support, counselling, nutrition and activities of daily living (ADL). In fact 18% of RES, 10% of CM, and 4% of ACM consumers were rated as able to function at a lower level of care. This was a retrospective study with a convenience sample so generalizability is limited.

Staff reluctance to discharge people even if they may not need that level of service was also noted to be a factor contributing to this overuse of services in another qualitative study that interviewed case managers on an assertive community treatment

(ACT) team (Bromley et al., 2014). In that study reasons contributing to failure to discharge clients included concerns about clients' future, how to manage disengaged consumers, and confusion about who decides who is to be discharged. A limitation of this study is that the data collected was related to male veterans who may have significant mental health issues when compared to the general population.Werner (2012) suggests that patients are sometimes provided with services because of their availability rather than because of an actual need which may lead to situation in which individuals are linked to available services rather than fitting the services to individual needs. This has also been observed in personal experience where clients a referred to a program that may not be appropriate however there are no other options. A closer look at services that target mental health consumers with mild to moderate mental illness may be warranted given that community health services generally do not dedicate sufficient attention to people with less severe symptoms (Ruggeri et al., 2007).

<div align="center">

Sociodemographic's

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Sociodemographic factors (e.g age, gender, socioeconomic status, ethnicity) have been linked to mental health consumer needs. Kohn et al. (2004) reported that the above sociodemographic factors all contribute to mental health consumer access to and engagement with services.

Age. Younger adults in need of community mental health services have been shown to have less access to services and disengage from available services earlier. Research has shown that younger mental health consumers have more unmet needs such as access to services (Urbanoski et al., 2008; Zuniga et al., 2013). Similarly, O'Brien et

al. (2009) in their literature review found that young people disengage from health care services because of difficulties with attendance, accepting help, developing therapeutic relationships, crafting mutual goals and, lower satisfaction with services, and stigmatization. Rates of dropout for age groups were not provided. In contrast, Routhier et al. (2012) found that age did not affect after care service use by consumers recently hospitalized for attempting suicide. These findings question the relationship between age and satisfaction with community health care services warranting more research in this area.

Education/Income. Education levels and income also impact service needs and engagement for community mental health consumers. Research shows that a lower education and higher income impacts voiced needs by these groups (Kreyenbuhl et al., 2009; Tiwari &Wang, 2008; Urbanoski et al., 2008). Urbanoski et al.'s (2008) Canadian survey reported that middle and high income earners had lower needs for mental health services in comparison to lower earners. In another large Canadian survey, it was discovered that consumers with less than 13 years education, were less likely to use mental health services (Tiwari & Wang, 2008). Fortney et al. (2003) measured the continuity of care for clients of public mental health systems and found that a housed group had substantial and significantly greater continuity of care while homelessness and economic disadvantaged was significantly (p<0.001) associated with lower continuity of care across all measures. Interestingly, Lasalva et al. (2007) found that sociodemographics do not impact worker rating of consumer needs however it is a significant predictor of consumer rating of needs. Findings such as this solidify the fact

that when coordinating resources for this population it is important to take into

consideration the actual and perceived needs of the consumer and the health care worker

to collaboratively develop a plan of care that meets their unique needs and decrease the

incidence of disengagement in services .

Gender. Some researchers have identified gender as being a predictor of the need

for and engagement with community mental health services. (Lasalva et al., 2007;

Routhier et al., 2012). Routhier et al. (2012) reported that males with a diagnosis of

mental illness and substance abuse had a higher service usage used after a hospital

admission than females. Lasalva et al. also noted in their prospective longitudinal study

of mental health consumers in the community, that being male predicted increases in the

health and social domains of need but did not for females. In contrast O'Brien et al.

(2009) found, in their review, that gender is not consistently a factor for service

engagement. This is interesting because hospitalization rates for women with anxiety

disorders, in Canada, are twice as high as those for men; Canadian women are 1.5 times

as likely to be hospitalized for an attempted suicide (Health Canada, 2002). This certainly

indicates that gender plays a role in service need and may be further identified in the

consultation component of this project.

Ethnicity. Ethnicity is also a contributing factor to service access and use for

mental health consumers. Research has shown disparities in community mental health

services for both immigrant populations along with Canada's indigenous populations

(O'Brien et al., 2009; Reitmanova & Gustafson, 2009; Tiwari &Wang, 2008; Wilson &

Cardwell, 2012).

Tiwari and Wang (2008), in their cross sectional survey compared ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. Service use was considered as having contact with a health care provder aobut their mental health in the past year. The use of services was significantly higher with white participants than non-white whereas Canadian born whites did not differ from white immigrants (Tiwari & Wang, 2008). Unfortunately this survey did not investigate reasoning for differences in service use. Interestingly, Tiwari and Wang discuss how immigrants' mental health may be influenced by a the process of acculturation and it has been shown that, during the first two years in Canada, refugee rates of depression approximated that of the majority culture but then declined to less than that population (Beiser & Hou, 2001).

Reitmanova and Gustafson (2009) investigated the availability of primary mental health care information and services for visible minority immigrants in St. John's, Newfoundland. In a community scan of available services they were unable to find any mental health services specific to immigrants. This was not surprising given that the needs of immigrants are not addressed in the NL mental health strategy. The Association for New Canadians (ANC) was the only organization providing counselling and group supportive services. Participants reported barriers related to lack of information, language and literacy issues, mistrust, stigma, wait times, finances, and insensitivity (Reitmanova &Gustafson, 2009). This was a community scan and a small sample of convenience so the results are not generalizable.

There is a body of literature that has examined the mental health of Aboriginal populations in Canada. This literature is important given the fact that Canada has about 1.4 million people who claim aboriginal identity and the population grew by about 20% between 2006-2011; which is far faster than the non-Aboriginal population that grew about 5% over the same time (Statistics Canada, 2011). As well, the suicide rate for First Nations people is 2.1 times higher than that of the Canadian population (Adelson, 2005). One cross sectional Canadian study that explored the needs of urban Aboriginals found that cultural factors are significantly related to health (Wilson & Cardwell, 2012). In fact, language and culture are considered protective factors for health and wellness (Napolean & Dickie). This certainly relates to Aboriginal access to mental health services in the St. John's area because more than 4500 Aboriginal people live in the metro area (Statistics Canada, 2011). A limitation of Wilson and Cardwell's study was that the most marginalized group, the homeless population, were not included in this survey and almost 7% of Aboriginal people living in urban areas experience homelessness (Patrick, 2014). This is a far higher percentage than the general population at 0.78% (Patrick, 2014). O'Brien et al. (2009) also found, in their review of literature, that ethnic minorities and those who live in urban environments have poorer social networks and lower engagement with mental health services. It is essential that any community based mental health program be sensitive to the cultural differences and values held by its ethnic and Aboriginal populations. For anyone to recover from illness they must have the freedom to express and live within their own cultural identity.

Chronic Disease Management

.   There is a great deal of literature examining the differences in physical health

concerns of those mental health consumers living in the community. De Hert et al. (2011)

note that health disparities among those people with severe persistent mental illness

translates to a mortality gap of 13-30 years shorter than the general population. Sixty

percent of this mortality is attributable to physical illness such as tuberculosis, human

immunodeficiency virus, obesity, diabetes mellitus, metabolic syndrome, hyperlipidemia,

stroke, myocardial infarction, and sexual dysfunction (De Hert et al., 2011; Torres-

Gonzalez et al., 2014). Thus, caring for this populations' physical needs are an important

aspect of their plan of care.

        People with serious mental illnesses are at higher risk for sedentary lifestyle,

unhealthy diets, substance use, and are twice as likely to smoke which has been linked to

chronic illness (Saddichha, Manjunatha, Ameen, & Akhtar, 2008 ; Torres-Gonzalez et al.,

2014). Furthermore, many prescribed medications for this population have negative

physical side effects. For example, atypical antipsychotics contribute to obesity,

metabolic syndrome , and diabetes (Saddichha et al., 2008). Treatment with clozapine

causes a significant weight gain which may be up to 12 kg after the first year (Newcomer,

2005). Psychotropic medications are also strongly associated with sexual dysfunction and

reduced social interaction; a common reason for rejecting medications (Torres-Gonzalez

et al., 2014). Mood stabilizers may increase one's risk for obesity (Torres-Gonzalez et al.,

2004) Among adults with serious and persistent mental illness the prevalence of obesity

has been reported to be as high as 55% (De Hert, Schreurs, Vancampfort, & Van Winkel,

2009).

Research has shown that mental health clients are at higher risk for diabetes. Dixon et al. (2000) found the rate of lifetime diabetes in those with mental health issues, was 14.9 % ;10.8 % of this was found in those living with schizophrenia. This rates is significantly higher than the general population which is approximately 7% (Dixon et al., 2000; Cypress & Gleeson, 2009). Another more recent study found that in a group of patients with schizophrenia, 7% were hyperglycemic,14.5% had diabetes, and more than one third were unaware of their status (Cohen, Stolk, Grobbee, & Gispen, 2006). Given the high rates of diabetes amongst those with mental health issues research has delved into the needs of this population.

Goldberg et al. (2007) cross sectional study compared the quality of care of patients with type 2 diabetes who have a serious mental illness with those who do not. Participants with type 2 diabetes but without a serious mental illness were also recruited as a comparison group. The six measures of quality care being measured were HbA1c testing, retinal eye examination, foot examination, blood pressure measurement, urine protein testing, and lipid assessment. Participant self-reports were used to identify any diabetes education they received in the last six months. Rates of smoking were significantly higher amongst the mental illness group. The group with serious mental illness received significantly (p<.05) fewer of the six recommended services including eye and foot examinations, than the group without mental illness.Those with serious mental illness were less likely to have received any diabetes education or glucose monitoring teaching in the last six months. Reasons for these differences in the self-report data were not given.

Dickerson et al. (2005) conducted a cross sectional investigation of diabetes knowledge of a group of individuals with a diagnosed mental illness (schizophrenia, schizoaffective disorder, or a major mood disorder). Participants (n=201) were recruited from six Baltimore public and private outpatient clinics. Assessment of diabetes knowledge was adapted from the standardized Diabetes Knowledge Test (DKT). Key results included a significantly (p<.0001) lower score on the Diabetes Knowledge Test for those with schizophrenia compared to the mood disorder population.. The receipt of diabetes education was associated with more diabetes knowledge when the effect of other variables, including cognitive level, were controlled. This does indicate that those with more serious mental illnesses still benefit from diabetes education. Limitations to this study are similar to Goldberg et al. (2007) being that self –reported date may not provide a true picture of the general population. Furthermore cross sectional design are open to contextual biases of the time of data collection. Dickerson et al. (2005) there was no measurement for the level of diabetes education that the participants received and there was no access to patient psychiatric history to evaluate acuteness of mental illness.

Research on the outcomes of lifestyle interventions designed for people with mental illness living in community have been positive. McKibbin et al. (2010), in a prospective investigation of a Diabetes Awareness and Rehabilitation Training (DART) program found that participants had significant improvement in body mass index (BMI), waist circumference and diabetes knowledge six months after the program had ended.

Disparities in Services Amongst Individuals living with a Mental illnesses

From the literature it appears that existing community mental health services tend to be more focused and effective with those living with schizophrenia. This is surprising given that that schizophrenia affects 1% of the population while major depression and anxiety disordesr affect between 8% and12% of the population respectively (Health Canada, 2002). Furthermore, that 56% of people with depression and 58% of people with generalized anxiety disorder go untreated worldwide (Kohn et al., 2004) Studies have shown that for those people who have psychiatric inpatient admissions, a large percentage (28% or higher) of them are depression or anxiety related whereas less than 25 were admitted with schizophrenia (Brems et al., 2004; Thompson et al., 2004). In Newfoundland and Labrador there are four times the number of days spent in acute care hospital beds by those with mood and anxiety disorders than those with psychotic illnesses (Johansen & Sanmartin, 2011).Given that those with schizophrenia often voice concerns with anxiety (Beebe, 2010) it is important that health care services are available in the community to address this need.

Despite the fact that anxiety and depression are a global issues, research indicates that those impacted by these illnesses are not getting the services they need in the community and at times disengaging from programs. Rugger et al. (2007) in their six year follow up study of a community based mental health program found that 49% of participants without a psychotic illness dropped out of the program due to service dissatisfaction whereas those with a diagnosis of schizophrenia were the more likely (90%) to stay in the program (Ruggeri et al., 2007). In a recent Canadian retrospective study of hospitalized people who attempted suicide (Routhier et al., 2012) the group with

depression had lower rates of contact (56%) with mental health services than the group

who had schizophrenia (77%). In addition, those who had schizophrenia were more likely

to receive specialized services than the group with depression who received general

practitioner services. This study was limited because it did not consider emergency room

visits.

In a review of literature on disengagement of mental health services, O'Brien et

al. (2009) found that diagnosis did relate to drop out rates. People with a diagnosed

personality disorder had high program dropout rates while those with schizophrenia had

lower dropouts (O'Brien et al., 2009). Individuals living with anxiety, depression, or a

concurrent disorder have less access to specialized services by comparison to those with

other mental health conditions such as schizophrenia. Simarily, Fortney et al. (2003) in

their research on continuity of care in publicly funded community mental health

programs found that a diagnosis of schizophrenia was a significant predictor of greater

quantities of specialized mental health services such as assertive community treatment

and intensive case management (Brodbent et al., 2008; Rosenheck, Neale, & Mohamed,

2010; Zuniga et al., 2013) . Limited access to treatments for anxiety and depression such

as cognitive behavioural therapy (CBT) has been observed observed at both the provider

and system level (Collins et al., 2004). One review of literature, reported that up to 60%

of people with anxiety or depression initially present to their family physician (Collins et

al., 2004).. Because of the physicians lack of experience with mental health conditions,

psychotherapy, and reliance on pharmacology, many people go undiagnosed, treated or

referred to specialty services (Collins et al., 2004).Thus, it is important to ensure that those delivering mental health services are prepared to do so.

Evidence suggests that existing services are inadequate for those who have a concurrent mental health disorder (e.g., psychotic or affective illness, schizophrenia) along with a substance dependence problem (Kim, Pfeiffer, Ganoczy, & Valenstein, 2011; Torres-Gonzalez et al., 2014; Urbanoski et al., 2008). In one Canadian study of psychological distress the prevalence of unmet mental health care needs (51%) was highest among those with a concurrent mental health disorder (Urbanoski et al., 2008). Substance abuse was noted to be the most common comorbidity among patients with schizophrenia and only 12.4% of American adults with a dual diagnosis receive treatment for both their mental health and substance issues (Torres-Gonzalez et al.,2014). Noteworthy is the fact that frequent monitoring of those with a concurrent disorder has been linked to a lower risk of rehospitialization (Kim et al., 2011). In order for a plan of care for this population to be successful it must be tailored to diagnosis and severity or they may disengage from the program (O'Brien et al., 2009). This means taking into consideration dual diagnosis and the impact that multiple risk factors such as substance abuse has on the recovery of those living with a mental health concern. This proposed practicum project will identify some of these factors in effort to advocate for resources to meet the actual and felt needs of this population.

