



**Mood Disorders** Society of Canada

La Société Pour **Les Troubles de L'Humeur** du Canada

## **Patient Wait Time Guarantees Mental Health**

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Research Report to Health Canada

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# **Patient Wait Time Guarantees Mental Health**

## **Abstract**

This exploratory research on Patient Wait Time Guarantees for mental health, led by the Mood Disorders Society of Canada, is based on key informant interviews from three sources of expertise: Direct service providers, researchers and consumers and families who have “been there.” Ten interviewees were selected from across the country but interest was so great that, in the end, 13 people were interviewed, mostly via telephone. Each interview was transcribed and returned to the informant for their corrections and approval. A qualitative analysis of the interviews produced the themes that are summarized in the section below. The research showed that there are wide disparities in access to mental health services across the country. It also uncovered a fully developed wait time strategy complete with guarantees, data collection methods and defined recourse – in Quebec. This strategy appears virtually unknown in the rest of Canada. Key informants unanimously endorsed a leadership role for the federal government in this important area, perhaps through the new Mental Health Commission. Recommendations for next steps include a two-day Assembly of experts to develop go-forward steps in establishing a Patient Wait Time Guarantee for Canadians with mental illnesses.

## **Summary of findings**

Answers to Health Canada questions:

1. What are the major issues for timely access for publicly insured mental health services?
  - Too few services
  - Stigma
  - Fragmentation in the system
  - Potential for the inefficient use of extremely scarce resources
2. What is the extent of waiting and the experiences of those waiting for publicly insured mental health services?

- Devastating and life threatening
3. Are there relevant data sets or information sources that exist for mental health service waits that would be informative for Health Canada?
    - There may be isolated pockets of wait list data in some organizations
  4. What policy challenges exist in managing and reducing wait times for mental health services?
    - Governments just don't care
  5. What are innovative approaches to managing or reducing waits for mental health services?
    - We do a poor job of disseminating information on Canadian innovation
      - The Nova Scotia story
      - The Quebec story
      - The Emergency Department story

Additional themes raised by this study:

1. We support early intervention, the recovery model and the value of help in the community.
2. We would have to define what we are waiting for.
3. Mental health is not the same as hips and knees.
4. We just can't just throw open the doors.
5. We should have a wait time guarantee. But can we even hope for such a thing?
6. We are doubtful about the idea of recourse.
7. We strongly support a federal role in mental health as a whole, and specifically with this issue.

## **Recommendations for next steps**

The Mood Disorders Society of Canada (MDSC) proposes a two-day Assembly of mental health experts to gather in the Fall of 2007 in Ottawa just prior to Mental Illness Awareness Week (October). The activities for this Assembly will be as follows:

1. In preparation for the Assembly, produce an academic wait times paper (literature review) for mental illnesses that draws on established literature and activities in Canada as well as in other jurisdictions. This paper, together with the exploratory key informant work contained in the present report, will provide a solid foundation for wait times work in mental health. As noted by Dr. Don Wasylenki, this is an area of study likely populated by grey literature (as opposed to an established body of best practice research), but it is expected that a consensus can be found.
2. Establish a list of no more than 50 invitees. Invitees would include noted academics and clinicians who are experts in defining and implementing solutions in the mental health field (many of whom would be engaged should a pilot be recommended by the Assembly and subsequently approved by the Minister of Health); international experts; consumers and families who have direct experience of what it is really like trying to find mental health services in this country.
3. Develop an agenda that builds on the findings of the foundational academic paper and this report, and which discusses the Quebec approach both as it is intended to work and as it is working, and other Canadian mental health wait times activities that either demonstrate promise, or teach valuable lessons.
4. Allow attendees to utilize their expertise (scientific, academic, clinical, and experiential) to produce go-forward advice on a Patient Wait Time Guarantee pilot project for mental health. The strategy will answer questions raised in the present research: Where are the known bottlenecks? Waiting for what – exactly? - the assessment versus treatment debate. What data sources are needed to monitor progress and report on success? Where is the best place to start? Who should be involved?

Expected outcomes:

1. Support Health Canada's role in wait times reduction through capturing expertise among Assembly attendees.
2. Showcase Canadian innovation and place it within the context of the academic literature.
3. Produce specific and focused advice on a wait times guarantee strategy that is practical and capable of implementation in a cost-efficient manner.

4. Identify the locus of federal leadership which will have the ability to drive this important issue forward.

This exploratory report has begun an important process that needs further action to bring to fruition a Patient Wait Times Guarantee for mental health.

## **A story**

Consumers and families often speak about the extreme burden of stigma. The following is a story of a recent experience of a mother and her daughter seeking treatment for a mental illness in an Emergency Department – in a prominent city in our country. Stigma related to mental illness is, sadly, alive and well.

Dr. Paula Stewart:

My daughter has had trouble with anxiety disorder since she was a little child but it was only recognized when she was 20. With the regular help of a psychologist and periodic help from a consulting psychiatrist and her family physician, she had been able to cope effectively with severe obsessive compulsive disorder and social phobia.

She entered a stable state when she was pregnant and subsequently when she was nursing her baby. She was off medication for a year and a half. When she stopped nursing, she entered a manic phase. She was euphoric – cleaning everything, constantly. She visited her psychologist who recommended she start back on the medication and after seeing her family physician he agreed and prescribed the same medication as before. After a short while she stopped because she didn't like the dopey feeling it gave her.

But then, she really plummeted. She was experiencing obsessive thoughts – there was no hope, you might as well kill yourself. The psychiatrist who has been consulted in the past said she could not provide consultative nor crisis care so would not see her. Her family physician said, "You're suicidal. You need to go to Emerg." Her psychologist, whom she had been seeing for years, said the same thing.

Her psychologist called ahead to the Emerg psychiatrist to say we were coming and he said, "Send her over." Having a referral like this was great because it means that my daughter wouldn't have to see the Emerg physician to be "medically cleared" before she saw a psychiatrist – one of the reasons people wait so long in Emerg.

We arrived at 1:00 PM. And we waited, and we waited. Almost two hours later, we were finally called to be registered. All this time, my daughter was experiencing symptoms and she felt exposed, judged – and along with that, intense anxiety. It was only because I was with her that she didn't walk out.

The triage nurse was actually wonderful. He said that he had battled depression himself. We waited some more as the forms were filled out and then we were sent over to psychiatric Emerg. So, after two hours, we got, formally, in line to wait to be seen.

I thought, OK, were on our way. However, it was not to be so. At six o'clock – three hours later, I complained. In all that time, we were kept in a stark, white room with two chairs, one of which was against one wall. My daughter became tired of sitting on this chair, and decided to sit on the floor with her back against the wall to see if she could sleep for a little while. The only contact we had during the three hours we

waited was a male nurse coming in and saying, "Please sit on the chair." We later assumed that it was so the camera could see her but he didn't tell us this. At the time, he was abrupt and seemed uncaring. This was the only encounter we had with staff in three hours. We were right outside the nursing station and I could see the nurses sitting on there but no-one came to talk to us and connect with us.

One of the reasons for the delay was that two men arrived in the Emergency department escorted by police and the hospital policy is that individuals escorted by police are seen first so the police can return to duty.

When I approached the nurse at six o'clock to ask when we would be seen, the nurse said that the Emerg psychiatrist – to whom we had originally been referred – had gone home. The nurse then said she wasn't sure when the junior resident would be coming in but the medical student would be there soon. As a physician I know the protocol of having a medical student see the individual first, then the junior resident then the senior and eventually the staff person. This would have been a problem for my daughter at any time but when we had already waited a total of five hours from the time we had arrived in the Emergency without being assessed this was unacceptable. My daughter was tired, feeling complete hopelessness and was not up to repeating her story many times. I explained this to the nurse and asked whether there were any other options, for example, being referred to the out-patient department or an assessment. She said no, this was our only option.

