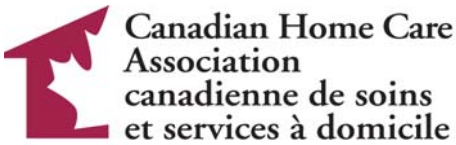

Home Care and Mental Health:

From Policy to Action

Policy Forum

January 29-31, 2006

Toronto, Ontario, Canada

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Home Care and Mental Health: From Policy to Action

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HOME CARE AND MENTAL HEALTH POLICY FORUM:

Key Messages

Forty-three key stakeholders from across Canada met for a day and a half in January 2006 for the Home Care and Mental Health Policy Forum, a facilitated discussion designed to support and enhance policy development for mental health home care. The forum was organized by the Canadian Mental Health Association National Office, the Canadian Home Care Association, and the Canadian Association for Community Care, with funding from Health Canada.

Key messages emerging from the forum discussion were:

- There is an urgent need for all mental health services. In a comprehensive continuum of care, home care must addresses the needs of people with mental illness as well as the mental health needs of all home care recipients.

- The First Minister's Ten Year Plan (2004) for short-term acute community mental health care mandates a two-week provision of case management and crisis response services. Two weeks is an unrealistic timeframe when dealing with people with long-term chronic illness who experience periods of acute distress. However, the limited mandate is a beginning step and a specific commitment toward providing home care to people with mental illness.

- The federal, provincial and territorial governments will need to work together to build momentum for the implementation of this short-term home care and to make long-term plans for the implementation of services to address the needs of persons with severe and chronic mental illness in their home and community.

- Previous work identified five main themes for planning, implementation and evaluation of mental health home care. These five areas continued to provide a framework for the 2006 Policy Forum:
  - Health human resources and training strategy;
  - Public education strategy
  - Research strategy;
  - Health information strategy; and
  - Service provision strategy.

- This mandate requires collaboration between the home care and mental health sectors in areas of training for management and front-line workers, and for coordination with existing health, community services and non-government organizations. In addition, diversity issues (such as age, gender, language, cultural identity, sexual orientation, religion and lifestyles) must be addressed for both consumers and caregivers in every area of planning and delivery of mental health home care.

- Success depends on adequate resources for staff, training and a willingness to collaborate. Essential elements include a comprehensive health information strategy, and mechanisms for monitoring, evaluating and reporting on the resources as well as the quality and outcomes of services

- Leadership for continued consultation and networking depends on the availability of further funding to ensure ongoing stakeholder involvement in the planning, implementation and evaluation of mental health home care.

The report, *Home Care and Mental Health: From Policy to Action* is available in English and French on the CMHA National website, www.cmha.ca

Executive Summary – Ideas and Directions for Action

A Policy Forum on Home Care and Mental Health was held in January 2006, with funding from Health Canada and sponsorship by the Canadian Mental Health Association, Canadian Association for Community Care, and Canadian Home Care Association. Following several national consultations on mental health and home care in the past few years, this Forum was developed for the purpose of moving the agenda forward in light of recent policy developments.

By December 2006, Federal, Provincial and Territorial Health Ministers must present a report to First Ministers on steps to implement coverage of short-term acute home care services, including acute community mental health, as agreed by the First Ministers in the September 2004 Ten Year Plan to strengthen health care for health care and the 2003 Accord on Health Care Renewal. The Policy Forum worked within this context to offer opportunities for dialogue among stakeholders.

The invitational Home Care and Mental Health Policy Forum in January 2006 brought together 43 key stakeholders for discussion on policy directions for the implementation of acute community mental health home care services. These stakeholders included government policy makers, members of home care provider organizations, and mental health organizations, including consumer and family representatives.

The specific goals of the Forum were:

- To engage key policy makers from home care and mental health sectors in dialogue with voluntary sector stakeholder representatives;
- To develop clear ideas and directions for implementation steps on acute community mental health home care in the ten-year plan for mental health home care services;
- To build a foundation for policy to support effective mental health home care that is integrated within a comprehensive continuum of mental health services; and
- To build sustainable networks and connections among policy makers as well as between policy makers and voluntary sector stakeholders from across the country in order to create a foundation for policy collaboration, present and future.

Themes developed at a national forum in 2004 served as the organizing structure for the discussions which fleshed out specifics of a human resources strategy; public education strategy; research strategy; comprehensive health information strategy; and service provision strategy. The Forum focused attention within these strategies on implementation of the Ten Year Plan mandate for home care services based on assessed need to provide first dollar coverage of *"short-term acute community mental health home care for two-week provision of case management and crisis response services."* These ideas and directions for action are drawn from the discussions at the Policy Forum:

Ideas and Directions for Action

Strategy	Action	Actors
General	Ensure mental health services are weighted equally with other priorities in the continuum of primary health care, chronic care and community services.	*F/P/T governments *Health regions *NGO community groups
Human Resources	Design and deliver training to upgrade current workers and train more human resources with specific skills for delivery of effective community mental health home care.	*F/P/T governments *Professional assoc. *Mental health & home care agencies *Families and consumers *Education facilities *Accreditation bodies
Human Resources	Establish wage parity between acute care and community service providers in order to recruit and retain trained workers. Hire a diverse workplace (race, gender, cultural identity, language, sexual orientation, etc.) to serve a diverse population.	*F/P/T governments *Health regions *Unions *Professional assoc. *Education facilities
Public Education	Inform the public, and all possible players from doctors and institutions to families and consumers, about the availability and scope of mental health home care services (and other resources for people with mental illness.)	*F/P/T governments *Health regions *NGO home care and mental health groups
Research	Launch baseline research and ongoing tracking systems to document, evaluate, account for, and report activities, limits and effectiveness of current services and the new mental health home care	*F/P/T governments *CIHI * Canadian Mental Health Commission *Other researchers
Health Information	Standardize assessment instruments and data collection to collect and share a comprehensive, unified data base for tracking patients and programs. Promote the safety, privacy and usefulness of the unified record sharing.	F/P/T governments *Collaboration among health provider agencies * Researchers * Accounting and reporting
Services	Ensure adequate resources for collaboration to develop and integrate acute community mental health home care into a comprehensive mental health system.	*F/P/T governments *Regional planners *Service providers

