Pilot Site Report: Prairie Mountain Health, Manitoba

Development of a Needs-Based Planning Model for Mental Health and Substance Use Services and Supports across Canada

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Background to the National NBP Project

1.1 Background and Need Addressed

Mental health services and supports have traditionally been funded without a comprehensive planning model to help allocate resources equitably and according to population needs (1). There is ample evidence in the Canadian context that this has contributed to a significant "treatment gap", such that the current capacity of mental health services falls far short of meeting the needs of the population (2, 3). Further, the planning and funding of mental health and substance use services remains quite siloed and hindered by the lack of a planning and resource allocation model that includes both these service delivery sectors. To support the allocation of resources, as well as future population-based performance indicators, work was needed at the national level on practical, evidence-based tools for mental health and substance use/addiction system planning.

A project aimed at improving the planning and allocation of resources for substance use and concurrent disorders services has been underway with Health Canada support from the Drug Treatment Funding Program (2010-14) and the Substance Use and Addictions Program (2016-18); the project being led by Drs. Jürgen Rehm and Brian Rush at the Centre for Addiction and Mental Health, with Co-Investigators Drs. Joel Tremblay and Daniel Vigo. Feedback during pilot work across Canadian jurisdictions as well as the project's summary evaluation report confirmed the high interest among the members of the National Advisory Committee, as well as important policy makers and planners in several Canadian jurisdictions, in expanding the work to better represent mental health services and develop a fully integrated, national mental health and substance use Needs-Based Planning model.

Importantly, during roughly the same time, a highly complementary project was funded by the BC Ministry of Health for the development of a comprehensive planning model for that province. While the goals of the two projects were very similar, different although complementary methodologies were utilized, and a collaborative process ensued between the investigators on the CAMH-led project and Dr. Daniel Vigo and his team at the University of British Columbia, supporting the respective projects through consultation and sharing of information.

This project was a continuation of this collaboration and aimed at ***the development of a national, mental health and substance use planning model that would support the development of more integrated, accessible, and effective services for all Canadians.*** The aim was to draw upon the strengths of each project through methodological and data source triangulation, as well as scale-up of the work to a national mental health and substance use planning model that would support the development of more integrated, accessible, and effective services for all Canadians.

The overall goal of the Needs-Based Planning project was to develop a quantitative model that key decision-makers in health planning jurisdictions across Canada can use to estimate the resources required to address the needs for services and supports relating to Mental Health and substance use problems in their population.

What is Need-Based Planning?

Needs-Based Planning (NBP) uses a systematic quantitative approach to planning mental health and substance use treatment and support systems. NBP estimates the required capacity of services and supports, based on needs of the whole population, and all levels of severity and complexity of those needs. A critical ingredient for NBP is an agreed upon set of "core" mental health and substance use services and supports that should be available and accessible to all those in need. The evidence-based foundation of NBP is rooted in systematic design and planning and includes these key principles[i]:

- a broad systems approach to address the full spectrum of issues
- accessibility and effectiveness through collaboration across stakeholders
- a range of system supports.

This evidence-based approach advances local planning and creates a more equitable balance of resources. It provides direction to decision-makers on their investment decisions and, when fully implemented, can reduce costs and improve access to services and client and family outcomes. It is the optimal way to use resources wisely, and to fit services to the dynamic, evolving needs of a population.

What promise does it hold?

Immediate

- increased understanding of population needs and the advantage of NBP over alternative existing approaches
- increased use of evidence-informed practices for planning and delivering services and supports
- improved decisions for optimal resource allocation for mental health and substance use/addiction services and systems

Medium to Longer term

- strengthened, evidence-informed treatment, support services and systems
- increased access to services and coverage of population needs
- improved client, family and population health outcomes

The Research

Canada has played a significant role in developing NBP models, first for substance use and addiction, and now also including a broader focus on mental health. The Canadian work has included model development and implementation for both adult[ii] and youth[iii] substance use services, as well as work based in British Columbia for (adult) mental health and substance use services. This work has built upon, and benefited significantly, from close communication with colleagues in the United Kingdom, Australia and elsewhere. Although there are differences in scope and methodology across countries, all NBP models have the same essential purpose, namely to bring a population health perspective to a quantitative, evidence-based approach to planning and resource allocation. To date the adult and youth substance use NBP models have been the most widely implemented in Canada.

Benefits of the model

The model is an overarching tool to assist in decision making and planning, prediction of resources that leads to an increase in appetite for increasing treatment resources in underfunded jurisdictions and parts of the treatment and support continuum. Embedding the tool in a National Framework encourages its use nationally.

The model is an aspirational goal. It leads to appreciation of unmet needs and highlights different elements across the continuum of care. Hence, it is not just the finished product but the process of development of the model itself that is also very helpful as it brings to light evidence- based practices and difference in opinions among planners and service providers. While the gap analysis provides an "outcome", the real value is that it provides funders with a powerful planning and prioritization tool that allows funding decisions to be made based on the evidence. The model yields examples of inequitable resource distribution, provides a common language, raises questions and issues for discussion regarding an evidence-based system and services.

Challenges of the model

Not everyone is represented in the population health data, for example, people who are homeless or institutionalized at the time of the key surveys, and a large percentage of Indigenous people. Other information must be incorporated to adjust for these data gaps.

There is no one simple formula for treatment system planning, but rather a collection of tools that can be used together to inform treatment gaps and resource allocation. A needs-based planning model is one tool that should be complemented with other information and methods.

1.2. Overview of the National NBP Project

The project involved five overlapping phases of work:

Phase I: Literature Reviews, and Establishing of the National Advisory Committee

- Re-instated and bolstered the mental health expertise of the National Advisory Committee, including a new cadre of research collaborators drawn from mental health services research groups across Canada.
- Established the workgroups of the National Advisory Committee.
- Updated literature on needs-based planning models, conceptual frameworks, comorbidity, and help-seeking for substance use/addiction to include mental health problems and illnesses.
- Undertook a national environmental scan of provincial/territorial strategic plans for mental health and addictions focusing on the status of mental health and substance use/addiction services integration, including opioid treatment services; the use of tiered service frameworks and identification of core services; and system-level, population-based performance indicators (e.g., help-seeking or level of coverage of need by existing treatment and support services).
- Developed the project performance measurement plan.

Phase II: Methods triangulation

- Reviewed, synthesized, and triangulated the methodologies and data sources used in the BC and previous national Needs-Based Planning projects.
- Derived robust population-based estimates of the numbers of people requiring mental health and substance use/addiction services in each planning region across Canada according to level of severity and need.
- Conducted a comparative analysis of prevalence and need estimates derived from the severity tiers approach based on complexity in the national project and the diagnostic-based approach in the BC project, including opioid use disorders and other 12 substance and mental disorders.
- Investigator team reviewed methodology and potential re-analysis of data, and assessment of the comorbidity and help-seeking literature covering both mental health and substance use/addiction.
- The sub-group of the National Advisory Committee focused on methodology was engaged in the review, assessment, and validation of the approach to reconcile the methodologies and results of the two approaches.

Phase III: Core services and full system modeling

- Translated the learnings from the Phase II work on the triangulation of the jointly held data with respect to substance use/addiction, to the various mental disorders covered by the BC project and the mental health-related data derived in the recently completed national SUAP- funded project.
- Developed a national consensus–based set of core mental health and substance use/addiction services (built upon the previous work of the BC and national projects).
- Drew upon extant literature and international experience with system design frameworks and evidence-based pathways for specific diagnosis and comorbidity. This involved ful engagement of the project's National Advisory Committee to ensure the outputs of the resulting planning model align well with current funding processes and national/provincial/territorial reporting requirements (e.g., functional centres and core services defined by CIHI and in provincial/territorial strategic plans).
- Integrated the information gathered in Phase I (i.e., needs-based planning, conceptual frameworks, comorbidity and help-seeking literature, evidence-based service pathways); Phase II (i.e., methods triangulation) and the above work on core service and conceptual framework to yield the full integrated mental health and substance use/addiction Needs-Based Planning model and which provides estimation of service capacity requirements (e.g., annual caseload across core services as well as capacity requirements expressed, for example, in FTEs within inter-disciplinary roles and treatment beds).
- At this stage the draft model was developed with significant input from the Working Group on Core Services and vetted through the full National Advisory Committee prior to pilot testing in the next phase of work.

Phase IV: Pilot testing and calibration

- Developed the criteria for selection of pilot sites, confirmation through the Advisory Committee and design of the pilot site protocol including local/regional context analysis and data requirements for gap analysis.
- Engaged the pilot sites, developed the required Memoranda of Understanding (MOU), and held the initial on-site meeting with key decision-makers and information specialists, followed by a period of data collection and analysis.
- Iterative pilot testing and calibration of the model from Phase III, with three pilot jurisdictions in Year Two of the project and three pilot jurisdictions in Year 3.
- Ongoing meetings with the pilot sites for discussion and interpretation of results followed by preparation of a case study report.

