Community Mental Health and Addiction Information

A Snapshot of Data Collection and Reporting in Canada
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Executive summary

The objective of this report is to provide an overview of the current state of Canadian data on community mental health and addiction (MHA) services, focusing on services that are funded by provincial or territorial ministries and departments of health. Understanding the current state is an important step toward developing better data on which to base policy, system management and treatment decisions. The current state was investigated through a review of publicly available documents and consultation with representatives in each province and territory. The state of community MHA data varied greatly and was influenced by many factors, such as the technological limitations of existing information systems. Several provincial and territorial health departments described initiatives to improve the quality and comprehensiveness of data collection, and to implement more sophisticated information systems.

This report identifies substantial gaps in community MHA data and information. Gaps in data collection, limited data integration and variation in data standards impede attempts to gain a system-level perspective on community MHA services. Filling the gaps and moving toward adoption of common data standards will enable those working in the MHA sector to better plan, evaluate and improve services. Efforts in these domains will support improved service quality and outcomes for persons with mental health and addictions issues. This report concludes with suggested next steps for enhancing the data collected as well as its utilization.
Introduction

Report objectives

The objectives of this report are

- To describe the current state of Canadian data and information on community mental health and addiction (MHA) services; and
- To describe the gaps in community MHA services data and information.

Better information on community MHA services has been identified as a priority in the strategies and plans established by several provincial and territorial ministries and departments of health. This report will promote an understanding of the existing data and its limitations, as well as initiatives that are under way to improve the data. The information provided in this report will support discussion about the development of data to enable more sophisticated monitoring of services, outcomes and system-level indicators.

The primary audience for this report is policy- and decision-makers working on questions related to mental health and addictions, as well as those involved in evaluation and data and information management for this sector. These groups may benefit from a better understanding of the existing data and the practices and initiatives in other jurisdictions. Researchers, advocacy groups and the public may also find this report useful.

Background

Mental health and addictions as priority issues for Canada

Mental health and addictions issues have a substantial impact on Canadians. Each year, approximately 1 in 5 Canadians experiences a mental illness. A mental illness is a disorder that affects mood, thinking and/or behaviour. Some of the more common mental illnesses in Canada are depression, anxiety and substance use disorders. Mental illnesses are associated with distress and impaired functioning. The Kirby report, Out of the Shadows at Last, offered extensive testimony from Canadians about their challenges in dealing with mental illnesses and addictions, including distress, despair, difficulties accessing the health system and stigma.

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i. Throughout this report, “community MHA services” refers to community-based mental health services and community-based addiction services.

ii. This estimate was based on mental illness defined as mood and anxiety disorders, schizophrenia, attention deficit/hyperactive disorders, conduct disorders, oppositional defiant disorders, substance use disorders and dementia.
Mental health and addictions issues require significant resources from Canada’s health and social systems. An economic study funded by the Mental Health Commission of Canada (MHCC) estimated the direct costs of mental illness and substance use disorders in Canada at more than $22 billion in 2011, with a projected increase to $105.6 billion in 2041.iii, 4 These estimates were informed by 2007–2008 expenses reported by the provinces for a previous study by Jacobs et al.6 Expense estimates for some types of services, such as community mental health, were not available in some cases. The MHCC study estimated that for the 10 provinces in 2011, direct costs were $3.6 billion for inpatient services and $6.1 billion for community and social services.4

Providing and managing MHA services have been identified as priorities for provincial and territorial ministries and departments of health and health system managers. A number of provincial and territorial government departments have action plans that include improvements to services, better data collection on mental health services and outcomes, and improvements in population mental health.1–3 Action plans and other jurisdiction-specific reports have highlighted priority issues such as access, wait times and service integration.2, 7, 8

Community MHA services play a major role in the care of those living with mental illnesses and addictions. A wide range of service types exist along a continuum, from less-intensive population-based interventions to more-intensive services for severe and persistent mental illnesses. For clientsiv who experience severe mental illnesses, community-based services typically provide support after an acute phase of an illness and promote stability, recovery and opportunities for employment and social reintegration. As stated in Changing Directions, Changing Lives: The Mental Health Strategy for Canada, a “transformed mental health system should primarily be based in the community, because obtaining services, treatments and support in communities improves quality of life and leads to spending less time in hospital.”9

Better data and information about community MHA services are needed to plan, provide and monitor these services. Current data gaps make it very challenging to accurately estimate service provision, efficacy and costs.6, 7 In its 2014 review of mental health data in Canada, the MHCC highlighted the need to fill data gaps by capturing information in diverse settings, including health and social services.10 In the case of community MHA services, many of which are provided outside of the sphere of the health system, this point is particularly salient.

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iii. These estimates included health and social services and are presented in future value terms. Costs associated with dementia were not included.

iv. Individuals who receive MHA services are referred to as “clients” throughout this report.
In Canada, the diverse and fragmented state of existing community MHA services data poses a significant challenge for comparative reporting and analysis, such as among provinces/territories, health regions and service organizations. As detailed in this report, regions within a given province or territory may use different data standards and data collection systems. Detailed assessment data held at the local level may not flow to provincial/territorial health departments, which may have only selected data. As well, there is sometimes no data holding at the provincial/territorial level that contains information on the range of community MHA services provided. Information on community MHA services is distributed across data sources that are held by different ministries (e.g., health, social services, education, children-/youth-specific ministries). Within the health care system, mental health services have historically been administered somewhat separately from addiction services, using different treatment approaches and by different service organizations. Although there has been increasing integration of mental health with addiction services in Canada, in some jurisdictions, there is not yet integration of data. As well, mental health assessment data may be collected in settings such as home care but not integrated into reporting on community-based mental health. There is a need to assess mental health issues across settings (e.g., home care, continuing care) to understand client needs, inform care planning and monitor health outcomes.

CIHI’s program of work in community mental health and addictions

CIHI identified mental health and addictions as a priority in CIHI’s Strategic Plan, 2016 to 2021. This is recognized as an area where there are opportunities to improve health outcomes for a substantial portion of the population by providing information for better system management. Data on community MHA services is needed to better understand the prevalence of issues in the population and the extent to which services are meeting population needs. Information about client outcomes following community MHA services would be valuable in evaluating the effectiveness of different interventions and care models. More comprehensive and integrated data will be essential to driving improvements in services and outcomes.

CIHI recognizes the importance of facilitating the development and adoption of health information standards for community MHA data, which would contribute to improved data quality. Data based on common standards would enable comparability (e.g., among service organizations and jurisdictions) and would help guide improvements in quality of care. Data integration through standardized linkage methodologies would help create a more complete picture of services received, transitions in care and client outcomes. The potential health system uses of community MHA data would be enhanced by common standards and integration with other data sources.

v. In the context of this report, “regions” refers to region-level entities that are defined for the purpose of administering health services.
To support the implementation of health information management standards for community MHA data, CIHI has been supporting a pilot project for collecting and using the interRAI Community Mental Health (interRAI CMH) and RAI–Mental Health (RAI-MH) (inpatient) assessments in Newfoundland and Labrador since 2012. Participating regions receive reports with client demographic information and an overview of the clinical complexity of the population being served. The reports also include various scales (e.g., Depressive Severity Index, Severity of Self-Harm scale) to monitor outcomes over time. The interRAI Addiction Supplement is also being piloted in Newfoundland and Labrador. The supplement is designed to complement the inpatient and community assessments by providing a more in-depth measure of addictions among those receiving mental health services and by informing a client-centred and recovery-based approach to treatment planning.

The interRAI CMH is fully compatible with interRAI assessments that have been widely implemented for other care settings, such as inpatient mental health care, home care and long-term care. Jurisdictions across Canada, including provinces, territories, health regions and Aboriginal communities, have adopted one or more assessments from the suite of interRAI tools. The use of the interRAI suite of tools enables integration of information across care settings and the sharing of comparable information among the various providers seen by a client.

Overview of community MHA services and data

Defining and scoping community-based MHA services

Community-based MHA services are assessment, treatment, education and support services. These services are recovery-oriented, referring to a person-centred approach that includes principles of hope, dignity and inclusion.12 These services support clients to remain in settings that provide them with choices in their care, empowerment to take risks and opportunities to engage in activities such as employment, volunteering or other activities that they find meaningful. Services are oriented toward clients who have mental health or addictions issues, who are in recovery or who are at elevated risk of developing an issue. Wellness and mental health promotion services also fall within the scope of community MHA services.

This report focuses on community MHA services that receive funding from provincial/territorial ministries and departments of health and that are typically delivered through regional health authorities (RHAs), either directly or through agencies that are contracted or funded to deliver
services. The scope of the report corresponds to services provided in a variety of settings, such as clinics, community centres, residential addiction treatment centres and clients’ homes. Services are also provided remotely, such as through telepsychiatry, phone consultations with case managers and online support resources. By examining these services, this report will illustrate the current state of the existing data for the majority of services that health ministries consider to be community MHA services.

For services that were within the scope of this report, 2 investigations were conducted. The first was an environmental scan of community MHA service types offered in each province and territory. The second was a review of community MHA data, reporting and initiatives in each province and territory. These investigations did not include review of private services (such as those provided by psychologists) or public services provided by the federal government or ministries other than health (e.g., justice, social services, education). The federal government has significant responsibilities for addressing the mental health needs of veterans, members of the military and the Royal Canadian Mounted Police, new immigrants and refugees, and First Nations, Inuit and Métis. Publicly funded MHA services provided by physicians and in continuing care facilities, although they play a significant role, were not included. The findings of this report do not incorporate information on the data and systems used for services that were out of scope. This limitation is particularly relevant for certain populations. For example, youth may receive a substantial portion of their community MHA services through ministries and departments that have a mandate other than health.