Strategy	Action	Actors
Services	Plan for crisis response, linkages to other resources and continuity of support for people with acute and chronic mental illness Ensure plans are in place for seamless transition to needed services after the two-week period.	*F/P/T governments *Regional planners *Service providers

The two week acute community mental health home care was seen as a beginning step and a specific commitment to meet the urgent needs of people with mental illness. However, it was recognized and clearly articulated that longer term community mental health home care is needed as part of a full range of services to meet the needs of people with mental illness. Sufficient leadership and resources must be dedicated to collaboration among all stakeholders, including families and consumers, as mental health home care is implemented.

1.0 Introduction

By December 2006, federal, provincial and territorial Health Ministers must present a report to First Ministers on steps to implement coverage of short-term acute home care services, including acute community mental health, as agreed by the First Ministers in the September 2004 Ten Year Plan for health care and the 2003 Accord on Health Care Renewal[1].

On January 30-31, 2006, the invitational Home Care and Mental Health Policy Forum brought together 43 participants from across Canada for facilitated discussions in Toronto. Of the participants, 30 % (n= 13) had a primary identification of government representatives / policy makers while 70 % (n= 30) came from community based organizations. Of the participants from community based organizations, nine (21%) were direct service providers, one person had a primary identification as a family member and two self-identified as consumers of mental health services. Other participants were managers, board members, and community leaders from groups that are concerned about mental health and/or home care. A list of participants and their e-mail addresses is found in Appendix "B".

The Forum was an opportunity for policy makers, service providers and consumers from mental health and home care sectors to explore policy options. It was hoped that the discussion would result in policy parameters to inform the development of implementation strategies for the Ten Year Plan and underpin the planning and delivery of home care services and supports for persons with mental illness.

The specific goals of the Forum were:

- To engage key policy makers from home care and mental health sectors in dialogue with voluntary sector stakeholder representatives;
- To develop clear ideas and directions for implementation steps on acute community mental health home care in the ten-year plan for mental health home care services;
- To build a foundation for policy to support effective mental health home care that is integrated within a comprehensive continuum of mental health services; and
- To build sustainable networks and connections among policy makers as well as between policy makers and voluntary sector stakeholders from across the country in order to create a foundation for policy collaboration, present and future.

With support from Health Canada, the Canadian Mental Health Association took the lead in organizing the Policy Forum in collaboration with the Canadian Home Care Association and the Canadian Association for Community Care. The Canadian Mental Health Association (CMHA) is a national, voluntary association that promotes the mental

[1] Ten Year Plan, Health Canada http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html

health of all people[2]. The Canadian Home Care Association (CHCA) is a national not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports which enable people to stay in their homes with safety, dignity and quality of life[3]. The Canadian Association for Community Care (CACC) is a national, non-profit, bilingual association, founded in 1995 with a commitment to a strong national voice for the community care sector, including home-based care, facility-based long term care, and community support programs[4]. These partners served as the Advisory Planning Committee that guided the planning of the Forum and the preparation of this report (see page i for names.)

The Policy Forum built on other initiatives of the federal government, the Canadian Mental Health Association, international United Nations documents, and the work of other community agencies.

The purpose of this paper is to provide background, an overview of the findings from the Home Care and Mental Health Policy Forum and possible strategies for policy and action to implement home care for people with mental illness across Canada.

The main body of the report describes the discussions and directions of the Home Care and Mental Health Policy Forum, and is organized around four main themes: 1) Context of the Forum 2) Strategies for Policy and Implementation of mental health home care 3) Priorities for the "two week" services and 4) Ideas and directions for action.

Appendices round out the report, including a preliminary definitions document provided to participants and a listing with e-mail addresses of the participants in the Policy Forum.

[2] www.cmha.ca
[3] www.cdnhomecare.ca
[4] www.cacc-acssc.com

2.0 The Home Care and Mental Health Policy Forum

The Home Care and Mental Health Policy Forum brought together key stakeholders from government, mental health and home care agencies, consumers, family members, and community groups to further develop policy directions on mental health home care. The parameters of the Ten Year Plan (2004) offer "short-term acute community mental health home care for two-week provision of case management and crisis response services" provided a context for the Policy Forum. Many participants expressed concern that this limited response did not meet the needs of people with chronic mental illness and/or addictions, their families and their caregivers. However, given the urgent need the Forum participants worked together to build strategies for action to address the commitment of the Ten Year Plan.

2.1 The Context of the Forum

Before the Forum, an attempt was made to develop a common vocabulary to promote a common understanding among diverse, cross-sectoral stakeholders. Previous projects recommended development of a preliminary glossary because people familiar with home care and people familiar with mental health did not use the same words and meanings. . . The list does not necessarily imply agreement or endorsement of the definition. Rather, the "definitions" reflect terms from the home care and mental health literature to provide a common ground for communication at this stage. As the development of policy and the implementation of mental health home care progresses, so too will agreement on a "working" vocabulary. See Appendix "A" for the preliminary definitions used for the 2004 Forum.

The Forum opened with remarks by Patricia Greenhalgh from Health Canada who reinforced the objectives of the Forum: first, to build a foundation for policy to support effective mental health home care that is integrated with other health services, and second, to develop a common understanding of the implementation of commitments made in the 2004 Health Accord by First Ministers, known as the Ten Year Plan.