Systems and Continuity of Care

Problems related to the management of the health care system that impact the experiences of those living with a mental health disease are threaded throughout the

literature. Sunderland and Findlay's (2012) nation wide survey reported that 20% of those needing mental health care reported systems level barriers. These include problems with continuity of care, wait times, and choice of provider (Barbato et al., 2014; Pagura et al., 2009; Raingruber, 2003). Although limited in its generalizability, Raingruber's (2003) study found that inconsistent staffing, gatekeeping, access to information, and compartmentalization of the mental health system interrupted the recognition and treatment of people with depression and suicidal ideation. This may lead to individuals seeking help being unable to gather information on or access specific services. Another qualitative study using focus groups found that 50% or more people with severe mental illness had negative opinions about choice of professional and wait times (Barbato et al., 2014). This same study also found that more that 25% of the group had negative opinions on access to information such as illness or medication (Barbato et al., 2014). One of the main reasons for not seeking help voiced by a group of people who attempted suicide was not knowing where to get help (Pagura et al., 2009). Access to information, shorter wait times and ease of system navigation are essential for mental health consumers to access resources that will enable their recovery.

Collaboration of services between inpatient and community psychiatric services was noted to improve quality of care such as early intervention, service transition and decrease wait times (Kisely & Chisholm, 2009; Hansson, Ovretveit, Askerstam, Gustafsson & Brommels, 2010; Holst & Severinsson, 2003; Mental Health Commission of Canada [MHCC], 2012). In fact coordination in networks improved mental health services in all themes of the Camberwell Assessment of Needs (CAN) including daytime

activities, psychotic symptoms and interaction with family (Hansson et al., 2010).

Imperative to the coordination of services in the development of individualized plans in order to guarantee services are tailored to individual recovery (MHCC, 2012).

Summary

Threaded throughout the literature are six key bodies of research that seek to identify gaps in community based adult mental health services. These include consumer identified fragmentation, disparities in worker and consumer priorities, sociodemographics, chronic disease management, disparities in service provision based on diagnosis and systems level fragmentation. Treating the mentally ill has evolved from a primarily institutional service to providing care for people in their own homes. New services have been developed to offer what organizations thought people needed but there is still several areas where we as providers fall short. Voiced needs of consumers range from increased socialization and help with building relationships to educational and vocational assistance. From the literature we see those with mental illness get unequal services depending on their diagnosis and physical health concerns are a neglected topic. Priority must be given to finding a balance in what consumers want and what providers believe is important to them. Finally, an open dialogue must take place between all programs and departments involved as to ensure people can move from one to the other without sacrificing their health. This literature review will be used to guide the next phase of this practicum. Consultation questions will be designed with a focus on the voiced needs of consumers and the identified gaps in community mental health service provision.

Appendix B: Literature Tables

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Barbato et al., (2014) Quality assessment of mental health care by people with severe mental disorders: a participatory research project. Aim- to obtain consumers' opinions about service organization and treatment aspects they deem meaningful to produce indications for the implementation of changes.	n=204 participants in Tuscany. Aged 18-60. 57% between 41-60. 54% male criteria included Dx of affective disorder or personality disorder or schizophrenia of other psychotic disorder as defined by the ICD-10. At least one involuntary admission or 2 voluntary admissions to acute inpatient care in previous year, or used of residential care program, or day treatment program, or home visit interventions, or social inclusion programming. 290 eligible participants. 12% refused.	Retrospective qualitative. Questionnaire developed from 21 others previously published. reviewed and modified by 4 focus groups. The authors discusses previous research that supports this method of tool development. 11 yes/no questions and 34 item Likert scale. Validity and reliability discussed. 6 mental health consumers delivered questionnaire. Framework of quality improvement using models of participatory research and quality improvement models.	Only very positive evaluations taken as an indicator of positive quality care and negative and very negative collapsed to one indicator due to research claiming that bias exists towards positive evaluations in consumer surveys. Relaibility of questions determined using Cohen's K statistic for yes/no questions. Weighted k for Likert scale questions. Items with scores below 0.4 were considered unreliable and excluded from analysis. (23% 0f Likert items and 2 of yes/no questions).	Positive judgements out numbered negative ones. relatively high proportion of negative ratings on most psychosocial interventions (15-26%) Most negative opinions related to choice of professional and wait times(56% and 50%). medication side effects (26.8%), illness information (29.1%) and medication information (26.1%) also had high negative perceived quality. Most valued intervention was vocational rehabilitation (50.5%) Low refusal rate of 12%	Self report. Retrospective Limited generalizability because tailored to needs of specific consumer group. Survey still trended toward positive results even though attempts are made to control for it.	Recommends careful implementation of psychosocial groups due to the negative results in survey. Special consideration must be paid to value of choices and protecting autonomy. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Beebe, 2010 What community living problems do persons with schizophrenia report during periods of stability.	Criteria included a chart diagnosis of schizophrenia, a period of stability of 6 months, ability to give consent and telephone access. 63 people with schizophrenia identified as potential participants. 5 did not meet criteria, 29 declined. N= 12 chosen at random to participate. Participants chosen from those receiving care from an outpatient clinic in the Southwestern United States. Convenience sample	Descriptive qualitative study Participants received at the Telephone Intervention Problem Solving Intervention (TIPS) designed by the author. This included weekly phone calls from a masters educated nurse trained in the intervention. Duration was three months. The author reviewed response forms to ensure fidelity to the intervention. TIPS protocol consists of identification and discussion of 6 items: Medications, appointments, coping skills, substances, social interactions, questions.	SPSS for basic descriptive statistics. 8 men, 4 women mean age 52 Answering of calls declined from 100% in first month to 57% by month 3.	Most frequently reported problem was missed appointments. (n=8) participants reported medication adherence problems. Social isolation also identified. Anxiety also identified. Conflicts at home	Selection bias Small sample size Only descriptive statistics. Self report. No baseline prior to intervention. No theoretical framework identified	Recommends increasing sample size in future studies. Also recommends comparison group not receiving TIPS. Discusses consideration of simplified intervention that may improve outcomes such as medication education and reminders Weak-medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Brems, Johnson, Corey, Podunovich and Burns (2004) Consumer perspectives on services needed to prevent psychiatric hospitalization. Aim- to determine what mental health consumers perceive as resources that may have prevented them from needing psychiatric (re)hospitaliza- tion, and what their access is to such services.	N= 657 All 18 and older 54% males. White (57%), followed by Alaska Native (27%), and African American (6%). Most common admission diagnosis was depression (28%). 25% Schizophrenia.	Mixed methods, cross sectional. interview All individuals admitted between July 1, 2001 and December 31, 2002 to the adult admissions unit of the only state-owned and operated psychiatric hospital in Alaska were asked to participate in project.	15-item scales to assess both patients' perceptions of services that may have helped them avoid their current psychiatric hospitalization, and patients' perceptions of current access to those same services. Patients also asked for additional suggestions for services.	"Frequency distributions revealed several discrepancies in helpfulness vs. access. Specifically, the following nine services were perceived as least available (over 50% of respondents indicating not having enough access), but potentially most helpful (over 50% of respondents indicating the resources might have prevented their hospitalization): (1) someone to help me remember to take my medications, (2) safe place other than the psychiatric hospital, (3) crisis phone line, (4) contact with other mental health consumers, (5) case manager, (6) ofcure place to live, (7) transportation to appointments, (8) someone who comes to my home to help me when I feel at risk, and (9) someone to help me find and participate in fun activities."	Frequency distributions only. Tools not validated No CI Lacks generalizabilit y Limitations not discussed by authors. No conceptual framework	Decision-makers need to recognize that relatively inexpensive resources may be exactly what are needed for individuals to receive the sup- port and caring to prevent rehospitalizati on (Rohland, Rohrer, & Richards, 2000). Weak

Study	Participants	Methods	Outcome Measurements	Results	Limitations	Comments
Brodbent, Kydd, Sanders and Vanderpyl, 2008. Unmet needs and treatment seeking in high users of mental health services: role of illness perceptions. Social cognitive model of illness perception	N=203 high users of mental health services in the northern New Zealand region. Aged 16-75 with greater than 2 years continuous use of mental health services. Mean age 40.86 54% female. Slightly more Maori than european. 122 Schizophrenia.	Mixed methods. Cross sectional Sample of convenience. Interview. Background and interviews compiled using- Camberwell assessment of need (CAN) 22 domains, Global Assessment of Functioning (GAF), Drug Attitude Inventory (DAI), Brief Illness Perception (BIP) questionnaire.	SPSS: Kolmogorov-Smirnov check for normality and non-parametrics for non-normal variables. Spearman correlations Chi-Squared. Minimum p value p<0.05	No relationship between clinician and patient rated needs. BIP suggests the average high user of services experiences a moderate number of symptoms and believes their condition will last for some time. Evidence of illness perception providing framework how heavy users think about their mental illness. Negative illness perception correlates with patient rating of unmet needs. Personal control perceptions correlate with functioning. Clinician rating of needs correlated with Global Assessment of Functioning. Perceptions of MH problem, greater emotional distress, negative consequences associated with having	No direction or causality. Selection bias Self report	Front line clinicians should understand patients perceptions of control and explore concerns. Future research should be longitudinal. How perceptions predict outcomes. Suggest increasing patients treatment control perceptions may improve adherence and functioning. Inclusion of family in discussion of perceptions may improve family relations. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Bromley, Mikesell, Armstrong, Young (2014) "You might lose him through the cracks": clinicians' views on discharge from assertive community treatment. Aim-Exploration of decision making process in judging readiness for discharge and barriers along with client and team level influencing factors.	n= 15 mental health intensive case managers from three study sites in the Los Angeles area, serving veterans. Inclusion criteria-clinicians (6) had recently discharged a client and permission was obtained for client to speak with clinician. Remaining 9 had not recently discharged a client. Cliniciand had between 1-8 years experience	Qualitative Semistructured interviews. Atlas.ti to thematically code narrative data. Thematic categories developed.	Distinguished descriptions of discharge process, descriptors of clients and descriptions of intensive case management interventions. Cross case comparison of clinicians who discharged and those who did not.	Over 18 months, 21 clients discharged, lower than anticipated 49 clients. Clinician identified barriers to discharge; Concerns about future stability, Uncertainty about management of disengaged clients, disagreement about who decides, perceptions about clients reluctance.	No discussion of coding tools validity/ reliability. No discussion to theoretical framework Non-random sample differences in Intensive case management and assertive community treatment. Discharged clients within VA system had access to alternative programming. Those who declined to participate may have been most reluctant to discharge.	Principle of distributive justice: the need to allocate scarce resources fairly. Weak

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Calsyn, Morse, Klinkenberg, Trusty & Allen (1998). The impact of Assertive community treatment on the social relationships of people who are homeless and mentally ill. Aim- to examine the effectiveness of assertive community treatment (ACT) teams on improving the social relationships of homeless mentally ill people.	2 studies measuring ACT effectiveness used in this study to identify social networks. Study #1 - n not given. 58% male, 52 % african-american. mean age 33.66. 80% had major axis 1 disorder. 23% substance abuse. Study#2- ACT team compared to ACT with community support professionals and brokered case management. n= 165. 54% african american, mean age 34.76. 58% males.	Study 1- Mixed methods, longitudinal. Random assignment to 3 treatment protocols (ACT, Drop in centre, out patient treatment, (office based)). Monthly interviews, 12 months. Study#2- similar to above measures. baseline, 3, 9, 15, 21 months. Clients also asked to rate quality of social relationships.	Study 1- Arizona social support interview schedule (ASSIS) plus identification od other social networks. Modified Personality and Social Network Adjustment Scale. Covariance analysis p<0.05 Study#2- 2x3 MANCOVA. Newman-Kuehls post hoc. Alpha .05	Study 1- Significant difference between sizes of professional networks (ACT). Professional contacts declined in all groups during study. No significant difference in social relations between three groups. Study#2- Significant differences in professional network. ACT teams larger. No significant differences in social networks. Significant difference for ACT-SW group in material support but no better outcomes in social relations.	Both lack generalizability. Validity of tools not discussed. Most participants living in shelters at baseline thus may be reason for decline in professional contacts. Convenience sample. No conceptual framework.	ACT does not assist with developing better relations and utilization of naturally occurring resources. Weak-Medium.

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Cook et al. (2009) Initial outcomes of a mental illness self management program based on wellness recovery actioning planning (WRAP). Aim- to examine changes in measures of recovery and other psychosocial outcomes among participants in a peer led, self-management intervention called Wellness Recovery Action Planning (WRAP).	108 individuals who enrolled in an ongoing study of WRAP at one of five sites in Ohio between October and December 2006. 64% women 66% caucasian, 25% African American. 81% high school education 80% previous psychiatric hospitalizations. 20% schizophrenia. 38% bipolar disorder. Paid for pre and post test interviews.	Pre/post test Interviews by telephone for base line then one month after WRAP intervention. Discusses validity and reliability of scales in measuring symptoms, recovery, hopefulness, self-advocacy, social support and self perceived physical health. WRAP delivered in 8 weekly sessions of 2.5 hours per week.	Frequency distributions Descriptive statistics. Chi squared and t-tests, $p < .05$	66% attended 6 or more sessions, a requirement for "graduation". Significant decrease in global symptom severity-psychoticism, depression, phobic anxiety, obsessive-compulsive, interpersonal sensitivity, paranoid ideation, and general anxiety also decreased significantly. Significant increases observed in scores for overall recovery, indicating improvement, and all of the five recovery subscales showed improvement: personal confidence, willingness to ask for help, goal orientation, reliance on others, and freedom from symptom domination. Significant increase in hopefulness. Unexpected significant decrease in self reported empowerment.	Convenience sample. No control/ comparison. Small sample Self report Short follow-up	Recommends longer follow up. Randomized-controlled design. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Dickerson et al. (2005). Diabetes knowledge among persons with serious mental illness and type 2 diabetes. Aim- To investigate diabetes knowledge of a group of individuals with a diagnosed mental illness.	The subjects (N=201) were recruited from 6 Baltimore clinics. The criteria included: age 18-65; diagnosis of schizophrenia (18%), schizoaffective disorder, or a major mood disorder (9%); english speaking; ability to provide informed consent. Approval for the research was granted by the University of Maryland School of Medicine and	Cross sectional. Interview. Assessment took place over 3 year period. Assessment of diabetes knowledge was adapted from the standardized Diabetes Knowledge Test (DKT). Diabetes Self Care Scale and the Diabetes Health Beliefs Scale. Within the assessment are various demographic variables and the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).	One way analysis of variance and Parsons product-moment correlation. significant associations were then tested in multiple regression analysis to control for other variables. p<.05	Significantly (p<.0001) lower score on the DKT for those with schizophrenia compared to the mood disorder population. The DKT was also significantly associated with educational level, score on the RBANS, receipt of diabetes education and race. The receipt of diabetes education was associated with more diabetes knowledge when the effect of other variables, including cognitive level, were controlled.	Validity of diabetes scales not discussed. No framework. Self reports. Convenience sampling. Limited generalizability.	This does indicate that those with more serious mental illnesses still benefit from diabetes education Medium-strong