Phase V: Reporting and knowledge exchange (KE)

- Project reports and other KE activities.
- In addition to the Health Canada reporting requirements, other reporting includes:
    - Project Technical report with sustainability plan
    - Project Evaluation report
    - Final Case Study reports
    - Implementation manual with required statistical tool

1.3. Pilot sites involved in the project

- There were a total of six pilot sites in the project:
    - Prairie Mountain Health Authority in Manitoba
    - North Bay-Nipissing in Ontario
    - Province of New Brunswick
    - Niagara Region in Ontario
    - Province of Nova Scotia
    - North Zone in Alberta

2.0 Prairie Mountain Health Authority, Manitoba Pilot Project

The Needs-based Planning model is comprised of the following elements and steps for implementation:

Table 1: Steps involved in implementation of the NBP model

Step 1	**Engagement** - With funders and other key stakeholders
Step 2	**Establishing the geographic boundaries, social indicators and community nuances** - Gathering population data and context description of local nuances.
Step 3:	**Estimating population level of need by severity**
Step 4:	**Mapping the system by core services** – Who is currently doing what and for whom?
Step 5	**Sizing:** Estimating level of need for core services

Step 6:	**Estimating <u>current</u> core service supply and utilization** - (number of individuals, FTE's, beds)
Step 7:	**Gap analysis** - by core service category (number of individuals, FTE's, beds)
Step 8:	**Interpretation** - Implications for the gap analysis

Step 1: Engagement

Requirements of a pilot site/clarification of roles and responsibilities

- Attend project meetings/presentations, and contribute to the group discussions
- Update the working group of the ongoing activities
- Complete the baseline evaluation survey
- Provide input into project materials
- Provide any relevant documents about their services and/or evolving community context
- Provide feedback on areas of the NBP model that may require adaptations or flexibility depending on local/regional context
- Contribute to the system mapping process for their organization
- Provide required information for gap analyses according to the core services (individuals served, FTEs by categories, # beds etc.)
- Assist in interpretation of the gap analyses and implications for the treatment and support system
- Provide feedback on strengths and limitations of the Needs-based Planning process, including participation in the follow-up evaluation

Working group engagement:

Members:

- Chris Bromley, Director Health Services, Mental Health
- Jamie Tompkins, Director, Addictions Services
- Colin Williams, Decision Support Analyst
- Jody Allan, Director, Patient Safety, Quality & Planning with Prairie Mountain Health
- Lynda Stiles, Director Mental Health (Retired)
- Jennifer Kary, Admin Secretary at Mental Health Services

Initial meetings were to provide orientation to the history of the model, learnings from the past projects and orientation to the National Core Service Framework. Follow-up meetings included establishing the geographic boundaries; gathering population data and context description; mapping the system by core services – who is doing what and for whom; estimating current core service supply and utilization - (number of individuals, FTE's, beds); and processing the results of the gap analysis (comparing the current core service supply against the estimates projected by the model by core service category (number of individuals, FTE's, beds)

Limitations of the work

It was made clear to the pilot site representatives that the model had the following limitations regarding what it can or not project:

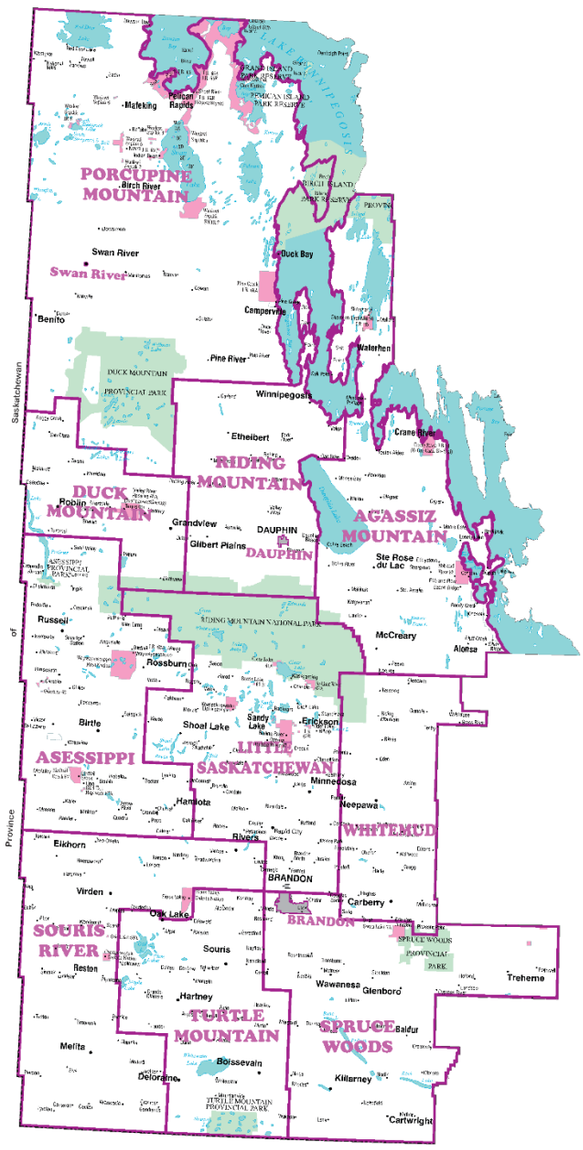
- Services targeted towards youth - model can't project needs for sub-15 aged population
- MH/SU diagnoses that were not included the 2012 Canadian Community Health Survey (CCHS) Mental Health (e.g., gambling, forensic populations)
- Core Service Platforms that fall outside of the model's scope or where there was no available data to compute a projection (e.g., Crisis Lines, Safe consumption sites)
- Collaborating Partner services that are serviced by other ministries/departments (e.g., schools, justice)
- Exclusions within the population health information – not everyone included in the underlying population health data – homeless, (process must be supplemented with other community needs assessment information homeless) First Nations on reserve, institutionalized populations
- Drilling down e.g., newcomers/refugees; rural/ remote, individual community level.
- Not a dynamic model, so it is not able to reflect individual, often complex treatment trajectories over time (e.g., natural recovery, recovery/ relapse).
- Not all local context can be taken into account

Step 2: Establishing the geographic boundaries, population, and community nuances

Geographic Boundaries: Selection of the geographic boundaries for developing the mental health and substance use service capacity requirements, which were essentially the health planning regions across the country (typically regional health authorities or planning zones of a provincial health authority or Ministry of Health).

In this case, the planning area was Prairie Mountain Health. The region covers a geographically large area, around 67,000 sq. kilometers. It runs east-west from Saskatchewan/Manitoba border communities like Benito, Elkhorn and Russell to Waterhen Lake, Lake Manitoba and Treherne. From north-south, the region runs from the 53rd parallel close to Dawson Bay right down to the United States border near communities like Melita, Deloraine, Boissevain, Killarney and Cartwright.

Figure 1: Geographic boundaries for implementation of the NBP model



Population:

- The population of Prairie Mountain Health on June 1, 2018 was 170,899, and composed of an almost exact 50:50 split between males and females. It was comprised of 40,651 or 23.8% in the North zone, 76,052 or 44.5% in the South zone and 54,196 or 31.7% in the Brandon zone[iv].
- The population of the region is around 12.9% of the Manitoba population. It is made up of 55 municipalities, which include the cities of Brandon and Dauphin[v].
- The land is defined as the traditional territories of the Cree, Dakota, Ojibway, Oji-Cree and homelands of the Metis. The region has 15 Northern Affairs community councils and 32 Hutterite colonies/communities.
- There are considerably higher proportions of residents self-reporting 'Aboriginal identity' in the North (33.6%) zone of PMH compared to the Brandon (13.7%) and South (11.6%) zones.
- Prairie Mountain Health had an immigrant population of 8.9% at the last Census (2016) evenly split between males (8.8%) and females (9.0%). This differs from the provincial value of 19.2%.
- The proportion of immigrants in the population is highest in the Brandon zone at 15.9%, less than half that in the South zone (7.2%) and very modest in the North zone (3.4%).

Income and Education

- The median household income for residents in Prairie Mountain Health was $50,888 as compared with $57,299 in the province.
- More than a quarter of residents do not have a high school diploma. Lower levels of education pose many challenges for residents in making healthy life choices and accessing health care as well as for service providers in delivering care.

Prevalence of mental health and substance use problems

- The prevalence of mood and anxiety disorders amongst Prairie Mountain Health adults is significantly higher than the provincial average and the highest in the province. More than 34,000 residents live with a mood and anxiety disorder. All five districts in the Brandon zone and three districts in the North zone have significantly higher prevalence that the provincial average, whilst six districts have significantly lower prevalence.[vi]
- The prevalence of Prairie Mountain Health adults living with a substance use disorder is significantly higher than the provincial average, with almost half of the districts significantly higher than Manitoba overall.

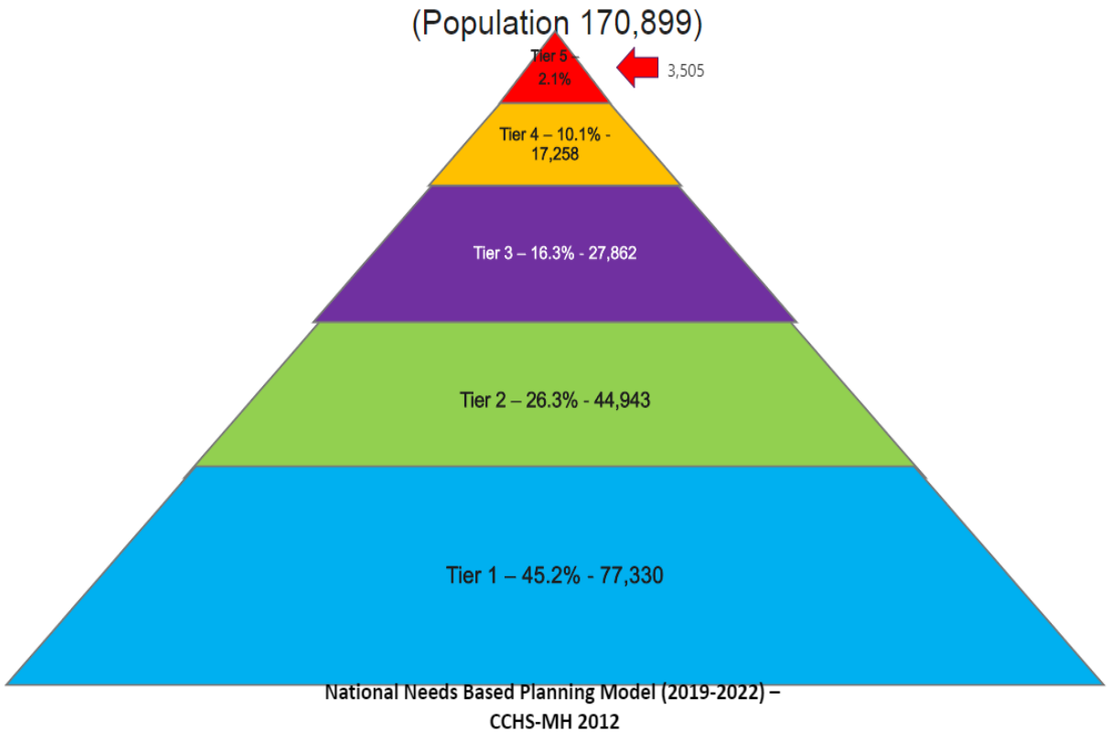
Step 3: Estimating level of need

Figure 2 shows the results of the analysis of the mental health and substance use severity population pyramid for the Prairie Mountain Health area.