A panel reviewed previous initiatives in mental health and home care that set the context for the Forum. Barbara Neuwelt noted that in the research for *Home Care and People with Psychiatric Disabilities* (CMHA, 2000)[5], most home care services excluded persons with mental illness. Three pilot sites developed models for effective provision of home care, and recommended further work at policy, system, and service delivery levels. Joelle Khalfa reported on the 2004 consultations and Policy Forum, a partnership of CMHA National and CMHA Ontario as part of the VOICE project[6]. It recommended a National

[5] http://www.cmha.ca/english/hmcare/
[6] http://www.ontario.cmha.ca/content/reading_room/policydocuments.asp?cID=5397

Health Care Policy Framework, and a National Strategy and Action Plans for Mental Health and Home Care. Jayne Whyte presented a consumer voice collected in a CMHA Web Discussion (2005)[7], and a caregiver perspective from a Health Canada survey by Decima Research, *Informal/ Family Caregivers in Canada Caring for Someone with a Mental Illness* (2004)[8].

A synthesis of work and themes from previous CMHA projects by Bonnie Pape introduced the five theme areas developed by the 2004 Policy Forum. That Home Care Sector and Mental Health Forum called for development of plans and action strategies for implementation of home care for people with long-term chronic conditions and short-term acute conditions of mental illness. These five themes formed a framework for the remainder of the Policy Forum 2006:

- Health Human Resources Strategy that addresses the supply, distribution, compensation and working conditions of mental health and home care service providers.

- Public Education Strategy designed to: reduce stigma, increase community acceptance of people with mental illness, and improve public attitudes towards home care service providers.

- Research Strategy to research and distribute information about best practices, and support distribution of pertinent documents.

- Comprehensive Health Information Strategy with a shared electronic health record that includes mental health related data, a defined minimum data set, and databases of statistical and financial information.

- Service Strategy that defines core values and guiding principles for service delivery and develops clear admission and discharge criteria, common assessment tools, service delivery standards, outcome measures, and performance indicators, with policies and procedures to improve integration between federally and provincially funded services. Provinces are encourage to strengthen access to and adequately fund community services as well as provide financial support for existing collaborative initiatives consistent with the national framework.

Plenary and small group discussions designed to use the collective knowledge, experience and vision of the participants shaped policy direction for immediate and longer term planning, implementation and evaluation of home care services for people with mental illness.

[7] Web Discussion http://www.cmha.ca/bins/content_page.asp?cid=7-13-980&lang=1
[8] http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2004-mental-care-soins/index_e.html

2.2 Who receives and who provides mental health home care?

The first discussion focused on two major questions. Who are the recipients (the target population)? Who delivers the services? Table groups with flip charts sought to define these populations. Discussions yielded the range of opinions reported here.

The broadest definition of who is eligible to receive services included "any and all individuals who need assistance to cope." There was concern that this very broad definition would over-extend services and available funding. Many asked whether the need should be based on a primary or secondary diagnosis of mental illness or if "assessed need" might be more useful than diagnosis. Although no definitive definition was achieved, there seemed to be consensus that the target population for mental health home care should include anyone with mental health needs should have access to home care to prevent hospitalization and/or homelessness. The Ten Year Plan specifies that services are provided based on "assessed need."

In the home care system, assessment is one of the roles of the manager or case manager, and is usually based on the health issues and living situation of the client. In the mental health system, a doctor, usually a psychiatrist, makes the diagnosis of illness. This raises questions of whether a previous diagnosis is necessary or whether assessment could be based on the health and crisis needs of the individual with mental illness and the people who support that consumer.

The questions of who is eligible for mental health home care, who makes that decision, and the criteria for intake and discharge need to be clearly defined for the family and formal caregivers and the consumers. In the case of the two-week period, it is not clear who identifies the acute crisis need: psychiatrist, mental health worker, home care assessment manager or mental health home care case manager? There was general agreement that a good assessment of needs and risk is crucial to ensure that mental health home care is effective and safe for both service recipients and service providers.

As to who should provide home based mental health services that are centred on needs and available supports, participants concluded that "one size does NOT fit all." Discussion of who should provide home care and home support recognized that because family, friends and the person with the mental illness are all involved in the care on an ongoing basis, they need to be fully involved decisions around crisis and ongoing care. Participants recognized that a provider from mental health home care (e.g., a case manager) could serve as the coordinator/broker among the diverse stakeholders (the consumer, family members, peers and peer support, professionals including doctors, nurses, social workers, and mental health workers, para-professionals and community agencies) who might provide a range of tailored social or homemaking support. Other team members might include crisis response workers, police and justice (probation) workers, depending on the circumstances. Referrals requesting service should be accepted from any sector of the informal or formal support networks and the case

manager / coordinator/ needs assessment professional would be expected to consult and coordinate the full range of support options.

3.0 Strategies

Discussion of policy implementation strategies proposed by the 2004 Policy Forum focused on the five themes: Health Human Resources and Training, Public Education, Research, Comprehensive Health Information, and Service. The 2006 Policy Forum did not see a need to change or add to the five theme areas. Diversity issues were discussed with the recognition that respect and sensitivity are intrinsic to all themes. The following five sections reflect the discussions recorded on flip charts at the Policy Forum.

3.1 Health Human Resources and Training Strategy

A well trained workforce is essential to effective and respectful community mental health services. Everyone who provides health services and home support (e.g. nurses, social workers, physicians, housekeeping and personal support workers, volunteers) needs appropriate training in mental health issues. Government, education facilities and professional associations must work together to implement university, vocational, and on-the-job training curriculums that provide base information plus specific training in the delivery model (nurse, social worker, home support worker). It was noted that case management is often included with other roles (nursing, home support, social work) but there should be consistent education and standards for people from any background who act as case managers.

To improve collaboration and team building, it is essential to create opportunities for inter-professional and cross-sectoral training and continuing education. To recognize that consumers and families are part of the team, they should be involved in the design and delivery of training.