The following descriptions reflect some of the broad service types that fall within the scope of this report. A more comprehensive list of community MHA service types that were reviewed for this report is available in Appendix A.

**Outpatient services** are provided through structured programs in a hospital or other facility or office setting (e.g., community health centre, community mental health clinic). In a hospital setting, these services are considered ambulatory care, referring to clinics where assessment, consultation, follow-up, treatment and teaching services are provided for registered clients. Some examples of outpatient mental health services are day programs and specialty clinics (e.g., for eating disorders). Outpatient addiction programs include day treatment and education delivered in counselling sessions (individual and/or group) and may also involve withdrawal management.

**Residential treatment** refers to programs in which clients live in a centre for a defined period of time and receive treatment such as counselling. This is a common approach to supporting clients living with addictions with a goal of preparing them to transition to a community setting with a lower level of supervision and supports.
Case management aims to coordinate clients’ care and connect them with appropriate support resources. Approaches to case management vary in terms of the range of services provided, the specialization of the person or team providing the service, and the intensity of services. In a brokerage model of case management, the focus is on screening, assessment, referrals to other services (e.g., housing), coordination of services and self-management support. In a full support model, case management provides a broader range of services, such as medical management, counselling and rehabilitation services. A distinction is also made between services that constitute regular case management and assertive or intensive case management.

Assertive or intensive case management involves a lower client-to-staff ratio, more frequent contact with clients and, in some models, more focus on assisting clients with activities of daily living. Assertive Community Treatment (ACT) is a case management model with a low client-to-staff ratio of about 10:1. An ACT team is multidisciplinary, including a psychiatrist and other members such as a social worker, nurse, vocational specialist, occupational therapist, peer support worker and addiction specialist. An ACT team provides psychiatric treatment, administers and monitors medications, helps clients access community services and assists clients in their activities of daily living. Support is provided 24 hours a day. ACT is typically for clients who have serious, persistent mental illnesses and functional impairment, and who are intensive users of the health care system.

Early detection and intervention programs respond to early signs of a mental illness to prevent or manage disease progression and improve client outcomes. These programs vary in their intended clientele and their intensity. For example, a low-intensity program called Bounce Back: Reclaim Your Health is in use in British Columbia. Bounce Back is designed to support adults experiencing symptoms of mild to moderate depression, low mood or stress. The program offers self-help resources and telephone coaching. Low-intensity programs may support a large number of clients in the community. An example of a more intensive early intervention model that has been implemented in Canada is Early Psychosis Intervention.

Vocational training and rehabilitation programs are designed to provide education, training and coping skills in support of meaningful employment for people living with mental illnesses and/or addictions. Programs include vocational assessment and career counselling, pre-employment and work readiness training, and volunteer and transitional employment.

Supported employment is a widely studied, evidence-based program guided by the following principles: competitive employment, rapid job search (no lengthy pre-employment assessment, training or counselling), integration of rehabilitation and mental health services, attention to client preferences, and time-unlimited and individualized support.

Peer support plays an important role in vocational training and rehabilitation. It can consist of informal self-help groups, independent peer-run organizations and peer support programs.
Housing services include supported housing, financial support for housing, and assistance with searching for and obtaining housing. Having an affordable, stable and secure place to live is important for supporting recovery. In Canada, the Housing First model, developed in New York state, is in use. It involves offering people who are homeless and living with mental illness access to a subsidized apartment of their choice, combined with a level of clinical services matched to their needs. This model was evaluated in a large multi-site research demonstration project called At Home / Chez Soi. To learn more about At Home / Chez Soi, see the reports from the MHCC.

Environmental scan of community MHA services in Canadian provinces and territories

An environmental scan was conducted to identify the community MHA service types offered in each province and territory. This scan identified the existing services about which data could potentially be collected for monitoring, research and policy development purposes. A list of 20 service types, some of which are described above, is available in Appendix A. The definitions in Appendix A are operational definitions for the purpose of categorizing services in the scan. To request methodological notes for the environmental scan, please email CIHI’s Mental Health and Addictions team.

The scan relied primarily on ministry/department of health websites, RHA websites and links from those sites to other web pages. The results of the scan (Appendix B) highlight differences among jurisdictions in terms of implementation of services. More types of service were offered for mental health than for addiction; some service types may be more applicable to mental health (e.g., shared care, telepsychiatry). An exception was residential treatment, which was more commonly found for addiction.

There are a number of limitations to consider when interpreting the results of the scan:

• In cases where a given service was not found, it may be that the service exists in that jurisdiction but information about it was not found through the search strategy.

• Where services are offered, they may not be uniformly available in all areas of a province or territory, or to all potential clients. Examining issues related to availability was beyond the scope of this report.

• MHA services are provided by a variety of health professionals, such as general practitioners, psychologists, social workers and occupational therapists. The search strategy was not designed to identify the services of these types of professionals.

• Service categories are not mutually exclusive, as some types of service can be provided within other types (e.g., concurrent disorders services within outpatient programs) and some services may belong to more than one category.
Service delivery and financial management

Community MHA services are organized, managed and funded in diverse ways across Canada. However, some common approaches and models of service delivery exist. Several levels and types of organizations (government and non-government) play key roles in the planning, delivery and monitoring of community MHA services.

Provincial and territorial ministries and departments of health play a centralized stewardship or governance role in the community MHA sector. These ministries or departments are often responsible, at the highest level, for policy development, performance monitoring and funding. Although differences exist in the extent and nature of regionalization in the health sector across Canada, typically health regions fund, coordinate and sometimes directly deliver community MHA services. Some provinces, such as Prince Edward Island and Alberta, have moved to a structure with a single health authority or organization responsible for health services delivery.

Many regions, provinces and territories fund or develop contracts with non-governmental organizations to provide MHA services to their populations. These organizations range from relatively small peer support or volunteer agencies to larger organizations and associations, such as the Canadian Mental Health Association, which has more than 120 divisions, regions and branches, and the Addictions Foundation of Manitoba, which provides the majority of addiction services for the province of Manitoba.

In general, community MHA services are funded and organized in a patchwork of systems across Canada. Clients access many programs and services in the community setting that are outside of what is commonly referred to as the health care sector. Some examples are housing services, employment services, services provided through the criminal justice system, and child and family services. These services come under the responsibilities of various federal, provincial, regional and municipal bodies.

MHA services that are delivered by hospitals or physicians are funded by provincial, territorial and federal governments. Services provided by other health professionals or providers may not be included in public health care plans. For example, private (residential and outpatient) addiction services are often paid out of pocket by the client or by a private insurance plan. Outpatient (facility-based) programs, case management, early detection and intervention, and vocational rehabilitation are some service types that are typically publicly funded by ministries and departments of health.
Current state of community MHA services data and information

The current state was investigated through a review of publicly available documents and consultation with representatives of each province and territory. Information is presented about each province and territory, followed by a summary.

Newfoundland and Labrador

Data and data management

The Department of Health and Community Services (DHCS) is responsible for setting the overall strategic directions and priorities for the health and community services system in Newfoundland and Labrador.21 Representatives of the DHCS and the Newfoundland and Labrador Centre for Health Information (NLCHI) contributed information for this section of the report.

The DHCS provides oversight to 4 RHAs that deliver MHA services to all age groups. Services are provided in hospitals, treatment centres and the community. The Department of Children, Seniors and Social Development also supports mental health promotion.22 The DHCS has integrated MHA programs at both the larger system and local service delivery levels. All RHAs have common intake processes for community MHA services. Intake refers to a screening process (in person or over the phone) followed by a biopsychosocial assessment that is conducted on paper and is kept with the client’s chart.

Community MHA services in Newfoundland and Labrador include a range of services, such as health promotion and prevention, outpatient counselling, day treatment programming, withdrawal management, opioid treatment and inpatient addiction treatment centres, and specific programs such as ACT Teams, intensive case management and a program for early psychosis.

The electronic documentation tool used for community health services in Newfoundland and Labrador, including community MHA services, is the Client and Referral Management System (CRMS). CRMS is a provincial case management application used by health and community service providers in all RHAs. It consists of 2 components:

1. Client management: Demographic, administrative and clinical information that forms the client’s health record
2. Referral management: A standardized process for managing all service requests
It is mandatory to document information in the CRMS, but regional variations exist with respect to the completeness and accuracy of the information collected. Significant efforts have been made over the past few years to improve the underlying standards and compliance with documentation requirements to improve the quality of the data in the CRMS. Few clinical assessment tools are built into the system; rather, the results are recorded in the clinical notes.

The majority of MHA services in Newfoundland and Labrador are provided under the jurisdiction of the 4 RHAs. Services that fall outside of the jurisdiction of the 4 RHAs, such as non-profit community-based organizations and private counselling services, do not use the CRMS even though they may be funded in part by grants to community organizations. Examples include Stella’s Circle and Choices for Youth, which are large community-based, non-profit service providers based in St. John’s, the province’s capital city.

A challenge that has been identified is that the CRMS is not connected with the vendor software used by hospitals. This creates challenges with continuity of care, such as when a case management client visits an emergency department.

The NLCHI is a Crown agency of the Government of Newfoundland and Labrador that is responsible for implementing the province’s electronic health record (EHR) and providing quality health information. The NLCHI is the custodian of many data holdings, which include administrative databases, EHR databases, surveys, Management Information Systems (MIS) data, and surveillance and research data. It provides leadership for the provincial development and adoption of health information standards and facilitates continuous improvement of provincial data quality.