Combining tiers 2-5 (Tier 2 – 26.3%, Tier 3 – 16.3%, Tier 4 – 10.1% and Tier 5 – 2.1%), a total of 54.8% of the population are at some level of risk and need for mental health and substance use services – a large majority in Tier 2 where these needs can perhaps be met with relatively brief and low intensity advice and consultation. While a comparatively small percentage of the area's population are classified in the upper Tiers 4 and 5 (10.1% and 2.1% respectively), together they represent a considerably large number of people with significant and complex needs, including the need for integrated/collaborative mental health and/or primary health services for those with concurrent mental illnesses and other health issues.

It is important to keep in mind that these data will under-represent the overall level of need for mental health and substance use services, given the exclusion criteria for the Canadian Community Mental Health population survey (e.g., Indigenous populations on reserve, homeless, institutionalized). Although excluded from the survey population, they are somewhat represented in the population pyramid below since they are included in the region's population statistics. Although represented in absolute numbers, their level of need will, however, be under-estimated because the unique population pyramids for these populations could not be estimated with existing data.

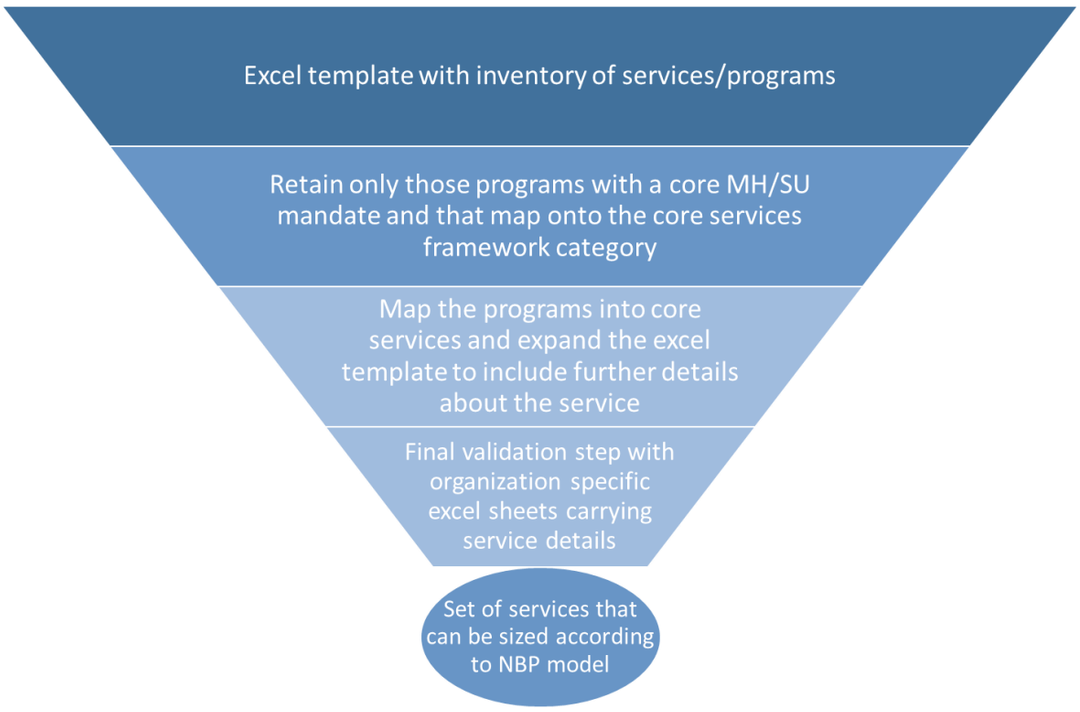
Figure 2 : CCHS Severity Tiers



Step 4: Mapping the system

Figure 3 summarizes the system mapping methodology that was used to create an inventory of services that can be sized according to the NBP model.

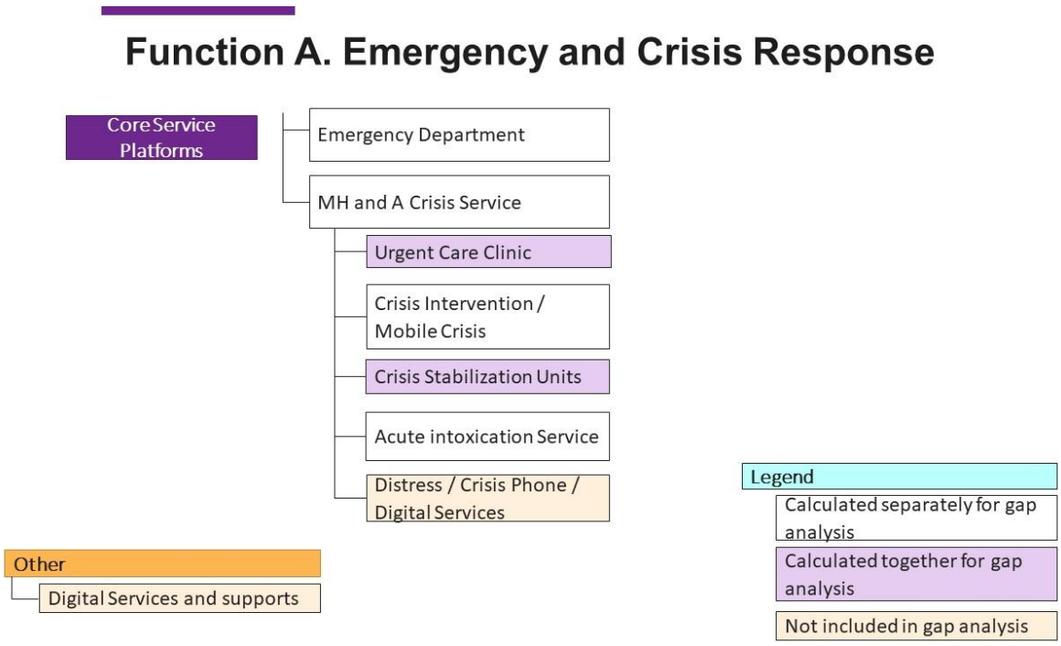
Figure 3: Graphic representation of the system mapping methodology



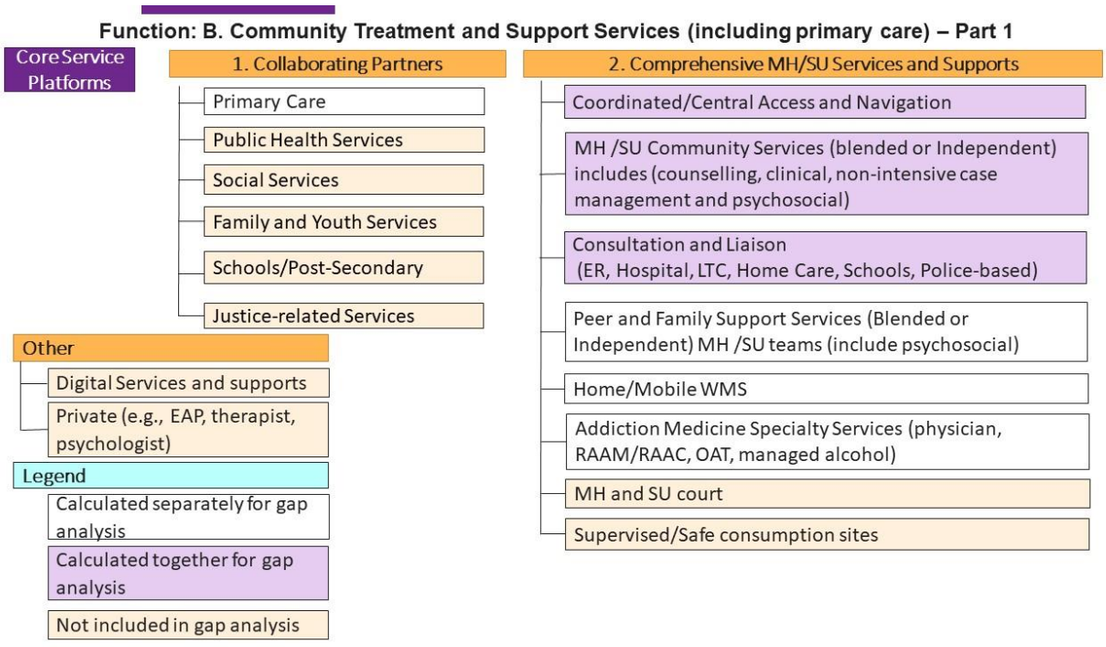
Step 5: Sizing

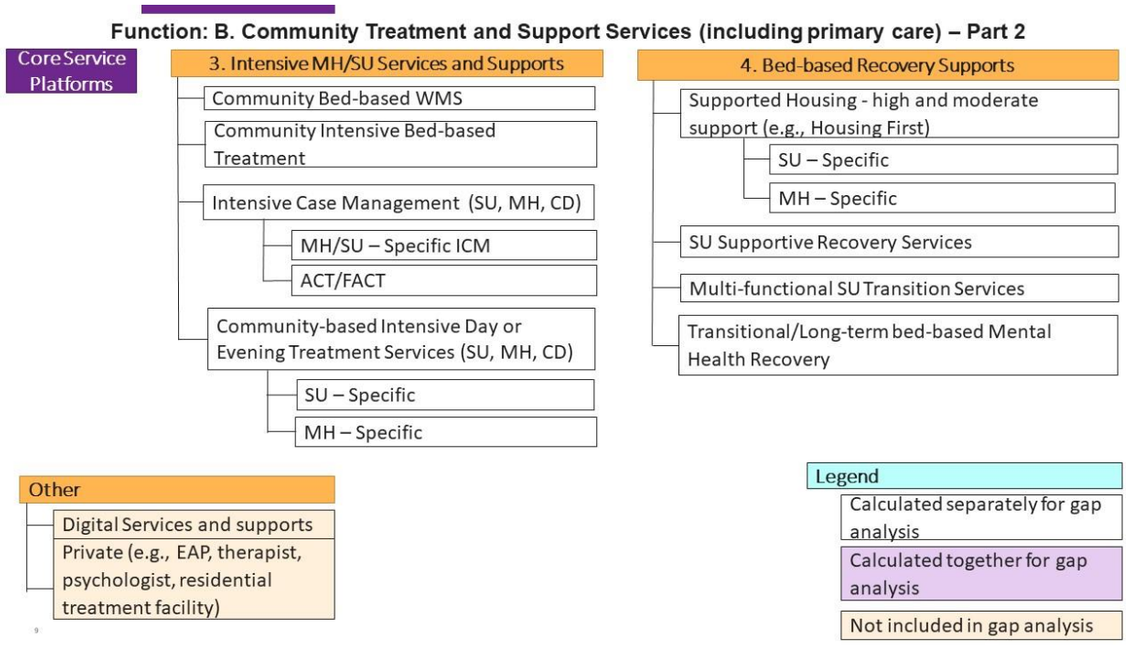
The charts below graphically depict the core service categories that were mapped on to the services available in the PMH region. A brief description of these categories is included in the sections below.

