1990

A mental health needs assessment of the industrial area of Cape Breton Island, Nova Scotia

James R.D. Ross
Wilfrid Laurier University

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents

A MENTAL HEALTH NEEDS ASSESSMENT OF THE INDUSTRIAL AREA OF CAPE BRETON ISLAND, NOVA SCOTIA

by

James R.D. Ross

B.A. Psychology, St. Mary's University, 1971

A thesis submitted to the Department of Psychology in partial fulfillment of the requirements for the Master of Arts degree

Wilfrid Laurier University

Waterloo, Ontario, Canada

ISBN 0-315-58913-2

ACKNOWLEDGEMENTS

First, I would like to thank all of those who participated in this study by sharing their thoughts and feelings regarding the delivery of mental health services in Industrial Cape Breton with me. Without their input this needs assessment would not have been possible. My thanks are also extended to the Cape Breton Mental Health Association, particularly those members who participated as part of the steering committee, for their support of this study. I thank Dr. Steve Chris for his enduring support and encouragement. His additional perspective always allowed me to see this project in a positive light. My thanks are also extended to my committee members Dr. Richard Walsh and Dr. Geoff Nelson for their valuable contributions and assistance. Finally, I would like to thank Dia for always being there and for her ongoing belief in and support of me.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

ABSTRACT

A mental health needs assessment of the industrial area of Cape Breton Island, Nova Scotia was conducted between September and December, 1989. The study was sponsored by the Cape Breton Mental Health Association. A collaborative approach which emphasized community involvement was utilized to design and implement the study. The study used a convergent analysis of the data to elicit a comprehensive and multidimensional perspective on mental health needs from four sub-samples, including the administrators of mental health services, socio-mental health professionals, consumers of mental health services, and the general public. Data were also obtained from five groups (i.e., youth, those with chronic mental health problems, the elderly, Natives, and women) that were identified as being underserved by the extant services. Finally, four groups (i.e., staff with the Cape Breton District School Board, members of Canadian Friends of Schizophrenia, administrators of homes for special care, and concerned citizens of New Waterford) with specific interests in the delivery of mental health services submitted input into the needs assessment. A variety of needs assessment techniques were used to collect data including a modified community impressions approach which was augmented with community forums, nominal and focus groups, key informant interviews, an analysis of existing services, and a mail survey.

The data were analyzed using the following seven mental health service categories which delineate the program areas of mental health services offered in the Industrial Area: 1) problem identification, 2) coordination and direction, 3) treatment/intervention, 4) familial

support, 5) accommodation, 6) transportation, and 7) education.

The identification of major mental health concerns reflects both inter-sample consensus and individual sample concern. The recommendations address the perceived needs documented in the study. They reflect the key findings of the study and indicate specific areas in which to encourage future efforts from the mental health delivery system and the community.

Recommendations were offered in all of the seven categories. The major concerns highlighted by the study are improved coordination of services, an emphasis on an outreach and community-based orientation in the delivery of mental health services, and augmented human resources. Given the limited resources, the use of the mental health professional as consultant was stressed. Youth and the psychogeriatric population were identified as groups who are in particular need of enhanced mental health services. The importance of working with these groups as part of the family unit is recognized. In addition to offering a range of recommendations for specific services the study also makes note of the importance of macroeconomic variables, including poverty and unemployment, and the effects these factors have on a person's mental health. Suggestions for a service delivery model which encourages local citizen participation are offered.

An executive summary offering recommendations was prepared and distributed to representatives of the various groups surveyed in order to validate the findings and solicit input regarding the implementation of the recommendations. A community forum has been planned at which time the results will be released to the public. The forum will serve as a

final verification of the findings and stimulate further dialogue within the community on how to implement the recommendations.

A Mental Health Needs Assessment of the

Industrial Area of Cape Breton Island, Nova Scotia

Overview Of The Project

This mental health needs assessment was conducted as a result of collaboration during the spring of 1989 between members of the Cape Breton Mental Health Association (CBMHA) and the author. Historically, the Association has had success in establishing a number of projects in the Industrial Area including group homes and a drop-in center for those with chronic psychiatric problems. However, it was concerned about what project it should tackle next and what the priority of the mental health needs of the Industrial Area is. Prior to this study there was no comprehensive data base to systematically document, substantiate, and rank the needs of the broad range of stakeholders involved in the delivery of mental health services. The importance of ascertaining the mental health needs of the Industrial Area was further emphasized with the release of the report of the Nova Scotia Royal Commission on Health Care and its recommendation that Cape Breton be designated as one of the areas where a regional authority would be established (Report of the Royal Commission on Health Care, p. 54).

In order to design and implement the needs assessment study a steering committee consisting of board members of the CBMHA was formed. The study was designed during the summer and early fall of 1989. The collection of data was completed between October 15 and December 31, 1989.

The research activities undertaken by the CBMHA were designed to

determine:

1) What mental health services are presently provided, by which organizations and agencies in the industrial area of Cape Breton?

2) What are the identified, perceived mental health needs of the Industrial Area?

3) What recommendations can be developed to meet the mental health needs of the population and strengthen the mental health service delivery system?

This study used a convergent analysis (Siegel, Attkisson, & Carson, 1978) of the data to elicit a multidimensional perspective on mental health needs from four sub-samples, including the administrators of mental health services, the consumers of mental health services, members of the public, and socio-mental health professionals. This latter group consisted of direct service providers of mental health and related services, including social workers, teachers, police officers, physicians, members of the clergy, and lawyers. Data were also obtained from five groups that were identified as being underserved, i.e., youth, senior citizens, those with chronic psychiatric problems, women, members of the Micmac community. Finally, four groups with specific interests in the delivery of mental health services requested the opportunity to submit input to the needs assessment. The four groups with special interests were the administrators of homes for special care, a group of educators from the Cape Breton District School Board, members of the Canadian Friends of Schizophrenia (CFOS), and a concerned group of citizens from New Waterford. The data were analyzed using the following seven mental health service categories which delineate the program areas of mental health services offered in the Industrial Area:

i. problem identification
ii. coordination and direction
iii. treatment/intervention
iv. familial support
v. accommodation
vi. transportation
vii. education

I distributed the first survey, a self-administered mental health questionnaire, to 45 administrators. It was to be returned by November 17, 1989. A total of 29 surveys were used in the analysis of the data. This questionnaire utilized the above-noted seven program areas of mental health services. The administrators were asked additional questions regarding: the availability and accessibility of services, groups that were underserved by existing services, and features of the community which they thought might contribute to the mental health problems of the residents.

The second survey group consisted of 47 socio-mental health professionals. I obtained information from this group through the use of an interview guide. In addition to asking questions about needed services I also asked this group about the accessibility, availability and acceptability of mental health services. I interviewed all of the socio-mental health professionals in person.

The third group that was surveyed was the public. In order to obtain information from this group, a media campaign was conducted and community forums were held in four of the communities in the Industrial Area: 1) Glace Bay, 2) New Waterford, 3) Sydney and 4) North Sydney. A nominal group process was used to obtain focused and ranked information from those in attendance.

The fourth survey in the study was designed to obtain information on the mental health care system from the unique perspective of service recipients and/or client advocates. I solicited consumer participation

through an intensive print and broadcast media campaign. The publicity encouraged potential respondents to call an advertised telephone number and arrange for an in person or telephone interview. Twelve persons were interviewed. I used an interview guide consisting of four questions relating to the accessibility and acceptability of services, as well as requesting suggestions for the delivery of mental health services to obtain information from this group.

In addition to obtaining data from the above four groups, I obtained information from five groups that were identified as being underserved by the existing mental health services, by the administrators and by the socio-mental health professionals. Focus groups were conducted with both a group of high school and junior high school students. Additionally, I conducted nominal groups in Glace Bay and Sydney with two groups of consumers of mental health services who were identified as having chronic psychiatric problems. A nominal group was conducted with representatives of the Micmac community. As well, I conducted focus groups both with a number of senior citizens in Sydney and with a group of women living on low incomes in Glace Bay.

I also conducted focus groups with representatives of CFOS, the administrators of homes for special care for Cape Breton and a group of educators from the Cape Breton District School system.

The following criteria were used to assist in making recommendations for the delivery of mental health services in the industrial Cape Breton area:

1) The more frequently the issue was expressed through individual samples and through inter-sample consensus, the higher the priority for the recommendation addressing that issue.

2) The more a recommendation pertained to a need in which no service was presently available in the mental health service system to address this need, the higher the priority.

3) The more a recommendation was directed towards the integration of the service delivery system for the Industrial Area as a whole, the higher the priority.

4) The more a recommendation would reduce the necessity for going out of the Industrial Area for service delivery, the higher the priority.

The identification of major mental health concerns reflects both inter-sample consensus (i.e., the majority of survey samples identified the need) and individual sample concern (i.e., within each sample a considerable portion of the respondents identified the concern). The recommendations address the needs documented in the report as perceived by a cross section of those concerned with the delivery of mental health services in industrial Cape Breton. They reflect the key findings of the study and indicate specific areas in which to encourage future mental health efforts from the mental health delivery system and the community.

An executive summary offering recommendations for the delivery of mental health services was prepared and distributed to representatives of the various groups surveyed in order to validate the findings. Furthermore, a community forum is planned at which time the results and recommendations will be released to the public. The forum will serve as a final verification of the findings and be used to stimulate a dialogue within the community of how to implement some of the recommendations.

INTRODUCTION

The purpose of this thesis is to describe a comprehensive mental health needs assessment conducted in the industrial area of Cape Breton, Nova Scotia. In order to properly describe this survey I believe it is essential to describe the setting or the geographical area both from the point of view of some of the demographic characteristics such as unemployment and poverty and the effects they have on the communities' mental health. Furthermore, I give a brief history of mental health services in Cape Breton, describing both the growth of services and the shift from a primarily institutionally-based and medical model to a bio-psycho-social or human systems model and a more community oriented approach. The context of the present study is set by a review of three recent assessments of health needs. Furthermore, I describe the conceptual framework within which the present study is conducted and include a discussion of the orientation of the researcher as a community psychologist. The importance of involving the residents of the community in the entire research process is also described in detail in this discussion. I discuss the issues that should be considered in planning and conducting a needs assessment. Additionally, I describe the methods and strategies used to conduct the study. In the Method section I describe in detail the application of needs assessment strategies with all the groups of participants. In the Results section I delineate the findings from all of the stakeholder groups. Summaries of the information obtained from the administrators, socio-mental health professionals, consumers, and the public are provided. The Discussion of Results and Recommendations offer a synthesis of the results and a

convergent analysis of the data illustrating how the recommendations based on the findings were derived. Furthermore, I integrate the results and recommendations of this needs assessment with the findings and recommendations of other research efforts as they relate to the mental health needs of the residents of Industrial Cape Breton. Additionally, I examine the groups identified as being underserved with regard to economic variables such as unemployment and poverty. In the Conclusion I provide the readers with a summary statement including what I believe has been accomplished by this research.

Setting

In order for readers to have an appreciation of the setting and context in which this study was conducted and to be sensitive to some of the demographic factors that affect the mental health of the residents of the Industrial Area I believe it is important to provide a brief description of the area and note some of the relevant demographic elements.

Cape Breton is an island joined by a causeway to the northeastern end of Nova Scotia. It is 10,295 square kilometers in area and has a population of 166,116 (Statistics Canada, 1986). While it is primarily rural it does have an industrial core which is commonly referred to as the "Industrial Area" (Appendix A). For the purposes of this study, the Industrial Area is defined as including the city of Sydney, the towns of Sydney Mines, North Sydney, Glace Bay and New Waterford and the area between these towns. North Sydney and Sydney Mines are often referred to, collectively, as the "Northside". The population of the Industrial

Area is approximately 123,600 (Statistics Canada, 1986). The Industrial Area is composed of towns ranging in size from 2,754 to the city of Sydney which has a population of 27,754 (Statistics Canada, 1986). In addition, there are many smaller communities between these towns and some of the Industrial Area is, paradoxically, rural. As well, there is a Native Indian population of approximately 2,000 living in the Industrial Area and environs (Statistics Canada, 1986). The city of Sydney contains the Micmac Indian reserve of Membertou.

The primary industries of the industrial area of Cape Breton have traditionally been the manufacture of steel, the mining of coal, and fishing. Historically, Cape Breton has been plagued by extremely high unemployment with rates which are usually more than twice the national average. During the period that this needs assessment was being conducted, the unemployment rate in Cape Breton was 17.3 % while the national average was 7.5 %. Furthermore, those living in the Industrial Area have an average income which is 13% below the provincial average (Statistics Canada, 1986). The incidence of those living on low income is 22.1% which is five to six percent greater than the provincial and national rates (Statistics Canada, 1986). In part, because of the depressed economy and high unemployment there has usually been an outward migration of people from Cape Breton to other parts of Canada (Statistics Canada, 1986). As a result of this emigration, the Industrial Area is left with higher than average percentages of youth who are of school age (5-19 years of age) and of those who are of retirement age (65 plus years of age) or older (Statistics Canada, 1986). For those 15 years of age and over who live in the Industrial Area there is a higher than average

percentage of individuals with less than grade nine education (Statistics Canada, 1986). Additionally, there is a higher than average number of lone parent families living in the Industrial Area (Statistics Canada, 1986). Furthermore, significantly high rates of cancer have been reported in the Industrial Area (Lavigne, P., 1987). Rates of alcohol abuse in Cape Breton are higher then the national average (M. Meagher, personal communication, August, 1990). Additionally, the number of those seeking help from the Nova Scotia Commission on Drug Dependency has shown an increase over the past five years (Reports of the Nova Scotia Commission on Drug Dependency 1985-1990). Historically, Cape Bretoners have felt isolated from the mainland of Nova Scotia and have considered themselves unique. They feel alienated by provincial government policy and frequently insist on special programs to meet what they perceive as their unique needs. In fact, at present, the Cape Breton Development Corporation (DEVCO), a federally funded community development agency and the Sydney Steel Corporation (SYSCO), a crown corporation are the Industrial Area's major employers.

To some extent these unique needs are related to the poverty and high unemployment that Cape Bretoners suffer. It has been documented in studies examining the relationship between unemployment and physical and mental health that the unemployed report significantly higher levels of psychological distress and greater health service utilization than employed persons (D'Arcy, 1986).

Given the magnitude of the environmental factors including the isolation, alienation, poverty and unemployment and the effects such factors have on the mental health of the residents I believe it is

important that some consideration be given to the history and nature of the provision of mental health services in Cape Breton.

History and Nature of Mental Health Services in Cape Breton

In addition to considering the environmental factors that relate to the mental health of the residents of the Industrial Area and prior to looking at how mental health services have been and are being provided to Cape Bretoners, it may be relevant to consider the following information compiled by Statistics Canada and the Canadian Mental Health Association (cited in Graham, 1988, p. 3).

a) one out of every eight Canadians can be expected to be hospitalized for a mental illness at least once during his or her lifetime;

b) suicide was the second most frequent cause of death among Canadians between the ages of 15 and 39;

c) mental illness was the second leading category in general hospital use among those aged 20-44 years;

d) over the next twenty five years we can expect a doubling of mental disorders for the elderly and a forty percent increase in chronic functional disorders with little change in the number of acute cases

The Cape Breton Hospital (CBH) has been providing psychiatric services to the residents of Cape Breton Island since 1902. Historically, there have been major shifts in terms of the type and quality of services offered to the community based upon a variety of factors including legislative changes, the emergence of new mental health professional groups, public attitudes towards the mentally ill, introduction of new treatment modalities, the emergence of community agencies, and new modes of support. Services have come a long way since the time when individuals were placed in psychiatric institutions for

everything from vagrancy to mental retardation. Then the criteria appeared to be more dependent upon whether the individual was socially "acceptable" to the community than what the type or magnitude of his or her mental illness was (J. Blackwood, personal communication, July 1989).

Prior to 1951 the CBH was a chronic or long-term facility. Most patients were permanent residents. As was the way in most of Canada, the psychiatrists and nurses in psychiatric hospitals, and to a much lesser extent the general practitioner in the community constituted the system's primary resources. As a response reflecting a new attitude of community-based treatment the Cape Breton Mental Health Clinic (CBMHC) was established in 1958. The establishment of CBMHC paralleled the beginnings of the community mental health movement in Canada which can be traced, in part, to the CMHA's pioneer report More for the Mind (1963). While presently this movement espouses a number of principles including an emphasis on prevention and a concern with the social environment one of the movement's initial concerns was a focus on the community rather than the psychiatric hospital as a locus of treatment (Heseltine, 1983).

In Cape Breton a move to "purer" or more active treatment psychiatric services occurred in 1976 with the establishment of Regional Mental Health Centers. Thereafter, many individuals who had previously been housed in psychiatric institutions were placed in these more appropriate facilities consistent with their behavioral/social difficulties and needs. As a result there was a major reduction in the number of individuals in psychiatric institutions with non-psychiatric diagnoses, allowing a greater opportunity to effectively deliver psychiatric treatment programs.

With the passage of the Hospitals Act in 1979, more appropriate controls were placed on the treatment of the mentally ill as well as upon the criteria and process for admissions to psychiatric institutions. In addition to the development of better services for the mentally handicapped and the development of group homes, these changes have had a significant impact on the number of inpatient beds within psychiatric institutions. With this policy of deinstitutionalization the primary mode of treatment has become outpatient and what has been referred to as "community-based" (The Submission of the Cape Breton Hospital to Nova Scotia Royal Commission on Health Care [Submission], 1988).

From its beginnings in 1958 with one clinic located in Sydney, staffed by one psychiatrist, the CBMHC has expanded to include full-time clinics in North Sydney and Glace Bay with a part-time clinic in New Waterford. Additionally, satellite clinics operate in a number of other communities outside of the Industrial Area one day a month or on an as-needed basis. The staff now includes psychiatrists, psychologists, social workers, and psychiatric nurses who specialize in a wide variety of areas including adolescence and gerontology. The C.B. Hospital's caseload has more than tripled in the last decade. Additionally, there has been a general increase in the number of referrals within certain groups including adults and children requiring crisis intervention services, children and adolescents, and adults over the age of 65 (Submission, 1988).

In addition to the Mental Health Clinic there are other services including Family Services of Eastern Nova Scotia, as well as a number of psychiatrists, psychologists, and social workers who provide

psychotherapy and counselling in private professional settings. There is also a variety of agencies and organizations offering related services such as housing, child protection, vocational services and addictions counselling. Furthermore, there are self-help and support groups such as Canadian Friends of Schizophrenia (CFOS) and Community Friends in the Industrial Area. A further presentation of the resources available will be included both in the Results section and in the Appendices.

In general, the delivery of mental health services in the Industrial Area has become more attuned to the needs of the consumer. There has been a shift from a purely medical organizational model and prime therapist delivery system to a human systems approach with the use of a consultation as well as prime therapist approach to delivering services. However, the discharge of patients from institutions combined with the economic problems and the scattered distribution of the population in the Industrial Area has created problems for those who administer provincial mental health systems. Given the forecasts that demands for services will continue to increase throughout the next decade, the dilemma of doing more with less will require creative use of all resources.

Previous Assessment of Needs

To this date there have been no attempts to conduct an overall mental health needs assessment of the industrial Cape Breton area. However, there have been studies and reports which have examined the health needs (including mental health) of Nova Scotians, in general, and those which have focused on a specific aspect of mental health in Cape

Breton. The following three reports constitute the most recent and relevant research in dealing with issues, concerns and needs in the field of mental health. While none of these three reports offer a general assessment of mental health needs, the reports both individually and collectively offer a number of useful perspectives on the mental needs of those living in Industrial Cape Breton. Furthermore, a discussion of the reports' findings help to set the present study in context.

In August, 1989 a document which dealt, in part, with mental health issues in the industrial area of Cape Breton was released. This report was entitled: Report of the Officials Committee of Industrial Cape Breton -Services for the Mentally Handicapped and Mentally Disabled. While the mandate of this Committee was to carry out, "...a total review and development of an overall plan for appropriate services and facilities for mentally handicapped and mentally disabled individuals in Industrial Cape Breton" (Report of the Officials Committee - Executive Summary, [ROCEC] 1989, p. 1), the Committee, in fact, dealt primarily with those individuals who were significantly handicapped, most of whom are presently institutionalized. The committee "utilized the skills and knowledge of a considerable number of provincial health and social services staff and consulted with a broad variety of advocacy groups and volunteer organizations" (ROCEC, 1989, p. 1).

In this report the Committee summarized their findings and offered recommendations relating to three groups: the mentally handicapped, the mentally disabled, and autistic adults. As there was considerable consistency in the recommendations I will summarize only those recommendations that deal, specifically, with the mentally disabled and

focus on the recommendations considered most important by the Committee. The recommendations are categorized in four service areas: a) residential, b) medical/psychiatric, c) vocational, and d) social/recreational. Regarding the issue of residential services the authors of the report included a projection of the need for more group homes and supervised apartment services. It was recommended that an "implementation committee" be mandated to ensure that "coordinated and comprehensive community programs are established for all new community placements including residential, day program, medical/psychiatric back-up and leisure time services. The Committee, additionally, recommended that there be a consultation with the Regional Housing Authority to ascertain if the housing needs of the mentally disabled can be included in plans for expanded public housing programs.

Regarding medical/psychiatric services: It was recommended that the implementation committee determine how to ensure that professional treatment services are available to all individuals moving into expanded community residential services.

It was suggested that Mental Health Cape Breton be consulted regarding a strategic plan for vocational services. It was also recommended that Cardeil Place, a drop-in center for those with chronic psychiatric problems, be considered a cornerstone for public funding and day programs and that there was need for decentralized services similar to those offered at Cardeil Place on the Northside and in the Glace Bay/New Waterford areas.

Under the social/recreational category it was recommended that municipal recreation departments be encouraged to act as consultants in

planning and to modify programs for those who are mentally disabled where applicable. The development of "drop in" programs and the inclusion of churches and social service agencies to help identify volunteers was encouraged by the Committee.

While the "Officials' Report" offers appropriate short and long-term recommendations for the population it deals with, its focus is rather narrow and does not address the mental health needs or resources of a large sector of the population.

A second project which addressed, at least in part, the mental health needs of the residents of the Industrial Area was a survey entitled, Speaking Out About Mental Health: A Needs Assessment. The report was released in October, 1989 by the Self-Help Connection of the CMHA, Nova Scotia division. This report "shared the language and views of consumers, family and friends, and key informants about mental health community living needs of consumers of mental health services" (Speaking Out About Mental Health [SOAMH] 1990, p. 63). Although responses were obtained from eight regions in Nova Scotia some common themes emerged. These important themes centered around the language used to talk about mental health, services available to consumers, and views about self-help. The report noted that the language used by professionals places consumers in diagnostic categories or "boxes" that lead to treatment choices. Consumers, on the other hand, see problems within the context of their whole life and often think professionals only see a small portion of their world. "The use of only partially shared language by consumers, family and friends, and mental health professionals complicates decision-making an decreases the sharing of power concerning

treatment choices" (SOAMH, 1990, p. 63).

Regarding the issue of services that are available to consumers: It was noted in this report that, while there is a basic "safety net" of services available to consumers, there are far fewer community-based mental health services. Furthermore, it was noted that in some rural areas the lack of transportation can create inequities in access to the existing social and mental health services. Respondents also described a lack of coordination among professionals and between the social service, health, and correctional sectors. This lack of coordination reportedly results in difficulty in gaining access to services, poor service or the inappropriate use of services. It was suggested that case management strategies which help professionals from different agencies "follow" a consumer are needed to coordinate services so that the consumer's potential to live successfully in his or her community will be maximized. While coordination is essential, it only works when the services are available. It was noted that services at the community level often do not have sustained funding. Housing, social-recreational programs, and informal, helping networks were three community services most often expressed as being needed for community living by the respondents. The report noted that self-help has the potential to meet some of the support needs of family and friends by expanding social networks, sharing information and strategies of help, and by providing understanding of the consumer/family and friend situation. The comments from the respondents indicated a general interest in self-help on the part of consumers family and friends. The responses from key informants, including health professionals, was mixed and ranged from enthusiasm to cautious

reservation. It was suggested that both self-help groups and professionals need to talk about the role of the professional in self-help. Even though the benefits of self-help have been documented, there is a need to get the message to both the community and professionals. Some respondents expressed the fear that governments might cut back funds to some programs, community groups or agencies if self-help is seen as the panacea for chronic mental health problems.

The report attempted to translate the themes of language, services and self-help into needs for community living. It was suggested that consumer's needs for community living could be captured under three broad categories: 1) information, 2) support, and 3) participation and trust. The report indicated that the consumer requires information about the causes and nature of their illness, treatment, side effects of medication, the availability of community services and how to use them, and about his/her legal rights. The consumer requires support from health professionals, family, friends, community, and self-help groups. It was noted that there must be a recognition that the consumer can participate in treatment choice and through self-help processes more actively participate in his or her own therapy. Confidence and trust must exist between the consumers and others in their social and professional networks.

The eight Community Resource Groups which participated in the study along with Self-Help Connection staff will use the findings to stimulate community discussion, foster awareness of community needs, and encourage the development of self-help initiatives. Community forums coordinated by the Self-Help Connection staff are planned throughout Nova Scotia.

This report was rather narrow in its perspective, addressing only the issue of self-help as it related to those with chronic psychiatric problems. Although some common themes emerged from the various groups surveyed throughout the province, the study did not, specifically, address the needs of those living in industrial Cape Breton, nor was an attempt made to describe the existing resources in that region.

In December, 1989, The Report of the Nova Scotia Royal Commission on Health Care - Towards a New Strategy- Summary was released. This report resulted, in part from public hearings conducted throughout Nova Scotia during the period of April 21 to July 13, 1988. While the complete report of the Commission is three volumes, there is a summary available. Although this summary report is 99 pages in length, less than two pages, specifically, address mental health services. Furthermore, the Report does not address the concerns of Cape Bretoners in general or the residents of the Industrial Area in particular. However, the Report does conclude that "decentralization of government functions and delegation of authority to the regions are integral to effective management and efficient delivery of health services" (p. 12). The Commission also proposes the creation of Regional Health Authorities which would be responsible for the planning and management of the full complement of health services and programs delivered within their regions.

The Report states that: "each Regional Health Authority will develop its Regional Services Plan for health programmes based on regional and local priorities (p. 42)". Beginning with an assessment of local needs, it will set priorities for health services and determine the range, extent, and quantity of health services offered in its

jurisdiction. Furthermore, the Commission notes the importance of including related services which assist the individual to cope with his or her condition. Common to these services is a need for coordination, integration, and accessibility throughout the province.

Regarding the area of mental health, the Report states that "the field of mental health is a complex, multi-disciplinary and multi-agency field" (p. 64). It is stated in the report that 80 percent of the budget of the Psychiatric Mental Health Division is taken up with inpatient hospitalization services. Very little of its budget or work could be described as community mental health services. It is suggested in the report that the Royal Commission's recommendation to drop the term "Psychiatric" in the Division's name signals a proposed broadening of approach. The report further states that psychiatric outpatient services offered through mental health clinics need to be evaluated both to clarify their appropriate function and role within the field of mental health care and to develop strategies for delivering disciplinary mental health services. It was noted that planning and information requirements for mental health services need to be reviewed and the overall quality of care evaluated, with a view to increasing the emphasis on community mental health services and mental health promotion.

Additionally, the report noted that human resource needs must be addressed and that the use of alternate professionals should be explored to meet the need for services. Alternate professionals who are specifically mentioned are clinical psychologists and social workers. Additionally, it was noted that the specialty of chid psychiatry continues to experience a steady increase in the demand for services. It

was also noted that under the Young Offenders Act, the courts require assessments of adolescents that the psychiatric facilities have been unable to provide. Finally, on the issue of mental health services, the Report states there is also a need to more effectively provide care for the health of Nova Scotia's correctional center population.

All three of these reports utilized a multiple-perspective approach, obtaining input from a wide range of stakeholders. Although the focus and magnitude of the reports varied considerably, there were some common themes that emerged including the need for decentralized and better coordinated services. In all cases the need for a move towards a more community-based approach was identified. There was also the recognition of the need to broaden the range of those included in the delivery of services from the need for more non medical professionals, including clinical psychologists, social workers, to those providing pastoral care. Additionally, the importance of self-help and volunteers was emphasized in the provision of services.

All of the above studies were useful interventions which can be used in program planning. However, these reports either deal with very specific elements of the population or deal with the issue of mental health and the geographical area of industrial Cape Breton as merely facets of other issues or areas. As such, whether these reports are viewed individually or are melded they do not provide a unified and global assessment of the mental health needs of the industrial area of Cape Breton. Furthermore, given the recommendations of the Royal Commission regarding the establishment of Regional Health Authorities and its suggestion that a local assessment of need be conducted to establish

priorities, the need for this present study is particularly timely. In the following section I discuss some of the concepts and values of community psychology in which this study is set.

Conceptual Framework

I believe that in order for readers to have an appreciation of this needs/resource assessment, it may be helpful for them to have an understanding of the theoretical and conceptual basis of community psychology. In recognizing the values that many community psychologists subscribe to, it is equally important to recognize the influence that values and biases play in every aspect of a research project. Furthermore, one should be aware of the effect these values may have on the relationship between the researcher and the community (Myrdal, 1969). Our values can affect our choice of research problem, how we frame the research questions, conduct the research, and interpret our findings. It is becoming clear that researchers are being influenced by the very processes they study. Rather than deny the importance of social forces and personal values we must recognize that science and values are not incompatible. Indeed, as these values can influence our research, it is important to make one's values and biases as explicit as possible and to attempt to understand their impact on our work.

Historically, psychologists have focused on the individual in attempting to understand the cause of mental health problems (Heller et al., 1984). Often individuals who failed to meet a single standard of competence were thought to be in need of the help of a professional. Such individuals, rather than developing their own strengths and

competencies frequently became dependent upon the professional, thus often feeling less in control of their lives or becoming disempowered (Walsh, 1988). However, the 1960's saw the beginning of a major reorientation in clinical psychology. Funding for mental health programs was becoming increasingly scarce and the demands for those funds were rapidly increasing. Treatment facilities were becoming overcrowded and there was a growing belief that traditional forms of psychotherapy were lacking in social utility. Too many troubled individuals did not meet the entrance requirements for treatment and for one reason or another were not seen as appropriate candidates for psychotherapy. Patients were being warehoused in public mental hospitals and even for those who were discharged little was provided to help with the resumption of normal community living. A part of this reorientation was the recognition that the traditional concerns of psychology such as individual behavior and psychological well-being could not be understood without consideration of broader social issues. Furthermore, the importance of prevention was recognized. In part, as a result of decreased resources and the recognition that, even if desirable, there could never be enough resources to satisfy all the needs of the population, community psychologists began to suggest that there be a shift from services which provide solely treatment to an emphasis on the prevention of mental health problems (Walsh, 1987; Heller et al, 1984).

Hand in hand with this reorientation came an evolving set of ideas such as the rejection of the "person blame" (Ryan, 1971) concept, which held the individual responsible for all of his/her woes, and its replacement with a systems-level explanation of mental illness. This

move to a systems-level explanation of mental health problems included a shift to an ecological orientation that emphasized the interactions of persons and their environments and a recognition of the importance of interventions at the organizational or community level to help prevent problems. Along with this shift to a systems approach came a belief in the competency of individuals, a respect for human diversity and an understanding that all people could gain increased control of their lives, thus achieving a sense of empowerment (Fisher, 1982; Rappaport, 1977; Walsh, 1987; Watzlawick, Welland & Fisch, 1979). Additionally, Sarason (1974) advanced the idea of a "psychological sense of community", that is, that the isolation and alienation of individuals could be decreased by networking or supportive links. Campbell (as cited in Patton, 1980) in speaking of making a commitment to social change suggested that citizens who were not service providers or part of the government bureaucracy should have the means to communicate their disagreements to those responsible for decision-making. Implicit in these ideas was the belief that there should be close collaboration between citizens and scientists (Chavis, Stucky & Wandersman, 1983).

Tied to the concept of collaboration was a recognition of the importance of responsiveness which was perhaps best articulated by Reiff (1974). He pointed out that many social systems (e.g., public schools, welfare departments) were not listening to their catchment populations and gave them no power in decisions that affected them. To make social systems more responsive their constituent populations have to be able to participate more directly in policy-making and decisions. As Neuber (1980, p. 15) notes, "It would seem that organizations have a greater

likelihood of achieving identified goals by developing a conceptual and operational framework for providing human services based on the perceived goals, needs, and characteristics of the community which the agency serves." Responsiveness has continued to be a basic value for community psychology. In the ensuing years there has been a distinct movement toward greater citizen participation in many areas. Needs assessment is one result of the move towards greater responsiveness and as Zautra and Bachrach (1983) note it is a useful tool in planning prevention programs.

A final community psychology concept that is relevant in the present study relates to the collection and analyses of data. Historically, psychologists have subscribed to a traditional model of research in which there is hierarchical control of the research process. In such a paradigm the researcher is detached from his or her "subjects" and they have little say in the research process. The researcher strives for objectivity which he/she presumes will increase the reliability and validity of the findings. Contrary to the values of traditional researchers, community psychologists would argue that the requirements of reliability and validity are not absolute but depend upon the researcher's objectives. Community psychology research is by nature applied research which is grounded in the philosophy of humanism and recently has turned to a more naturalistic approach to inquiry. The newer methodologies do not always mesh well with the traditional experimental methods used in laboratory research. However, quasi-experimental and non-experimental methods, including surveys, can permit an understanding of real world behavior and assist in identifying areas of need (Fisher, 1982). It is now clear that the objectivity and

validity of research is increased through interpersonal exchange between the researcher and the data source (Walsh, 1987), and that failing to obtain input from all sectors including the client or the consumer will likely result in a biased evaluation or assessment (Siegel, Attkisson & Carson, 1978). In many cases, researchers have abandoned the more traditional scientific methodologies and have attempted to involve citizens in the research process through cooperation and collaboration. This idea of the importance of obtaining information about a specific area from a number of separate sources is often referred to as the concept of "multiple perspectives" (Patton, 1980). It is based on the belief that each source of information may have a different but equally valid perspective.

It is clear from the above discussion that community psychologists have not only established a new orientation to conducting research and adopted new methods and strategies of collecting data but have made a value commitment to social change in the community. Price and Cherniss (1977) summarize several characteristics that would be appropriate for psychologists conducting research in the community: 1) Research issues or problems should be stimulated by community need; 2) Research should be a tool for social action; 3) The research should yield useful products; 4) Evaluation of social action is an ethical imperative.

While this discussion of the conceptual framework within which the present study has been conducted is by no means exhaustive, the goal was to provide the reader with a basic understanding of the community psychology concepts and values which are relevant to this investigation. Throughout this thesis the themes discussed in this section will

resurface. The importance of each will become clear through its application.

Community Involvement

Running throughout the above discussion of the concepts and values of community psychology is the theme of the importance of responsiveness and collaboration or involving consumers and citizens throughout the research process. As noted, far too often researchers have failed to recognize the needs of community members. As such, researchers have often contributed little to communities in return for observing and altering community processes as they please. This is particularly unfortunate as the residents are often in a unique position to help researchers improve their methods and to provide insight into the meaning of research findings. Furthermore, numerous authors have reported a discrepancy between service needs given priority by client populations and the needs attributed to that population by the professionals who provide service to them (Posavac & Carey, 1985; Miller, 1981; Hodgson, 1984; Crocker & George, 1985). This may, in part, be due the fact that professionals have their own interests which are not necessarily in agreement with the interests of their clients (Dubey, 1970; Rappaport, 1977). Alternatively, it may simply reflect the traditional medical model of problem definition and solution in which the professional is expected to possess all the answers and the idea of consulting the client population is never considered.

In addition to the importance of obtaining information from residents and consumers because of the discrepancy between data obtained

from service providers and users there is a number of other rationales for resident and consumer participation. The first relates to program relevance and adequacy. The lack of basic involvement of the people the programs try to serve often leads to programs which are insufficient and inappropriate. It is therefore considered important to involve the consumer in order to obtain a realistic perspective on the appropriateness and effectiveness of services. The consumer is in the best position to define his or her own needs and to suggest appropriate use for government funds. Another reason for involving the consumer is to facilitate the establishment of a power base both through the networking of various fragmented groups and by vesting the residents with ownership or control of the programs. Furthermore, involving residents and consumers in the planning process will increase their support for program development efforts and in so doing increase the likelihood that they will volunteer their time. Consumers begin with a basic knowledge of other consumers' concerns and likely with established empathy. With the appropriate training, volunteers can work hand in hand with professionals to improve the delivery of services (Hodgson, 1984). Citizens who are involved in the planning process will increase the probability that the new or restructured programs will be used (Rothman, 1978; Crocker & George, 1985). Another reason for involving community residents lies in the value of participatory democracy. It is generally assumed that every citizen should contribute to the working of society to the fullest possible extent. More so, encouraging the fullest possible citizen participation by actively involving residents, particularly consumers in the planning process helps to increase their sense of self-

worth and empowerment as they become aware of the contributions they are able to make.

In the following section I discuss factors which should be considered in conducting an assessment of need. It will become apparent that the most effective means of conducting a needs assessment is through ensuring the involvement of all of the stakeholder groups.

Needs Assessment

In this section I examine some of the important issues that need to be considered in planning and implementing a needs assessment. It should become clear that while the assessment of need is not a precise science and that there is not a standard format to follow in determining the needs of the community, a careful consideration of the following issues will help to ensure that a comprehensive needs assessment can be conducted. The basic assumptions on which this section is based are that the assessment of need must be undertaken at the community level in order to stimulate the coordination of human services, that the assessment acts as a rationalizing force in the planning process of human services, and that it must blend citizen and consumer participation with that of the service provider in a planning process which will stimulate program relevance to human service needs. Furthermore, a community needs assessment can be conducted in a spirit which is consistent with the philosophy of community psychology.

As noted, previously, the assessment of need is one result of the greater societal movement toward increased responsiveness. Needs assessment has its roots in epidemiology, which is by definition

preventative (Zautra et Bachrach, 1983). Although the concept and orientation of needs assessment continues to be largely preventative, the technology for implementing needs assessment has progressed a long way from the rather simple and detached analysis of health indicators to determine needs. Indeed, both the concept and technology of needs assessment are ideally suited to conducting community research which is consistent with the values and concepts of community psychology. Needs assessment is suited to examine the system in which the individual functions and to determine what the individual needs to function more effectively within his/her environment. The methods and strategies are suited to permit input from diverse sources including consumers and the public. Such input can help to facilitate or enhance the empowerment process by allowing individuals to see that they are being listened to, that their opinions are respected, and that they can effect change. Furthermore, the use of group techniques such as community forums, can help to reduce the sense of isolation and to encourage networking. Most all of the methods and strategies of needs assessment allow for a close collaboration between the researcher and the residents which helps to ensure a greater understanding and sensitivity to the needs of the citizens.

In general, need assessment strategies are designed to provide data that will enable planners to determine the extent and kinds of needs there are in a community, to evaluate existing resources systematically, and to provide information for planning new service programs in the light of the communities' needs and human service patterns. The major goal of any needs assessment is to make a reasonable match between needs and

services. According to Bloom (1977) the assessment of need involves two distinct steps: a) the application of a measuring tool or assortment of tools to a defined social areas, and b) the application of judgement to assess the significance of the information gathered to determine the priorities for program planning and service development.

While the data obtained through needs assessment basically describe and define social conditions, the conditions are not necessarily predetermined as positive or negative and will depend to a large degree on the values and expectations of those making the interpretation. In some respects the same rationale applies to a definition of need. Need, at best, is a relative concept and its definition will depend upon those who are undertaking the assessment. Nguyen, Attkisson, and Bottino (1983) have developed a useful definition of unmet need. According to these authors, unmet need is defined contingently upon:

1) The recognition of a problem, a dysfunctional somatic or psychological state, or an undesirable social process

2) The judgement that satisfactory solutions are not accessible, are not currently adequate, or do not exist in the community

3) The necessity to reallocate existing resources or to appropriate new resources.