Since 2012–2013, 2 RHAs have been participating in a pilot of the interRAI CMH standardized assessment system. Clients are assessed at the start of services and then semi-annually; comprehensive information is collected in 19 areas such as client demographics, mental status, behaviour, cognition, functional status, harm to self and others, substance use, medications, treatment, social relationships, employment status and diagnoses. The assessments are designed to provide real-time electronic feedback to clinicians and other caregivers on risks and best practices. One feature of the interRAI CMH is that it includes Mental Health Clinical Assessment Protocols (MH CAPs) to support the development of care plans. For example, if the Self-Harm CAP is triggered based on an assessment, care planning focuses immediately on interventions that address safety and prevention. The system generates a variety of outputs based on assessments, including measures of the client’s aggressive behaviour, depressive severity and ability to care for him- or herself. CIHI receives this interRAI CMH data and provides analytical reports, including quality indicators and outcome measures, to the 2 RHAs for planning and policy decision-making purposes. For inpatient mental health services, the RAI-MH assessment is being used in
3 regions. The use of RAI assessments in both inpatient and community mental health settings represents an opportunity to track clients’ clinical and functional status across the continuum of care. The 2 RHAs are also participating in a pilot study coordinated by interRAI, in which RHA staff will use the interRAI Addiction Supplement to accompany the interRAI CMH assessment.

**Regular reporting and uses**

In 2015, the NLCHI released the report *Mental Health and Addictions Programs Performance Indicators*. This report includes 41 indicators to address the accountability and performance monitoring needs of the RHAs and the DHCS related to MHA programs and services. The NLCHI noted that the majority of indicators were hospital focused due to the lack of data available for community services at the time. One indicator related to community MHA services, Direct Operating Expense to Total RHA Operating Expense (ratio), was derived from the provincial MIS database.

Newfoundland and Labrador implemented quarterly wait list reporting for MHA counselling programs at the beginning of 2012–2013. RHAs are mandated to report wait times to the DHCS on a quarterly basis. RHAs each have their own methods for monitoring wait lists; this functionality is not within the CRMS.

Newfoundland and Labrador has contributed data on publicly funded, specialized substance use treatment services to the annual National Treatment Indicators reports published by the Canadian Centre on Substance Abuse (CCSA). Publicly funded substance use treatment services include residential treatment, non-residential treatment and residential withdrawal management.

**Data initiatives**

Newfoundland and Labrador is interested in using a consistent, standardized electronic assessment tool for community MHA programs. Although the provincial CRMS system captures some clinical information upon intake, the information is very basic and limited in the types of reports that can be produced for program- and system-level planning and outcome evaluation. It also does not provide any form of real-time clinical feedback, in contrast to the interRAI CMH.
Prince Edward Island

Data and data management

The Department of Health and Wellness (DHW) is responsible for developing health policy and strategies throughout P.E.I. Health PEI, the single health authority in the province, is responsible for the operation and delivery of publicly funded health services in P.E.I. A representative of Health PEI contributed information for this section of the report.

Integrated Services Management (ISM) is a case management and financial benefit adjudication application used within non–acute care service delivery programs across Health PEI, the DHW and the Department of Community Services and Seniors. ISM currently supports many program areas, including Addiction Services, Community Mental Health, Home Care and Long-Term Care.

P.E.I.’s Community Mental Health services include a range of programs that offer assessment, consultation, treatment, crisis intervention, medication administration and monitoring, and outreach. Programs offered include primary mental health care, outreach, and care to adults and children experiencing mental illness and mental health problems. Similarly, Addiction Services provides a range of programs, including inpatient and outpatient withdrawal management, outpatient counselling, extended care and methadone maintenance. ISM includes data on adult and child/youth community MHA services. Reporting is mandatory for providers employed with Community Mental Health or Addiction Services within Health PEI. ISM does not include data on services that are not publicly funded. ISM collects information such as service organization identifiers, client identifiers, socio-demographic information, diagnoses, type of service provided and alcohol or substance use.

An assessment tool was developed based on clinician expertise and experience and implemented for all service providers that report to ISM. As part of the assessment tool, the CAGE questionnaire is used to assess alcohol or drug use.

Regular reporting and uses

Health PEI’s annual report includes the following statistics related to community MHA services:

- Counts of crisis response visits, admissions to Addiction Services and referrals to Community Mental Health;
- Percentages of youth and adult clients seen by Community Mental Health within access standards;
- Wait times for inpatient and outpatient withdrawal management; and
- Community Mental Health expenses and Addiction Services expenses.
Health PEI contributes province-level data on publicly funded substance use treatment services to the annual National Treatment Indicators reports published by the CCSA.  

**Data initiatives**

Health PEI has implemented a provincial acute care–based EHR and has been working to expand EHR coverage across service areas. Health PEI anticipates that an expanded provincial electronic medical record (EMR) solution will provide significant support for the province’s Community Mental Health, Addiction Services and other program areas.

**Nova Scotia**

**Data and data management**

The Department of Health and Wellness (DHW) is responsible for setting the strategic policy direction, priorities and standards for the health system, monitoring health system performance and ensuring accountability for funding. The Nova Scotia Health Authority (NSHA) is the single health authority for the province. The NSHA and the Izaak Walton Killam (IWK) Health Centre are responsible for managing and providing health services in the province, including community MHA services. A representative of the DHW contributed information for this section of the report.

Community mental health services data is collected using electronic vendor software systems. Data is collected on client demographics and visits. The use of assessment and screening tools is not standardized across the province. Clinicians and other service providers select the tools they use. From 1992 to 2006, the Mental Health Outpatient Information System (MHOIS) was used to collect data on publicly funded community mental health services across the province. The MHOIS included information about client demographic characteristics, diagnoses, services used and providers. Health Data Nova Scotia, part of the Department of Community Health and Epidemiology at Dalhousie University, is the custodian of several health service data holdings, including the MHOIS.

The Addiction Services Statistical Information System Technology (ASsist) application is a provincial client information system used by the DHW, NSHA and IWK Health Centre. Data from ASsist is centralized at the DHW. The application is used to collect data on addiction services that are funded by the DHW, including withdrawal management, structured treatment programs and community-based services. All community-based addiction services are provided by NSHA and are represented in ASsist. Private clinics do not report to ASsist. Some of the types of data collected include client identifiers, demographic data (e.g., employment status), risk assessment at time of program registration, substance use and gambling activity, services used and information on referrals. The ASsist system is not linked with other information systems for health care services.
Regular reporting and uses

The DHW publishes wait times online for more than 200 procedures and services. Mental health departments in hospitals and clinics provide the DHW with wait time data on community-based services for adults and community-based services for children and adolescents. Wait times for several types of addiction services are published based on ASsist data.

The DHW contributes province-level data on substance use treatment services to the annual National Treatment Indicators reports published by the CCSA. The DHW previously published an Addiction Services Annual Report, from 2009–2010 to 2012–2013. This annual report, based on ASsist, included the number of individuals who were active clients of each program type, as well as basic statistics on the education level, employment status and marital status of clients.

Data initiatives

In 2012, the province launched Nova Scotia’s first-ever MHA strategy, Together We Can. An identified priority area in the strategy is to shorten wait times and improve care for mental health and addictions. The strategy noted the importance of having better information on population needs and the types of mental illnesses and addictions treated in the community, to inform decision-making. The DHW has been reviewing options for a new health information system that would capture community MHA services information.

New Brunswick

Data and data management

In New Brunswick, community MHA services are delivered through 2 RHAs that are accountable to the Department of Health. The Department of Health is responsible for planning, funding and monitoring community MHA services offered throughout New Brunswick by 13 community mental health centres (CMHCs) and 7 regional addiction centres. The Department of Social Development is responsible for a range of long-term care services, including special care homes. A representative of the Department of Health contributed information for this section of the report.
The service delivery overseen by the RHAs includes

- Addiction services (short- and long-term rehabilitation services, detox services, outpatient services and methadone clinics);
- Community mental health services (including prevention, intervention services and mobile crisis services);
- Inpatient psychiatric care (inpatient and day hospital services through the psychiatric units of regional hospitals and the province’s 2 psychiatric hospitals);
- Flexible ACT; and
- The Critical Incident Stress Management program for front-line workers.

The Client Service Delivery System (CSDS), available to providers of community MHA services and other service providers, is a database with an online portal. The CSDS includes data on all community MHA services that are delivered through the RHAs. The CSDS was implemented in 2001. In 2012, addiction program services were incorporated into the CSDS and data from the Regional Addiction Services System was migrated to the CSDS.

The CSDS (which is owned by the Department of Health) is accessible from anywhere in New Brunswick, allowing service providers to input service data, track referrals and services, and produce reports. The CSDS includes information on demographics, presenting problems, referrals, service types, treatments and assessments. The system’s functions include

- Intake (initial contact, needs assessment and determination of eligibility for services);
- Case planning;
- Service planning;
- Service delivery monitoring;
- Outcome monitoring; and
- Inventory of policies, procedures and standards.

**Regular reporting and uses**

Although RHAs have their own networks, employees in community MHA services have access to the ministry’s network information system, through which the data is entered and included in the CSDS in real time. Remote areas have access to a separate secure portal to upload data to the CSDS.

**Data initiatives**

RHAs have developed operational guidelines, including a common assessment tool, that are being implemented. A screening tool was developed by the Department of Health and includes some standardized and established questionnaires.
A performance indicator working group (with RHA and Department of Health representation) is working on standardizing indicator reports. These will be shared with both RHAs to provide information on key indicators and will include utilization information.