Overview of Emergency and Crisis Response

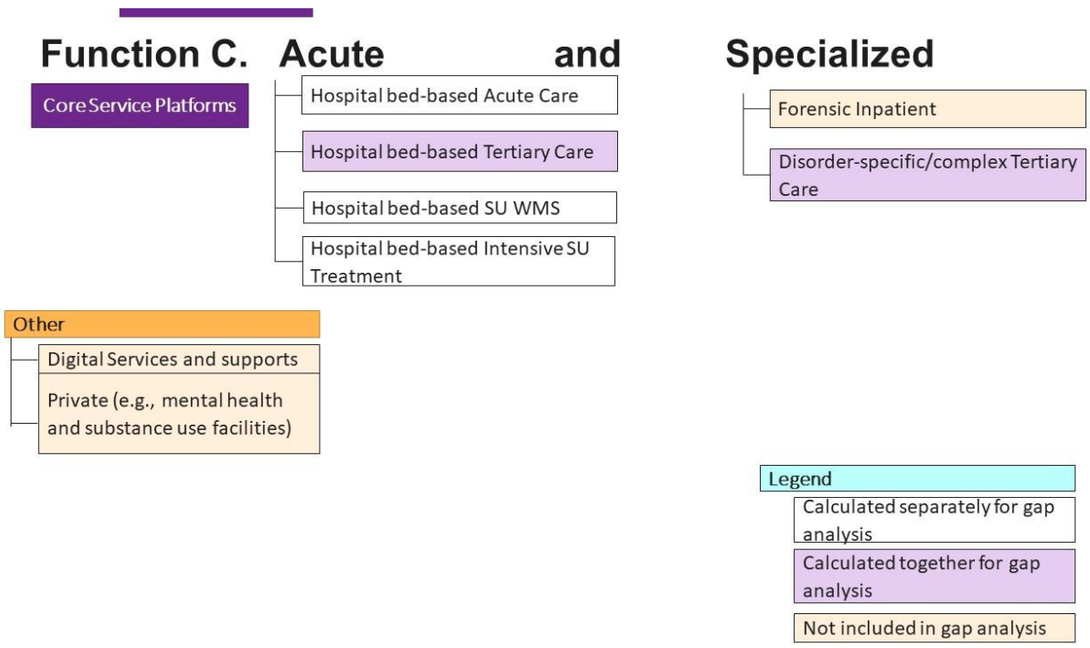


Overview of Community Treatment and Support Services





Overview of Acute and Specialized Services



Step 6: Estimating current core services supply and utilization

In this step, the NBP team worked to estimate the current core services supply and utilization by identifying where there are gaps (and potential surpluses) in each of the Core Services.

Step 7: Gap Analysis – by Core Service Category (number of individuals, FTE's or Beds)

In this step, several meetings were organized with a focus on validating the initial findings. It included:

- identifying areas that the working group found to be inaccurate or odd,
- following up with contributing stakeholders to review data submissions,
- re-examining the excel spreadsheets for errors or omissions, and
- presenting data findings to the working group, responding to questions and verifying the data.

Step 8: Interpretation - Implications of the Gap Analysis

In this step, NBP team worked closely with the working group to review the executive summary document and the key findings document. The team received and incorporated feedback on these documents, and provided additional details where requested.

Key Considerations for interpretation of findings:

When reviewing the following information, it will be important to keep the following points in mind:

1. The term core service typically implies "universal" **access** within a given geographic jurisdiction, including concrete provision, and accountability for ensuring that access is possible in another jurisdiction if not available geographically (e.g., given economies of scale some specialized services cannot realistically be available in all local areas). Core services should also be **available**

to all residents – that is, that the funder should ensure there is adequate capacity of services for individuals who need this type and level of support, while also maintaining service quality.

2. The results of Needs-Based Planning are intended to complement other information at hand and the experience of the members of the Working Group. It will, however, bring an evidence-based approach to the decision-making process that others have found helpful.
3. Some of the gaps that may be identified may well be best filled through resources dedicated to larger regions or even the province as a whole. Examples would include some intensive bed-based services such as hospital-based medical withdrawal management, or specialized mental health tertiary care.
4. For people with mild to moderate Mental Health and Addiction challenges (E.g., Tier 2 and part of Tier 3) the model estimates the need for primary care and some other services such as peer and family support. This is important because of the significant size of the population at that level of severity and highlights the important role of these services.
5. The estimated need is based on 100% help seeking, meaning that we are estimating that 100% of people that need help will actually seek the help they require. Based on this assumption the resulting gap is often quite large, and unrealistic to fully address in the immediate term, but it does show the overall level of population need as well as the importance of sequencing system enhancements through careful planning.
6. The population survey data upon which the community needs are estimated typically exclude certain groups. For example, people who are homeless or institutionalized (e.g., hospital or correctional facility) are not represented in underlying survey data. In addition, First Nations people living on-reserve are typically involved in other surveys. Further, problem gambling is not represented in the needs-based planning model as this is also not included in the population survey data. To compensate for some of these omissions, administrative health data have been used to supplement the community survey data.
7. Given the changes in service delivery and the manner in which individuals have sought service during the pandemic, pre-covid service numbers were utilized for this pilot site.
8. Lastly, when the Needs-based Planning process identifies a gap in a particular core service category there will still be work needed to identify the specific ways, means and service pathways to deliver that core service in the Manitoba regional context. Further, it will be important to ensure that identified service delivery models will be planned and implemented according to accepted standards. In short, this is where Need-Based Planning ends and implementation of evidence-based and high-quality service improvements begins.

The following sections of the report are organized around the core services included in the Needs-Based Planning process, and sometimes bundling this together to assist in presenting the gaps and interpretation to date.

For each core service (or sub-group of core services) we summarize things according to four sub-heading

- What do we mean by this core service?
- What did the gap analysis show?
- How should we interpret this result and what are the implications?

Mental Health/Substance Use Community Services

What do we mean by this core service?

This is a broad category of community-based services that provide screening, assessment and implementation of individualized treatment and support plans to people with mental health and/or substance use challenges that do not require the level of treatment and supports provided through bed-based services, including hospital services. Some services in this category may be focused primarily on mental health, others on substance use and, increasingly in many jurisdictions, blended services are offered. While there are many variations within this service category, this typically involves a scheduled course of one – two-hour sessions for mental health, substance use and related problems - in group sessions or individual formats.

One challenging aspect for this community service category concerns case coordination and case management since activities and supports for these important functions vary widely in scope and intensity. Included are case coordination activities as well as case management that is typically provided by individual staff members are included. However, more intensive, team-based case management such as provided through Substance Use or Mental Health Intensive Case Management Teams and inter-disciplinary Assertive Community Treatment (ACT) teams are identified as a separate core service.

Since many hospital-based mental health outpatient services provide services off-site in the community, often with strong collaborative arrangements with community mental health and substance use services, these outpatient services are also included in this category. Some of these outpatient services are population or diagnosis-specific (e.g., PTSD, Borderline Personality Disorders, Mood Disorders; Early Intervention for Psychosis, Community Geriatric Services) although the NBP model does not project capacity requirements for these diagnosis-specific challenges at the present time.

Importantly, in the NBP model, two additional core services fall in this broad category, but which also cannot be separated out for gap analysis. This includes:

- Coordinated/Central Access and Navigation Supports: *Centralized access* typically describes a one-stop shop or a “hub and spoke” model where clients go through a central intake and assessment process after which they are referred to the level of treatment and support that best matches their strengths and challenges. The model offers a single, central point of contact to access services offered by multiple providers. C*oordinated access*, in contrast, focuses on ensuring commonality in key intake, screening and assessment processes across the participating service providers, as well as agreements on pathways and protocols for referral and transitions among the providers and beyond. The general aim of a centralized/coordinated access model is to minimize the barriers people confront in locating and accessing the help they need. Specific features of centralized/coordinated models may include multiple means of access including web-based technology and direct walk-in services; structured, validated screening and assessment tools and processes; clear and consistent processes for referrals or authority for direct admission into required services; and system navigation supports in making transitions which may include the use of peer-support workers.

- Consultation and Liaison Services which are comprised of professionals designated specifically to work as a liaison between a specialized mental health, substance use or concurrent disorder service and a community or hospital service which is frequently accessed by people with mental health or substance use challenges, including concurrent disorders. This may include consultation to one or more hospital departments, including but not limited to the ED, long-term care homes, housing services and secondary and post-secondary educational institutions

What did the gap analysis show?

The gap analysis showed a large and significant gap in community mental health and substance use services, particularly with respect to physicians (Level 1), staff complement (Level 2) that are trained and certified to deliver evidence-based psychotherapy, and staff complement (Level 5) workers with lived experience providing peer/family support or healthy living activities. There is an oversupply in the staff complement (Level 3) Professionals providing counselling, case coordination/management, transitional supports, medication supports, and staff complement (Level 4) that provide psychoeducation and psychosocial supports.

How should we interpret this and what are the implications?