Having established the purpose of conducting needs assessments and the factors to be considered in establishing an unmet need it may be appropriate to discuss some of the factors that must be considered prior to conducting a community needs assessment. According to Siegel et al. (1978, p. 219), the following issues should be considered prior to undertaking an assessment of needs: The first is that while some of the data obtained may be objective, planning itself is a "human and-value based process" (Siegel et al. 1978, p. 219). This is true because all

human service programs have a heterogenous group of stakeholders. These stakeholders not only represent diverse vested interests and often disparate values but may have conflicting expectations based on their particular values and interests. Given these diverse perspectives, it is essential that the program planning process provide a forum for these perspectives and that this process allow an equitable voicing of views to prevent domination by particularly vocal individuals or groups.

In addition to the perspectives of the stakeholders and their influence on the interpretation of the data, there are the interrelatedness and diffuseness of mental health needs. Such needs can rarely be identified specifically enough to differentiate between those which are primary and those which are secondary, given each agency's unique responsibilities and resources. As a result, it may be difficult to establish priorities rationally and to determine which needs can be met most effectively by which agencies.

Additionally, there is the dynamic nature of human service needs which further complicates the assessment process. The communities that we live in are in a perpetual state of flux such that the needs that give rise to the original objectives may no longer be of the same magnitude or even exist by the time the program is fully implemented.

Finally, it should be kept in mind that the translation of needs into programs will also be influenced by a number of other factors not addressed in the community-oriented need identification efforts. These factors include the capabilities of the staff, the availability of appropriate service technology, and adequate financing.

The difficulty of conducting a needs assessment is further

complicated by the previously noted fact that the concepts of needs assessment are such that there is no one set of generally agreed upon rules to follow in order to obtain a comprehensive assessment of need needs. The reality is that those conducting the assessment must decide what information will generate the most comprehensive identification of needs in a specific geographic area. To this end, Siegel et al. (1978, p. 218) highlight some relevant variables which should be carefully considered when planning an assessment of human service needs. These variables include:

1) Information - Which data are most relevant? How easily can this information be obtained? How accurate and useful are these data likely to be?

2) Available Resources - What staff and fiscal resources are available? What is the cost of collecting the data? Will the expected benefits outweigh their cost?

3) State of Program Development - At what stage of development is the service system? What is the range of services currently available? Is there an existing organizational network?

4) Community Attitudes - What is the community tolerance for surveys, community forums, and other assessment strategies?

It is apparent that care must be taken to plan needs assessment studies systematically. Thoughtful planning is necessary to enhance the acceptability of such efforts by the community and service agencies. Careful planning also ensures maximum utilization of the assessment data for planning new services or restructuring existing services to meet the needs that may be identified during the assessment process. Bell, Nguyen, Warheit, and Buhl (1978) identify the following four steps as being the most important elements in planning a need assessment study:

1) Securing a commitment to use assessment data for planning purposes

2) Establishing a steering committee that includes the broadest range of community and professional representatives

3) Locating information sources and fiscal resources

4) Selecting need assessment approaches which are most appropriate for the agency or community that conducts or sponsors the project

In the next section I consider the various methods and strategies to be used such that a comprehensive and systematic assessment of the mental health needs of the Industrial Area can be made. I discuss the establishment of a steering committee, securing a commitment and the locating of information sources in the Method section.

Parameters of a Needs/Resources Assessment

Based on the foregoing discussion of the factors to be considered in conducting a needs assessment it is evident that the selection of the strategies and methods to be used in the needs assessment constitutes an important part of process of implementing a through study. While there is no agreed upon formula for a comprehensive assessment of need, there is a clear consensus in the literature that in order to obtain a valid picture of needs and extant services it is necessary to use multiple assessment techniques (Warheit, Bell, & Schwab, 1977). Siegel et al. (1978) have called the use of multiple assessment techniques "convergent analysis", noting that it is important that the selected techniques be used to secure data from multiple sources. The specific techniques chosen will depend on a number of factors including the goals of the assessment; how easily the data can be obtained; which data are most important; how accurate the data will be; the types of individuals and groups to be surveyed; and the size and specific demographic variables of

the area in question (i.e., the catchment area). Of equal importance are the resources which are available to conduct the needs assessment. These resources include both budgetary (i.e., financial) considerations and the availability of personnel. Finally, there is the issue of the amount of time available in which to conduct the needs assessment and any constraints that it places on the techniques and methods used.

A wide range of needs assessment techniques is available for estimating service needs, each designed to obtain estimates of different aspects of need. Siegel et al. (1978, p. 228), identify eight needs assessment techniques: 1) Social and Health Indicators Analyses, 2) Demands for Services, 3) Analysis of Existing Service Resources, 4) Citizen Surveys, 5) Community Forums, 6) Nominal Group Technique, 7) Delphi Technique, 8) Community Impressions. Additionally, as noted by Krueger (1988), the Focus Group technique may be used in the assessment of needs.

Each of these techniques serves one or more data gathering functions including the compilation of data that are already available, the development of new information, and/or the integration of all relevant information. Furthermore, each of the above techniques requires varying time and resources to implement. I offer definitions of the techniques I used and briefly describe their advantages and limitations. Following, in the Method section, I delineate how the various methods and strategies were implemented in this study.

1. Demands for Services - This approach makes use of existing data to estimate the needs of the community. Most agencies and organizations have records of service utilization, requests for service, frequency of

referrals, and average time on waiting lists which can be examined to determine the needs of a particular group or community. The information may be obtained through a variety of means, including mailed questionnaires, telephone surveys and in-person interviews. This method is simple, inexpensive and the data may be quite specific. Additionally, an analysis of demands for services may facilitate the integration of services by increasing communication between agencies. Increased communication may be accomplished by feedback procedures that either bring representatives from the various agencies together or which encourage networking by providing information on the types of services each agency offers.

A disadvantage of the demand for service approach is that the information obtained may not be comparable across agencies (Bell et al., 1978). Furthermore, as Siegel et al.(1978) point out, one cannot conclude that a particular service is addressing a high priority need because it is well utilized. A final weakness of this method is that service needs are almost always underestimated because the transition of needs into demand for service depends on a number of factors including the accessibility, affordability, availability, and acceptability of services (Bell et al., 1978; Siegel et al., 1978).

Service availability refers to the actual existence of specific services in the community of interest. An assessment of services' accessibility requires the examination of a number of barriers to service utilization, including culture, language, and geography, limited hours of operation, eligibility criteria, ease of getting to the service, and awareness of the existence of the service. The latter includes an

awareness both on the part of the professional and community agencies as well as community residents and potential users. Service affordability requires an examination of the cost of the services for individuals at various income levels.

2. Inventory of Resources - Utilization of an inventory of resources as a needs assessment technique involves a listing and analyses of resources and services already available to meet the groups' or communities' needs. This enumeration of services may also include information related to the accessibility, availability, affordability, and acceptability of such services. Additionally, a variety of other information can be obtained from the service provider such that a clear picture of the service resources in the community emerges, including the type and frequency of requests for service, pattern and interrelationship between services, gaps in or duplication of services, and an estimation of the affordability, etc. of services. Much of this information can be obtained from existing public records. Alternatively, the information can be obtained from questionnaires distributed to the administrators of the services. Although the mail survey is economical in terms of time invested, it has the disadvantage of possible misinterpretation of questions. In addition mail surveys are commonly associated with a high refusal rate (Bell et al., 1978). However, the refusal rate can be reduced considerably by follow-up telephone calls and "mailouts" (Milord, 1976; Siegel et al., 1978). The primary advantage of this method is that it is relatively simple and inexpensive. An inventory and analysis of existing service resources is an integral and important component of any needs assessment (Morrell, 1986).

3. Community Forum Approach - A community forum is an open "town meeting" to which all citizens are invited and asked to present their views on the community's needs. Usually pre meeting publicity and advertising helps to focus the specific needs which the meeting will address. It is particularly useful with all levels of needs from individuals to groups and it can provide valuable information on the service needs of diverse elements of the community. Other advantages of the community forum approach include the fact that it simple, inexpensive and may encourage public involvement and networking. The liabilities of this particular method include the possibility that the meeting may not be well attended especially if there is no "burning" issue to address, the difficulty in giving all present the chance to speak, the possibility that important needy groups will not be represented and the possibility that expectations for changes in services will be raised without subsequent changes (Siegel et al., 1978). Questions concerning need should be specific and this method should be used in conjunction with other methods. The community forum approach may be more effective and work better if several forums are used, each representing a different segment of society or neighborhood in the community. Follow-up procedures include feedback to all participants and scheduled meetings for individuals interested in volunteering their time.

4. Nominal Group Technique - The nominal group technique is a group approach to problem identification and program planning. It is principally a non-interactive workshop designed to maximize creativity and productivity and to minimize the argumentative style of problem-solving and competitive discussion. This approach initially involves a

10 to 15-minute silent period during which group members generate answers to questions raised by the group leader (e.g., What are the mental health needs of your community?). Next the group leader asks the each participant to offer one idea from his or her list in a round robin fashion. The ideas are recorded exactly as stated on a large flip chart in front of the group. A discussion period follows during which ideas are clarified and re-organized. Next, each participant selects the ten ideas he or she believes are most important, ranking them 1 to 10. Finally, the results are tallied for the group.

The nominal group process accomplishes a number of objectives: 1) It allows the target group to identify, and rank critical problem dimensions; 2) It provides a means to aggregate individual judgements; 3) It allows for multiple, individual inputs at a single time without the dysfunctional dynamics of many public hearings, such as domination by militant leaders, unbalanced participation, etc. The major weaknesses of the nominal group approach are that it requires an experienced facilitator for the group meeting. It can be imprecise. Additionally, as the structure is highly organized it may alienate some of the participants (Delbecq & Van de Ven, 1971).

The nominal group approach is most appropriately used as method for obtaining citizen and consumer input into the need assessment and program planning process.

5. Focus Groups Technique - A focus group is defined as a "carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive nonthreatening environment" (Krueger, 1988, p. 23). The focus group technique may be used for a variety of purposes at

different stages of the program development process. Specific ways in which the focus group technique may be used before the program begins include assets analysis, program design, market research, and needs assessment. The advantages of the focus group are that it is a socially oriented research procedure. Focus groups place people in relaxed, real life situations where they are more likely to be candid (Krueger, 1988). Another advantage of this format is that it allows the moderator to probe for a further understanding of issues raised. A third advantage is that it has high face validity. The technique is easily understood and the results seem believable to those using the information. The cost is low. The focus group can provide speedy results.

The disadvantages are that the interviewer has less control than in an individual interview. The discussion can be influenced by those present and may get off track. The data obtained from a focus group can be more difficult to analyze. Comments must be interpreted in their appropriate context. Focus groups can vary considerably depending upon the dynamics and so can the results obtained. The groups may be difficult to assemble and a suitable location may be difficult to find.

6. Surveys - Surveys involve the development of new information through the sampling of a particular group or population. Information provided may include an analysis of the service needs, an awareness of existing services, attitudes toward utilization of specific services, satisfaction with service provided and types of services which would most likely be utilized (Siegel et al., 1978). Surveys often identify individuals who are in need of service but are not using these services (the service gap), who can be put in contact with the appropriate service provider.

Three possible techniques may be used to gather the required information: 1) mailed questionnaires; 2) telephone surveys; and 3) "in person" interviews with key informants. Surveys can be used at the individual, group or community level. Surveys may be the most accurate method of conducting needs assessments. They can be more focused on a target group or population.

While this method is the most accurate and most widely accepted it requires careful planning, considerable expertise and more extensive resources. It may require a sampling procedure and data analysis techniques. A weakness of the survey technique is that it is difficult to determine the validity and reliability of survey responses, particularly if the information is of a personal nature (Bell et al., 1978). The survey may be used to obtain an inventory of resources and the information required to analyze the demand for services.

7. Community Impressions Approach - The community impressions approach combines existing data about human service needs with community impressions of those needs. It involves three major stages. The first stage involves a series of key informant interviews. A key informant is an individual who has lived or worked in the community and has knowledge of the service needs of the community. The key informants are interviewed regarding what they perceive the needs of the community to be. If the needs assessor is not familiar with the community, the names of appropriate key informants can be obtained by using a technique known a "snowballing" (Fisher, 1982, p.102) in which five or six key informants are interviewed and then asked to identify other key informants in the community. The key informants responses are summarized to produce an

overall picture of the community's needs. Siegel et al. (1978) recommend that discrepancies in the obtained data be resolved by erring in favor of groups having unmet needs.

The advantages of using key informants include the fact that it is inexpensive, simple to implement, promotes networking, and develops the support of some influential people in the community for future program development (Fisher, 1982; Rossi et al., 1979; Crocker & George, 1985). A weakness of key informants may be that the individuals may not be representative of the community or familiar with its unique service needs outside of their clientele (Royce & Drude, 1982). Rossi et al. (1979) suggest two techniques for reducing this bias. First, they suggest that questions be selected that are specific and concrete. Secondly, it is suggested that care be taken to select key informants who are maximally familiar with the topic area.

The second component of the community impressions approach involves the integration of information from a wide range of needs assessments methods (inventory of resources, survey and/or group data) with the impressionistic data obtained from the key informants. Finally, a community forum is held and groups identified as having unmet needs comment on the data, either validating it or suggesting changes that should be made. Furthermore, those in attendance may assist in establishing the priority of the identified needs. The community impressions approach is an economical and necessary step on the path to a creative convergence of need assessment information gained from the other need assessment approaches. However, as with most needs assessment techniques the results are of questionable reliability and validity

(Siegel et al., 1978).

Selection of Appropriate Assessment Strategies

It may be apparent from the above discussion, particularly given the limitations of the various methods, that the findings of a needs assessment study must be considered cautiously. However, the validity of data obtained is increased substantially when a variety of assessment techniques are used (Siegel, et al., 1978). As noted previously there is a number of factors to be taken into account when selecting the appropriate needs assessment strategies. In this particular study the task is to conduct a comprehensive mental health needs assessment with numerous stakeholder groups who inhabit a relatively large and diverse geographical area. Furthermore, the research had to be conducted with both an extremely limited budget and few personnel. In addition, the amount of time available in which to design and carry out the study was limited.

I reasoned that none of the methods or strategies outlined above would, on their own, provide a comprehensive assessment of need of all of the stakeholder groups. As outlined above, most of methods are designated for use with only one or two specific groups and some of the methods, such as the citizen surveys and the social and health indicator analysis approaches require extensive time and resources to implement.

The steering committee established by the CBMHA chose to utilize a modified community impressions strategy which could be augmented with community forums, nominal and focus groups, and a mail survey which would yield data relating to demands for existing services and an inventory of

existing resources. The community impressions approach was selected as input could be considered from the widest range of stakeholders including citizens, consumers, and service providers. Additionally, according to Siegel et al. (1978) the time and resources required to implement the community impressions strategy are "minimal". Furthermore, the community impressions approach allows for the "development, compilation and integration of data" (Siegel et al., 1978, p. 229).

I modified the community impressions approach by obtaining additional information from those groups identified as undeserved, the clients or consumers of mental health services, and the public. I submitted a summary of the findings to key members of the various stakeholder groups for comments and feed back in order to ascertain the accuracy and appropriateness of the results and recommendations. Additionally, I am considering a holding a community forum so that all of those who participated in the research may meet to discuss the recommendations and provide a final validation of the results and recommendations.

I augmented the initial stage of the community impressions approach with a survey of the administrators to ascertain what the existing resources are to gain some insight to the demand for services. I chose to use a mail survey due to the considerable volume of information requested. However, as the steering committee elected to use a relatively intact questionnaire, this method was relatively inexpensive and not prohibitively time consuming. Furthermore, the steering committee and I chose to augment the community impressions approach both with the use of community forums and the nominal and focus group

strategy. I preferred community forums over citizen surveys as a means of obtaining information from the residents of the communities because of the large geographic area, the diverse demographics including the blend of rural and urban populations. Citizen surveys tend to require extensive resources and a high degree of measurement expertise (Siegel et al.,1978). The nominal and focus group strategies were used at community forums, with groups identified as being underserved, and those groups with special interests. Both of these methods are inexpensive and permit the orderly collection of data. The nominal group method was the preferred method as it permitted the ordering or ranking of data. I used the focus group with those groups that preferred less structure.

Although there are budgetary constraints and restrictions on both the number of personnel available and the amount of time available in which to conduct the study, the validity of the findings should be increased by the use of multiple assessment strategies and the input from numerous stakeholder groups. In the next section I will provide a discussion of the research questions designed to address a global assessment of the mental health needs of the residents of Industrial Cape Breton.

Research Questions

The present study is an investigation of the mental health needs of the residents of the industrial Cape Breton area. In order to maximize the credibility of the investigation, service providers, the client or consumer, the general public, groups identified as being underserved, and groups with special interests in the delivery of mental health services

were invited to participate and provide input. A variety of techniques including a self-administered mail questionnaire, an interview guide, community forums and nominal and focus groups were used to obtain the required information. No formal predictions were made as most needs assessments techniques do not produce data that are amenable to inferential or predictive statistical analyses. However, the steering committee established by the CBMHA to oversee the project postulated three formal research questions to help guide the study. The research activities undertaken by the CBMHA were designed to answer the following questions:

1) What mental health and related services are presently provided by which organizations and agencies in the industrial area of Cape Breton?

2) What are the identified, perceived mental health needs of the Industrial Area?

3) What recommendations can be developed to meet the mental health needs of the population and strengthen the mental health service delivery system?

The first question is answered by the information provided by the administrators of the agencies and organizations providing mental health and related services in the Industrial Area. The data supplied are augmented with information from a number of community service directories.

The second question is answered by information supplied by the service providers (i,.e., the administrators and socio-mental health professionals), the consumers or clients of mental health services, the public, those groups identified as being underserved, and submissions of special interest groups. A convergent analysis (Siegel et al., 1978) is used to synthesize and order the data from all of the groups to

strategy. I preferred community forums over citizen surveys as a means of obtaining information from the residents of the communities because of the large geographic area, the diverse demographics including the blend of rural and urban populations. Citizen surveys tend to require extensive resources and a high degree of measurement expertise (Siegel et al.,1978). The nominal and focus group strategies were used at community forums, with groups identified as being underserved, and those groups with special interests. Both of these methods are inexpensive and permit the orderly collection of data. The nominal group method was the preferred method as it permitted the ordering or ranking of data. I used the focus group with those groups that preferred less structure.

Although there are budgetary constraints and restrictions on both the number of personnel available and the amount of time available in which to conduct the study, the validity of the findings should be increased by the use of multiple assessment strategies and the input from numerous stakeholder groups. In the next section I will provide a discussion of the research questions designed to address a global assessment of the mental health needs of the residents of Industrial Cape Breton.

Research Questions

The present study is an investigation of the mental health needs of the residents of the industrial Cape Breton area. In order to maximize the credibility of the investigation, service providers, the client or consumer, the general public, groups identified as being underserved, and groups with special interests in the delivery of mental health services

were invited to participate and provide input. A variety of techniques including a self-administered mail questionnaire, an interview guide, community forums and nominal and focus groups were used to obtain the required information. No formal predictions were made as most needs assessments techniques do not produce data that are amenable to inferential or predictive statistical analyses. However, the steering committee established by the CBMHA to oversee the project postulated three formal research questions to help guide the study. The research activities undertaken by the CBMHA were designed to answer the following questions:

1) What mental health and related services are presently provided by which organizations and agencies in the industrial area of Cape Breton?

2) What are the identified, perceived mental health needs of the Industrial Area?

3) What recommendations can be developed to meet the mental health needs of the population and strengthen the mental health service delivery system?

The first question is answered by the information provided by the administrators of the agencies and organizations providing mental health and related services in the Industrial Area. The data supplied are augmented with information from a number of community service directories.

The second question is answered by information supplied by the service providers (i,.e., the administrators and socio-mental health professionals), the consumers or clients of mental health services, the public, those groups identified as being underserved, and submissions of special interest groups. A convergent analysis (Siegel et al., 1978) is used to synthesize and order the data from all of the groups to

ascertain the perceived mental health needs of the Industrial Area. Comparing perceived need with the availability, accessibility, and acceptability of the extant services will allow a determination of need to be established.

The final question is answered by examining the identified needs including the issues of accessibility, availability, and acceptability of services and offering recommendations that will best address these needs. Recommendations will be based on suggestions offered by the stakeholders as well as on knowledge and theory and the values of community psychology which are consistent with the needs of the stakeholders.

The appropriateness and usefulness of the results and recommendations will be validated by the submission of: a) an Executive Summary, and b) a Discussion of Results, and Recommendations document to a selected group of representatives of the participating stakeholders groups. Additionally, a community forum is planned to obtain additional verification of the findings. In the following section I describe the ways in which the steering committee implemented the various methods and strategies.

METHOD

Introduction

This needs assessment was conducted as a result of meetings in the spring of 1989 between the executive director of the Cape Breton Mental Health Association (CBMHA), members of the board of directors of that association, and myself. The relationship was collaborative from its inception, both in terms of designing the methodology and with regard to implementation of the study. Although many decisions were the result of consensus, as coordinator of the project, I had the responsibility for ad hoc and "in the field" decisions.

I considered the fact that the Board had requested the needs assessment as part of its planning strategy and allocated a portion of its budget for its implementation to constitute its commitment to utilize the results. After securing a commitment to use the results, a budget to conduct the study, and academic approval of the study as an M.A. thesis project, the next step in the process of conducting the needs assessment was the formation of a steering committee. This committee consisted of Mental Health Association Board members and included a clinical child psychologist, a social worker, an advocate for those with chronic psychiatric problems, an administrator of a social service agency, a direct service provider who worked with those who have chronic psychiatric problems, a community development worker, a university student, and myself. In addition to this core group there were a number of ad hoc members. There were, at least, two consumers of mental health services on the committee. There was some turnover with the committee's members, as individuals were transferred and/or promoted and had to

assume other responsibilities. A number of people who were not members of the board was enlisted to assist the committee with specific tasks. The president of the board, while not officially a member of the committee, offered some input and guidance as well as validation or approval of the committee's decisions. The committee was also fortunate to have the services of the public relations officer of the Cape Breton Hospital (CBH) to assist in utilizing the media. All of the committee members were stakeholders in the delivery of mental health services in Industrial Cape Breton. They were all knowledgeable of various aspects of the mental health service delivery system and could be considered key informants. I acted as facilitator of the steering committee. The committee held regular, once a week, two to three-hour meetings. As well, the committee members worked individually or collectively taking on a variety of tasks. The committee assumed responsibility for the design and implementation of the needs assessment. Some of the tasks the committee worked on included delineating the geographical area for the study, defining the research questions, identifying the agencies, groups and individuals to be surveyed, developing the appropriate assessment instruments (including questionnaires and interview guides), planning community forums, mailing out questionnaires, arranging interviews, designing and distributing a poster to advertise the project, and working with the media consultant towards implementing a publicity campaign.

As stated previously, in order to obtain a comprehensive assessment of need it is necessary to use multiple assessment techniques and to sample from a variety of sources. I obtained data for this study from four divergent sources including 13 purposefully selected samples. Data

were obtained from the following sources: the administrators of mental health agencies and those agencies whose mandate included a mental health service component; socio-mental health professionals including teachers, police officers, social service workers, and physicians; consumers of mental health services; the public; groups identified as being under served by the existing mental health services, and submissions by special interest groups. A modified Community Impressions approach (See: Needs Assessment-Parameters section) was employed to collect the data. This approach utilized five needs assessment strategies, including a mail survey of administrators of services; the use of an interview guide and "in person" interview with the socio-mental health professionals; the use of an additional interview guide and "in person" interviews to obtain data from the consumer; community forums to obtain information from the public; and the use of nominal and focus groups to elicit information from the groups that were identified as being underserved and the special interest groups. All community forums and most nominal groups were conducted by myself and Mrs. Charlene Hines, who is a board member of the CBMHA. A degree of flexibility was necessary when collecting the data as circumstances sometimes dictated a change in methodology (e.g., while a nominal group approach might have been the preferred method, a focus group or simply recording the groups remarks was more practical). In one case, it was necessary to enlist the assistance of a school teacher to help collect data. Data collection began in the first week of October and was completed the third week of December, 1989. Following, the next section on publicity, is information relating to groups surveyed, the method by which the information were obtained, and an

indication of how the data were analyzed.

Publicity

In order to create an awareness of the needs assessment project in the community a diverse and ongoing multimedia campaign of publicity was implemented by the public relations director of the Cape Breton Hospital in collaboration with the steering committee. This campaign included regular public service announcements on radio and television; interviews on radio, television, and in the newspaper; and the use of posters and newspaper advertisements. (An effort was made to have the interviews precede the community forums by approximately one week.) Posters were mailed to the administrators of socio-mental health agencies and most clergy and physicians in the Industrial Area with the request that the posters be placed prominently, such that they could be viewed by their patients, parishioners and clients. The purpose of these posters was to encourage input from consumers and those with a knowledge of mental health services. A week prior to each community forum posters were placed in various public places, including stores and government buildings in the community where the meeting was to be held. Additionally, the forums were advertised in the various media. An advertisement, similar to the poster sent to the administrators, clergy, and physicians, was placed in the Cape Breton Post (a daily newspaper serving Cape Breton Island) twice, soliciting input from users of mental health services. Feature stories, which included a request for input from those with knowledge of mental health services, were run in other newspapers and hospital newsletters in the area. A complete list media

related material, including copies of press releases, advertising posters, dates of radio and television interviews and copies of newspaper and newsletter stories is included in Appendix B.

Surveyed Groups

Administrators - The steering committee generated a list of agencies whose mandate, or at least a part of their mandate, consisted of providing mental health services. A number of sources of information were used to assemble this list including: 1) The Directory of Community Services 1986-1987, City of Sydney; 2) The Contact Guide 1987, (1987 Community Organization Directory) - Municipality of the County of Cape Breton; and 3) The Directory Of Clubs and Services on Cape Breton Island 1988. Furthermore, the committee used their personal knowledge to complete and shape the list. The criteria for inclusion in the list was that some component of the organizations service be directed towards the provision of mental health services and that the agency or organization be located in the Industrial Area. The steering committee compiled a list of 45 services (Appendix C). I, then, sent a letter (Appendix D) and questionnaire (Appendix E) to the administrators of the 45 agencies. The purposes of the letter were to introduce the project; explain the purpose of the research; request that the recipient place a poster in a prominent place soliciting input; and request that administrators complete the questionnaire.

The questionnaire was adapted by the steering committee from one used by the Waterloo District Health Council in Waterloo, Ontario. It was pilot tested by having five administrators complete it and submit

their comments. The administrators were asked questions about the type and description of services they provide, their perception of needed services, the accessibility of their service, any additional organizations that could be utilized in providing mental health services, the identification of underserved groups, and features of the community that might contribute to the mental health problems of the residents. A complete list of the questions the administrators were asked is contained in Appendix E.

The administrators were asked to return the questionnaire within three weeks. If a completed questionnaire was not returned within the three week time period, three follow-up telephone calls were made at one-week intervals to the administrators requesting the return of the questionnaire.

I used the seven mental health service categories included in the questionnaire (i.e., Problem Identification, Coordination and Direction, Treatment/Interventions, Familial Support, Accommodation, Transportation and, Education) to categorize the data. Data analysis consisted of frequency counts and percentages of the responses. When available and where appropriate, I used quotations to illustrate specific points.

Socio-Mental Health Professionals - This group consisted of 47 seven socio-mental health service providers (Appendix F), including police officers, teachers, social workers, lawyers, and physicians, etc. The committee wanted the input of those who made use of mental health services through the referral of their clients. In order to compile a list of socio-mental health professionals, the steering committee utilized a process called "snowballing" (Fisher, 1982, p. 102), that is,

they contacted key individuals in the various communities who were known to have a knowledge of mental health services, explained the nature of the research, and asked them submit list of names of individuals in their various communities who could assist in answering the research questions. From the names submitted, the committee then compiled what they felt was a knowledgeable list of key informants to be interviewed in the Industrial Area. These individuals were contacted by telephone and an "in person" interview arranged. The purpose of the research was explained to them, as well as why they were selected, how they could help the CBMHA achieve its research goals, and what the limitations and possible positive outcomes (including how the research might contribute positively to the delivery of mental health services) of the research were. I conducted all of the interviews myself.

An interview guide (Appendix G) was used to obtain information from this group. The socio-mental health professionals were asked questions relating to their perceived need for mental health services including the accessibility, availability, and acceptability of the extant services. They were also asked to help identify underserved groups and features of the community which might contribute to the mental health problems of the residents. Data from this group are analyzed utilizing the seven conceptual mental health service categories contained in the questionnaire that was used to survey the administrators. The use of such a priori categories is suggested by Miles and Huberman (1984). Frequency counts of mental health needs and other issues are tabulated and illustrated with quotations.

A comment on the relatively large number of socio-mental health

professionals is appropriate. The usual procedure in selecting key informants is to purposively select a small number of well-informed individuals and rely upon the "richness" and "thickness" of the data obtained from them rather than selecting a larger random sample (Patton, 1980, p. 98). Although the steering committee had stated that they did not wish to have the data analyzed by geographical area, there was some concern on the part of my thesis advisory committee that the data be collected such that it could be analyzed to compare the needs of the various communities. As such, rather than simply having a total of 10 key informants I secured enough key informants in each community so that, if necessary, the data could be analyzed by geographical area.

Consumer - Input from the consumers of mental health services was solicited through the use of a multimedia campaign utilizing posters, newspapers, radio, and television. Specific details relating to publicity can be found in the Publicity section and in Appendix B.

Those wanting to offer input were instructed to call a telephone number to arrange for an interview. Consumers of mental health services were given the choice of either participating in an "in-person" or telephone interview. While I hoped to increase the likelihood of participation by allowing participants to participate in "in person" and telephone interviews rather than have them complete written statements, it was recognized that there may have been those that would have preferred the written format. To help clients who were unable or unwilling to articulate their mental health concerns, client advocates and family members were encouraged to participate in the survey. I began each interview with an explanation of the purposes and goals of the needs

assessment. Furthermore, I explained to those I was interviewing that they were free to withdraw from the interview at any time. All of those who were interviewed in this aspect of the study were provided with "informed consent forms" (Appendix H). An interview guide (Appendix I) containing four questions was used with this group. They consumers were asked questions relating to the accessibility and the acceptability of services. Additionally, they were asked to offer suggestions for the extant mental health services and to identify what the mental health needs of the Industrial Area are. The seven mental health service categories were used to assist in categorizing the data.

Obtaining information from the consumers of mental health services can present problems, both in terms of obtaining a random sample (Waterloo District Health Council, 1986) and with regards to the ethical concerns of confidentially. The logistical problems of gaining the cooperation of the service provider to provide the names of clients did not seem justified, given that there was no guarantee that a random sample could be obtained. The steering committee decided that an ongoing, intensive, media campaign would, at least, increase the numbers of consumers who agreed to be interviewed. While this method would likely yield a biased sample, I thought that the validity of the data obtained would be increased as the participants would have time to give their responses some thought. Additionally, the committee anticipated that the richness of the data would compensate for the relatively small sample. The method presented here, while having some problems in terms of sampling, ensured that consumers' rights would be respected.

Public - Information from the public was obtained through community

forums. One meeting was held in each of the four communities of Glace Bay, New Waterford, Sydney, and North Sydney during the months of October and November. These meetings were well publicized through the media. As the Board of the Mental Health Association had decided that they did not wish to differentiate between the needs of each community, the purpose of holding the meetings in different communities was to allow for as much public input as possible. The committee speculated that it was probable that those attending a particular meeting would not likely be only from that community and that it would be difficult to ensure that input from a particular meeting was relevant to only that community. A nominal group strategy was used to obtain information from those in attendance. I began each meeting with an introduction including information about the Mental Health Association, the purpose of the research, its limitations, and the goals for the evening. The question for those in attendance was: "What are the mental health needs of the Industrial Area?" Data from this source were categorized using the seven mental health service classifications and summarized by community. An overall summary of the data obtained from all of the community forums is also provided.

Underserved Groups - As part of the needs assessment strategy the committee decided that it would be helpful, in fulfilling the research goals, to obtain input from groups that were underserved by the existing mental health services. The administrators and socio-mental health professionals were asked to identify groups that they perceived were underserved by the existing mental health service delivery system. Additionally, the steering committee identified the groups that they perceived were not being adequately served. The groups identified as

being underserved were youth, senior citizens, members of the Micmac community, those with chronic mental health problems, and women. Women were identified as being underserved in a number of contexts. The selection of the appropriate group of women to meet with is discussed later in this section. The committee established that there were no existing groups of youth, seniors, or Micmacs that were also consumers of mental health services. It was decided, as an alternative means of collecting data, to assemble representatives of the above groups in the hope that, regardless of whether they presently utilized mental health services, they could be of assistance in identifying the needs of the group they represented. I began the meeting with each of these groups with a similar introduction to the one used at the community forums. The question posed to each of the groups was specific (e.g., "What are the mental health needs of senior citizens in the Industrial Area?").

Staff at the Cape Breton District School Board assisted the committee in assembling a group of high school students who were aware of social issues and, who it was felt, could help identify the mental health needs of youth. The nominal group strategy was used to obtain information from the high school students. A teacher from the Northside/Victoria school system agreed to help assemble a group of junior high school students who could help identify the needs of that group. Unfortunately, due to a conflict in scheduling interviews and approaching examinations for the students, it was impossible for me to meet with this group. However, a teacher who was familiar with the purpose of the research and the type of information that the committee hoped to obtain from the students was instructed in the focus group

method and agreed to assist in obtaining data from the students. The data from both groups are summarized.

It was virtually impossible to assemble a group of senior citizens who were also consumers of mental health services. As such, the committee agreed that it would be appropriate to meet with members of a senior citizens' organization. A member of this organization agreed to assemble an ad hoc group that was familiar with social issues. There was great difficulty in scheduling the meeting with this group because of the proximity to Christmas and the fact that the members had busy schedules. Although I met with this group for 90 minutes only a small core of those present remained constant. Others came and went, staying from 15 minutes to a half hour offering input and making suggestions. A focus group strategy was used to obtain information from this group. The information obtained in this section is not ranked because of the turnover in those in attendance. Again, the data are categorized using the seven mental health service categories and is presented in summary form.

Members of the committee were familiar with an organization called Community Friends which was a support group for those with chronic psychiatric problems and those who had been deinstitutionalized. There were two branches of this group; one which held its meetings in Glace Bay and the other which met regularly in Sydney. I obtained permission to attend meetings in both communities. My intention was to use a nominal group technique at both meetings. However, while the group in Glace Bay was able to express its needs, they had some difficulty in ranking the items. The group in Sydney, only reluctantly, agreed to

rank their needs, indicating that all of the issues that they identified were equally important. Data from these sources were sorted using the seven mental health service categories. A convergent method of analysis was used to combine the information from these two sources and the results are offered in a summary.

Again, it was virtually impossible to meet with a group of Micmacs who were also consumers of mental health services. I arranged to meet with Micmacs who were socio-mental health service providers and volunteers on the Membertou Reserve in Sydney. They were holding a staff meeting and agreed to allow Mrs. R. Meahan, the Director of the CBMHA, and myself to attend. The nominal group method was used to collect data from this group. Data from this group were categorized as noted and a summary is offered.

As with the other groups identified as being underserved the committee's initial intention was to locate an existing group or groups of women whose members were consumers of mental health services and arrange to meet with them. Women had been identified as being underserved in a number of ways, including: teenage girls requiring counseling, female alcoholics, victims of violence, primary cargivers, and single mothers living on low incomes. Although it was relatively easy to identify existing groups of female consumers, the task of actually meeting with these groups proved considerably more challenging. Of the two groups the committee had initially selected, one group decided it was unwilling to meet with us, because it was in the process of taking in some new members and the other group was unable to meet with us due to other commitments. I was eventually able to contact a third group

who indicated that I could attend one of their meetings but that they did not wish to participate in a "group" or engage in a formal discussion of mental health issues. As a group, they were not consumers of mental health services. I decided to meet with them, listen to the types of issues they were discussing, and if possible, engage the women in a discussion about what sort of things might make their life better and what sort of things they did to reduce stress. I met with this group for approximately 90 minutes. As with the other groups, I spoke about the Mental Health Association, the purpose of the research, why I selected them, how they could contribute to the study, and what the possible benefits and limitations of the research were. Although I did not pose a formal question, I attempted to direct or focus the discussion on what sort of thing would make their life better and what they could do to reduce stress. The data from this group are provided in summary form.

Submissions from Special Interest Groups - During the course of the data collection, representatives of four groups responded to the publicity with an invitation that I attend meetings of their members and listen to suggestions that they had regarding mental health services. I attended meetings of: 1) Canadian Friends of Schizophrenia (CFOS); 2) an ad hoc group of concerned citizens of New Waterford; 3) a group of educators, including guidance counsellors from the Cape Breton District School Board; and 4) the administrators of homes for special care.

A focus group strategy was used to collect data from these groups. Data from these groups were coded according to the mental health service categories with the frequency of their responses being noted. A summary of each group's submissions is provided in the Results section.

Available Resources - A list of available mental health services and resources was compiled using the data supplied by the administrators, personal knowledge of the members of the steering committee and from the directories noted at the beginning of the Method section (Appendix M).

Data Analysis - Tabulation and analysis of the data within surveyed groups were performed as noted above. Comparisons were not made between groups. However, percentages with which a specific mental health service category were noted as being needed, and in the case of the more qualitative data, the emphasis that a group placed on particular category was recorded. Overall rankings to assist in determining the priority of need were made by calculating the percentage (or emphasis, in the case of the qualitative data) with which a mental health service category is indicated and the percentages are examined across groups. The perceived need was then compared with the list of available resources to determine the gaps and needs in mental health services.

Recommendations were not ranked sequentially, but the highest priorities for the Industrial Area were identified using the following criteria as a guide.

1) The more frequently the issue was expressed through individual samples and through inter-sample consensus, the higher the priority for the recommendation addressing that issue.

2) The more a recommendation pertained to a need in which no service was presently available in the mental health service system to address this need, the higher the priority.

3) The more a recommendation was directed towards the integration of the service delivery system for the Industrial Area as a whole, the higher the priority.

4) The more a recommendation would reduce the necessity for going out of the Industrial Area for service delivery, the higher the priority.

In order to establish the trustworthiness of the data and validate the recommendations, I sent: 1) an Executive Summary, and 2) a Discussion of Results and Recommendations document to 20 representatives (Appendix Z-1) of the various groups that were surveyed and requested feedback. Additionally, a community forum is tentatively planned at which time a final validation of the findings will be conducted.

LIMITATIONS OF METHODOLOGY

Introduction

This section identifies and addresses the limitations associated with the data bases included in the mental health needs assessment. Limitations related to the following issues will be discussed: sampling techniques, data quality, and currency of findings. Although I believe that this study provides a comprehensive assessment of mental health needs in the Industrial Area, it should be noted that there were limitations placed on the project. These limitations included a shortage of time in which to conduct the study, as well as extremely limited financial and human resources. The efforts taken to validate the recommendations and establish the trustworthiness of the data, including the submission of an Executive Summary to representatives of the various stakeholder groups and a planned community forum, serve to minimize the limits imposed on the results and recommendations of the needs assessment.

Limitations Related to Sampling Methods

Data were collected from 13 purposefully selected samples. A convergent analysis of needs was the overall approach used in the needs

assessment. The convergent analysis of needs indicates that the information gathered from a range of methods, deployed both systematically and sequentially, yields a reasonably accurate identification of community needs and an assessment of the relative priorities among the needs identified.