She then said, I'll just finish my noodles (she was eating her dinner) and I'll be right with you. Twenty minutes later, she came to see us. My daughter told her about hearing voices and her thoughts about harming herself. She took notes and then returned to the nursing station. She then returned and said the senior resident had arrived and would see us. This was great news.

At about the same time another nurse just arriving for his shift checked in on us and found out that we had been there for almost six hours. He was wonderful, and said he would do what he could to speed it up. He also pointed out where we could get something to eat. (They had provided a dinner for my daughter but as she was bulimic, it was totally inappropriate food for her)

When the resident finally came in, he spoke to me first and asked, "So, what are you hoping to get out of this?" I said that 3 health care providers said they were not able to help my daughter and she needed one person to give her hope that things could be better. Just then my daughter burst into the room and said we might as well go as the police had just arrived with someone else. The new male nurse said, no, she has waited long enough and she would be seen next. This was music to our ears.

The senior resident who saw her was excellent. He listened and told her that her obsessive-compulsive disorder was causing all her symptoms, and this reassured her tremendously. He prescribed medication and arranged follow-up. We finally left the hospital by 9:30 PM.

So, we had two totally different experiences. One was very difficult, and one was really very good. With the first we were left in silence to wait a long time, and with the second people communicated with us and we felt they cared.

As a physician, I am not intimidated by the hospital or health professionals, I could advocate for my daughter. I was able to clearly articulate what she needed. I just wonder what happens to others who feel unsure of themselves in this setting.

I think it would have been much better for the staff to greet us immediately and find out what the problems was. Then they could have let us know what was going on. They could have given us updates. It would have taken two minutes every half hour. They could have offered my daughter a cup of tea. The first nurse could have told us that people brought in by the police go first. This communication would have shown value for her as a person. We would have understood, and we would have been able to express our needs and concerns.

My daughter entered the Emergency in crisis, hopeless with suicidal thoughts. She waited over five hours for someone to assess her and communicate with her. She needed someone to say, "I can help." In many little ways staff could have communicated this to her from the very beginning. It is not too much to ask. A long waiting time for people with mental illness seems like an eternity. Thoughts jumbled through their heads and like my daughter they feel like leaving if they don't get a sense that people care.

## **Introduction**

In March, 2007, the Mood Disorders Society of Canada was commissioned by Health Canada to provide impartial expert advice on the key issues and challenges in accessing timely care for patients with mental illness in Canada. The work is in support of Health Canada's role in facilitating wait times reduction.

Accessing mental health services is a significant issue in all regions of Canada.<sup>1</sup> Recent federal and provincial emphasis on patient wait times has achieved significant success in reducing the length of time patients who must wait for joint replacement, cataract surgery, diagnostic imaging, cancer and cardiac care.<sup>2</sup>

However, the concept of wait time targets or guarantees for mental health services has not been explored on a national level.<sup>3</sup>

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<sup>1</sup> Canadian Psychiatric Association (2006). Wait times benchmarks for patients with serious psychiatric illnesses. Available at: <http://64.233.167.104/search?q=cache:E5Lp6JeEu84J:www.cpa-apc.org/media.php%3Fmid%3D185+wait+time+benchmarks+canadian+psychiatric+association&hl=en&ct=clnk&cd=1&gl=ca>

<sup>2</sup> For example, see: Kirby, M. (January, 2007). A review of Ontario's wait time information system. Available at: [http://www.health.gov.on.ca/english/public/pub/ministry\\_reports/kirby\\_rep/kirby\\_re\\_p.pdf](http://www.health.gov.on.ca/english/public/pub/ministry_reports/kirby_rep/kirby_re_p.pdf) In addition, see the Alberta Wait Times Registry, available at: <http://www.ahw.gov.ab.ca/waitlist/AWRInfoPage.jsp?pageID=9>

<sup>3</sup> Other health sectors have received federal attention:  
Radiation therapy:

## Why this issue is important

One in five Canadians will experience a mental illness in their lifetime. Research shows that there is a significant cost to the Canadian health care system related to the needs of people with mental illness.

- Of all hospitalizations in Canada, 33% are due to mental illness as either a primary or secondary diagnosis.
- People with mental illnesses spend twice as long in hospital relative to other diagnoses.<sup>4</sup>

In addition, the costs of untreated mental illness to the Canadian economy is staggering.<sup>5</sup>

- Annual losses to the Canadian economy due to mental illness in the workplace are \$33 billion.
- Of all short term disability claims, 75% are related to mental illness.
- Of all long term disability claims, 79% are related to mental illness.
- The fastest growing category of disability costs to Canadian employers is depression.
- Ninety percent of people who are depressed *never* access treatment; however, research finds that 80% of depressed people who seek treatment respond well.
- For those who get treatment, employers will save, per employee per year, from \$5000 - \$10,000 in average wage replacement, sick leave and prescription drug costs.

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Getting things done: Patient wait times guarantee. April 10, 2007. Alberta agrees to a wait time strategy for radiation therapy by 2010. Available at:

<http://www.conservative.ca/EN/2459/75620>

Manitoba joins with Canada's government to announce patient wait times guarantee.

March 30, 2007. Available at: [http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2007/2007\\_34\\_e.html](http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2007/2007_34_e.html) radiation therapy

Nova Scotia joins with Canada's government to announce patient wait times guarantee. March 26, 2007. Available at:

[http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2007/2007\\_28\\_e.html](http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2007/2007_28_e.html)

Children's health:

Prime Minister announces pilot project for wait time guarantees for children (Ontario). Available at:

[http://www.pm.gc.ca/includes/send\\_friend\\_eMail\\_print.asp?sendFriendEmailFlg=True&URL=/eng/media.asp&id=1495&langFlg=e](http://www.pm.gc.ca/includes/send_friend_eMail_print.asp?sendFriendEmailFlg=True&URL=/eng/media.asp&id=1495&langFlg=e)

<sup>4</sup> Quick facts: Mental illness and addiction in Canada. The Mood Disorders Society of Canada. Available at: [www.mooddisorderscanada.ca](http://www.mooddisorderscanada.ca)

<sup>5</sup> *ibid*

## Methodology

The question of establishing patient wait time guarantees is a complicated one that cannot be answered in isolation from the health care system as a whole.<sup>6</sup> Thus, this study sought to explore wait time guarantees from a number of perspectives. First, consumers and families constitute a significant source of advice and innovation when it comes to improving mental health care in this country. They experience, first hand, the frustration with obtaining even basic services. Second, direct services providers share this struggle as they work in the over-burdened and under-resourced “system” which tries, and often fails, to serve people in a timely manner. Third, researchers examine mental health practices and services through quantification, investigation and the reporting of findings. They provide the objective measurement of what is, or is not going well. This report’s findings are based on views from these three sources. See **Appendix 1** for a list of interviewees.

Interviewees were selected for their considerable expertise and for their ability to provide a selective regional picture of the Canadian experience. In all, 13 people were interviewed. All those approached responded positively to our request for an interview and contributed a considerable amount of their time and energy. The Mood Disorders Society thanks them for their commitment to the project.

Interviewees were asked exploratory questions about what they thought about the subject area, along with ideas about barriers and opportunities. Each interview lasted from ½ hour to an hour, with most conducted by telephone. See **Appendix 2** for the interview template.