- Psychiatry is spread across different core service platforms and the 2 Full Time Equivalents under-represent the current capacity.
- This gap in Level 2 presents significant challenges for supporting people requiring specialized treatment such as Cognitive Behaviour Therapy (CBT); Dialectical Behaviour Therapy (DBT); and/or Mindfulness Cognitive behaviour Therapy (MCBT). However, it is important to note that this gap is based on 100% help seeking, meaning that this gap identifies the number of FTE's at this staffing level required if everyone who required help, presented for help. Also, this level of expertise is available through private therapists and non-for-profit organizations.
- Given that there is an oversupply in Level 3 & Level 4 Clinicians, there may be an opportunity here to review how these professionals can be supported to gain credentialling to move into Level 2 positions where there is a large and significant gap.
- Given the significant issues with recruitment and retention in rural areas, consideration may be given to innovative practices such as hiring Level 2 clinicians to provide treatment virtually via larger urban centres within Manitoba, and/or investigating how a regional or provincial training program could train existing clinicians to a level required to deliver evidence based structured psychotherapy.
- There is a need for sustainable investments in Level 5 professionals – programs are currently being funded on a yearly basis.

As noted earlier, gap is based on 100% help seeking, meaning that this gap identifies the number of FTE's at this staffing level required if everyone who required help, presented for help.

MH/SU Community Services (blended or Independent) includes (counselling, clinical, non-intensive psychosocial)	**Current Capacity**	**GAP**

Level 1 - Physicians (Community Psychiatry)	2 Full Time Equivalents	30 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	6 Full Time Equivalents	93 Full Time Equivalents
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	121 Full Time Equivalents	Overcapacity (+ 59 Full Time Equivalents)
Level 4 - Professionals providing psychoeducation and psychosocial supports	51 Full Time Equivalents	Overcapacity (+ 45 Full Time Equivalents)
Level 5 - Workers with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents	43 Full Time Equivalents

Mental Health and Substance Community Services – Peer Support

What do we mean by this core service?

Peer and family support is a supportive relationship between people who have a lived experience in common. Some peer and family support services are focused on substance use, others on mental health and other in a blended service model. They have in common a shared experience with respect to mental health and/or substance use-related challenges.

Peer and family support is characterized by a set of values and processes of peer support—among them, recovery, empowerment, and hope. The most common form of peer and family support is self-help support groups where peers or family meet regularly to provide mutual support, without the involvement of professionals, and one-to-one peer and family support such as co-counseling, mentoring, or befriending. With increasing levels of recognition and government investment, there are also many types of peer and family support services that are more specialized, many of which are delivered through, or in collaboration, mainstream providers. Examples include support in housing, education, and employment; support in crisis (e.g., emergency department, and crisis services); traditional healing, especially with Indigenous people; system navigation (e.g., case management); and material support (e.g., food, clothing, storage, internet, transportation).

What did the gap analysis show?

The gap analysis showed a large and significant gap with respect to peer and family support services.

How should we interpret this and what are the implications?

While the gap analysis showed a large gap in peer and family support services, further work may be required to assess what peer and family supports are available in local community services but not separated out for the gap analysis (e.g., intensive case management, supported housing), with consideration being given to the variety of ways and means to incorporate peer and family support across the mental health and substance use treatment and support services.

MH/SU Community Services (blended or Independent) includes (counselling, clinical, non-intensive psychosocial)	Current Capacity	GAP
Level 5 - Workers with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents	43 Full Time Equivalents

Intensive Case Management/Assertive Community Treatment Teams

What do we mean by this core service?

There are two important sub-categories in this category. The first category in Intensive Case Management, which can either be focused specifically on substance use or more broadly on mental health, including concurrent disorders. While this intensive case management model is similar in many ways to the Assertive Community Treatment model (see below) clinicians have larger caseloads (20-1 client to staff ratio); frequency of visits is less (1-3 times per week), and the range of services are more frequently provided through a collaborative approach with other community providers rather than through one team.

The integrated team generally includes access to medical and psychiatric supports varies, staffing generally includes case managers, peer support workers, nurses, housing specialist and access to a psychiatrist.

The second model is the well-known Assertive Community Treatment (ACT) team which is distinguished from other models of intensive case management by its focus on adults with serious and persistent mental illness and which challenges the management of many aspects of daily living. Highly integrated interdisciplinary teams provide assertive wraparound coordination, services, and outreach, with low client-to-provider ratio (e.g., 10-1), and high frequency of visits (1-3 times per day).

Both ICM and ACTT are meant to be integrated teams that generally includes access to medical and psychiatric supports varies, staffing generally includes case managers, peer support workers, nurses, housing specialist and access to a psychiatrist.

What did the gap analysis show?

The gap analysis showed a significant gap with respect to intensive case management services for both substance use and mental health.

How should we interpret this and what are the implications?

Case management is delivered along a continuum of low to high intensity, the highest level being Assertive Community Treatment Teams. The gap analysis has identified a significant gap with respect to intensive case management services for substance use and mental health. Given that there is not currently a FACT team available in this region, consideration ought to be given to developing this resource where the existing Intensive Case Management team, a new FACT team and the existing ACT team can work together as a continuum, stepping up or down as individual need demands. Further, it is noteworthy that no intensive case management services exist for individuals living with a substance use

issues, and likely contributing to the pressure on the Emergency Department and Crisis Stabilization Services. Consideration should be given to the development of a FACT or ACT team dedicated to individuals living with Substance use issues.

Intensive Case Management Services (ICM)	**Current Capacity**	**GAP**
ICM, FACT & ACT for Mental Health	16 FTE	12 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Service does not exist in region	31 Full Time Equivalents

Community-based Intensive Day or Evening Treatment Services

What do we mean by this core service?

Day/Evening treatment may be focused on either substance use or mental health challenges, the latter sometimes very specific to a grouping of diagnoses, such as PTSD, Mood Disorders, Borderline Personality Disorder or Eating Disorders.

Day/Evening treatment is sometimes referred to as “partial hospitalization” or “day hospital” and is an intensive type of non-bed-based services for individuals whose substance use or mental health-related needs are more complex than can be managed through standard outpatient services but yet do not require an inpatient stay. A structured, scheduled program of treatment and support activities is provided for a certain number of days or evenings per week (typically 4-5 days per week) and a certain number of hours per day/evening (typically 3-4 hours per day) while the client resides at home or in another setting such as a multi-functional bed-based service. There is variability in total number of hours of service per week. The distinguishing feature, however, is that there is no live-in component, although arrangements may be made with other services for accommodation while the person participates in the day/evening treatment services and supports.

As with Community Mental Health and Substance Use Services, and depending on organizational size and community context, many hospital-based mental health or substance use services deliver treatment on a Day/Evening basis off-site from the hospital, perhaps in collaboration with community mental health and/or substance use service, and, therefore, these services are also included in this category. These Day/Evening programs may be specialized in concurrent disorders.

What did the gap analysis show?

The gap analysis showed a significant gap with respect to Day/Evening treatment services for Substance Use Services and the ability for the current Mental Health Day/Evening Treatment Team to serve the number of individuals that require this service.

How should we interpret this and what are the implications?

Missing a Day/Evening Treatment program for Mental Health and Substance Use is a significant gap in the treatment continuum. As with other service continuums, when some parts are missing, the parts that are available will become overburdened; people will not seek treatment; and/or people will not receive the level of treatment they require. Consideration ought to be given to the development of this intensive type of non-bed-based services for individuals whose substance use and/or mental health-related needs are more complex but yet do not require an inpatient stay.

Day/Evening (Day Hospital, Partial Hospitalization)	**Current Capacity**	**GAP**
Substance Use	Service does not exist in this region	Total of 248 individuals in need of this service
Mental Health	Service does not exist in this region	Total of 1,075 individuals in need of this service

Addiction Medicine Specialty Services

What do we mean by this core service?

Addiction medicine is a medical sub-specialty that deals with the diagnosis, prevention, evaluation, treatment, and recovery of persons with substance use disorders, and of people who otherwise show unhealthy use of substances including alcohol, nicotine, prescription medicine and other illicit and licit drugs. Addiction specialists may work independently or be part of another core service such as Rapid Access to Addictions Medicine (RAAM), or an Opioid Agonist Treatment (OAT) program.

What did the gap analysis show?

The gap analysis showed a small gap in this category of specialized Addiction Medicine. Also, it is worth noting that there is currently no capacity for a Managed Alcohol Program.

How should we interpret this and what are the implications?

The gap shows a need for additional investment in Addiction Medicine Services such as RAAM or an Addiction Medicine Consult Service. This said, any new investments must consider the challenges this region (like other jurisdictions) are experiencing in transitioning people from RAAM Clinics to a Primary Care Provider for ongoing support. With this in mind, consideration may be given to the further exploring the Primary Care Outreach Clinic model as a way to support those who are ready to transition back to Primary Care; and/or the development of a Community of Practice for Primary Care Providers that is focused on the delivery of Opiate Agonist Therapy.

There is also an opportunity to continue to build capacity and continuity of care for individuals who access hospital in crisis as a result of their substance use. Leveraging the existing Mental Health Nurses within the Emergency Department, consideration could be given to embedding Addiction Medicine Specialists within this existing team.

Addiction Medicine	**Current Capacity**	**GAP**

Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	4 Full Time Equivalents	7 Full Time Equivalents

Continuum of Withdrawal Management Services (WMS)

What do we mean by this core service?

This broad service category is comprised of:

- Acute Intoxication Services, sometimes referred to as "sobering centres", "brief detox" or "acute sobering unit" provide safe, short-term monitoring and management of symptoms of an episode of heavy alcohol and/or other drug use that cannot be managed at home. A core objective is to minimize ED presentations related to acute intoxication. There are two models of acute intoxication services – one community-based and other hospital based, the latter typically connected to the ED itself. These two models exist along a continuum of what could be described as "medically monitored" to "medically managed". Length of stay is brief, typically less than 24 hours although this will be somewhat longer in hospital-based models for medical management.
- Community home or mobile WMS provide supports in the person's home or other safe accommodation via on-site visits or via Internet-based supports. It may also involve visits to a central location (e.g., community addictions program, or a "safe home" in the community) during the day, while returning home at night. This is sometimes referred to as "daytox". Length of services depends on the range of supports offered, included access to low intensity case management after the immediate needs for safe withdrawal have been met.
- Community Bed-based WMS involves withdrawal management supports in a non-hospital, bed-based setting, and although "community-based", these services are often sponsored or otherwise administratively linked to a hospital to ensure quick access on an as-needed basis for medical emergencies. These community-based services may, however, provide some medical management and include a medical assessment and regular supports during the withdrawal process by physician, nurse practitioner, other nursing and/or other health care worker. The intensity of the medical management and monitoring varies by setting, and withdrawal may be supported with or without medication management. Length of stay is typically 8 days.
- Hospital Bed-based WMS involves withdrawal management supports in a health care setting for stabilization, withdrawal management and medical and psychosocial supports. While many community bed-based WMS services also offer medical supports, the hospital-based services in this category provide access to a significantly higher level of individualized medical and mental health treatment and support. This may include medication management such as tapering from opioids with a goal being to transition to in-house or externally offered Opioid Agonist Treatment, or other treatment and support depending on client choice for that option. Length of stay is typically less than 7 days but this can be quite variable depending on individual strengths and needs.