> Convergent analysis of needs is based on a stepwise multilevel, multitechnique assessment strategy. Each technique (e.g., formal and informal surveys, nominal groups, and community forums) is targeted at an appropriate informant group (e.g., citizens, consumers, mental health professionals). The results of convergent analysis is an integrated and maximally validated description of the needs in a social area that provides input into a rational planning process. (Siegel et al., 1978, p. 221)

As one objective of the needs assessment was to compile a list of resources of mental health services in the industrial Cape Breton area sampling of the administrators was purposeful. With the mental health service administrators survey, attempts were made to solicit data from all possible contributors to the mental health care system. Steps were taken to obtain a comprehensive list of organizations providing mental health services by using the steering committee's knowledge of existing social and mental health services augmented with information from various community directories. Results were limited by respondents who were not identified as part of the sample and by other mental health service providers who did not respond to the survey (i.e., nonrespondents). It should be noted that responses were not received from the Nova Scotia Commission on Drug Dependency, the primary organization dealing with issues relating to alcohol and drug abuse.

Key-informants representing the socio-mental health professionals were identified in each of the four main communities. Royce and Drude

(1982) state that "a major weakness of the key informant approach is the possibility that selected individuals will not be representative of the community or familiar with its unique service needs outside of their own clientele." To ensure that the key informants had a broad range of exposure to different types of clients, those whom I interviewed were selected purposively (Lincoln & Guba 1985, p. 40) from the list of key informants provided, being sure to include a broad range of disciplines. As the steering committee was familiar with the services and service providers in the different communities, the risk of selecting informants who were not representative or knowledgeable was reduced.

Although measures were taken to generate a representative client/consumer sample, the final results represent input from a self-selected sample. Other means of selecting and surveying consumers were considered but were discounted due to the inherent biases described in the Method section. While I hoped to increase the likelihood of participation by allowing participants to participate in "in-person" interviews rather than complete written statements, there may have been those who would have preferred the written format. To help clients who were unable or unwilling to articulate their mental health concerns, client advocates and family members were encouraged to participate in the survey. Considerable effort was expended to inform as many residents of the region about the opportunity to participate in the survey.

Given the limited time and resources that were available to conduct the study, the steering committee decided that the best way to obtain input from and involve the residents of the community was to conduct public forums. Two of the criticisms of community forums are that

everyone will not be given the opportunity to speak and that important needy groups will not be represented (Siegel et al., 1978). To ensure that those in attendance had an opportunity to speak I chose to use a nominal group format (NGF). Other advantages of the NGF are discussed in the section on needs assessment. Furthermore, in order to guarantee that as many people as possible were aware of the meetings, the community forums were well advertised. To ensure that as many of those that wished to come to a meeting could, a forum was held in each of the four communities. There was, of course, no way of knowing who would appear at the meetings. In fact, a range of individuals attended, including consumers of mental health services, direct service providers, administrators of mental health services, and those who represented groups with special interests. It is difficult to make a summary statement regarding the types of people who attended the various community forums. However, it seems that the majority of those who came to the meetings were direct service providers including school teachers, police officers, and social service workers.

I was confident in the selection of groups identified as being underserved, as there was considerable consistency between the responses of the administrators, socio-mental health professionals, and the steering committee. The problems of locating groups to be interviewed were delineated in the Method section. These groups were sampled purposively. While the style of the meetings held with the different groups varied, the members of all of the groups could be considered to be key informants. Although Patton (1980, p. 183) states that "the danger in using key informants is that their perspectives will be distorted and

biased", it is precisely the biases or unique perspective in which I was interested. The groups were not expected to provide a broad overview of the communities' mental health needs but rather to provide a unique perspective of their own groups needs. Each of the special interest groups needs is viewed as an integral piece of the whole communities' mental health needs picture.

Limitations Related to Data Quality

This study assessed the mental health care system within the industrial Cape Breton area from a comprehensive, multidimensional perspective rather than limiting the study to those services under Ministry of Health and Fitness jurisdiction or to services needed only by the mentally ill client population. The limitations pertaining to the present study are similar to all ambitious studies which examine and incorporate results from diverse samples.

The aggregate results from the survey of service providers, socio-mental health professionals and consumers were limited by the variable methods of record keeping, perspectives of mental health needs, and knowledge of existing mental health services. For example, in the administrators' questionnaire, several respondents indicated that they were unable to provide data on the actual number of their clients due to internal record keeping methods. Since it is not possible to identify multiservice mental health users, the total number of individuals on agency case loads may have included repeat counts of clients. Additionally, there was a number of administrators who did not respond to the survey. Thus only an estimate of the number of individuals requesting mental health services was available.

The disadvantages of the community forum approach are that the meetings may not be well attended and that they may be dominated by a few individuals, thus not guaranteeing freedom of expression. As stated previously, given that members of other surveyed groups attended the public meetings, there may be some overlap in the data obtained. It was not the intention of the study to differentiate between the various communities or the surveyed groups but rather to provide an overall comprehensive picture of the communities' needs. However, considering the consistency of the information obtained from the different meetings, the data would seem to be an accurate reflection of the public's perception of their mental health needs.

The quality of the data obtained from the five underserved groups varies both as a function of the method used to obtain the data and the group itself. Care was taken to ensure that all groups interviewed were knowledgeable of the research issues and could be considered key informants. However, in some instances, the groups interviewed were consumers or actual users of mental health services. In other cases, members of the groups may have or may have not been users of mental health services. In yet another case, the members of the group were service providers. Nominal and focus groups strategies were used to obtain information from the groups. Siegel et al. (1978) note that the use of nominal group input is recommended for obtaining information from targeted groups. Cases in which the nominal group approach (i.e., high school students, Micmacs, community friends) was used provide more structured data than those in which the focus group (i.e., senior citizens and women) was used. Given the care taken in selecting the

various groups of key informants, I believe the information obtained from each group is indicative of the needs of the group it is intended to represent and is an integral facet of the assessment of needs in the Industrial Area. However, a note is warranted regarding the needs of women. In this study women were identified as being underserved in a number of contexts. Furthermore, it has been documented (Graham, 1988; Rickel, Gerrard, & Iscoe, 1984) that women seek services more than men. As such, I have some concerns about the data obtained from the women that I met with, not so much as they reflect the needs of that particular group, but rather, because both the noted documentation and the fact that women were identified in a variety of contexts suggest that the magnitude and range of women's needs transcends the problem areas identified by the women with whom I met.

The representatives of the special interest groups were, by definition, knowledgeable key informants. The information obtained from the three groups was intended to reflect only each group's needs. The use of focus and nominal groups was used to ensure an orderly collection of data.

Results of the consumer of mental health services survey represent retrospective, subjective responses to experiences with the mental health care system. All respondents were self-selected. However, the frequent repetition of themes gives me confidence that the sample was not idiosyncratic - except, perhaps with respect to motivation.

A further limitation which applies to all of the groups relates to the assumption chat respondents were using similar conceptual definitions for mental health, mental illness, and mental health services Heseltine

(1983) noted in his discussion paper that there was no universally accepted definition of mental illness. Some of the comments from the administrators' survey suggested that different operational definitions and theoretical models of mental health were used by different organizations. Some of the respondents also questioned their inclusion in the study since they did not perceive that they provided mental health services. In the needs assessment, the omission of a definition of mental health was intentional. This was done to encourage input from broad range of direct and indirect service providers rather than restricting responses to a sample focusing on a narrow range of emotional or psychiatric problems.

To standardize the terminology and interpretation of questions in the administrators' questionnaire survey, the conceptual framework (see Appendix K) was used. As noted previously the use of a priori categories was suggested by Miles and Huberman (1984, p. 57). Although some respondents objected to this framework, it facilitated a common conceptual basis for responding to survey items. The same framework was not included in the surveys of the other survey samples. Thus, interpretation of their responses is limited due to their potentially different perspectives. Despite this, a consensus of regional mental health needs was obtained from these disparate samples.

A final limitation related to data quality is associated with the respondents' ability to identify needed mental health resources. A necessary assumption in the various surveys was that the respondents were knowledgeable of the existing mental health care system and were able to determine gaps and needs in services. Given the fragmentation in the

delivery of mental health services, it is unlikely that the majority of respondents possessed a complete knowledge of all of the existing services in the Industrial Area. In fact, several respondents from the administrator sample indicated that their responses were based on knowledge of mental health concerns salient to their target population or their specific community, rather than the entire mental health care system of the industrial Cape Breton area. Although this may appear to be a limitation within the needs assessment, all respondents surveyed were key informants. Hence, their responses should be considered valid within their respective areas. The common needs or issues identified from different samples in a convergent analysis of needs will augment the validity of the need identified by any one sample (Siegel et al., 1978).

Limitations Related to the Currency of Findings

Data were collected for the needs assessment over an 11-week time period. Within this relatively short data collection time-frame, it is unlikely that external factors in the industrial Cape Breton area would have significantly altered responses for data collected at different times during the 11-week period. Data within individual survey samples were collected over shorter time periods. The results of the administrators' questionnaire describe the situation during the October to December 1989 time period and thus may not reflect the current demand for mental health services.

RESULTS

Introduction

Data for this study were obtained from four divergent sources which included the administrators of mental health services, socio-mental health professionals, the consumer of mental health services, and the public. Information was also obtained from five groups that were identified by the administrators, the socio-mental health professionals and the steering committee as being underserved by the existing mental health service delivery system. These groups were youth, senior citizens, those with chronic psychiatric problems, members of the Micmac community, and women who are single and living on low income. Finally, information was obtained from the following four groups that requested that I listen to their submissions: the administrators of homes for special care for Cape Breton Island, educators from the Cape Breton District School Board, the Canadian Friends of Schizophrenia (CFOS), and a group of concerned citizens from New Waterford. In total information was obtained from 13 purposfully selected samples. It should be noted with regard to those surveyed that in some cases the participants played multiple roles. For example, some of those attending the community forums were administrators of services, socio-mental health professionals, and consumers of mental health services. Furthermore, some of administrators provide direct service to clients.

In collecting these data a variety of methods and instruments were used including a self-administered questionnaire with the administrators. Additionally, two interview guides were utilized: one for the socio-mental health professionals and one for use with the consumers of mental

health services. Finally, the nominal or focus group strategies were used to obtain information from those attending the public forums, the groups that were identified as being underserved and those groups that requested the opportunity to make submissions.

I used a variety of methods to analyze and present the findings. With the data obtained from the administrators and the socio-mental health professionals I have used frequency of responses and percentage of total sample; the more frequently noted and/or insightful points are illustrated with quotations. The data gathered from the community forums, the groups identified as being underserved, and those groups that made submissions are presented in summary form with percentages of frequently mentioned points. The data obtained from the consumers of mental health services are qualitative and are presented with particular themes being highlighted.

In analyzing the data from all of surveyed groups, when considering the issue of "perceived need" I have used the seven Mental Health Service Activity categories contained in Administrators Questionnaire (i.e., Problem Identification, ..., Education). The use of a priori categories to analyze data was suggested by Miles and Huberman (1984). These categories are defined in Appendix K. I have collapsed all of the seven service categories activities except Treatment/Intervention and Education. These categories were left intact, because the subsections seemed to clearly differentiate areas of need. Furthermore, in the case of Treatment/Intervention there was a greater range and magnitude of responses within this category than with the other categories.

Section 1

Survey of Administrators of Mental Health Services

Information was obtained from the administrators with a self-administered questionnaire (Appendix E) which was mailed to them. It was pilot tested by having five of the administrators complete the questionnaire and submit their comments.

Questionnaires were sent to the administrators of 45 organizations or agencies which provide mental health services in the Industrial Area. Of the 29, or 64 % of the questionnaires returned, two were not used as they were not properly completed. Some administrators did not complete specific questions. With the responses to each question I have indicated either the number or the percentage of respondents who completed the question.

In reporting and analyzing the results for the needs assessment I have, selectively, made use of only the responses to the items in the questionnaire that are relevant to the research questions. The remainder of the results may be tabulated and kept on file by the Cape Breton Mental Health Association.

Description of Respondents

Of the 27 usable questionnaires returned by the administrators, 13 were from organizations which provide services to all of the Industrial Area; four provide services primarily to the city of Sydney; four of the administrators indicated that their services are offered mainly to the residents of Glace Bay; three of the respondents provide services mostly to those from the Northside area (North Sydney, Sydney Mines); and two

respondents stated that their service is used primarily by those from New Waterford. It should be noted that questionnaires were not returned from the Cape Breton Mental Health Clinics in Sydney River and New Waterford, Family Services in New Waterford, and the Nova Scotia Commission on Drug Dependency. Sixty-three percent of the usable questionnaires were from organizations where a woman is the administrator. A complete list of the agencies/organizations from which questionnaires were returned is included in Appendix L. The type of services they offer is included in Appendix M.

Service Accessibility

The administrators were asked a number of questions to assist in determining the accessibility of mental health services for the consumer.

Setting in Which Service is Provided

In item # 1 the administrators were asked to:

> Please describe the mental health services you provide according to the following criteria: ____ outpatient department ____, day program ____, private professional setting ____, inpatient ____, residential ____, client's home ____, other (specify) _____

Ten of the respondents stated that they provide services in a private professional setting. Ten of the administrators provide services from an outpatient department setting. Furthermore, ten of those who responded to the mail survey stated that they would provide services in the clients home. Six stated they provided services in a residential setting. Four of the administrators indicated that they offered their services in an inpatient setting. Two provided services in a day program. One respondent provided services on a university campus

setting. One administrator did not answer this question. The setting in which the agencies/organizations offer their services can be found in Appendix N.

Hours of Operation

As a part of item # 1, the administrators were asked to indicate their agencies' "hours of operation". Seventeen of the administrators stated that they provide services for eight hours a day from Monday to Friday (i.e., 8:30-4:30, or 9:00-5:00). Three respondents stated they provide services 24 hours a day. Four of the administrators indicated that their service was open, at least, one day a week from five to nine p.m. Four stated that they provide emergency service, on stand-by basis, after regular office hours and on weekends. Ten administrators did not respond to this question. A list of the agencies/organizations and their hours of operation is contained in Appendix O.

Ethnic Group

In item # 15 the administrators were asked: "Are your services directed specifically to any ethnic group?" Twenty-five of the administrators indicated that "No" their service was not directed to a specific ethnic group. Three respondents indicated that their service, or at least a component of their service, was designed to provide service specifically for Micmacs. Micmac Family and Children's Services and the Native Alcohol and Drug Counselling Association offer services specifically to the Micmac community. As well, the Children's Aid Society of Sydney has a component of their services which is offered to

the Micmac community.

Language Service Provided In

In item # 16 the administrators were asked: "In which language(s) does your organization provide mental health services?" Twenty-seven of the administrators indicated that they provided services in English. Four indicated that were able to provide services in Micmac. One indicated that they provided services in French. One person did not respond to this question.

Transportation

In item # 17 the administrators were asked to: "Describe any transportation problems that your clients have in getting to the mental health service you provide." Eighteen, or 67 percent of the administrators who responded to this question indicated that, "Yes", their clients did have problems with transportation when trying to get to the service they provided. Six of the administrators indicated that, "No", their clients did not have difficulty. All but one of these six services were located in central core of the communities. The other was on a university campus. Two of the administrators did not respond to this question and one said that it was not applicable.

One administrator stated concisely and articulately just how important the issue of transportation was to her clients - and how poor transportation affected the utilization of her service.

> The lack of adequate pubic transportation services is the single most critical factor contributing to under-utilization of our facilities in Cape Breton. Patients from New Waterford, Glace Bay, North Sydney, Sydney Mines and even certain areas

within Sydney may have to travel several hours per day at irregular hours to keep an appointment.

One administrator from New Waterford expressed the concerns of a number of respondents when she raised the additional issues of money and motivation that her agencey's clients were required to expend in order to use mental health services:

> People from Waterford, the Bay, and the Northside can not benefit from this service due to economic limitations, long waits and poor motivation....our clients lack the finances, let alone the motivation to travel to Sydney River.

In item # 18 the administrators were asked: "Does your program/service assist with arrangements to transport clients to your services?" Thirteen, or 48 percent of the administrators indicated that they provided assistance with transportation. Assistance included paying for taxi and bus fares, reimbursing their clients for money spent on gas, and driving them to and from appointments. Eleven of the administrators noted that they did not provide any assistance with transportation, although one speculated that their clients might receive assistance from other sources. Three administrators responded that the question did not apply to them. In two of the cases it was because their agency provided in-home service.

Wheelchair Accessibility

In item # 19 the administrators were asked: "Is your facility accessible to wheelchairs?" Fifteen, or 56 per-cent of the administrators indicated that, "Yes", their facility was wheelchair accessible. Twelve of the respondents indicated that, "No", their facility was not.

Organizations' Operating Capacity

In item # 10 the administrators were asked:

> Which of the following statements best describes your organization's general operating capacity?____ could handle a larger client load, ____ have an appropriate client load, ____ client load is too large

Four of the administrators did not respond to this question. Five or 20 % of the respondents indicated that they "could handle a larger client load". Forty-four percent of the administrators indicated that they "have an appropriate client load"; and nine, or 36 % of the administrators indicated that their "client load is too large". Services that were noted as being under utilized were the crisis response service and the day center program at the Mental Health Clinic. The majority of services that were noted as having case loads that were too large provided assessment, counselling and psychotherapy. The individual agencies'/organizations' operating capacity is contained in Appendix P.

Waiting Periods

In item # 25 the administrators were asked:

> What is the average waiting period that your clients have for mental health services from the time they first contact your organization until their first appointment?

Five administrators did not respond to this question. Thirteen of those who responded stated that the client would receive an appointment within a week. Five stated that the first appointment would be between one and two weeks. Two administrators indicated that it would be between two weeks and a month for the first appointment. Six responded that the first appointment would not be for at least one month. The most consistently long waiting period for services appeared to be with child

and adolescent services where the waiting period ranged between 15 and 20 weeks. The waiting period for services for all of the Family Services agencies was reported to be between six and eight weeks. A list of the agencies/organizations and the waiting period waiting period for their services is contained in Appendix Q.

Affordability

Fee for Service

In item # 20 the administrators were asked: "Must clients pay a fee in order to receive service?" Twenty-three of the administrators indicated that, "No", there was not a fee for service. Three of the administrators indicated that, "Yes", they did charge for, at least, some aspect of their service. They were also asked in item # 21: "How is this fee determined?" One administrator stated that there was a "set hourly rate". One administrator stated the fee was determined on a sliding scale, "according to total family income." One agency administrator stated that they charged for medication if there was no third party coverage.

Perceived Need for Services

In item # 29 A the administrators were asked to indicate "the programs/services in which there is a need for more services." In item # 29 B the respondents were asked to "indicate the communities in which additional mental health services are required." Twenty-five of the administrators responded to both of these questions indicating where the services are needed and in which community they were needed.

First, I examined the frequencies with which the administrators identified the need for services in each community. Twenty-eight percent of the administrators responses' indicated a need for services on the Northside area. Twenty-five percent of their responses indicated a need for mental health services for both Glace Bay and Sydney. Twenty-three percent of the administrators responses' indicated a need for services in New Waterford. Appendix R contains the raw frequencies of responses by mental health service category and by community.

TABLE 1

Percent of Administrators Who Indicated, at Least Once, the Need for Mental Health Services

	Syd.*	G.B	N.S	N.W.
MENTAL HEALTH ACTIVITY				
Problem ID	48	48	57	44
Coordination	26	26	35	22
Treatment/Intervention				
Crisis Responses	35	35	48	26
Therapy	52	48	61	44
Vocational	43	35	52	39
Social/Recreational	22	22	35	22
Familial Support	35	39	39	39
Accommodation	39	35	30	30
Transportation	13	13	17	17
Education				
Public	39	35	43	39
Professional	17	17	22	22

Note: These percentages are calculated on n=25, the number of administrators who responded to items 29 A and 29 B.

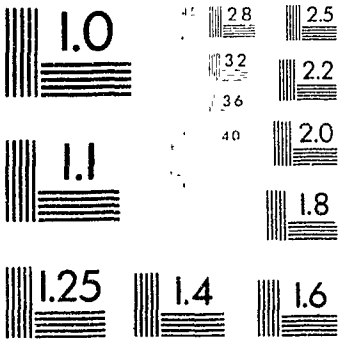
* Sydney - Syd., Glace Bay - G.B., Northside - N.S., New Waterford - N.W.

Next I examined the percent of Administrators who signified a need for a specific service. The data in Table 1 indicate: 1) the

percentage of administrators who noted, at least once, the need for more mental health services, and 2) which community they feel requires the services. As can be see in examining the data in Table 1 the perceived need for more services which provide therapy is ranked the highest, by frequency in all of the communities. This mental health service category includes psychological and physical therapy for children, adolescents, families, adults, and seniors. A analysis of the data in this category (Appendix T) indicates that 76 % percent of the administrators identified adolescents as the group most in need of services which offer therapy. The second most frequently noted group was children who were identified by 60 % of the administrators. Seniors and families were identified by 44 % percent of the respondents as being the group who required services offering therapy.

In addition to the communities indicated in Table 1, 25% of the administrators noted a need for more mental health services in the rural areas of Cape Breton and Victoria Counties. Three of the respondents suggested that the entire range of mental health service activities were needed in these areas. Two of administrators noted that Problem Identification and Treatment/Intervention services were required in the rural areas.

When all of the mental health activity categories areas are considered across all of the communities the second highest ranked perceived need is for services which offer problem identification. Problem Identification includes assessment, evaluation and diagnosis. Sixty-four percent of the administrators indicated that there was a need for more services offering psychological evaluation.


1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0

The third ranked area of perceived need is for Vocational services. The perceived need for the remainder of the mental health service activities across all of the communities is: Public Education (39 %), Familial Support (38 %), Crisis Responses (36 %), Accommodation (34 %), Coordination and Direction (27 %), Social/Recreational (25 %), Professional Education (20 %), and Transportation Services (15 %). A complete breakdown of the perceived need for services within each category is contained in Appendix L.

In addition to the specified mental health service categories 25% of the administrators noted a need for a variety of self-help and support groups. This need was perceived in all communities and included groups for victims of sexual abuse, victims of those who batter, single-mothers, men who batter, and adolescents. The following administrators remarks were fairly typical:

> We need a service specifically directed towards those who feel the effects of violence and abuse, particularly for victims of sexual assault and incest. ...there is a need for a service for men who are violent towards women.

One administrator seemed to be expressing the sentiments of others regarding the importance of self-help groups with the following statement: "....people to facilitate the starting up of self-help groups for various problem areas would be my number one priority."

Degree of Urgency

In item # 33 B the administrators were asked to indicate the "urgency of need" with which the mental health services identified in item # 29 A were required. Twenty-five, or 92 % percent of the administrators answered this question. Two of the respondents did not

signify the degree of urgency with which services were required. In Table 2 the mental health service category, along with the percent of administrators responses which indicated that a service was needed in a particular year is illustrated.

TABLE 2

Degree of Urgency:
Percent of Administrators Indicating
the Need for a Mental Health Service Category

MENTAL HEALTH ACTIVITY	<1Yr.	1-2Yrs.	3-5Yrs.
Problem ID	81	17	2
Coordination/Direction	69	14	17
Treatment/Intervention			
Crisis Response	88	12	0
Therapy	69	16	15
Vocational	43	52	5
Social/Recreational	54	29	17
Familial Support	70	30	0
Accommodation	63	30	7
Transportation	69	30	1
Education			
Public	74	18	8
Professional	56	38	6

An examination of the data in Table 2 shows that the need for more crisis response services was identified most frequently by the respondents as being the mental health service category which was needed within one year. The second highest ranked category was problem identification, followed by the need for more public education. When all categories are considered together 66% of the administrators responses signified that services were needed within one year, 93% of their responses indicated that services were needed within two years. All of the perceived mental health needs noted by the administrators were

deemed to be required within five years. Within all categories, except Vocational, the majority of the administrators responses indicated that services were required within one year.

The notable exception to the above was that 100% of the administrators in Sydney indicated that accommodation needs should be met within one year. A complete list of the administrators responses by the degree of urgency is included in Appendix T.

Setting

As the setting may affect the adequacy of mental health service provision, the administrators were asked in item # 30 to: "....indicate the setting required to meet the additional needs previously identified in response to item # 29 A". Twenty-three administrators signified the setting for the services identified in item # 29 A. The type of setting in which the administrators perceived there was a need is shown in Table 3.

The administrators were not asked to indicate the communities in which the particular settings were required. An examination of the data in Table 3 shows that the outpatient department followed by private professional setting were perceived as being the most appropriate settings for services offering problem identification and therapy. The administrators perceived that the clients home was the most appropriate setting for both crisis response and familial support services. Community settings such as schools, church halls and recreation centers were viewed as the most appropriate locations to offer vocational services and social/recreational programs. The need for public education

services was perceived as being needed most in a variety of community settings such as schools and churches as well as the settings noted above. The private professional setting followed by the clients home was perceived as being the most appropriate setting for coordination and direction of services. This category includes follow-up services. A complete breakdown of the administrators' responses by mental health service category is contained in Appendix T.

TABLE 3

Percentage of Administrators Responses Indicating Setting for the Mental Health Service Activities

MENTAL HEALTH ACTIVITY	SETTING						
	IP	DP	OPD	PS	R	CH	Other
Problem Identification	10	14	36	23	10	7	0
Coordination/Direction	0	14	21	36	0	29	0
Treatment/Intervention							
Crisis Responses	9	2	35	13	2	39	0
Therapy	12	20	30	22	7	9	0
Vocational Services	15	10	10	20	5	5	35
Social/Recreational	5	30	0	0	10	5	50
Familial Support	0	0	6	10	14	70	0
Accommodation	Not applicable						
Transportation	Not applicable						
Education							
Public	9	20	13	15	10	13	21
Professional	17	17	25	25	17	0	0

IP - Inpatient
DP - Day program
OPD - Outpatient
PS - Private professional setting
R - Residential
CH - Clients home
Other - Other settings

Services Requested to Provide, but Unable

In item # 8 A the administrators were asked: "What mental health services are you requested to provide, but UNABLE to offer?" Seven administrators did not answer this question. Six of the respondents stated that there were no services that were requested of them, but that they could not provide. Fifteen, or 52 % of the administrators indicated that there were services that they were asked to provide but that they were unable to offer. While there was a range of services requested, 50 % of the requested services that the administrators were unable to provide were for either counselling and/or assessment. Twenty-five percent of the requests related to children and/or adolescents.

In item # 8 B the administrators were asked:

> For which reason(s) are you unable to provide the services indicated in 8 A? (Indicate all that apply). ____ insufficient funding, ____ insufficient staffing, ____insufficient training, ____ inadequate physical resources, ____ more appropriate facilities are available elsewhere, other _____

With most of the agencies or organizations a number of reasons was offered for being unable to provide services. Of course, some of the reasons are interrelated. For example, if an agency has insufficient staff it would be unable to acquire the staff without sufficient funding. In 44 % of the cases the reason offered for being unable to offer a requested service was "insufficient staff". Thirty-eight percent of the time the reason offered was insufficient training or more appropriate facilities elsewhere. Less frequent responses (19 %) were insufficient funding and inadequate physical resources. One administrator stated that his agency was unable to provide services due to lack of bilingual staff.

Expanded Hours of Service

The adequacy and accessibility of mental health services may be affected by the days and hours of operation during which services are available. In item # 31 the administrators were asked to: "Indicate those mental health activities and expanded hours/days of service that are required." Thirteen administrators did not respond to this question. Seventeen, or 68 percent of the administrators noted on 25 occasions the need for expanded hours of operation. Of these, twelve were suggestions that services providing therapy be expanded to include evening and weekend hours. The most frequently noted responses were for expanded hours in the evening, from 5 to 9 pm, and the addition of weekend hours for working people, by those providing therapy in an outpatient or private professional setting. One administrator stated that: "....the biggest request is for evening hours." On nine occasions the administrators mentioned the need for expanded crisis services. They noted that the crisis services should be available in more communities. Respondents perceived that crisis services were needed on a 24 hour a day, seven days a week basis. One administrator mentioned that crisis services were needed for seniors. An administrator who works almost exclusively with adolescents suggested: ".... a crisis intervention unit that is readily accessible to the public seven days a week from 11 pm to 8 am - and advertised." Two administrators noted the need for increased hours of operation with services offering problem identification and assessment.

Another administrator mentioned the need for a recreational and social program for those with chronic psychiatric problems, in the

downtown area from 6:00 pm to 8:00 pm. Additionally, he suggested the need for a day hospital program for those with ongoing mental health problems. Finally, an administrator of a Sydney program suggested:

> ....the day treatment program should expand to provide evening programs(6:30 p.m.-9:30 p.m.) and offer 24 hour emergency backup. This would result in outpatient day treatment becoming a truly viable cost and clinically effective alternative to inpatient hospitalization.

Additional Organizations

The administrators were asked in item # 36 to: "List and describe additional organizations that could have a role in providing mental health services and resources." The committee wanted to obtain this information as they thought the responses might give them some indication of the direction to take with planning mental health activities. While there was not a consensus regarding the additional organizations that could be used there were some good suggestions.

Seventeen administrators responded to this question with a variety of suggestions. Twelve choose not to respond. The most frequently mentioned organization was the public school system which the administrators thought could provide more comprehensive counselling and mental health services to students. The church and municipal recreation departments were also mentioned as additional organizations which could have a role in providing mental health services. It was suggested that the recreation departments could offer leisure and time management programs. Other organizations that were mentioned were the Adult Vocational Training Center (AVTC), the University College of Cape Breton (UCCB), and the Canada Employment Center which it was suggested could offer academic up-grading and vocational training programs. Other

organizations that were suggested were the YMCA, senior citizens organizations, the family court, probation and parole services, and the Elizabeth Fry Society. Others mentioned the importance of the increased use of volunteers to complement or expand existing services, including the use of volunteers to visit and sit with seniors, to provide transportation to such people as single parents and seniors. One respondent mentioned the importance of including physicians in mental health delivery system and suggested: "....a better liaison and improved communication between the family practitioner and mental health services is needed." In many respects what the administrators seemed to be suggesting with their responses was a melding of traditional and non traditional services.

Features of the Community

The administrators were asked in item # 37 to: "List any features of your community which you feel have contributed to mental health problems of the residents." Twenty-four administrators responded to this item and two did not. The administrators listed a total of 23 separate features. However, there were three factors which were noted as being particularly salient. These included unemployment, economic conditions and isolation/alienation. Of the 24 who did respond 17, or 71 percent indicated that unemployment was a feature of the community which contributed to mental health problems of the residents. Seven, or 29 percent of the respondents indicated that economic conditions or poverty contributed to mental health problems of the people in the area. Furthermore, seven of the administrators noted that isolation or

alienation were features of the community contributing to mental health problems. The following quotation illustrates the deleterious effect that not having a family member in the community could have:

> The lack of family support and limited involvement due to distance between family and clients location and the tendency to forget member when placed in a residential home or institution often lets the person down at a time when they need you most. It seems like they feel you've deserted them.

Additionally, as this administrator notes: "The geographic distribution of the population over wide areas reduces the access to needed services".

Five, or 21 percent, of the respondents indicated drug and alcohol abuse to be factors. In addition, four of the respondents listed under education and the lack of emphasis on education to be features of the community that contributed to mental health problems. Four of those who responded to this question noted that a lack of recreation facilities and services for teenagers was an important contributing feature. Three administrators also mentioned violence in the community to be a feature of the community which contributed to mental health problems. The respondents, specifically, mentioned family violence and violence against women. Fifteen other features were also noted by the administrators.

One administrator expressed the feelings of a number of others when she offered the following thought in which self-esteem is connected with geographical location:

> Insular attitudes which are encouraged by the public media, as well as being supported privately - connecting low self-esteem with location i.e., Cape Breton Island, rather than the interior qualities of the individual.

In many respects, the following statement by one of the administrators seems to sum up the feelings of a good deal of the

respondents. Furthermore, the following sentiments are related to the issue of indigenous low self-esteem sometimes attributed to Cape Bretoners which was expressed in the previous quotation.

> Unemployment, underemployment, alienation and poverty as well as, lack of infrastructure like adequate transportation have contributed to a chronic response of anxiety, pessimism, and depressive, powerless thinking.

A complete list of the features that the administrators felt could contribute to mental health problems of the residents can be found in Appendix U.

Underserved Groups

The administrators were asked in item # 32 to: "List any groups within the community which you feel are not adequately served by the existing mental health services". It was the intention of the committee to arrange to meet with representatives of the groups that were identified as underserved in the hope that they might help us identify what their needs are. Twenty-three administrators identified groups that they felt were underserved. Three administrators did not respond to this question. One respondent indicated that they did know of any underserved groups. In Table 4 the groups that the administrators identified as being underserved and the number of administrators who identified each group is shown.

As can be seen from examining Table 4, nine or 39 percent of those who answered this question felt that the youth of the Industrial Area were a group that was underserved. One administrator noted that the care-givers of youth were underserved. Thirty percent of the administrators noted that seniors were an underserved group, particularly

the "old-old" (those over seventy-five years of age. Five, or 27 percent, of the respondents identified those that were affected by violent acts such as rape, incest and family violence were not being adequately served by the existing services. They also noted that there was no help for the perpetrators of such acts. Seventeen percent of the administrators noted that those on low income were underserved. As well, seventeen percent of the administrators noted that nearly all groups in Victoria County were underserved Thirteen percent of the administrators identified that those with chronic mental health problems were a group that was not adequately served. Thirteen percent of the respondents also identified members of the Micmac community as being underserved.

TABLE 4

Groups Identified as being Underserved and Percent of Administrators (N=23) who Identified Each Group

Children/Adolescents	39	Mentally Handicapped	9
Seniors	30	Drug/Alcohol	9
Victims of Violence	22	Hearing Impaired	4
Low income/Unemployed	17	Blacks	4
Chronic PMI	13	Care-givers of Youth	4
Micmac	13	Sex Offenders	4

Summary of Data obtained from the Administrators

With the data obtained from the questionnaire distributed to the administrators I was able to ascertain their perceived need for more services, the communities in which the services are required and, the setting in which the services are felt to be needed. Furthermore, I was able to gain some insight into the accessibility and affordability of

services. I also obtained information regarding what groups the administrators thought were underserved and which features of the community they thought might contribute to mental health problems of the residents.

An examination of the data reveals that there is little variation between the various communities in terms of the number of mental health services that the administrators perceive are needed. The range in their responses indicating need varies between 23 percent in New Waterford to 28 percent for the Northside area.

An overview of the information offered by the administrators indicates that 51 % of them perceive that there is a need to provide more services which offer psychotherapy and counseling in all communities. The respondents indicated that adolescents followed by youth were the groups most in need of services that offer therapy. Senior citizens were also identified as groups that needed more services offering therapy. The second greatest perceived need is for problem identification services including those which offer assessment and diagnosis. The administrators most frequently noted the need for psychological assessment services. The third ranked perceived need is for vocational services with the need for such services fairly evenly distributed between the sub-categories including counselling, assessment, training, and job placement. The administrators also perceived a need for more services in the other four mental health service categories, ranging from 39 % for public education services to 15 % percent for services which provide transportation. In addition to a perceived need for services in all seven of the mental health service categories, twenty-five percent of the administrators

indicated a need for more self-help and support groups. Groups that were identified as being in need of such services were single mothers on low income, victims of sexual abuse and violence, and adolescents. The administrators most frequently identified crisis response services as the mental health service activity that was most urgently needed with 88 % of their responses indicating that such services were required in one year. Services offering problem identification were ranked second in degree of urgency. When all of the services in all of the communities are considered together 92 percent of the administrators responses indicated the need for mental health services should be meet within two years.

The outpatient setting, followed by the private professional setting were perceived as being the most appropriate settings for providing assessment, diagnosis and therapy. The client's home was noted as being the most appropriate setting for providing familial support and crisis intervention. The administrators considered that vocational and social/recreational programs should be offered in community settings schools, church halls, and community centers. Public education was perceived as being needed almost equally in all settings, as well as being required throughout the community, including in places of employment.

A majority of the administrators indicated the need for expanded hours of operation. Services offering therapy were identified most frequently as the category in which expanded hours were needed. The administrators suggested that services offering psychotherapy be provided in the evenings and on the weekends. They also suggested that crisis services be made more accessible by being offered in all communities, 24

hours a day, and by being advertised.

Over 50 % of the administrators indicated that there were services that they were requested to provide but were unable to offer. One half of these requests were for either counselling and/or assessment services. Twenty-five percent of the requests for such services were for children and/or adolescents.

Access to services was seen by a majority of respondents as being limited by inefficient and relatively expensive transportation services. Slightly over a third of the administrators assisted their clients, in some way, with transportation. While transportation was an issue in all of the communities, the magnitude of the problem increased, particularly with regard to child and adolescent services, in the communities other than Sydney.

Ninety-three percent of the administrators stated that their organizations either had an appropriate client load or that their client load was too large. Fifty-six percent of the respondents indicated that the waiting period for their services would be a week or less; 27 percent of the administrators noted that the waiting period before clients could receive services at their organization would be a month or more. All of the services for which the waiting period would be a month or more provide counselling or psychotherapy services. The longest waiting period for services appeared to be with child and adolescent services where the waiting period ranged between 15 and 20 weeks.

All agencies/organizations offered services in English, while four could provide services in Micmac. Two administrators indicated that their services were offered in French. Two of the respondents indicated

that their service was offered, specifically, to the Micmac population.

Only two of the organizations surveyed indicated that they charged a fee for their service.

Thirty-six percent of administrators noted that the services were not wheelchair accessible.

The administrators suggested that organizations such as the church, schools and recreation departments could fulfil a role in assisting to deliver mental health services to the Industrial Area.

The issues of unemployment, poor economic conditions, alienation and isolation were seen as being factors of the community which could contribute to mental health problems of the residents.

The administrators most frequently identified the youth of the Industrial Area as being underserved by the existing mental health services. Other groups that were mentioned were senior citizens, those that were victims of violence, those that were unemployed or on low income, members of the Micmac community and those with chronic mental health problems. Women were identified as being underserved within a number of the groups noted above.

Section 2

Survey of Socio-Mental Health Professionals

Introduction

The socio-mental health professionals surveyed consisted of a total of 47 direct service providers from the Industrial Area. This group consists of, among others, social workers, teachers, police officers, physicians, and lawyers. All of those interviewed utilize the mental

health services in the Industrial Area and make referrals to a variety of agencies and organizations. Twenty of the socio-mental health professionals were from agencies that provided services to the entire Industrial Area. Nine offered services in Glace Bay. Seven offered services to the Northside area. Six provided services to Sydney and five delivered services to New Waterford. Twenty-seven, or 57 %, of the socio-mental health professionals were male. A complete list of the socio-mental health professionals and the agencies they are employed by is contained in Appendix F.

To obtain information from our second source, the social service providers I used an interview guide (Appendix G). In addition to asking this group help identify what the mental health needs of the industrial Cape Breton area are, they were also asked questions relating to the accessibility, availability, and acceptability of services. This group was asked about their knowledge of the extant services (i.e., their perception of the which agencies provide which services) and if cooperation between themselves and the agencies they refer to could be improved. The direct service providers were also asked to help identify groups that they thought were underserved and to comment on features of the community which they thought might contribute to mental health problems of the residents.

Perceived Need for Mental Health Services

I first look at the responses to item #16 in which the respondents were asked to: "List any mental health services, and or resources that you think are needed in the industrial area of Cape

Breton. Please elaborate?"

While the service providers were not presented with a formal frame work of mental health service activities as the administrators were, the same conceptual framework of the seven categories were used in analyzing these data. In addition to delineating the specific categories I will report needs which are not covered by our categories and if appropriate note themes which cut across categories. This group of respondents was not asked which communities they thought the services were needed in. The following results are presented in ranked order, beginning with the mental health service that was perceived as being needed by the greatest percent of service providers. I have used quotations to more accurately illustrate the context and magnitude of the needs.

Need for Services offering Therapy

Across the Industrial Area 35, or 75 percent, of the direct service providers identified on 48 occasions the need for more psychotherapy/counselling services. As with the administrators, the group most frequently identified as requiring more therapy services was adolescents. The following teacher's comments illustrate both the severity of the problem and the scarcity of services:

> With the increase in family breakups we see more kids who are distraught and under extreme stress. Their behavior is becoming more and more bizarre. They have no one to turn to and our staff is not equipped to handle them....what the school needs is a clinical psychologist

While there was a recognition that adolescents and children were in need of more services the importance of working with families as a unit was also noted. The following comment from a counsellor illustrates this

concern:

> My concern with the kids is that we see them in isolation of the family unit. Sure they have problems but what is the family for, if not for support. Many times the problems these kids present with are the result of screwed up family dynamics. I'm not so sure that seeing these kids and their parents separately doesn't contribute to the problem.