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Fortney et al. (2003)	n= 622 shelter, n=175 street sector and =217 clinic (stable housing) sector.	Observational, retrospective, cross sectional designs.	Spearman Rank Correlation Coefficient for each day of previous 365 days then averaged for year.	housed group had substantial and significantly greater continuity of care.	Does not capture some of the conceptual dimensions of continuity of care.	Homelessness may indicate longer duration between health care encounters.
Measuring continuity of care for clients of public mental health systems.	Multistage random sample of two populations (homeless and housed) in three sectors (clinics, shelters, streets) of Huston, Texas.	interviews (compensated) of participants for demographics and clinic information plus Composite International Diagnostic Interview (CIDI). For clinic subjects, diagnosis was obtained from clinic.	T-tests (p<0.01), coefficient of variations	Homelessness significantly (p<0.001) associated with lower continuity of care across all 5 measures.	Not assessed for predictive validity.	Measures have uses in measuring continuity of care.
Aim- to generate a set of time variant measures of continuity of outpatient care using administrative data and to evaluate the validity of the measures for community living persons with severe mental illness (SMI)		Literature review to identify measures of continuity of care.	Proxy measures of continuity identified as 1)frequency of encounters 2)the quantity of encounters 3) locational consistency of encounters 4) Variety of types of services received 5) receipt of case management services.	comorbid substance abuse was significant predictor of variety. Schizophrenia predictor of greater quantity of services.	All participants had at least one health contact in the previous year. No conceptual framework. Limited generalizability.	Identifying clients at risk for poor health outcomes.
			Construct validity discussed			Weak-medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Goldberg et al. (2007) Quality of diabetes care among adults with serious mental illness. Aim-to compare the quality of care of patients with type 2 diabetes who have a serious mental illness with those who do not	N= 201 participants with a serious mental illness and type 2 diabetes. 100 participants with type 2 diabetes but no mental illness. Recruited from outpatient clinics in Baltimore area. Ethical approval discussed. Group with mental illness more likely to be younger and caucasian (p<.005).	Cross sectional with control group. Retrospective Chart reviews. Interviews Diabetes Quality Improvement Project (DQIP) indicators used when reviewing charts	Six measures recommended by the Diabetes Quality Improvement Project DQIP being HbA1c testing, retinal eye examination, foot examination, blood pressure measurement, urine protein testing and lipid assessment. The investigators also utilize participant self reports to identify any diabetes education they received in the last 6 months. Chi square tests for the categorical variables, independent t-tests for the normally distributed variables and Wilcoxon two-sample tests for the skewed variables. Multiple logistic regression for demographic sp<0.05	Group with mental illness received significantly fewer than the recommended interventions. Both groups had signicintly lower HbA1c levels than recommended but mental illness group had lower than control group. Mental illness group had significantly lower retinal examinations. they also had significantly lower diabetes education and glucose monitoring in the last 6 months.	Validity and reliability of the DQIP is not discussed. No framework. Self reports. Convenience sampling. Limited generalizability.	Medium-strong

Study	Participants	Methods	Outcome Measures	Results	Limitations	Commments
Hanson, Houde McDowell, and Dixon (2007) A population-based needs assessment for mental health services. Aim- (1) assess the level of met need of clients currently in three core types of community mental health services, and (2) develop service and system level recommendations for better responding to client needs in the least restrictive setting.	N=1855 from the three programs- Case management, (CM) Assertive Case Management (ACM) and residential care (RES). Used stratified random sampling. Fraser Health region, British Columbia, Canada %males in CM, ACM and RES= 45, 57,59. Mean age in CM,ACM and RES = 45, 45, 54. % schizophrenia in CM,ACM and RES = 53,83,82.	Mixed, retrospective cohort. Assessment based on interviews with case managers of above clients. Clients/ families not included. Discusses training of n=10 reviewers who interviewed CM's of the sample. Interviews completed between 2002-2004	The Colorado Client Assessment Record (CCAR), validity and reliability discussed. Ordinal scale. Domains of CCAR include symptoms, problem areas, functioning, risk and strengths focused on the period of time the client was last seen for clinical care. levels-of-care planning model, validity discussed. provides a means of determining level-of-care (intensity and range of services) needed by clients of mental health services. Kruskal–Wallis test; Mann–Whitney U-test. Chi Square Test and scale data were analyzed using ANOVA and t-test $p<.001$	20% gap in CM and ACM service use and needs for supported education, vocational services, supported housing, peer support and group therapy. No over met needs for ACM and CM however however RES had overmet needs in medication support, supportive counselling, nutrition and ADL's 44% of those in CM are receiving appropriate level of care. 50% of ACM. 18% of RES, 10% of CM and 4% of ACM were rated as be able to function at a lower level of care.	It has been suggested that the needs assessment should combine both quantitative and qualitative techniques retrospective and prospective data collection and involve both carer and client as informants" Needs assessment focussed only on the previous several weeks.	"Simple recognition of these unmet needs on an individual level does not appear to always be sufficient in improving individual care plans to better meet needs" 6 recommendations from this study-"(1) match care to client needs; (2) increase capacity of ACM; (3) bridge levels of care (including primary care) and improve flow-through; (4) provide more educational and vocational services; (5) enhance services for clients with substance abuse; (6) improve client and family collaboration in care." Medium-Strong

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Hansson, Ovretveit, Askerstam, Gustafsson, Brommels (2010) Coordination in networks for improved mental health services Aim- to document and describe a well established coordination structure within a mental health and social care consortium but also to explore these structures impact on care organisation and client outcomes.	n=1262 clients and n=6 coordinators. Stockholm, Sweden. Primary diagnosis is schizophrenia. Some have bipolar disorder 10 key informants identified to explain consortium. 3 primary changes. Formation of a joint steering group. Implementation of standardized assessment (CAN). Introduction of joint coordinators from psychiatry clinic and municipalities.	Mixed methods. Ethical approval discussed. Action research identified as conceptual framework. Interviews of the 6 joint coordinators Review of CAN for service recipients. .	Comparison of the patients Camberwell Assessment of Need (CAN) from 1997/98-2008. Content analysis of interviews Factors described as helping and hindering coordination identified. Demographics excluded.	Increases in all five themes of CAN. Daytime activities +27%, psychotic symptoms + 6%, money +11%, interaction with family + 8%, drug and alcohol +15% Hindering factors described by coordinators included financial savings, role ambiguity and unclear guidelines.	Retrospactive. Thematic list approved but not validated No CI or p values.	Differentiates linkages, coordination and full service integration. Care teams described as those who maintain contact with clients, monitors progress and facilitate access to services. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Happell (2008). Determining the effectiveness of mental health services from a consumer perspective: Part 1: Enhancing recovery. Aim- Mental health consumers to identify factors that promote and impede recovery. Identify principles and values participants believe should be used in evaluating mental health services.	N=16. 7 from rural and 9 from urban Victoria, Australia.	2 focus groups. Facilitated by a nurse researcher and consumer researcher. 3 open ended questions to stimulate discussion. Recorded and transcribed. Conceptual model of recovery guides the study. Ethical approval discussed.	Data analysis completed by two researchers. Identified thematic framework, indexing themes, charting themes, mapping and interpreting. Data presented bases on items that help recovery, hinder recovery and guiding principles.	Two main themes identified. Treatment and Support and Social connections. Medication considered important when doctors consider consumer concerns. Cigarettes important as self medication and coping response. Staff and peer support considered more important than medications. Being listened to considered important.	Self report Convenience sample. Small sample size. Lacks generalizability	Criticism of routine outcome measurement tools used in evaluation of services and the exclusion of consumers in designing these tools. Coping strategies and anxiety reduction in the absence of cigarettes. Weak

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Holst and Severinsson (2003) A study of the collaboration inpatient treatment between the community psychiatric health services and a psychiatric hospital in Norway. Aim- To identify factors that may influence collaboration between health-care professionals in a psychiatric hospital and 2 mental health community services.	n=9. 3 psychiatric nurses. One medical practitioner. One health and social manager. 2 cultural workers and 2 cultural workers. Urban and rural participants. 6 females (44-55 years old) 3 males (45-52 years old)	Qualitative, content analysis. One on one semistructured interviews (tape recorded) with open ended questions with follow up. Two pilot interviews performed prior to study and questions were modified accordingly. Ethics review is discussed.	Authors completed independent analysis of data. Themes identified The use of discourse criterial and a measure of validity.	Three factors reported by respondents. 1) The need for common understanding between professionals. 2) The need for collaboration within community health care and a link to mental hospital care in order to better evaluate the outcomes of the care provided. 3)The need for team collaboration in order to improve the quality of care and enhance the professionals' resources.	No conceptual framework. Convenience sample Limited participants which limits generalizability.	Emphasis on collaboration especially between hospital and community. Recommends a cross-professional group that includes both in and out patient workers. Weak-medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Kim, Pfeiffer, Ganoczy and Valenstein (2011). Intensity of outpatient monitoring after discharge and psychiatric rehospitalization of veterans with depression Aim- To assess whether increased mental health and substance use outpatient visits is associated with decreased risk of psychiatric re-hospitalization in the overall popula- tion of patients with depression who are discharged from a psychiatric hos-pitalization.	n= 17852 patients receiving depression treatment be-tween April 1, 1999, and September 30, 2004, in the Veterans Health Administration (VHA) health system, USA. Both a diagnosis of a depressive disorder and an antidepressant medication fill from VHA providers or if they had two visits with diagnoses of depressive disorders. Mean age=50.5	Matched case-control design. Patients who had at least two inpatient psychiatric hospitalizations were identified then matched with up to two patients who also had been discharged from psychiatric inpatient settings but were not rehospitalized for the number of days between the case-group patient's discharge and subsequent rehospitalization (N=35,511)	Covariates identified- age at index discharge; race; Hispanic ethnicity; diagnoses of a substance use disorder, PTSD, major depression, personality disorder, anxiety disorder and bipolar disorder type II; service connection; prior suicide attempt and outpatient/ inpatient visits. Diagnosis based on ICD-9-CM Monitoring visits counted for 12 weeks after discharge. Both in person and telephone visits counted. End point was rehospitalization. Logistic regression Relative risk-p<0.05	No significant difference between the cases and controls in rehospitalizations. A significant differential relationship between psychiatric rehospitalization and monitoring that depended on comorbid substance use disorder status was found. those with a comorbid substance use disorder who received very high monitoring (weekly or more frequent visits) had lower risk of rehospitalization than those who received less frequent monitoring.	limited generalizability Case group had greater hospital days than control group in previous year (8.3 vs. 5.4). No gender of cohort given but likely majority male because veterans. Validity of indicators not assessed. Non standardized clinical encounters. Under detection of substance abuse. No conceptual framework.	Depression with comorbid substance need monitoring in post discharge critical period. Medium-Strong

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Kisely and Chisholm (2009) Shared mental health care for a marginalized community in inner-city Canada. Aim-to describe the experience and evaluation of a shared care project targeted at marginalized individuals.	n=243 intervention, n=29 control. North end of Halifax, NS. Users of North End Community Health Centre (NECHC) that provides consultation and liaison services to primary care and outreach services. Staffed by mental health worker who liaises with clients and other clinicians at center. 48% female in intervention group, 60% in control. mean age 30 in both groups	Convenience sample Mixed methods survey 2 years after implementation. Pre/post test design of three intervention sites Control GP clinic that does not offer collaborative care.	Access partly assessed by median wait times Duke Health Questionnaire. follow up survey of n=101 GPs.	Median wait time for NECHC 6 days versus 39.5 days for comparison clinic. Statistically significant improvements in general (44 to 56) and mental health (40 to 53). Not seen in control group. Patient satisfaction between 71 and 78% GP survey result showed significantly higher knowledge levels in areas of psychosis and childhood behavioural problems as well as greater satisfaction with mental health services when working collaboratively.	Limited generalizability. Validity of tools not discussed. Lack of conceptual framework. discusses significance but does not give p values. only 10 control subjects agreed to complete Duke. Could not differentiate which GPs in survey participated in NECHC Absence of control data self report.	Marginalized defined as the homeless, living with addictions, living with disabilities, street youth, sole support parents, aboriginal peoples, the disabled, mentally ill, LBGT, racial minorities. Weak-medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Lasalva et al. (2007) Predictors of changes in needs for care in patients receiving community psychiatric treatment: a 4-year follow-up study. Aim- To explore impact of community based mental health care of people with full spectrum of mental disorders, assessed according to both staff and patient perception.	n=188 (patients) n=110 (staff) participants from South-Verona Italy. Convenience sample from a outpatient treatment centre in the city. Informed consent and confidentially discussed 63.8% female average age 44.2	Quantitative. Prospective longitudinal cohort. Data collected from patient, clinician and medical records at baseline and 4 years. Tools included the Camberwell Assessment of Needs (CAN) for patient and staff, Global Assessment of Functioning (GAF), Disability Assessment Schedule (DAS). Reliability and validity discussed.	Pearson chi-square, Mann-Whitney U-test ($p<0.05$) Wilcoxon test $p<0.05$) Regression analysis for comparison of staff/patient needs.	At cohort level, only changes at follow up were a decrease in unmet health needs and met social needs decreased significantly. At patient level there was a trend for improvement of needs at follow up. At cohort level, staff-rated need identification had no significant change. At patient level Health domain showed a significant reduction in met needs. At follow up there was a significant increase in other met needs. Being male and unmarried predicted an increase in patient rated needs. Diagnosis shows a significant impact on needs. Changes in GAF main predictor of unmet needs. Sociodemographics do not effect changes on staff ratings. Patient ratings significantly related to Sociodemographics and global functioning. Staff rated needs related to clinical.	Combination of long term and new patients. Convenience sample, naturalistic. Sample not representative of other settings. Unable to disentangle which components of care had more impact. No conceptual framework.	Patients focus on social while staff focus on clinical. Value judgements important to consider. Patient needs change over time and must be considered when planning care (collaboratively) Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Mallakh et al. (2004). Follow up after psychiatric hospitalization with a partial control of system responsiveness variable. Aim- To determine, with partial control of system responsiveness, what additional factors may be associated with after care compliance.	N=81. Louisville community. Inpatient stay the month of February 2001. mean age= 34.6. 65.4% women.	Retrospective evaluation. Collaboration between Louisville community hospital and Seven Counties Services which provides outpatient services. 2 week follow up appointment for all	Chi square for categorial variables. voluntary/ involuntary admission. substance abuse. Diagnosis. Previous admissions. $p<0.05$	Those with primary substance abuse disorders were least likely to follow up (16.7%). But substance abuse did not predict compliance. Preadmission care predicted post discharge after care.	Convenience sample. Could not control for insurance. Only housing status used in community support factors. No conceptual framework.	Complex interaction of client venerability, system responsiveness and community support predict likelihood of aftercare. Weak-Medium.