What did the gap analysis show?

The gap analysis showed an adequate capacity at present for Community-Bed-based Withdrawal Management Services but no current capacity for the other WMS options within this broad category.

How should we interpret this and what are the implications?

As in many other jurisdictions investments have not been made to diversify the continuum of withdrawal management services. In terms of addressing the gaps in this continuum consideration should be given to determining a home/mobile WMS alternative for the region. There are several examples to draw upon, including Winnipeg as well as other provinces (e.g. Ontario). Research in BC that has shown this model can reduce ED presentations for substance use. Further, it will be important to carefully plan for transitions from the RAAM-based Addiction Medicine Services and any new mobile/home-based WMS services, as well as the existing Community Bed-based WMS.

With respect to a specialized Acute Intoxication Service, there may value in exploring how a more formalized organized model for provision of acute intoxication services could streamline current activities and better meet the needs of people presenting with the full range of acute intoxication challenges, including addressing the concurrent mental health issues.

With respect to hospital bed-based, this may speak to a need for larger provincial capacity in this category.

Continuum of WMS	**Current Capacity**	**GAP**
Acute Intoxication Service	Service doesn't exist in region	1 bed
In Home/Mobile WMS	Service doesn't exist in region	7 FTEs
Community Bed Based WMS	6 beds	1 bed
Hospital Bed Based WMS	Service doesn't exist in region	2 beds

Substance Use Bed-based Treatment Continuum

What do we mean by this core service?

This broad service category is comprised of:

- Community Intensive Substance Use Bed-based Treatment whereby clients reside on-site and participate in a structured, scheduled program of interventions and activities with access to 24-hour support. While considerable variability exists within and across jurisdictions in program structure and activities a harm reduction approach is recommended which, among other things, means meeting people where they are at in their recovery journey; accepting people into treatment who are being treated with opioid agonist treatment and acceptance of relapse as part of the recovery journey. Quality of life and well-being are among the criteria for successful outcomes, which may or may not also include complete abstinence, depending on the

individual's treatment goals. Programs generally range from 30-90 days with a variable length of stay recommended based on client strengths and needs.

- Supportive Recovery Services which provide temporary accommodation in a safe supportive, recovery-oriented environment often as a step down from intensive bed-based substance use treatment. These services may also be accessed when there is a high risk of relapse and individuals may simultaneously access outpatient and other community treatment services and supports. Programs generally range from 30-90 days but may be six months or even longer depending on program structure and target populations served.
- Multi-functional Substance Use Transition Services offer a variable length stay up to a maximum of 30 days of support (as a guideline) for physical, social, and psychological stabilization for people with moderate to severe substance use disorders. A key distinguishing characteristic is that there is minimal in-house programming given the focus on rest and stabilization. A focus on rest and stabilization, with minimal in-house programming, allows the individual to plan for entering a residential or non-residential treatment service (e.g., while on a wait list after withdrawal management). These transition beds may also be used to help the person make the transition from a residential service to a community non-residential service, for example after housing in the community has stabilized. In some cases, these beds can be part of a mobile withdrawal management program. (e.g., STAR beds in BC or Manitoba).
- Hospital Bed-based Substance Use Treatment, commonly referred to as "inpatient substance use treatment" or perhaps a "concurrent disorders unit" this involves a number of designated beds for stabilization, assessment, treatment and psychosocial supports for people with severe substance use disorders. This may be preceded by a period of medically supported withdrawal management. The distinguishing characteristic of these bed-based substance use treatment services is their capacity to offer in-house treatment of significant health, mental health, and other complex conditions. A variable length of stay is recommended but is typically over 21 days or longer based on clinical presentation. This core service also includes specialized beds for people with opioid use disorder (typically a 4-5 month stays) who have a high level of mental health and other co-morbidities.

What did the gap analysis show?

The gap analysis showed a small overcapacity in Community Bed-Based Substance Use Services, and a significant gap across all the other components of this continuum for bed-based substance use treatment and support.

How should we interpret this and what are the implications?

The small surplus in the Community Bed Based Substance Use Services is due to the availability of these services to population outside of PMH. Further investigation may be worthwhile to determine if some of these beds could be transitioned to either Multi-functional Bed Based Substance Use Services or Supportive Recovery Services to address the gap in this service.

Consideration should be given to increasing capacity for the region in Multi-functional Substance Use Transition Services, and Supportive Recovery Services where there is currently no capacity, and the gaps are large and significant. Supportive Recovery Beds are integral to the long term stability of many individuals who have completed a Community Bed-Based Substance Use service.

With respect to Hospital Bed Based Substance Use Services, this may speak to a need for larger provincial capacity in this category.

Continuum of Bed Based Substance Use Services	**Current Capacity**	**GAP**
Multi-functional Bed Based Substance Use Services	0	27 beds
Community Bed Based Substance Use Services	42	Overcapacity (+7 Beds)
Supportive Recovery Bed Based Substance Use Services	0	61 beds
Hospital Bed Based Substance Use Services	0	14 beds

Primary Care

What do we mean by this core service?

People commonly receive primary care services from physicians (general practitioner or family physician) or a nurse practitioner and this can be in solo or group practices or other service delivery models such as a family health team. Such primary care services are critical components of the overall community treatment and support services with mental health and substance use challenges; what are termed *core collaborating service providers* in the national core services framework.

For people with mild to moderate mental health and/or substance use challenges the primary care service may provide structured screening and brief intervention and referral to specialized services if needed. Primary care practitioners may also provide counselling, and medication management for people across a wide spectrum of severity living in the community.

What did the gap analysis show?

There is a significant need for primary care providers to be providing mental health and addictions support to their rostered patients. It was estimated that more than 69,000 people in the Health Authority could benefit from this support.

How should we interpret this and what are the implications?

There are challenges interpreting this gap analysis for primary care for two important reasons. The first is that current data were not available on the number of people currently accessing these services and secondly, it would be rare indeed for a primary care professional to dedicate all their time to this important population. Without a quantitative estimate of the size of the gap the information is still important and shows:

- the importance of including primary care in the planning process (e.g., discussions about coordinated access);

- identifying the role of primary care in specific service pathways, and for specific populations (e.g., medication management for substance use or specific mental health challenges after specialized stabilization and treatment);
- advocating for continuing and perhaps enhanced training for primary care professionals in mental health and substance use, especially in the areas of screening and brief intervention;
- support for primary care professionals to be a part of a team that are able to support those individuals with complex needs, those who are marginalized and/or those who experience homelessness;
- the need for primary care providers to be attached to community mental health and addiction programs (e.g., ACTT); and
- the need for primary care providers to be involved with those individuals who are experiencing less severe symptoms, but where consultation would prove beneficial.

Given the large number of individuals requiring some form of mental health and/or addiction support from their primary care providers, it is imperative that as future system planning is conducted, primary care providers must be active partners and collaborators in the co-design of the Mental Health and Addiction System.

Primary Care	**Current Capacity**	**Projected Need**
Physicians & Nurse Practitioners	2 FTE's (7th Street Health Access Centre) *Other data on people accessing their PCP for MHA issues not available.	65,097 people require Mental Health and/or Addiction care from their Primary Care Provider

Emergency and crisis

What do we mean by this core service?

This broad service category is comprised of:

- Emergency Departments (ED), including those that are specialized in mental health and substance use and which may be affiliated with a specialized mental health facility.
- Urgent Care Clinics, including those specialized in mental health and substance use, and which offer walk-in support to those with less urgent needs than typically requiring support in an ED.

- Crisis Stabilization Units which are 24/7 bed-based services that offer a short-term alternative to acute hospital-based care, providing crisis response and assessment and short-term interventions.
- Crisis Intervention Services which may be delivered through a mix of options including a mobile crisis team, distinguished for its outreach capacity, and sometimes including police officers, and/or located on site at a hospital for walk-in support as well as via telephone and/or Internet-based contact.

The focus of all these options is to support the management of an acute situation with the goal being to transition the individual to the next appropriate level of treatment and support based on individual strengths and needs, for example, inpatient services in the hospital or follow-up and continuing treatment and support in community-based services.

What did the gap analysis show?

The bed gap/surplus within the Emergency Department is unknown as this information was unavailable, though it is projected that 2 beds are required that are completely dedicated to individuals living with Mental Health and Substance Use issues. The current capacity for bed-based crisis stabilization is significantly over the required capacity (if the current community mental health and substance use services were enhanced).

How should we interpret this and what are the implications?

Interpretation of the gap analysis is challenged by several factors. For example, the estimate of required ED beds for mental health and substance use, like the estimate for primary care, is based on assumption that these beds (the estimated requirement being 3 beds), would need to be dedicated 100% time to these individuals in need.

With respect to Urgent Care/Crisis Stabilization, the information suggesting that current capacity may be larger than actually required no doubt reflects the significant gap in community mental health and substance use services which, if new investments brought it much closer to the required capacity, would reduce the need for crisis intervention as well as ED utilization.

Given that local stakeholders report very heavy use of the existing crisis services, and the number of people in receipt of Crisis services is nearly triple that of the projected need, the data from the gap analysis should NOT signal a need to reduce current capacity. Rather the data illustrates the inter-connectedness of all the components of a mental health and substance use treatment and support system and signal the need to invest in those community-based resources.