**Quebec**

**Data and data management**

The ministère de la Santé et des Services sociaux (MSSS) is responsible for overseeing, funding and evaluating the delivery of health and social services. Community MHA services are mainly provided under the umbrella of corporations called integrated health and social service centres (centres intégrés de santé et de services sociaux, or CISSSs). These corporations operate in multiple locations that typically include local community service centres (centres locaux de services communautaires, or CLSCs) (for health services outside of hospital, including mental health) and rehabilitation centres for addiction. Individuals may also access assessment and treatment in their community through their general practitioners, psychiatrists and other mental health professionals, such as psychologists.

Services provided by the CLSCs are captured in the Intégration CLSC (I-CLSC) information system. Selected data flows from the local I-CLSC applications to a province-level database that is stored by the Régie de l’assurance maladie du Québec (RAMQ). The main module of the I-CLSC, SIC-Plus, allows capture of service use information (e.g., intake, caseload, case management).

The I-CLSC includes various types of information at the client level, including demographic, diagnostic, treatment and program information. For services provided in rehabilitation centres, clinical and administrative data is collected using the SIC-SRD (Système d’information clientèle pour les services de réadaptation dépendances).

**Regular reporting and uses**

Within a CLSC, staff can use a standardized reports module of the I-CLSC system to generate and customize reports about clients and services. The SIC-SRD enables various statistical reports to be produced regarding services provided in rehabilitation centres for addiction.

The RAMQ uses I-CLSC data to produce reports at the provincial, regional and local levels, and distributes these to authorized users. These reports contain statistics on clients and services, such as the distribution of clients by age group and type of intervention. The MSSS also publishes some reports online, based on information that CISSSs and other corporations submit through another information system (GESTRED, the Système de suivi de gestion et de reddition de comptes).
The MSSS monitors indicators of MHA services including:

- The number of clients who received first-line mental health services provided by CLSCs;
- The number of clients who waited more than 30 days for a consultation with a psychiatrist or pediatric psychiatrist (based on outpatient clinics only); and
- The percentage of persons who received a specialized evaluation within 15 working days of requesting services in a rehabilitation centre for addictions.

**Ontario**

**Data and data management**

In Ontario, most community MHA service delivery falls under the Ontario Ministry of Health and Long-Term Care (MOHLTC) and is planned and managed by 14 local health integration networks (LHINs). The Ontario Ministry of Children and Youth Services funds community-based mental health services for children and youth. The content of this section was informed by consultation with representatives of the MOHLTC, ConnexOntario, Community Care Information Management (CCIM) and the Centre for Addiction and Mental Health (CAMH).

Aggregate financial and administrative data on community MHA services (among others) is collected by MOHLTC-funded service delivery organizations and submitted to the MOHLTC based on the Ontario Healthcare Reporting Standards (OHRS). A subset of data is held in the Ontario Healthcare Financial and Statistical System (OHFS) database (an MIS data warehouse) and is available to authorized users through the Health Data branch’s IntelliHEALTH tool. The OHRS focuses on financial and statistical data and provides the “Ontario-specific standards of the Standards for Management Information Systems in Canadian Health Service Organizations (MIS Standards),” Community health care organizations that submit data include

- Community care access centres;
- Children’s treatment centres;
- Community mental health and addictions organizations;
- Community support services; and
- Community health centres.

The MOHLTC also collects aggregate clinical administrative data from publicly funded community mental health service providers, based on the Common Data Set–Mental Health (CDS-MH). The CDS-MH is specifically for community mental health services. This data set includes, for example, volumes of clients and their distribution across demographic and diagnostic groups for each OHRS functional centre.
In addition, the Ontario Common Assessment of Need (OCAN) was selected as the standardized assessment for community mental health in Ontario by the Community Mental Health Common Assessment Project steering committee. The OCAN focuses on perceived needs in multiple domains (e.g., self-care, accommodations, psychological distress), from the perspectives of clients and staff. The OCAN is required by some LHINs and has been implemented by 77% of eligible community mental health organizations. Agencies use one of several electronic vendor software systems. The OCAN is made up of 4 components (Consumer Information Summary, Mental Health Functional Centre Use, Consumer Self-Assessment and Staff Assessment), which in turn make up the following 3 data collection options:

- CORE OCAN: Consumer Information Summary and Mental Health Functional Centre Use
- CORE + Self OCAN: CORE OCAN + Consumer Self-Assessment
- Full OCAN: CORE OCAN + Consumer Self-Assessment and Staff Assessment

The consumer and staff assessments are based on the patient-rated version of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS-P) and the Camberwell Assessment of Need (CAN-C), respectively.

Health service providers can upload OCAN assessment data to the Integrated Assessment Record (IAR), a clinical viewer system that is facilitated by CCIM. Authorized users in multiple settings (e.g., community mental health, long-term care) can view clients’ assessments using the IAR. This allows assessment information to move with a client from one provider to another, facilitating care planning and delivery. Providers and LHINs have access to standardized clinical reports based on aggregate data from OCAN assessments uploaded to the IAR.

The Drug and Alcohol Treatment Information System (DATIS) is the system used to collect data on services provided by MOHLTC-funded substance abuse and problem gambling agencies. This comprehensive province-wide client information system is funded by the MOHLTC and is a program of CAMH’s Provincial System Support Program. Client demographic and service utilization data is collected. Service utilization data is grouped based on functional centres defined in the DATIS Substance Abuse Statistical Tables, 2007–2008 to 2012–2013. Statistical tables are issued annually.

DATIS also includes a suite of admission and discharge assessment tools (ADATs) and 2 Global Appraisal of Individual Needs (GAIN) assessments: GAIN-I (Initial) and GAIN-SS (Short Screener). ADATs are completed by 85% of participating organizations at initial
In 2016–2017, the ADATs will be replaced by GAIN Q3 MI (Brief Interventions and Referrals), GAIN-SS, POSIT (Problem Oriented Screening Instrument for Teenagers), MMS (Modified Mini Screen) and EPYC (Evaluation Plan for Youth Care). The use of GAIN tools was mandated by the MOHLTC in October 2015 for agencies funded to provide addiction and problem gambling services. Implementation of GAIN tools has been proceeding using a staged approach across LHINs.

ConnexOntario houses and maintains 3 databases of MHA service organizations (Mental Health, Drug and Alcohol, Problem Gambling) and operates 3 helplines (among other services and initiatives) to connect individuals seeking help to appropriate services. ConnexOntario is financially supported by the MOHLTC.59

Information and referral specialists at ConnexOntario provide information (service location, access, anticipated wait times) on services offered by MOHLTC-funded MHA agencies. These specialists provide central intake and coordinated access to services, referring individuals to the appropriate service provider based on information contained in each database. Individuals can access an information and referral specialist by phone, email, webchat or mobile phone app.60

### Regular reporting and uses

<table>
<thead>
<tr>
<th>Data source</th>
<th>Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHRS</td>
<td>Data is submitted to the MOHLTC quarterly for the second and third quarters and at year end. Reports on various indicators of community MHA services (e.g., Total Full-Time Equivalents, Number of Face-to-Face Community Visits) are generated based on OHRS data.</td>
</tr>
<tr>
<td>CDS-MH</td>
<td>Data is submitted to the MOHLTC semi-annually using a web-based tool.51</td>
</tr>
<tr>
<td>OCAN</td>
<td>Standardized reports are available to participating organizations and LHINs.52, 54</td>
</tr>
<tr>
<td>DATIS</td>
<td>Data is submitted to the MOHLTC and LHINs quarterly with real-time local collection.</td>
</tr>
<tr>
<td>ConnexOntario</td>
<td>Information is continually updated in the ConnexOntario database using validated information from participating organizations. Reports are available on demographic and geographic trends of requestors, as is tracking of referral patterns.60</td>
</tr>
</tbody>
</table>

Ontario contributes province-level data on publicly funded substance use treatment services to the annual National Treatment Indicators reports published by the CCSA.27
Data initiatives

2 data-related projects were supported through 2016 by the Drug Treatment Funding Program (DTFP), which is a contribution program under Health Canada’s Anti-Drug Strategy Initiatives Program:61

- Improving Reporting Compliance and Data Quality Among Ontario’s Addiction Treatment Agencies
  - This project aims to improve the quality of data entered into DATIS by Ontario addiction agencies through training modules and materials that cover reporting requirements and procedures, records management and protection of personal health information.

- Development and Standardization of Cost-Based Performance Indicators (the Costing Project)
  - This project aims to continue to improve the quality of OHRS reporting related to the cost of addiction treatment in order to improve the reliability and validity of indicators available through Ontario’s Health Indicator Tool. This project includes the development and evaluation of a standardized set of cost-based indicators for addiction services.

Additionally, the following DTFP projects deal with screening and assessment tools:

- EPYC
- Implementation of a New Staged Screening and Assessment Process for Addictions
- Implementation of Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA)
- Trauma-Informed Substance Use Screening and Assessment Tools for First Nations and Inuit Peoples

Information about these and other DTFP projects is available through the Evidence Exchange Network.

DATIS is expanding to include a database for harm reduction services that will be available to service providers in April 2017. Harm reduction services data will include information on needle exchange, HIV and hepatitis services provided by Ontario public health units and their subcontractors. DATIS is also undergoing software restructuring to align with SNOMED standards, to obtain single sign-on capability with eHealth and to allow for self-serve, real-time reporting.

Further, from a systems perspective, a task group in Ontario is developing and implementing indicators that can be “standardized across hospitals and community-based mental health and addictions organizations, and can provide high quality, comparable data.”62
Ontario’s Mental Health and Addictions Leadership Advisory Council, in partnership with Addictions and Mental Health Ontario, the Ontario Division of the Canadian Mental Health Association, CAMH, the Institute for Clinical Evaluative Sciences and the MOHLTC’s Mental Health and Addictions branch, has been developing a new data and performance measurement framework for the province. The purpose of this work is to create a high-performing MHA system through a standardized, province-wide system of evidence-based performance measurement for the MHA sector.