Accreditation bodies, academic institutions and professional associations all have responsibility for implementing accountable training, with accountability mechanisms, whose curriculum and evaluation are based on national standards for education for mental health care with a goal of excellence in meeting the complex needs of people with mental illness.

A number of employment issues need to be considered related to recruiting and retaining trained workers for mental health home care. Lack of wage parity between acute care and community service providers, and low wages and status for home care workers must be addressed, especially when care is delivered through community-based organizations that generally have fewer resources than the public sector. One suggestion included the need to develop recognition and incentives for workers in the field, for example, for those who have training and provide mentorship in specialties such as depression among older adults.

There was some debate about whether there needed to be a new type of worker specific to mental health home care, or if cross-training and teamwork would enable current home care and mental health workers to address the need. There was general agreement that whatever the decision, the worker would be expected to support the person with mental illness and their family as well as coordinate with other professionals, volunteers and community agencies. In addition, the worker would be expect to understand that the dynamics of working with someone in his or her own home and with families is different than in a health care facility. Likewise, there was general agreement that one of the goals of mental health home care would be to assist people to help themselves and build on the strengths of their family and informal support network.

Continuity of service providers was discussed as a concern because it takes time to build trust with someone who is coming into a person's home and physical/emotional space. Flexibility in the program and the workers will also be necessary because the home could mean a temporary space such as a coffee shop for someone who does not want a worker in their apartment and for people who are homeless.

Building a relationship requires sensitivity to issues related to age, gender, cultural identify, race, sexual orientation, religion and background as well as the identified diagnosis and symptoms of mental illness. Lifestyle awareness includes recognizing potential conflicts between an unemployed consumer and an employed caregiver. In service delivery, diversity of providers as well as care recipients can increase the complexity of the relationships and entail necessity for choices. Valuing diversity in hiring the human service workforce increases the capacity to be sensitive to the variety of needs and strengths of care recipients.

Community staff need adequate and available supervision along with opportunities for regular interaction with colleagues to encourage team work and reduce the isolation of being in client's homes. Working alone in the home and community raises safety concerns for service providers that need to be addressed through proper assessment, adequate training, and suitable back-up for front line workers.

3.2 Public Education Strategy

For mental health home care to work, home care workers will need more education about working with people with mental illness. Families and consumers have a role in teaching potential caregivers.

The full range of communication methods (media, advertising, marketing, public relations and education) are needed to spread accurate and realistic information on mental health, mental illness, and available services. When hiring spokespersons, government and community agencies are encouraged to hire high profile advocates and consumers to get the word out. The proposed Mental Health Commission[9] should implement an anti-

[9] Kirby, The Honourable Michael J. *A Proposal to Establish a Canadian Mental Health Commission*, October 2005 http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep16nov05-e.pdf

stigma, anti-discrimination campaign. The CRTC has expressed an interest in seeing diverse programming that spotlights people with disabilities in the media.

Awareness of mental health home care must reach consumers, family and neighbours, physicians, health care workers, police and justice workers, income support workers, government workers in all departments from municipal to federal levels, including recreation and cultural services.

On a long-term basis, students in schools need information suitable for their age, presented by people who talk openly about healthy living, mental illness and necessary supports, including suicide prevention.

3.3 Research Strategy

Mental health research is long-term and complicated so there is a need to attract the best teams for clinical and community research. The proposed Mental Health Commission would support research and share information.

Cross-sectoral baseline and long-term research are necessary to evaluate the effects of different policies and models and outcomes including cost-benefit analyses in community mental health

Treatment and research methodologies must recognize different cultures, lifestyles and preferences among consumers and service providers. Community groups, practitioners, managers, family members, consumers, along with universities and interest groups must work together to ensure that all stakeholders are involved. Opportunities for shared funding between public and private sectors in research could be investigated. Best practices from within and outside Canada should be shared, for example through the proposed Mental Health Commission, to promote the best evidence-based practices.

Little research has been done on best practices to support diverse populations. Cultural background can affect the stigma or acceptance of a mental illness diagnosis, and the role of the home care worker in that setting. Does peer support by another person or consumer who shares (or lacks) the cultural or lifestyle identity change the results?

Diversity of subjects in research may also suggest that different models and standards may apply based on age or other characteristics. For example, a unit of care may change if viewed through the “age lens” when children or seniors require more time for activities.

3.4 Comprehensive Health Information Strategy

Opportunities and technology exist to link records from hospital, home care and community services to ensure seamless transfers from one service provider to another, to allow quick access to what works and what to avoid in crisis situations, and to ensure ongoing treatment of both physical and mental illnesses. A comprehensive, unified data base for tracking individuals and groups could be helpful for research, monitoring, and evaluation purposes with the goal of improving care and outcomes for people with mental illness.

The public in general, and people with mental illness in particular, have high concern about the security and privacy of their personal records fearing harm if their medical histories become public knowledge. Adequate safeguards need to be in place and publicized to increase public confidence in record storage, referral, and management.

Differences among professionals and turf protection can create barriers to communication. There needs to be willingness and clear protocols to share information among health professionals in different sectors, and with the consumer and family, again with respect for privacy and personal preference.

Information provided to the public, to consumers and their families must be culturally appropriate and in a language that can be understood. English as a second language and literacy levels need to be considered in client education and in public education.

3.5 Service Strategy

Of critical importance to any service strategy is the issue of human resources and training mentioned above including training. Partnerships could facilitate specialized training from VON and other agencies from both the public and private sectors with experience in mental health and home care

Implementation of mental health home care, even the very limited case management and crisis response of the two-week service will require investment in extra human and financial resources, particularly trainers, coordinators and front line staff, since the existing workforce (both home care and mental health) is already stretched in their ability to provide services. In addition, strategies must be developed to assist consumers to purchase medical supplies and medications that would be supplied in hospital are not covered under home care even when home care is the alternative to hospital or institutional care.