Emergency and Crisis	**Current Capacity**	**GAP**
Emergency Department	Information not available	2 Beds
Urgent Care/Stabilization Unit	18 beds	Overcapacity (+17 beds)

Crisis Intervention/Mobile Crisis	974 people being served	It is estimated that approximately 380 will be in need of Crisis service each year. (Note: This estimate is provided with the understanding that all other parts of the system would be in place, thereby reducing the reliance on Crisis Services)

Supportive/Supported Housing - High and Moderate Support

This core service category includes a large number and variety of service delivery models.

- In Supportive Housing, housing and support are linked, with staff members providing various levels of support within the residences. This type of housing usually features group home settings but can sometimes include low-support, self-contained apartments.
- In Supported Housing, housing and support are separate functions. There are no staff members on-site. Support services are provided from outside the home, usually in the form of case management. Supported housing usually consists of independent apartments, housing co-operatives or other government-funded social housing for people with low income. Important features included social support, good housing quality, privacy, a small number of residents and resident control.
- Some jurisdictions such as Ontario provide Substance Use-Specific Supported Housing and in others (indeed the majority of Canadian jurisdictions) the housing supports are targeted at needs related to both mental health and substance use.
- The "Housing First" model encompasses both a set of key principles (e.g., housing is a basic human right; the separation of housing and services; personal choice and self-determination, recovery orientation and harm reduction) as well as key features such as scattered-site housing and independent apartments and provision of significant supports for mental health and substance use (e.g., an ACT or ICM team). Importantly, housing is provided first and then supports are provided including physical and mental health,
- Supportive and supported housing are similar in many respects (e.g., provision of housing and supports such a medication management when needed), focusing on community integration). Coupled with case management, persons living in supportive or supported housing can also be linked to a wide variety of social services as job training, life skills training, community support services (e.g., childcare, educational and recreational programs, support groups).
- "Low barrier" housing is another approach to supported housing for individuals with substance use challenges who are continually at risk of being homeless, or who are homeless and require a safe place to live. There is no requirement for the person to be abstinent or involved in treatment to access this housing. However, it is important to note that in some jurisdictions an important distinction is drawn between sober housing and other low-barrier housing.
- Importantly, the capacity requirements for Supportive/Supported Housing also includes estimated level of need for financial supports through rent supplements or other means of

financial subsidy. Rent supplements are also often included in Supported Housing models, for example in Ontario. The NBP model can separate out supported or supportive housing, inclusive of rent supplements, from subsidized housing.

What did the gap analysis show?

As the current capacity for Supportive Housing and Subsidized Housing was not available, the gap could not be projected. The projected need therefore has been estimated, providing system planners with an understanding of what the projected need is for their region.

How should we interpret this and what are the implications?

Given that the information is currently not available for Supportive Housing and Subsidized Housing, it would be worthwhile for system planners in Manitoba to spend the time required to obtain these numbers in order to understand the gap and plan accordingly based on that gap.

Supportive Housing	**Current Capacity**	**GAP**
Substance Use Supportive Housing	Information not available	218 units (Projected Need)
Mental Health Supportive Housing	Information not available	717 units (Projected Need)
Subsidized Housing	**Current Capacity**	**GAP**
Substance Use Subsidized Housing	Information not available	424 (Projected Need)
Mental Health Subsidized Housing	Information not available	1,376 (Projected Need)

Mental Health Bed-based Continuum

What do we mean by this core service?

This broad service category is comprised of:

- Hospital Bed-based Acute Care commonly referred to as an Acute Inpatient Psychiatry Unit (AIPU), General Psychiatry Unit (GPU) or Mental Health Unit (MHU) or just under the broad umbrella of “acute care inpatient psychiatry” (this category includes Psychiatric Intensive Care Units/Beds - PICU). This involves a number of designated beds for stabilization, assessment, treatment and support for people experiencing an acute mental health condition and who may need safety monitoring, stabilization, assessment, treatment and support, including but not limited to medication management. Length of stay can be variable but often the anticipated duration is 1-2 weeks, and which may complement additional services provided through longer stay inpatient units. The focus is on support in managing an acute situation with the goal being to transition the individual to the next appropriate level of treatment and support based on

individual strengths and needs, for example, longer term inpatient or outpatient, community-based services. As such the focus of these services is two-fold – treatment and support as an inpatient but also discharge planning to other appropriate supports.Hospital Bed-based Tertiary Care commonly referred to as "a psychiatric or mental health facility", this involves a number of designated beds for longer-term stays than for the acute care mental health services. That being said, admissions can be quite variable in terms of duration. The focus is on assessment, treatment and support for people experiencing severe and refractory mental illness who have not responded to treatment and/or have difficulty maintaining successful community tenure despite exhausting all available supports and interventions. Where possible, the aim is to transition the individual to outpatient, community-based services for ongoing treatment and psychosocial support. Some of these tertiary care services may have highly specialized units, for example, for people with Acquired Brain Injury, and may be considered in the core service category Disorder-Specific/Complex Tertiary Care (e.g., Psychogeriatrics, Acquired Brain Injury) or Inpatient Forensics.

- Transitional/Long-term Bed-Based Mental Health Recovery, which includes several sub-categories that vary across provinces and territories. In Ontario, the longer-term facilities typically fall under the jurisdiction of Homes for Special Care (HSC), the Ministry of Health and Long-Term Care province-wide residential care program for adults with serious mental illness. The HSC Program offers more than just residential group homes and, depending on location/site, includes a variety of services to assist people to explore and fulfill life expectations beyond psychiatric stabilization and health maintenance.
- Transitional/Long-term Bed-based Mental Health Recovery – (Respite), this Core Service is the same as described above, except that this service is specifically for individuals living with a Developmental Disability.

  Other terms and examples include:

  - Licensed Community Residences which provide supervision (24 hours a day, 7 days per week) and with professional staff available to assist residents as needed, including managing the storing and dispensing of patients' medications.
  - Supported Living Homes which offer staff support during certain daytime hours and where residents are responsible for taking their own medication.

What did the gap analysis show?

The gap analysis showed that capacity for Hospital-based Acute Care was about right-sized to meet the current needs. Within the category of Transitional/Long-term Bed-Based Mental Health Recovery services there was a gap identified for both respite services and long-term services within this category. There was a large gap for Hospital-Based Tertiary Care as well.

How should we interpret this and what are the implications?

Based on these data, new investments in the regional capacity for acute inpatient mental health treatment would not be an immediate priority, especially when compared to the major gaps across the various community-based core services.

Interpretation of the gap for the other services along the continuum is somewhat challenged. In regard to Transitional/Long-term Bed-Based Mental Health Recovery, the lack of available supportive housing in the region, means that many individuals living in the existing group home or apartment cluster are there largely due to the lack of availability of alternative supportive living arrangements. This shortage of supportive housing services in the region is having an impact on the ability for this service to be transitional in nature.

The existing hospital-based tertiary care bed are fully dedicated to the geriatric population. This means that no other hospital bed based tertiary level care or disorder specific service (i.e.: Eating Disorder beds or Forensic beds) service exists in the region. Consideration ought to be given to developing bed capacity for those 18-65 years in need of complex/disorder specific/tertiary care.

Mental Health Bed Based Continuum	**Current Capacity**	**GAP**
Hospital Based Acute Care	35 beds	1 bed
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Respite services do not exist in region	48 beds
Long-term bed-based Mental Health Recovery/Transitional	16 Beds	16 beds
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	22 beds	9 beds

3.0 Summary of Highlights

1. Gap in Community Treatment and Support Services: The gap analysis showed a large and significant gap in community mental health and substance use services, particularly with respect to the staff complement (Level 2) that are trained and certified to deliver evidence-based psychotherapy. Given the significant issues with recruitment and retention in rural areas, consideration may be given to innovative practices such as hiring Level 2 clinicians to provide treatment virtually via larger urban centres within Manitoba, or investigating how a regional or provincial training program could train existing clinicians to a level required to deliver evidence based structured psychotherapy. It is noteworthy that there is an overcapacity with respect to the staff complement Level 3 & 4, though it is anticipated that these staff may be (by default) filling gaps in other areas of the continuum where we see gaps (i.e.: Intensive Case Management).

2. Fulsome Continuum for Withdrawal Management Services (WMS): The gap analysis showed a lack of diversity along the continuum of withdrawal management services, including no capacity for Acute Intoxication Services, no capacity for In-Home/Mobile WMS, and no capacity for Hospital Bed-Based WMS. Missing these parts of the WMS continuum means that the part of system that is in place

(Community Bed Based WMS) may become overburdened; individuals will not seek treatment as Community Bed Based WMS is the only options; or individuals will not receive the level of treatment they require. As in many other jurisdictions investments have not been made to diversify the continuum of withdrawal management services and diversification of WMS should be considered an area of priority for this region. Consideration should be given to developing an In-Home/Mobile WMS alternative for this region, and developing a formalized model for the provision of Acute Intoxication Services, streamlining current Emergency department activities. There must be a medical component to both of these new services, so that those individuals who choose to withdraw with medical support may do so.

3. Intensive Case Management: The gap analysis showed a large and significant gap with respect to intensive case management services, both substance use and mental health focused, and future investment in this area should be considered. Given that there is not a FACT Team in this region, nor is there capacity to provide intensive case management services for those living with a substance use disorder, priority could be given to the development of both of these services.

4. **Fulsome Continuum for Bed Based Substance Use Services:** Consideration should be given to increasing capacity for the region in Multi-functional Substance Use Transition Services, and Supportive Recovery Services where there is currently no capacity, and the gaps are large and significant. There is a small surplus in the Community Bed Based Substance Use Services, and further investigation may be worthwhile to determine if some of these beds could be transitioned to either Multi-functional Bed Based Substance Use Services or Supportive Recovery Services.

5. Supportive Housing: Given that the information is currently not available for Supportive Housing and Subsidized Housing in this region, it would be worthwhile for system planners in Manitoba to spend the time required to obtain these numbers in order to understand the gap and plan accordingly based on that gap.

6. Community Based Day/Evening Treatment Services (SU, MH, or CD): Given that there is no capacity for a non-bedded intensive service, consideration ought to be given to the development of this intensive type of non-bed-based services for individuals whose substance use or mental health-related needs are more complex but yet do not require an inpatient stay.