Need for Problem Identification Services

Twenty-one, or 45 percent, of the service providers identified the need for more services which could offer diagnostic assessment services. The groups identified as being most in need of such services were adolescents and seniors. In both cases the issue was the unavailability of services.

> There are simply no services for seniors or psycho-geriatric cases. When a older person needs an assessment, say they are presenting with alzheimer like symptoms, they often have to be sent to Halifax. This makes things very difficult and expensive for them. It can be very stressful on the family. What we need is a local assessment team, ideally one that would make home visits.

A concern that I had heard frequently from those that work with youth was the need for a local assessment unit so that the kids would not have to leave their community: "....and what is needed is an inpatient assessment unit for adolescents with severe behavioral and emotional problems."

Need for Services Offering Coordination and Direction

Twenty-one, or 45 percent of the direct service providers identified the need for better coordinated services. While there was a recognition of the need for more services for young people some of the service providers identified the importance of a coordinated effort by all of

those involved in the delivery of services to young people. It seems that they believe that this effort should transcend simply those agencies that deliver traditional mental health services to the young. As one social service workers' comments illustrate:

> We need more services for young people. All the concerned mental health and social service agencies, service clubs and organizations like the YMCA should get together - take an inventory of resources , and work together in a coordinated fashion to set priorities.

While the service providers identified a variety of needed services and underserved groups a number of them suggested that the area had enough services and resources but that they were not being used efficiently. The following quotation illustrates how poorly coordinated services may affect the mental health service consumer:

> The ability to work together and collaborate has broken down - you take care of depression and we'll take care of the rest, or we'll see the kids and you see the family. Often the delivery of services is fractured and the best interests of the client are lost. The client must go to two agencies to get treatment and often times were talking about people of limited means.

One clinical social worker expressed a similar concern and one that I heard numerous times about the fragmentation of services.

> This agency will no longer pick up on clients from the Mental Health Clinic who are on meds.... we feel that one agency should deal with the whole client/family.

Finally, there were those who expressed their frustration with what they saw as an unnecessary duplication and fragmentation of services and offered suggestions for an alternative means of delivering services. The following comments by a psychiatrist emphasize the importance of well coordinated services:

> The whole model is the shits - the Glace Bay Community is not community at all. ....We should meet patients on their own turf, where they are more receptive, see them at home, in the

> pool hall... .There are lots of good people but the system is so fragmented. We have all the resources that we need - we just need to use them in a different way. We should broaden our base to include community based resources. We need a comprehensive system, with continuity of care, we should use a team approach. For example, a psychiatrist, psychologist, social worker, and mental health nurse could work in well defined catchment area. Each unit could be used for a different catchment area, then the patients could get used to staff and teams. Presently the quality of care suffers due to the fragmented delivery of services. Each therapist works independently, in isolation.... Presently the patient is seen by too many people. From the time they are admitted until they are released the patient could see up to four separate psychiatrists. It's no wonder families get so pissed off. There is generally poor communication between us.

Need for Social/Recreational Services

Eighteen, or 38 percent, of the service providers noted the need for more social and recreational services for the post-mentally ill and those with chronic psychiatric problems. Some of those I spoke to mentioned that such programs should have a rehabilitation component. Regardless of the focus of the programs, the emphasis was on having such programs in the community as the following quotation illustrates:

> There is a need for the expansion of community programs for the chronically disabled - some sort of supervised, structured activity, sort of a combination of Cardeil Place and a sheltered workshop. Such programs should be offered not only in the day but in the evening. It might give those people some structure and an opportunity to make friends - perhaps help to put some meaning in their lives and reduce the likelihood of them ending up back in the hospital.

The Need for Accommodation

Twelve, or 26 percent, of the respondents indicated the need for more and better accommodation. Both the post-mentally ill and seniors with chronic mental health problems were noted as groups requiring such

services. Suggestions were made for a variety of housing options including supervised apartments; clean, well run boarding homes; and units in homes for special care for those mental health problems. For those with chronic psychiatric problems the concerns were for cleanliness and increased independence. A worker at a hostel for men said that something had to be done about sub-standard and slum housing for those living on social assistance (who often include those with chronic psychiatric problems).

> These people are really taken advantage of, often the landlord exploits them, taking their cheque and then charging them for booze and cigarettes. They end up being constantly indebted or owing their cheque to the landlord. Some of those places are filthy, unsanitary, infested, and very poorly heated. These folks need clean, decent rooms at a reasonable price.

A lawyer I interviewed expressed the concern of a number of others in suggesting that there was an increase in the number of youths from broken homes and that they were often in need of emergency shelters.

> The kids are the ones I feel sorry for they have little to do and no money to do it with, and no hope for the future, no dreams.... often the ones I see are from broken homes , and neither parent seems to want them. I haven't actually seen kids who are living on the street, but I do know of some who live in cars and spend one night at one relatives place and one night at another's. Some just need a warm, safe, dry place where they can get a decent meal.

Need for Educational Services

Eleven, or 23 percent, of service providers identified the need for more educational services. Some of those I spoke to identified the importance of education and community involvement at an early age as an important intervention. A guidance councillor expressed the feelings of many about the importance of education with the following statement:

> We need to give kids a sense of their community, take them to various places. I took the students on a tour of the Cape Breton Hospital. They were very apprehensive before we left, but they came home with some of their myths about the hospital and mental illness shattered....There should be a place in school to discuss mental health issues just the way we talk about physical health. Stress and how to deal with it is a very real concern today. We could talk about values, feelings, coping strategies, and other mental health concerns.

This group stated that they felt that the consumer and potential consumer needed more education/information about what services were available and to get access to those services.

> Listen! I'll tell you most people don't even know what's out there. As service providers we don't always know what's available. We may have difficulty getting access to services. I don't think we have any idea how difficult it must be for those who are unfamiliar - its a maze.

Need for Crisis Response Services

Ten, or 21 percent, of the social service providers identified the need for a more accessible and efficient crisis response unit. A police officer who regularly deals with those in crisis had some thoughts on the present crisis unit and an idea on how to improve it, including having an outreach crisis worker go into the home. He said that if there was a concern for safety the worker could be accompanied by a police officer. A social worker commented on the inaccessibility of the present crisis services, and as with the police officer emphasized the importance of making the service more available.

> I think what would be far more effective than what we presently have is a store front clinic. This type of operation would not only be far more accessible and effective in providing ongoing treatment but in dealing with crisis situations. The present crisis response unit can be difficult and cumbersome to get access to. As well, most people don't even know it exists.

Need for Vocational Services

Six, or 13 percent, of the service providers identified the need for more vocational services. One rehabilitation worker who covers most of the Industrial Area recognized the importance of acquiring life and job skills in enhancing self esteem.

> Many of our clients have very few academic or job skills. They tend to be down on themselves. We often see a change in them once they begin to acquire skills and feel that they may have a future.

Other Issues

In addition to the perceived needs that were identified by the service providers that fit into the seven specified categories there were a number of other issues that were identified including self-help groups and the use of volunteers. It was felt that by using self-help groups and volunteers that the mental health professionals would have more time to devote to tasks that required their skills. The direct service providers identified the need for self-help groups as a means of support for a variety of groups including single mothers on low income, adolescents, seniors, victims of physical and sexual abuse, the unemployed, and men who batter. Once again the issue f the accessibility of services is touched upon:

> We live in a community that is very spread out geographically. This often makes it very difficult for those in need to get access to services. The setting up of local self-help groups in various communities could provide a lot of help and support to those in need. Those of us that are professionals could act as a resource. Our time would be used more productively and those involved in the groups could begin to take more control of their lives.

The direct service providers mentioned the need for the inclusion of volunteers to assist with and/or provide a wide range of services.

> Volunteers could be used for such a wide variety of activities, including; visiting, outings, driving, outreach - we could select and train people to assist with many support services. Volunteers can be the backbone of many services. It can leave the more highly trained professionals to do the jobs that require their skills. Volunteers can provide efficient, low cost support services.

Other socio-mental health professionals addressed the issues of respect and the type of treatment those with chronic psychiatric problems and the post-mentally ill received. One social service provider expressed the concerns of many with the following comment:

> They (those with chronic psychiatric problems) are often treated like trash by welfare officers - if people know you have a mental problem you loose all credibility and respect.

Cutting across the need for more or augmented services including treatment, problem identification, social/recreational, and crisis response services was the sentiment that if the services were to be really useful and truly accessible than they have to be provided directly in the community, including in the home. In many respects a guidance counsellor summed up the frustration of trying to deal with adolescents with emotional problems and provide them with effective services. She also offered a suggestion for an alternative way to deliver services to youth:

> These kids are reluctant to go to the mental health clinic. We live in a small town, everybody knows each other - going to the clinic means 'you're nuts' to them and that is really scary. Even if they would go, there are no adolescent services over here and the waiting period in Sydney is often three to four months for the first appointment - then it's too long between appointments - if we do get them over there they often won't return .... why couldn't staff from the clinic either spend one day a week here, or at least act as consultants to our staff? Perhaps they could teach one of our guidance people to run groups for the kids who need them.

Those with chronic mental health problems were also identified as a

group who could benefit from an outreach approach when delivering services. Closely allied with the recognition of more outreach work was the perception that better follow-up services were needed for patients when they leave the hospital. Most socio-mental health professionals recognized that those with chronic psychiatric problems and the post-mentally ill had difficulty getting services in the community and that there was a need for follow-up in the community. Both of the following quotes illustrate the importance of providing services to consumers on their own turf to help reduce recidivism:

> We need to bring services to them (those with chronic mental health problems) directly - these folks have the most difficulty of any group. They have little money , no access to transportation. Often by the very nature of their illness they maybe confused and or poorly motivated. Is it reasonable to expect them to travel considerable distance at what to them may be substantial cost to get services?

A social worker and former police officer stressed the importance of providing follow-up with the patients who are released from the Cape Breton Hospital.

> These folks are stabilized on meds in the hospital then released with no support services. Often they feel that they are fine, discontinue their medication, then have to be readmitted. There appears to be a reluctance on the part of the resources in the community to help this segment of the population. The hospital act reads 'may' rather than 'shall', as such, often the problem gets shifted between the police and the family doctor. We need an extended service which should include home visits by a social worker and a community mental nurse.

Accessibility of Mental Health Services

In addition to asking the socio-mental health professionals to help identify needed mental health services and resources in the Industrial Area, I also asked them a number of other questions, including ones

relating to the accessibility, availability, and acceptability of mental health services. These issues are an integral part of Nguyen's (1978) definition of unmet need.

Problems in Making Referrals

The issue of the accessibility of services was a theme that was emerging from the other groups surveyed, including the administrators, the consumers and the public. I began by asking a general question. In item # 7 the socio-mental health professionals were asked: "Do you encounter problems making referrals to any of the agencies/organizations offering mental health services? Please elaborate."

Twenty-three, or 49 percent, of the respondents indicated that "Yes", they did encounter problems making referrals. Forty-three percent of the key informants said that they did not have difficulty making referrals. Six people did not respond to this question. The respondents offered numerous reasons for why they had difficulty making referrals; 50 percent of those who said that they had difficulty indicated that the reason was unduly long waiting periods. Waiting periods were noted as presenting a problem when trying to get people into upgrading and vocational programs and in trying to get them decent housing. However, 95 percent of those who noted that waiting periods presented a problem stated that they were a problem when making referrals on behalf of children and adolescents. These included referrals for therapy and assessment.

> The situation is really critical. We have kids that we just don't know what to do with. We can't always be sure what the problem is, so we're not sure where to begin. When you have to wait some times for up to six months (for services) - the

> situation can really deteriorate. It's hard for us to reassure these kids when we can't get them the help they need.

While the issue of waiting periods was noted most frequently as a problem in making referrals a number of other themes also emerged. Twenty-seven percent of these service providers noted that they regularly had difficulty making referrals to the Cape Breton Hospital or when attempting to get someone admitted in a crisis situation, often because of the necessity of going through a physician. As one social worker noted:

> Everything has to go through the doctors (they have all the power) the physician is frequently the point of entry for the client/patient; yet this person, often an intern has no psychological training - little or no knowledge of psychology and he determines if the person will see a non medical person.

The issue of transportation also arose frequently (20 percent of respondents mentioned it) when discussing making referrals for children and teenagers.

> ....the agency can often help get them to the clinic for the first appointment but when they have to return for the next and subsequent sessions it's often just takes just too much trouble and time. The bus service here is really lousy.

A issue that arose with considerable regularity when trying to make referrals was the lack of services available. The groups that were mentioned most frequently were the elderly, adolescents (particularly for inpatient assessments), survivors of sexual abuse and incest, housing for the post and chronic mentally ill, and programs for female alcoholics. Additionally, a number of respondents mentioned the lack of self-help groups to refer people to including groups for those have been sexually and physically abused. A representative response from those who worked with the elderly was:

> ....what services are there for the seniors. If they are over sixty-five we can't get them admitted to the Cape Breton Hospital. Where are they to go? Even if they require an assessment we have to arrange for them to go to Halifax. Is this reasonable for someone who is old and maybe confused.

The issues of turf and competitiveness were mentioned as being problems when making referrals.

> I've worked in a number of agencies and I know how certain agencies see a particular case as their own. Sometimes they are concerned about referring a client for a service as they feel the agency may grab their client.

Finally, for those who indicated that they did not have difficulty making referrals the reasons were usually that their clients were adults or that the worker repeatedly referred to the same agencies and was familiar with both the staff and protocol. However, the most frequently recurring theme mentioned by those who did not have problems making referrals was the perception that they had built good personal relationships. As one worker put it:

> It often doesn't matter so much what is done at the administrative level as what the relationship between the various workers is. If I can call someone I know, it often makes the road easier(when making a referral).

To assist in further determining the accessibility of services the committee thought that it would be helpful to gain some insight into what factors would keep people from utilizing mental health services. In item # 10 the socio-mental health professionals were asked: "What factors, if any, do you feel would keep people from seeking help from an agency that provides mental health services? Please elaborate."

The issue of stigma was mentioned by thirty-four or, 72 percent, of the direct service providers as being a reason why people would not seek help from a mental health agency. One worker I spoke to addressed the

issue of stigma without mentioning a specific group:

> People have a great deal of pride. It's not just a matter of admitting you need help. It's the 'They'll think I'm crazy syndrome'. If you want to maintain your self respect, it's not smart to admit you went to the 'Sydney River'. This is a small community and people tend to know other people's business.

The issue of stigma as a deterrent to youth seeking help, particularly, as it is associated with services located in the Cape Breton Hospital is noted in the following statement:

> ....it's a very intense experience for kids to go to clinic. The Butterscotch Palace has terrible reputation. They should get child and adolescent services out of there - have them somewhere more accessible and less intimidating.

The issue of transportation was mentioned by 53 % of those I interviewed as a reason why people would not seek help from a mental health agency. As one psychologist said:

> It's the location. I mean how are people supposed to get there; it can be hours by bus, and then the bus doesn't even go directly to the hospital...many of my clients have to get an early afternoon appointment as it is the only one that they can get to and then get home. The effort required to get there makes it very unlikely people will follow through if the miracle doesn't happen in the first session or two.

A variety of other reasons was mentioned by the respondents for why people would not seek help from a mental health agency including: lack of money, motivation, waiting periods and lack of knowledge of the availability of services.

> People don't know where to turn for help. They don't know what's available, or the range of services that's available.... many think there are only psychiatrists. Many don't even know there is a clinic at the Cape Breton Hospital.

As the issue of waiting periods emerged as an impediment to the utilization of services, it was considered appropriate to ask the service providers directly about their perceptions of waiting periods for mental

health services. In item # 8 the key informants were asked: "Is the waiting period for mental health services acceptable? Please elaborate."

Twenty-four, or 51 percent, of service providers indicated that, "Yes", the waiting period for mental health services was acceptable. Sixteen, or 34 percent, of the respondents said that, "No", the waiting period for mental services was not acceptable. Ten people were not asked this question. Understandably, some of the respondents indicated that waiting periods with some agencies were acceptable while with others the waiting time was not. Furthermore, people have different experiences with the same agency. However, some consensus emerged from the data. Ten, or 63 percent, of those who indicated that the waiting period for mental health services was not acceptable noted that this was the case when making referrals for assessment and treatment of children and adolescents. Waiting periods of three to six months were mentioned regularly. A response that reflected the feelings of numerous people I spoke to was: "....six months is an eternity in the life of a kid."

The factors that emerged in the cases where waiting periods were not cited as a problem were basically the same as those who did not have problems making referrals and included referrals that were made on behalf of adults. Additionally, the degree to which the person making the referral was acquainted with the person they were referring the client to was considered a factor in reducing, at least to a degree, the length of the waiting period.

Finally, all of those who chose to comment on it indicated that if they emphasized that the case they were referring was in crisis it would be dealt with appropriately.

> The waiting period for normal referrals is getting ridiculous, although with cases that are critical they will usually see us immediately or within twenty-four hours.

Availability of Mental Health Services

To assist in ascertaining what services were unavailable the committee thought it would be helpful to inquire into what type of referrals, if any, were made to agencies outside the Industrial Area. In item # 11 the socio-mental health professionals were asked: "Are there occasions when you make referrals to agencies or organizations outside of the Industrial Area? Please elaborate."

Twenty-eight, or 60 percent, of those I interviewed indicated that "Yes" there are occasions when they make referrals outside of the Industrial Area. Thirteen, or 28 percent, of the respondents stated that they did not make referrals to agencies outside of the Industrial Area. Six people did not respond to this question.

Fifteen, or 54 percent, who said that they made referrals to organizations outside of the Industrial Area stated that these referrals were on behalf of children or adolescents. Youth were referred for a variety of reasons including inpatient psychological assessment, treatment for severe behavior disorders, treatment for eating disorders, and to schools offering special services such as instruction for those with learning disabilities.

> There is no inpatient assessment or treatment unit in this area. We have little choice with kids with serious problems but to refer them to Halifax.

In some cases it appeared that regardless of the inconvenience, parents wanted what they perceived as being best for their children as the following quotation illustrates:

> ....often parents want their kids referred to the IWK. They have inpatient services, a comprehensive team approach, and good follow-up... It is perceived as being more credible than what we have here.

Second to youth, the elderly were referred most frequently outside of the Industrial Area. Those requiring psychological assessment or diagnosis were regularly referred to the Nova Scotia Hospital in Halifax for assessment.

> ....to my knowledge there is no specialist in geriatrics in this area. There is definitely no assessment or treatment unit for those over sixty-five.... Right now we may have to wait a few months to get an appointment with Dr. X... in Halifax.

Acceptability of Mental Health Services

The steering committee for the needs assessment was interested in the socio-mental health professionals' perception of the quality or acceptability of the mental health services their clients received. In item # 9 these key informants were asked: "Are you satisfied with the quality of service that clients you refer receive? Please elaborate."

The data received in response to this question are rather difficult to quantify, as the respondents tended to be satisfied with some aspects of some services and not so satisfied with other aspects. Typical responses were: "Generally, I am happy, but....."; or "Yes, except for....". Twenty-eight percent of those I interviewed responded that, "Yes", they were satisfied with the quality of services that there clients received. Twenty-seven, or 53 three percent, of the direct service providers said that they were not satisfied with other aspects of the quality of service that the clients they referred for service received. The respondents mentioned a number of different service areas

and groups that they perceived were not receiving acceptable services. However, with those I interviewed, the predominant concern was with different aspects of care that those with chronic psychiatric problems receive. As the following quotation illustrates this group was concerned with the clients' early release from hospital and the lack of follow-up or support for these people.

> People are released from the hospital with little, or no support or guidance. The inpatient department assumes that the patient knows about the clinic. They should help to familiarize the patient with the community resources. The patient also requires follow-up once they are released.

An issue that was related to that of follow-up was a concern expressed by, among others, some of the physicians and police officers whom I interviewed. They felt that they should be apprised when some one they had been instrumental in admitting was released. As the following comment illustrates this group was also concerned with what they perceived was the early release of some patients from the CBH.

> There is poor communication between some of us and the psychiatrists. We don't know who gets admitted....often they (the patients) are released too soon. We go to all the trouble of getting them admitted, and they're back on the street - sometimes within a few hours. Some of those people should not be on the street.

The service providers in New Waterford had specific concerns both about the lack of services in their community and the lack of continuity with what services they presently have. As one physician commented:

> The Clinic should be over here on regular days of the week with regular staff. Jesus! Who the hell knows who there going to see when they go there. Every time they (the clinic) comes it seems like the patient sees some one different. There is a lack of continuity at the clinic, no steady psychiatrist or regular staff, even the secretaries are always changing.

Some of the key informants I interviewed were unhappy with the

quality of care they felt their clients were getting from some of those in the psychiatric community. As the following quotation shows the consensus of opinion was focused primarily on the relatively short amount of time the psychiatrist spent with their clients and the amount of medication that was prescribed.

> The psychiatrists spend too little time with the clients. They are too quick to prescribe drugs. Although I've heard fewer complaints from my clients lately, I still hear that they are not keeping their appointments because 'they just give me a pill.'

Finally, a concern expressed by a direct service provider was the issue of medical services and the chronic patient. At the time this research being conducted there was an investigation regarding the death of a individual in the community, who it was commonly known had a history of mental health problems. Given the death of Mr. X.... it is perhaps surprising that this issue did not receive more attention. Given the discussion regarding a possible public inquiry to investigate this man's death, I thought the following worker's comments should be included in this document.

> There is a problem with medical services that the chronic patient receives. As you know they have to go through a physician to get admitted to the Cape Breton Hospital but often the chronic has little credibility. The doctors just think so and so is crazy and regardless of what the problem is, even if it is a severe, medical, emergency the patient can wait sometimes for hours before they get looked at. Take the case of Mr. X. He was shuffled back and forth between St. Rita's and the Cape Breton Hospital and of course you know the outcome of that case. (Note: Mr. X died.)

In addition to the those with chronic psychiatric problems the service providers identified adolescents and those over 65 of age as being groups that were not always adequately served. The following guidance counsellors comments reflect the feelings of many of those who

work with adolescents:

> Generally, I am happy with the quality of service - except with the students who are of control. Those kids require more than once a week sessions. An inpatient assessment and treatment unit would be desirable.

As in the case of those concerned with youth services those addressing issues of the elderly were concerned with the lack of services as the following comments illustrate:

> Absolutely not! What services? There are no services here for the older person with psychological problems. If they are under sixty-five their family don't want them in the Cape Breton Hospital, if they are over sixty-five the Cape Breton Hospital won't take them, so we get them. We need a unit for those over sixty-five who are violent or have severe psychological problems. Why can't a mental health person see our residents here (in the home for special care)?

Underserved Groups

The committee was interested in determining what, if any groups might be underserved by the existing mental health service system. In item # 12 the socio-mental health professionals were asked: "Are there particular groups in the Industrial Area that you believe are not provided adequately for by the existing mental health services? Please elaborate."

Thirty-nine, or 83 percent, of the key informants stated that, "Yes", there were groups that were underserved. Forty-nine percent of those who indicated "Yes" stated that children and teenagers were a group who were underserved. It was suggested that this group was underserved for a number of reasons including unacceptable waiting periods for an appointment, the difficulty in getting to an appointment, and the lack of services.

> In this town there are very few services for young people....no movie theatres, no recreation facilities, no organized activities outside of school. Believe me, the lack of such services contribute to the problems kids may have. There are no diversions, no appropriate outlet for their frustration.

Thirty-six percent of those who said that there were underserved groups in the community stated that seniors or the elderly, particularly those over 65 were not adequately served by the existing mental health services. The issues of assessment for those with Alzheimer-like symptoms and dementia were mentioned. Furthermore, the lack of appropriate housing for those with mental health problems was frequently raised. Additionally, it was noted that senior citizens often do not receive respect when seeking help. One physician shared the following comment regarding the treatment of the elderly by some of his colleagues: "....if there over 65 their off their rocker. Give them meds."

Six or, 15 percent, of those who said that there were underserved groups indicated that those with chronic psychiatric problems are not adequately served.

> There are no services for those with chronic problems. Once they leave the shelter of the hospital they're on their own....no sheltered workshops, no recreational activities. You see them wandering the street.... We get calls of desperation from members of their families who don't know what to do with them. They (the family) feel like they are being held prisoner.

As well, 15 percent of those interviewed identified women who are victims of violence and abuse as being underserved in a variety of ways by the existing mental health services. As the following comments by a social worker who works with women indicate:

> We need far more services for women who are victims of physical and sexual abuse....including more female counsellors, more second stage housing, child care services, and more support groups. When women leave an abusive relationship there is

> little in the way of long-term support. These women usually have very few resources and are often very vulnerable.

Other groups that were identified as being underserved were single mothers living on low incomes, the poor, native Indians, and those with addiction problems. Women were also noted as constituting a portion of these groups. A complete list of those groups that were identified as not being adequately served are include in Appendix N.

Working Relationship

The steering committee was interested in knowing what the relationship was like between those making referrals and the agencies they referred clients to so that such factors might be taken into consideration when planning. In item # 13 the socio-mental health professionals were asked: "Could the relationship between you and the mental health agencies you make referrals to be improved? Please elaborate."

Thirty-one, or 66 percent, of the direct service providers said, "Yes", the relationship could be improved. They noted lack of communication, poor feedback regarding clients, a faulty perception of what services were offered, and a lack of respect as contributing to poor relations between agencies.

> People have fixed perceptions and attitudes about what goes on here(CBMHC). Very few of them, I would say, are accurate. People are confused about what we do.

Many respondents said that they were not always aware of what services all the other agencies offered as the following quotation illustrates:

> It is very difficult to stay informed about staff changes and who does what. I'm not sure I really know the difference

> between the Mental Health Clinic and Family Services, let alone what the individual staff areas of specialty are.

The socio-mental health professionals cited communication and the sharing of information with all of those involved in delivery of mental health services as being essential to improved relations. The most frequently mentioned ways of improving relations were regular interagency staff meetings, more workshops, and more in-service training programs. As one police officer who supported inter-organizational meetings said:

> We try and have regular in-services for our staff. We actively invite folks from different agencies to come and talk to us. It's the only way to keep informed. You have to make an effort to find out about what different agencies offer. I think half the problems that arise occur because we don't fully understand each other's mandate. You can't get together too much.

The respondents including physicians, police officers, and social workers expressed concern about not being apprised when patients they had helped admit to the Cape Breton Hospital were released. As one physician said:

> We (the family and I) may go to considerable trouble to get some one admitted to the Cape Breton Hospital and the next time I turn around there they are back on the street. I would appreciate a 'phone call when the person is released(or if they are admitted). The family physician should be kept involved. (A discharge summary is fine when we get it, if we get it, often it's a week after the patient is back on the street.

The second most frequently noted way of improving cooperation was through an improved system of sharing information through better follow-up reports and discharge summaries. Two respondents mentioned that, with the volume of information on both clients and services, maybe it was time to consider establishing a central registry with a data base.

The issue of respect arose with a number of the direct service providers. They expressed the concern that they felt their opinions were

not always taken seriously by professionals in some of the mental health agencies.

> I feel that some of the professionals don't respect our opinion. We work directly with the client and we know what their needs are, and yet they (the professionals) rarely consult us. In fact it can be difficult for us to get information on a client once they are in treatment. It should be a collaborative effort. There should be more case conferences.

Seven, or 15 percent, of the respondents felt that their relationships with the various mental agencies were satisfactory. In most cases it seemed to be because the worker was usually working with the same agencies and had often developed a good personal relationship with the staff: "....often I feel it is a function of the worker's personal relationship he has with the other agencies." Additionally, the use of formal inter-agency meetings was felt to contribute to positive inter-agency relationships and understanding.

Knowledge of Agencies/Organizations

The steering committee was interested in knowing what the socio-mental health professionals knowledge of the existing mental health services was. This interest was based, in part, on responses to previous questions where the service providers indicated that they were not always clear on the differences between various agencies. It was thought that this information might be useful in planning. In item # 14 the socio-mental health professionals were asked: "Is it clear to you which agencies handle which types of problems? Please elaborate."

Twenty-three, or 58 percent, of the direct service providers said that, "Yes", it was clear to them which types of problems the various agencies handled. Seventeen, or 36 percent, of the respondents said they

were not sure what services different agencies provided. Thirty-five percent of those who stated that they weren't clear about the roles of the various agencies said that they were not sure which services the Cape Breton Mental Health Clinic offered. Others said that they were not sure about the differences between the CB Mental Health Clinic and Family Services. One administrator who was complaining about the lack of services was about 200 hundred yards from an agency that offered mental health services. He was unaware of the mental health agency's existence. As the following quotation illustrates the Cape Breton Hospital Complex remains an enigma to many direct service providers:

> The Cape Breton Hospital seems like an entity unto itself out there. It's so removed and it sort of reminds me of bee hive - you know there is lots of activity but you're not really sure what's going on inside.

Fifty percent of the service providers said that they felt that they knew what services the different agencies provided. The reasons offered for this knowledge were years of experience, the building of personal networks and relationships, and the use of formal structures for the exchange of information.

> The IAAPD offers a good opportunity to network with other professionals. It makes me feel included and if I make the effort I can keep on top of what's going on. Perhaps we should invite more of those in related services such as physicians, lawyers, guidance counsellors etc. These professions often make referrals to us and I think it would be helpful for them and us to network.

Features of the Community

The committee was interested in knowing what, if any, features of the community might contribute to mental health problems of the residents. It was felt that having such information could be helpful in

planning interventions. In item # 15 the service providers were asked: "Are there features of your community which you feel contribute to the mental health problems of the residents? Please elaborate."

Forty-five percent of the respondents said that they felt that the economy was a feature of the community which contributed to the mental health problems of the residents. Closely allied with the economy was unemployment which was identified by 21 percent of the respondents. Seventeen percent of those who identified features of the community said that family breakdown or the lack of family support could contribute to the residents mental health problems. In many cases they said that family breakdowns resulted from economic stresses. Other features were the abuse of alcohol and drugs which often contributed to acts of violence. It was noted that unemployment and the state of the economy contributed to the abuse of drugs and alcohol. Those interviewed noted that a lack of adequate transportation which can contribute to isolation is a negative feature of the Industrial Area. In many respects, the following two quotes capture the relationship between one's mental health and the economy:

> It's unemployment. It's a killer. How can you be unemployed and maintain your self-esteem? It can lead to drinking, violence, family problems. It can become a vicious cycle.

> The economy is a major feature. I see more people who have headaches and backaches. These are often symptoms of depression. They want a pill. They think their back is the problem. They don't want to focus on the real problem which is lack of work and money.

A social worker summed up the feelings of many about conditions in the Industrial Area with the following comment.

> This is not a vibrant community....can we hang onto what we've got? There is no positive sense of community. You don't hear

'We're important. This is a great place to live'. We need more things like the Oilers....that team brings us together as community.

Summary of Data obtained from the Socio-Mental Health Professionals

In summary, the socio-mental health professionals identified a wide range of mental health services as being needed in the Industrial Area. Services were identified as being required in all of the seven mental health service categories.

The most frequently identified service category was the need for more services and staff who would provide psychotherapy/counselling. This area of need was identified by 75 percent of this surveyed group. The second most frequently identified category of need was Problem Identification (i.e., diagnostic and assessment services). Forty-five percent of the service providers noted the need for better coordinated services. This group suggested that the fragmented delivery of services was detrimental to the quality of service that was delivered and could have deleterious effects on the clients. The direct service providers suggested that the need for a coordination and planning body made up of traditional mental health service providers as well as other service agencies, such as the police, school board, and organizations such as service clubs, was indicated. The direct service providers also identified the need for social/recreational services for those with chronic psychiatric problems. The need for more educational services was noted. The socio-mental health professional stated that such services should be provided in the school as a preventative measure and to the public as an informational service. Accommodation services were also indicated as being required in all communities. The need for more

accessible crisis response services was noted. The importance of providing vocational services and their positive effect on one's self-esteem was recognized.

Groups that were identified as being underserved were adolescents, senior citizens and those with chronic psychiatric problems, the poor, and victims of violence. Adolescents were identified as being the group most in need of diagnostic and counselling services. The elderly were also noted as being a group that urgently required assessment services. Seniors and those with chronic psychiatric problems were identified as being most in need of accommodation. Those with chronic mental health problems were identified as requiring more social/recreational services. Additionally, those with ongoing mental health problems were viewed as requiring more attention and less medication from the psychiatric community. They were also seen as requiring follow-up services in the community. Women were identified as victims of violence, as adolescent girls requiring counselling, and as those with addiction problems.

Barriers to providing services included stigma, unduly long waiting periods, inadequate transportation services, and the lack of existing services in the Industrial Area. Waiting periods were noted as being prohibitively long for child and adolescent services. As well, the fact that many services, including services for youth, were located in Sydney River made them difficult for the consumer to use. The groups that were referred out of the Industrial Area most frequently were youth and seniors. In both cases the groups were referred to Halifax for diagnostic services.

The socio-mental health professionals suggested that relationships

between the different agencies could be improved by an increased sharing of information through more network building and more inter-agency workshops. It was felt that the increased sharing of information could assist in increasing respect between the staff of the various agencies and clarifying the roles of different agencies.

The poor economy and unemployment were noted as being features of the community which contribute to family problems, increased alcohol and drug abuse, violence, and the mental health problems of the residents, in general

The service providers recognized that, if services were to be provided effectively in the Industrial Area, then a better coordinated effort among the service agencies was necessary. Furthermore, they recognized that an outreach or community-based approach would be helpful. It was suggested that services for adolescents could be provided in the schools, in-home assessment could be offered to seniors, and a number of services, including follow-up and support services, should be offered to those with chronic mental health problems on their "own turf". This group also recognized the importance of self-help groups particularly for women, adolescents, seniors, the unemployed, and men who batter. They also noted that volunteers could be used for a variety of support services.

Section 3

Survey of Consumers of Mental Health Services, Family Members and Advocates

Introduction

The third survey in the mental health needs assessment was designed to obtain information on the mental health care system in the industrial Cape Breton area from the unique perspective of service recipients. Consumer participation was solicited through advertisements placed in/on the various media over a 10 week period. I asked those who responded to the publicity to participate in an interview. A copy of the interview guide is included in Appendix I. All of those who agreed to an interview we asked to complete an informed consent form (Appendix H) prior to participating in the interview.

A total of 12 individuals agreed to an interview. Nine, or 75 %, of those interviewed were female. I interviewed all of those who participated in this portion of the research in person. Six, or 50 percent, of those who responded were relatives of consumers. Five of those interviewed were consumers or people who had used the mental health system directly. One of the people interviewed, while not officially an advocate, was concerned about specific sectors of the client population.

Those who were interviewed in this survey were asked to answer four questions: 1) Tell me about any difficulties you encountered when trying to find the mental service(s) you needed in industrial Cape Breton, 2) Tell me about the reasons you were satisfied or dissatisfied with the mental health service(s) you received, 3) Tell me what the mental services you think are missing or in need of more programs, and 4)

Tell me about any suggestions you have for mental health services in the Industrial Area. Data from this sample were content analyzed and coded according to the seven conceptual framework categories used for the Administrators Questionnaire ((i.e., 1. Problem Identification, ..., 7. Education).

Need for Services Providing Therapy

Many of those interviewed said that they were dissatisfied with some aspect of the existing mental health services which provide psychotherapy or counselling. Some of the reasons for their dissatisfaction included the inaccessibility of the Cape Breton Hospital, unduly long waiting periods, the feeling that patients were released too soon, and the suggestion that there was poor communication between psychiatrists, leading to inappropriate changes in medication. However, the most salient issue, mentioned by 50 percent of those I spoke to, was medication and counselling, including the perception that the psychiatrists rely too heavily on medication when treating their clients and do not allow time for therapy or counselling. Virtually all of those interviewed who had a history of mental health problems were concerned about the issue of medication.

> ....I mean we're supposed to be sick. How are you supposed to get better when you get to see the psychiatrist maybe once a month for five to ten minutes. He might ask: 'how you're doin'?', and then he gives you your script. I never had counselling as an outpatient.... all I got was medication. Sometimes it just seems as if they don't listen or know what's going on. You can walk around stoned, and out of it, for days.

Comments regarding the Cape Breton Hospital varied in their perspective. However, family members were fairly consistent in their

observations regarding the tertiary unit. As one relative said:

> Tertiary is a real shame. It's dirty. Patients are treated roughly. They seem to have little freedom or privacy. Often their clothes are stolen. They always seem so out of it on drugs.

The majority of those I interviewed had suggestions for the services offering psychotherapy or counselling. There was little consensus and the suggestions covered a broad range. The suggestions included the addition of new services such as an unit to deal with psychogeriatric cases, more therapists to provide treatment for youth, less reliance on medication, and more time spent counselling. A recurring issue amongst those who answered this question was the need for more decentralized services. Those interviewed suggested that services should be located in more central parts of the communities, rather then in the Cape Breton Hospital. Groups that were specifically mentioned as being in need of additional or improved services were youth and those with chronic psychiatric problems. A person who has been receiving psychotherapy for a number of years expressed her frustration in trying to get help.

> That hospital is so difficult to get to, 'specially in the winter. There should be a clinic downtown. It just seems that things are made more difficult for us.

Additionally, a mother of a young boy commented on the issue of the stigma associated with the Cape Breton Hospital and suggested the possibility of outreach services.

> Kids do not like to go to Sydney River. It has a very bad reputation. Is there any reason why the psychologist can't come to the school? Maybe he could go to a different school each day.

Need for Services Providing Coordination and Direction

The consumers identified poor coordination and continuity of services as an area that they were dissatisfied with, including the lack of follow-up services. Furthermore, they felt that some of the physicians and many of the psychiatrists preferred to work independently, thus providing a reduced quality of service to the client. I noted that the lack of coordination of services was an issue with those seeking services for youth and for those with chronic psychiatric problems.

> It was so difficult just trying to get help for J___. The professionals here didn't seem to talk to each other, not like in Halifax. One psychiatrist didn't seem to want to work with J__ if a certain doctor worked with him. It was so hard to get an accurate diagnosis because I had to go from one to the other getting different opinions. There was never a case conference....and they never called to see how things were going....no follow-up.

Suggestions that were offered to improve services offering coordination and direction dealt both with improved communication between psychiatric staff within the Cape Breton Hospital, between psychiatric staff within the hospital and the psychiatrists in the community, and between some of the physicians and the mental health professionals.

This group also said that there was a need for follow-up an support services in the community, particularly, for those who have chronic psychiatric problems and these who are released from hospital. The following quotations illustrate the loneliness, frustration, and need of those who know what it is like to be released from a "mental institution."

> What is needed is someone from outside to do social type work, a volunteer could come and talk and socialize with patients

> I'm so god damned mad there are just no services for when they get out. They just let them out the door - then what the hell do they do?
>
> When your inside your warm, and protected, and well cared for then all of a sudden your outside often with no one to talk to. Sometimes that's when it gets bad - if only there was some one to talk to, why can't some one from the hospital come and visit?

Need for Crisis Response Services

Virtually all of those who had been admitted to the Cape Breton Hospital and those who were relatives of people who had been admitted were dissatisfied with crisis response services. They were concerned with the often time-consuming and bureaucratic procedure that was required to get a person admitted to the Cape Breton Hospital. One former patient expressed the frustration and fear surrounding the admittance procedure.

> Sometimes it can be a nightmare. You always have to go through a doctor no matter how many times you've been there. If your freakin' out how do you get to the hospital? The doctor won't come to your house, a taxi is not likely to take you. Being taken by the police is humiliating. If you get an ambulance it's means you have to go to the hospital first. You may have to wait in emergency for an hour or more. Then you may or may not get referred on to the Cape Breton Hospital. If you do get referred on ...., if it is after hours or on weekends you may have to wait for the admitting psychiatrist. God knows how long this can take - then the admitting psychiatrist may or may not see fit to admit you.