Finally, results are reported in response to the five questions contained in the Health Canada’s Statement of Work for the project, but also in terms of additional themes that emerged through discussion and which were revealed through supplementary questions (as contained in the interview guide).

Health Canada’s specified questions were:

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<sup>6</sup> Postl, B. (June, 2006). Final Report of the Federal Advisor on Wait Times. Available at: [http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2006-wait-attente/index\\_e.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2006-wait-attente/index_e.pdf)

1. What are the major issues for timely access for publicly insured mental health services?
2. What is the extent of waiting and the experiences of those waiting for publicly insured mental health services?
3. Are there relevant data sets or information sources that exist for mental health service waits that would be informative for Health Canada?
4. What policy challenges exist in managing and reducing wait times for mental health services?
5. What are innovative approaches to managing or reducing waits for mental health services?

Interviews were typed into transcripts from notes taken during the encounter. All interviewees received a copy of their interview so that they could provide corrections or additional thoughts. Results are provided in terms of direct quotes – all of which were approved by interviewees for inclusion in this report.<sup>7</sup>

## **Results**

### **Question 1: What are the major issues for timely access for publicly insured mental health services?**

Interviewees' responses fell into four categories: Lack of resources, endemic stigma that prevents people from seeking services and governments from paying attention to mental health issues, fragmentation within the system - for those who actually are able to access services - and the potential for inefficient use of the few resources that do exist.

#### ***Too few services***

Lack of resources has to be number one. You cannot access services easily throughout the province. I moved from a center 500 miles from Winnipeg back to Winnipeg and presumed the situation to be better "in the south", only to find it's not the case.

...Carol Hiscock, Executive Director  
Canadian Mental Health Association, Manitoba

Lack of resources is one of the key issues. There is almost universal acknowledgement of this. (Of the people I consulted to prepare for this interview), I don't know anyone who didn't say this.

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<sup>7</sup> The first time an interviewee is quoted in this report, their full title, affiliation and location are noted. When they are quoted subsequently, only their name appears. Some quotes have been re-organized slightly for better flow.

...Dr. Manon Charbonneau, President, Canadian Psychiatric Association, researcher and psychiatrist at Hôpital des Sept-Iles

Lack of sufficient quantity of services has always been a problem.

...John Trainor, Administrative Director  
Community Services and Research Unit  
Centre for Addiction and Mental Health  
Toronto

The biggest issue is that mental health services haven't been supported or adequately funded at the same level as services for physical disorders, yet there is the same level of mortality and disability. But we have come to think of this as normal. For example, a child with a life threatening mental disorder such as anorexia nervosa has to wait 6 months for help. If that was leukemia, it would NEVER be tolerated.

...Dr. Elliot Goldner, Professor  
Simon Fraser University, Vancouver

In Manitoba, we wait for six months to see a psychiatrist.

...Chris Summerville, Interim Executive Director  
Schizophrenia Society of Canada, Toronto

When people come to the realization that they need mental health services, they've been coping with illness for some time. Unless they are manic or psychotic, no one pays much attention to them. People can't get into service unless they are in crisis and deemed an emergency. In BC, if your GP refers you to a psychiatrist, it can take a year or longer to get an appointment. There is no timely access. If it can't be handled by a GP, you're out of luck.

...Rennie Hoffman, Executive Director  
Mood Disorders Association of BC  
Vancouver

As a psychiatrist, I treat high blood pressure and diabetes, as well as mental illness because I cannot refer my patients back to a family physician – because there isn't one for them. So there are two parts: You don't have a family physician to refer you to a psychiatrist. And psychiatrists can't refer stable patients back to a family doctor.

...Manon Charbonneau

## ***Stigma***

The second issue is discrimination.

...Carol Hiscock

Part of the reason we don't talk wait times for mental health is because no one cares.

...John Trainor

The problem doesn't seem that urgent to people... "It's not as if people are dying" - but they are.

...Dr. Don Wasylenki, Chair, Department of  
Psychiatry, University of Toronto and  
Chief of Psychiatry, St. Michael's Hospital

Mental health services are so startlingly absent, we risk diluting what is available if we concentrate on particular areas of need. On top of this, stigma inhibits a person from seeking service. There is an inertia to overcome to even accessing those few services that are available.

...Julian Somers, Executive Director  
Centre for Applied Research in Mental Health and  
Addiction, Simon Fraser University, Vancouver

The attitude of health providers in the Emergency Department really bothers me. One person can be attentive and try to relate to you as a person but this is not common. I can't help but see the attitude come out in the lack of response.

...Vicki Rogers, Education Director  
Mood Disorders Association of BC  
Vancouver

One major barrier has been that a lot of first line caregivers are not keen on treating mental illness. GPs are reluctant to take mental health patients because they take more time and they are more demanding. In a lot of cases, as soon as a GP sees a mental health client, they refer them to secondary services. This is why the wait times have been so long.

...Nicole Germain, Assistant to the Director  
General, Douglas Hospital  
Montreal

The barriers come down to the fact that the government has figured out – or the bureaucracy has figured out that people with mental illness aren't going to protest, aren't even going to identify themselves. So it is a low priority. People who suffer in silence are being ignored.

...Rennie Hoffman

Care providers who are knowledgeable, effective and who are sensitive exist but it is blind luck if you get to one. There are greater odds that you get someone who either can't help at all – or who is unable to accurately interpret your pattern of symptoms. People become alienated from seeking care at all. They are worn down and turned off.

...Elliot Goldner

### ***Fragmentation within the system***

And the third (barrier) is fragmentation within the system. If you DO get into services, for example, you may have three workers telling you to go in four different directions to the point you nearly forget why you went there in the first place.

...Carol Hiscock

I always thought it was essential for a Toronto Mental Health Board. Good will is short lived and the mechanisms to get people to work together have to be

institutionalized. Right now, everyone can do whatever they want. Somebody has to be empowered for managing the issues regionally.

...Don Wasylenki

And services, themselves, are divided into silos. People responsible for the delivery of mental health services have nothing to do with primary care – and primary care may know nothing about mental health services. Siloing is a serious problem and it came out clearly in the Kirby Committee hearings.

...Elliot Goldner

### ***Potential for the inefficient use of extremely scarce resources***

One problem is the need for resources. The other is the need to match need to resources. There is a lot of over-serving that goes on in mental health. Lots of people can live on their own in their own apartment without high support. However, many people stay in high support services because there are limited rent subsidy spaces available so they can move to a more independent situation. At CAMH, we often have problems getting people out because there are no housing spaces. People need a minimum of services – that are adequate – most people can live in their own apartment.

...John Trainor

Stepped care is not innovative in that it's not new – but it is sadly not implemented. Stepped care means very efficiently providing services at the level of need. Mental health services are precious resources that are often distributed in an inefficient way. Waiting until people are so ill – to the point where we fear a law suit – means that when people actually get to service, they need the most expensive care there is. This has been known for decades but we just can't seem to shift the health care behemoth towards early intervention, self-management and prevention.

...Elliot Goldner

### **Question 2: What is the extent of waiting and the experiences of those waiting for publicly insured mental health services?**

The theme raised by this question was that wait times for mental health services had a destructive effect on the person and his or loved ones and, in some cases, were life threatening.

### ***Devastating and life threatening***

Families say that trying to get people into care (both inpatient and community services) is extremely difficult. When a person is deteriorating, not accessing help is devastating.

...John Trainor

The waits are horrific. People die on waiting lists or the illness progresses to the point that it isn't treatable and, during these times, a wide circle of friends and family are also affected.