To complete this work, a Data and Performance Measurement Task Group composed of health, policy and performance measurement experts, as well as leaders in mental health and addictions, was tasked with developing the new framework in 2015. The task group developed a logic model and a scorecard of performance indicators to establish a common understanding of performance measurement and to provide high-quality, comparable data; both the logic model and indicators were approved by the Mental Health and Addictions Leadership Advisory Council and released in 2016. The Data and Performance Measurement Strategy is currently in development and will outline the plan to create the high-performing system envisioned for Ontario.

**Manitoba**

**Data and data management**

Manitoba Health, Seniors and Active Living (MHSAL) is responsible for overseeing provincial policy, planning and funding related to community mental health services in Manitoba, through the Mental Health and Spiritual Health Care branch. Community mental health services are delivered by RHAs and mental health agencies. The Addictions Policy and Support branch of MHSAL funds community-based addiction services and provides policy direction related to problematic substance use and gambling. The content of this section was informed by interviews with representatives of the Mental Health and Spiritual Health Care branch and the Addictions Policy and Support branch of MHSAL.

The main community mental health database in Manitoba is the Mental Health Management Information System (MHMIS). This database was created in 1990 as a central repository for data from the RHAs on the community mental health services that they deliver. MHMIS also includes some data on inpatient psychiatric services provided at Eden Mental Health Centre. The Winnipeg Regional Health Authority (WRHA) does not enter data directly into MHMIS. WRHA enters data into its Mental Health Information Database (MHID) and transfers a set of required data to MHSAL.
Mental health services data from the following providers is not included in MHMIS: acute care facilities, the Manitoba Adolescent Treatment Centre, the Selkirk Mental Health Centre, psychogeriatric programs, grant-funded community agencies and services reported through physician billing claims.63

The MHMIS is maintained and managed by the Information Management and Analytics branch in MHSAL. The Manitoba Centre for Health Policy (MCHP) receives an annual data cut of the MHMIS and acts as a data steward. Researchers may apply to the MCHP for access to MHMIS data.63

The MHMIS contains case management information for Manitoba residents who receive community mental health clinical, social or rehabilitative services. These services include psychosocial counselling/therapy, psychosocial rehabilitation, physical rehabilitation and medication therapy. The data is structured into sections including client, case and encounter/consultation data. MHMIS includes data on demographic characteristics, client identifiers, service provider types, service events, diagnoses, referrals and legal status.

Community-based addiction services are administered and reported on separately from community mental health services. The Addictions Policy and Support branch of MHSAL receives information from 16 addiction agencies that receive financial support through provincial grants, including the Addictions Foundation of Manitoba (AFM). AFM is a Crown agency that provides a range of addiction services through 26 locations across the province.64 The agencies vary in terms of their data collection systems. Some agencies have an electronic records management system; others use Excel or paper for record-keeping. The variation in data collection processes poses challenges for assessing the reliability of the data. The agencies also vary in the assessment tools they use for addictions clients. 5 agencies use the Substance Abuse Subtle Screening Inventory (SASSI). The SASSI is used to screen for substance use disorders. Some of the concepts examined are the client’s level of defensiveness and willingness to acknowledge experienced consequences of substance use disorder.65

All 16 agencies submit aggregate information on clients and services to the Addictions Policy and Support branch. This aggregate information includes the number of clients in various groups, such as those defined by demographic characteristics (e.g., region of residence, Aboriginal status); type of substance use; referral source; income status; program completion; and primary substance for which treatment was sought. AFM collects data about its clients and services, and provides an annual statistical report to the Addictions Policy and Support branch of MHSAL. AFM also conducts quarterly reporting on admissions and discharges from all of its programs.
Regular reporting and uses

MHSAL, RHAs and Eden Mental Health Centre may independently produce reports from MHMIS for their information needs. The Addictions Policy and Support branch produces reports for government use. At the service level, data on addiction services is used for tracking and research purposes. The Addictions Policy and Support branch also contributes information to the annual National Treatment Indicators reports published by the CCSA.27

Data initiatives

One of the goals of the provincial mental health strategic plan, Rising to the Challenge, is to undertake a process to identify data and structures required both to measure key mental health outcomes and to support decision-making and planning related to mental health and mental illness in Manitoba.3

Saskatchewan

Data and data management

The Ministry of Health is responsible for publicly funded MHA treatment services in Saskatchewan. These services are delivered through 12 RHAs, a unique RHA (Athabasca Health Authority) in northern Saskatchewan and community-based organizations (CBOs). The main database for mental health services is the Mental Health Information System (MHIS). Data on community-based addiction services is held separately in the Alcohol, Drug and Gambling (ADG) system. The content of this section was informed by consultation with representatives of the Ministry of Health.

11 of the 13 RHAs use the MHIS to collect data on the mental health services they provide. Data collected on mental health services by RHAs that do not use the MHIS is integrated into the MHIS on an annual basis. MHIS data resides on a server maintained by eHealth Saskatchewan.66 Services operated by CBOs funded by RHAs are not represented in the MHIS. The MHIS includes demographic data, client identifiers, service providers and types, service events, diagnoses, referral sources and status at time of referral (voluntary/involuntary).66

The ADG system is used by providers of publicly funded alcohol, drug and gambling services to collect admission and discharge information. The ADG system includes demographic data, client identifiers, service providers, service types and referral information. In the ADG system, detailed substance use information is collected for clients of alcohol and drug services only, whereas gambling problem information is collected for clients of gambling services.67,68
The Saskatoon Health Region does not use the ADG system but provides the information that the Ministry of Health requires on an annual and ad hoc basis. CBOs funded by the Ministry of Health and RHAs to provide alcohol and drug treatment services also use the ADG system.

Mental health service providers in the RHAs use 2 standardized assessment tools. The Screening Tool is used to collect information on clients’ presenting problems, coping, suicidal thoughts and other items important to a client’s admission. This tool assists in triaging clients by severity level, supports decision-making for assignment to a specific clinical area and guides the development of service plans for clients. The Primary Assessment Tool is used to collect client history, clinical information (e.g., mental and general medical disorders) and information about the client’s psychosocial and environmental problems (e.g., housing). The Primary Assessment Tool is used to develop a treatment plan in partnership with the client. Some CBOs that provide alcohol and drug residential treatment (funded by the Ministry of Health) have adopted these as standard tools as well.

**Regular reporting and uses**

The Community Care branch of the Ministry of Health produces a Community Program Profile report on an annual basis. The Community Program Profile includes sections highlighting MHA services data across the province. Examples of statistics that are produced using the MHIS are number of active clients and rate of registrations by RHA. The report includes statistics based on the ADG system, such as admissions to outpatient services by RHA and gender demographics for alcohol and drug service clients. The Community Program Profile also includes information about performance on wait times relative to benchmarks.

The Ministry of Health contributes data on publicly funded substance use treatment services to the annual National Treatment Indicators reports published by the CCSA.

**Data initiatives**

The Ministry of Health, in collaboration with the RHAs, developed wait time benchmark targets for adults and youth who access outpatient MHA services, with a goal of decreasing wait times for MHA treatments, services and supports. Benchmark targets for wait times for outpatient MHA services have been established for 4 triage levels: very severe, severe, moderate and mild. Health regions are implementing strategies to ensure benchmark targets are met. Wait time reporting began on April 1, 2013. Benchmark targets for wait times for psychiatrists have also been established. Wait time reporting supports the measurement of progress toward increased access to quality MHA services.
The Ministry of Health has begun implementing the Level of Care Utilization System (LOCUS), an electronic system for care needs of individuals, in 3 test sites. LOCUS and the version for children and adolescents (CALOCUS) are being piloted to guide matching of client needs to services available and to promote a stepped care approach to services. The Ministry of Health completed a privacy impact assessment in 2014–2015. These activities support future work toward an integrated information system for MHA services.

Alberta

Data and data management

Alberta Health Services (AHS) is the single health authority providing publicly funded care in Alberta and is accountable to the Minister of Health of the Government of Alberta. AHS is divided into 5 geographic AHS delivery zones (North, Edmonton, Central, Calgary and South) that facilitate local decision-making. The content of this section was informed by consultation with representatives of AHS.

Community mental health data in Alberta is not centralized; data is collected by many information systems across the province, and each delivery zone may have multiple systems. Province-wide AHS reports on community mental health are based on data extracted ad hoc from local information systems. Historically, many community clinics have been using the Alberta Regional Mental Health Information System (ARMHIS) to capture client contacts with them. ARMHIS includes information on client demographics, presenting problem, program enrolment and services received.

For community addiction services, 2 databases are in place. The Addiction System for Information and Service Tracking (ASIST) captures data on services provided directly by AHS; data for AHS-contracted services is captured in the Service Tracking and Outcome Reporting System (STORS). ASIST and STORS include information on client demographics, substance use and treatment. They allow for tracking client movement through community addiction services. Treatment settings include residential treatment (excluding hospitals), non-residential treatment (outpatient clinics) and residential withdrawal management (detox centres). For community MHA services, information systems used to track services are changing as services evolve. A listing of programs, services and initiatives was prepared as part of a 2013 gap analysis of public MHA programs in Alberta. This information is now housed in a database of services, programs and initiatives.
The Health of the Nation Outcome Scales (HoNOS) and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) are instruments used by clinicians to rate problem severity in clients living with addictions and mental health issues. The HoNOS is a set of 12 scales that cover a “wide range of health and social domains — psychiatric symptoms, physical health, functioning, relationships and housing.” The HoNOSCA is composed of 15 scales and is used for children and adolescents.