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Pagura, Fotti, Katz and Sareen (2009). Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors.	N= 4872 N=1234 with suicidal ideation, N= 230 had attempted. 15 years or older.	Canadian Community Health Survey, Cycle 1.2 (2002). 10 provinces. Three territories and First Nation excluded. Multistage stratified cluster. 77% response rate. Anderson's behavioural model of health services use.	Multivariate logistic regression p<.05 Demographics Diagnostic content based on World Mental Health Composite Diagnostic Interview (WMHCDI). Reliability discussed. Covariate included to examine help seeking behaviours in those with a mental disorder. Multivariate logistic regression p<.05	41% with suicide attempt in last year felt needed help but did not receive it. 24% with suicidal Ideation. Most common need was therapy or counselling. SI significantly more likely than those with mental disorder without SI to endorse perceived need for information, counselling and skills training. 48% of SI and 24% attempters did not seek help. few significant differences in satisfaction (49%-92%). Barriers- Attempt -Not knowing where to get help,	Cross sectional. Self report. Timing of services not assessed. Assessment of suicidal lethality. Most suicidal, institutionalized, not assessed.	Central determinant to help seeking is perceived need. Enabling resources. Medium

Study	Participants	Methods	Outcome measures	Results	Limitations	Comments
Raingruber (2003) Gaps in service in the recognition and treatment of depression ans suicidal ideation within a four-county area. Aim- to identify gaps in care for depressed and suicidal clients.	n= 10 clients who were living independently, n=40 service providers that included police officers, social workers, nurses and physicians. Combined urban and rural participants in 4 counties.. Ethical approval and consent discussed.	Qualitative, Phenomenology. Four open ended questions. Responses tape recorded and transcribed. Comments were interpreted using methods of searching for paradigm cases, analysis of exemplars and identification of common threads of meaning.	Group interviews for the mental health professionals. Primary care physicians interviewed individually. Individual opinions as well as emerging themes recorded.	Specific problems identified- Lack of holistic and humane care, inconsistent staffing, gatekeepers and access systems that limited services, lack of communication and continuity across systems of care. Three Themes - 1) The lack of personal interaction and caring within the mental health system 2) The system is compartmentalized and fragmented 3) Reimbursement structures contribute to lack of personal attention.	Sample of convenience. limited generalizability. Age range, ethnicity or gender not disclosed. City or state not identified Self report	Fragmented care emphasized. No examples of a time when the system worked well together. recommends visiting employee/ exchange programs. release of information policys stall services. Weak

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Reitmanova and Gustafson (2009) Primary mental health care information and services for visible minority immigrants: gaps and opportunities Aim- To identify gaps and opportunities for improving access to information on primary mental health care for visible minorities in St. John's, NL.	n=8 interview participants. This was the claimed saturation point on meta-themes. St. John's, NL. 6 female aged 30-40 All married 3-10 year residency 5 different languages in sample. Consent discussed	Qualitative Environmental scan of print (Yellow pages and health care brochures) and internet materials using cultural sensitive key works. Interviews using 'snowball' technique for finding participants. Discusses ethical approval	interviews 1-2 hours. Recorded and transcribed. Meta-themes identified. Reread for descriptors/ properties of meta-themes. Environmental scan compared to themes of interviews. Literature review then completed to establish consistency with other findings and generate recommendations.	Environmental scan showed no mental health services specific to immigrants. Most print information written in english others in french. Psychology services are not publicly funded and therefor present financial barriers. immigrants not represented in the NL mental health strategy Association for New Canadians (ANC) only organization providing counselling and group supportive services. Participants confirmed barriers in finding and using mental health services. 7 barriers identified- lack of information, language and literacy issues, mistrust, stigma, wait times, finances and insensitivity.	Convenience sample. lacks generalizability. No conceptual frame work Self report (?)	Recommendations- multiple types of media to connect, enhance websites, include immigrants in mental health plan, religious and cultural group involvement, provincially funded access to fee for service providers, cultural/ linguistic match between client and provider, collaborative research. Weak

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Rosenheck, Neale and Mohamed (2010) Transition to low intensity case management in a VA assertive community treatment model program. Aim- To study transition to lower intensity services in a national VA program modelled on assertive community treatment (ACT).	n=2137 participants from a nation wide (U.S.) sample of Veterans Affairs involvement and under the care of intensive case management services (ICMS, ACT like). n=196, lower intensity treatment. 87% diagnosis of psychosis. Average age 51.1, 49.4 (low intensity) % male 92.5, 90.7 (low intensity)	Prospective, cohort. Transition criteria-Clinically stable, not abusing substances, not relying on emergency or inpatient services, maintaining themselves in community living. Transitioned participants-Clinicians documented how they met criteria. Whether they returned to high intensity services. What services they currently receive.. 6 month clinical outcome assessment completed on all veterans.	Sociodemographic Clinical diagnosis, Brief psychiatric rating scale (BPRS) for symptom severity. Global severity index (GSI) to measure distress. Addiction severity index. Suicidality and violence self assessment (Likert). Global assessment of functioning (GAF) Lehman quality of life inventory. Structured summaries by case managers. Therapeutic alliance (Likert) Chi square, ANOVA. $p<0.01$ Logistic regression and paired t tests.	No difference in sociodemographic or clinical characteristics between groups. Did show less intensive service use in previous 6 months. Average transition 4.1 years after program entry. Those who transitioned had a significantly lower proportion of crisis interventions and significantly higher family education education and support. Transitioned participants had lower symptoms on BPRS and BSI, higher quality of life, higher quality of family relationships but less contact with case managers. $p<0.01$ 5.7% had transitioned back to intensive services.	Prior decrease in services may have just been formalized. Limited ability to infer due to lack of base line data immediately after transition. Unable to verify validity of administrative data. VA sample predominantly male and older.	ICMS should be reserved for those who need it most. Brings into question the time unlimited nature of ACT programs but research is limited. Family education Medium

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Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Routhier, Leduc, Lesage and Benigeri (2012) Service utilization by hospitalized suicide attempters with schizophrenia or depression in Montreal.	Montreal, Quebec. n=525 people aged 15 or over with diagnosis of schizophrenia (195) or depression (330) that were hospitalized for attempting suicide. Drawn from the entire population of Montreal 15 years of age or older. 281 female Average age 42.9	Retrospective cohort. Quantative. Discusses ethics approval and permissions. The Quebec hospitalization discharge database, Quebec physician compensation database and local community health canters (I-CLSC) database.	Contact with health related services within 3 months post attempt was primary outcome measure. At least one or none. Contacts in the 12 months prior were also measured. Types of care pre and post. Schizophrenia versus depression. comorbid substance abuse also identified. p<0.05	Depression group had lower rates of contact prior to attempt 56% vs. 77%. diagnosis, age and after care not associated with aftercare. Comorbid males had increased likelihood of aftercare, no effect with females. Increasing rates of contact greater for depression (from 56 to 77%) than schizophrenia (77% to 83%) Schizophrenia group received specialized services (69% outpatient, 22% inpatient). 50% of depression group only received GP services.	Databases only reveal contacts not nature. Privately funded services such as psychology or EAP not included. No theoretical framework. Generalize ability limited to most severe cases because emergency room visits not in database.	Notes poor coordination between primary care and specialized services recommends improving services for those who use emergency services as point of entry. Strong

Study	Participants	Methods	Outcome Measurements	Results	Limitations	Comments
Ruggeri, Salvi, Bonetto, Lasalvia, Allevi, Parabiaghi, Bertani, and Tansella, 2007. Outcome of patients dropping out from community-based mental health care: a 6-year multi wave follow-up study.	N=273 participants from South-Verona Italy. Convenience sample from a outpatient treatment centre in the city. Informed consent and confidentially discussed. No information about how many declined to participate. Other than those that did not follow up during the study. 65% female Mean age 45.3 30% depression 18% Schizophrenia/psychosis	Quantitative Logitudinal with repeated assessments of cohort. Data collected from patient, clinician and medical records at baseline, 2 and 6 years. Tools included the Brief Psychiatric Rating Scale, Disability Assessment Schedule and the Global Assessment of functioning. Reliability and validity of tools is discussed.	Cross sectional analysis of groups performed with Kruskal-Wallis, Chi squared and Mann-Whitney tests. P<0.05 was significance value. Binary logistic regression used to predict characteristics of patients who discontinued treatment.	Dissatisfaction with service was main reason for dropping out. Especially true for non-psychotic patients. (49%) 22% dropped out due to other responsibilities Outcome of those who drop out is poorer than those who who appropriately terminate. However there is evidence that appropriate termination does not mean patients are well. Interruption of contact rates may hide unmet needs for care. Those who were most likely to follow for entire study were the most unwell and likely had a schizophrenia Dx.	Convenience sample Sample not representative of other settings Significant attrition rate Group sizes declined over time so percentage comparisons No theoretical framework identified.	Suggests initiatives to address patient expectations of services along with building therapeutic alliances and worker burn out. Community health services offer good continuity for people with psychosis however they do not dedicate sufficient attention to patients with less severe symptoms. Suggests evaluation of services for those with mild to moderate mental illness. Medium-strong

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments.
Sunderland and Findlay (2012) Perceived need for mental health care in Canada: results from the 2012 Canadian community health survey- mental health.	N= 25113 people aged 15 and over. 10 Canadian provinces. response rate 68.9% Excluded those living on reserves and Aboriginal settlements.	Cross sectional survey. Retrospective. Questions about 4 types of help for problems with emotions, mental health or use of drugs and alcohol. Information about problems, treatments, services. Medication. Counselling. other services. 4 level need status variable created based on responses.	Descriptive statistics. Odds ratios, 95% CI Anderson's Behavioural Model of Health Services Use used to identify predisposing, enabling, and needs related factors within the last 12 months. Within needs related- 6 mental disorders: depression; bipolar disorder; generalized anxiety disorder; alcohol abuse/ dependance; substance abuse; cannabis abuse. K6 scale for psychological distress. discusses validity. 3 perceived barriers	17% 0f Canadians 15 or older reported having a need for mental health care (MHC) in the last 12 months. 12% reported need for counselling. 10% need for medication. 7% need for information. 3/4 with depression or anxiety reported a MHC need. Most common need was for counselling. 600,000 (12%) Canadians report an unmet need for MHC. 1,000,000 partially met. Those with moderate distress levels were twice as likely to report unmet or martially met needs	Composite International Diagnostic Interview (CIDI) responses/ not diagnosis Cross sectional. Self report. Personality disorders, psychosis not included. Perceived need.	20% reported systems related barriers. Medium

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Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Tiwari and Wang (2008) Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. Aim- To estimate the 12-month prevalence of mental health service use by ethnicities, overall and among those with major depression and to identify factors associated with mental health service use in different ethnic groups in Canada.	n=108,192 white Canadian born, n=10,892 white immigrants, n=1785 Chinese immigrants, n=1214 South Asian immigrants, n=818 South East Asian immigrants. 10 provinces and 3 territories. Informed consent discussed	Quantitative. Descriptive. Canadian Community Health Survey (CCHS-1.1). Conducted by Statistics Canada between January 2003-December 2003. Stratified random sample. Face to face interviews. Socio-demographics discussed.	Past episodes of major depression assessed using the World Health Organizations composite international diagnostic interview-short form for major depression (CIDI-SFMD). Discusses validation. STATA 95% CI Regression analysis 80.7% response rate at national level.	White participants had significantly higher prevalence of depressive episode (7.6%, 6.4%) than non-white (3.6%, 5.2%, 2.9%). No significant difference between Asian populations. Service use was significantly higher with white participants than non-white. Canadian born whites did not differ from white immigrants. Chinese and South Asian women more likely to use mental health services. White participants and Chinese immigrants who were unmarried, more likely to use services. White participants with less than 13 years education, less likely to use service. Employed low income whites were more likely to use services.	Self report. Retrospective. Cross sectional. No causal relationships. Excluded native populations living on reservations and military.	Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Urbanoski, Cairney, Bassani and Rush. (2008). Perceived unmet need for mental health care for Canadians with co-occurring mental and substance use disorders.	N= 4052 participants that met criteria for a mood or anxiety disorder. Canadian Community Health Survey, Cycle 1.2 (2002). 15 years or older Included: 20.8% substance dependance, 70.3% mental disorder only, 8.9% concurrent.	Cross sectional survey. Diagnostic content based on World Mental Health Composite Diagnostic Interview (WMHCDI) and the Diagnostic and Statistical Manual-IV (DSM-IV). Demographic variables, previous exposure to both community and hospital base services. Distinguished between both formal and informal services.	Multivariate logistic regression $p < .05$	Prevalence of perceived unmet need was 22%. 51% for those with concurrent disorder. Concurrent highest even after adjusting for predisposing and enabling factors. Unmet need more common among those aged 30-39 years. Middle and high income earners lower needs. Substance dependance more common among men. Mental disorder without substance more common among women. Psychological distress highs among concurrent and lowest among substance dependance alone.	Substance abuse, personality disorders and psychosis not assessed. Cross sectional. Self report.	Trend (not significant), preference to self manage symptoms among all diagnostic groups. Substance dependance more likely to report they did not know how to get help. Concurrent more likely to report the "did not get around to it" Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Werner (2012). Needs assessment of individuals with serious mental illness: Can it help in promoting recovery. Aim- To examine the needs of individuals who receive services under the Israeli Rehabilitation of Psychiatrically Disabled Persons in the Community Act (RPDPCA). Investigate differences in perceptions of needs between patients and service providers.	N=206 individuals with a serious mental illness (SMI). N=112 professional care givers. Rehabilitations settings in Israel. 119 men Most had diagnosis of schizophrenia. Ethical approval discussed	Cross sectional. Interview. Chart review. Camberwell Assessment of Need-Patient (CANSAS-P). Assesses needs in 22 life domains on 4 point scale. Reliability and validity discussed. Demographics and disease related information also collected. Including age at first admission and Global Assessment of Functioning (GAF). Interviewers trained for one month.	Pearson correlations, indépendant t-tests, one-way ANOVA. P<0.05	Highest percentage of unmet needs (35.9%) intimate relationships. 31.6% sexual expression. 24.8% company. Highest % of total needs (met and unmet) were accommodations (82.1), psychotic symptoms (55.8) and psychological distress (55.3). More unmet needs among those who had no daytime activities than those who were in a sheltered or open work environment. Those living in supportive environments reported highs unmet needs in area of money. Higher number of areas of no need reported by patient versus worker. Workers reported higher number of met needs. Patients reported higher number of unmet needs.	Convenience sample. Lack of worker consent. No conceptual framework. Self report	Idea that needs are socially negotiated and important to account for several perspectives. Needs assessments recommended for care provision. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Wilson and Cardwell (2012) Urban Aboriginal health: examining inequalities between Aboriginal and non-Aboriginal population in Canada Aim- To examine the health of urban Aboriginal population in Canada.	n=130,827 non Aboriginal, n=98,649 Aboriginal Canadians living in urban settings,	Quantitative, cross sectional survey. Population Health conceptual framework Data from the 2001 Aboriginal peoples survey (APS) and the 2000/2001 Canadian Community Health Survey (CCHS). Validity discussed.	Health measured using three variables- dichotomized self rated health status, dichotomized chronic conditions and activity limitations. health care contacts in last 12 months. Sociodemographic's, socioeconomics, health behaviours, Logistic regression of dependant variables. Odds ratios, frequency distributions of socioeconomic, demographic, health behaviours, geography and health care use. $p<0.05$	Urban Aboriginals younger than non Aboriginal population. Non-Aboriginal higher levels of education and household income. Non-Aboriginals report more chronic conditions. Aboriginals report more activity limitations. Gender is a significant determinant of activity limitation for Aboriginals. Cultural factors significantly related to Aboriginal health outcomes.	Self report. Health related measures on surveys have not been extensively tested for validity. Cultural factors on surveys have not been extensively validated. Defining urban Aboriginal populations is complex The most marginalized i.e.) homeless excluded.	Determinants of health are similar in both groups. Medium

Study	Participants	Methods	Outcome Measures	Results	Limitations	Comments
Zuniga, Navarro, Lago, Olivas, Muray and Crespo, 2013. Evaluation of needs among patients with severe mental illness. A community study. Aim- To describe the subjective profile of the needs of outpatients with severe mental illness.	N= 518 in Barcelona, Spain from the severe mental illness program (SMI). 809 eligible. 291 did not give consent. Primarily single unemployed men. 309 men, 207 women. over half were very low socioeconomic level (poverty level) Mean Global assessment of functioning = 46.86 Most prevalent disorders were schizophrenia and schizoaffective DO (72.7%)	Descriptive mixed methods. Cross sectional Camberwell Assessment of Need (CAN) is identified as instrument. Reliability and validity of instrument are discussed. Interviews with the participants identified sociodemographic variables along with 22 subjective needs on the CAN	Descriptive statistics of sociodemographic variables and need items. Poisson or negative binomial regression models. p<0.05	Needs most often voiced: anxiety or psychological distress (65.4%), psychotic symptoms (49.4%), household skills (49.2%) and company (46.5%). The above needs were also the ones most often met. unmet needs most often voiced were company (19.3%), anxiety (18.5%) and daytime activities (11.8%). Ratio of higher unmet needs to met needs was identified in the low and very low socioeconomic classes, younger age, poorer global functioning and few years duration of illness. Family support exceeded services in areas of household skills, food, money management and anxiety.	Limitations not discussed by authors other than to point out the cultural norms in Spain where those with severe symptoms live with their families. Self report High level of refusal to consent convenience sample No theoretical framework identified	Definition- a need is unmet when no intervention is received or the intervention is only partially effective, and potentially more effective interventions are available. SMI diagnosis included schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, delusional disorder, OCD, borderline PD, schizotypal PD, panic disorder with agoraphobia. Medium

Appendix C: Consultation Report

Memorial University of Newfoundland
School of Nursing
Master of Nursing Program

<u>Practicum: Report on Consultation with Colleagues</u>

Student Name: Scott Beattie   ID# 009259961

Course Name and Number: Nursing 6660

Supervisor Name: Dr. April Manuel

Title: A Needs Assessment: Gaps in Adult Community Mental Health Services in the Metro St. John's Region.