There were also concerns about the availability of crisis services after midnight and on weekends. The concerns that people had about crisis services appeared to be exacerbated if you lived out side of Sydney. One lady I spoke to in North Sydney told me it took five hours to get her son admitted. There was a strong consensus and virtual unanimity in this group's suggestion that those in crisis be dealt with

in a more sensitive; less bureaucratic, and less time-consuming way. None saw the necessity of having to go to the emergency services of a general hospital to be seen by a general practitioner in order to be admitted to the Cape Breton Hospital.

Need for Problem Identification Services

Close to one-half of this sample said that they were dissatisfied with some aspect of those services offering Problem Identification. These people stated that two main reasons for their dissatisfaction were extremely long waiting periods or the simple lack of services. Youth and those over sixty-five were identified as groups who were in need of assessment and diagnostic services. One person we spoke to expressed the concerns of others familiar with the problems of older people with mental health problems in the following statement:

> There is no assessment or treatment unit here - people over sixty-five must be sent to Halifax. This can be stressful, disruptive, and expensive on both the families and the individual. If the person is having problems he/she may become even more disorientated and confused.

Those who are familiar with the mental health issues relating to youth spoke of waiting periods of up to four and five months to get a psychological assessment. They noted that there was a need for an inpatient assessment unit in Cape Breton and suggested that some assessments, particularly those of children and seniors, would better be done in the individual's home.

Need for Accommodation Services

A number of those I interviewed perceived that there was a need for

more accommodation, specifically supervised housing for those with chronic psychiatric problems.

> Supervised apartments are desperately needed .... people end up back in the hospital with out the supervision and support. Housing should be arranged for people before they leave the hospital.

People I interviewed who had ongoing psychiatric difficulties or were familiar with the difficulties that those with chronic mental health problems spoke of the concern about patients losing their accommodations if they are in the hospital for more than thirty days.

Additionally, there was some concern expressed about the lack of accommodation for seniors and the types of problems which arise when those with different mental health problems are housed together.

> There is no appropriate housing available for seniors with mental health problems. Nursing homes are over crowded and can't meet the needs of all the types of patients. Often a patient with one type of diagnosis aggravates the others. People with Alzheimer's tend to wander - this can be a real problem. We need special facilities for such people.

Need for Transportation Services

While this group did not address the issue of transportation specifically as a mental health issue, many of those I spoke to noted some dissatisfaction with issues relating to transportation. They emphasized the amount of time it takes to get to and from the Cape Breton Hospital and the fact that there is no bus service directly to the Hospital. Not only is poor transportation inconvenient but as the following illustrates it can be humiliating.

> Public transportation stinks. It takes two buses and forever to get to the Cape Breton Hospital, and even then you have to walk 1/2 mile through a hay field....is there any dignity in having to walk a half a mile through muck and snow and dog shit behind the Woolco?....the staff all pull up in nice cars.

A mother of an ex-patient, one with ongoing mental health problems, expressed the anger and frustration of others in the following statement illustrating the detrimental effects that an inaccessible service can have:

> I'm a prisoner in my own home. There is no transportation to get M_____ to services, he will not take busses .... people must recognize how peculiar mental illness may be. He looks OK physically but he can't take a bus. Can you expect someone who is paranoid to take public transportation....so if he can't get to the service how can you expect him to get better. In the meantime I get worse - so not only is the system not helping him but it's causing my condition to get worse.... there's a great deal of stress on the family.

This group also had suggestions for improved transportation services including the use of Handi-trans and volunteers to help assist people keep appointments.

Need for Social/Recreational Services

Many of those I interviewed, including consumers and relatives, were concerned about what the person with chronic psychiatric problems does to fill his/her time. This concern was noted as being a more predominant issue in communities other than Sydney.

> There is a real need for social activities and support groups. There is no place for B__ to go during the day. What we need is a place like Cardeil Place over here-where people can get together. Otherwise there is no social life for those people.

Other Concerns of the Consumers, Family Members, and Advocates

Need for Self-Help

In addition to issues related to the seven service categories those that who were interviewed felt that there was a need for more self-help

and support groups. They said that there was a need for such groups for families of those with mental health problems and for those with mental health problems. It appears that the need for such groups is greater in communities other than Sydney.

Respect and Stigma

A recurring theme amongst those I interviewed in this sample was a concern they had about a perceived lack of respect from various mental health professionals, including psychiatrists. Family members sensed that they were not respected.

> What really bugs me is how the psychiatrist just ignores us (family members) when he's admitting L___. They just don't seem to have any respect for our opinions . I mean we live with the person. We know what he is like, and what he was like just before coming to the hospital. Often the doctor really doesn't see in how bad a shape he really is. There is no consultation with family members. We are treated very poorly by the doctors.

> They give him too much medication. We try and explain it was too much but it doesn't seem like we get much respect. They don't believe that we might know what's best.

One ex-patient summarized the feelings of others in commenting on the stigma of mental illness.

> People are treated differently when they have a mental illness. For example when you have cancer you get cards, flowers and visitors. When you have a mental illness, what do you get?

Money

The issue of money was always present when talking with consumers whether it was with regard to the cost of transportation, housing, or simply the amount they received in their disability pension. Many seemed

to feel very restricted in what they could do:

> They don't give us enough money to live on: $550.00 a month for rent, lights and food is hardly enough. I don't have enough for proper clothes. I can't get a 'phone. A person with mental problems needs a phone so they can talk. I can't buy smokes. It costs seven dollars every time I go to the Cape Breton Hospital. Me and S_____ want to get married. How are we supposed to on my cheque?

Medical/Legal Concerns

A view expressed by a number of relatives of those with chronic psychiatric problems was the concern about the difficulty of having someone who was being extremely disruptive and possibly dangerous admitted to the Cape Breton Hospital against their will. While those expressing such concerns seemed to recognize the patient's rights, at the same time they were concerned about their own safety or the safety of other family members.

> This can be a very confusing and potentially dangerous area. If S.... becomes abusive or violent in the home and the doctor or police see no clear evidence, and S.... refuses to go to the Hospital, it often becomes a standoff, with it being our word against his. I love S.... but I will not have my own safety or that of my children jeopardized. The rights of the patient can't override those of the safety of society.

Satisfaction with Services

Those who were interviewed were satisfied with various aspects of the mental health service system. They mentioned, specifically, the care that they received on the active treatment unit. Furthermore, they mentioned the high quality of treatment that they received from various mental health professionals including some of the nurses, social workers, and a couple of specific psychiatrists, as the following quotation illustrates: "He is so patient. He always takes the time to listen. He

has a way of making me feel good."

Comments regarding the Cape Breton Hospital varied although those regarding the active treatment unit were generally positive. The following two quotations illustrate this point:

> The active treatment unit is good. The staff are approachable and the patients seem more content. There seems to be more time for patients.

> Some of the psychiatric care we have received has been both very accessible and good but we do need more specialized services.

Summary of Data obtained from Consumers of Mental Health Services, Family Members and Advocates

The consumers and relatives of those who use the extant mental health services identified needs in all of the mental health service categories. Cutting across the service categories was a number of themes including the accessibility, availability and acceptability of services. As might be expected these issues were not always clearly delineated. However, there was considerable consistency about the need to provide services in locations that were easy to get to. Furthermore, the stigma attached to the CBH is seen as a deterrent to providing effective services. The lack of cooperation and coordination between various helping professionals was also seen as an impediment to obtaining suitable services. The lack of specific services such as appropriate accommodation, particularly, for psychogeriatric cases and those with chronic psychiatric problems was noted. The lack of assessment and treatment services for seniors with mental health problems was indicated. Virtually all of those interviewed were dissatisfied with the time-

consuming and often humiliating experience of being admitted to the Cape Breton Hospital.

In addition to these three themes there was the recurring issue of groups that are underserved by the existing mental health service delivery system. With this particular sample those with chronic psychiatric problems were mentioned most frequently as being underserved and appeared as group in need in all of the service categories that were mentioned. As with the other sources of data, youth and those over 65 years old were also identified within the various categories as being groups in need of services. The individuals that I spoke to did not speak in terms of priorities of needs, but rather they indicated that there are a range of concerns which all must be addressed. While the service category that was mentioned most frequently by those interviewed was psychotherapy or counselling, there was little differentiation amongst the remaining categories in terms of perceived needs.

In addition to the need for services in the seven categories this group also identified the importance of having self-help groups both for those with mental health problems and family members of those with such problems. The issue of respect or the lack of respect and credibility that those with chronic psychiatric problems often receive from those in the helping professions was mentioned. Often the patient felt that he/she was simply being prescribed medication and was not being listened to. At the same time consumers did express satisfaction with particular mental health professionals. The consumers of mental health services thought that there was a stigma that was attached to those with mental health problems that people with physical problems did not experience.

They expressed concern and frustration about the difficulty of living on a disability pension. Additionally, the medical/legal issue of the problems related to potentially violent patients and their rights versus societal rights was addressed.

Section 4

Community Forums

Introduction

Consistent with the values of community psychology and as a result of a directive from the Board of the Cape Breton Mental Health Association, the steering committee decided to solicit input from the public as part of the needs assessment. The committee decided that, given the limited resources for this research, the most effective way to obtain input from the public was to hold community meetings. Because of the relatively large geographical area in the catchment area and the fact that the committee wanted to allow as many people as possible the opportunity for input, it was decided to hold meetings in four of the communities. The meetings were held in Sydney, New Waterford, Glace Bay and North Sydney. They were well publicized through all of the media. It was not expected that all of the people attending a particular meeting would be from that community. As such, it is not intended that the data from a specific meeting be viewed as reflecting only the needs of that community but rather as one piece of the public's perception of need. The strength of the public meetings was that they allowed for the

generation of ideas from a wide range of people. The relatively small numbers of those attending the meetings permitted the use of the nominal group technique to generate a list of ranked needs. One of the possible weaknesses of the community forums was that those in attendance, in many respects, closely represented the group of socio-mental health professionals who were interviewed.

All of the community forums were conducted by myself and an assistant, Charlene Hines. Ms. Hines, a board member, received instruction in the nominal group technique. I began each meeting with a brief introduction explaining what the Mental Health Association is, the purpose of the research, what the goals of the meeting were, and what the potential uses and limitations of our research were. The question asked those who attended the meetings was: "What are the mental health needs of the industrial area of Cape Breton area?"

Those in attendance at the meetings included a variety of individuals with a range of interests in mental health issues including mental health professionals, teachers, police officers, community development workers, and consumers of mental health services. However, the meeting held in North Sydney also included a separate group of people who were concerned, specifically, with issues of those with chronic psychiatric problems.

As stated, it is not the purpose of this facet of the research to differentiate between the various communities. However, when a need is identified as being required in a specific community I comment on it. First, I provide brief summaries of the data obtained from each community. Then I offer an overall summary of the data collected from

all of the forums. In order to analyze these data I have examined the top ten items generated at each meeting and fit the needs listed into the seven mental heath service categories used on the administrators questionnaire. The complete list of needs, where they were ranked, and the number of people in attendance at each meeting is contained in Appendix W.

Glace Bay

The input from the group that attended the meeting in Glace Bay was primarily orientated towards prevention. Their number one ranked-need was for steady employment for the residents of the community. Furthermore, they mentioned the need for more suitable housing for those living in Glace Bay. However, the most frequently mentioned need (40 % of their responses) by those in attendance was the need for more educational programs and services. The need for a variety of educational programs was noted including values education in the school system, educational programs to help prevent drug abuse, programs to help overcome the stigma of mental illness, and parenting programs for parents of troubled adolescents. This group also identified the need for more group homes for those with chronic psychiatric problems. They noted the need to provide group counselling to students in the school setting. Finally, they noted the need for an emergency number to help make crisis services more available.

Sydney

The most frequently mentioned issue at the Sydney meeting was the need for more educational programs. In fact, 30 % of this group's responses related to public education issues. The item that those in

attendance ranked highest in priority was the need for a "preventative mental program for children". Other educational programs that those in attendance suggested were the need for a program "to educate physicians on mental health issues", the need for more community forums to share information, and the need to conduct research into the reported low levels of self-esteem in the community (and to offer programs to act on the research.) The second highest ranked need of those attending the meeting in Sydney was the need for: "more mental health professionals in the field". It was noted that professionals are needed to provide such additional services as an inpatient assessment unit for youth, and services for men who batter. Additionally, they also recognized the need for more female psychiatrists. Other mental health needs this group had were for "the examination of medical/legal issues of confidentiality (the effects on the client, once labelled)". They also mentioned the need for a: "mental health team to deal with community-wide trauma and threats".

New Waterford

The need that was ranked highest by those attending the community forum in New waterford was the need for a full-time mental health clinic. However, 33 % of the responses of those attending this meeting were concerned with better coordinated services. They said that: "a better liaison was needed between local school personnel and the mental health clinic", that a team approach was needed with clients in the community, and that there should be better sharing of information among agencies. The second most frequently noted categories (23 % of the responses) of perceived need were the need for more services offering psychotherapy and

the need for more emphasis on educational concerns. In addition to noting the importance of a full-time clinic another perceived need that was identified was: "to provide counselling for seniors in seniors complexes". Educational concerns expressed by those in attendance were the need for "positive education on mental health"; the need to "reduce the stigma attached to mental health (treatment through a holistic approach to medicine)". This group also noted the need for more funding for research. They also mentioned the need for improved admittance procedures to the Cape Breton Hospital for those in crisis situations.

North Sydney

The mental health service area that the group attending the North Sydney meeting identified as being most important and most frequently (44 % of their responses) was the need for better coordinated and follow-up services. They mentioned the need for a: "central clearing house of mental health information" and the need for "better coordination of efforts between existing helping agencies. They also saw the need to develop better follow-up and support services in the community for those with chronic psychiatric problems. Such support services would include more attention from their family benefits workers, including counseling as to what services are available, and an advocacy group that could offer assistance and advice. This group also identified the need for vocational training programs for those with chronic psychiatric problems. Furthermore, they recognized the need for supervised accommodations for those with chronic mental health problems. This group also mentioned the need to provide services for adolescents in crisis.

Summary of Data obtained from the Community Forums

In summarizing the input from all of the communities I examined the first ten ranked-items generated at each meeting, collapsed them across the communities and fit the needs listed into the seven mental health service categories used on the administrators questionnaire. In using this approach, I think it is important to note that an important need, such as the issue of providing steady employment, which while ranked the highest in Glace Bay but not mentioned in the other communities, tends to get overlooked in the summary. However, as mentioned, the purpose of the community forums was not to distinguish between the various communities needs but rather to allow for as much input as possible from the public.

The most frequently identified issue by those in attendance at the various meetings was the need for more educational programs and services. Overall, 32 % of the identified needs were within the domain of education, with the majority of the participants responses denoting the need for more or augmented public education programs. Furthermore, they recognized the need for preventative programs in schools for children and the need for values education. Also suggested was the need for regular public forums to discuss issues of public interest. The importance for regular, ongoing educational programs to help reduce the stigma and negative image of mental illness was underlined. The need of education to help prevent alcohol and drug abuse was noted. There was a perceived need to help the mentally handicapped to deal with inappropriate sexual behavior through educational programs. Additionally, those in attendance noted the need for educational programs on mental health issues for physicians.

The second most frequently identified area of need (23 % of responses) by those attending the community meetings was the need for better coordinated services and resources. It was suggested that there was a need for a central clearing house for mental health information. Furthermore, it was suggested that there should be better coordinated efforts between existing agencies, including improved sharing of information, and a team approach to working with clients in the community. The importance of an improved or stronger liaison between the mental health agencies and the school system was also recognized.

The third most frequently mentioned need by those attending at the community forums was the need for more staff and programs, specifically to provide more treatment and therapy. It was suggested that there was a need for more professionals such that the maximum waiting period for appointments is three days. The imbalance between male and female psychiatrists was also addressed with the suggestion that more female psychiatrists are needed. Furthermore, the need for an inpatient assessment unit for adolescents was noted. Also, mentioned was a need for services for men who batter. Those in attendance recognized the importance of making counselling available to students in schools and to offer a service for students in crisis. It was also suggested that counselling services be provided to seniors in senior citizen complexes. Those attending the community forum in New Waterford strongly emphasized the importance of a full-time mental health clinic in their town.

The needs of the post-mentally ill and those with chronic psychiatric problems were recognized and it was suggested that these groups required better follow-up and support services in the community,

better accommodation, more vocational and social/recreational services, and a formal system of familial support for family members of those who are mentally ill. The need for an advocacy group to work with post-mentally ill was also identified.

It was also noted that the existing crisis services be made more accessible. Efforts should be made to reduce present time consuming and complicated admissions procedures to the Cape Breton Hospital. It was also suggested that crisis services could be made more accessible through the use of a standard and well publicized telephone number.

Other issues addressed by those at the community meetings included the medical/legal issues of confidentiality; the need for research on mental health issues such as self-esteem in the Industrial Area; the need for mental health initiatives to help deal with community wide traumas such as industry layoffs and business shut-downs; and the opportunity for steady employment.

Section 5

Groups Identified as being Underserved

Introduction

As outlined in the Introduction, and consistent with the philosophy that emphasizes the importance of including the perspectives of the consumers and the public in this study, a component of this research was directed to ascertain if there were groups in the community that were not adequately served by the existing mental health service system. Both the administrators and the socio-mental health professionals were asked to help identify groups that they thought were underserved. Furthermore,

the steering committee had also identified some groups which they believed were underserved. Generally, the groups identified by the service providers were consistent with those selected by the steering committee. Adolescents were identified, most frequently, as the group which was perceived as being underserved. The second most frequently identified group was senior citizens followed by those with chronic psychiatric problems. Additionally, members of the Micmac community and women with various types of problems (e.g., victims of violence, those requiring housing, adolescents in need of counselling) were identified as being underserved by the existing mental health service delivery system. The purpose in meeting with the above groups was to have their members help us ascertain what the needs of their particular group of are. Because of the relatively small size of the groups a nominal or focus group strategy could be used. As with the community forums I began each meeting with a brief introduction explaining what the Mental Health Association is, the purpose of this study, what the goals of the meeting were, and the potential uses and limitations of the research. A complete list of the needs identified by those groups designated as being underserved is contained in Appendix X.

Youth

The group identified most frequently as being underserved by both the administrators and the service providers was youth. Consultation with a child psychologist on the needs assessment steering committee indicated that there was not an existing group of child or adolescent consumers and that it was unrealistic to assemble one for the purpose of

the research. It was agreed that meeting with groups of students would be helpful in giving us the kind of information that was needed. Staff at Cape Breton District School Board and Breton Education Center in New Waterford helped assemble a group of high school students who had an interest in social issues. Some of these students were involved in a student group that was concerned with abuse of drugs and alcohol.

It was decided by the committee to obtain information from younger students regarding their needs. Although a teacher from one of the schools with the Northside/Victoria School board agreed to assist in arranging a meeting with a group of junior high school students (whom he thought could articulate the needs of that age group), because of scheduling problems the meeting could not be arranged. The teacher then agreed to meet with the students and collect the information. The teacher had been briefed on the purpose and goals of the research and it was felt that any data he and his group could provide us with would be helpful.

In order to summarize the data from the students their identified needs have been content analyzed and sorted according to the seven mental health service categories.

The most commonly identified area of need identified by the youth was the need for more educational programs in a variety of areas. The students were particularly concerned about drug and alcohol issues and suggested educational programs for parents, students, and teachers. They also suggested an educational program to help reduce the negative image that mental illness has. The junior high school students wanted information on a variety of mental health services in the community.

They seemed to have a fear of the unknown and what could happen to them, if they became involved with the agencies providing mental health services. Furthermore, they wanted to know what services were available to them. Both groups strongly identified the need for more social and recreational activities in the community. They also identified the importance of having a mental health professional in the school to assist them with problems. They suggested that there be a helpline available to them for crisis and information services. A complete list of the needs as identified by the youth is contained in Appendix X-1.

Senior Citizens

The group that was identified as being underserved with the second greatest frequency by both the administrators and the direct service providers was senior citizens. Further exploration of this generic label usually revealed that the group that was being identified were those over sixty-five years of age, and/or those with symptoms of psychopathology. I was unable to assemble a group of seniors who were consumers of mental health services. However, I was able to meet with a group of seniors who were actively involved in the community. I was unable to use a nominal group strategy, because, with the exception of a small core group who remained for the entire meeting, other people came and left the meeting, offering suggestions while they were present but not staying to rank the needs. As such, while the group quite capably generated a list of needs these needs are not ranked in terms of importance. In order to summarize these data I have content analyzed it and sorted it into the seven mental health service categories.

The seniors' main concern was with educational issues, specifically knowing what services are available to them, having speakers on specific topics address them, and using cable TV to maintain contact with those who are shut in. Their second-ranked-concern was with the issue of the lack of respect that they perceived they received, particularly from physicians. They felt that the physicians provided too much medication and that they were reluctant to refer to other professionals such as social workers.

> It seems that after you get to a certain age you're well it's not exactly that your not human but it's more like they don't feel that you should expect any more, they don't want to listen to you - they just give you a pill, as if that would solve your problems.

This group also recognized the need for care for Alzheimer's patients, the need for more recreational centers, and the need to enhance transportation services through the use of car pools. A complete list of the seniors identified needs is contained in appendix X-2.

Other data which are relevant to the needs of senior citizens was obtained from the administrators of homes for special care and is contained in Section 6.

Single Mothers Living on Low Income

Women were identified in a number of contexts as being in need of services including: as victims of violence, as those in need of second-stage housing, as adolescents in need of counselling, as those with addiction problems, and as victims of sexual abuse. As with the other groups identified as being underserved, the committee's initial intention was to identify existing groups of consumers of mental health services

and arrange to meet with them. Although the job of identifying existing groups of female consumers proved relatively easy the task of actually meeting with such groups was considerably more challenging. I tried, unsuccessfully, for approximately a two-month period to arrange meetings with two separate groups of women I was told might be receptive to sharing experiences they had with the mental health system and in identifying areas of need. In the end, I was told that one of the groups was unwilling to meet with me because they were in the process of admitting new members and that the other group was unable to meet with me due to added commitments. While conducting the survey I contacted a third group of women who indicated that I could attend one of their meetings but that they did not wish to participate in a group or engage in a formal discussion of mental health issues. While they were not, as a group, consumers of mental health services and while it was apparent that there might be limitations placed on the collection of data, I nevertheless decided to attend one of their meetings in Glace Bay.

I met with this group of 15 women in the basement of a church for approximately 90 minutes. They ranged in age from early twenties to mid sixties. They eschewed any attempt to label them. They said, simply, that they were either single, separated or divorced and that they all lived in the same neighborhood. All but one woman had families and she was expecting a child within weeks. I later learned that all of the women received Family Benefits. The group did not appear to have a leader as such, however, the group seemed to be coordinated by a nun. Although they did not describe themselves as a support group per se, I thought that this group provided these women with both a feeling of

companionship and a chance to acquire information on a wide range of topics. The day that I attended the meeting they were watching a film on child birth. As I indicated they were reluctant to talk about "mental health" issues, so we talked informally about what the group did for them and what sort of things would make their life easier by reducing stress and anxiety. They all agreed that attending the weekly meetings gave them a feeling of "freedom" and allowed them to share information.

This group repeatedly raised three issues in response to the question about what sort of things would make their life easier and reduce stress. The first issue was money. They all agreed that the amount of money they received from family benefits was not enough to live on. They said that their income affected all aspects of their life including housing and food. The second issue that this group raised was the lack of respect that they received from some of the staff of agencies that they dealt with, including the department of Community and Social Services and Canada Employment and Immigration. The third issue was that of information. The consensus was that they did not "understand how the system worked" and that they found it difficult to get information about changes in their Family Benefits cheques or information about what training programs were available to them. Furthermore, they said that information on a variety of subjects including nutrition, money management, pricing, drugs and alcohol (including prescription drugs), and funding that was available for academic upgrading and vocational training programs would be helpful. Additionally, this group mentioned the need for affordable and available day care noting that without day care they could not take advantage of upgrading and training programs.

They felt that many women could learn to deal with and solve their own problems through groups such as this one. They emphasized that for the group to be a success in must be held in a neighborhood and easily accessible to all.

It should perhaps be mentioned that the group appears to be a good example of how to establish and maintain a local neighborhood group which provides ongoing support, is virtually self-sustaining, and works as a positive intervention. A list of the needs identified by the women is contained in Appendix X-3.

Those with Chronic Psychiatric Problems

Those with chronic psychiatric problems were also identified as a group that was underserved by the existing mental health service system. I obtained consent to attend two meetings of a group called Community Friends. Community Friends is a support group for "ex-psychiatric" patients. However, many of the groups members are under active treatment and continue to have admissions to the Cape Breton Hospital. One meeting was held in Sydney and the other in Glace Bay. Although the needs identified by the group in Sydney are ranked, those present were reluctant to order them, suggesting that their needs were all equally important. Given the members' reluctance to rank their needs, the priority of this group's needs should perhaps be viewed cautiously. When meeting with the group in Glace Bay I decided not to attempt to rank-order their needs, as members of this group seemed to having difficulty with the ranking process and I was concerned with the accuracy of the outcome. In summarizing the data from these groups I have categorized

their needs, using the seven mental health service categories.

The need for more financial resources or alternatively to have various needs covered by third party payment was identified most frequently. The need for more money for a variety of purposes was raised on numerous occasions by the group in Sydney. It was noted how a lack of money for transportation, telephone, and recreation could contribute to increased isolation. The group in Sydney also identified the need for a social worker in the community who could visit them and who could be available for help so that they would not have to go into the Cape Breton Hospital in Sydney River. Both groups noted the need for more social and recreational activities. Furthermore, they noted the need for improved transportation services, including direct transportation to the Cape Breton Hospital. The need for easier access to admission to the Cape Breton Hospital was also recognized. Additionally, it was noted that more attention and counselling and less medication should be given to the patient by the psychiatrist. They also felt that those who were readmitted to the hospital were not treated for a long enough period. There was a concern about improving the negative image surrounding those with mental health problems. The need for more education was identified with the suggestion that students be invited to meetings of Community Friends.

The complete list of needs as presented by those at both meetings is presented in Appendix X-4. Other data relating to the needs of those with chronic psychiatric problems were obtained from members of the Canadian Friends of Schizophrenia (CFOS) and is presented in Section 5.

Micmacs

I arranged to meet with a group of Micmacs who had knowledge of the mental health needs of their community. The group consisted of professional social workers, social service workers, and volunteers from the Membertou reserve. This reserve is within the city limits of Sydney. The question asked of those in attendance was: "What are the mental health needs of the native community in the Industrial Area?"

The group emphasized that they felt that they should speak only on behalf of those living on the Membertou reserve.

Those in attendance highest ranked concern was for a person to act as a liaison and facilitate communication between the reserve and the mental health services in Sydney. The most frequently noted need was for more staff to provide both treatment and crisis response services. Specifically, they identified the need for a counsellor with specialized skills to work with youth and families. Additionally, they noted the need to have more staff to work with those in crisis and for more volunteer, lay counsellors to work with youth. This group suggested that there be more professional staff at the Cape Breton Mental Health Clinic. They recognized the need for self-help groups for youth, those who have been sexually abused, and single mothers. Those in attendance suggested that there should be regular on-going workshops to address community concerns. Finally, they suggested the need for suitable transportation services to ferry those in crisis to the Cape Breton Hospital. The Micmacs repeatedly identified youth as the group that was in need of services.

The list of needs identified by representatives of the Micmac

community can be found in Appendix X-5.

Section 6

Data Received From Special Interest Groups

Introduction

The final source of data for the needs assessment is from groups who were concerned with the delivery of mental health services in industrial Cape Breton. Representatives of three concerned groups responded to the request for input to the needs assessment with the invitation that I meet with them. Input was received from a group of concerned citizens from New Waterford, members of Canadian Friends of Schizophrenia (CFOS), and a group from the Cape Breton District School Board. As with the other groups I began with an introduction including information about the Mental Health Association, the purposes and limitations of the research, and my goals for the meeting. I suggested that it would be helpful if those present could phrase their concerns in terms of mental health needs. As it was not always appropriate because of the format of our meetings, the data from these groups are not ranked. A focus group strategy was used with all of the special interest groups. Summaries of data from the above groups were prepared in the same fashion as the information obtained from the other surveyed groups, that is, by content analyzing their responses and fitting the responses into the seven mental health service categories. A complete list of the needs identified by the groups with special interests is contained in Appendix Y.

Meeting with Concerned Citizens in New Waterford

This group consisted mainly of members of the board of directors of the New Waterford office of Family Services of Eastern Nova Scotia. Their primary concern is to have a full-time Mental Health Clinic established in New Waterford. Otherwise their list of needs was not ranked. In addition to suggesting the need for full-time staff for the clinic they also suggested the need for staff to offer outreach programs so that mental health professionals could visit clients in their homes. Consistent with the outreach approach was the feeling that diagnostic assessments should be done in New Waterford rather than having clients go to Sydney River. Other needs that were identified included an improved liaison between mental health workers and visiting homemakers, educational programs to be offered for youth in the schools, an inpatient assessment unit for youth in the Industrial Area, and evening and weekend hours for the Mental Health Clinic in Sydney River.

A group that was identified as being particularly in need of services were those with chronic psychiatric problems. Suggestions that were made for this group were: an activity/resource center, supervised housing, outreach programs to allow mental health staff to visit clients in their homes, a self-help group in New Waterford, less complicated and time-consuming admission procedures to the CBH. A complete list of mental health needs as identified by this group are include in Appendix Y-1.

Meeting with Cape Breton District School Board Staff

I was invited by one of the psychologists from the Cape Breton District School Board to meet with a group of educators. Their primary

concern was the need for improved education regarding what specific mental health services are available in the community. They suggested a directory of mental health professionals which could include their professional qualifications, areas of specialty, and telephone number. This group also indicated the need for an education program to help reduce the stigma of mental illness in general and the CBH in particular. Furthermore, they felt there was need for improved communication and sharing of information between educators and those providing mental health services. One of this group's suggestions was to have more case conferences and a formal procedure to provide follow-up information on children who are referred for mental health services. Those present suggested that a coordinating, inter-disciplinary committee be established for youth in each region. A complete list of needs as identified by the school board staff is included in Appendix Y-2.

Meeting with CFOS

This group consisted mainly of family members and relatives of those with schizophrenia. Members are concerned with helping those with schizophrenia and educating the public about the effects and costs of schizophrenia. This group's concerns and needs centered, primarily, around the treatment of those with chronic psychiatric problems, specifically those with schizophrenia.

Their primary area of concern was with crisis response services, particularly, the simplification of what is perceived as the inconsistent, complicated and time consuming procedure of having someone admitted to the Cape Breton Hospital. There was a recognition of the

importance of having better coordinated services both between mental health staff within the hospital and between hospital staff and those in the community. They also suggested the need for programs of education to help reduce the stigma associated with mental illness. The need for primary prevention programs on mental health issues to be held in schools was noted. Other needs identified by this group included the need for: better follow-up and support services for people after they are released from the hospital, in-home psychological and psychiatric assessments, extended evening and weekend hours at the Mental Health Clinic, and the need for psychiatrists to spend more time listening and counselling with the client. A theme which appeared throughout many of this groups responses was the lack of respect that family members perceive they get from some of the mental health professionals. A complete list of the mental health needs as identified by CFOS members is contained in Appendix Y-3.

Meeting with Coordinators of Homes for Special Care

This group consisted of administrators of homes for special care. All, but one, were from the Industrial Area. The group that they were most concerned with was senior citizens, particularly those with symptoms of psychopathology. All of the following concerns and suggestions relate to this group. The group's main concerns were for improved assessment and treatment services including an inpatient assessment and treatment unit in the Industrial Area. They also suggested the importance of having an in-home assessment team. Additionally, this group identified the need for more accommodation, including a unit in a nursing home for

those who do not require active treatment but who may cause problems for others living in the home. This group would like to have clarification of the CBH's policy regarding admission of those over 65 and improved communication between hospital and nursing home staff. Furthermore, they would like to have outreach, mental health, support services to the homes for special care. A list of needs identified by this group is contained in Appendix Y-4.

DISCUSSION OF RESULTS AND RECOMMENDATIONS

This final section discusses the pertinent results of the needs assessment which delineate the perceived needs of the different sectors of the mental health care system, that is, the administrators of mental health services, the socio-mental health professionals, the consumers of mental health services, and the public. As well, others with a vested interest in the delivery of mental health services including those groups identified as being underserved by the existing mental health services and those with special interests were surveyed as to their particular perception of mental health needs. The groups identified as being underserved are children and adolescents, senior citizens, those with chronic psychiatric problems, members of the Micmac community, and women. Representatives of groups with special interests that requested an opportunity for input included the administrators of homes for special care, educators from the Cape Breton District School Board, members of the Canadian Friends of Schizophrenia (CFOS), and a group of concerned citizens from New Waterford. In this study a convergent analysis (Siegel et al., 1978) was the methodological framework employed to collect, analyze, and synthesize data pertaining to the mental health needs of the industrial Cape Breton region. By surveying the different samples with diverse interests, values, and attitudinal perspectives, a profile was developed of the perceived unmet needs and inadequacies in the local mental health delivery system. In some respects, the results of this study confirmed the prevailing, but previously undocumented concerns expressed by mental health advocates, providers and consumers in the Industrial Area.

The discussion of mental health needs is based on the conceptual framework outlined in Appendix K. Although this conceptual framework was used only in the survey of the administrators the remaining samples identified mental health needs and concerns consistent with the seven functional categories of the framework:

i. problem identification
ii. coordination and direction
iii. treatment/intervention
iv. familial support
v. accommodation
vi. transportation
vii. education

Because of the inter-relatedness of certain functions within the conceptual framework some of the identified needs and related recommendations pertain to more than one functional category.

The discussion of the results from each survey group includes percentages; or in the case of qualitative data, an indication of where the emphasis was placed, to indicate the relative intra-sample weighting of responses since each survey sample was a different size. The identification of major mental health concerns reflects both inter-sample consensus (i.e., the majority of survey samples identified the need) and individual sample concern (i.e., within each sample, a majority of respondents who emphasized the concern).

A recognized limitation of this approach is the possibility of dismissing or overlooking isolated comments or concerns raised by only one or two sub-samples. However, since this complete document will be available for reference, it will be possible to reexamine under represented issues as necessary.

According to the definition of unmet need (Nguyen et al., 1983), the identification of needs in this section reflects the judgements of the research samples that satisfactory solutions were not accessible, not

currently adequate, and/or did not exist in the community. Hence, the proposed recommendations reflect possible solutions to meet the profile of needs identified for the mental health care system in the industrial area of Cape Breton.

The recommendations address the needs documented in the report as perceived by a wide cross-section of those in the Industrial Area. They reflect the key findings of the study and indicate specific areas in which to encourage future mental health efforts from the mental health service delivery system and the community. It should be noted that this report is not intended as an evaluation of the services offered by the Cape Breton Mental Health Clinic in Sydney River. However, as the "Clinic" was: 1) often perceived as "The" agency offering mental health services in the Industrial Area; 2) that services such as those offered for the child and adolescent population are only offered at the "Clinic"; and 3) as children and adolescents were identified as the group most in need of services, a portion of the discussion and some of the recommendations relate to services offered at the Mental Health Clinic in Sydney River.

The recommendations were not ranked sequentially, but the highest priorities for the Industrial Area were identified using the following criteria as a guide. Those recommendations preceded by an asterisk are considered of higher priority than the others.

1) The more frequently the issue was expressed through individual samples and through inter-sample consensus, the higher the priority for the recommendation addressing that issue.

2) The more a recommendation pertained to a need in which no service was presently available in the mental health service system to address this need, the higher the priority.

3) The more a recommendation was directed towards the integration of the service delivery system for the Industrial Area as a whole, the higher the priority.

4) The more a recommendation would reduce the necessity for going out of the Industrial Area for service delivery, the higher the priority.

Regarding the degree of urgency: The administrators were the only group asked to rank the urgency with which services were required. Although I will mention the percent of the administrators who indicated that a service is needed within one year it should be noted that 93 percent of their responses indicated that all of the services in the seven categories are perceived as being required within two years, suggesting an overwhelming degree of urgency for all services.

Where relevant, I will allude to the findings of the three studies relating to the assessment of need that were reviewed in the introduction to this study that is: 1) Report of the Officials Committee of Industrial Cape Breton, 2) Speaking Out About Mental Health: A Needs Assessment, and 3) The Report of the Royal Commission on Health Care. As noted previously, the authors of the Royal Commission stated that in order for the Regional Health Authorities to develop a regional service plan they should "....begin with an assessment of local needs" (Royal Commission, 1989, p. 42). It is anticipated that the following discussion of the results and recommendations will provide those concerned with planning health services some direction with regard to the domain of mental health services.

Finally, as researcher and consultant, I have attempted to offer recommendations that are sensitive to both the rural and urban populations and to the groups that are identified as being underserved.

While it recognized that there is a need for more professionals in some fields, particularly for youth, the following recommendations should not be viewed as an argument for simply hiring more staff. Indeed it is unreasonable to expect that the resources would be made available for such staffing; and that, simply, providing more therapists will stem the tide of the increasing numbers of those requesting services. Furthermore, while recognizing the need to maintain some of the traditional modes of service provision, I believe that the data strongly suggest that those concerned with the mental health of the residents must seriously consider a shift in the provision of services which emphasize treatment to a system in which the competency and well-being of individuals is promoted, a system that attempts to deal with the onset and exacerbation of problems, and a system in which an effort is made to eliminate disempowering social conditions. To a considerable extent these goals may be accomplished by improving the fit between people and their environment.

Throughout the following discussion and in the recommendations a shift to the above points is emphasized. An attempt to improve the person environment fit is suggested through the improved access to services via smaller, decentralized, and "user friendly" clinics, the offering of services in the home and in schools, and the utilization of existing services and resources, including self-help groups and the use of trained volunteers. Offering services on the residents' own turf, the facilitation of social networks and an emphasis on education should assist individuals in becoming empowered. It is hoped that a shift in orientation to prevention can be accomplished through the identification

of underserved groups and the implementation of education programs both directed to such groups and the community at large.

While youth, seniors citizens, and those with chronic mental health problems have been identified as being underserved, the importance of dealing with these groups within the context of the family has been recognized and is emphasized. Furthermore, while an effort has been made to obtain reliable and useful information from groups identified as being underserved, it is recognized that any attempt to modify or implement services for such groups must include collaboration with and input from such groups. In the case of women, data obtained from this report strongly suggests that more research is required to ascertain the needs of the various groups of women identified as being underserved.

While it is difficult to ascertain the magnitude of the economic problems in the Industrial Area, it is recognized that such problems have a considerable impact on the individuals living in the area (Collier, McMillin, & Paufler, 1982). The solution to such problems are beyond the scope of this study. However, those concerned with the delivery of mental health services, perhaps in collaboration with community economic development agencies, must seriously consider interventions to deal with such community-wide issues if the needs of the residents, including the mental health needs, are to be properly addressed.

Need for Problem Identification Services

Problem identification refers to the series of activities which focus on the identification and detection of individuals requiring some assistance with respect to their emotional well-being. It includes

psychological, psychiatric, and family and social problem identification. The individuals and agencies responsible for problem identification and coordination act as "gate keepers" of mental health services. Heseltine (1983) suggests that they are the single most important group in terms of what happens to the client entering a mental health service. Although assessment and diagnosis are provided to various degrees by a variety of agencies in the Industrial Area, the main organization providing psychological and psychiatric assessments in the Industrial Area of Cape Breton is the Cape Breton Mental Health Clinic in Sydney River. Assessments of children and adolescents are conducted, almost exclusively, at the "Clinic". Eighteen agencies/organizations in the Industrial Area reported that they offer family assessments. There is presently not a unit or team in industrial Cape Breton which attends to the assessment of psychogeriatric cases.

Some of those surveyed (e.g., Micmacs) noted the need for services which provide treatment. However, in order to provide such treatment an assessment of the case would likely be needed. In considering the need for mental health problem identification services, I have used only the information where groups have, specifically, indicated the need for problem identification services. As such, the actual need for diagnostic services may be greater than is indicated in this study.