Policy makers, managers and service providers are encouraged to share best practices and tools; learn from promising practices; and listen to families and consumers. Consumers and family members want to be involved in all aspects of planning, implementation, training for, and evaluation of services that affect them.

Mental health home care opens an opportunity for closer links between mental health and primary health care services. Integration of addictions and mental health services is a good example of collaboration that has recently occurred in some parts of Canada. Another link may be between mental health services and programs tailored to other chronic diseases, such as multiple sclerosis, diabetes and arthritis, and. physical disabilities.

Treating mental illness in the same manner as any other illness or condition means responding to needs in ways that increase access and reduce the stigma of mental illness. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH)[10], a coalition that includes CMHA, calls for a national strategy so that all Canadians with mental illnesses, their families and care providers have access to the care, support and respect to which they are entitled and in parity with other health conditions.

The diversity in Canada can be seen in federal, provincial, and territorial differences as well as at regional, municipal and rural jurisdictions. Rural and remote areas present additional challenges to consumers, families and service providers. Small populations in rural and remote areas may hamper accommodation of diversity. Tele-health and family doctors offer potential resources for mental health care in remote, less populated communities.

A point of potential conflict is between the short term acute interventions of medicine and the more holistic, inclusive approaches to healthy living in other cultures. Sensitivity, respect and flexibility are basic values in dealing with vulnerable and diverse populations.

Case management connects physical and mental health care as well as economic, housing and social support. One of the challenges is "overcoming the belief that there is not enough time for humanizing services." Expanding and integrating community mental health care may require changes in policy and service delivery, for example, requirements for a psychiatric diagnosis to have access to services, models of crisis intervention in the home. In the past, many home care programs excluded persons with a psychiatric diagnosis. Even the definition of "home" must be broad enough to include the "homeless."

Accreditation could look at standards that encourage opportunities for seamless service delivery including shared assessment tools, indicators and teamwork. Since specific funds are being allocated for community mental health home care, accountability structures need to be maintained for all service areas.

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[10] Canadian Alliance on Mental Illness and Mental Health. *A Call for Action*: *Building Consensus: National Action Plan for Mental Illness and Mental Health* (2002) http://www.camimh .ca/callforaction.htm

Participants looked more specifically at the proposed two-week community mental health services delivery. They noted the need to clearly define the target population before services are designed. They raised questions including: Who defines crisis? What does crisis intervention in the home look like? Will the limited time lead to limited health care assessments?

Case management is part of an ongoing continuum, not a two week intervention. If a person is in hospital, the planning for the two week intervention should begin at least two weeks before discharge. In a two week period, the focus would have to be on connecting the person with ongoing programs that they can access after the two-week period has ended. Do the necessary programs exist in the community?

Additional questions were raised: What happens after the two weeks? At the end of two weeks, can the situation be re-assessed and services continued for an additional two weeks? If a person is stabilized and in a few days, weeks or months, again goes into crisis, is there a maximum to the number of interventions in a year?

4.0 Priorities for the "two week" services

In the Ten Year Plan, First Ministers agreed to provide first dollar coverage by the end of 2006 for certain home care services, based on assessed need, to include, short term acute community mental health home care for two-week provision of case management and crisis response services. It was hoped that the Forum discussions would result in policy parameters to inform the development of implementation strategies for programs and services.

To meet this objective, seven table groups were asked to respond to this question: What are the priorities in policy and action for the two week period? Their responses are synthesized below according to themes and issues that emerged from the discussion.

4.1 Continuum of Care

The two week acute community mental health home care must be situated in a broader context in the continuum of care that includes prevention and promotion, crisis intervention, medication, recovery, maintenance, and community integration.

For example, other community services need to be continued, created and enhanced, such as walk-in crisis centres and short-term residential facilities (e.g. Gerstein Centre in Toronto).

4.2 Government Priorities

Provinces and territories have the jurisdiction for health and each province, and health regions within provinces are in the process of developing the policies and services to implement community mental health home care. Opportunities to share good ideas and best practices and to create and enhance collaboration will be essential to ensure accessible, high quality community mental health home care services across the country. The following were identified by participants as priorities that governments must address:

- The two week acute community mental health home care is a beginning step. F/P/T governments have to find ways to integrate mental health home care into long term services for people with mental illness.
- Establish pan-Canadian standards for care, principles and values, and guidelines for orientation and cross-training of staff, sensitivity to consumer rights, and suitable hiring, wage and employment regulations for staff.
- Allocate time and resources for collaboration and team building. Consider ongoing communication / opportunities (paper, in-service, electronic) to build and maintain awareness and cooperation.
- Human resources teams must be hired, trained, oriented and prepared for this new service.

    - Set minimum training standards.
    - Train case managers for mental health assessment and planning.
    - Share promising models of case management and crisis intervention across the country.
    - Include mental health training for all home care workers.

- At Federal and Provincial/Territorial levels, partnerships among Ministries (health, education, justice, housing, etc.) have to be worked out for effective coordinated programming.
- Ensure Ministers of Health in each province mandate their health regions to have an action plan, resources and people, and facilitate necessary collaboration among primary care, long term care, social services, and other agencies as well as health.
- Develop both short-term and long term plans.
- In jurisdictions that have excluded persons with mental illness from receiving home care, a first step will be to change home care policies to include persons with mental illness and their families..
- Review payment schedules for psychiatrists involved in home care to recognize home visits, consultation time with case manager, community nurse, or other team members as needed.
- Set up linkable health information systems to collect and share data among professionals and across services to meet the needs of the client first, then the needs for reliable information for tracking, evaluation and research. Set up levels of security to protect sensitive information from people who don't need it. Allow staff time and training for acceptance of electronic sharing. Reassure consumers and the public about the privacy and responsible use of information.
- Address wait lists for mental health services.
- Ensure crisis response teams are available in both rural and urban areas: case manager, psychiatric nurse, peer support worker, telephone support. Prepare for culturally appropriate response
- Ensure portability of 2-week benefits across provincial and territorial boundaries.
- Implement "resources follow the client" as he/she moves from one level of services to another (e.g. from hospital to acute community home care to community programs.)