...Elliot Goldner

There was a woman in our group who has a son with bi-polar. He has never wanted to address the issue. She finally worked her way into a mental health team but her son was still reluctant to go. She wanted things to go smoothly so she was candid and told the full story. After two years, she finally got him seen. The mental health worker says to the son, "So, your mother says you're delusional." The son jumped and ran and won't come back. The system has found a way to avoid new cases. It's not individuals. It's the system.

...Rennie Hoffman

My sense is that problems are growing but it is difficult to talk about it only in terms of wait times. To wait 3 or 4 months when you are in critical need is not right.

...Ella Amir, Executive Director  
Ami Quebec, Montreal

It's pretty bad and it has deteriorated. The wait lists can be from 1 month to 1 year. Someone who has the attention of the system – is shouting, has his or her GP make lots of phone calls usually gets in the swiftest. Sometimes it is the most in need – but not always. Consumers are becoming more aware of these problems but the strange thing is, they almost accept it. The expectations are very low on the part of the system, the clinicians, the patient and the family. This is unfortunately the case mostly for those with severe illnesses, who don't advocate well for themselves, and don't understand that there is really a lot of work to be done once an acute episode is over, just when the system discharges you. It's part of the stigma – everyone accepts the status quo as OK.

...Claire O'Donovan, Academic Director Mood  
Disorders, Queen Elizabeth II Health Sciences  
Centre, Halifax

What do families do when they are concerned with immediate physical deterioration due to mental illness? I refer people to homecare where at least someone will come and see them. But they should be able to go to mental health services.

...Carol Hiscock

### **Question 3: Are there relevant data sets or information sources that exist for mental health service waits that would be informative for Health Canada?**

The answers for this question were uniform. Most interviewees didn't know of any data sources. Some pointed to some data in isolated locations.<sup>8</sup>

#### ***There may be isolated pockets of wait list data in some organizations***

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<sup>8</sup> There is one exception – the Quebec experience – that will be discussed under emerging wait times strategies.

The Toronto Early Intervention Network is making some strides. It looks at the network's capacity in relation to the number of expected cases of early onset psychosis – which can be measured fairly accurately on a population data basis. Then it measures how long people stay in services (about 3 years), and asks do we have the capacity and what strategies will increase capacity if we are falling short? The network is growing and, as I recall, can serve 50 -60% of the need. In our world, this is not bad. In other worlds, it would be considered terrible.

...John Trainor

Each hospital keeps wait time information for each specialty and the data can be compared among hospitals. Every month, we get these figures. And the regional authorities keep length of stay figures etc. Wait lists for community clinics and community psychiatrists are not maintained in a systematic manner. Many of our members limit use of wait lists in order not to give people false hope. The Canadian Psychiatric Association did a survey of members a number of years ago. It has lots of limitations – but gives some indication. It is on our web site at:

<http://ww1.cpa-apc.org:8080/Publications/Archives/Bulletin/2001/Mar/Mar2001.asp>

All I can say is we need data! That's the conclusion!

...Manon Charbonneau

#### **Question 4: What policy challenges exist in managing and reducing wait times for mental health services?**

While interviewees raised concerns regarding siloing and cross-jurisdictional issues, the main theme in answer to this question was the need for focused attention on the issue. Governments have to care enough to take action.

#### ***Governments just don't care***

At a time of rising health care costs, I don't see any appetite for adding new mental health services to the public system. Every government is looking for a way to decrease costs. Mental health has no parity now, so we're out of luck in the present atmosphere. There is little motivation for governments to change their positions and the mental health lobby is neither prominent nor important.

...Elliot Goldner

I don't know of any policies standing in the way. I know of practices that get in the way. People who are psychotic get in – people who are "just" suffering can't get help. We see the people that the system says aren't "ill enough" to get treatment and that is MOST people. When you talk of the percentage that don't comply with treatment, this is a very small number in comparison with the people that don't get treatment at all.

...Rennie Hoffman

There are significant policy challenges relating the administrative siloing – of funding, of practices, and now there is regionalization. Funding for different branches of our system comes through different sources. The whole area requires integration – of funding and of information. In some ways, mental health may have more to do with other parts of the health system, like acute or primary care, than with specialized services. Our clients are distributed throughout the whole of the health care system.

...Julian Somers

Cross-jurisdictional issues are a real problem. The Ministry of Housing, for example, is not well linked to the Regional Health Authorities. Housing is extremely important but that Ministry is isolated from the health concerns of its tenants. There is a similar problem with income supports.

...Carol Hiscock

The secret is getting people to work together. There is the federal/provincial split and now we have the provincial/regional split. We must create incentives for people to work together. It is amazing how fast solutions are found when people own the problem. You note that if it were a cardiac issue – it would likely be solved in 3 weeks. In mental health, we take years and years – and still it's not solved.

...Don Wasylenki

Anybody who really cares about this issue is wearing out. People are going to walk away. We can't see the light at the end of the tunnel. We can't even find the tunnel.

...Rennie Hoffman

### **Question 5: What are innovative approaches to managing or reducing waits for mental health services?**

There were two prominent themes in the answer to this question: Most people said that someone, somewhere, likely in another country, must have a model we can borrow from. The second theme was that there are pockets of Canadian innovation that no one seems to know about.

#### ***We do a poor job disseminating information on Canadian innovations***

Three interesting examples of innovation (some more successful than others) came to light in the course of this research. They seem to be understood only in the community or province where they have occurred.

#### **The Nova Scotia story**

The Standards for Mental Health Services in Nova Scotia, published in February, 2003,<sup>9</sup> stipulated that all core mental health programs must be accessible to all Nova Scotians (Section 2.1). Section 2.7 addressed wait times stating, “where a wait lists exist the service has a ‘wait list’ policy and procedures. The clinical team has a mechanism for assessing ‘urgency,’ risk, and the need for timely/early intervention, as well as a mechanism for maintaining and reviewing waiting lists.”

Claire O’Donovan described the results of this policy:

We have committed to everything for everybody (oh my God!).

We used to have a system where access was good for people with serious mental illness but there was poor access for people with less severe illness. In fact, they wouldn’t even get into the mental health system. Now, it’s an open system. Everyone gets in – in theory – but no one gets in in a timely fashion. There has been a change of policy and anyone with any sort of problem can be referred to mental health services. In the absence of skilled triage, the wait for people with serious mental illness has become longer. Any system contemplating wait times must be very skilled at triage. Right now, there is chaos. People who are having a break-up in their relationship and people with evolving psychosis get the same sort of access, with the exception of a few specialized services.

And, people who are less ill are much better advocates for themselves. Thus, access is more or less random with a bias towards those who can speak well for themselves.

The provision of mental health services to everyone is a massive undertaking and the range of problems and disorders is enormous. The ability to classify clients and identify who needs what, when and where is poor. The key issue is that we could spend billions and end up with chaos. We have expertise at the back end of the system – but not at the front end where the triage is done. It must be remembered that in psychiatry, we depend on symptoms, not tests. There is a tremendous amount of experience and judgment required.

In some ways the new policy was positive, but in others, it was naïve.

Most people are seen by clinicians who could be nurses, occupational therapists or social workers. They may or may not have had specialized training in mental health. The staff have minimal training in assessment and do the best they can. If we wish these staff to do front-line assessments, then we need to give adequate psychiatric back up (not 5-10 minutes of time) and we need to spend a lot of money on training them in assessment so that they know when they need further expertise. Most of the younger staff coming on don’t get much contact with psychiatry, or training and hence the access to assessment and diagnosis that the patient gets is, if anything, less than what they had with the family physician who referred them (in the first place).

