

Using lived experiences to help identify needed mental health services changes

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Over the past several years, mental health care has moved from the sidelines and into the spotlight of health policies throughout Canada. In 2006, a Senate committee prepared an in-depth report on the state of mental health care in Canada and urged a transformation of the country's mental health system to a "community-based, integrated continuum of care."¹ This idea is not new, however, as Ontario's mental health policy has been struggling since 1993 with the notion of creating "a coordinated system with greater emphasis on community-based mental health care."² These grand views are to be commended, but it is difficult to quantify and measure any movement toward these goals. While data about the access and use of mental health services provided by hospitals can be easily gathered,³ the challenge is in collecting data from community-level organizations.⁴ There appears to be a lack of standardized reporting structures that follow transitions from hospital-provided services to community services, thereby making analysis of the effectiveness of changes challenging. Likewise, there are few qualitative studies that examine Canadian client experiences within mental health care systems that bridge hospital and community.

As a doctoral student with mental health issues, I recently experienced the mental health care systems in three communities within 150 kilometers of each other simultaneously. Using my own experience as a backdrop for this discussion, I encountered the following realities as I tried to advocate for help during my crisis. The first responder was a small community hospital where my needs were quickly addressed and I was required to speak with a crisis counsellor before being released. I continued to see the counsellor and attended a six-week wellness group session to fill the wait time between intake and availability of a mental health therapist. Once assigned a therapist, I then had access to the visiting psychiatrist. From the moment of my crisis until I released myself from their care,

I had continual connections with people who provided me with supportive assistance.

My family physician, in a much larger city, realized my need for immediate psychiatric assistance and made a referral within his community. The centralized intake and referral program put me on a waiting list that was expected to take at least four months. All other programs were similarly waitlisted and no other interventions were immediately available. Frustrated with the wait times to see a psychiatrist, I also searched a smaller city nearby. There was no centralized system for psychiatric or other services and no one I contacted was able to provide alternatives or suggestions of available services.

All three communities were vastly different in their approach to mental health care even though they all fall under the same Local Health Integration Network (LHIN) in Ontario. The mandate of the LHIN is the development of health priorities and strategic directions for their communities and includes increasing access to mental health services.⁵ However, Kirby and Keon¹ anticipated this type of variance and noted that services would not be the same between provinces, regions, and even municipalities due to differences in communities. While this would make the creation of one national health care model unwise, they do state it is important to provide a continuum of basic services.¹

In many regards, I understand that my experiences were not unique. The Senate report¹ contained the voices of many people with mental illness who shared their experiences within the mental health care system in Canada. They noted six-month wait times, lack of information about support, confusion and frustration in accessing services, and even services which were not available.¹ Service providers themselves continue to identify areas that are lacking, such as client input, coordination with service ►

systems, overall resources, accessibility to treatment, and an absence of collaboration between service providers.⁶ Even family physicians are frustrated by wait times for mental health referrals, feedback regarding their clients, and overall knowledge of services available.⁷

However, unlike my experience, many people are only able to access services within their area. It is therefore important to realize that if someone only experiences something in one way, how can he or she know to ask for something different? Further, how can communities know which changes to make to address these unknown gaps? With very few research studies investigating the lived experiences of outpatient and community mental health service clients in Canada, addressing change proves difficult. However, Rudnick et al. remind us that “knowing the lived experience of people who have mental health challenges is considered instructive and hence potentially helpful for... mental health care providers.”⁸ Utilizing this qualitative approach in and across communities throughout Canada may help identify differences between communities and provide options for change. Only by encouraging clients to identify what works, what does not work, and what they need, can true mental health service reformation begin. ■

References

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Lorna Corzine is a doctoral student in Nipissing University's Educational Sustainability program and is using narrative research to learn how youth with mental health issues are supported in schools and identify needs that still need to be met. She received her Master of Education in 2011 after examining her own experiences with mental health, depression, and anxiety through story. Previously, Lorna has worked on literacy initiatives for children and adolescents and with aboriginal students and communities. Residing in Sudbury, Ontario she also has an interest in service availability in the North.