January 17, 2015

Background

Mental illness on an international, national and provincial scale is monumental problem. Worldwide about one person in one-hundred is considered to have a chronic mental illness (Greenblatt & Norman, 1983). The combined prevalence of mood disorders, anxiety disorders, and substance disorders is about 11.1 percent; approximately 21 percent of Canadians are affected by a mental illness at some time in their lives (Arboleda-Florez, 2005). Mental health disorders are the leading cause of disability in the U.S. and Canada for ages 15-44 (National Institute of Mental Health, 2009). In Newfoundland and Labrador 11.0% of mental health patients had three hospital admissions between 2010-2011 (Canadian Institute for Health Information (CIHI), 2011). In efforts to address the needs of this population there has been a shift from

institutionalization towards deinstitutionalization; caring for individuals in the community.

The trend of deinstitutionalization of the mentally ill began in the 1950's due to acknowledgement of the ill effects of prolonged stays within large institutions (Kelly & McKenna, 2004). In St. John's alone this movement was the impetus behind the reduction in hospital beds from 1000 to less than 200 (Eastern Health, 2007). This shift in management of those with mental health issues led to the immediate dismantling of the psychiatric inpatient system and posed several challenges to the health care system related to the lack of planning for community support (Talley & Coleman, 1992). Community health facilities did not have the adequate supportive and psychiatric health-care services or infrastructure to support this transition or the needs of this population (e.g, development of coping, social, and self-care skills) (Greenblatt, & Norman, 1983; Talley & Coleman). This had left many mental health consumers living in poverty, socially isolated and without hope for recovery.

Over the years many outpatient and community based programs have been developed and evolved into the existing Eastern Health services such as case management and outreach services, discharge liaison programs, day treatment facilitates, addictions counselling, education and employment services, as well as housing support. There are also agencies in the metro St. John's area that assist people in recovering and integrating in the community. These agencies may work in partnership with or independently of Eastern Health (e.g., Stella Burry, The Canadian Mental Health Association and The John Howard Society).

Although there is some research that has examined patient health care outcomes for those individuals living in the community setting, almost no research has been completed in the St. John's region specifically. With the exception of an environmental scan of mental health services focused on visible minorities (Reitmanova &Gustafson, 2009) there has been no needs assessments done on this population. The most recent provincial report entitled Working Together for Mental Health: A Provincial Policy Framework for Mental Health and Addictions Services in Newfoundland and Labrador (Government of Newfoundland and Labrador, 2005) advocated for a person centred multidisciplinary approach to community based services as a foundation for management of care (Government of Newfoundland and Labrador).

Despite existing outpatient services for those living with mental health illnesses we have failed to replace institutional care with sufficient services and supports in the community (Mental Health Commission of Canada (MHCC), 2012). That is existing mental health programs are not comprehensive and do not offer sufficient services and supports needed (Kirby and Keon, 2005). For the last six years I have worked as a psychiatric nurse in the community. From my experience, it is apparent there are a group of people with mental illness that require community based services but are unable to access them readily. I have encountered multiple instances and have had many discussions with colleagues about the lack of resources available for those individuals who do not fit into the specific criteria for admission into a particular program. These people are at risk of becoming unwell and being hospitalized because they are often wait-listed or declined for services. Also, individuals may be included in programs that may

not be the best fit for their needs however, because there is no other program that will

accept the person, programs may be reluctant to discharge them. This leaves less space

available for those that may be a better fit with the program.

Based on a comprehensive literature review and discussions with key

stakeholders in St. John's, about the needs of mental health services in the community, a

report of findings including priority areas for action will be presented to management.

This report will provide evidence as to the gaps in existing services and advocate for the

supports needed to help this population manage their health.

Objectives

1. To collect information through stakeholder consultations as to the needs of individuals

living with mental health disease in communities within the St.John's Region.

2. To identify gaps in mental health services within the St. John's Region.

3. To identify common themes discussed by stakeholders and compare these with the

literature pertaining to community health needs of individuals living with mental illness..

4. To use information gathered to inform a formal needs assessment of the mental health

services within the community.

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Setting and Sample

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The consultants were chosen based on their roles and experience within the adult

Mental Health and Addictions program. The group ranged from senior executive to front

line personnel. Both nursing and non-nursing consultants were chosen because a large

number of community mental health workers are trained in other disciplines and they can

offer varied perspectives. The consultants were all initially contacted by email and asked

to participate. At that time they were given a short overview of the practicum and methods of maintaining confidentially. Consultants were sent an advance list of the questions (see Appendix A) that would be asked during the meeting.

A total of ten consultations have taken place with members of Eastern Health's Mental Health and Addictions program. This included, one executive administrator (social worker), two division managers (one nurse, one social worker), five clinical leaders (three nurses, two occupational therapists), one psychiatrist, and one front line community mental health nurse. The two managers oversee outpatient mental health programs and have more than 30 years' experience in mental health care. The five clinical leaders have extensive combined inpatient and outpatient experience with mental health consumers.

Verbal agreement for voluntary participation was obtained prior to the start of the interview. The consultants chose the location of the meetings; eight chose their offices while two meetings took place in a coffee shop. As no confidential information was being shared, public locations were suitable. The meetings ranged from 45-90 minutes. I provided an overview of practicum including rationale for the project and how confidentiality would be addressed.

Data Collection and Analysis

Data was collected through in-person, one–to-one interviews at the location of the informants choosing. A series of open ended questions (see Appendix A) were asked in order to identify areas where gaps in service may exist. The informants were given the opportunity to add any additional comments they feel the questions did not address.

All responses were recorded by hand verbatim. A thematic analysis was done to identify emerging themes. The responses were reviewed for discrepancies between what the literature indicates are a service gap and what the informants identified as existing gaps in mental health services. .

Ethical Considerations

A meeting was held with the Regional Director of Mental Health and Addictions, Eastern Health to get support for this project and permission to speak with staff members of the various programs. Ethical concerns were discussed with my practicum advisor, Dr. April Manuel. According to the Authority Screening Template (see Appendix B), as this project is research but to inform quality improvement of mental health services. All informant responses are kept confidential in a cupboard in a locked office within a secure Eastern Health Facility at 296 Waterford Bridge Rd., St. John's, which only I will have access. Hand written data was coded and only I will be aware of the respondents' identity. Informants were ensured that confidentiality of all data will be maintained and this information will not impact their employment in any way. The only other person with access to the coded hand written notes is Dr. Manuel. Participation in the interview was voluntary and at any point they may withdraw from the process. In such a case the transcribed notes with be shredded immediately.

Key Findings

The key stakeholder consultations were done in order to gain an overview of the gaps in mental health services from the perspective of health care professionals who work with this population. Overall, there was a sense of consistency in the responses of the consultants with the identified gaps in service evident in the literature review. There were however some diverse viewpoints that are presented. The key findings are presented as the dominant themes that emerged from these discussions.

Service Needs and Service Matching

The first two questions (see Appendix A) were to identify groups of mental health consumers that were not or under served by existing programs. The questions were also to identify issues with existing programs and their possible exclusion of these same groups and why. Most of the consultants identified the most severely ill consumers as not getting the services they need to maintain stability in the community. These included those with forensic histories, such as people who have arson charges and extreme violent or sexual offences. It was also noted that if there were a program that worked with this forensic population, this may ease the congestion of other programs.

Contradictory to the literature = consultants did not identify those with anxiety and depression as lacking in or receiving insufficient services but did note that concurrent disorders were an underserved group. People with a mental illness and substance abuse issues were described as having insufficient services to meet their needs partly because those with dual diagnosis are difficult to treat and existing services are not equipped to handle the demand. Consultants advocated for the expansion of services to meet the needs of these consumers. Another group identified by the consultants, but not

emphasized in the literature, as not receiving adequate services, was people with diagnosed personality disorders. Consultants referred to this group has having complex needs, requiring multiple services over a long period of time, and being described as "hard to work with". This population is sometimes excluded from community services because their presentation is dismissed as behaviour rather than illness, which limits their service options in the community.

Although gender was not identified in the literature as a barrier to mental health services two consultations revealed that sexual identity issues as an area where staff lacked the training and skills to properly serve those with sexual identity issues.. Lack of training amongst staff was also noted with respects to working with the diverse cultural needs of those consumers from visible minority groups.. For example it was felt that staff do not receive cultural sensitivity training that would allow them to work comfortably with populations who have a strong spiritual component to maintaining their health and well-being such as the aboriginal population.

An unexpected group was identified through the consultations; those living with autism spectrum disorders. Consultants stated they are receiving more referrals to provide services for this population than ever before. This is concerning because most staff have no experience or training in working with this group of people. Individuals living with brain injuries and cognitive impairments were noted as receiving inadequate services and being referred to mental health programs at an alarming rate. They explained that although the cause of a brain injury may be physical in nature, the symptoms often manifest as those of mental illness. medical and mental health programs reject referrals

for this population which could leave these people with no services at all. Continuing

education for staff was recommended as an important component of service provision for

this group.

Generalized Services and Service Expansion

All consultants agreed that the existing system is not comprehensive and people

who need a service sometimes "don't fit" program parameters. There was a sense that

program criteria sometimes excludes some people who may need a less specialized or

intensive service. For example there is a lack of services to to assist people with

activities of daily living such as medication support and monitoring, appointment

reminders and system navigation. Some people voice very simple needs that can be

hugely beneficial to their recovery. "They want to know there is somebody they can call

with a question or some help". A generalized case management services was expressed as

important however there was an acknowledgement that the existing specialized services

were essential. A team that would assist people with activities of daily living and

community access along with support around symptom management would be beneficial.

Consultants suggested that the diagnostic criteria for such a program should not be too

restrictive as to allow the consumer to decide the level of involvement they desire. On the

other hand if existing programs were to allow admission of people who do not meet its

criteria, then the integrity and fidelity of that program may be compromised.

Most consultants agreed that existing programs needed to be enlarged. Waitlists

were identified as problematic with one program reportedly having a waitlist of two

years. As well, it was voiced that some programs should not be so strict in their admission

criteria. This was reinforced by one consultant who voiced their frustration about trying

to find a community based service for several clients who were turned down from all

existing programs. "Where do they go?". Again this lends to the above discussion that

there is a lack of service for those who do not meet the criteria for the existing more

specialized programs.

Regarding physical health issues (Question six, see Appendix A), the consultants

all agreed that the existing program does not meet the needs of mental health consumers.

Services offered within programs include healthy lifestyle and other group health sessions

but these are only available to consumers within specific programs. There is also a foot

care nurse and a nurse practitioner that offer outreach services once a week but this is not

enough to meet demand. The consensus is that there is a dearth of services for chronic

disease management (e.g., diabetes) for those with mental health issues in the community.

One consultant explained that referrals are made for medical health care such as diabetes

education but these rarely meet the needs of mental health consumers as they may need

additional support in the community and often have less education than needed to

understand and carry out the education provided. There was unanimous agreement that

mental health consumers are stigmatized within the medical system and because of this

many do not seek medical care or are denied service because "they're trouble makers".

System Navigation

Both the literature review and the consultants identified system navigation as a

serious barrier for people wanting community services. This issue is not only a consumer

issue but a provider problem as well. Several consultants voiced that they are unclear

about existing services in the metro area and their criteria for admission. Both public and provider education is voiced as necessary to improve awareness of the mental health system. Clearly defined points of entry for programs was also identified as a need.

Fostering Multidisciplinary and Client/Provider Collaboration

Consultants were asked to discuss their thoughts on inter-program coordination, communication and collaboration. When asked about this, the consultants unanimously expressed that communication/collaboration was a serious problem within the system. Some did however report that they believe it is improving but slowly. Community workers are being invited to inpatient discharge planning meetings and there is a trend of agreement that "we are all trying to do what's best". Consultants however, expressed some frustration with the current state of communication with regards to confidentiality policies. They believe that although protecting consumer's right to privacy is important, existing privacy legislation has limited their ability to communicate with other health care workers to provide best possible patient care. There was also a sense that confidentially policy's are misunderstood and clinicians practice a 'better safe than sorry' approach to communication. Collaboration difficulties were also identified in the literature review. Consultants spoke to the fact that collaboration and communication problems are wide spread and that services working in silos is common. It was suggested that further education regarding client confidentially is a must along with a better sense of programs working together rather than independent of one another.

Many of the consultants also offered nearly identical responses regarding coordination of services. They voiced that clients' service needs change over time and

because of this, other programs may be more suited to meet their needs. Shifting needs of consumers was also identified in the literature as a concern warranting attention. Programs need to be able to adapt to this change of consumer needs. Consumers must be offered the opportunity to transition from one program to another without gaps in service provision. It was suggested that services must work on a continuum where discharge or graduation from one service would make a client eligible for another service, if they so choose. Examples of patients being discharged from service with the expectation that they would be eligible for another were given. In some cases those patients were not accepted to other services and ended up with no support.

The seventh question addressed who directs service provision; consumers or providers. Some consultants identified that at the provincial level, allocations are based on budgets. But at the program level, consumers are having more influence on service provision "within reason". Some requests of consumers are not possible based on program budgets (eg., more money for a larger apartment). Programs are taking a more "evidenced based approach to need" and are sometimes changing directions to better meet those voiced needs of consumers. Examples given included a recognition of the need for peer support services and physical activity. Sheltered employment was an example given that is currently requested by consumers but has very limited availability. Sheltered employment has been defined as employment programs for people with disabilities who are unable to work in a competitive employment setting (Kregel and Dean, 2002). The consultants also reported that clients want access to a psychologist but it is extremely limited unless they have private insurance. From the consultants point of

view, there was an optimistic tone that consumers have more of a voice then they have

ever had before. During this question, it was restated by a number of consultants that a

more generalized community service without highly specific criteria was needed.