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<sup>9</sup> Available at: <http://www.gov.ns.ca/heal/downloads/Standards.pdf>

With a lack of expertise in front-end assessments, timely access to “appropriate treatment” is chaotic. What has been misunderstood is the complexity of triage. The person assessing needs at the front end must have excellent training in mental health and disease classification sufficient to recognize when, where and for how long the person with illness needs to be seen. As it is now, a person with a manic episode, for example, might be referred back to a family physician with little preparation for the longitudinal course of a bipolar illness, because they were well in three weeks of treatment. A person with coping difficulties might get 20 sessions with a nurse therapist. A person with psychosis might get one hour with an occupational therapist and 10 minutes with a back-up psychiatrist.

As a specialist, I see the end result in the consultations sent to me, where the basic appropriate treatment has not occurred years after entry into the assessment process. Pressures in the system over time make shared care into inept “pretend care”, with a lot of shuffling of numbers. As a patient, you may get your assessment, and treatment, neither of which is of any help to you - and you don’t know why, so you can’t even advocate for yourself.

I can’t begin to tell you how this has all gone wrong.

## **The Quebec story**

Nicole German, Assistant to the Director General of the Douglas Hospital describes the changes.

When the Charest government came to power, they made mental health their number one priority and began a complete reform of services.

The new action plan<sup>10</sup> takes a population health perspective and organizes services in a hierarchical manner [first (primary), second (secondary), and third (tertiary)]. It is good on paper but, as always, the devil is in the details.

The idea is that first line organizations <sup>11</sup> – some who have some mental health expertise – will be reinforced overall through resources from psychiatric hospitals. Once the transfers have occurred, the first line teams will have much more mental health expertise and will be better able to deal with mental health patients. The patients, themselves, are also going to be transferred from second to first line care.

Each first line care organization will have a reference psychiatrist (shared care approach) – psychiatrists are not being transferred. The reference psychiatrists will

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<sup>10</sup> The Mental Health Action Plan or Plan d’action en sante mentale (2005 – 2010) – see <http://www.douglas.qc.ca/news/details.asp?l=e&ty=a&id=71&yr=2005&> was announced by Health Minister Phillippe Couillard on June 15<sup>th</sup> 2005. It has not been translated into English but is described in some detail in the Douglas Hospital’s newsletter, douglas.com (Fed 21<sup>st</sup> & Sept 28<sup>th</sup> editions).

<sup>11</sup> In Quebec, primary care organizations have been re-named Centre de sante et de services sociaux of CSSSs.

decide if a patient will go to second line or will remain in first line care and be treated there.

The new plan establishes clear targets for first line services (to serve 70% of patients), second line (to serve 29%) and third line (to serve 1%). We are in the process of transferring resources from second line to first line. There will be a lot of resources that will go from the Douglas (12 million) to new first line care organizations. All psychiatric hospitals in Quebec will be transferring resources to reinforce services at the first line level. And it is not just psychiatric hospitals transferring resources, but all general hospitals with psychiatric units as well.

The goal was to have the transfer begin by April 1, but that was delayed until September and now it is to be done zone by zone. There is also a plan to involve everyone so no one feels left out. As you can imagine, staff feel very insecure. It is a big change.

This government just doesn't provide a plan – it puts teeth into its plans with clearly defined numerical, measurable targets. Now, the requirement is that no one should wait more than 60 days for treatment. The target ratio is that 7 patients will be served in first line care for every 3 patient transferred to second line.

The wait times process is (with the target of 60 days):

1. Request for service received
2. A professional assessment is made
3. The patient sees a psychiatrist
4. The patient remains in first line care and is treated there with advice, or
5. He or she is transferred to secondary services

There is also a centralized data gathering system where every organization must provide statistics in the following categories:

1. Assertive Community Treatment (ACT) team activity (adults)
2. Variable level follow-up (adults)
3. Numbers of patients (children and adults)
4. Wait times (children and adults)

Every year, they add data points to this central system. We now have management agreements – well, not agreements actually. They are imposed by the regional health agency. We must abide by certain things and the statistics show whether or not we are doing well.

This is positive, in a way, as it forces us to look at inefficiencies - but negative as a lot of caregivers see it as statistics for the sake of statistics – and that it is not improving outcomes. I can understand why the government wants this.

We also have a Complaints Commissioner in every institution and he or she reports directly to the Board of Directors. Each Board has to have a Watchdog and Quality Committee. This is where the responsibility for responding to accreditation recommendations goes. Then, we each have a Medical Examiner where complaints against physicians and dentists go. The complaints from the Commissioner and the

Examiner go to a centralized office and there are also very clear deadlines for responding. This is not just lip service.

In addition, the Quebec government has added a new article to the Act (Bill 33)<sup>12</sup> making the Director of Professional Services responsible for access to specialized and super-specialized services (tertiary care). The Act specifies a centralized mechanism for access and there are defined wait times. If these times are not met, the Director must see that an alternative is provided. This provision just came into effect on March 1<sup>st</sup>. "Alternative" is defined as another hospital or referral to a private practitioner. It is likely the private practitioner will charge the government but this is not clear at this point. This provision is a result of the Chaoulli decision.

Nicole points out that these changes have not been without problems.

#### Problem 1

The main barrier to implementing the new action plan has been medical and I think these problems are specific to Montreal. The implementation has been financially driven – only. So physicians have felt out of the loop and they began to oppose change. Even institutions feel that it won't work if the only tactic is financial incentive.

#### Problem 2

The Quebec rule is that a psychiatrist can't move from one organization to another – and if they insist on moving, they have to re-locate outside of Montreal. This coupled with the fact that all new graduates have to locate outside of Montreal makes the supply of psychiatrists very limited. We can streamline the process, but there is only so much we can do. We have developed some creative joint appointments to obtain some resources from outside – that helps a bit. Currently, the average age of psychiatrists at the Douglas is about 57. So we have a manpower problem.

#### Problem 3

The fact that we used to be able to fast track urgent cases is now less of an option. This is not clinically wise as we need to see urgent patients on a priority basis.

#### Problem 4

Another difficulty with specified wait times is that patients cancel their appointments – or they don't show up – but the clock is still ticking. An audit of patients who wait for more than 60 days shows that 78% had either cancelled or didn't show up for their appointment. We now have a policy where, if you cancel, we send you a letter with a copy to the referring physician to say that you are now off the list and we will reopen the file if you are re-referred. But, it must be said, since the action plan, our wait times have come down so it has helped.

And a final concern

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<sup>12</sup> See Section 7 (pg 6 – 7) of the amendment. Available at:  
<http://www.douglas.qc.ca/news/details.asp?l=e&ty=a&id=71&yr=2005&>

The worry is – if patients are not served effectively at the first line level, they will come back to the second level anyway and we won't have the staff anymore.

Ella Amir, Executive Director of Ami Quebec sees the reform in a negative light.

Maybe other countries have done better with reform, but in Quebec, reform is good on paper – we talk the talk, but we are not walking the walk. We are not investing in services. So, it is not getting better. It is getting worse. And families are getting increasingly concerned.

### **The Emergency Department bottleneck**

Repeatedly, interviewees identified wait times in emergency rooms for people with mental illness as excessive. Typical wait times were identified as at least 5 hours, but often 10 hours or even longer. The Canadian Institute of Health Information reviewed Emergency Department wait times across the country <sup>13</sup> and reported that the median wait time for all patients was two hours with only 10% of patients spending over six hours. The variation in wait times was attributed to the severity of the illness, the age of the patient, the time of day and how busy the Emergency Department was. Interviewees argue that it is stigma that causes people with mental illness to drop to the bottom of the list when they present in Emerg.