As of 2016, the HoNOS and HoNOSCA tools were fully implemented in the Calgary and Edmonton zones and partially implemented in the North and South zones. HoNOS and HoNOSCA data is entered into different data systems across the province, however, primarily into the HoNOS Data System. Data can be used to provide a profile of clients’ problem severity when entering a service and to assess the effectiveness of services.

**Regular reporting and uses**

AHS provides an annual System Level Performance Report for Addictions and Mental Health. The report covers a broad range of areas such as service utilization, wait times, client satisfaction, continuity of care and clinical outcomes. It provides information about the current state of the system in a given year, and helps with observing and monitoring changes over time. This allows for evaluation of the overall performance of the system.

In addition, AHS performs monthly calculations of an indicator of access to children’s mental health services. The indicator measures the percentage of children (younger than age 18) enrolled in programs at community mental health clinics who had face-to-face contact within 30 days of being referred. The indicator is calculated at the provincial and zone levels using 3 data sources: ARMHIS, an electronic vendor software system (Meditech) and the Regional Access Information System. This indicator is a part of AHS’s Quarterly Performance Reports.

Finally, the data from the information systems for addiction (ASIST and STORS) is used for annual province-level reporting and is also included in the annual National Treatment Indicators reports published by the CCSA.

**Data initiatives**

AHS Addiction and Mental Health (AMH) has developed an AMH information technology (IT) long-term plan. This plan identified future IT initiatives that are important to achieving AMH priorities through enhanced information flow that provides clinicians with timely access to comprehensive information, facilitating the transition of clients to community services.
British Columbia

Data and data management

2 provincial ministries are responsible for community-based mental health and substance use (CMHSU) services in B.C.: the Ministry of Health and the Ministry of Children and Family Development (MCFD). Services funded by the Ministry of Health are managed by 5 RHAs and the Provincial Health Services Authority (PHSA). The Ministry of Health is responsible for mental health services for adults and substance use services for people of all ages. The Ministry of Health also provides some community-based mental health services to children and youth, primarily through outpatient resources and some programming for youth and young adults (e.g., Early Psychosis Intervention) as well as most tertiary child and youth mental health services. The MCFD provides community-based mental health services to children and their families and is also responsible for some tertiary services for children and youth (e.g., youth forensics, an adolescent treatment facility). The content for this section of the report was informed by consultation with representatives of the Ministry of Health and the PHSA.

The Ministry of Health has an information system called the Mental Health and Substance Use Minimum Reporting Requirements, also referred to as the MHA MRR. The 5 RHAs are mandated to collect and submit data to the ministry for CMHSU services that they deliver. The RHAs also maintain their own information systems to manage programs and services.

The MHA MRR includes administrative, client, service, substance use and diagnostic information. It includes standardized assessment through the HoNOS. As mentioned above, the HoNOS is a set of 12 scales that cover a wide range of health and social domains. The HoNOS has been implemented in all health authorities in B.C. However, the extent to which it is used varies among regions.

The Ministry of Health has mandated MHA MRR data collection for a wide range of services. However, the level (i.e., detail) of mandated reporting varies among service types. For example, collection of the HoNOS assessment is not required for service types such as substance use outreach and community crisis response.

The MHA MRR system does not currently include data on
- Specialized, province-wide programs provided by the PHSA (e.g., forensic services);
- Services provided through the MCFD; and
- Services delivered by providers under contract with an RHA. A substantial proportion of substance use services (funded by the Ministry of Health) are contracted out.
The PHSA maintains its own information system about the services it provides. The system is based on an electronic vendor software system (Cerner). The PHSA operates several agencies that provide province-wide health care services, including B.C. Mental Health and Substance Use Services (BCMHSUS). BCMHSUS provides a range of specialized mental health services, including forensic psychiatric services for adults. The PHSA information system is used to collect data on community-based mental health services, including

- Forensic services provided through community clinics;
- Day treatment at the Eating Disorders Program for Children and Adolescents; and
- Outpatient mental health and substance use services of the B.C. Children’s Hospital and the B.C. Women's Hospital and Health Centre.

All services operated through the PHSA must perform client registration through the electronic system. Administrative and demographic data elements are collected. The system does not accommodate all fields that exist in the MHA MRR that was developed by the Ministry of Health. PHSA data on community-based MHA services is not submitted to the Ministry of Health.

**Regular reporting and uses**

The Ministry of Health releases health indicators and targets in its annual service plan reports. These are broad-based indicators for the entire health system. The 2015–2016 annual service plan report included a performance measure of community mental health services, which was the percentage of people admitted to hospital for mental health and substance use who were readmitted within 30 days.

The Ministry of Health does not report publicly on community mental health and substance use services. However, it does conduct regular internal reporting on service availability across the province for specific community-based services. Information for this type of reporting is from sources other than the MHA MRR.

The PHSA uses its information system to generate reports for internal use. These reports examine service utilization and client characteristics (e.g., age group, region of residence).

**Data initiatives**

The Ministry of Health continues to enhance the MHA MRR system, with the intent that it will include data on inpatient and forensic services and CMHSU services provided by agencies contracted with an RHA.

The PHSA is implementing a new clinical information system that is intended to capture all data elements of the MHA MRR.
Yukon

Data and data management

In Yukon, community MHA services are the responsibility of the Department of Health and Social Services (DHSS). Mental Health Services is under the Health Services branch and Alcohol and Drug Services (ADS) is under the Social Services branch. The content of this section was informed by consultation with representatives of the DHSS.

Mental Health client information (demographic and clinical) is housed in an EHR system within the DHSS. Providers who submit data include psychiatrists, clinicians, nurses, support workers, speech–language pathologists and psychologists. Summary reports can be generated to examine the number of referrals, clinical hours and clients served. The HoNOS and HoNOSCA assessment tools are used, and results are captured in the EHR system.

Services provided by ADS are not captured in the EHR system. ADS counsellors and nursing staff collect data and prepare summary information on a number of areas (i.e., inpatient, outpatient, withdrawal management). Diagnosis information is not typically collected. Steps have been taken to standardize information received and improve data collection. Staff, including community addiction workers, use various assessment tools to assist in planning treatment and assessing outcomes. These tools include the Alcohol Withdrawal Assessment (CIWA-Ar), Outcome Questionnaire-45 (OQ-45), Psychiatric Diagnostic Screening Questionnaire (PDSQ), Beck Depression Scale and GAIN-SS instruments.

Regular reporting and uses

Although the Yukon government has developed initial indicators for its health and social services, these do not include indicators related to community MHA services. The recent report Yukon Government Health and Social Services Performance Measure Framework, 2014–2019 does, however, identify potential future indicators in this area.86

The Yukon government provides information for the annual National Treatment Indicators reports published by the CCSA.27

Data initiatives

The DHSS is exploring Ontario’s DATIS system to determine its applicability for community MHA services in Yukon. DATIS is described in the Ontario section of this report.
Northwest Territories

Data and data management

In the Northwest Territories, community MHA services are the responsibility of the Department of Health and Social Services (DHSS). An integrated service delivery model is favoured, underscored by a population health approach to this and other areas of health care.\textsuperscript{82} The content of this section was informed by consultation with a representative of the DHSS.

Health authorities submit aggregate information in Excel format to the DHSS regarding community MHA services. Although data has been consistently submitted since April 2015, some concerns with data quality remain. At the local level, clinical information is not maintained in electronic form. Data is collected in 9 key areas, including services provided, client demographics, presenting concerns (both primary and secondary concerns), clinical supervision, referrals, wait list times and Community Counselling Program (CCP) staffing levels.

Regular reporting and uses

Information received from the health authorities is compiled and provided to senior management at both the health authority and DHSS for planning purposes. These reports include utilization rates, staffing and presenting issues at the regional level; they are used for program planning and development (e.g., informing the development of staff competencies and professional development opportunities). Community and regional reports are circulated to health authorities monthly, while territorial reports are released quarterly.

Data initiatives

Although no data holdings currently exist to store mental health and/or addiction services information, the DHSS is seeking to implement an MHA information management system. Such a system would be used by all CCPs for mental health and addiction information.\textsuperscript{1}

As part of its Updated Action Plan for Addictions and Mental Health, the government has identified the following objectives:

- “Establish and maintain data collection and reporting systems around mental health and addictions.”\textsuperscript{1}
- “Regularly report data and outcomes from HSS Authorities and community partners to ensure program effectiveness.”\textsuperscript{1}
Surveys to help inform planning have been completed. These include the Northwest Territories Community Survey, which covers alcohol use and heavy drinking,83 and a CCP Client Satisfaction survey.84

With respect to standardized assessment tools, staff training has been provided for use of the GAIN-SS tool, along with a series of other evidence-based assessment tools that practitioners may choose from depending on client needs. The GAIN-SS is a brief instrument designed to screen general populations of both adults and adolescents for possible internalizing or externalizing psychiatric disorders, substance use disorders, or crime and violence problems. The GAIN-SS comprises 4 subscreeners (5 to 7 items each): the Internalizing Disorder Screener, the Externalizing Disorder Screener, the Substance Disorder Screener and the Crime and Violence Screener.85

**Nunavut**

**Data and data management**

The Department of Health funds and manages community-based mental health services in Nunavut. Specialized addiction services are not available in Nunavut; however, the Department of Health provides funding for some residents to travel to Ontario, Manitoba and the Northwest Territories for services. The content of this section was based on consultation with a representative of the Department of Health.