Psychosocial Supports

Services such as social and peer support, housing and home support were

identified as essential factors for a community mental health system. Psychosocial

supports were identified as inadequate by all consultants. The most frequently cited were

peer support and home support services. Peer support was discussed as being important

in a comprehensive program. It is available within a small number of Eastern Health

programs however the primary organization that offers this service is outside of Eastern

Health. All consultants expressed that the service should be available to all consumers

within the program. Again, all consultants agreed that home support is an important

service that is not readily available to mental health consumers being that it is for the

most part, allocated by an agency outside of the Mental Health and Addictions program

and has been difficult to access as one consultant stated, "it's like jumping through

hoops". This is another example of service fragmentation discussed by the consultants

and also identified in the literature.

Housing was also identified as a very serious problem within the St. John's area.

There were various responses regarding whether the Mental Health and Addictions

program should be more involved. Several consultants expressed that other agencies

should carry this responsibility and the program should be less involved. The literature

also identified lack of safe affordable housing as a barrier to recovery however it did not

discuss specifically who is responsible. All consultants agreed that safe, secure housing is essential for recovery from mental illness.

Summary

This consultation process allowed for the identification of several themes related to community mental health service needs in the St. John's ares. Expansion of existing services which included a need for a more services for those with concurrent disorders as well a those with personality disorders. However there were also groups discussed that were not identified in the literature. These included those with autism and brain injuries, as well as those with extensive forensic histories. There was also a voiced need for a more generalized community service program that does not have stringent admission requirements. Wait lists for programs were identified as problematic by both the consultants and the literature. Minority groups and ethnicity were noted as potential groups lacking services in the literature however were not emphasized by the consultants with exception to those with gender identity issues and our aboriginal population. Collaboration and communication between services was emphasized as an area in need of improvement . As discussed in the literature, the consultants voiced a need to allow for better consumer transition between services. Poor service transition was a recurrent theme in both the literature and the consultations. Physical health such as chronic disease management, is not being adequately addressed by most programs and there is a need for better access to these services where lack of understanding of mental illness and stigmatization is a possible barrier. There appears to be a growing number of programs that are adapting to the voiced needs of consumers but this has not translated to the

provincial and executive levels where much of the resource allocation decisions are made. Finally, more services need to be offered in psychosocial areas including peer and home support. It remains unclear as to the need for direct program involvement regarding housing however it is essential.

The literature review provided a comprehensive view of the needs of consumers and gaps in community mental health services however, did not address the specific population in the St. John's area. These consultations provide a unique perspective to this population and have been essential in identifying the directions needed for the adult Mental Health and Addictions program.

Appendix A

Questions for Key Informants

1) Do you believe there are group(s) or specific populations of mental health consumers (this may include gender, sexual identity, specific mental health conditions, ethnic backgrounds) that lack services or are under served in the existing system? Who are they?

2) Within the existing system, are there programs that are too specific or broad in their criteria for intake or discharge? Names of specific programs are not needed. Is there a specific group of mental health consumers (this may include gender, sexual identity, specific mental health conditions, ethnic background) that are not or underserved because of this?

3) Is there a specific service that is needed or needs to be expanded upon?

4) What is your opinion on the state of inter-program collaboration/communication?

5) Do you feel that services are coordinated? Why or why not?

6) For those with a mental illness, do you feel that the current services offer enough support around physical health concerns? Why or why not?

7) Do you believe the existing programs are focused on the needs voiced by the consumers or are they operated based on what providers believe is best for the consumer? Why or why not?

8) Do you feel the current services adequately address psychosocial needs of consumers? This may include community integration services such as social and peer support, housing, transportation or other logistical resources, home support, work/educational opportunities.

9) Are there any other potential service gaps that we may not have addressed in the above questions?

Appendix B

Health Research Ethics Authority Screening Tool

	Question	**Yes**	**No**
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review		X
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?		X
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.		
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	X	
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?		X
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?		X
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?		X
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?		X
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		1	

8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?		X
9.	Is the project intended to define a best practice within your organization or practice?		X
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	X	
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	X	
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		X
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		2	
	SUMMARY **See Interpretation Below**	3	

Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.

- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).

- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/ Ethics-Review-Required.aspx.

Appendix D: Environmental Scan

Eastern Health Adult Community Mental Health Services in Metro St. John's and Surrounding Area

Emergency Services

Service Name	Service Provided	Length of Service Provision	Criteria
Psychiatric Assessment Unit. Waterford Hospital	Emergency assessment, crisis intervention. Point of entry for inpatient services. 3 holding beds	Up to 23 hours for holding bed. Assessment unit open 24 hours a day	Walk in service for psychiatric emergencies.
Psychiatric Emergency. General Hospital	Emergency assessment, crisis intervention. Point of entry for inpatient services.	Open 24 hours per day.	Walk in service for psychiatric emergencies
Mental Health Crisis Line	Telephone based crisis intervention	24 hours per day	Anyone in crisis.
Gambling Helpline	Telephone based service for those seeking support for themselves of another's gambling problem. Entry point for referral to other services.	24 hours per day	Anyone seeking help for gambling related issues.
Mobile Crisis Response Team	Community crisis response/ intervention. Entry point for inpatient services. Entry point for referral to other services.	11am-11pm 7 days per week.	Anyone in community in mental health crisis.

Community Mental Health Services

Service Name	Service Provided	Length of Service Provision	Criteria
Addictions Services Counselling Program	Addictions counselling for individuals concerned about their own or another's use of alcohol, drugs or gambling. Entry point for referral to other services.	Based on need	Individuals concerned about their own or another's addictions issues.
Mental Health Discharge Liaison Nurse	Liaise with clients transitioning between inpatient and outpatient services. Home visits, advocacy, other clinical services. Entry point for referral to other community services	Based on need. Until client has been connected with community services if needed.	Voluntary service for those being discharged from acute care inpatient mental health services.
Mental Health Community Liaison	Social worker who acts as consultant in the development of service plans. Advocates, counsels and provides education.	Based on need. Until client has been connected with community services if needed.	Voluntary service. People with complex mental health needs

MENTAL HEALTH COMMUNITY SERVICES

Service Name	Service Provided	Length of Service Provision	Criteria
START Clinic	Short term rapid access to mental health services. Nursing, psychology, psychiatry, occupational therapy, spiritual counselling. Intake completed within 30 days of receipt of referral. Entry point for referral to other community services	6-8 office visits.	Voluntary service for those in need. individuals not connected with other community mental health programming.
Community Mental Health Counselling Services	Counselling services for individuals in the areas of mental health and addictions. Entry point for referral to other community services	Based on need	Voluntary service for those in need.
LeMarchant House	Short term counselling services. Individual, couple, family and group therapy.	Short term.	Not specifically for those with primarily addiction, active psychosis, or actively suicidal.

Service Name	Service Provided	Length of Service Provision	Criteria
Terrace Clinic	Assessment, diagnosis, treatment planning; individual counselling and psychotherapy; medication therapy; and family therapy.	Based on need.	No identified service restrictions. Mental health need.
Mental Health Court	Social workers and psychiatric licensed practical nurses who support individuals with mental illness in the community.	Decided by the Mental Health Court	Individuals, 18 and over, with a diagnosed mental illness.
Provincial Forensic Coordinator	Co-ordinates care in the hospital and community for those found unfit to stand trial due to a mental illness and those found not criminally responsible.	Based on need.	Individuals with a mental illness charged with a crime under the criminal code of Canada.
Supportive Board and Lodging Subsidy	Financial support for those individuals with a mental illness living in a board and lodging situation with or without a relative.	Time unlimited	Individuals with a psychiatric diagnosis and is based on acuteness of illness, impact of illness, and need

MENTAL HEALTH COMMUNITY SERVICES

Service Name	Service Provided	Length of Service Provision	Criteria
Community Care	24 hour care for individuals who require special residential, recreational and psychiatric services. Privately operated homes with 186 beds. Case management, recreation program and psychiatric services.	Time unlimited	Chronic severe persistent mental illness.
Family Care	Community based Board and lodging. Residential and rehabilitative services. Collaboration between home operators and nursing team to provide rehabilitative services.	Time unlimited	Severe persistent mental illness

Specialized Services

Service Name	Service Provided	Length of Service Provision	Criteria
Day Treatment Program	Group treatment program that embraces a holistic, recovery based approach to mental illness.	8 weeks. Monday-Thursday, 9am-3pm	Referral from psychiatrist. For individuals with a major psychiatric Illness seeking this service.
Clinical Sexuality	Services for adults who have issues with sexual dysfunction, paraphilia, atypical sexual dysfunctions, gender identity and orientation.	Based on need	Priority given to those already in the mental health and addictions program.
Traumatic Stress Services	Individual and group counselling for those who have experienced significant trauma.	Based on need however time limited.	Individuals who have experienced significant trauma.
Concurrent Disorders Services	Treatment counselling for individuals with both a psychiatric illness and a substance abuse or gambling issue.	Based on need	Individuals with both a psychiatric illness and a substance abuse or gambling issue.

MENTAL HEALTH COMMUNITY SERVICES

Service Name	Service Provided	Length of Service Provision	Criteria
Outpatient Clinics	Outpatient follow up for individuals recently discharged from inpatient stay and do not have other community services. Health care team provides assistance with symptom and medication management.	Based on need however time limited.	Individuals recently discharged from inpatient stay and do not have other community services.
Nursing Services	Nurse assesses, monitors and evaluates ongoing care, provides depo-neuroleptic clinic, acts as advocate and works collaboratively with case managers and families.	Based on need however time limited.	Individuals without primary care providers
ECT Service	Electro-convulsive therapy	Based on need	Prescribed ECT by psychiatrist.
PIER Program	Intensive early intervention. Psychiatrist, case management, nursing, social work, occupational therapy	3 years	Individuals experiencing first episode psychosis

Service Name	Service Provided	Length of Service Provision	Criteria
HOPE Program	Outpatient day treatment program for individuals with eating disorders. Individual and group counselling and meal support. Dieticians, psychologists, social work, occupational therapy, nursing physiotherapy and a part time physician.	Based on need.	Individuals with eating disorders.
Dental Department	Dental services for those with a mental illness.	Based on need.	Involvement with the Mental Health and Addictions Program. In receipt of AE&S support.
NavNet	Collaboration of health, justice, housing, and financial programs to provide community based support for those with very complex needs.	Time unlimited	Individuals with very complex needs. Traditional/existing services have had limited benefit. Need for multiple organization involvement. Case management or other community based professionals already working with individual.

Prevention/Promotion & Outreach

Service Name	Services Provided	Length of Service	Criteria
Promotion and Prevention Services	Educational and training programs for individuals, families and groups in an effort to prevent alcohol, drug and gambling problems. Along with services to promote mental health. Increase public awareness.	Based on need	Those seeking information and expressing need.
Outreach	Multidisciplinary team work in a brief intervention with individuals who have a variety of needs in mental health and addictions. Works in partnership with several community based organizations.	Based on need	Those seeking assistance. Youth and adult.

Community agencies whose primary mandate is working with adult population with mental illness.

Housing/Shelters

Service Name	Service Provided	Length of Service Provision	Criteria
Jessie's Place	Shared living for women recovering from addictions.	Based on need. Short term	18 years or older. Agree to remain abstinent while residing. 6-8 consecutive days abstinent prior to acceptance.
Pleasant Manor	Shared living for up to 4 people. Support, counselling and life skills teaching.	1 year in traditional placement. Option of long term NL housing placement in independent units.	18 years or older. Psychiatric illness. Stable symptoms for 3 months. Not be an active drug or alcohol abuser. Have a professional contact in the community.
Stella Burry	Affordable housing development. Emmanuel House. Naomi Centre. Carew Lodge. Affordable independent housing, supported group living, Young women's shelter, transitional housing.	Based on service and need. Short term to unlimited.	Housing services not specifically for those living with a mental illness however Stella Burry does work with a large population of mental health consumers.
Wiseman Center	Emergency shelter, skills development, counselling, housing support.	Short term, 6-8 weeks.	Adults 30-64 years of age. Not specifically for mental health consumers however those with complex needs.

MENTAL HEALTH COMMUNITY SERVICES

Housing/Shelters

Service Name	Service Provided	Length of Service Provision	Criteria
Marguerite's Place	Supportive housing, counselling, group living but may transition to independent.	Up to 3 years	Women over the age of 30. Complex needs however not specific to mental health consumers.
Native Friendship Center	Shelter, counselling, housing support, arts programs, Employment assistance	Short term	People of Aboriginal descent. Not specifically for mental health consumers.
Tommy Sexton Center	Emergency and short term shelter. Priority to those with HIV/AIDS. Individual counselling, life skills teaching,	Short term. Up to 3 weeks.	Between 16-65 years of age. Complex needs. Not specifically for mental health consumers.

Employment Support

Service Name	Service Provided	Length of Service Provision	Criteria
Avalon Employment	Job assistance and support.	Based on need	Adults with developmental disabilities. Not specifically for mental health consumers.
Independent Living Resource Service	Employment counselling	Based on need	All ages, cross-disabilities. Not specifically for mental health consumers.

Employment Support

Service Name	Service Provided	Length of Service Provision	Criteria
New Hope-Building Service Worker Program	Non-credit certificate program in building services.	12 weeks	30 years or older. Not specifically for mental health consumers.
Partners for Workplace inclusion.	Employment services. Vocational planning. Access to training and job accommodations.	Based on need	Must have a disability. not be eligible for employment insurance. Be unemployed.
Stella Burry	CAN-DO, Hopeworks, New Beginnings. Short term, training for long term job opportunities. Job seeking assistance and counselling.	Depends on program. From daily employment opportunities to long term.	18 years or older. Mental illness or other identified barriers to employment.

Education

Service Name	Service Provided	Length of Service	Criteria
New Hope-Building Service Worker Program	Non-credit certificate program in building services.	12 weeks	30 years or older. Not specifically for mental health consumers.
HOPEworks	ABE program, K-6	Based on student's level	18 years or older. Not specifically for mental health consumers.

Education

Service Name	Service Provided	Length of Service	Criteria
Discovery Center	ABE program. High school equivalency	Based on student's level	18 years or older. Not specifically for mental health consumers.

Socialization/Support

Service Name	Service Provided	Length of Service	Criteria
CHANNAL	Drop in, Bipolar group, Depression/ anxiety group, Peer support, Wellness Recovery Action Plan workshops	Based on need	Any person with a mental health concern/issue
Canadian Mental Health Association	Education, Advocacy, Community development. Justice Project	Based on need. Justice Project	Any person with a mental health concern/issue
Schizophrenia Society	Education, support for this affected and their families, public policy, and research.	Based on need	Persons and families affected by schizophrenia. Clinicians and organizations
Autism Society NL	Adult social club, Adult one-to-one	Based on need	Adults with autism spectrum diagnosis
NL Brain injury support group	Social/recreation activities	N/A	Persons with a brain injury.
The Pottle Centre	Social/recreation activities.	Time unlimited	Receiving mental health services. 19 years or older.