People who don't get an urgent appointment with their clinician, go to Emerg! At enormous distress, time and cost to the patient and the system. What the assigned clinician, who knows the patient, can sort out in 20 minutes, takes 6 hours through Emerg, and is far less likely to be the best approach. The chances of hospitalization are very poor. Very little treatment other than hospitalization is offered in Emerg, just a triage back into the regular system. Patients must feel like they are on a meaningless merry go round

...Claire O'Donovan

And then, of course, you could end up in an Emergency Department, where again there is a challenge to being seen. There are many stories of individuals spending 10 hours in Emergency Departments, where they are sent home to see their family doctor – when they may not have a family doctor in the first place.

...Carol Hiscock

When we talk about wait times, we tend to speak about the time police officers spend in Emerg trying to get an admission for a person on a Section 28. It used to be a very long time but the Canadian Mental Health Association

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<sup>13</sup> Understanding Emergency Department wait times (2005). Canadian Institute of Health Information. Available at:  
[http://secure.cihi.ca/cihiweb/products/Wait\\_times\\_e.pdf](http://secure.cihi.ca/cihiweb/products/Wait_times_e.pdf)

got some money to look at what was going on. But the problem was not solved. Some waits are 12 – 24 hours outside the city and in Vancouver; I would say that 6 – 7 hours is not uncommon.

...Rennie Hoffman

Don Wasylenki, Chair of the Department of Psychiatry at the University of Toronto and Chief of Psychiatry at St. Michael's Hospital describes the problem from his perspective – and offers a solution.

This is a genuine bottleneck... The availability of urgent and emergent assessment in Emergency Departments. People are not seen for hours. They are put at the bottom of the list because they are not having a heart attack or a stroke. They are not bleeding. Sometimes, people just leave. If they are eventually seen by psychiatry and not admitted, there are very few services for people in urgent need in the community. Hours and hours of time are spent trying to find them something.

And this is Toronto where we are rich in services.

If they are assessed as needing an admission, there is no bed and likely no other beds in other hospitals. Hospitals are always full, always inundated yet, there are enough resources, generally – but not well coordinated.

When people are acutely ill, they need an intensive care bed – and even if other, lower support psychiatry beds are available, they have to wait because there is no intensive care bed.

Every teaching hospital in Toronto has 24/7 psychiatric coverage. So, the problem with long wait times in Emerg is that psychiatrists don't see anyone until they are "medically cleared." And the triage nurse can put people with mental illness at the bottom of that list because there is no known physical complaint. So they wait hours for that. Then, and only then, do they start the psychiatric assessment. Why can't these processes go in parallel?

The response is all about liability. It becomes framed as a medical/legal question. "We need to be sure they are not going to die over some medical condition we missed – and then they can go to psychiatry."

The Emergency Alliance Initiative is a project to bring together emergency rooms in Toronto that serve people with mental illness and get people talking about what to do about this. The idea is to identify 2 or 3 full-services sites, with the others as secondary. It started with 5 hospitals with an investment of \$100,000 each and works under the auspices of the Toronto Academic Health Science Network (TAHSN). Eventually, there should be an electronic communication component to the project.

(If I were to approach the wait times problem), I would get the emergency departments together and get them to unblock the system. We need some best practices developed in this area. The approach to the ACT team development was a good model. The Federal/Provincial/Territorial group funded Paula Goering and her team for a literature review and then satisfied themselves that what she found was valid. The approach was marketed federally and then to the provinces.

It is true that there is not a lot of best practice literature in this area but I bet there is a significant amount of grey literature – and it would likely reveal a consensus.

## **Additional themes**

Interviewees were asked some additional questions, and they also felt free to address the topic of wait times from a variety of angles. Thus, important, additional themes arose that merit inclusion in this report.

### ***1. We support early intervention, the recovery model and the value of help in the community.***

Early intervention services are addressing this issue and doing better. The approach has been 1) to connect with gatekeepers and by this, I mean high schools and colleges, teachers and guidance counselors. If these people are aware and are trained; they do very well in making good referrals. And 2) the other gatekeeper is the GP – and similarly, with outreach, they can identify and get people to services.

...John Trainor

Quite simply, follow the recovery model. Start in the community with proactive prevention. We don't want people to get to the point where they collapse on the door step of the hospital. We need more community-based alternative services focused on prevention in the first place, and relapse prevention, in the second. Interventions and treatments should be in the community. The hospital should confine itself to the bare minimum of crisis intervention. It uses a medical model focused on the management of symptoms – period. Psychiatry should handle crises and everything else should be in the community. Early intervention is a very important innovation and is showing better outcomes.

...Ella Amir

I would much rather see a focus on early identification and intervention.

...Rennie Hoffman

Community resources, of all types, they really help the system function.

...Claire O'Donovan

Leaving aside the opportunity for cost effectiveness, the possibility of positively impacting the health of a population is at the earlier stage of illness. There needs to be a policy shift towards illness prevention and early intervention.

...Julian Somers

### ***2. We would have to define what we are waiting for.***

We must find an accurate definition of “waiting” and describe clearly what we mean. Waiting for what?

- Waiting for triage?
- Waiting for diagnosis?
- Waiting for treatment?
- Waiting for the services that are important to maintaining stability and recovery – such as supported housing.

And then waiting for what kind of treatment? Medication? Psychotherapy? Group therapy?

...Manon Charbonneau

It's the breadth of WHAT is included in mental health services. It's not just getting access to a psychiatrist. It's getting safe and affordable housing, and adequate income supports. In the hierarchy of needs, safe housing is critical.

...Carol Hiscock

We don't know what's going on now. Many people don't even bother to try and get an appointment or to get to services because it's been so bad. They just give up – and that's not measured.

...John Trainor

It's difficult to keep track of people who haven't even made a connection with the formal delivery system. Regardless of how we improve our data collection systems for the actual waiting lists, we won't be able to count those who haven't been able to make contact in the first place.

...Julian Somers

If we concentrate on wait times for *only* those in the system, we will miss the extent of the unmet need.

...Elliot Goldner

### **3. Mental health is not the same as hips and knees.**

In a procedural specialty – which psychiatry is not – people talk about the number of hips and knees required, and then calculate the number of orthopods required to meet that figure. It is not a matter of a simple calculation in psychiatry.

...Don Wasylenki

The first thing is you can't treat mental health the same as other health disciplines. It is very different. It is not the same – at all. I am concerned with using the wait time language because this not the same as cancer or a broken leg. Psychiatry must be treated as a different discipline. Mental illness is not a condition that can be "fixed" or "corrected" as a one shot deal. People have to have ongoing access to help.

...Ella Amir

People with serious mental illness are not screaming for treatment – not like people with hips, knees and hearts. Families are the only advocates for them and they need more power.

...Claire O'Donovan

We tend to think of wait times in terms of an eager customer trying to get to a known, well-defined service. In Early Intervention services, the person is not identifying him or herself – and is not thinking in terms of getting to services. Early intervention is not strictly about reducing wait times. It's about reducing the duration of psychosis.

...John Trainor

#### **4. *We just can't just throw open the doors.***

I would say, choose who you really need to serve. Like many physicians, I don't believe that we can offer mental health services to all of Canada. The burden, perhaps the privilege, of health prevention, promotion and maintenance, if taken on by health care, will bankrupt the system. Yes, we should liaise closely with the community, general society and the individual but no, we should not take it all on – I have had friends who have recently separated and are distraught, and they want to see a mental health clinician or psychiatrist - they don't even think in terms of friends, clergy, or self-help organizations.