4.3 Mental Health Home Care

- Consider creative and innovative ways to implement community mental health case management and crisis response. Who takes the leadership for this service? Is mental health home care a new service program for mental health? Or new clientele and approach for home care?
- Build on what exists and what could exist.
- Recognize the need for new financial and personnel resources.
- Make training a priority.

- Use current agencies including CMHA and other service providers (VON) as resources for staffing and training.
- See acute care / hospital staff as part of the team: training, team referrals, professional resources, with ongoing involvement in the consumer's care.
- Develop a common assessment protocol.
- Ensure continuity of service.
- Explore, document and evaluate the role of mental health home care in a continuum of crisis intervention, mental health care, and home care services.

4.4 Implementation Issues

- Plan for acute, emergency response: rapid intake, assessment, and intervention within the first 24 hours. The current mental health system does not have the capacity to handle quick diagnosis and acute care. A person in crisis does not have capacity for navigating a complex system.
- Launch a public awareness campaign to inform the public and stakeholders about the availability of short term mental health home care. Inform the whole system including doctors, hospital, mental clinics and workers, community agencies, police, homeless shelters, etc. about the new program and know how to access it quickly and easily.
- Develop criteria for admission and discharge. Adapt and create a system for flexible and smooth entry and referral so the "right people access mental health home care in a timely manner." Ideally the system would be a unified continuum with many doors, including family doctor, mental health services, home care services and community referrals.
- Define key terms such as "community mental health", "crisis", "home care", "home support", "case management" to ensure all stakeholders understand the criteria and limitations of the programs
- Ensure referral to appropriate resources for continuity of care. Enhance community services and community based organizations as necessary for ongoing programs.
- Possible services to be included in the acute care community team:
    - 24/7 availability
    - Mobile crisis team
    - Case management
    - In home professional care
    - Family crisis counseling
    - Personal care (not necessarily bathing)
    - Home making
    - Discharge planning and referrals to ongoing services
    - Ongoing assessment to ensure necessary services are in place

- Designate adequate resources for a full range of professional services as needed, plus supports to create a successful outcome for the consumer, the family, the worker, and the system. Recognize that service agencies must have the capacity to incorporate this "added service" for their workload.

- Prepare to offer intensive case management with low client load and frequent contacts.
- In the same way that discharged patients may be readmitted to hospital if the crisis continues or in a new crisis, set criteria for subsequent two week acute mental health home care access.
- Allocate both time and funding for necessary team building and collaboration at all levels.

4.5 Evaluation

When adding or changing programs, planning and preparation includes development of an evaluation plan to track, evaluate, and report the strengths and gaps with the goal of developing a quality system that meets the needs of consumers, their families and other stakeholders.

- Define outcome measures and evaluation indicators.
- Conduct both cross-sectional and long-term research to allow comparisons of "before and after" pictures and investigations of the outcome effects of mental health home care.
- Look at who was served, first time and repeat usage, to build policy and improve programming.
- Collect data to track effectiveness and ensure accountability (include hospital, community and related sectors such as housing, income support, employment) for evaluation and research purposes.
- Develop accountability mechanisms to show that resources have actually been used for the designated programs. Earmark funds and expect transparency in all health program spending. For example, with the First Minister's Ten Year Plan that specifies three areas of home care: acute health care, community mental health services, and end-of-life care; monitor that mental health gets its fair share.
- Ask an outside agency (Auditor General, ombudsman, mental health advocate office) to audit and report to the media about both money and services.
- Report regularly with clear accountability by regions and province; share data across the provinces and territories.

5.0 Ideas and Directions for Action

Strategy themes developed at a forum in 2004 continued to be relevant in 2006 as participants added content to five strategy areas: health human resources; public education; research; comprehensive health information; and service. The Forum focused attention on implementation of the Ten Year Plan mandate for home care services based on assessed need to provide first dollar coverage of *"short-term acute community mental health home care for two-week provision of case management and crisis response services."* These ideas and directions for action are drawn from the discussions at the Policy Forum:

Strategy	Action	Actors
General	Ensure mental health services are weighted equally with other priorities in the continuum of primary health care, chronic care and community services.	*F/P/T governments *Health regions *NGO community groups
Human Resources	Design and deliver training to upgrade current workers and train more human resources with specific skills for delivery of effective community mental health home care.	*F/P/T governments *Professional assoc. *Mental health & home care agencies *Families and consumers *Education facilities *Accreditation bodies
Human Resources	Establish wage parity between acute care and community service providers in order to recruit and retain trained workers. Hire a diverse workplace (race, gender, cultural identity, language, sexual orientation, etc.) to serve a diverse population.	*F/P/T governments *Health regions *Unions *Professional assoc. *Education facilities
Public Education	Inform the public, and all possible players from doctors and institutions to families and consumers, about the availability and scope of mental health home care services (and other resources for people with mental illness.)	*F/P/T governments *Health regions *NGO home care and mental health groups
Research	Launch baseline research and ongoing tracking systems to document, evaluate, account for, and report activities, limits and effectiveness of current services and the new mental health home care	*F/P/T governments *CIHI * Canadian Mental Health Commission *Other researchers
Health Information	Standardize assessment instruments and data collection to collect and share a comprehensive, unified data base for tracking patients and programs. Promote the safety, privacy and usefulness of the unified record sharing.	F/P/T governments *Collaboration among health provider agencies * Researchers * Accounting and reporting

Strategy	Action	Actors
Services	Ensure adequate resources for collaboration to develop and integrate acute community mental health home care into a comprehensive mental health system.	*F/P/T governments *Regional planners *Service providers
Services	Plan for crisis response, linkages to other resources and continuity of support for people with acute and chronic mental illness Ensure plans are in place for seamless transition to needed services after the two-week period.	*F/P/T governments *Regional planners *Service providers

The two week acute community mental health home care was seen as a beginning step and a specific commitment to meet the urgent needs of people with mental illness. However, it was recognized and clearly articulated that longer term community mental health home care is needed as part of a full range of services to meet the needs of people with mental illness. Sufficient leadership and resources must be dedicated to collaboration among all stakeholders, including families and consumers, as mental health home care is implemented.