The perceived need for additional problem identification services was cited by respondents from all four of the survey groups. The administrators indicated that the services that were most frequently requested to provide but were unable to were assessment and psychotherapy. Forty-nine percent of the administrators and 45 % of the

socio-mental health professionals recognized the need for more services that provide diagnosis and assessment throughout the Industrial Area. Eighty-one percent of the administrators responses indicated that the need for more identification and assessment services should be met within one year.

All the four surveyed groups recognized that children and adolescents followed by seniors were the groups that were most in need of assessment services. As well, the Royal Commission noted an increased demand for child psychiatric services. The administrators and the socio-mental health professionals indicated that there was a need for more resources offering family assessments. The waiting period for assessments of youth was indicated as being a problem by the administrators, socio-mental health professionals, and consumers. Waiting periods of up to six months were noted. However, it was emphasized by those making referrals for assessments in crisis situations that their plea for help was addressed in an appropriate period of time. Other issues affecting the accessibility of problem identification services were stigma, specifically as it related to services offered in the Cape Breton Hospital (CBH), transportation to and from Sydney River, and the need for extended hours of services. Although most groups appeared satisfied with diagnostic services, the socio-mental health professionals were discontent with assessment services for youth with severe emotional and/or behavior problems. The socio-mental health professionals indicated that 50 percent of the referrals they made to organizations outside of the Industrial Area were for youth. Senior citizens were ranked second in frequency as the group which was referred

out of the area. In both cases one the main reasons for referring cases outside of the Industrial Area was for assessment and diagnostic services. Three of the four surveyed groups noted the need for an inpatient assessment unit in industrial Cape Breton for youth with "severe behavioral and emotional problems." Four of the groups, as well as the administrators of homes for special care, noted that there was a need for diagnostic and assessment services for the psychogeriatric population in the Industrial Area.

The outpatient setting followed by the private professional setting were cited by the administrators most frequently as being the appropriate settings for diagnostic services. However, all groups noted the importance of making services more accessible to consumers through outreach and community-based services by offering diagnostic and assessment services in each of the communities included in the study. It was suggested that offering services in a smaller, "more friendly" and accessible facilities could help to reduce the stigma associated with the CBH. Furthermore, it was suggested that diagnostic services be offered in the client's home for both children and seniors. The authors of the Officials Report expressed concern about the need to provide assessment and treatment services to those who will be moving from institutions to the community. Given the orientation of community psychology of focusing on the strengths of individuals, organizations, and communities I believe that those concerned with the provision of mental health services should consider the assessment of strengths and resources of equal, if not greater, importance than the identification of problems or deficits.

Recommendations Related to Problem Identification Services

R1 +*THE STUDY RECOGNIZES THE NEED FOR ENHANCED COMMUNITY-BASED ASSESSMENT SERVICES THROUGHOUT THE INDUSTRIAL AREA PARTICULARLY FOR CHILDREN, ADOLESCENTS, AND THE ELDERLY.

R2 THE STUDY SUGGESTS THAT THE FEASIBILITY OF ESTABLISHING A SECURE ASSESSMENT UNIT FOR YOUTH IN THE INDUSTRIAL AREA BE INVESTIGATED.

R3 *THE STUDY RECOMMENDS THE CREATION OF A PSYCHOGERIATRIC ASSESSMENT TEAM - WITH THE CAPABILITY OF PERFORMING IN-HOME AND COMMUNITY-BASED ASSESSMENTS - FOR THE INDUSTRIAL AREA.

+ Community-based services in this report refers to small, non-institutional services located so as to provide easy access to the majority of the residents. It includes services which may be offered in the home and school. Additionally, the establishment of self-help and support groups, the use of volunteers, trained lay counsellors, and advocates are encouraged in a community-based approach. Refer also to Recommendations 29, 30, and 31.

When planning for improved assessment services adequate treatment resources must be in place to meet the assessed needs.

Need For Coordination and Direction of Mental Health Services

The second functional category in the conceptual framework is Coordination and Direction. Coordination and direction activities attempt to link the individual/client with the services required to meet his/her identified mental health needs and to promote the continuity of care within the network of available of mental health services. Some of the suggestions for change and recommendations offered in this section are similar to those covered in the section on education (i.e., the dissemination of information).

The administrators of virtually all the agencies that were surveyed indicated that they offered interagency referrals, case management, and follow-up. However, the type and degree of aftercare may vary from organization to organization. At present, there does not exist in the

Industrial Area a formal body to coordinate and plan mental health services. Cooperation and coordination between agencies often seem to be informal and to depend upon the established relationship between the various staff and administrators involved.

All three of the previous reports strongly advocated the importance of the improved coordination of services to avoid duplication, to ensure an efficient and sensitive allocation of resources, to improve access to services, to ensure the appropriate use of services, and to provide appropriate follow-up in the community of those released from psychiatric hospitals. This final issue, regarding follow-up care, which is advocated in Recommendation 5, was consistently supported in the feedback I received. Concerns pertaining to the existing inadequacies of services offering coordination and direction were reported by all survey samples. Twenty-seven percent of the administrators and 45 % of the socio-mental health professionals identified the need for better coordinated services. Sixty-nine percent of the administrators responses indicated that the need for these services should be met within one year. The administrators viewed the private professional setting, the outpatient department and the client's home as the appropriate setting in which to provide follow-up services. Other groups that were surveyed, including the socio-mental health professionals, consumers and those attending public forums noted that the follow-up services should be offered in the community, on the clients "own turf". Twenty-five percent of the input received from the community forums related to issues of coordination and direction. The major concern of the educators from the Cape County School System was for better coordinated services for

children and adolescents. The concerns of the surveyed groups related to the lack of coordination of services providing treatment and the deleterious effects it could have on the client because of the inconvenience, expense, and possible confusion to the client of having to use more than one service. Three of the four surveyed groups expressed concern about the lack of follow-up services for those with chronic psychiatric problems and the possible iatrogenic effects the lack of continuity of care could have. The authors of report Speaking Out strongly advocated the need for follow-up services in the community to enhance the quality of life those released from psychiatric institutions and those with chronic psychiatric problems. As noted above, the importance of follow-up support was consistently supported in the feedback I received.

The socio-mental health professionals, including physicians and police officers were concerned about the failure of mental health agencies to share information with them on individuals who they had referred. This view was supported in large part by the findings of the report Speaking Out in which the consumers described a lack of cooperation between social services, health, and correctional services. Sixty-six percent of the socio-mental health professionals said that they thought that the relationship that they had with the agencies that they referred clients to could be improved. Thirty-six percent of this same group indicated that they were not sure about the different functions that the various agencies performed. They specifically mentioned their confusion about the services that were provided at the Cape Breton Hospital complex. Furthermore, they were not sure what the differences

were between services provided by the Mental Health Clinic and Family Services. Other concerns expressed by the consumer, underserved groups and representatives of the special interest groups were the lack of cooperation between professional staff in the Industrial Area and the effect that it could have on getting proper services. This later problem relating to the lack of cooperation was mentioned particularly with regard to obtaining services for children and adolescents.

A variety of suggestions was offered to assist in improving the coordination of services including a central clearing house of mental health information containing the details on what services are offered by different agencies; the opportunity for more networking particularly the inclusion of non mental health professionals such as lawyers, clergy, physicians, teachers and police officers in mental health in-service training programs; the use of a central data base to assist in following clients; the establishment of a regional planning board to plan and coordinate mental health activities in the Industrial Area; and the establishment of an aftercare program for those with chronic psychiatric problems. The students noted their desire to have a "Helpline" type of service that they could use to obtain information about available mental health services. The Micmacs emphasized the importance of having a liaison between their community and the remainder of mental health services in the Industrial Area. The group from the school board suggested a coordinating and planning body to examine the delivery of child/adolescent services.

Recommendations Related to Coordination and Direction

R4 THE STUDY RECOGNIZES THE NEED TO IMPROVE COORDINATION AND NETWORKING AMONG MENTAL HEALTH SERVICE PROVIDERS FOR CLIENTS AND THEIR FAMILIES. FOUR WAYS IN WHICH THIS MAY BE ACCOMPLISHED ARE:

R5 *TO ESTABLISH A FORMAL AFTERCARE PROGRAM FOR THOSE WHO HAVE BEEN RELEASED FROM THE CAPE BRETON HOSPITAL AND THOSE WITH CHRONIC PSYCHIATRIC PROBLEMS. SUCH A PROGRAM SHOULD INCLUDE THE ESTABLISHMENT OF A NETWORK OF SUPPORTS AND SERVICES.

R6 A CENTRALIZED MENTAL HEALTH INFORMATION SERVICE TO IDENTIFY, FOR BOTH PROFESSIONALS AND THE PUBLIC, AVAILABLE MENTAL HEALTH SERVICES AND RESOURCES IN THE INDUSTRIAL AREA.

R7 TO INCREASE INTER-ORGANIZATIONAL COMMUNICATION THROUGH FORMAL AND INFORMAL NETWORKS TO FOSTER AN UNDERSTANDING OF THE SERVICES OFFERED BY THE AGENCIES AND SELF-HELP GROUPS. REPRESENTATIVES OF THE UNDERSERVED GROUPS SHOULD BE INCLUDED IN SUCH NETWORKING ACTIVITIES.

R8 *TO ENCOURAGE COLLABORATIVE LOCAL PLANNING FOR CHILDREN'S MENTAL HEALTH SERVICES INVOLVING ALL STAKEHOLDERS INCLUDING: PARENTS, THE APPROPRIATE MINISTRIES, PHYSICIANS AND CHILD/ADOLESCENT MENTAL HEALTH PROFESSIONALS.

The Need for Treatment and Intervention Services

Once an individual has been identified as needing emotional help there is a variety of treatment services to which he/she may be directed. Treatment refers to the series of planned activities aimed at reducing or alleviating the problems or symptoms that are inhibiting the individual's functional abilities. Included in this functional category are rehabilitation activities aimed at developing the physical, intellectual and emotional skills which enable the person with mental health problems to live, learn, and work in the community with a minimal amount of support from the helping professions. Maintenance activities are also included within the scope of treatment and represent the activities/programs which are required to maintain the individual at his/her fullest potential and/or prevent a deterioration in his/her level

of functioning.

The need to enhance or augment existing treatment services in the Industrial Area was identified by representatives from all of the survey samples. Mental health treatment services are provided by numerous agencies in the region. There is a variety of funding sources and jurisdictional bodies associated with treatment services (e.g., Department of Health, Department of Community and Social Services, United Way, Diocese of Antigonish, Maritime Medical Services, direct user fees). Certain issues discussed in this section are related to needs identified and discussed under other functional categories of the conceptual framework (e.g., Problem Identification, Coordination and Direction and Accommodation).

The Need for Crisis Response Services

Crisis response services are those activities which are available on an immediate but short-term basis and include emergency medical services, acute-care crisis services, and crisis intervention services.

The need to enhance crisis response services was supported by all of the four surveyed samples. Thirty-six percent of the administrators and 21 % of the socio-mental health professionals indicated that there was a need for enhanced crisis response services. The administrators ranked crisis responses services as the mental health service that was most urgently needed. Eighty-eight percent of their responses indicated that more or augmented crisis response services should be provided within one year. The administrators indicated that the most appropriate setting for providing such services was the client's home or outpatient department.

Essentially, there were two perspectives on the issue of crisis services. Some of the service providers suggested that crisis services could be made more accessible through the availability of small, store front, clinics and/or the capability of the crisis worker to go into the home of the person in need. The idea of in-home access was supported by a number of those who were interviewed including some of the socio-mental health professionals (e.g., police officers), consumers, and members of CFOS. The service providers also noted the need for crisis services to be available on a 24-hour a day, seven-day a week basis, in all of the surveyed communities. This suggestion was consistently confirmed with the feedback that I received regarding the Executive Summary. It is supported with Recommendation 9. It was suggested by those attending the community forums that they were not aware of what to do in a crisis involving a person with psychological problems. They suggested that crisis services be advertised and that one telephone number be used to obtain such services in all communities. The high school students identified the importance of having a "Helpline" type of service for crisis and information purposes. The representatives of the Micmac community identified the need for more staff to work with those in crisis. They also said that there was reluctance on the part of the ambulance drivers to transport those having a severe emotional crisis. It was noted by family members that the difficulty in securing crisis services often appeared to be exacerbated in communities other than Sydney, particularly with regard to the response time.

The consumers were also concerned about the availability of crisis services. However, their major concern, as voiced by virtually all of

the consumers, particularly those with chronic psychiatric health problems, relatives, and advocates of consumers, was the time-consuming, bureaucratic, and often humiliating experience of how the consumer is dealt with in a crisis situation. This experience appeared to be particularly true when the person was seeking admittance to the Cape Breton Hospital. Furthermore, this group expressed concern about the necessity of them having to go to a general hospital and be examined by a physician as part of the admission process to the CBH. This view was supported by some of the socio-mental health professionals. Family members also noted their concern with the issue of persons who required assistance but were unwilling to seek or accept it. Finally, there was concern about the quality of medical care that persons with chronic mental health problems received when presenting with a medical emergency.

Although almost 50 % of administrators of the surveyed agencies/organizations indicated that they provided some type of crisis service there is only one organization in the Industrial Area which specifically provides crisis intervention services. It appears that the Sydney Hospitals' Crisis Program, primarily, provides services to Sydney and the immediate Cape Breton County area. The administrator of the Crisis Program indicated that 75 % of the cases her organization dealt with were from Sydney, with less than one percent of the remaining cases being from each of the following communities: North Sydney, Sydney Mines, Glace Bay, and New Waterford. The administrator of this program indicated that her service "could handle a larger case load".

Recommendations Related to Crisis Response Services

R9 *THE STUDY RECOGNIZES THE NEED TO EXTEND CRISIS SERVICES TO ALL COMMUNITIES ON A 24-HOUR A DAY BASIS.

R10 THE STUDY RECOGNIZES THE NEED TO EXTEND CRISIS INTERVENTION SERVICES TO COMMUNITY-BASED SETTINGS SUCH AS THE CLIENT'S HOME.

R11 IN ORDER TO MAKE CRISIS SERVICES AVAILABLE TO ALL IN NEED, IT IS RECOMMENDED THAT THE AVAILABILITY OF SUCH SERVICES BE ADVERTISED TO THE GENERAL PUBLIC.

R12 *THE STUDY RECOMMENDS THAT A COMMITTEE BE FORMED CONSISTING OF THE STAKEHOLDERS INCLUDING PHYSICIANS, CONSUMERS, AND REPRESENTATIVES OF THE HOSPITALS TO EXAMINE THE ISSUE OF ADMISSIONS PROCEDURES TO THE CAPE BRETON HOSPITAL.

The Need for Services Offering Therapy

The Therapy category consists of psychological therapy including those therapies directed to self-understanding, those aimed at modifying behavior, and physical therapies including chemical and physical means which are used to provide relief.

In addition to identifying the need for an increase in specific treatment services, selected targeted groups were also denoted as deserving a high priority for treatment programs. Three major target populations were emphasized: children/adolescents, the psychogeriatric population and those with chronic psychiatric problems. The authors of the Royal Commission also noted an increased demand for child psychiatric services. The administrators and representatives of the Micmac community emphasized strongly the need for more therapists to provide services to families. The need for additional and/or augmented services which provide therapy was identified by the four groups surveyed. As indicated under Problem Identification, those services offering assessment and psychotherapy were the ones that were most frequently requested of the

administrators and also the ones which they were most frequently unable to provide. Fifty percent of such requests were for services for youth. The need for more services which offer psychotherapy was identified by the greatest number of administrators (56 %) and socio-mental health professionals (75 %). Eighty-three percent of the administrators who noted the need to provide more services which offer therapy indicated that adolescents were the group most in need of services. However, many of those surveyed emphasized the importance of dealing with the family as a unit. The need for treating the family as a unit should perhaps be seen as being particularly germane, given that the breakdown of the family was identified as one of the features of the community which contributes to mental health problems of the residents. Sixty-nine percent of the administrators' responses indicated that the need for more services which provide therapy should be met within one year. The administrators noted that outpatient services, the private professional setting, and the day program are the most appropriate settings in which to provide services offering therapy. However, the need to provide such services in an outreach or community-based fashion was emphasized by the other groups surveyed including the socio-mental health professionals, those attending the public forums, students, and representatives from the Micmac community. Suggestions included providing child and adolescent services in communities other than Sydney, offering services to students in schools, providing services to young children and seniors in their homes, and offering services to those with chronic mental health problems "on their own turf". Graham (1988, p. 37) supports this philosophy, suggesting that the mental health professional in rural areas "must

become a part of the community". The authors of the Officials Report expressed concern about providing adequate treatment services to those who are released to the community. Additionally, the authors of Speaking Out noted the importance of consumers becoming actively involved in how they are treated. One way of doing this that was suggested was through self-help groups. The use of self-help and support groups as a therapeutic intervention was supported by the administrators, socio-mental health professionals, those attending public forums, and representatives of the underserved groups including the single mothers. The single mothers noted the importance of having the support groups meet in informal settings in "local neighborhoods". The Micmac representatives suggested the use of trained lay counsellors to work with youth.

All groups noted barriers to services including stigma, waiting periods, lack of specific services, poor transportation, and the unavailability of services on evenings or weekends. Services for children and adolescents are generally only available at the Cape Breton Mental Health Clinic in Sydney River which necessitates time, travel, and money for virtually all consumers in the Industrial Area. The Cape Breton Mental Health Clinic is not open evenings or weekends. Furthermore, it is not located on a public transportation route. Many of those surveyed indicated a reluctance on the part of many consumers to utilize services at the CBH because of the negative image of the facility. Waiting periods for child/adolescent services are reported to be as much as six months.

At the time this study was being conducted there were no treatment

services specifically offered for those with psychogeriatric problems. However, a number of the administrators who were surveyed did indicate that they provided psychotherapy/counselling for seniors.

While the consumer and advocates also reiterated many of the above concerns they additionally identified some specific concerns of those with chronic psychiatric problems. Some of these concerns were consistent with those expressed in the Speaking Out document. In many cases consumers and family members were dissatisfied with services that those with chronic mental health problems received from certain sectors of the psychiatric community. Their perception was that the patient with chronic psychiatric problems often received too much medication and too little counselling from some psychiatrists. It should be noted that consumers also perceived that sectors of the psychiatric community were attentive and responsive to their needs. The senior citizens complained of a lack of respect from physicians. They felt that rather than being listened to they were too often given medication for their problems. The families of consumers were dissatisfied with conditions on the tertiary ward of the CBH. The same group seemed pleased with the assessment unit and many of the professional staff at the CBH. They were, however, dissatisfied with the lack of continuity of care which patients received during their stay in hospital. This view was supported by some of the psychiatric staff within the hospital.

All of the groups surveyed identified concerns about the quality of mental health services in New Waterford. Lack of continuity of care and long waiting periods were noted as being concerns. The need for a full-time mental health clinic in New Waterford was noted by three of the four

surveyed groups as well as the special interest group from New Waterford.

Recommendations Related to Therapy

R13 *THIS STUDY RECOGNIZES THE NEED FOR ALL MENTAL HEALTH SERVICE PROVIDERS IN THE INDUSTRIAL AREA TO REVIEW THEIR MENTAL HEALTH PROGRAMS WITH A VIEW TOWARDS IMPLEMENTING EVENING AND WEEKEND HOURS OF SERVICE.

R14+*THIS STUDY RECOMMENDS THE VARIOUS AGENCIES PROVIDING MENTAL HEALTH SERVICES IN THE INDUSTRIAL AREA EXAMINE THEIR REQUIREMENTS WITH A VIEW TO RECRUITING ADDITIONAL MENTAL HEALTH PROFESSIONALS TO MEET THE REQUIREMENTS OF THE CHILD/ADOLESCENT AND PSYCHOGERIATRIC POPULATIONS.

R15 *THIS STUDY DEMONSTRATES THAT ADDITIONAL THERAPY SERVICES ARE REQUIRED IN A VARIETY OF SETTINGS SUCH AS THE CLIENT'S HOME, SCHOOLS, DAY PROGRAMS, AND PRIVATE PROFESSIONAL SETTINGS. FURTHERMORE, THE IMPORTANCE OF PROVIDING ADOLESCENT SERVICES IN COMMUNITIES OTHER THAN SYDNEY IS RECOGNIZED.

R16 THE STUDY RECOGNIZES THE IMPORTANCE OF SELF-HELP GROUPS, VOLUNTEERS AND LAY COUNSELLORS AND ENCOURAGES THE SERVICE PROVIDERS TO DEVELOP TRAINING PROGRAMS FOR VOLUNTEERS; AND TO WORK TOWARDS THE DEVELOPMENT OF A VARIETY OF SELF-HELP GROUPS FOR THOSE WITH MENTAL HEALTH PROBLEMS AND THOSE GROUPS IDENTIFIED AS BEING UNDERSERVED.

+ Given the difficulty in attracting clinical psychologists and psychiatrists to the Industrial Area, consideration should be given to recruiting other mental health professionals (e.g., social workers) with training or specialization in areas such as adolescent or family counselling. (The authors of the Royal Commission Report also suggested a multidisciplinary approach to treatment.) Additionally, those professionals presently in the community could act as consultants, training others and facilitating self-help groups.

Need for Vocational Services

The need for more or augmented vocational services was identified by three of the four surveyed groups. Forty-two percent of the administrators and 13 % of the socio-mental health professionals identified the need for vocational services. As noted, only the administrators were provided with the seven conceptual categories. Perhaps the reason for the socio-mental health professionals relatively

low ranking of the services in this category is that they simply did not perceive the area of vocational and job training as being within the domain of mental health needs. The need for vocational services was ranked lowest in degree of urgency with only 43 % of the administrators indicating that the need should be met within the one year. This is perhaps surprising, considering that the need for vocational services was ranked third by the administrators. Furthermore, both the administrators and direct service providers identified unemployment as one of the features of the community which contributes to the mental health problems of the residents. However, as the "poor economy" was also identified as a feature of the community it may be that the service providers felt that regardless of ones skills or training the likelihood of obtaining employment would remain low. Community settings such as industry, business and schools were noted as being the most appropriate locations for vocational programs and job training. The need for more vocational services was mentioned only once by those at public meetings and once by the advocacy groups. The consumer group did, however, mention the need for more money but did not equate the likelihood of improved income with increased training or enhanced job skills. Given the extraordinarily high rate of unemployment in the Industrial Area, the difficulty in securing employment, the fact that many more fortunate than the consumers interviewed for this study are unemployed, and the extraordinarily long waiting periods for vocational training programs, it may be that many of those in the consumer group do not see any other choice but to remain on Family Benefits. Those in the group of single mothers living on low incomes noted the importance of having accessible and affordable child

care available if they are to take advantage of vocational training programs.

There is a variety of government supported training and employment programs including academic upgrading, life skills, vocational training and job placement. However, waiting periods are reported to often be many months and sometimes years (MacDougall, J., personal communication, October, 1989)

The importance of employment, training and time spent volunteering to an individuals mental health has repeatedly been documented (Goering, et. al., 1988). As such, it would seem beneficial, in spite of the present waiting periods for services to encourage those with mental health disabilities to pursue vocational and job training options as well as volunteer opportunities. Both the Officials Report and Speaking Out commented on the need for vocational programs. The former report noted that Cardeil Place be used as the cornerstone for public funding and that there was a need for decentralized services similar to those at Cardeil Place in the Northside and Glace Bay/New Waterford areas. The Speaking Out document stressed the importance of ensuring permanent funding of vocational services for consumers of mental health services.

Recommendation Related to Vocational Services

R17 THE STUDY RECOGNIZES THE NEED TO DEVELOP VOCATIONAL SERVICES FOR THOSE WITH CHRONIC PSYCHIATRIC PROBLEMS. SERVICES SHOULD INCLUDE COLLABORATION WITH LOCAL BUSINESS AND INDUSTRY. CONSIDERATION SHOULD BE GIVEN TO VOLUNTEER OPTIONS, SMALL BUSINESSES, TRAINING ON THE JOB, AND SUPPORTED EMPLOYMENT.

R18 THE STUDY RECOMMENDS THAT THE VARIOUS ORGANIZATIONS PROVIDING VOCATIONAL TRAINING PROGRAMS EVALUATE THEIR REQUIREMENTS WITH A VIEW TO REDUCING WAITING PERIODS FOR TRAINING AND ACADEMIC UPGRADING PROGRAMS.

Need for Social/Recreational Services

Social and recreational programs offer non-treatment services such as leisure activities, life skills, and counselling that may help to develop social skills and offer an opportunity for social interaction. Social and recreational programs to develop these skills are offered through a number organizations and agencies including some group home programs; the day hospital, and occupational therapy programs at the Cape Breton Hospital; some of the educational programs at the Adult Vocational Training Center (AVTC), and Cardeil Place in Sydney. Additionally, there are variety of social and recreational programs offered through other organizations including municipal recreation departments, churches, the Sydney Boys and Girls club, and the YMCA.

All of the four surveyed samples, as well as, representatives of the Micmac community, youth, and those with chronic psychiatric problems identified the need for more social/recreational programs. Twenty-five percent of the administrators and 38 % of the socio-mental health professionals indicated a need for more services that provide social and recreational services. The administrators noted that the most appropriate setting for such services was in the community (i.e., church halls, schools, the YMCA etc.); through day hospital programs and in residential settings. Fifty-two percent of the administrators responses indicated that additional social and recreational services should be provided within one year. The groups that were identified as being most in need of social/recreational programs were those with chronic mental health problems and youth. Consumers and advocates identified the need for more social/recreational programs for those with chronic psychiatric

problems in the communities other than Sydney. Those in Sydney suggested the need for the existing services to offer social/recreational programs for those with chronic mental health problems in the evenings and on the weekends. Consumers, family members, and advocates from both Sydney and other communities complained about the difficulty of getting to Sydney River for the day hospital program offered at the CBH. The youth that were surveyed noted the lack of social and recreational programs for them in the community and emphasized the importance of establishing such programs as one of their needs. As well, the Micmacs noted the need for social/recreational programs for the youth of their community.

The importance of social/recreational programs in helping to reduce readmissions to hospital (Bill, 1970, cited in Wasylenki, Goering, Humphrey, Martin, & Glasser, 1989), and as a preventive intervention with youth (Fuchs, & Bracken, 1984) has been well documented. Although the focus of such programs for those with chronic mental health problems and youth may be different similar community resources may used to implement both types of recreational programs. This is a case where those services, such as the church, schools and recreation departments, which do not traditionally provide mental health services, could be included in the planning and implementation of programs. This is a good example of where volunteers could be utilized to reduce expenditures. Both the Officials Report and Speaking Out recognize the importance of social/recreational programs to consumers of mental health services particularly with regarding to networking. Those surveyed in the Speaking Out report also stressed the importance of social/recreational services for those with ongoing mental health problems by noting that it

was one of the three services most frequently required for community living. It was suggested that staff of municipal recreation departments be encouraged to act as consultants to those planning programs for those with chronic psychiatric problems and that non-traditional mental health service providers participate in offering programs for those with mental health problems.

Recommendations Related to Social/Recreational Needs

R19 THE STUDY RECOGNIZES THE NEED TO FORM A PLANNING GROUP FOR YOUTH COMPRISED OF THE VARIOUS STAKEHOLDERS, INCLUDING YOUTH, EDUCATORS, LAW ENFORCEMENT OFFICIALS, AND RECREATIONAL STAFF, WITH A GOAL OF ESTABLISHING PROGRAMS APPROPRIATE FOR YOUTH.

R20 THE STUDY RECOGNIZES THE NEED TO PROVIDE COMMUNITY-BASED SOCIAL/RECREATIONAL PROGRAMS FOR THOSE WITH CHRONIC MENTAL HEALTH PROBLEMS IN ALL OF THE SURVEYED COMMUNITIES. THESE PROGRAMS SHOULD BE ACCESSIBLE BOTH WITH REGARD TO LOCATION AND THE TIME THE SERVICE IS OFFERED.

Need For Familial Support Services

Familial support services pertains to those services that assist the family to cope with emotional and financial concerns associated with the long-term management of individuals with psychiatric or emotional disorders. This category includes vacation relief, counselling/mutual aid homemaking services. While it was noted that only one agency provided all of the above services the administrators of five organizations stated that they offered counseling and mutual aid.

In many cases, the client/patient is the central focus of mental health management and the concurrent needs of the patient's/client's family or significant other are underestimated and/or neglected. This needs assessment incorporated the unique perspective of family members and advocates of mental health clients to provide direct information on

the needs of those who share responsibility for the well being of the chronically mentally impaired. In the present study, the majority of data supporting the need for familial support was derived from the administrators and consumers groups, although input was also received from the those attending community forums and the socio-mental health professionals. Additional factors have an impact on familial support (e.g., public education and information, coordination, accommodation, and crisis services) but are discussed within the respective sections of the conceptual framework.

Thirty-eight percent of the administrators noted the need for more familial support services. Their perceived need was distributed about evenly between vacation relief, mutual assistance, and homemaking services. Seventy percent of the administrators responses indicated that the need for familial support services be met within one year. The most appropriate setting for familial support services was deemed to be in the home. The need for such services was indicated as being needed equally throughout the Industrial Area. Both the administrators and socio-mental health professionals noted the need for self-help and support groups for the families of those chronic mental health problems. The perceived need for the self-help groups was noted as being greater in areas other than Sydney. Family members reported feelings of isolation both in terms of being distanced from the Cape Breton Hospital and with regard to support services. With few or no support and/or follow-up services parents often bear the brunt of the responsibility of caring for the patients when they leave the hospital. Parents reported feelings of "being held prisoner" because their son or daughter had "nothing to do

and no where to go". The findings of the Speaking Out document emphasized the importance of supportive networks for those with persistent psychiatric problems as well as the need for similar networks for their families and friends. Furthermore, the importance of strong social networks has been documented (Schoenfeld, 1986, cited in Wasylenki et al., 1989).

Family members also had concerns about some legal issues relating to mental illness. An area of concern pertained to the unsatisfactory situation in which disruptive and/or dangerous individuals are not recognized as such according to the existing medical-legal standards and are left in the care of family members. Family members reported they receive little or no support with tne legal aspects of having a family member committed. Other responses indicated a need for a legal mechanism by which family members could have a client or family member admitted involuntarily in order to receive appropriate services. Heseltine (1982) identified similar concerns. While considerations for effecting changes with the mental health legislation are beyond the scope of this report the problem should be recognized and given further study.

Recommendations Related to Familial Support

R21 THE STUDY DEMONSTRATES THE NEED TO ENHANCE FAMILY SUPPORT BY PROVIDING SUCH SERVICES AS FAMILY COUNSELLING, FAMILY EDUCATION, PSYCHO EDUCATIONAL PROGRAMS, AND VACATION RELIEF. THESE SERVICES SHOULD BE INCORPORATED INTO COMMUNITY-BASED PROGRAM PROPOSALS.

R22 THE STUDY ENCOURAGES THE CAPE BRETON MENTAL HEALTH ASSOCIATION TO ASSIST IN THE DEVELOPMENT OF SUPPORT GROUPS FOR FAMILIES OF THOSE WITH CHRONIC MENTAL HEALTH PROBLEMS.

R23 THE STUDY ENCOURAGES THE MINISTER OF HEALTH AND FITNESS TO PROCEED WITH A REVIEW OF THE MENTAL HEALTH ACT.

Need for Accommodation

The accommodation category pertains to any supportive living arrangement that provides food, shelter, support, and/or treatment to individuals with varying mental health needs including psychiatric patients. "Appropriate accommodation can do a great deal to enhance the client's transition to fully independent living or, at a minimum, reduce the likelihood of readmission to the hospital and provide a better life" (Heseltine, 1983, p. 126). Indeed, the focus of the Officials Report was the need for accommodation in the community for those with ongoing disabilities and how best to provide an environment consistent with their needs. The need for community housing was one of the areas identified most frequently by those surveyed in the Speaking Out report.

Concerns about existing inadequacies of community and institution based accommodation facilities and the need for the different levels of housing were identified by all of four surveyed samples. The need for more accommodation was identified by 34 % of the administrators and 26 % of the socio-mental health professionals. Sixty-three percent of the administrators responses indicated that the need for accommodation should be met within one year. However, 100 % of the accommodation needs in Sydney were perceived as being needed within one year. The need for more accommodation was perceived as being required on a region wide basis. The groups that were most often identified as being in need of better or more housing were those with chronic psychiatric problems and the psychogeriatric population. According to some of service providers, including the administrators of homes for special care and some of the social workers who work with the elderly, there appears to be a genuine

crisis in locating appropriate accommodations for seniors with psychological problems. There is not presently a psychogeriatric ward in any of the hospitals or homes for special or extended care in the Industrial Area. As noted by the administrators of the homes for special care: Patients with psychological problems can be extremely disruptive when placed in regular wards. In addition to the shortage of accommodation there appears to be some confusion about the admission policy relating to those 65 years of age and older to the Cape Breton Hospital. The concerns pertaining to accommodation for those with psychogeriatric problems were consistently supported in the feedback I received regarding Recommendation 26.

Most of the surveyed groups also identified problems that those with chronic psychiatric problems had getting clean, affordable housing. Advocates also expressed concern about the exploitation of those with chronic psychiatric problems by unscrupulous landlords. The issues of cleanliness, affordability, and exploitation were raised primarily by the consumers and advocates while the service providers addressed the need of providing more half and quarter way houses offering various degrees of supervision. The consumers expressed concern about losing their accommodations if they were admitted to the hospital for more than 30 days. The socio-mental health professionals also noted the need for a hostel which could provide shelter to the youth of the area and for those who are indigent.

Only three of the administrators indicated that their agency/organization provide accommodation. In all cases it was residential accommodation for groups with special needs. Waiting periods

for such accommodation may be many months or years. None of the agencies that responded to the survey provide accommodation specifically for those with chronic psychiatric problems or for those with psychogeriatric problems. However, residential accommodation for those with chronic psychiatric problems is offered in the Industrial Area. It is understood that waiting periods for accommodation for both these groups can be many months and in some cases years (Woodford, J. personal communication, December, 1989). The importance of a supportive living situation in developing effective programs for those with chronic mental problems has been documented (Budson & Jolley cited in Wasylenki et al. 1989).

Recommendations Related to Accommodation

R24 **THE STUDY RECOMMENDS THAT A HOUSING REGISTRY BE DEVELOPED IN THE INDUSTRIAL AREA. ITS INITIAL FOCUS SHOULD BE THE ESTABLISHMENT OF AN INVENTORY OF ACCOMMODATIONS FOR THOSE WITH CHRONIC PSYCHIATRIC PROBLEMS AND SENIOR CITIZENS WITH PSYCHOLOGICAL PROBLEMS. THIS WOULD ALSO ASSIST IN AN ASSESSMENT OF THE CONTINUUM OF HOUSING NEEDS FOR INDUSTRIAL CAPE BRETON.**

R25 **THE STUDY RECOGNIZES THE NEED FOR MORE HOUSING FOR THOSE WITH CHRONIC PSYCHIATRIC PROBLEMS AT A VARIETY OF LEVELS AND SETTINGS INCLUDING SUBSIDIZED, SUPERVISED, AND COOPERATIVE HOUSING.**

R26 ***THE STUDY RECOMMENDS THAT CONCERNS ABOUT HOSPITAL AND HOMES FOR SPECIAL CARE PROGRAMS IN PSYCHOGERIATRICS BE ADEQUATELY ADDRESSED BY THE APPROPRIATE STAKEHOLDERS AND THAT TOGETHER THEY DETERMINE PROGRAM REQUIREMENTS AND THE APPROPRIATE FACILITY TO HOUSE SUCH PROGRAMS.**

R27 **THE STUDY RECOMMENDS THAT THERE BE A REVIEW OF THE DISABILITY PENSION PAID TO THOSE WITH CHRONIC PSYCHIATRIC PROBLEMS TO DETERMINE IF IT IS ADEQUATE TO MAINTAIN INDEPENDENT LIVING.**

Need for Transportation Services

In the conceptual framework, the transportation category focuses on activities which facilitate the clients access to needed mental health services. Only with the survey of the administrators were the

respondents directed, specifically, to consider the potential for transportation needs. Transportation was ranked lowest by the administrators. While the Micmacs, senior citizens, and the consumers noted that transportation was an issue, most of the other samples surveyed did not, specifically, mention transportation as a mental health need. In the case of the service providers perhaps this is because it was less salient to mental health professionals who deal primarily with individuals who have overcome transportation barriers in order to attend their programs/services. Perhaps it is because some of the agencies surveyed do provide services in the client's home or perhaps it is simply because transportation is not seen as a mental health need per se.

Although transportation was designated as a service category it also emerged as a theme which cut across the need for many of the other services. Indeed, when the issue is reframed that is, as a problem in making referrals or as a factor which would keep people from using a mental health service, or when it is addressed directly, the magnitude of the issue of transportation as it relates to the accessibility and use of mental health services becomes apparent. For example, 62 % of the administrators said that their clients had problems relating to transportation when using the mental health service. Twenty-five percent of the socio-mental health professionals stated that problems relating to transportation including the expense, time, and effort, are factors that would keep people from seeking mental health services. The consensus appeared to be that while transportation became more of an issue the farther the client was from Sydney River or if the client lived in a rural area the lack of adequate transportation also presented a problem

for those living in Sydney. As one administrator said: "The lack of adequate public transportation is the single most critical factor contributing to the under utilization of our facilities...."

Since many of the key mental health services (e.g., child and adolescent services) are located at the Mental Health Clinic in Sydney River, which is not located on a public transportation route, access may be a limiting factor for some residents when attempting to obtain required services. Often clients have to travel many hours a day at irregular hours to get to the service. The issues of motivation and money are also factors for those that must use transportation. Often those most in need of services can least afford them. By the vary nature of their illness some of those with mental illness may have great difficulty using public transportation. Many noted that the lack of adequate transportation serves to increase isolation in the community. Isolation is a feature of the community identified by both the administrators and the socio-mental health professionals as a factor which is considered to contribute to the mental health problems of the residents. The consumers spoke of the detrimental effects an inaccessible mental health service can have including both the increased frustration and added stress that the financial burden of transportation causes. The issue of transportation was addressed in the Speaking Out document. Specifically, it was noted that the lack of adequate transportation, particularly, in rural areas leads to inequities in access to social and mental health services.

Thirty-eight percent of the administrators indicated that they provided some type of assistance to aid their clients with transportation

including paying fares, providing group taxis, and reimbursing them for expenses incurred. Suggestions, in addition to the types of assistance already provided to assist alleviate the problems of transportation included volunteer drivers, utilizing Handi-trans and the formation of car pools.

Given the long-term nature of many emotional problems, the availability of affordable and accessible transportation is an important factor in the use of treatment and/or support services. However, given the relatively large area and diverse demographics of industrial Cape Breton the idea of transporting people to relatively centralized services may not be the most effective way of providing services.

In considering the data obtained form this survey perhaps it is appropriate to look at a more community-based approach to delivering services. As previously stated, the mental health professional in rural areas "must become part of the community" (Graham, 1988, p. 37). Repeatedly, most of the surveyed groups mentioned the formation of self-help groups, both to assist in decreasing isolation and as therapeutic or support intervention. As stated, the single mothers emphasized the importance of establishing support groups in local neighborhoods. Service providers and consumers alike often suggested bringing services to the consumer. This suggestion was repeatedly made with regard to the treatment and assessment of young children in the home, children and adolescents in the schools, the assessment of senior citizens in the home, and for outreach support services for those with chronic mental health problems. For a variety of reasons, including its relative inaccessibility and the stigma associated with the CBH, most of the

surveyed groups suggested the relocation of many of the mental health services presently located in the Cape Breton Hospital complex to smaller, more centrally situated, "user friendly" locations. The usefulness of offering services for children and adolescents in additional communities to Sydney was consistently supported in the feedback I received and is supported with Recommendation 32.