...Claire O'Donovan

Not all mental health problems are equal in terms of severity or disability and therefore, the urgency to achieve timely treatment is different. A student who's been dumped by his girlfriend may be in distress but it is not the same as a life threatening mental illness. There is a spectrum of mental health problems that covers a huge range. We can't reasonably expect the public system to respond to everything. So we have to wrestle with what is appropriate. It may mean we turn to a two-tiered system. But we have that already. Nonetheless, we haven't tackled the issue of the spectrum of mental disorders.

...Elliot Goldner

#### **5. *We should have a wait time guarantee. But can we even hope for such a thing?***

Interviewees were asked how they would go about developing wait time guarantees for mental health. There were some thoughtful suggestions. Others were not so sure it could be done. Some felt that it was so important, yet so far fetched, that they wouldn't even dare to hope.

#### Some strategies

Manon Charbonneau suggests:

1. Assess the amount of resources required to respond. Do we have what we need? Do we need more? We need the answer to this question to understand the gap and be realistic about it.
2. Find the best data we can from national or international sources – to see if we can develop evidence-based national tools. These tools would underlie everything – from the projects we undertake to the training we do.

3. And we must have evaluation tools and processes in place – we need to know how well we are doing.
4. These tools must take into account the three types of waits – to triage, to diagnosis – to treatment.
5. We need to focus more on functional criteria NOT just diagnosis. For example, your diagnosis could be “social crisis” due marital breakdown, but you are very seriously suicidal. Or you could be diagnosed with schizophrenia, yet you are stable, working and in good housing. In these cases, the diagnosis doesn’t tell you very much. We need a national consensus on functional criteria.

Claire O’Donovan

1. Know what the wait times are now – and be accurate about it.
2. Define wait times according to acuity.
3. Decide what time to what? Is it wait time to treatment (which I advocate for) or wait time to assessment (not that useful, when the assessment is not well done)? Note that making these things concrete and measurable is harder in mental health.
4. We must have competent expertise at the triage level. You can’t read what you need to know in a book and you can’t learn it in a day – if you are to do competent triage. Competent triage means you will get the best value for your psychiatric resources.
5. These steps must be identified before you go forward or you can eat up a lot of money to no effect.

Ella Amir

I would suggest that we need to build a consensus model – a commonly-agreed – upon blueprint on the treatment approach to take. Hospital is medical, community is recovery. These are quite different approaches. We have to agree on a blueprint that looks at all components:

- a. Who does what
- b. Where the money goes
- c. Roles and responsibilities

It is not helpful to look at this in a piece meal fashion. It must be global with everyone agreeing. Wait times would come out of this approach.

Those who were less sure about the possibility of wait time guarantees – or who just couldn’t imagine it.

Guarantees are not at all likely. Any government that would guarantee timely access would be so far, far away from where we are that they would naturally exclude mental health. Guarantees would be great but they would be political suicide. Targets are difficult enough. People are not even aware of the extent of the mental health problem.

...Elliot Goldner

In the mental health field, we are nowhere near talking about guarantees.

...Don Wasylenki

I guess the question is, are we looking at the art of the possible? Or are we trying to define the ideal? I would prefer a guarantee – but I don't think we'll get there. If we had good information, targets may be possible. Wait times targets are useful as an advocacy tool, as well.

...John Trainor

Even if we could do this, it is not a panacea. Wait times are not the most important factor. They are only one factor. We are not talking about an occasional acute condition. We are talking about a chronic condition. So wait times used in the same vein as other health conditions could actually perpetuate chronicity. You get to see your psychiatrist, guaranteed in three months and then again in three months and then three months again – but who is addressing the chronicity?

...Ella Amir

Wait times are not even on the radar screen here. There is so little in the way of service. Any wait time is too long. People have known for a long time that something was wrong before they come forward and ask for help. They shouldn't wait at all.

...Rennie Hoffman

## A final comment that sums up the tension between hope and skepticism

The British have implemented some guarantees along with payment for results. I am smitten by the idea. I think it is a non-starter, but I harbour fantasies. It could serve to alter the landscape of stigma if government were to assert a guarantee. It would radically message the legitimacy of accessing services. It would be a mechanism of change – it would immediately reveal the complete inadequacy of the capacity of the health system to respond and further thrust it towards bankruptcy. It could also mean that services are diluted and pharmacotherapy would become the *only* service. Services which are more labour-intensive such as ACT teams, rehabilitation and psychotherapy – the person-to-person interventions – would immediately be labeled as inefficient bottlenecks.

...Julian Somers

## **6. We are doubtful about the idea of recourse**

One of companion strategies for wait time guarantees is recourse, meaning that people who do not access services within a specified period of time, are offered help in another institution, by another practitioner in another community or, further away in another jurisdiction. Interviewees were skeptical that such a strategy could work for mental health.

My experience would be with cancer wait times. The dollar value attached to sending people one or two provinces over – or even one or two communities over – is too costly. Personally, I'd rather see the money invested in people's home communities so they can get the services there. Guarantees are just

too costly and people don't appreciate "recourse." They want to get help at home. Their supports are there. This is the recovery model – an emphasis on relationships and active monitoring overtime – not an instant cure.

...Carol Hiscock

Mental health services are not procedural. I would say, put the money into services rather than sending people to the United States for services.

...John Trainor

We have the concept of (recourse) – if it can be demonstrated that a certain treatment is not available here – people can be sent to the US – but that is very costly. Mental health problems require longer term relationships. Maybe it could work for inpatient treatment ..... It is hard to think of sending someone to Buffalo for treatment for depression.

...Don Wasylenki

I don't think (recourse) is applicable in psychiatry. People must be rooted in their own neighbourhoods. It is very different to go elsewhere for help, for say, schizophrenia, than it is for chemotherapy – not that this is not difficult. But chemo is time-limited. It is totally ludicrous to think of sending people elsewhere. It doesn't work.

...Ella Amir

Well, if we decide to send people somewhere else, it should be somewhere where it really hurts to pay for it – so it's never used. If people go anyplace, it should be to another province – not out of the country – that's too costly. Maybe there should be an Overflow Centre that all the provinces could use! The big value of guarantees is that they put pressure on the system to meet the wait times – so people *don't* have to be sent elsewhere.

...Claire O'Donovan

I don't think anyone should have to wait, but if we are going to pursue the idea of recourse, I think recourse should be compensation to the person for the lost wages, the lost opportunities and that compensation should be for the rest of their lives. They have lost so much. But no one thinks in those terms for mental health. Every suicide can be attributed to not having services. Every dollar of lost productivity because people couldn't get help has to be returned to the people. We should say, "We guarantee you appropriate services in a timely manner and if you don't get it, we acknowledge that your life is ruined and we will compensate you for this loss."

...Rennie Hoffman

When I have a patient I need to transfer to third line services, they DO NOT like being transferred. Often, they prefer to wait here. They experience transfers badly and so do their families. Sending people away is very traumatic. We see this a lot because we have to send people to Quebec City or Montreal. We know a lot about this and it is very hard. And the same thing happens if we refer to certain expertise. It is traumatic 75% of the time. They say, "They don't know me." I am more about bringing services to clients, than clients to services. For example, if I want a patient assessed for dangerousness, I can ask telepsychiatry to evaluate. Sometimes the services come in person or we use telecommunication. We have the literature. We know what to do here.