Appendix "A" Definitions

Definitions for the Home Care and Mental Health Policy Forum

Toronto, January 29-31, 2006

Prepared by Jayne Whyte, Project Manager

The Policy Forum is intended to be a cross-sectoral opportunity. Definitions have been compiled from a range of current literature. This list does not necessarily imply agreement or endorsement of the definition. Rather, this document uses the home care and mental health literature to suggest words to give a common ground for communication at this stage. As policy and implementation of mental health home care progress, so too will agreement on a "working" vocabulary.

A respondent to the Web Discussion, Mental Health and Home Care, Next Steps urged the development of a common vocabulary.

> *A lack of common language between home care and mental health organizations makes communication unnecessarily difficult. The lack of communication which often exists between the two sectors needs to be overcome in order for a trusting and collaborative relationship to be developed. [*Whyte 2005*]*

DEFINITIONS

Acute community mental health services are intended to assist individuals to avoid admission and/or reduce length of stay in an acute care facility. Most jurisdictions that provide some form of community mental health services deliver them through mental health programs rather than through home care. Acute community mental health services usually take the form of rapid response and include:

- assessment and intensive *case management*;
- crisis services;
- psycho-social and/or addictions counseling;
- crisis phone lines;
- medication management; and
- sometime rehabilitation (e.g. occupational therapy).

Medical equipment/supplies and medications may be supported through separate programs where clients pay all or part of the cost.

Basket of services. The "basket" agreed upon in the 2004 Ten Year Plan states that the First Ministers agree to provide first dollar coverage by 2006 for short-term acute community mental health home care for a two week provision of case management and crisis response services. This will be the way "basket of services" is understood for the purposes of this Forum.

Best practices in acute community mental health services have been developed across Canada. Elements include quick and early response; comprehensive assessment; multidisciplinary teams that include psychiatric back-up; coordination / integration / communication across the continuum of care; intensive case management and 24/7 support; medication management and compliance; family engagement; peer support; and support for the reintegration into school and work activities. [Health Council, p. 30]

Caregivers/ Family Caregivers are individuals who provide care and assistance for their family members or friends who are in need of support because of physical, cognitive or mental health conditions. The term *family* denotes both a biological family and/or a family of choice; the caregiver, whether legally related or not, is considered to be part of the family. Caregivers play an integral role in supporting Canadians who require care, in all the possible settings in which care may be provided. An estimated three million

Canadians are caregivers, spanning the age ranges from youth to old age. A recent draft document by the Canadian Caregiver Coalition requests policies for employment and financial support for family caregivers. [CCC 2005]

Case Management is a collaborative client-driven strategy for the provision of quality health and support services through the effective and efficient use of resources in order to support the client's achievement of goals. Case management is respectful and creative engaging the client, health care professionals, family and community resources for needed support. Case management is not an independent function or designated to a specific discipline but is built into all health professionals' scope of practice. [CHCA 2005]

Community Resource Base (CRB) rethinks the traditional approach to mental health policy and service development. The vast majority of consumers now lives most of their lives in the community and is impacted by a wide range of factors besides mental health services. By looking at the whole process of people's lives, the CRB model introduces a more comprehensive notion of what policy should seek to influence. Besides formal mental health services, it identifies people with mental illness, their families and friends, and generic organizations and groups among the various resources in the community that help contribute to the person's inclusion and recovery. In this way, the CRB assumes the perspective of the person in the centre: the person who is actually living and coping with a serious mental health problem. [CMHA 2004]

Concurrent disorders refer to a combination of substance abuse and mental health problems. Such combinations may result in the disastrous accumulation of three, four or more diagnoses, e.g. HIV, tuberculosis or hepatitis related to intravenous drug use, liver cirrhosis consequent to chronic alcohol use, etc. [Kirby] Addictions are not mentioned in the 2004 plan as a criterion for acute community mental health services. People with mental illness have much higher rates of addiction and those with an addiction problem have higher rates of mental illness than the general population. [Health Council p. 8-9]

Consumer, consumer/survivor, survivor, and client or patient are among the various terms used for the person receiving mental health services and/or a person who has experienced a mental illness. *Client* is the term most often used in the home care setting for the person receiving care and may also include caregivers who are family and friends of the person receiving service; *patient* is most often used in the medical/hospital setting; and *consumer* is generally used by the Canadian Mental Health Association and some peer support services; and *consumer*, *consumer*/survivor or *survivor* are commonly used as self-designation by some individuals who are recipients of mental health services. For the purposes of the Forum, any of these terms may be used.

Crisis and Crisis response. A recent paper on Ontario mental health reform defined a crisis as "the onset of an emotional disturbance or situational distress (which may be cumulative), involving a sudden breakdown of an individual's ability to cope. Crisis intervention refers to active treatment and support offered as soon as possible after an individual has been identified in acute distress. There is a need to provide immediate relief from symptoms and rapid stabilization so that the condition will not worsen. It holds the potential of mobilizing community resources and averting the need for short and/or long-term hospitalization." [Ontario Ministry of Health] Crisis specific functions include:

- telephone crisis services;
- walk-in crisis intervention services;
- mobile crisis outreach;
- short-term residential placements for crisis stabilization in protective and supportive settings; and
- medical services including inpatient services when other options have been exhausted.