Recommendations Related to Transportation Services

This study recognizes the need for mental health service providers to be sensitive to transportation needs of clients. However, when considering the information obtained in this survey, thus far efforts in the Industrial Area to assist clients with transportation do not appear to have been particularly successful. The issue of either unavailable, poor, and/or expensive transportation both as it relates to the accessibility and use of services and how it serves to exacerbate feelings of isolation were repeatedly emphasized. The recommendations of this study, therefore, emphasize the need for mental health agencies, particularly, the Cape Breton Mental Health Clinic, to reexamine the way they deliver their services. The advantage of employing an outreach and community-based system of delivering services including training lay people (Heyman, 1983) and para-professionals (e.g., school guidance counsellors), utilizing self-help groups (Heller et al., 1984), and the use of smaller more accessible clinics has been documented (Graham, 1988; Mahoney & Heymen, 1983). The following recommendations are based on information obtained in a number of the mental health service categories including Coordination and Direction, Problem Identification and Therapy. While the following recommendations are offered in the Transportation

category they are particularly relevant to those services offering assessment, diagnosis, and psychotherapy/counselling. Although these recommendations may not appear to address the issue of transportation per se it is suggested that they do offer effective solutions to the problems caused by an inadequate public transportation system.

R28 *THE STUDY RECOGNIZES THE NEED FOR AGENCIES TO EXAMINE THE WAY THEY DELIVER SERVICES WITH A VIEW TO THE ISSUES OF ACCESSIBILITY RAISED IN THIS REPORT, INCLUDING TRANSPORTATION.

To assist in achieving the above recommendation the following suggestions are offered:

R29 *THAT THE TRAINING OF SCHOOL GUIDANCE COUNSELLORS/TEACHERS, SUCH THAT THEY CAN INTERVENE EFFECTIVELY WITH STUDENTS WITH PSYCHOLOGICAL PROBLEMS, BE SUPPORTED.

R30 THAT THE ESTABLISHMENT OF SUPPORT GROUPS FOR THOSE WITH A VARIETY OF PSYCHOLOGICAL PROBLEMS THOSE BE ENCOURAGED.

R31 THAT THE CAPE BRETON MENTAL HEALTH CLINIC OFFER SERVICES IN SMALLER, MORE CENTRALLY LOCATED, NON-INSTITUTIONAL FACILITIES.

R32 THAT SERVICES FOR CHILDREN AND ADOLESCENTS BE OFFERED IN COMMUNITIES OTHER THAN SYDNEY.

Need for Public and Professional Education

The final category of the conceptual framework includes a range of activities aimed at increasing the awareness, knowledge and/or understanding of mental illness, the application of psychological intervention concepts, the prevention of mental illness, and increasing the awareness of available mental health services. Some issues relating to educational needs but not mentioned, specifically as such, are discussed in other parts of this section (e.g., Coordination and Direction). The need for more educational programs was identified by all of the groups surveyed. Thirty-nine percent of the administrators and 23

% of the socio-mental health professionals identified the need for more educational mental health programs. The need for more educational programs received the strongest emphasis in the feedback that I received and is supported with Recommendation 33 . In terms of urgency, the administrators ranked the need for more public education programs third after crisis response services and services which provide therapy. Seventy-four percent of the administrators responses indicated that the need for public education should be met within one year. However, with 56 % of their responses indicating that professional education services were needed within one year, the need for professional education was ranked lowest in urgency of perceived mental health needs. The perceived need for more public educational programs related primarily to programs that would provide information about available resources and services, as well as educational programs that would help to reduce the negative image and stigma associated with mental illness. Many of those surveyed, including the youth, single mothers and the representatives of the Micmac community recognized the importance of obtaining information and education to the process of becoming empowered. The consumer and consumer support groups also indicated that information on services in the community should be made available to those who are released from the Cape Breton Hospital. Those attending public forums, representatives of special interest groups, and members of groups identified as being underserved tended to mention the need for more educational programs most frequently in their list of needs. Many of those attending the public meetings said that they were not sure where to turn to for help or what mental health services were available. Lack of information

regarding crisis services, in particular, was noted. The seniors citizens identified the need for informational seminars on specific topics (e.g., prescription drugs) and services (e.g., legal) that are available. Furthermore, the single mothers emphasized the importance of obtaining information on a variety of topics including the availability of vocational training and academic upgrading programs. The administrators of homes for special care said that they required clarification about admissions policies, relating to those over 65 to the CBH. The consumer and consumer support groups noted the need for educational programs to help reduce the stigma associated with mental illness. All settings, including a variety of community locations were seen as appropriate for public education. Most agreed that there was a place for mental health education both in the workplace and in the school system. The report Speaking Out noted that those surveyed emphasized the importance of providing information to consumers on a variety of topics including the causes and nature of their illness, treatment, side effects of medication, the availability of community services and how to use them, and information about his/her legal rights.

Other topics included in the category of education are prevention and intervention initiatives. Both the administrators and socio-mental health professionals emphasized the issue of unemployment as a feature of the community which contributes to the mental health problems of the residents. Given this acknowledgement, it is reasonable that there was a recognition of the importance of interventions to deal with community-wide traumas such as plant shut downs and the ongoing stress of high unemployment. Additionally, there was an awareness by some of those that

were surveyed that the youth of Cape Breton Island reportedly have low self-esteem relative to other youth in Canada and the importance of developing an intervention to address this need. All of the surveyed groups recognized the importance of offering instructional programs within the school system (e.g., stress reduction techniques).

In some respects, the issues covered under the need for more educational services are similar to those discussed under the need for the enhanced coordination of services (e.g., the dissemination of information about services/resources). This point is particularly true with regard to the need for more professional educational programs, specifically those that assist in increasing the awareness of what functions other agencies perform. Many of the socio-mental health professionals said that they were not clear on the roles of some agencies. A number of those surveyed were unaware of the range of services, including the specialties of the various staff, offered at the Cape Breton Hospital. Still others had concerns about poor relationships between some of the agencies that they made referrals to and themselves. The importance of providing ongoing, regular, in-service programs to all professionals in mental health and related fields was suggested. It was noted that the Inter-Agency Association of Professional Development (IAAPD) does a particularly good job of keeping many of those in the helping professions informed. As per the suggestions offered by the administrators of mental health services this appears to be an opportunity to include agencies and organizations not usually involved with mental health issues (e.g., teachers, clergy, police officers and physicians) with planning regarding both professional public education

initiatives. As there are presently a variety of agencies and organizations involved in performing educational roles coordination of these services is suggested.

Recommendations Related to Educational Services

R33 *THE STUDY RECOGNIZES THE NEED FOR EDUCATIONAL PROGRAMS IN MENTAL HEALTH AND ENCOURAGES THOSE ACTIVITIES WHICH INCREASE THE KNOWLEDGE AND APPLICATION OF POSITIVE MENTAL HEALTH COPING SKILLS. SUGGESTED TARGETS FOR SUCH PROGRAMS ARE STUDENTS AND GROUPS IDENTIFIED AS BEING UNDERSERVED.

R34 THE STUDY IDENTIFIES THE NEED FOR ACTIVITIES/PROGRAMS WHICH PROMOTE PUBLIC AND PROFESSIONAL RECOGNITION OF INDICATORS OF POSSIBLE MENTAL ILLNESS. PROGRAMS SHOULD BE TARGETED TOWARDS PARENTS, PEERS, EDUCATORS, AND HEALTH CARE AND SOCIAL SERVICE PROVIDERS.

R35 THE STUDY SUPPORTS THE DEVELOPMENT AND ANNUAL UPDATING OF A DIRECTORY OF MENTAL HEALTH RESOURCES IN THE INDUSTRIAL AREA. SUCH A DIRECTORY SHOULD INCLUDE AREAS OF PROFESSIONAL SPECIALTY.

R36 THE STUDY RECOGNIZES THE NEED FOR ONGOING PROFESSIONAL DEVELOPMENT THROUGH ORGANIZATIONS SUCH AS THE IAAPD AND ENCOURAGES THE COORDINATION OF EDUCATIONAL PROGRAMS FOR PROFESSIONALS IN THE INDUSTRIAL AREA.

R37 THE STUDY RECOGNIZES THE NEED FOR PROGRAMS WHICH INCREASE PUBLIC AND PROFESSIONAL AWARENESS OF THE AVAILABILITY AND SCOPE OF MENTAL HEALTH SERVICES IN THE INDUSTRIAL CAPE BRETON AREA.

* *

GENERAL RECOMMENDATIONS

R38 THE STUDY RECOMMENDS THAT A MECHANISM BE DEVELOPED TO CONVEY THE RESULTS OF THIS STUDY TO THE COMMUNITY.

R39 *THE STUDY RECOMMENDS THAT THE CAPE BRETON MENTAL HEALTH ASSOCIATION INVESTIGATE THE POSSIBILITY OF A COMMUNITY WIDE ORGANIZATION TO PROVIDE COORDINATION FOR EXISTING PROGRAMS AND SERVICES.

R40 *THE STUDY RECOMMENDS THAT A COMMITTEE OF STAKEHOLDERS BE FORMED TO ADDRESS THE NEEDS OF WOMEN IN THE INDUSTRIAL AREA.

R41 THE STUDY RECOMMENDS THAT CURRENT MENTAL HEALTH PROVIDERS EVALUATE THEIR PROGRAMS TO DETERMINE THEIR SUITABILITY FOR THEIR CLIENTS.

R42 THE STUDY RECOMMENDS THAT THE CAPE BRETON MENTAL ASSOCIATION ADVISE THE APPROPRIATE MINISTRIES OF THE NEED TO DEVELOP A CONFIDENTIAL AND STANDARDIZED DATA BASE TO IMPROVE THE SCOPE AND METHOD OF DATA COLLECTION CONCERNING THE PREVALENCE OF MENTAL HEALTH DISORDERS AND THE UTILIZATION OF MENTAL HEALTH SERVICES.

+++

The researcher is both aware of the substantial cost of implementing some of these recommendations and the fiscal constraints imposed on many of the organizations and agencies in the Industrial Area at this time. It is in part, for this reason that the importance of establishing a coordination and planning body is emphasized. The establishment of such a body should involve a relatively minimal expense and provide for an orderly, logical, and sequential planning and implementation of mental health services. Such a body could perhaps be used as a vehicle to consider, and possibly implement some of this report's recommendations.

The coordination and planning body may consist of either volunteers or a paid administrator and one or two support staff. Representatives of all stakeholder groups including consumers and/or advocates, administrators of mental health agencies, and members of other groups who have a vested interest in the delivery of mental health services in the Industrial Area such as physicians, the police force, and representatives of local school boards could actively participate in such a body. The selection of a sponsoring and facilitation agency with the goal of establishing the coordinating and planning body should be a priority for those concerned with the delivery of mental health services in industrial Cape Breton.

With regard to the establishment of a coordinating and planning body for services according to Goering et al. (1986) the following considerations should be kept in mind: 1) define which functions are to

be coordinated; 2) facilitate change that is anchored in front-line problems and flows from the bottom up; 3) involve in the planning those that will be affected; 4) specify the benefits and responsibilities of membership; 5) inure that there is enough power to implement change; 6) assign responsibility for leadership to skilled and respected individuals; 7) build upon existing positive linkages; 8) allow sufficient time for change; 9) commit the necessary resources; and 10) the coordination of services should first be considered for a well defined target population. This final suggestion is based on negative experiences in establishing well-intentioned but broad scoped coordination services which were ineffective. The present assessment of need indicates that the first priority for a well defined target population should be children and adolescents.

FEEDBACK ON RECOMMENDATIONS

Upon completion of a first draft of this needs assessment a draft of an Executive Summary, including the recommendations of this report was sent to 20 of the stakeholders (Appendix Z-1) who had participated in the study. I selected these individuals as I thought they were knowledgeable about the issues and represented the various groups who participated in the research. Furthermore, I contacted each person by telephone explained the purpose and importance of the feedback and obtained a commitment from them to complete the Recommendation Feedback Form (Appendix Z-2). Those who agreed to complete the feedback form were subsequently sent a letter (Appendix Z-3) reiterating the purpose and importance of obtaining feedback and a Recommendation Feedback Form. A draft of the Discussion of Results, and Recommendations section of this study was sent to the Cape Breton Metal Health Association in Sydney so that those who chose to, would have an opportunity to pursue a more detailed discussion of the findings of the study. Based on my discussion with the 20 individuals selected to receive the feedback materials I decided not to send this more lengthy document (approximately 50 pages) to each of them. Most of those I spoke to indicated they would likely not have the time to read such a document but would appreciate having it available if there were points they chose to pursue.

The following is an analysis of the data obtained from the Recommendation Feedback Form. The data noted in this section has been incorporated in the Discussion of Results and Recommendations. Thus far 11 of the forms have been returned. The respondents were first asked:

Do you believe that the recommendations contained in this summary offer appropriate and useful solutions to the mental health needs in industrial Cape Breton? Yes ____ No ____

In answering this question, one hundred percent of the respondents indicated "Yes".

Those surveyed were then asked to: "Please elaborate". Although the respondents' elaborations varied there was some consistency in their responses. Table 5 shows the most frequently noted recommendations that the respondents commented on and the number of times they were referred to by the respondents. A complete list of the recommendations noted and the frequency with which they were noted can be found in Appendix Z-4.

Table 5

Frequency of Recommendations Noted by Respondents

Recommendation Number & Mental Health Service Category		Number of times the Recommendation was Referred to by Respondents
R33	Education	6
R32	Transportation	5
R9	Crisis Response	5
R29	Transportation	4
R26	Accommodation	4
R5	Coordination	4

All of the responses to the recommendations were favorable. While the representatives of the different stakeholder groups emphasized different points the following comments are typical of those received: "All the recommendations noted in the report are excellent." "You have certainly 'zeroed' in on the prime needs for Cape Breton." Although all of the recommendations were viewed favorably a number of additional

suggestions were offered. These suggestions stressed the importance of working with the family as a unit rather than focusing on individual centered needs and problems. Furthermore, it was suggested that more attention needs to be directed to community needs and problems.

> I find that most of the recommendations are centered on individual needs/problems or at best family centered. There is no attention paid to community centered needs/problems.

There were also respondents who felt the report had neglected the needs of specific groups including the needs of men, particularly sexual offenders and those who are violent. However, the most frequently noted area that the respondents felt the report neglected was the needs of women. As one respondent noted:

> I'm surprised there is no emphasis on services for women in particular. So many clients are women struggling to fulfill so many roles and meet so many needs with so few resources. Poverty, societal expectations and violence towards women are taking a large toll in women's mental health.

The respondents were also asked:

> What would you suggest is an appropriate format to release the findings of the needs assessment survey to the community?" Public Forum ____, Executive Summaries Distributed to key individuals and agencies ____, Through the media ____, Other (please specify) _____

Ten of the respondents indicated that "through the media" would be the most appropriate format. Nine persons that the Executive Summary format would be most appropriate, and six indicated that the public format would be most appropriate format. It is apparent that most of the respondents indicated more than one means to disseminate the information. Other suggestions offered included giving summaries to "family members and patients who come to the hospital"; "panel group discussions"; "formal invitations to come together and develop a planning

and coordinating committee"; and "teams set up to do presentations through schools, colleges etc. with the cooperation of people like guidance counsellors as a resource - in conjunction with health courses at the junior high level"

The respondents were also asked:

> Would you be receptive to the idea of a coordinating and planning body for the delivery of mental health services in the industrial area of Cape Breton? Yes ___ No ____.

One hundred percent of the respondents indicated "Yes". Additional comments included: "long overdue"; "especially agree with the selection of children/adolescents as first priority target group".

They were then asked: "If 'Yes', would you participate in such a body?" All of the eleven respondents indicated that "Yes" they would participate in such a body. Some indicated that they would participate if someone else took responsibility for coordinating such a body.

Finally, those surveyed were asked:

> If you agree with the idea of a coordination and planning body can you suggest an individual, agency or organization that would be appropriate to help establish such a body?

Three individuals did not respond to this question. Five of those surveyed mentioned that a coordinating and planning should be comprised of the representatives of the stakeholder groups. Three of the respondents specifically mentioned that the Mental Health Association in collaboration with representatives of various stakeholder groups should be included in such a body. Furthermore, it was noted that front-line workers, members of the medical community, representatives of M.S.I., and representatives from the Ministries of Health and Community and Social Services should be included in a coordination and planning body. It was

noted that the media should be used to encourage participation in such a group.

ANOTHER PERSPECTIVE: THE OPPRESSED

In the Discussion of Results and Recommendations section I considered the data obtained in this document primarily with regard to other studies relating to the needs of those living in the Industrial Area. In this section I consider the findings of this study in light of some additional investigations of mental health needs and policy statements with particular emphasis on those groups who have been identified as underserved. Such a discussion should not only reinforce the recommendations offered in this study but also allow the reader to note some of the issues that I did not fully consider but which, nevertheless, are important. Although I was able to meet with the groups that were identified as underserved, they, along with most of the other participants, tended to view the issues of mental health from a traditional perspective. There is a segment of community psychology which suggests that many of the mental health problems which people experience can be attributed to the degree of economic oppression they experience (Goldenberg, 1978). As a researcher/consultant, I feel some responsibility to look at the results of this study in the context of some of the literature in community psychology which deals with the empowerment of those groups which are oppressed in society. This discussion will also allow the reader to contemplate, within the context of federal policy statements and recommendations of other studies, the direction that the provision of mental health services is taking.

Furthermore, in examining the data of this study in the light of other reports it will enable readers to look at mental health concerns within the framework of broader social and economic issues. In the Conceptual Framework section of this document I discussed some of the values and concepts of community psychology noting the shift from a medical model of institutionally based treatment to a community-based approach in which a bio-psycho-social model is utilized and the preventative aspects of mental health are emphasized. In such a model the whole person is recognized in the context of his/her environment. While many of those involved in the delivery of mental health services cling, almost exclusively, to aspects of the traditional approach there are those who strongly believe in implementing prevention programs and utilizing an ecological approach.

An important and timely document for Canadians involved in the delivery of mental health services was the publication in 1988 of the Department of National Health and Welfare's Mental Health for Canadians: Striking a Balance. In this report the authors presented what was for the federal government a dramatic shift in their perception of how the issue of mental health should be viewed.

> ....the new understanding of health dwells less on peoples traits as individuals and more on the nature of their interaction with the wider environment. Environment in this context is interpreted in the broadest sense and includes not only our physical surroundings ....but also the social cultural, regulatory and economic conditions that impinge on our everyday life.

The authors of this report described a number of guidelines which they suggested were important in achieving good mental health for all including: 1) human rights and citizenship, 2) mutual aid and voluntary

service, 3) consumer participation, 4) professional participation, 5) strengthening communities, 6) knowledge development, and 7) policy coordination. I believe these guidelines have been followed, for the most part, in the recommendations of this study. The value and importance of education has been recognized through the emphasis on both public and professional education. Both consumer and professional participation were encouraged in this needs assessment. The importance of collaboration between these two groups and the use of the professional as a consultant, sharing his or her knowledge with lay people, has been encouraged and supported. Communities may be strengthened by the use of outreach and consultation services, indigenous self-help groups and tne establishment of multi-service centers. Furthermore, I would envision the empowerment of both individuals and communities through local participation in the design and implementation of new and augmented programs and services. Coordination of services was a theme which permeated the data and is reflected in the recommendations both with regard to the development of services for specific groups and for the overall development of policy. Such coordination is essential in providing the best interventions for the community. Coordination will not only provide maximum value with the limited resources but will encourage cooperation and collaboration.

The authors of Building Community Support For People: A Plan For Mental Health In Ontario (The Provincial Community Mental Health Committee [PCMHC], 1988), espoused a similar philosophy to that offered by the above noted federal document. While Cape Bretoners are often reluctant to be compared with those from "upper Canada", there is much in

this document which supports the three previous alluded to studies which dealt with the mental health needs of those living in the Industrial Area. The PCMHC (1988) makes note of the lack of coordination of services, the gaps in services, the disparities in services related to region, and the lack of long range planning. The PCMHC (1988) offers recommendations which are consistent with those recommendations and guidelines offered in Striking A Balance and with the recommendations offered in this report. The multi-dimensional nature of mental illness is recognized. Coordination and planning are emphasized as are collaboration between consumers, professionals, and policy makers. The establishment of local mental health authorities is recognized. The establishment of community-based services and increased access to those living in rural areas is encouraged. An evaluation component is noted as being an essential constituent in the establishment of any new services. Furthermore, the importance of pubic education and professional staff development is emphasized. Finally, the authors of Building Community Support For People recognize that all people should have access to an adequate income so that they will be insured of proper accommodation, nutrition, and dignity. The PCMHC (1988) utilized a framework of services similar to the seven mental health service categories used in this study and suggest that there is a need to describe how these essential functions will be carried out in each area. The present needs assessment has offered specific recommendations in each of the seven service categories. In addition, eight special target groups that are susceptible to mental health problems were identified in Building Community Support For People. The special target groups are: 1) the

chronically mentally ill, 2) native population, 3) youth, 4) those with dual diagnosis, 5) cultural groupings, 6) the elderly, 7) women, 8) the mentally-ill within the correctional system. The authors of the report also noted that these groups tend to be disadvantaged in terms of obtaining the services they need. For the most part these groups are similar to groups identified as being underserved by the participants in this study.

The chronically mentally ill are frequently identified as being in need of enhanced services (Waterloo District Health Council, 1986); PCMHC, 1988). One report which examined the needs of those with ongoing mental health problems from a national perspective is Chronic Mental Disorders in Canada (Health and Welfare Canada, 1982). As with the participants in this study, those with chronic mental health problems were identified as being in need of an improved standard of living, improved accommodation, access to social and recreational services, and better support networks in the community. Furthermore, both studies addressed the issues of stigma as experienced by those with ongoing mental health problems. Additionally, both studies identified the fact that those with chronic psychiatric problems often thought that they were over-medicated. Both studies emphasized the importance of public and professional education. They recognized the importance of strong supportive networks in the community for those with ongoing mental health problems. As with this report the Health and Welfare Canada (1982) recognized the importance of involving the consumer in planning services and assisting them in becoming more independent through the use of self-help and support groups. Furthermore, the authors of Chronic

Mental Disorders in Canada recommended that more research be implemented on the needs of those with chronic mental health problems in rural communities and that consumers, families, and friends be consulted in the research process. The importance of being employed to those with chronic mental health problems has also been documented (Canadian mental Health Association [CMHA], 1984; CMHA, 1983). Similarly, the authors of the Waterloo District Health Council study and Chronic Mental Disorders in Canada support the need for improved employment opportunities for those with ongoing mental health problems. While data obtained in this study identified the need for those with chronic psychiatric problems to have a greater income, they did not emphasize the importance of employment. As stated previously, the reason for this may be that, in general those with chronic mental health problems recognize that many other people who are more capable of working are unable to secure jobs in industrial Cape Breton. Given the numbers of people in the Industrial Area who subsist on unemployment insurance and social assistance payments, such sources of income are more socially acceptable than they are in central Canada. As in other areas of Canada, those with chronic mental health problems in the Industrial Area continue to have below average incomes (CMHA, 1984; CMHA, 1983) which limits them in the range of services they may take advantage of and in the quality of life they experience.

Youth or the child/adolescent population are regularly identified as being a group which is underserved by the existing mental health services (PCMHC, 1988; Waterloo District Health Council, 1986; Michel, 1990). In the present study it was emphasized that youth were the group most in need of services. As with other mental health needs studies (e.g.,

Waterloo District Health Council, 1986) they were identified as requiring a variety of services. In the present study, as with the other reports (PCMHC, 1988; Waterloo District Health Council, 1986) a major concern is severely disturbed youth. With a lack of available staff and interventions what initially appear to be mild problems in young children often intensify into behaviors which become increasingly difficult to manage. Youth in this study were identified as requiring more and augmented assessment and treatment services. As in the other studies (PCMHC, 1988; Waterloo District Health Council), there was an emphasis on making services more available in the community and offering them in alternate settings. Depending upon age, it was suggested that services be offered in the home and/or school. As was noted elsewhere (Waterloo District Health Council, 1986; PCMHC, 1988), as the number of youth not living at home increases, the need for alternate accommodation becomes more important. Although treatment services was identified as a need, other prevention programs/services were also perceived as necessary. The importance of strengthening the family unit was noted in this needs assessment as it was in other studies ((Waterloo District Health Council, 1986; PCMHC, 1988). The youth, themselves, emphasized the importance of having educational and social/recreational programs. For those not in school and/or unemployed, life can have little meaning. The need for public education programs in the schools was strongly emphasized. The importance of offering academic upgrading and vocational training programs to the older youth was stressed. However, as the CMHA (1984) notes youth are becoming increasingly disinterested in learning as they recognize that future job opportunities are scarce (p. 11). This is

particularly true in the Industrial Area where both the number of youth over the age of 16 with less than grade 10 education and the unemployment rate are above both the provincial and national average. It has been noted (Ross, 1977 cited in CMHA, 1983) that school leaving combined with unemployment are highly related to drug abuse and suicide. As well, the CMHA (1983) also notes that unemployed youth are likely to have lower self-esteem than their peers who are employed or attending school, blame themselves, experience depression, and express a variety of psychological fears.

The native population is another group which was identified as being underserved by the participants in this study. Various mental health problems of native Indians have also been documented (Bennett, 1982; PCMHC, 1988) and include a suicide rate which is four times the Canadian average, major problems with family violence and alcoholism, and difficulty in adapting to a changing culture. Bennett (1982) attributes many of these problems to two basic issues: 1) power-loss and cultural identity, and 2) power-loss and the economy. Essentially, Bennett's argument is that native Indians lose or become confused about their identity both as individuals and as a culture. In addition to being absorbed and influenced by the ambient white anglo-saxon culture, their traditional values and social and economic structure have been altered radically. The resultant standard of living which natives experience is considerably below that of the white culture. Bennett discusses ways in which those concerned with the mental health problems of native Indians can help the natives to gain more control over their lives and thus regain some of their lost power. He suggests that a mental health

professional can act as a consultant/facilitator training paraprofessionals, helping to establish self-help groups, and building networks to share solutions as well as problems. The authors of the Building Community Support For People note that "all areas surveyed expressed concern about providing mental health services which are culturally relevant to their Native populations" (p. 21). The data obtained from the Micmacs in this study suggested both a desire to liaise with non-Native agencies and organizations and to establish programs which stimulate and support the Micmac culture. Furthermore, they expressed a desire for ongoing workshops to process problems, the use of volunteers to work with youth, and the need for job training. To a considerable degree the Micmacs have services which are culturally relevant as they are staffed by Micmacs. Two agencies which are designed specifically for and serve Micmacs are Micmac Family and Children's Services and the Native Alcohol And Drug Counselling Association. In addition to these agencies, the Micmacs receive funds for community development projects. However, in spite of the efforts directed at improving economic conditions on the reserves the Micmacs, like other Native groups in Canada, continue to a have lower per capita and family income than non-Native people living in the Industrial Area (Statistics Canada, 1986).

The elderly or senior citizens were also identified by both the authors of Building Community Support For People and the participants in this study as being a group that is underserved by the existing services. Statistics Canada (1981) reported that 10.1 percent of the population of Canada was over the age of 65. The percentage of those

over the age of 65 living in the Industrial Area is higher than both the provincial and national average. "The percentage of those over the age of 65 will increase in the decades to come. With it, will be an increase in mental disorders in the elderly" (The Provincial Community Mental Health Committee, 1988, p. 24). In one study (Niagara District Health Council, 1985 cited in The Provincial Community Mental Health Committee, 1988), it was stated that "20 to 30 percent of the elderly suffer from some type of mental disorder" (p. 24). The report stressed the need for community and family support services, as well as alternatives to institutionalization, education for mental health professionals and physicians, and readily available psychiatric consultations. The findings of the present study documented the extreme shortage of services for the elderly, particularly those with mental health problems, in the Industrial Area. While there was an expressed need for more institutional beds there was an equally strong perceived need for community-based services, including in-home assessment, support and treatment services. A shortage of trained specialists was also noted. As with other studies (Niagara District Health Council, 1985 cited in The Provincial Community Mental Health Committee, 1988), those surveyed in the present study expressed concern with the misuse of over-the-counter and prescription drugs. The participants also recognized the need for better coordinated services, consultation and collaboration with family members, and the need of education for physicians and mental health professionals. In addition to the above needs it has been documented that the elderly experience reduced levels of economic security and that, as they retire, their dignity as contributing members of the community

may be reduced (CMHA, 1983). As with the poor in other groups, poverty serves to decrease their mobility and access to services and may be responsible for a myriad of mental health related problems (CMHA, 1984).

One final group which was identified as a group being underserved by the existing mental health services is women. Although women were identified as being underserved in the Building Community Support for People report, the needs of women have frequently been ignored in mental health studies (CMHA, 1987). However, there is evidence that the majority of those using mental health services are women (CMHA, 1987; The Provincial Community Mental Health Committee, 1988). Additionally, there appears to be a consensus that women experience more anxiety and depression than males (CMHA, 1987). These facts are not surprising, given that women are more often single parents; they more often have poorer accommodation; they are more often victims of violence; they are more often dissatisfied with their living conditions, and they have lower per capita incomes than men. In light of the women's need for support, it is perhaps notable that women report that services are neither accessible nor responsive (The Provincial Community Mental Health Committee, 1988). Women report a variety of barriers to obtaining appropriate services including the fact that the mental health field is dominated with men which reflects the male-female power differential; that women may be viewed as "sex-objects"; that there is a sex-bias in diagnosis; that services simply don't exist; that they are often the primary caregiver to their children; and that because women often have a lower standard of living they are less mobile and less able to get to services. In this study women were identified as being underserved in a

number of ways including as single parents; as being in need of second stage housing; as victims of violence and abuse; as primary care-givers; as abusers of alcohol; and as those in need of an improved standard of living. As well as the needs voiced by some of the women in this needs assessment the authors of Women and Mental Health in Canada: Strategies for Change (CMHA, 1987) including the need for more services such as day care, the need for more therapists with a feminist orientation, and the need for increased educational opportunities. As well, many of the issues identified by the authors of Women and Mental Health in Canada relating to income, labour force participation, education and training and family structure are equally true for those living in the Industrial Area. Women tend to work in jobs that are unskilled and semi-skilled, low paying, non-unionized, part-time, and often insecure.

In the Industrial Area there have been a variety of programs and services established for women including specific academic upgrading and retraining programs for single mothers, a variety of self-help and support groups including those for victims of violence and abuse, and a "safe" house for those seeking refuge from abusive relationships. Additionally, there is local involvement with the Women's Health Education Network (WHEN) and the National Action Committee on the Status of Women (NAC). As a researcher/consultant who lived in the industrial area of Cape Breton for over 10 years, I am aware of a heightened consciousness of women's issues among certain factions of the community. However, many Cape Bretoners tend to hold on to established values fostered by strong religious and cultural traditions. The idea of the male steel worker, fisherman, or woodsman being the primary breadwinner

is still widely accepted in Cape Breton. Historically, roles for males and females were more clearly defined than is presently the case. While the authors of Women and Mental Health in Canada point out that women are moving into what were male-dominated professions, for the most part "women continue to be over-represented among the economically disadvantaged" (CMHA, 1987, p. 87). For those women who chose to stay in the industrial area, given the poor economy and the high employment rate the opportunities for them to secure any type of employment remains extremely limited.

Numerous recommendations are offered in Women and Mental Health in Canada to help improve women's general status in society and thus help improve their mental health. Many of the recommendations dealing with improving women's mental health refer to the need for more research on women's issues, that is, the collection of accurate information relating to women's mental health needs and the dissemination of such information to groups such as mental health professionals. As "women in rural areas represent a particularly underserved group" (CMHA, 1987, p. 99), there is a need for increased funding for research and services. The authors of the report note the importance of women being active participants at all levels and stages in developing mental health programs. Furthermore, it was noted that mental health programs should avoid exploiting the voluntary nature of women's work. Although the job of consciousness raising continues, such education in itself does little to improve the condition of women in the Industrial Area. While more needs to be done to improve the responsiveness and availability of mental health services it would seem that significant improvements in women's well-being can

only be achieved if there are general gains in the status of women in education, employment and representation in decision-making roles.

There are a number of common themes which run through the data relating to the above groups. Notable are the barriers to services including the fact that services may be unavailable, inappropriate, and inaccessible. However, perhaps one of the most striking themes that arises from the above discussion is the economic oppression that all of the identified underserved groups experience. In this study the participants identified the high rates of unemployment and the poor economy as being the main features of the community which contribute to the mental health problems of the residents. Clearly, economic conditions affect us all and can play a critical role in both our physical and mental health. As the authors of Unemployment: Its Impact on Body and Soul (CMHA, 1987) note, the inability to find work, being laid off, and unusually high rates of unemployment can have far reaching effects on society including one's mental health. It has been documented (CMHA, 1983; CMHA, 1984; Cahill, 1983) that all of the groups noted above are more seriously affected than other sectors of society by downturns in the economy and rising unemployment rates. Women, Natives and those with chronic psychiatric problems historically have had higher rates of unemployment and lower per capita incomes than other sectors of society. With the elderly, often their level of economic security decreases along with their dignity as valued contributing members of the community. While youth in some regions of the country are able to find employment they are much more dissatisfied with their current jobs than older employees (CMHA, 1984). Given that many young workers can only find low-

paying, unstable, part-time jobs with little chance for advancement, it is little wonder that they are becoming increasingly frustrated and disillusioned. The realization that future satisfying job opportunities are scarce is leading youth to become increasingly disinterested in learning (Burke, 1984 cited in CMHA, 1984). In Unemployment: Its Impact on Body and Soul the impact and deleterious effects that unemployment can have on one's mental health was documented. It was noted (CMHA, 1983) that unemployment affects the basic family unit leading directly or indirectly to increases in family violence and to marital breakups. Rising unemployment has been linked to an increase in child abuse. Having the primary breadwinner in a family unemployed has also been associated with children experiencing problems in school. Additionally, numerous other negative effects of unemployment and poverty on a person's physical and emotional health, including self-deprecation, depression, anxiety, suicide, divorce, alcoholism, more mental hospital admissions, and inadequate nutrition and housing have been documented (CMHA, 1983).

It seems apparent that if there is to be a decrease in the likelihood of these groups experiencing mental health problems then their economic and social position in society must be improved considerably. If we are serious about trying to promote mental health on a large scale we must utilize a social action approach which recognizes that the unequal distribution of power and wealth in society creates stresses and health problems for the poor, minority groups and women in our society (Ratcliffe cited in Pancer & Nelson, 1990). The social action approach to the promotion of mental health involves consciousness raising among both professionals and the public about the relationship between

socioeconomic conditions and mental health. Further advancement in community mental health promotion requires political and economic change, as well as individual and community change. While individual, organizational and community interventions are important, given the effect that the economy can have on people's mental health an intervention may be required at the social policy level since the larger economic factors may be more powerful than the coping mechanisms of some of the demographic subgroups (Cahill, 1983). This does not mean that those involved in the delivery of mental health services need to become experts in economics or social policy. However, they do need to become knowledgeable of such factors. The role of structural economic variables in creating stress represents a significant challenge for those involved in the delivery of mental health services who have an integrated view of primary prevention. In pursuing the goals of a healthy society the structural economic issues must be explored.

CONCLUSIONS

The present study was grounded in the values of community psychology, particularly the belief in a collaborative approach to community research, the need to include all stakeholders, and the ecological perspective or the understanding that there should be a congruence between one's personal needs and the environment. As a researcher and consultant I have attempted to be sensitive to the diverse rural and urban populations, the needs of the groups identified as being underserved and the limited resources within the community.

A convergent analysis approach was used to complete a comprehensive mental health needs assessment of the industrial region of Cape Breton Island. The major concerns highlighted by the study are improved coordination of services, an emphasis on an outreach and community-based orientation in the delivery of mental health services and augmented human resources. Youth and the psychogeriatric population were identified as groups who are in particular need of enhanced mental health services. The importance of working with these groups as part of the family unit is recognized. Furthermore, those with chronic psychiatric problems, members of the Micmac community, and women, are identified as being underserved by the existing mental health service delivery system.

Many of the findings of this study verify those of other recent assessments of community need including the need for more services which are accessible, the need for follow-up services for those who have been released from hospital, enhanced crisis intervention services, the use of self-help groups to assist people to gain increased independence, improved and augmented housing and social/recreational programs, enhanced

education programs to provide information on mental health issues, and perhaps, most importantly, the need for the improved planning and coordination of services.

The major contributions of this study are: the assembly of a data base of mental health and related services for the Industrial Area; a comprehensive assessment of mental health needs which includes the perspectives of numerous stakeholder groups, the identification of groups targeted as being undeserved by the existing services; the confirmation and validation of findings of other recent assessments of need; and the production of a document which can be used by those with a vested interest in the mental health care system for planning the delivery of mental health services.

This report should provide some food for thought for those who are responsible for the delivery of mental health services as it advocates an examination of the manner in which services are presently being provided. While recognizing the need to maintain some of the traditional modes of service provision, those concerned with the mental health of the residents must seriously consider a shift in the provision of services which emphasize treatment to a system in which the competency and well being of individuals is promoted; a system that attempts to deal with the onset and exacerbation of problems; and a system in which an effort is made to eliminate disempowering social conditions. To a considerable extent these goals may be accomplished by improving the fit between people and their environment.

The above points are emphasized in the recommendations offered in this report. An attempt to improve the person-environment fit is

suggested through the improved access to services via smaller, decentralized, and "user-friendly" clinics, the offering of services in the home and in schools, and through the utilization of existing services and resources including self-help groups and the use of trained volunteers. Offering services on the residents' own turf, the facilitation of social networks, and an emphasis on education should assist individuals in becoming empowered. Suggestions for how coordinated and integrated services might be delivered to the various communities throughout the Industrial Area include the Center local de services communautaires (CLSC) model which is used in the province of Quebec or the District Health Council (DHC) model used in Ontario. Both of these models are made up of concerned citizens who volunteer their time and expertise and are based on the belief that the people who live and work in a community are best able to determine their health needs. In the case of the CLSC, the centers offer not only basic health and social services but also preventative and community action services.

It is hoped that a shift in orientation to prevention can be accomplished through the identification of underserved groups and the implementation of education programs both directed to such groups and the community at large. A specific example of how those concerned with the delivery of mental health services in the Industrial Area might address the issue of primary prevention from a long range perspective is the "Better Beginnings, Better Futures" project. This is a longitudinal research demonstration project being launched by the Ministry of Community and Social Services in Ontario which will examine factors which prevent social, emotional, behavioral, physical and educational problems

in children.

The present study also touched, briefly, on the importance of addressing such major environmental factors as the massive unemployment and the poor economy of the Industrial Area. It is more than evident to those who live in this area the toll that such factors take and the numerous efforts that have been made to strengthen the economy. However, it seems apparent that, until there is a paradigm shift from services offering primarily treatment to an emphasis on primary prevention, community economic development, and social action, providing more or augmenting services regardless of their community thrust will not eliminate the essential elements that contribute to the mental health problems of the residents. It is hoped that one of the major and overarching recommendations of this report, that is, the development of a community-wide organization to provide coordination and planning for mental health programs and services, will be implemented and that this body will be used as a vehicle to explore the root causes of mental health problems and consider innovative ways to deal with these problems.

REFERENCES

Bell, R.A., Warheit, G.J., & Schwab, J.J. (1976). Need assessment: A strategy for structuring change. In R.D. Coursey, G.A. Specter, S.A. Murrell, & B. Hunt (Eds.), Program evaluation for mental health: Methods, strategies, participants (pp. 67-76). New York: Grune and Stratton.

Bell, R.A., Nguyen, T.D., Warheit, G.H., & Buhl, J.M. (1978). Service utilization, social indicator, and citizen survey approaches to human service needs assessment. In C.C. Attkisson, W.A.Hargreaves, M.J. Horowitz, & J.E. Sorensen (Eds.), Evaluation of human service programs (pp.253-300). New York: Academic Press.

Bennett, E. (1982). Native persons: an assessment of their relationship to the dominant culture and challenges for change. Canadian Journal of Community Mental Health, 1(2), 21-32.