...Manon Charbonneau

I've been part of this domain of recourse as a psychologist. My practice was populated by people who had means. This is only one component - but consider the potential contribution of psychology. If one is sincere in a commitment to publicly insured health care, psychologists should not be practicing privately. They should be a resource to the public system. Now, if someone wants cognitive behavioural therapy after discharge, they must have the money to pay for it.

...Julian Somers

Some families with means have been successful in persuading the provincial government – when they can't keep them quiet and off the pages of newspaper – to have their loved ones sent to the US. The costs involved are huge. Detractors say that money would have helped us create great programs here. The only way I can foresee a solution – perhaps it is cynical – but I've had many years of hoping – is to set up private services. It would be inevitable that people would have to turn to them. Homewood is an example. The public system is buying service. It is not ideal, but there doesn't seem to be an alternative.

...Elliot Goldner

I think we could go with (wait time) guarantees. I don't trust the system's ability to monitor (strategies of recourse)

...Chris Sommerville

Nicole Germain comments on the Quebec experience on wait time guarantees and recourse:

Well, the new law says that the Director of Professional Service's head is on the chopping block regarding guarantees (and recourse). But this has only been since March so we will see.

### ***7. We strongly support a federal role in mental health as a whole, and specifically with this issue***

Interviewees clearly understood jurisdictional differences between the provinces, territories and the federal government and they understood the tensions. They felt that a profile for mental health, led by the federal government (perhaps through the new Mental health Commission) and accompanied by strong leadership, would be welcomed with enthusiasm – even though it could cause some consternation at provincial and territorial levels.

(The federal government could lead the development) of strategies based on evidence-based decision-making.

...Chris Sommerville

I think the role of the federal government is to get us information – that is what is missing – population health data on incidence and prevalence. When I research the issue, I often have to turn to US data – but Canada is different than the US. We need our own data. And we need research, guidelines and standards. I think that is the role of the federal government.

...Nicole Germain

The federal government can create knowledge and align incentives for uptake. So federal mental health policy could address the issue of wait times. In the case of ACT teams, the best practice work was done and then the Accord money came along – but the federal government did not direct how the money was to be used.

...Don Wasylenki

It is sensible, in an ideal situation, for there to be federal policies shared across this country. Now, the provinces set out whatever policies they like and some provinces and territories can go off the rails. A healthy system should have another layer, a safety net. The federal government should say, "We have identified this health issue and our role, as a federation, is to protect the health of Canadian citizens." Right now, the provinces and territories are loath to accept any federal role. They say, "Give us the money and stay out of it." Then there are the partisan issues like the place of French Canada. I'd like to see a role for the federal government, but it is difficult to achieve in Canada.

...Elliot Goldner

I don't think we're going to make progress unless the federal government institutes some demands on the provinces and territories. It is a federal responsibility. If the provinces and territories are left to their own devices, we'll just have different types of inequities. Mobility and equal access will never be achieved. But I think it's a non-starter. The provinces and territories are clear that decision-making is hands off. As we saw with the transition funds, targeted monies have a negligible impact because the provinces allocate them in ways that appear targeted but really, they just use them to maintain the status quo.

...Julian Somers

The federal government should hold the provinces to standards and if they don't perform to standard, they should take the money back. And if they continue to perform poorly, the federal government should take it over. The provincial government holds our organization to standards. Why can't they be held to standards?

...Rennie Hoffman

It should be a shared responsibility. The federal government could define wait times and audit efficiency. We are still very capable of wasting a lot of money. Perhaps the national Mental Health Commission could have both an advocacy and an audit function.

...Claire O'Donovan

It's traditional for the federal government to set the broad context for health care so, if they were going to get into this, it would be standard-setting.

Perhaps this is a role for the new Commission. I'd say, keep the focus on standards and on dissemination of information.

...John Trainor

This is a task for the Mental Health Commission.

...Ella Amir

This is a hard one. The more we develop national tools, then it is easier to change local activities. They have credibility. Everyone says, "Of course!"

...Manon Charbonneau

Leadership, plain and simple. The federal government, working with the provinces and territories, could identify good practices and see that they were disseminated. It is important to recognize health care delivery as provincial jurisdiction, but a collaborative coordinated approach is always preferable.

...Carol Hiscock

## **Discussion**

This exploratory study has obvious limitations in that time constraints prevented including representatives from every province and territory in the schedule of interviews. Nonetheless, what was discovered is intriguing and merits further attention.

Regional disparities for mental health services are known but the extent of the differences is problematic in the extreme, especially for a country whose commitment to publicly funded health care includes the principles of comprehensiveness, universality, portability, public administration and accessibility. People from British Columbia argue that access to publicly funded mental health services is so limited that only those in the most extreme crises ever gain the attention of an over-burdened system. Nova Scotia has "thrown open the doors" to all – a laudable intent but its implementation is described as chaotic and inadvertently penalizing of the seriously mentally ill. Quebec has a full-blown wait times strategy, complete with data gathering mechanisms, defined targets, guarantees and assigned responsibility for recourse if guarantees are not met.

A second finding of this work is that we don't know what is happening in other parts of the country. Because mental health has lacked federal leadership and the new Commission is not yet in operation, provinces and territories develop whatever approach to mental health care they see fit. Some consider this area of health care important. Others do not. These inequities might be expected – although not supported –

given the current federal/provincial/territorial approach to the distribution of health care resources. However, what is surprising is that seasoned professionals, researchers and consumer and family advocates do not know what is going on in other jurisdictions and thus, cannot learn from one another's experience.

Third, there is a painful tension between what is, and what could be. Interviewees may appear pessimistic and focused on complaints instead of solutions. A state of demoralization exists in some quarters of this country where people are so worn out that they are afraid to rekindle any hope that something *can* be done to make things better.

Finally, the research uncovered a unanimous endorsement for a centralized federal role in mental health and a palpable hunger for leadership.

## **Conclusion**

As expected, wait time targets and guarantees for mental health treatment and services is a complicated subject area. However, there are solutions that merit further investigation and certainly, dissemination. For example, one of the most innovative and comprehensive wait times strategies for mental health in the developed world exists in Canada, in Quebec, but it is virtually unknown. There is also strong commitment for going forward, with the support of federal leadership, perhaps in the form of the Mental Health Commission.

I don't want the result of this to be some 10 year plan.

We need to move on this and do something.

There needs to be a sense of progress.

...Carol Hiscock

## APPENDIX 1

### Interviewees

Wait time strategy (April 2007)

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## APPENDIX 2

### Interview template

Federal wait time strategy for mental health – initial exploration with key informants.

This is a project approved by the Federal Minister of Health and administered through Health Canada. The project lead is the Mood Disorders of Canada and the researcher is Barbara Everett.

1. What are the major issues for timely access for publicly insured mental health services?
2. What is the extent of waiting and the experiences of those waiting for publicly insured mental health services?
3. Are there relevant data sets or information sources that exist for mental health service waits that would be informative for Health Canada?
4. What policy challenges exist in managing and reducing wait times for mental health services?
5. What are innovative approaches to managing or reducing waits for mental health services?
6. If you were to begin to design a wait times strategy, what would be the first steps?
7. In talking about wait times, people often divide discussion around setting wait time *targets* and then monitoring performance – and setting wait time *guarantees* – with an option for recourse if the guarantee is not met. What are your views on wait time targets versus wait time guarantees?

8. In some jurisdictions, the concept of "recourse" exists. That is, if people don't get to service in a timely fashion, they are served elsewhere. How would you design this strategy?
  
9. There are provincial strategies regarding wait times. And then there are federal projects. What do you see as the jurisdictional issues in respective federal and provincial roles in relation to wait times.
  
10. Other questions I should have asked? Other issues you would like noted?  
General comments?