The Department of Health has a database for mental health services in the Iqaluit area that are provided by the Qikiqtani General Hospital, the Akausisarvik Mental Health Treatment Centre and a community-based clinic. Both inpatient and community-based services are included in the database. An electronic vendor software system is used to collect clients’ demographic information, their reason for visiting and other data. Assessment data, based on questions developed by the mental health program area of the Department of Health, is also collected via the electronic system. Diagnosis information is not always included, as a psychiatrist is available on a visiting basis only. For the 3 facilities mentioned above, there is also a flow of referral information from the providers to a central intake worker at the Department of Health. Outside of Iqaluit, 3 other communities have started using the electronic vendor software system for electronic data collection. The Department of Health receives community mental health service data from those communities on an occasional basis.
Regular reporting and uses

The data described above for services provided in Iqaluit is used for internal reporting within the Department of Health. For example, reports examine the distribution of clients based on characteristics such as age, gender and reason for referral. This reporting is based on data collected through the electronic vendor software system and referral information.

Data initiatives

Implementation of an electronic vendor software system continues, with the goal of expanding to the 12 out of 25 communities that have adequate internet access. Increased use of electronic data collection is expected to facilitate more communication and greater consistency of information. The Department of Health has also identified hiring and retention of mental health nurses as a priority, with a goal of having a permanent nurse in each community. In recent years, the small number of nurses and high turnover have hindered effective and consistent communication between service providers and the Department of Health.

Summary of the current state in the provinces and territories

For this report, representatives of each province and territory were consulted regarding the community MHA data, information systems, standards and initiatives in their respective jurisdictions.

In several provinces and territories, there is variation within the jurisdiction in terms of the data collected. For example, various assessment tools are sometimes in place. Even where guidelines or standards are in place, there are some regional variations in data quality. Several jurisdictions reported ongoing efforts to improve data quality, such as to improve accuracy during data collection and to increase the proportion of service providers that report to the system.

There is some momentum in Canada toward province-/territory-wide implementation of validated, standardized assessments. In 4 jurisdictions (Alberta, B.C., Yukon, Nunavut), the HoNOS has been implemented or is being rolled out for community mental health services. In Alberta and B.C., the HoNOS is also used for community addiction services clients. In Newfoundland and Labrador, there is some use of the interRAI CMH assessment. In Ontario, the OCAN assessment has been implemented by most Ontario community mental health agencies, and the GAIN has been mandated for agencies funded to provide addiction and problem gambling services.
The consultation also revealed that few jurisdictions have a system that is integrated across community mental health and community-based addiction services. 11 out of 13 provinces and territories have at least one system that is centralized at the department/ministry of health (or a province-level custodian) and that receives client-level information. However, only 4 provinces have such a system that includes both community mental health and community-based addiction services data: Newfoundland and Labrador, P.E.I., New Brunswick and B.C.

The provincial and territorial representatives who provided information for this report were able to comment on the types of providers that report to each information system, but none provided an estimate of the coverage — that is, the percentage of services for which data is reported as compared with the percentage of services for which data is not reported. Some of the common reasons for providers not reporting were that

- Contracted providers do not have their services represented in the database because such reporting is not mandated;
- Some organizations have a funding agreement (e.g., block funding) that does not entail detailed reporting; or
- Data is collected and stored locally, and in some cases is not in electronic form.

Although the coverage of the existing data systems could not be estimated, it seems reasonable to infer that the data gaps are considerable.

**CIHI data holdings**

CIHI maintains a number of data holdings that include information relevant to MHA services. For an overview of CIHI data sources and the MHA data that they contain, please see CIHI’s *Mental Health and Addictions Data and Information Guide*.87 Data sources that are described in Table 1 are of particular relevance to community MHA services. Data availability and jurisdictional coverage for all data holdings can be found on CIHI’s [Data Holdings web page](#).
### Table 1  CIHI data sources relevant to community MHA information

<table>
<thead>
<tr>
<th>Data holding</th>
<th>Description</th>
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<tr>
<td><strong>Home Care Reporting System (HCRS)</strong></td>
<td>HCRS is a longitudinal database maintained at CIHI that captures clinical, demographic and administrative information on clients receiving publicly funded home care services (see the <a href="#">HCRS Metadata web page</a> for more information). HCRS data may be used to examine mental health issues among community-dwelling individuals.</td>
</tr>
<tr>
<td><strong>Canadian MIS Database (CMDB)</strong></td>
<td>The CMDB includes organization-level financial and statistical information about health care services (see the <a href="#">CMDB Metadata web page</a> for more information). This database can be used to examine expenses for MHA services in hospital (inpatient and ambulatory) and community settings.</td>
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<tr>
<td><strong>National Prescription Drug Utilization Information System (NPDUIS) Database</strong></td>
<td>The NPDUIS Database contains prescription claims-level data, collected from publicly financed drug benefit programs in Canada (see the <a href="#">NPDUIS Metadata web page</a> for more information). The database also contains supporting contextual information for drug claims data, including drug product information. This database may be used to study utilization patterns of drugs used in the treatment of mental health issues (e.g., antipsychotics, anxiolytics, antidepressants).</td>
</tr>
<tr>
<td><strong>Health Workforce Database (HWDB)</strong></td>
<td>The HWDB contains information on groups of health care professionals in Canada (see the <a href="#">HWDB Metadata web page</a> for more information). The HWDB includes information on the education, supply, distribution and/or employment characteristics of health professionals. Occupational therapists, psychologists, registered psychiatric nurses and social workers, who provide services to individuals living with mental illness and addictions, are included in this database.</td>
</tr>
<tr>
<td><strong>National Ambulatory Care Reporting System (NACRS)</strong></td>
<td>NACRS contains data for hospital-based and community-based ambulatory care (see the <a href="#">NACRS Metadata web page</a> for more information). For example, facilities may submit data from specialty MHA clinics. In 2015–2016, Alberta was the sole jurisdiction that contributed data on this type of ambulatory care.</td>
</tr>
<tr>
<td><strong>National Physician Database (NPDB)</strong></td>
<td>The NPDB provides information on socio-demographic, payment and service utilization data of physicians (see the <a href="#">NPDB Metadata web page</a> for more information). The NPDB contains information about physician specialty, including psychiatry. One of the service types reported in NPDB data is “psychotherapy and counselling.” Service utilization data, by age group and sex, is also available.</td>
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</table>
Momentum toward Mental Health indicators

Over time, MHA indicators and other measures (e.g., cost of service provision) have gained traction as ways to monitor health system performance in important areas such as service delivery and outcomes of care. As noted in the jurisdiction-specific sections above, governments are monitoring indicators that are mapped to their strategic priorities for health system improvement and population health. A key domain of interest is access to services; 4 provinces are monitoring wait times for specific services. However, with limited availability of standardized and comparable community MHA data, the ability to provide meaningful pan-Canadian performance measurement within the community MHA sector remains limited.

According to a report by the MHCC, *Overview of Mental Health Data in Canada*, “at the national level, there is a variety of mental health–related information initiatives, and yet Canada still lacks a comprehensive set of mental health data to answer important questions about elements of mental health such as community mental health and serious mental illness.” As noted in the Mental Health Strategy for Canada, “agreement on a comprehensive set of indicators would allow each jurisdiction to measure its progress in transforming the system and improving outcomes over time.”

Following the release of the Mental Health Strategy for Canada in 2012, the MHCC led an initiative called Informing the Future: Mental Health Indicators for Canada. The report *Informing the Future* contains the first-ever national-level set of indicators, anchored in the Mental Health Strategy for Canada, that reports on the mental health of Canadians. In 2015, the MHCC, along with its collaborators, published 55 indicators on mental health in different settings and aspects of services and supports used by people living with mental health problems and illnesses.

These indicators cover a broad range of topics, providing information on access and treatment, caregiving, diversity, economic prosperity, housing and homelessness, population well-being, recovery, stigma and discrimination, and suicide. Several indicators of particular relevance to community MHA services are highlighted in the following figure. *Informing the Future* outlines Canada’s performance on each of these indicators to highlight successes and identify areas of improvement. The initiative aims to inform and promote discussion about how to improve mental health policy and practice.
Another key initiative in Canada is specific to reporting on publicly funded, specialized treatment services for substance use, through the National Treatment Indicators project. 5 National Treatment Indicators reports have been released annually that provide a multi-jurisdictional picture of treatment system use, through aggregate data collected according to a set of common indicators. For the report on the 2013–2014 data year, 7 provinces, 1 territory, 1 federal association and 1 provincial association contributed information. The National Treatment Indicators working group was formed in 2009 with representation from provinces, territories and federal departments. The working group is coordinated and supported by the CCSA with funding from Health Canada. The most recent report included information such as the volumes of clients for various service categories (e.g., residential treatment) and the distribution of clients across various groups (e.g., age groups). The report also
highlights some limitations of the data collected and the information systems in participating jurisdictions. The working group continues to work toward inclusion of other jurisdictions and associations in the report, as well as enhanced data collection and indicator reporting.

As provinces and territories continue their efforts to develop or enhance data collection and information systems, possibilities for monitoring health system performance within the community sector (and across the continuum of care) are expanding. Regardless of stage of development or implementation, all jurisdictions are actively working to develop or improve systems, tools and processes to obtain better information, with a view to delivering better care for clients. Additionally, several provinces are in the process of defining or redefining appropriate measures to assess system performance at multiple levels, including the regional and provincial/territorial levels. Given this evolution, the timing is optimal to decide on a minimum data set for community MHA that would serve to populate a pan-Canadian set of indicators that complements and leverages the measures and data collection already in place.