Socialization/Support

Service Name	Service Provided	Length of Service	Criteria
The Women's Centre	Multiple support groups i.e.) Healthy living, Morning yarn, Empowerment groups.	Time unlimited	Females
Stella Burry	Inclusion Choir, Community Kitchen, Shared Spaces.	Based on desire	No criteria
New Hope Community Centre	Weekly meals, socialization, counselling. On site social worker and Nurse practitioner (Eastern Health). Mental health support group	Time unlimited	No criteria

Appendix E: Report to Eastern Health

Community Mental Health Services in the St. John's Area:

Challenges and Opportunities

Scott Beattie

Memorial University School of Nursing

Acknowledgements

Executive Summary

This report provides an analysis of exiting mental services within the St. John's metro

region. A needs assessment was completed using the Recovery Model as the theoretical

framework. This needs assessment was comprised of three phases (1) a literature review,

(2) stakeholders consultations, and (3) and an environmental scan. Based on the needs

assessment, gaps in services and recommendations to meet the needs of the current

mental health consumer were identified.

Phase 1. The literature identified system navigation and access to services such chronic

disease management, social supports, housing, and skill development as impeding the

health of this population. Discrepancies in the allocation of services were evident; those

living with depression, anxiety, and concurrent disorders had limited resources.

Inconsistencies between health providers and consumers as to the type of service required

were present. Evidence also suggested that community mental health services struggle

with maintaining continuity of care and intersectoral collaborations with other services to

optimize the consumers' health care. Sociodemographics was found to impact the needs

and the priorities of mental health consumers.

Phase 2. Consultations with ten key stakeholders in the field of mental health in the St.

John's region were done. Consultants identified those with forensic histories, concurrent

disorders, personality disorders, autism spectrum, brain injuries, sexual identity issues,

and from ethnic minorities as being in need of improved community services. The need to

balance available specialized mental health services with more generalized mental health

programming was clear. Challenges in the existing service structure included inter-program collaboration, psychosocial supports, and a clear means to navigate the system.

Phase 3. An environmental scan revealed that between Eastern Health and the private community agencies, there are over 60 services available to community mental health consumers. Challenges include system navigation, access, service continuity, program collaboration., and duplication of services such as employment support and skills development. Although this gives the consumer options it also depletes finite resources. Limited services exist for those with forensic histories, concurrent disorders, gender identity issues, ethnic minorities, and Aboriginal groups.

Recommendations. Campaign efforts that address the stigma of mental health need to be strengthened. Efforts must be made to ensure those groups without appropriate service are supported (e.g autism, brain injuries, aboriginal population). The implementation of a needs assessment tool such as the *Camberwell Assessment of Need* will help tailor programs to the specific needs of the mental health consumer. Health care providers must be educated to provide specialized and general services that support these populations in their homes and community such as chronic disease management and housing. Efforts to promote self-management foster a sense of control and recovery. Part of this is having access to health care providers outside regular office hours and on the weekends. System navigators that provide information about access to resources and how to transition through the mental health system are also needed. Partnerships and collaboration between Eastern Health and the private agencies will help to decrease duplication of services and also improve navigation.

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Limitations. This needs assessment did not include mental health consumers, adolescent and geriatric services. These groups should also be included in any future needs assessment of community mental health programs.

In the last fifty years there has been a shift in the treatment of individuals living

with mental illness from institutionalization towards deinstitutionalization or community

based treatments (Kelly & McKenna, 2004). Advocates of deinstitutionalization, argued

that higher level psychological needs, such as self-esteem, were not being met in the

institutional setting (Kelly & McKenna). It is estimated that the number of inpatient beds

in Canadian psychiatric hospitals decreased from four beds per 1000 population in1964 to

less than one bed per 1000 population in 1979 (Sealy & Whitehead, 2004). The primary

psychiatric hospital in Newfoundland housed 1000 people in the 1960's and today has

less than 200 beds (Eastern Health, 2007).

The rapid trend towards deinstitutionalization led to the immediate dismantling of

the psychiatric inpatient system and posed several challenges related to the lack of

planning for community support (Talley & Coleman, 1992). For example community

health facilities did not have the adequate supportive and psychiatric health-care services

or infrastructure to support this transition or the needs of this population (e.g.,

development of coping, social, and self-care skills) (Greenblatt, & Norman, 1983; Talley

& Coleman). Suddenly, people who may have spent much of their lives in institutions

were expected to house, cloth and feed themselves with little or no education and social

support networks (Accordino, Porter, & Morse, 2001). These factors coupled with

feelings of stigmatization, victimization, and poor housing reduced their quality of life

and increased difficulty with community living (Kelly & McKenna, 2004).

Integration in the community was another challenge facing individuals living with

mental illness during the shift towards deinstitutionalization. A lack of understanding and

compassion for people with a severe mental illness can foster resentment, intolerance, and negative attitudes within communities towards those with a mental illness (Kelly & McKenna). In fact these negative community attitudes were often found to have caused this cohort more problems than their illness (Accordino et al., 2001). That is, they found it difficult to cope with the challenges of their mental illness while trying to live in a community where they may not be welcomed. Collectively these factors create an environment wherein those living with a mental illness become marginalized as their mental illness and their personal circumstances exacerbate each other, making life in the community very difficult (Johnson & Montgomery, 1999). As a result many are left homeless or living in conditions that are deplorable and dangerous. Some beg for money for food while others may turn to prostitution. Many turn to street drugs, adding an addiction to their long list troubles, or end up in the justice system.

Although there has been an increase in mental health outpatient resources there remains a treatment gap between those that have a mental illness and those who receive treatment. It has been found that the treatment gap for schizophrenia and other psychotic illnesses is as high as 32%, depression 56%, bipolar disorder 50% , and generalized anxiety disorder 57% (Kohn, Saxena, Levav & Saraceno, 2004). In Newfoundland and Labrador 2009-2010, 11.4% of those discharged from a mental health inpatient stay were readmitted within 30 days; 13.8% had two or more admissions within the year (Canadian Institute for Health Information (CIHI), 2011). Since the release of the document entitled, Working Together for Mental Health (Newfoundland and Labrador, 2005), there have been great efforts made to improve existing and create new community based

services for mental health consumers in Newfoundland and Labrador. Today there are many more outpatient options for those adults suffering from mental illness. Case management programs, crisis response teams, trauma programs, out-reach organizations, early psychosis intervention programs, housing and employment supportive services are offered with the intent to help those in the community move forward in their recovery (CIHI; Eastern Health; Stella's Circle, ND).

Despite the efforts to introduce innovative programs to address this populations' health care needs, existing services still fall short in meeting the challenges of this cohort. Furthermore, there is a sense that mental health consumers (MHC) are not receiving the full benefit from existing mental health services in the metro St. John's area. In order to examine the opportunities to improve delivery in health care services a needs assessment comprised of four phases was completed; (1) review of the literature,(2) key stakeholders consultations in the mental health community, (3)an environmental scan, and (4) recommendations. Phase four includes this document; an overview of the findings from this needs assessment and recommendations.

This report contains five components:

1) Theoretical framework

2) Literature review

3) Key stakeholders consultations

4) An environmental scan

5) Recommendations

Theoretical framework: Recovery Model

The Recovery Model has provided the theoretical framework for this needs assessment. The Recovery Model proposes the unification of consumers, providers, advocates, and policy makers with a common goal of developing a recovery-oriented mental health system that promotes hope, healing, empowerment, and connectedness (Jacobson & Greenley, 2001). Underlying this model is that recovery is a subjective experience and is attainable (Jacobson & Greenley). In order for health care providers to truly facilitate a recovery approach, they must embrace the client as a co-participant in the development in of their plan of care. As health care providers, to adopt a recovery oriented approach, we must not impose our perceptions of what recovery is but rather facilitate the journey for our consumers.

Literature Review

The challenges that impact the recovery of MHC include 1) access to resources, 2) socio-demographics, 3) appropriateness of resources and 4) disparities in services.

Access to Resources

Access to resources such as information, social supports, housing, and skills development were key factors that influence the health of MHC. Adding to this are concerns around coordination and collaboration of these services, as MHC needs for specific services merge.

Information. Lack of knowledge about the management of their health as a key concern for MHC. This ranged from general information about their illness to management of prescribed medications (Barbato et al., 2014; Brems, Johnson, Corey,

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Podunovich & Burns 2004; Sunderland &Findlay, 2012), and to physical health issues

related to living with a chronic disease. This is concerning given that those living with a

with severe persistent mental illness have a life expectancy of 13-30 years shorter than

the general population (De Hert et al., 2011) because of a high incidence of chronic

illness (e.g., obesity, diabetes mellitus, metabolic syndrome (De Hert et al., 2011; Torres-

Gonzalez et al., 2014.). In addition, MHC's are at higher risk for sedentary lifestyle,

unhealthy diets, substance use, and are twice as likely to smoke thus,access to

information to manage these comorbidities critical (Saddichha, Manjunatha, Ameen &

Akhtar, 2008 ; Torres-Gonzalez et al., 2014).

MHC often have complex medication regimes the can result in negative physical

side effects and lead to chronic disease. For example, some atypical antipsychotics

contribute to obesity, metabolic syndrome, and diabetes (De Hert et al., 2009; Saddichha

et al.,2008). Psychotropic medications are also strongly associated with sexual

dysfunction and reduced social interaction; a common reason for rejecting medications

(Torres-Gonzalez et al., 2014).

Social Supports. A social connection with other consumers, peer support

programs, participation in daytime activities, and intimate relationships have all been

identified as voiced needs of the MHC (Barbato et al., 2014; Beebe 2010; Brems et al.,

2004; Lasalva et al.,2007; Werner,2012; Zuniga et al.,2013). In fact, between 17% and

75% of individuals living in the community stated they lacked supports such as

counselling, medication support, opportunities for social interaction, and help with

activities of daily living needed for recovery (Brodbent, Kydd, Sanders & Vanderpyl,

2008; Pagura, Fotti, Katz & Sareen, 2009; Sunderland & Findlay, 2012; Urbanoski, Cairney, Bassani & Rush, 2008). Werner used the Camberwell Assessment of Need-Patient (CANSAS) and reported that a significant percentage of consumers identified intimate relationships (35.9%), sexual expression (31.6%), and company (24.8%) as unmet needs. Zuniga et al. also used the CANSAS and noted that a significant percentage (19.3%) of MHC identified company and daytime activities (11.8%) as unmet needs.

Evident in the literature is the lack of formal support networks to enable this population to remain in their homes, such as community health workers, case managers, counsellors, and mental health workers (Barbato et al., 2014; Brems et al.2004; Pagura et al., 2009; Sunderland & Findlay, 2012). This lack of supports often delays necessary interventions such as liaising with other agencies or landlords, assisting with appointment attendance or medication changes which can negatively impact MHCs health care outcomes and perceptions of care (Barbato et al., 2014).

Literature suggests that MHC concerns may not be related to the need for more intensive services but rather a different approach to service provision (Morse, Calsyn, Allen, Tempelhoff, & Smith,1992; Morse et al.,1997 ; Calsyn, Morse, Klinkenberg, Trusty and Allen (1998). Such as in home and community based services rather than clinic and office based. Others state that it may be related to a lack of community engagement, stigma, and knowledge (Kohn, Saxena, Levav, & Saraceno, 2004). This is significant because there is a large community mental health service network in the metro St. John's area yet are still service gaps remain.

Housing. The relationship between mental illness and access to safe affordable housing is clear within the literature. People living with a mental illnesses often face challenges relating to employment and income, thus struggle with maintaining adequate housing (Munn-Rivard, 2014). Inadequate housing can lead to a multitude of stressors that impact coping skills, self-esteem, emotional well-being (Canadian Institute for Health Information (CIHI), 2007), and exacerbation of a mental illness (Munn-Rivard). Research has shown that 80% of MHC felt that having secure housing is a key factor in preventing hospitalization (Werner, 2012; Brems et al, 2004). Hanson, Houde, McDowell, and Dixon (2007) found that even with case management or assertive community treatment, the need for housing services was paramount in the recovery of those living with mental health concerns.

Skills: New and Evolving. In order to move towards recovery MHC need essential skills that include maintaining a household (e.g., cooking), vocational rehabilitation (e.g., upgrading), and accessing/maintaining educational opportunities (e.g., college) (Barbato et al., 2014; Hanson, Houde, McDowell, and Dixon, 2007; Pagura, Fotti, Katz & Sareen 2009; Werner, 2012; Zuniga et al., 2013). Of these, vocational rehabilitation was identified 50% of the time as a priority skill (Barbato et al.). Part of tailoring progams focused on daily skills is an awareness that the skill set of MHC is transient (Torres-Gonzalez et al., 2014). Longitudinal research has found that over time health needs of consumers declined yet social needs increased (Lasalva et al., 2007). This may indicate that there is a shift in priority for the MHC; once their higher health needs are met, they identified other areas of importance such as socialization.

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Coordination and Collaboration. The literature has shown that problems at program and administrative levels of services related to coordination and collaboration create barriers to those seeking services (Sunderland and Findlay, 2012). Lack of continuity of care, wait times, and choice of provider can negatively impact the mental health consumer (Barbato et al., 2014; Pagura et al., 2009; Raingruber, 2003). Inconsistent staffing, gatekeeping, and compartmentalization of the mental health system was found to hinder the treatment of people with depression and suicidal ideation (Raingruber). A big concern is that people fail to seek help simply because they do not know where to avail of desired services (Pagura et al.).

Collaboration of services between inpatient and community psychiatric services was noted to improve quality of care such as early intervention, service transition, and decrease wait times (Kisely & Chisholm, 2009; Hansson, Ovretveit, Askerstam, Gustafsson & Brommels, 2010; Holst & Severinsson, 2003; Mental Health Commission of Canada, 2012). In fact coordination in networks improved mental health services in all themes of the Camberwell Assessment of Needs (CAN) including daytime activities, psychotic symptoms, and interactions with family (Hansson et al., 2010).

Sociodemographics

Age, education and income, gender, and ethnicity were all found to influence the health of MHC.

Age. Although there is some conflicting research, young adults have been shown to have less access to community mental health services, disengage from services earlier, and have more unmet mental health needs (Urbanoski, Cairney, Bassani &Rush, 2008;

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Zuniga et al. 2013). Reasons cited as to why this is the case include difficulty with attendance, accepting help, developing therapeutic relationships, crafting mutual goals, lower satisfaction with services, and stigmatization (O'Brien, Fahmy, & Singh**, 2009**, 2009). In contrast, Routhier, Leduc, Lesage and Benigeri (2012) found that age did not affect after care service use by consumers recently hospitalized for attempting suicide. These findings question the relationship between age and satisfaction with community health care services warranting more research in this area.

Education and Income. Education levels and income have also been found to impact the need for mental health services. One Canadian survey found that those with less than 13 years education, were less likely to use mental health services (Tiwari & Wang, 2008). A second Canadian survey reported that individuals with low incomes required more mental health services than those in middle and high income brackets (Urbanoski et al., 2008). Continuity of care is also impacted by income levels. In one study, a housed group had a significantly greater continuity of care of services in comparison to those who were homeless and economically disadvantaged (Fortney et al., 2003). Lasalva et al. (2007) also found that sociodemographics is a significant predictor of consumer rating of needs such as access to services including counselling.