First dollar coverage, in insurance literature, means there is no deductible limit that the individual must pay either through private insurance or out of pocket. As a result, first dollar coverage can mean full public funding with no deductibles or public funding with no deductibles but with user charges / co-payments. First dollar coverage does not mean *full-dollar coverage*. Provincial/ territorial programs could charge or continue to charge user fees for home care services in the *basket of services*.

Full dollar coverage of home care services would mean publicly funded coverage for any services and supplies in the home that would have been provided if the person were hospitalized.

Home Care is an array of services which enables individuals to receive care and treatment at home and/or live as independently as possible, when they may otherwise have to be in a hospital setting. Home care services may include:

- health promotion and teaching;
- curative intervention;
- end-of-life care;
- rehabilitation, support and maintenance;
- social adaptation and integration; and
- support for the informal (family) caregiver [CHCA].

Home care has three main functions:

- Maintenance and Prevention: Maintenance of ability to live independently in the home setting, and prevention of health and functional breakdowns and eventual institutionalization.
- Long Term Care Substitution: Meeting the needs of people who would otherwise require institutionalization.
- Acute Care Substitution: Meeting the needs of people who would otherwise remain in, or enter, acute care facilities [HR Sector Study].

The VOICE Policy Forum on Home Care and Mental Health held June 2004 put forward this vision:

> "The right level of care and support provided in the person's home (as he/she defines it), by qualified people, for the length of time needed, to individuals whose mental health care and support needs are accepted and addressed with the same dignity and respect as the needs of individuals dealing with a physical illness." [CMHA, ON 2004]

Mental health is the capacity to feel, think and act in ways that enhance one's ability to enjoy life and deal with challenges. Expressed differently, it is how people look at themselves and their lives; relate to other people; handle stress; evaluate the challenges and the problems, explore choices and make decisions. … Good mental health leads to high self-esteem, happiness, interest in life, work satisfaction, mastery and sense of coherence. [Kirby 2003]

Mental illnesses. The term "mental illness" is used here for convenience. It is recognized that some of the many cultural groups that make up Canadian society have different ways of conceptualizing the phenomena that are referred to as mental illness. Some members of the consumer community also have different ways of conceiving the issue. [CMHA 2004]

Mental illnesses are characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning over an extended period of time. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio-economic environment. … Ordinary coping skills are overwhelmed, and people may need help in regaining balance and restoring their fullest functioning. …. Mental illnesses may occur together. An individual can experience both depression and an anxiety disorder, for example. [Health Canada 2002, p. 16]

Mental illnesses take many forms, just as physical illnesses do. The major mental illnesses include: schizophrenia, mood disorders (depression and bipolar disorders), anxiety disorders (phobias, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder), eating disorders (anorexia nervosa and bulimia), personality disorders, organic brain disorders (Alzheimer's disease, AIDS dementia complex and damage from strokes or accidents). Suicidal behaviour and addictions are often correlated with mental illness. Most major mental illnesses are chronic disorders that require long-term treatment. [Kirby]

Note: The current definitions for acute community mental health home care do not include Alzheimers disease, dementias and acquired brain injury.

Recovery, as described by consumers and some academic writers, challenges the traditional belief that serious mental illness must by definition follow a chronic and deteriorating course. The promise of recovery is that it will lead to fuller lives for people with mental illness. However, recovery is not to be confused with cure. People who have recovered may still experience symptoms and struggle with the consequences of their diagnosis. For those who have experienced this journey first hand, recovery is defined as living consciously and fully despite life's burdens. [Whyte 2005]

Ten Year Plan of the Federal/Provincial/Territorial First Ministers specified a limited mental health home care service. ***The scope of the current policy forum must address the immediate policy developments specified in the Ten Year Plan.***

Home care is an essential part of modern, integrated and patient-centered health care. Improving access to home and community care services will improve the quality of life for many Canadians by allowing them to be cared for or recover at home. Services provided in the home can be more appropriate and less expensive than acute hospital care. Greater use of home and community care services can reduce wait times for acute hospital beds by making beds available for those who are more acutely ill, can provide choices for end-of-life care, and be an effective option for some patients with chronic mental health concerns.

All governments have recognized the value of home care as a cost-effective means of delivering services and are developing home care services to prevent or follow hospitalization.

First Ministers agree to provide first dollar coverage by 2006 for certain home care services, based on assessed need, specifically to include:

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
- **short-term acute community mental health home care for two-week provision of case management and crisis response services;** and
- end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.

Each jurisdiction will develop a plan for the staged implementation of these services, and report annually to its citizens on progress in implementing home care services. First Ministers task their Health Ministers to explore next steps to fulfill the home care commitment and report to First Ministers by December 31, 2006. [Prime Minister News Release]

Who receives acute community mental health home care?
No agreement has been determined about who will be eligible to receive community mental health home care services nor on a shorthand term to define this population. For the purposes of the Forum discussion, the Planning Committee suggests the "target population" includes people who need or use mental health services, including a) individuals whose primary diagnosis is mental illness *and* b) recipients of home care services for physical needs who also need mental health support. Home care should address mental health needs regardless of who delivers the service.

Sources
Note: Definitions from these sources may have been adapted for plain language and/or to combine two or more perspectives.

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Appendix "B" Participant list and e-mail addresses

Participants were asked to sign a sheet with e-mail addresses to facilitate keeping in touch. Anyone who did not sign was asked by e-mail if they wished to be on the list. Two members of the Advisory Planning Team (Joan Campbell and Nadine Henningsen) who could not attend the Forum have been added.

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Home Care and Mental Health: From Policy to Action is available on-line in English and French at www.cmha.ca