7. Peer Support: The gap analysis showed a large and significant gap with respect to workers with lived experience providing peer/family support (staff complement Level 5). The benefits of the supportive relationship between people/families who have a lived experience with people who are seeking treatment/in treatment are well known. Consideration ought to be given to providing sustainable, base funding for the delivery of Peer Support Services in this region.

8. Addiction Medicine: The gap analysis showed a fairly significant gap in this category of specialized Addiction Medicine, presenting an opportunity to expand existing RAAM clinics; develop an Addiction Medicine Consult Service (AMCS) to build a continuity of care for individuals who access hospital in crisis as a result of their substance use; and/or develop a managed alcohol program. Given the challenges transitioning individuals back to Primary Care who live with a substance use issue, careful planning and/or innovative models must be considered.

9. Emergency and Crisis: Given that the information is currently not available for Emergency Department Beds in this region, it would be worthwhile for system planners in Manitoba to spend the time required to obtain these numbers in order to understand the gap and plan accordingly based on that gap. With respect to the significant over capacity in Urgent Care/Stabilization Beds, this overcapacity reflects an ideal state where the necessary investments in community mental Health and substance use services have been made, thereby reducing the need for crisis intervention as well as ED utilization.

10. Mental Health Bed Based Continuum: The gap analysis showed a lack of diversity along the continuum of Mental Health Bed Based Continuum with gaps identified in the respite services and long-term services of the Transitional/Long-term Bed-Based Mental Health Recovery services category, and the Hospital-Based Tertiary Care category. The gap in Transitional/Long term Mental Health Beds is further exacerbated by the lack of available supportive housing in the region, placing much pressure on this already limited resource. The gap in Hospital bed-based tertiary care or disorder-specific beds is further exacerbated by the fact that the existing beds are fully dedicated to Alternate Level of Care (ALC) for seniors waiting placement in a Long-Term Care (LTC) facility. *Note: More detailed work will be completed on the methodology specific to Long-term bed-based Mental Health Beds with the extension of this pilot project.

11. Primary Care: There is a significant need for primary care providers to be providing mental health and addictions support to their rostered patients. It was estimated that almost 70,000 people in the region could benefit from this support.

Given the large number of individuals requiring some form of mental health and/or addiction support from their primary care providers, it is imperative that as future system planning is conducted, primary care providers must be active partners and collaborators in the co-design of the Mental Health and Addiction System.

4.0 Recommendations for Planners and Health Service Providers

The recommendations below reflect both the quantitative analysis and the experience and knowledge of the Prairie Mountain Health Working group.

Priority Areas for Investment:

1. **Mental Health/Substance Use Community Services**: Investment in Level 2 clinicians who are able to provide specialized treatment.
2. **Continuum of Withdrawal Management Services (WMS):** Diversify the continuum of WMS services with the development of an In-Home/Mobile WMS, and the development of an Acute Intoxication Service (within or within close proximity of the Hospital Emergency Department). Note: There must be a medical component to both of these new services
3. **Substance Use Bed-based Treatment Continuum:** Diversify the continuum of Substance Use Bed-Based Treatment starting with the development of a Multi-functional Substance Use Transition Service and a Supportive Recovery Service.

4. **Addiction Medicine Specialty Services:** Consideration should be given to investing in additional Addiction Medicine services such as Rapid Access Addiction Medicine (RAAM) services and/or Addiction Medicine Consult (AMCS) services, and/or embedding medical staff (Nurse practitioners, nurses and/or physicians) into existing addiction services.
5. **Peer Support:** Consideration ought to be given to providing sustainable, base funding for the delivery of Peer Support Services in this region.
6. **Day or Evening Treatment Service**: Consideration ought to be given to the development of this intensive type of non-bed-based services for individuals whose substance use or mental health-related needs are more complex but yet do not require an inpatient stay.

Priority areas for System Planning work:

1. **Primary Care:** As future system planning is conducted primary care providers must be active partners and collaborators in the co-design of the Mental Health and Addiction System. Given the challenges transitioning individuals back to Primary Care who live with a substance use issues, this is an area of priority.
2. **Supportive Housing:** It would be worthwhile for system planners in Manitoba to spend the time required to obtain the number of Supportive Housing units and Subsidized Housing units available in their region in order to understand the gap and plan accordingly based on that gap.
3. **Emergency and Crisis**: It would be worthwhile for system planners in Manitoba to spend the time required to obtain Emergency Department Bed Numbers dedicated to individuals living with mental health and substance use issues in order to understand the gap and plan accordingly based on that gap.

Appendices:

Appendix A: CCHS 2012 Tier Severity Criteria

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
Tier 1	No CIDI disorder **-and-** No non-cannabis illicit drug use **-and-** Prescription drug use only as prescribed **-and-** No perceived need for care **-and-** Drinking below **(our approximation to)** the low-risk guidelines: Men: Up to 15 drinks per week; Up to 3 drinks per day most days Women: Up to 10 drinks per week; Up to 2 drinks per day most days **-and-** Cannabis use: never, **-or-** just once (past 12m or lifetime), **-or-** more than once > 12m ago, **-or-** more than once in the past 12m **and** frequency was < once a month.	No CIDI alcohol **-or-** drug disorder **-and-** No non-cannabis illicit drug use **-and-** Prescription drug use only as prescribed **-and-** No perceived need for care **-and-** Drinking below **(our approximation to)** the low-risk guidelines: Men: Up to 15 drinks per week; Up to 3 drinks per day most days Women: Up to 10 drinks per week; Up to 2 drinks per day most days **-and-** Cannabis use: never, **-or-** just once (past 12m or lifetime), **-or-** more than once > 12m ago, **-or-** more than once in the past 12m **and** frequency was < once a month.
Tier 2	One <u>abuse</u> problem (out of 4) related to alcohol **-or-** cannabis **-or-** other drugs excl. cannabis, 12m **OR** Binge drinking (5+ drinks on one occasion), *once a month* **-or-** *2-3 times a month* **-or-** *once a week* **-or-** *more than once a week* **OR** Drinking above the LRDG: Men: **(**> 3 drinks per day on most days **-or-** >15 drinks per week**)** Women: **(**>2 drinks per day on most days **-or-** >10 drinks per week**)** **OR** Any self-reported disorder, current *[schz/psychosis/mood/anxiety/PTSD/learning/ADD/eating]* **-and- (***no perceived need* **-or-** *all needs met***)**. *[PNCDNEED in (1,2)]* **OR** Any drug use, 12m, excl. one-time cannabis use **OR**	One <u>abuse</u> problem (out of 4) related to alcohol **-or-** cannabis **-or-** other drugs excl. cannabis, 12m **OR** Binge drinking (5+ drinks on one occasion), *once a month* **-or-** *2-3 times a month* **-or-** *once a week* **-or-** *more than once a week* **OR** Drinking above the LRDG: Men: (> 3 drinks per day on most days **-or-** >15 drinks per week**)** Women: **(**>2 drinks per day on most days **-or-** >10 drinks per week**)** **OR** Any drug use, 12m, excl. one-time cannabis use

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	Any prescription drug use not as prescribed **OR** Cannabis use more than once in the past 12m, **-and-** frequency was once a month or more.	 **OR** Any prescription drug use not as prescribed **OR** Cannabis use more than once in the past 12m, **-and-** frequency was once a month or more.
Tier 3	**(**2–4 abuse problems **-or-** 1–2 dependence problems on any one (or more) of alcohol **-or-** cannabis **-or-** other drugs, 12m**)** **OR** **(One** 12m CIDI disorder that is not alcohol, cannabis, other drugs, and bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale <4. *MHPFINT=2 (not sig. interference)***)** **OR** **(**Any self-reported disorder, current *[schiz* ***-or-*** *psychosis* ***-or-*** *mood* ***-or-*** *anxiety* ***-or-*** *PTSD* ***-or-*** *learning* ***-or-*** *ADD* ***-or-*** *eating]* **-and-** Perceived needs *partially met* **-or-** *not met***)** **OR** Perceived need for care *(needs partially met* **-or-** *needs not met).*	**(**2–4 abuse problems **-or-** 1–2 dependence problems on any one (or more) of alcohol **-or-** cannabis **-or-** other drugs, 12m**)** **OR** Perceived need for care *(needs partially met* **-or-** *needs not met).* (*May include some mental health comorbidity*)
Tier 4	**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis**)** [AUDDYD or SUDDYCD or SUDDYOD] **OR** **(One** 12m CIDI disorder that is not alcohol, cannabis, other drugs, or bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-**	**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis**)** [AUDDYD or SUDDYCD or SUDDYOD] (*May include some mental health comorbidity, but not meeting criteria for Tier 5*)

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	Sheehan >=4. *MHPFINT=1 (significant intf).***)** **OR** **(**2+ CIDI disorders including alcohol **-or-** cannabis **-or-** other drugs, interference not necessary**)** [alcohol abuse or dep. (12m), cannabis abuse or dep. (12m), drug abuse or dep. (12m), major depressive episode (12m), bipolar II (12m), hypomania (12m), GAD (12m)**]** **OR** **(**Self-reported schizophrenia **-or-** self-reported psychosis **-or-** bipolar I**)** **OR** **(**Self-reported mood **-or-** anxiety **-or-** PTSD **-or-** ADD **-or-** learning disability **-or-** eating disorder**)** **-And-** **(**Hospitalized overnight for a mental health, alcohol, or drug problem **-or-** Had suicidal ideation**)** **OR** K6 >=13. *(Serious distress.)*	
Tier 5	**Four stand-alone sets, separated by 'OR':** **(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **-And-** **(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4.**)** *MHPFINT=1 (signif. interference)* **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]**	**Dependence and interference is required, and then either one of the two sets after AND, separated by -OR-, is required:** {**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **AND** **(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4**)**. MHPFINT=1 *(signif. interference)* **-And-** **(**1+ chronic condition *(out of 7)*

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
Tier 5, contd	**OR** **[(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4**]**. *MHPFINT=1 (signif. interference)***)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]** **OR** **[(**Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]**. **OR** **(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **-And-** **(**Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]**	**-or-** WHO_DAS=high *(90th pctile)***)** **-OR-** **[(**Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]}.**

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