Gender. Gender has also been identified as a predictor of the need for and engagement with community mental health services (Lasalva et al., 2007; Routhier, Leduc, Lesage and Benigeri, 2012). However evidence remains unclear as to the strength of this relationship. Males with a diagnosis of mental illness and substance abuse were found to use more community services post hospital discharge than females (Routhier et

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al., 2012). Lasalva et al (2007) noted that being male was linked to an increase in health and social domains of need (Lasalva et al.). In contrast O'Brien et al. (2009) found, in their review, that gender is not consistently a factor for service engagement. This is interesting because hospitalization rates for women with anxiety disorders, in Canada, are twice as high as those for men (Health Canada, 2002). Women are also 1.5 times as likely to be hospitalized for an attempted suicide than men despite the fact that the suicide rate is almost five times higher with males in Newfoundland and Labrador (Edwards et al., 2008; Health Canada, 2002).

      Ethnicity. Research has shown disparities in the use of community mental health services for both immigrant populations along with Canada's Aboriginal populations (O'Brien et al., 2009; Reitmanova & Gustafson, 2009; Tiwari &Wang, 2008; Wilson & Cardwell, 2012).

Reitmanova and Gustafson investigated the availability of primary mental health care information and services for visible minority immigrants in St. John's, Newfoundland. In a community scan of available services they were unable to find any mental health services specific to immigrants (Reitmanova & Gustafson). The Association for New Canadians (ANC) was the only organization providing counselling and group supportive services. Participants reported challenges with obtaining information, language and literacy, mistrust, stigma, wait times, finances, and insensitivity (Reitmanova &Gustafson).

      There is also a body of literature that has examined the mental health of Aboriginal populations in Canada. There are about 1.4 million people who claim

aboriginal identity and roughly 4500 of them live in the metro St. John's area (Statistics

Canada, 2011). Both the rate of depression and suicide for First Nations people is two

times higher than that of the Canadian population (Adelson, 2005; Khan, 2008). It has

been found that ethnic minorities and those who live in urban environments have poorer

social networks and lower engagement with mental health services (O'Brien et al., 2009).

Thus, it is essential that any community based mental health program be sensitive to and

educated about the cultural differences and values held by its ethnic and Aboriginal

populations.

Appropriateness of Services

Health care workers' priorities sometimes differ from the client's identified needs,

including the priority of treatment goals, what needs are met/unmet, and the importance

of therapeutic relationships (Brodbent, Kydd, Sanders and Vanderpyl, 2008; Happell,

2008; Kreyenbuhl, Nossel, and Dixon, 2009; Lasalva et al.,2007; O'Brien et al., 2009;

Raingruber, 2003; Werner, 2012). This can lead to an inappropriate use and allocation of

services however there is a dearth of literature that examines the inappropriate use of

services by MHC. To clarify, MHC's may be getting a service that does not meet or

exceeds their actual needs, meanwhile there may be other MHC's waiting for this exact

service. Excessive service provision in such a case restricts the availability of resources

for those who do have a need for that service. Rosenheck, Neale and Mohamed (2010)

investigated consumer responses to being transitioned to a lower intensity service from a

high intensity service that traditionally does not discharge. They found that individuals

who transitioned required significantly lower crisis interventions and had significantly

less symptoms on the Brief Psychiatric Rating Scale (BPRS). Similarly, Hanson, Houde

McDowell, and Dixon (2007) did a comparison of assertive case management (ACM),

office based case management (CM) and residential treatment (RES). Findings show that

programs offered in each management approach used excessive resources in areas of

medication support, counselling, nutrition and activities of daily living (ADL). In fact

18% of RES, 10% of CM, and 4% of ACM consumers were rated as able to function at a

lower level of care (Hanson, Houde McDowell, &Dixon).

Staff reluctance to discharge people even if they may not need that level of

service has also been noted as a factor contributing to this overuse of services (Bromley,

Mikesell, Armstrong, & Young, 2014). Reasons contributing to failure to discharge

clients included concerns about clients' future, how to manage disengaged consumers,

and confusion about who decides who is to be discharged (Bromley, Mikesell, Armstrong

& Young). Werner (2012) suggests that patients are sometimes provided with services

because of their availability rather than an actual need. This can lead to situation wherein

individuals are linked to available services rather than the appropriate one.

Disparities in Service

There is inconsistency in the literature as to the criteria for allocation of mental

health resources. Existing community mental health services such as assertive community

treatment and intensive case management tend to be more focused on those living with

schizophrenia (Brodbent, Kydd, Saunders and Vanderpyl, 2008; Rosenheck, Neale, &

Mohamed, 2010; Zuniga et al., 2013), as opposed to those living with anxiety,

depression, or a concurrent disorder (O'Brien et al., 2009). In a recent Canadian study of

individuals hospitalized for attempted suicide (Routhier, Leduc, Lesage & Benigeri, 2012) those with depression had lower rates of contact (56%) with mental health services than those with schizophrenia (77%). This is surprising given that that schizophrenia affects 1% of the population while major depression and anxiety disorders affect between 8% and12% of the population respectively (Health Canada, 2002). It is also true that of those psychiatric admissions, a large percentage (28% or higher) of them are admitted with depression or anxiety related whereas, less than 25% were admitted with schizophrenia (Brems et al., 2004; Thompson et al., 2004). In Newfoundland and Labrador alone there are four times the number of days spent in acute care hospital beds by those with mood and anxiety disorders than those with a psychotic illnesses (Johansen & Sanmartin, 2011).

Despite the fact that anxiety and depression are a global issues, research indicates that those impacted by these illnesses are not getting the services they need in the community thus disengage from programs (Ruggeri et al.2007; Routhier, Leduc, Lesage & Benigeri, 2012). One study of a community based treatment program showed that 49% of participants without a psychotic illness dropped out of the program because of service dissatisfaction whereas, those with a diagnosis of schizophrenia were more likely (in 90% of cases) to stay in the program (Ruggeri et al., 2007). Similarly, people with a diagnosed personality disorder were found to have higher program dropout rates by comparison to those living with schizophrenia (O'Brien et al., 2009). Limited access to treatments for anxiety and depression such as cognitive behavioural therapy (CBT) has been observed at both the provider and system level (Collins, Westra, Dozois, & Burns, 2004). One review

of literature, reported that up to 60% of people with anxiety or depression initially present to their family physician (Collins et al., 2004). Because of the physicians lack of experience with mental health conditions, psychotherapy, and reliance on pharmacology, many people go undiagnosed, treated or referred to specialty services (Collins et al.).

Evidence also suggests that existing services are inadequate for those who have a concurrent mental health disorder (e.g., psychotic or affective illness) along with a substance dependence problem (Kim, Pfeiffer, Ganoczy, &Valenstein, 2011; Torres-Gonzalez et al., 2014; Urbanoski, Cairney, Bassani & Rush, 2008). Substance abuse was noted to be the most common comorbidity among patients with schizophrenia; only 12.4% of American adults with a dual diagnosis receive treatment for both their mental health and substance issues (Torres-Gonzalez et al.,2014). Noteworthy is the fact that frequent monitoring of those with a concurrent disorder has been linked to a lower risk of re-hospitialization (Kim et al., 2011).

Summary of the Literature

The literature identified several areas in the provision of community mental health care that continue to be less than ideal. Access to services such as chronic disease management, social supports, housing, and skill development are key needs of mental health consumers threaded throughout the literature. These needs are influenced by ones sociodemographic profile and continue to impact not only the needs but also the priorities of mental health consumers. Furthermore there appears to be discrepancy in the allocation of services leaving those living with depression, anxiety and concurrent disorders with limited resources, warranting a different approach to service provision.

Adding to this issue is a lack of clarity with MHC regarding where to go for help. Evident in the literature is that community mental health services struggle with maintaining continuity of care and effectively collaborating with other services to optimize care provision for the consumer. The general consensus in the literature is that there continues to be differing priorities between health providers and consumers as to the type of service required. This discrepancy continues to impede the health and well-being of MHC.

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Consultations

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Consultations with ten key stakeholders in the field of mental health were done to gain a better understanding of the potential needs of MHC in the St. John's region. Members of a multidisciplinary group were chosen based on their community mental health expertise at various levels of Eastern Health's Mental Health and Addictions programs; including senior (1) and division managers (2), patient care coordinators (1), clinical leaders (4), front line clinical employees(1), and one physician. Participants' health disciplines included nursing, social work, occupational therapy, peer support, and medicine (psychiatry). Three key areas of concern were identified (1) access to services: specialty and general, (2) program collaboration, and (3) psychosocial supports.

Access to Services: Specialty and General

Specialty Services. There was a general consensus that a discrepancy exists between the MHC needs and what services are actually being provided in the community. That is, although the majority of this population did receive some type of community services they were not necessarily the 'best fit' for the MHC needs. However, as one stakeholder summarized, "it was the only service available close to what they needed at

the time". This was the case for several groups such as those with forensic histories (e.g., arson charges, extremely violent, sexual offences), concurrent mental health disorders, personality disorders, sexual orientation concerns, autism, and those with brain injuries.

In the case of those living with some personality disorders or a concurrent disorder, limited service access was attributed to difficulty in treating such complex cases, requiring long term management, with finite resources. Hence, members of this group would often find themselves attending services that were not inclusive of their entire needs. Noteworthy, was the fact that this population have limited service options being that some presentations are dismissed as behaviour rather than illness, which limits their service options in the community.

An unexpected MHC group was identified through the consultations; those living with autism spectrum disorders. Stakeholders reported that they are receiving more referrals to provide services for this population. This is concerning because most staff have no experience or training in working with this group of people. Individuals living with brain injuries and cognitive impairments were also noted as receiving inadequate services and being referred to mental health programs at an alarming rate. It was explained that although the cause of a brain injury may be physical in nature, the symptoms can often manifest as those of mental illness. As a result medical and mental health programs reject referrals for this population which could leave these people with no services at all.

Stakeholders stated that sexual identity issues was an area where staff lacked the training and skills to properly meet the needs of MHCs. The lack of training amongst

staff was also noted with respects to working with the diverse cultural and spiritual needs of those consumers from visible minority groups (e.g., Aboriginal groups).

General Services. Common concerns cited were that MHC need more generalized services such as medication support, appointment reminders and chronic disease management. These services sometimes "don't fit" under the parameters of a specific program. This has led to growing waitlists and problems with system navigation. System navigation was specifically identified as a consumer and provider problem. Several consultants voiced that they are unclear about existing services in the metro area and their criteria for admission. Adding to this is the limited human and financial resources to support these programs.

Program Collaboration

Inter-program collaboration is on the rise within the Mental Health and Addictions program. The health care system however is not fully prepared to handle such an approach whereby MHC can transition between services based on their shifting needs, without gaps in service provision.

MHC are starting to advocate more for themselves however the reality is that many resources are based on program budgets and are not feasible. Programs are working with MHC to identify needs and develop plans of action to tailor services.

Psychosocial Supports

Psychosocial supports (peer support and home support) were noted as being inadequate. Peer support is available within a small number of Eastern Health programs

however the primary organization that offers this service is outside of Eastern Health's
authority. The consensus was that a peer support program should reside under Eastern
Health so that all MHC could equally avail of this opportunity. These sentiments were
similar in the case of home support services but not for housing. Housing was identified
as a very serious problem within the St. John's area and essential for recovery from
mental illness. There were various responses regarding whether the Mental Health and
Addictions program should be more involved in housing allocation.

Summary of Consultations

There are specific groups in need of improved community services (forensic
histories, concurrent disorders, some personality disorders, autism spectrum, those with
brain injuries, sexual identity issues and ethnic minorities). Evident in the comments was
the need to balance available specialized mental health services with more generalized
mental health programs. An important aspect of any mental health program is inter
program collaboration, psychosocial supports, and a clear means to navigate the system.

Environmental Scan

A review of approximately 60 community mental health services operated by 1)
Eastern Health and 2) community agencies was completed (see Appendix A and B).
Strengths of the service provision and existing challenges are listed.

Strengths

- Several service options for consumer depending on need (e.g. counselling, housing,
  employment, skills).

- Partial continuum of services offered by agencies (e.g. Stella's Circle, Eastern Health).

- Many services are long term or time unlimited.

- Improved clarity in point of entry (e.g. Central Intake).

- Some collaboration between Eastern Health and community agencies (e.g. Stella's Circle, Salvation Army).

Challenges

- Large duplication of services.

- Limited forensic services.

- Few options for those with concurrent disorders.

- System navigation remains complex.

- Few male only services .

- Minimal options for those with gender identity/sexual health concerns.

- Limited services for ethnic minorities and Aboriginal groups.

- Generalized services primarily community agency while Eastern Health offers more specialized services.

Recommendations

Despite the apparent large number of services available to the MHC, there remains opportunities to improve service provision in the St. John's area. Based on the literature review, key stakeholder consultations, and the environmental scan several areas have been identified where there are opportunities to improve community service provision for MHC's. 13 key recommendations are listed below.

- Continue to challenging stigma and misconceptions about mental health. Social media campaigns can increase visibility while providing information on system entry and navigation.

- Education of health care providers in existing treatment modalities and available resources. Specialized skill development is needed to address the needs of those with diverse cultural and health care needs, such as in the case of aboriginal groups, those with sexual identity concerns, forensic histories, and autism and brain injuries. This may be accomplished through the use of educational modules on best practices, inservicing, and/or the expanded use of clinical educators with expertise in this field.

- Improve access to housing by improving coalitions with the private agencies so a true collaborative network can evolve.

- Continue working toward eliminating silos and improving service coordination. Developing partnerships between programs so they may come together and identify gaps as well as duplication of services. This may mean removal of health care programs that offer duplicate services in lieu of a central point of access, more inter(intra)disciplinary case management meetings, and a reevaluation of existing services including a cost-benefit analysis.

- Continue to work toward non-traditional modes of service delivery such as expanded hours of operation, weekends, and in home services.

- Expansion of the peer and home support programming.

- Introduction of standardized needs assessment (e.g. Camberwell Assessment of Need) to better identify existing and evolving needs of the consumer. This will ensure the

right service is being offered to the right client, by the right health care provider, and in the right setting. Hence, avoiding service duplication while providing appropriate treatment options for the consumer.

- Services must work on a continuum where discharge or graduation from one service would make a client eligible for another service.

- Establish system navigator roles/positions.

- Generalized case management services.

- Expanded education on chronic disease management for both consumers and providers.

- Increased access to specialized services for those traditionally difficult to service in the community (e.g. forensic population, autism, brain injury).

- Increase collaborative opportunities between in and outpatient systems.

Limitations that require further attention

The scope of this report was limited to adult mental health services that are available in the metro St. John's area. It did not include consumers of services in the investigation. It also did not include informants from agencies outside of Eastern Health. It is essential that mental health consumers as well as private sector workers are invited to participate in further identification of needs and the future direction of community services. As well, both adolescent and geriatric services were not included in this investigation but most certainly require their own attention in the decision to allocate services.

Conclusion

This report identified existing challenges in community based adult mental health service provision in the St. John's area. Using a literature review, consultations with key informants and a community environmental scan, recommendations were made to improve service access for these marginalized individuals. Efforts to improve worker education and program collaboration can make great strides in eliminating barriers for those seeking service. Access to information, shorter wait times and ease of system navigation are essential for facilitating recovery. Program expansion and the addition of services for those difficult to engage and support is also recommended. It is important that the next step in this process be to work with consumers of mental health services in identifying what is most important to them.