Moving forward, CIHI aims to engage with provinces and territories to guide the development of a minimum data set and indicators for community MHA, setting a foundation for meaningful, comparable reporting across community sectors and across the continuum of mental health and addiction care in Canada.

Discussion

This report summarizes the state of data and information on community MHA services in jurisdictions across Canada. Throughout, investigations have demonstrated that data on this sector is varied in content and quality, and is sometimes limited to basic administrative elements used, for example, for billing purposes.

There are examples across the country of the implementation and systematic use of assessments designed for the community MHA sector. There remain, however, many gaps in terms of data and data standards that would form the basis of evidence to guide progress. This question of data coverage will be particularly significant for certain jurisdictions and at-risk populations, such as people who are homeless and those living in remote regions. A concerted effort to identify and fill data and information gaps with standardized, sector-relevant assessment instruments will be a fundamental step in establishing an information and evidence base for community MHA services.

In light of existing limitations and the significant challenge of establishing more comprehensive data coverage, an important intermediary step is to investigate the leveraging of current data resources to address even basic questions, such as who gets access to services and who does not. An example may be taken from the hospital sector, where comparative evaluations based on basic indicators of performance and quality of care cover a number of areas and are fundamental to informing efforts at quality improvement.
As the report suggests, it is reasonable to expect that the data and information available on community MHA services will continue to be diverse, in light of the many different types of services available across the various jurisdictions. Nonetheless, an investigation to determine what could constitute a minimum data set for the sector is warranted. Once determined, a minimum data set could form the basis for initial comparative analyses and could be considered a minimum requirement for new information systems.

It will be important to look beyond the sector itself and to situate information on community MHA services with information on hospitalization, primary care, prescription drugs, etc., to better understand the pathways of the individual receiving care. In this sense, thoughtful integration of existing and future data resources would allow for a more comprehensive understanding of the individual's experience of mental health and addiction care and facilitate the management of transitions across care settings. Building the capacity for the capture and storage of community MHA information within existing EHRs will be necessary to achieve such integration. Capacity-building through comprehensive education and training of front-line staff for standardized assessment and coding is also a prerequisite.

Beyond the enhancement of community MHA data through the adoption of assessments that are designed for sector-specific use, there is the question of the application of such data and how it can affect the field. Use of this data to guide clinical decisions, develop indicators of care quality and system performance, and measure resource intensity — among other applications — represents an evolution toward an evidence-informed sector, where there is an appreciation for the role of good data and its impact on service quality, efficiency and outcomes.

With guidelines that emphasize a person-centred care approach to community MHA services, it is important that the client's voice be heard and considered. To this end, assessments based on the client's report on his or her experience of care as well as his or her care outcomes should be part of a comprehensive approach to data.

As recognition grows for the prominent role of community MHA services in the spectrum of care for people with mental health and addictions issues, it is anticipated that evidence based on standardized and validated assessments will be increasingly fundamental. Coupled with increasing demands to demonstrate value for money, the systematic implementation and use of sector-specific standardized assessment instruments is required to allow for in-depth monitoring and evaluation of the clinical efficacy of services and their impact on people's quality of life.
Appendix A: Definitions of community MHA service types

Residential treatment

Clients using this service type live at a treatment centre for a period of time. These services are designed to be time-limited (i.e., the centre is not intended to be permanent housing). This category does not include acute inpatient services, long-term care, continuing care or home-based care.

Transitional care

Transitional care services help clients transition from an inpatient or residential program to living in their community. These services may involve an overnight stay in a non-hospital setting.

Home-based care

Mental health or addiction services are provided in a client’s place of residence or an alternate location that best meets the needs of the client (e.g., a public meeting place).

Early detection/intervention

Programs are designed to intervene at early signs of a mental illness or an addiction, to prevent or manage disease progression and to improve outcomes. Early Psychosis Intervention programs are an example of this type of program.

Outreach

Outreach services are designed to contact and engage persons with disorders or who are at risk of disorders, and link these individuals with treatment and support systems. Delivery of the service to the client’s location is not sufficient to be counted as outreach, by this definition. Outreach as defined here does not include health promotion and prevention activities aimed at the general population. This category also does not include Assertive Community Treatment, which is represented by its own category.
Assertive Community Treatment

ACT is an intensive community mental health service providing comprehensive services for clients with serious mental illness and complex needs. For more details, see the previous description of ACT in the section Overview of community MHA services and data.

Housing support

This category includes programs for subsidized housing, rent supplements, supportive housing, supported housing and group homes. For more details, see the previous description of housing services in the section Overview of community MHA services and data.

Outpatient programs

A variety of services may be provided as part of an outpatient program, such as individual and group counselling, day programs, day hospitals and specialty clinics (e.g., for eating disorders). Services may be provided within or by a hospital and do not involve an overnight stay. Clients go to the service provider’s location. For more details, see the previous description of outpatient programs in the section Overview of community MHA services and data.

Crisis services

Crisis services assist clients experiencing crisis situations. This category includes short-stay crisis units and crisis phone lines.

Case management

Case managers link clients to other services and develop a supportive relationship with clients. Implementation varies and may include direct service provision by the case managers. For more details, see the previous description of case management in the section Overview of community MHA services and data.

Community treatment orders

CTOs are part of a client’s care plan in several provinces such as Ontario, Saskatchewan and Alberta. Similar legal mechanisms for enforcing compliance with community treatment, such as “community committal” and “certificate of leave,” have been implemented in some jurisdictions. CTOs provide a treatment and care plan for a client to receive supervision and treatment in the community rather than in an inpatient facility. A CTO outlines care specific to the client’s needs, which may include medications and visits with care providers.
CTOs are governed by provincial legislation that sets out the criteria for their use. Depending on the jurisdiction, CTOs are issued by physicians or the court system. When a client does not adhere to the outlined treatment plan, specified actions are authorized under the CTO. For example, a peace officer may be authorized to apprehend the individual and bring him or her to a physician for examination.

Shared care

In a shared care model, there is collaboration between general practitioners and psychiatrists and/or other mental health or addiction specialists. Shared care may involve general practitioners having access to psychiatrists by phone, co-location or other collaborative activities.

Telepsychiatry

This refers to electronic communication and information technologies that support psychiatric care, usually at a remote location.

Concurrent disorders

These programs are designed for clients with both a mental illness and an addiction.

Skills training

These programs support clients in learning behavioural or cognitive skills to help them manage the effects of a disorder. For example, clients may be supported in recognizing early warning signs of a relapse, and developing a personalized plan to intervene and prevent relapse. Other areas that skills training may address include coping, social interactions, relaxation and communication.

Vocational training and rehabilitation

These programs are designed to provide education, training and coping skills to support meaningful employment for people living with mental illness and/or addictions.

Consumer groups

Self-help, peer or family support groups are run by persons affected by mental illness or addictions. These groups provide support, information and education to clients and/or their families.
Respite care
These programs admit clients with mental or substance use disorders for a limited time to relieve their caregiver of caregiving responsibility.

Info lines (information and referrals)
Confidential phone lines provide information and/or referrals.

Health promotion and education
These programs promote health and educate the community, including the public, professionals and other sectors, about mental health or addiction.

This list is not intended to be exhaustive. For an excellent resource on the continuum of community MHA services in Canada, see Davis.14
## Appendix B: Implementation status of community MHA service types

### Table B1  Community mental health services, implementation status by province/territory, 2015

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### Notes
- Concurrent disorders programs are designed for clients with both a mental illness and an addiction.
- No information found using the defined search strategy.
- The above does not reflect all implemented services, only those for which information was publicly available and found through the defined search strategy.
- If a government website described programs for its residents that were located in another province or territory, these programs were counted as being implemented in both provinces/territories.
### Table B2  Community-based addiction services, implementation status by province/territory, 2015

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**Notes**

— No information found using the defined search strategy.

The above does not reflect all implemented services, only those for which information was publicly available and found through the defined search strategy.

If a government website described programs for its residents that were located in another province or territory, these programs were counted as being implemented in both provinces/territories.

ACT was defined in this report as a mental health service and is not included in this table.

Information about concurrent disorders programs is found in Table B1 and is not repeated in this table.
Appendix C: Text alternative for figure

Figure Mental Health indicators for Canada

From the indicators published by the Mental Health Commission of Canada, 5 indicators in 5 focus areas were selected as examples that are particularly relevant to community MHA services.

Employment Among People With Common Mental Health Conditions was selected as an indicator in the focus area recovery. Participation in the workforce is an important aspect of recovery and well-being among people with mental illness.

Unmet Need for Mental Health Care Among People With Mental Disorders was selected as an indicator in the focus area access and treatment. Receipt of timely mental health care can support improvement and prevent worsening of mental health problems.

Caring for a Family Member With Mental Illness was selected as an indicator in the focus area caregiving. Caregivers may experience stress associated with caregiving responsibilities. This stress has been linked to poor outcomes such as depression.

Receipt of Stress Reduction Resources in Colleges and Universities was selected as an indicator in the focus area children and youth. Emergence of mental health problems in adolescence and early adulthood makes post-secondary institutions a key setting in which to provide mental health supports.

Willingness to Seek Help From a Mental Health Professional — College and University Students was selected as an indicator in the focus area stigma. Stigma can prevent people from seeking help. A willingness to seek help increases the likelihood of early intervention and better outcomes.

The other focus areas are adults, diversity, economic prosperity, housing and homelessness, population well-being, seniors and suicide.
References


14. Davis S. *Community Mental Health in Canada: Theory, Policy, and Practice*. 2013


26. Newfoundland and Labrador Centre for Health Information. Mental Health and Addictions Programs Performance Indicators. 2015.