Bill, A.Z., (1970). Social clubs help prevent readmission. Hospital and Community Psychiatry, 21, 1023-1028.

Bloom, B.L. (1977). The assessment of community structure and community needs. In B.L. Bloom (Ed.), Community mental health: A general introduction (pp.173-205). California: Brooks/Cole.

Budson, R.D., & Jolley, R.E. (1978). A crucial factor in community program success: The extended psychosocial kinship system. Schizophrenia Bulletin, 4, 609-621.

Cahill, J. (1983). Structural characteristics of the macroeconomy and mental health: Implications for primary prevention research. American Journal of Community Psychology, 11(5), 1983.

Campbell, D. (1974). Qualitative knowing in social action research. Presented at the 1974 annual meeting of the American Psychological Association, New Orleans.

Canadian Mental Health Association. (1984). A framework of support for people with severe mental disabilities. Toronto, Ontario, Canada: CMHA.

Canadian Mental Health Association. Mental health is costly. Mental health is priceless. Toronto: CMHA.

Canadian Mental Health Association, Nova Scotia Division. (1989). Speaking out about mental health: A needs assessment. Halifax, Nova Scotia, Canada: CMHA.

Canadian Mental Health Association. (1983). Unemployment: Its impact on body and soul. Toronto, Ontario, Canada: CMHA.

Canadian Mental Health Association. (1979). What is mental health? Toronto, Ontario, Canada: CMHA.

Canadian Mental Health Association. (1987). Women and mental health in canada: strategies for change. Toronto, Ontario, Canada: CMHA.

Canadian Mental Health Association. (1984). Work and well-being: The changing realities of employment. Toronto, Ontario, Canada: CMHA.

Cape Breton Hospital. (1988). Submission of the Cape Breton Hospital to Nova Scotia Royal Commission on Health Care. Unpublished paper.

Cohen, D. B. (1982). Mental health service provision in Ontario - A conceptual and definitional framework. Oshawa, Ontario: Durham Region District Health Council.

Collier, G., McMillin, J. & Paufler, R. (1982). The psychological impact of unemployment. Unpublished manuscript.

Crocker, P.J., & George, M.S. (1985). Participation and utilization: Assessing the skills and training needs of the chronically mentally ill. Canadian Journal of Community Mental Health, 4, 73-82.

D'arcy, C. (1986). Unemployment and health: Data and implications. Canadian Journal of Public Health, 77 (Supp. 1, May-June), 124-131.

Delbecq, A.L., & Van de Ven, A.H. (1971). A group process model for problem identification and program planning. Journal of Applied Behavioral Science, 7, 466-492.

Dubey, S.N. (1970). Community action programs and citizen participation: Issues and confusions. Social Work, 15, 76-84.

Fisher, R.J. (1982). Social psychology: An applied approach (pp. 86-113). New York: St. Martin's Press.

Fuchs, D., & Bracken, D. (1984). Self-help network and community-based diversion. Canadian Journal of Criminology, 26(2), 343-353.

Goering, P. & Rogers, J. (1986). A model for planning interagency coordination. Canada's Mental Health, 34, 5-8.

Goldenberg, I. (1978). Oppression and social intervention. Chicago: Nelson-Hall.

Health and Welfare Canada. (1982). Chronic mental disorders in Canada. Ottawa, Ontario, Canada: Health and Welfare Canada.

Health and Welfare Canada. (1988). Mental health for Canadians: Striking a balance. Ottawa, Ontario, Canada: Minister of Supply and Services Canada.

Heller, K., Price, R., Reinharz, S., Riger, S., & Wandersman, A. (1984). Psychology and community change: Challenges of the future (2nd ed.). Chicago: Dorsey Press.

Heseltine, G.F. (1982). A discussion document - Blueprint for change: The next ten years (Interim Report). Toronto: Ontario Ministry of Health.

Heseltine, G.F. (1983). Towards a blueprint for change: Mental health policy and program perspective - Discussion paper. Toronto: Ontario Ministry of Health.

Heymen, S.R. (1983). Problems in program development and the development of alternatives. In A.W. Childs, & G.B. Melton (Eds.), Rural psychology, (pp. 233-275). New York: Plenum Press.

Hodgson, S. (1984). Efficient and effective human services: Some assumptions about why and how to involve community residents. Canadian Journal of Community Mental Health, 1, 27-38.

Krueger, R.A., (1988). Focus groups: A practical guide for applied research. California: Sage.

Lavigne, P.M. (1987). A report on the Cape Breton risk factor. Halifax: Nova Scotia Department of Health.

Lincoln, Y.S, & Guba, E.G. (1985). Naturalistic inquiry. California: Sage.

Marti-Costa, S., & Serrano-Garcia, I. (1983). Needs assessment and community development: An ideological perspective. Strategies for needs assessment in prevention (pp. 75-88). Harworth Press.

Michael, S. (1990). Proposed mental health services for the Sir Thomas Roddick Hospital. Stephenville, Newfoundland, Canada: Sir Thomas Roddick Hospital.

Miles, M., & Huberman, A. (1984). Qualitative data analysis: A source book of new methods. Beverly Hills: Sage.

Milord, J.T. (1976). Human service needs assessment: Three non-epidemiological approaches. Canadian Psychological Review, 17(4), 260-269.

Miller, F.T. (1981). Mental health center versus community perceptions of mental health services. Journal of Community Psychology, 9, 204-209.

Ministry of Health Planning Division. District health councils: partners in health planning. Toronto, Ontario, Canada: Ministry of Health.

Morrell, T.L. (1988). Towards the development of a resource center for individuals with anorexia nervosa and/or bulimia: A needs/resources assessment, professional network and program planning process. Unpublished master's thesis, Wilfrid Laurier University, Waterloo, Ontario, Canada.

Myrdal, G. (1969). Objectivity in social research. New York: Random House/Pantheon.

Neuber, K.A. (1980). Needs assessment: A model for community planning. Beverly Hills: Sage.

Nguyen, T.D., Attkisson, C.C., & Bottino, M.J. (1983). The definition and identification of human service needs in a community. In R.A. Bell, M. Sundel, J.F. Aponte, S.A. Murrell, & E. Lin (Eds.), Assessing health and human service needs: Concepts, methods and applications (pp.88-110). New York: Human Sciences.

Nova Scotia Commission on Drug Dependency. (1985-1989). Report of the Nova Scotia commission on drug dependency. Halifax, Nova Scotia: Nova Scotia Commission on Drug Dependency.

Nuefeldt, A.H. (1983). Searching for new directions in mental health services....for new times. Canada's Mental Health, December, 20-24.

Officials Committee of Industrial Cape Breton. (1989). Executive summary: Report of the officials committee of industrial Cape Breton-Services for the mentally handicapped and mentally disabled. Sydney, Nova Scotia, Canada: Officials Committee.

Ontario Prevention Clearinghouse. (1990). Better Beginnings Better Futures. Toronto, Ontario, Canada: Ministry of Community and Social Services, Ministry of Education, & Ministry of Health.

Pancer, M.S., & Nelson, G. (1990). Community-based approaches to health promotion: Guidelines for community mobilization. International Quarterly of Community Health Education, 10, 91-111.

Patton, M. Q. (1980). Qualitative evaluation methods. California: Sage.

Posavac, E.J., & Carey, R.G. (1985). Program evaluation: Methods and case studies (3rd ed.). New Jersey: Prentice Hall.

Price, R.H., & Cherniss, C.T. (1977). Training for a new profession: Research as social action. Professional Psychology, 8, 222-231.

Quebec Federation of CLSC. There is a CLSC in the neighbourhood. Quebec, Quebec, Canada: Department of Social Affairs.

Rappaport, J. (1977). Community psychology: Values, research, and action. New York: Holt, Rinehart and Winston.

Reiff, R. (1974). The control of knowledge: The power of the helping professions. Journal of Applied Behavioral Science, 10, 451-461.

Rickel, A., Gerrard, M., & Iscoe, I. (Eds.), (1984). Social and psychological problems of women: Prevention and crisis intervention. Washington: Harper & Row/Hemisphere.

Robin, S. (1965). A procedure for securing returns to mail questionnaires. Sociology and Social Research. 50, 24-35.

Rossi, P.H., Freeman, H.E., & Wright, S.R. (1979). Evaluation: A systematic approach. California: Sage.

Rothman, J. (1978). Conversion and design in the research utilization process. Journal of Social Service Research. 2, 117-131.

Royce, O., Drude, K. (1982). Mental health needs assessment: Beware of false promises. Community Mental Health Journal. 18, 97-105.

Ryan, W. (1971). Blaming the victim. New York: Random House.

Sarason, S.B. (1974). The psychological sense of community. San Francisco: Josey-Bass.

Schoenfeld, J., Halevy, J., Hemley-Vander Velden, E. (1986). Long-term outcome of network therapy. Hospital and Community Psychiatry, 37, 373-376.

Siegel, L.M., Attkisson, C.C., & Carson, L.G. (1978). Need identification and program planning in the community context. In C.C. Attkisson, W.A. Hargreaves, M.H. Horowitz, & J.E. Sorensen (Eds.) Evaluation of human service programs (pp. 215-251). New York: Academic Press.

Statistics Canada. (1986). Nova Scotia part 1. CA1SC86, 94-106.

Statistics Canada. (1986). Nova Scotia part 2. CA1SC86, 94-106.

Statistics Canada. (1989). Labour force annual averages.

Stefel, M.E., & Prosperi, D.C. (1985). Barriers to mental health service utilization. Community Mental Health Journal, 21, 167-168.

Stewart, R., (1979). The nature of needs assessment in community mental health. Community Mental Health Journal, 15 (4), 287-295.

The Nova Scotia Royal Commission on Health Care. (1989). The report of the Nova Scotia Royal Commission on Health Care: Towards a new strategy. Halifax, Nova Scotia, Canada: Royal Commission.

The Provincial Community Mental Health Committee. (1988). Building community support for people: A plan for mental health in Ontario. Toronto, Ontario, Canada: Ministry of Health.

Walsh, R.T. (1987). The evolution of the research relationship in community psychology. American Journal of Community Psychology, 15, 773-778.

Walsh, R.T. (1988). The dark side of te moon: Iatrogenic aspects of professional psychology. Journal of Community Psychology, 16, 296-305.

Warheit, G.L., Bell, R.A., & Schwab, J.J. (1977). Needs assessment approaches: Concepts and methods. Washington, D.C.: U.S. Government Printing Office.

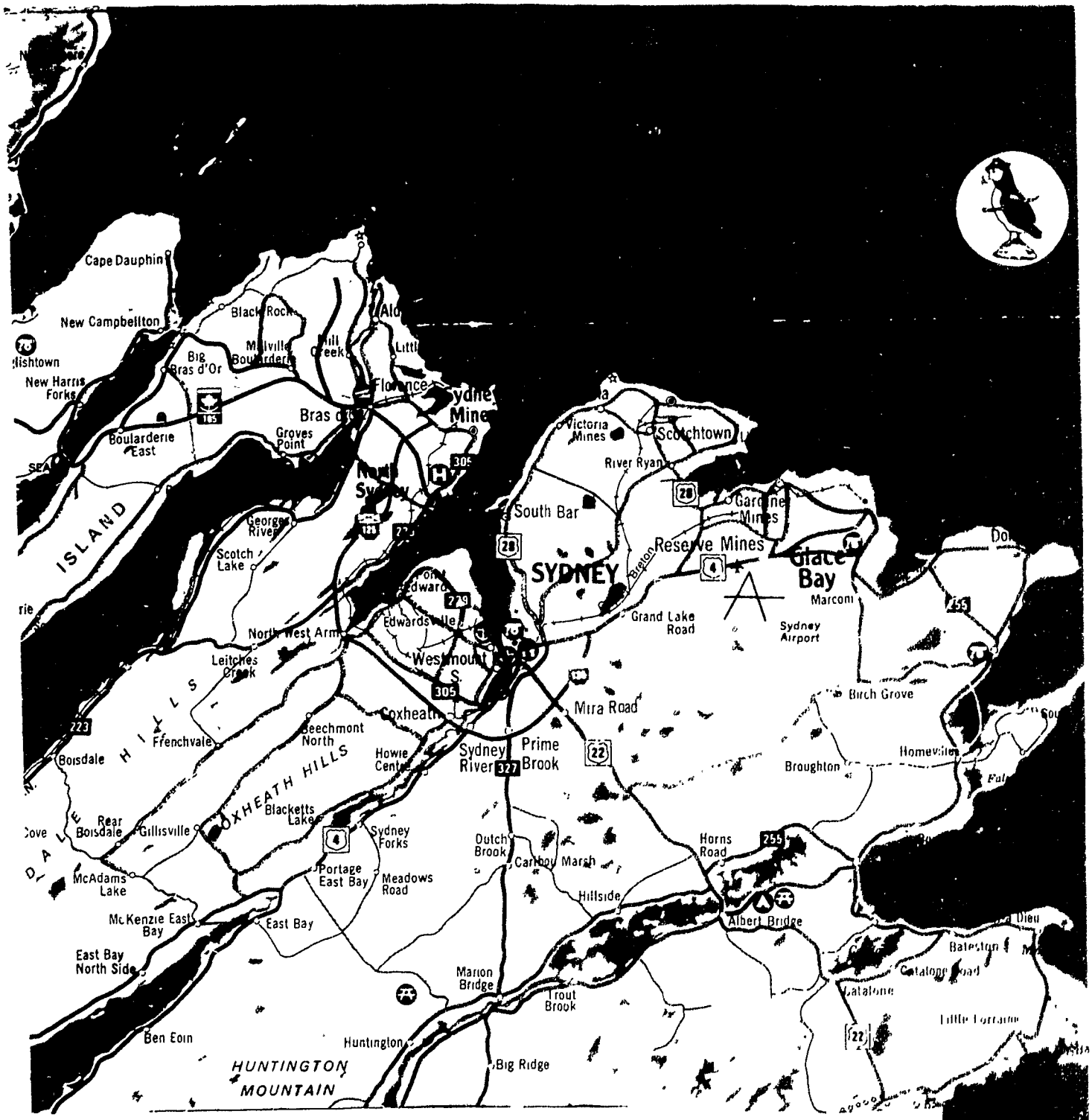
Waterloo Region District Health Council. (1986). Towards health in the Waterloo region: Mental health needs assessment study. Waterloo, Ontario, Canada: Waterloo Region District Health Council.

Watzlawick, P., Wealland, J., & Fisch, R. (1979). Change: Principles of problem formation and problem resolution (pp. 92-109). New York: W.W. Norton & Co.

Wasylenki, D., Goering, P., Humphrey, B., Martin, B., & Glasser, F. (1989). Components of care for patients with schizophrenia. Psychiatric Journal of the University of Ottawa, 14(1),287-295.

Zautra, A., & Bachrach, K. (1983). Strategies for needs assessment in planning. Harworth Press.

APPENDIX A



LEGEND

One inch equals approx 4.5 miles or 7.25 kilometres

miles 5 4 3 2 1 0 5 10 miles

kilometres 5 4 3 2 1 0 5 10 15 kilometres

- Main paved highway
- Other paved and high standard gravel road
- Local roads
- Railroad
- Ferry(Fy)
- Historic Site and Museum
- Significant Beach
- Government Campground
- Government Picnic Site
- Yacht Club
- Launch Ramp
- Hospital
- Lock
- Ferry
- Airport
- Lighthouse
- City
- Town
- Village
- Community

Produced by ALLMAPS CANADA Limited Markham Canada for CAPE BRETON DEVELOPMENT CORPORATION

Appendix - B

Media and Publicity Information

Appendix B-1

Promotion Schedule - Needs Assessment Project -Jim Ross

July 1989: Initial meeting to plan publicity schedule and media strategies

August 1989: Meeting to determine timetable for public service announcements (PSA) and feature stories

August 1989: Interview for News & Views article and public forum schedule

September 1989: News & Views article appears

September 1989: General news release is written, approved and sent to all local media

September 1989: Interview for feature story in weekly paper - Cape Breton County Monitor

October 1989: Interview on CBC, Sydney TV, evening news report, Oct. 2, 1989

October 1989: Public service announcements regarding the community forums are aired daily on radio and TV and in the Cape Breton Post through December 20

October 1989: Cape Breton Post interview. Story appears on October 27, 1989

November 1989: Interview on CJCB radio Talkback program, Nov. 2,1989

November 1989: Poster appears in Northside/Harbourview Hospital's monthly newsletter Pulse

November 1989: PSA's containing poster information are mailed to all all media outlets

APPENDIX B-2: General News Release

September 25,1989

ASSESSING THE MENTAL HEALTH NEEDS OF CAPE BRETON

The Cape Breton Branch of the Canadian Mental Health Association wants to determine the mental health needs of the local population. In an effort to create a long range service plan , the Association has enlisted the services of former board member , Jim Ross who will conduct a Mental Health Needs Assessment as part of his Masters Thesis in Social Community Psychology.

Ross began collecting data in September , following months of preliminary work with Mental Health/Cape Breton . The assessment will be done through questionnaires , public forums and interviews to be conducted throughout the industrial area.

"We want to try to identify any gaps or needs within current mental health services ," Ross explains , " and to determine what the future priorities of the Association should be."

Needs Assessment Committee members will meet with Cape Bretoners from all walks of life over the next few months as they receive input from groups and individuals such as health care administrators , service providers , police , school officials and consumers . Following these sessions ,a planning document will be produced , with reccomendations for the future direction of mental health services in the area.

-30-

FOR MORE INFORMATION CONTACT:

Jim Ross /539-3370, local 171
Dr. Lowell Blood /539-3370, local 215

APPENDIX B-3: Newspaper Advertisement

MENTAL HEALTH

Have you ever been involved with mental health services in the Cape Breton Region as a user, family member, client supporter, or are you interested in providing input?

A Mental Health Needs Assessment is being conducted by the Cape Breton Mental Health Association. The Association would like information from service users, family members, advocates, and the general public on the needs of those with emotional or psychiatric problems.

If you have any concerns or suggestions about mental health services and would like to provide input, either in writing or by participating in an interview, please call the Mental Health Association between 8:30 a.m. and 4:30 p.m. Monday to Friday before December 22, 1989 at the number listed below:

539-3370 — EXT. 171

mental health cape breton

CANADIAN MENTAL HEALTH ASSOCIATION

APPENDIX B-[illegible]: Public Service Announcement

Cape Breton Hospital

P. O. BOX 515 PHONE 539-3370

SYDNEY, NOVA SCOTIA

B1P 6H4

October 30, 1989

MENTAL HEALTH SURVEY

Are You interested in providing input into mental health services in Cape Breton ? The Cape Breton Mental Health Association is currently conducting a Needs Assessment and welcomes your concerns or suggestions about local mental health services . To participate in this assessment, in writing or through an interview, call the Mental Health Association office at 539-3370, Ext.171 , before December 22nd.

APPENDIX B-5: General Poster

MENTAL HEALTH

Have you ever been involved with mental health services in the Cape Breton Region as a user, family member, client supporter, or are you interested in providing input?

A Mental Health Needs Assessment is being conducted by the Cape Breton Mental Health Association. The Association would like information from service users, family members, advocates, and the general public on the needs of those with emotional or psychiatric problems.

If you have any concerns or suggestions about mental health services and would like to provide input, please call the Mental Health Association between 8:30a.m.-4:30p.m. before November 30, 1989 at the number listed below.

539-3370 Ext. 171

mental health/cape breton
CANADIAN MENTAL HEALTH ASSOCIATION

MENTAL HEALTH

Have you ever been involved with mental health services in the Cape Breton Region as a user, family member, client supporter, or are you interested in providing input?

A Mental Health Needs Assessment is being conducted by the Cape Breton Mental Health Association. The Association would like information from service users, family members, advocates, and the general public on the needs of those with emotional or psychiatric problems.

If you have any concerns or suggestions about mental health services and would like to provide input,

you are invited to a community meeting at ;

Place:

Date:

Time:

If you wish further information, call -

539-3370 ext. 171

mental health cape breton
CANADIAN MENTAL HEALTH ASSOCIATION

Mental health needs project under way

The future of mental health care in Cape Breton could be determined by a project currently underway in the industrial area.

The Cape Breton Branch of the Canadian Mental Health Association wants to determine the health needs of the local population. In an effort to create a long-range service plan, the association has asked former board member Jim Ross to conduct a mental health needs assessment.

Ross, currently working on a Masters degree in Social Community Psychology at Wilfred Laurier University in Ontario, began collecting data in September, following months of preliminary work with the Cape Breton branch. The assessment will be done through questionnaires, public forums and interviews to be conducted throughout the industrial area.

After working for Social Services in Sydney for 10 years before returning to university last year, Ross is familiar with the area. He feels a project like this is a good, practical way to approach the situation.

"It seemed like a project worth doing," says Ross, when asked what made him decide to get involved. "There were related studies in the past, but we were looking at a broad-based sort of thing.

"What we wanted to get was a document that the association could use for planning. We wanted a list of mental health needs — a goal perspective of what the people involved in the services felt the gaps or needs were."

One of the aims of this assessment is to take a closer look at the preventative aspects of mental health. "This might mean such things as better housing or job security, rather than just needing more psychiatrists," says Ross. "We think it's important that we get all perspectives."

Eventually, Ross hopes that some of the information gathered can be put to specific uses. "One other thing we want to do later on is isolate some specific groups that we feel need special services — for instance, natives, women and adolescents — and do some interviews."

Though the original meeting to get things off the ground took place last winter, the culmination of all the effort will come sometime after Christmas.

"We hope to have our preliminary thoughts and and suggestions by February," he says. "When we come up with our preliminary list, we will conduct another community meeting and ask people to come and comment on our findings.

"This will give us a chance to double check what we've done."

Community-minded citizens can see that things get off on the right foot by participating in any one of a number of public forums set for the industial area over the next month or so.

In Sydney, a public forum is slated for the Steelworker's Hall on Prince Street, Oct. 10, at 7 p.m. Public forums are also scheduled for Glace Bay, Sydney Mines, New Waterford and North Sydney, but no dates have been set at this time.

cape breton HOSPITAL
Braemore Home Corp.

NEWS & VIEWS

September, 1989

ASSESSING THE MENTAL HEALTH NEEDS OF CAPE BRETON

It sounds like a very tall order. Assessing the current and future mental health needs of Cape Bretoners and preparing a long range plan for services. This is the task facing Jim Ross, former Mental Health Cape Breton/Board Member, now completing his Masters degree in Social Community Psychology at Sir Wilfred Laurier University in Waterloo, Ontario.

A familiar face at CBH during the summer of 89, Jim has just begun this mental health needs assessment with the help of a Mental Health/Cape Breton Committee. This is the topic of his master's thesis and will hopefully become the Mental Health Association's future planning document.

"It's a mutually beneficial arrangement," Jim explains, "after working with social services in Sydney for many years and working with the Mental Health Association, I went back to school and was aware that my program of study was in sync with their needs." Jim made a formal proposal to the association's board in April and the agreement was reached. He arrived in the area in June and began preliminary work, much of it here at CBH. It was decided the needs assessment will be broad-based, enabling the association to determine future needs and priorities.

Cape Breton Hospital is represented on the Needs Assessment Committee by Child & Adolescent Services Director, Dr. Lowell Blood and Social Worker, Jerome Aucoin. The group began collecting data this month. They hope to hear from a wide range of groups and individuals including administrators, service providers and front line workers, referral sources such as police, legal aid workers, etc., and of course the consumer.

This community input will be gathered using several methods. The committee will hold a series of public forums in the various communities of the industrial area this fall. Several types of questionnaires will also be distributed. "A major, very structured questionnaire will be distributed to health care administrators," Jim explains, "this will deal with data on current programs and services, and existing and future needs A second modified questionnaire will go to the direct service providers such as social workers, psychologiests, police and other referral sources. We'll ask basically the same questions on quality and availability of services and hopefully gain their prospective on the needs."

The third sector of the population this questionnaire is meant to reach will be dealt with on a more personal basis. "For the mental health consumer or client we must consider confidentiality," Jim notes, "we will offer the opportunity for anonymous telephone interviews or in-person if the individual desires." The interviews will be informal, allowing the consumer a chance to tell his story.

The data will then be analyzed to produce a master plan for Mental Health/Cape Breton. "The mental health board will have practical information to begin working with, in their hands by January," Jim says, "and the written document will be completed by spring."

In the meantime, there's much to be done. Anyone wishing to contribute to the Needs Assessment Survey can contact Jim here at CBH or participate in the public forums to be held throughout the area in the next few months.

Appendix C

Names and Addresses of Agencies/Organizations in the Industrial Area that provide Mental Health Services

Dean Donald Fewer,
Dean of Student Services,
University College of Cape Breton,
P.O. Box 5300,
Sydney, N.S.
B1P 6L2

Mr. Wayne Yorke,
Regional Coordinator,
Cape Breton Addiction Center,
P.O. Box 640,
Sydney, N.S.
B1R 6H7

Ms. Bea LeBlanc,
Administrator,
Transition House,
P.O. Box 487,
Sydney, N.S.
B1P 6H4

Dr. John Campbell, Ph.D.
Administrator,
Mental Health Center,
P.O. Box 399,
North Sydney, N.S.
B2A 3M4

Mr. Al MacLean, M.S.W.,
Administrator,
Mental Health Center,
300 South St.,
Glace Bay, N.S.
B1A 1K9

Dr. Lowell Blood, Ph.D.,
Administrator,
Child And Adolescent Services,
P.P. Box 515,
Sydney, N.S.
B1P 6H4

Ms. Thalia MacLellan,
Acting Supervisor,
Family Services,
48-50 Dorchester Street,
Sydney

Ms. Fran Tessier,
Family Services,
9 Minto Street,
Glace Bay, N.S.
B1A 5B2

Ms. Ilona McKenzie,
Family Services,
3390 Plummer Ave.,
New Waterford, N.S.
B1H 1Z1

Mr. Ray Musgrave:
Supervisor,
Northside Family Services,
18 King Street,
Sydney Mines, N.S.
B1V 1L8

Ms. Josephine Peck,
Supervisor,
Micmac Family & Children Services,
Eskasoni,
Cape Breton County, N.S.
B0A 1J0

Mr. Joseph Denny,
Native Alcohol & Drug Abuse
Counselling Association,
c/o General Deliveries,
Eskasoni, N.S.,
B0A 1J0

Mrs. Lee Easterly,
Director of Nursing,
Cape Breton Hospital,
P.O. Box 515,
Sydney, N.S.
B1P 6H4

Dr. Linda Courey, Ph.D.,
Unit Administrator
Day Center,
P.O. Box 515,
Sydney, N.S.,
B1P 6H4

Mr. Ashok Deshpande, O.T.,
Director of Occupational Therapy,
Cape Breton Hospital,
P.O. Box 515,
Sydney, N.S.
B1P 6H4

Ms. Marie MacAcadam,
Crisis Intervention Officer,
Sydney Community Health Center,
409 King's Road,
Sydney, N.S.,
B1S 1B4

Mrs. Catherine Schella,
Director - Social Work Dept.,
Glace Bay General Hospital,
300 South Street,
Glace Bay, N.S.,
B1A 1K9

Ms. Monica MacMillan,
Director - Social Work Dept.,
Glace Bay Community Hospital,
197 Main Street,
Glace Bay, N.S.
B1A 4Z8

Ms. Francis Butler, M.S.W.,
Director-Social Work Dept.,
Sydney Community Health Center,
409 King's Road,
Sydney, N.S.
B1S 1B4

Ms. Suzanne Merner,
Director - Social Work Dept.,
Sydney City Hospital,
50 Hospital Street,
Sydney, N.S.
B1P 2H8

Sr. Anne Aucoin, M.S.W.,
Director - Social Work Dept.,
New Waterford Consolidated
Hospital,
716 King Street,
New Waterford, N.S.
B1H 3Z5

Mr. Ian MacPherson,
Children's Aid Society,
Provincial Bldg.,
360 Prince Street,
Sydney, N.S.
B1P 5L1

Dr. John Gainer,
207 Alexandria St.,
Sydney, N.S.
B1S 2E8

Mr. Gordon Granchelli, M.S.W.,
Unit Administrator,
New Waterford Mental Health
Center,
P.O. Box 515,
Sydney, N.S.
B1P 6H4

Mr. Warren Zisserson, M.S.W.
440 George St.,
Sydney, N. S.
B1K 1K5

Sr. Phyllis O'Donnell, M.S.W.,
118 King's Road,
Sydney, N.S.
B1S 1A1

Dr. Arvind Kumar,
Medical Arts Bldg.,
336 Kings Road,
Sydney, N.S.
B1S 1B3

Mrs. Hildegarde O'Neill,
Children's Aid Society,
21 Sterling Rd.,
Glace Bay, N.S.
B1A 3X6

Ms. Sandra MacNeil,
Children's Aid Society,
Provincial Bldg.,
360 Prince St.,
Sydney, N.S.
B1P 5L1

Ms. Sharon Unsworth,
Medical Arts Bldg.,
2nd Floor, Suite 209,
36 Kings Rd.,
Sydney, N.S.
B1S 1B3

Lowell Mullins & Carolyn Toomey,
Northside Private Counselling
Service,
18 King St.,
Sydney Mines, N.S.
B1V 1L8

Mr. Gordon Granchelli, M.S.W.,
Unit Administrator,
Sydney Mental Health Center,
P.O. Box 515,
Sydney, N.S.
B1P 6H4

Dr. M. Mian,
Cape Breton Hospital,
P.O. Box 515,
Sydney, N. S.
B1P 6H4

Dr. A. K. Munshi,
207 Alexandria St.,
Sydney, N.S.
B1S 2E8

Dr. Paul Sheard,
98 Regent St.,
North Sydney, N.S.
B2A 2G5

Mr. Mike Walsh
Resi-Care
70 George St.,
Sydney, N.S.
B1P 1H7

Mr. Jim MacDougall,
Dept. of Community Services,
60 Prince St.,
Sydney, N.S.
B1P 5L1

Ms. Ann MacPhee,
Ann Terry Women's Outreach
Project,
P.O. Box 368,
436 George St.,
Sydney, N.S.
B1P 6H2

Mrs. Ann Shears,
Director,
Youth Resources Center,
571 Esplanade,
Sydney, N.S.
B1P 1B4

Mr. Terrance Crawley,
Center For Unemployment,
145 MacDonald Place,
Sydney, N.S.
B1N 2A1

Mrs. Pat Graham,
Project Coordinator,
Island Alternative Measures
Society,
P.O. Box 1769,
Sydney, N.S.

Mr. Cyril Connors,
N.S. Community College/AVTC
Campus, Cape Breton Region,
P.O. Box 1042,
Sydney, N.S.
B1P 6J7

Community Residence Program
Attention: Mr. John Woodford,
192 Charlotte St.,
Sydney, N.S.

Appendix C-1

List of Agencies and Organizations offering Mental Health Services in the Industrial Area

1 Resi-Care - 880 George St., Sydney
2 North Sydney Mental Health Center- North Sydney
3 Cape Breton Mental Health Day Center - Sydney River
4 Boys Residential Center - New Waterford
5 Sharon Unsworth: Private Counselling
6 New Waterford Consolidated Hospital (Social Work Department)
7 Family Service of Northside - Sydney Mines
8 Glace Bay General Hospital (Social Work Department)
9 Glace Bay Community Hospital - Glace Bay
10 Family Service Counselling Center of Sydney - Sydney
11 University College Cape Breton (Counselling Center)
12 Family Services New Waterford - New Waterford
13 Family Services of Eastern Nova Scotia - Glace Bay
14 Child and Adolescent Services Cape Breton Mental Health Center
15 Department of Community and Social Services (Vocational Rehabilitation Program)
16 Sydney City Hospital (Social Work Department) - Sydney
18 Glace Bay Mental Health Clinic - Glace Bay
19 Department of Community and Social Services (Single Parents Program)
20 Dr. J. Gainer
21 Mental Health Clinic - New Waterford
22 Children's Aid Society of Cape Breton - Sydney
23 Dr. A. Kumar - Sydney
24 Resi-Care Association, 70 George St.- Sydney
25 Community Residence Program*
26 Cape Breton Hospital - Sydney River
27 Sydney Hospitals Crisis Program - Sydney
28 Salvation Army Cape Breton Resource Center - Sydney
29 Mental Health Clinic - Sydney River
30 Children's Aid Society - Glace Bay
31 Ann Terry Outreach Project
32 Native Alcohol and Drug Association - Membertou
33 Sydney Community Health Center (Social Work Department)-Sydney
34 Child Welfare Service - Sydney
35 Children' Aid Society Northside Office - North Sydney
36 W. Zisserson Private Counselling and Consultation Services
37 Micmac Family and Children's Services - Eskasoni
38 N.S. Community College (AVTC)
39 Howard House Association of Cape Breton - Sydney
40 Cape Breton Hospital (Occupational Therapy Department)
41 Transition House - Sydney
42 Dr. A. Munshi - Sydney
43 North Sydney Private Counselling
44 N.S Commission on Drug Dependency
45 Dr. P. Sheard - Sydney

Appendix D

mental health/cape breton

CANADIAN MENTAL HEALTH ASSOCIATION

P.O. Box 515,
Sydney, N.S.
B1P 6H4
September 28, 1989

Dear

My name is Jim Ross and I am a graduate student in the Social-Community Psychology program at Wilfrid Laurier University (WLU) in Waterloo, Ontario. I am presently working on my thesis with the Mental Health Association of Cape Breton and Dr. Steve Chris, a faculty member in the Psychology Department at WLU. I am writing to you because I believe the project which we are conducting may be of some interest to you and you agency/organization.

The Cape Breton Branch of the Canadian Mental Health Association is sponsoring a needs assessment survey designed to make short and long-term recommendations for meeting the mental health needs in Industrial Cape Breton. The purpose of the assessment includes:

(1) Description of the present services provided in Cape Breton.

(2) Identification of service gaps.

(3) Issues of concern relating to mental fitness (e.g., access to service, quality of services.)

(4) Determining short and long-term priorities to meet identified needs.

The assessment will involve several stages and input will be sought from service providers, referring individuals and agencies, consumers and the general population. Service providers and referring professionals will be asked to either complete a questionnaire developed for this purpose, or to participate in an interview as a "key informant".

The purpose of the present letter is to inform individuals and agencies of the assessment and to solicit assistance in several areas. First, we are asking that you complete the enclosed questionnaire, which is designed to gather information regarding the services offered by your service or agency. Additionally, your opinions regarding the mental

health needs of Cape Breton are sought. Your participation in completing this questionnaire is, of course, voluntary and you may omit or refuse to answer any of the questions that you wish. It would be helpful if this questionnaire could be completed and returned by November 10, 1989.

Second, we have also enclosed a flyer, which we would ask you to post in a location visible to consumers of your service or agency. Finally, we will likely be contacting you or members of your staff over the next several months and asking for input through either an individual interview or one of several public forums scheduled to be held in the Industrial Area.

Thank you for your anticipated cooperation. In return for your participation we will provide you, at your request, with a copy of the results of the research. If you have any questions or comments, please feel free to contact Jim Ross at 539-3370, Ext. 171.

Sincerely,

Alexis MacQueen/MacDonald, M.S.W.
President, Mental Health/Cape Breton

Steve Chris, Ph.D.
Thesis Advisor

James Ross
Project Coordinator

/mw
Enclosure

Appendix E

Questionnaire used with Administrators of Services Providing Mental Health Services

Mental Health Services may be provided as a major or minor component of an organization's activities. In this survey, it is important that you describe only those services provided to identify and/or meet the mental health needs of your clients. Your participation in completing this questionnaire is, of course, voluntary and you may omit or refuse any of the questions that you wish.

SECTION 1: SERVICE/PROGRAM DESCRIPTION

1. Please describe the mental health services you provide according to the following criteria: (Use supplemental pages as needed if describing several individual programs.)

NAME OF ORGANIZATION/AGENCY: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON: _____

HOURS OF OPERATION: _____

SETTING: (check all that apply)

____ out-patient department ____ residential

____ day program ____ client's home

____ private professional setting ____ in-patient

____ other (specify): _____

STAFFING: number and qualifications/licensure of service deliverers, (e.g., M.D., M.S.W., R.N., Ph.D., B.A., B.S.W., L.P.N., C.CN.,volunteer)

_____

_____

_____

2. METHOD OF REFERRAL INTO PROGRAM/SERVICE:

_____ self _____ social service professional

_____ health professional _____ other

3. FUNDING/USER FEES: (e.g., Ministry of Health & Fitness, Community Services, United Way, specified user fees, other - please specify)

_____

_____

_____

_____

4. CRITERIA FOR ACCEPTANCE INTO PROGRAM: (e.g., age, sex, type of problems, prerequisites for treatment)

_____

_____

_____

_____

_____

5. SERVICES PROVIDED: (briefly describe - indicating areas of specialization, if any)

_____

_____

_____

_____

6. OTHER COMMENTS: (e.g., restrictions on duration of services)

_____

_____

_____

_____

7. What mental health problems (in terms of age, diagnosis, etc. (does your organization handle that are OUTSIDE it's terms of reference or mandate?

_____

_____

_____

8. A. What mental health services are you requested to provide but are UNABLE to provide? (If answer is "none" then go on to Question 9.)

_____

_____

_____

B. For which reason(s) are you unable to provide the services indicated in 8 A? (Indicate all that apply.)

____ insufficient funding
____ insufficient staffing
____ insufficient training
____ inadequate physical resources
____ more appropriate facilities are available elsewhere
____ other:

_____

_____

9. What associated mental health problems or concerns does your organization NOT ACCEPT?

_____

_____

_____

_____

10. Which of the following statements best describes your organizations's general operating capacity?

____ could handle a larger client load

____ have an appropriate client load

____ client load is too large

11. Approximately how many clients were seen for mental health services during the past year?

_____

12. Of these clients how many were?

0 - 12 years	_____	20 -64 years	_____
13 - 19 years	_____	65+ years	_____

SECTION 2: MENTAL HEALTH SERVICE UTILIZATION

13. For data provided in Question 11, what percentage of the total stated would represent NEW cases (as opposed to continuing cases?
_____ %

14. Estimate the percentage of clients requiring mental health services who reside in the following areas:

RESIDENCE OF CLIENTS	%
Sydney	_____
North Sydney	_____
Sydney Mines	_____
Glace Bay	_____
New Waterford	_____
Other (specify) _____	_____

15. Are your programs directed specifically to any ethnic group?
____ NO
____ YES (specify _____)

16. In which language(s) does your agency/organization provide mental health services?

_____

17. Describe any transportation problems your clients have in getting to the mental health services you provide:

_____

_____

_____

18. Does your program/service assist with arrangements to transport clients to your services?

____ YES (specify _____)
____ NO
____ NOT APPLICABLE

19. Is your facility wheelchair accessible?

____ YES
____ NO

20. Must clients pay fee in order to receive service?

____ YES
____ NO

21. How is this fee determined?

_____

_____

SECTION 3: REFERRAL PATTERNS

22. Clients and health professionals learn about mental health services from a variety of sources. Indicate which sources CLIENTS use to learn about your service by checking the left-hand column below. Indicate which sources are used by PROFESSIONALS by checking the right-hand column below.

CLIENTS	SOURCE OF INFORMATION	PROFESSIONALS
_____	family physician	_____
_____	other health professionals	_____
_____	previous users of services	_____
_____	community information directory	_____
_____	pamphlets or handouts	_____
_____	public broadcast announcement	_____
_____	presentations to professional organizations	_____
_____	other: (specify _____	
	_____)	

23. This is a two-part question.

A. What agencies or organizations refer clients to you?

B. On average, how many clients are referred from these sources

1=less than 1 client/month
2=1-5 clients/month
3=more than 5 clients/month

Source of Referral	Frequency of Referral
_____	_____
_____	_____
_____	_____

24. Using the Master Response Sheet, (at the end of this questionnaire) indicate (x) the MENTAL HEALTH SERVICES that you provide.

25. For your clients, what is the average waiting period for Mental Health Services from the time they first contact you until they are seen by your organization?

PROGRAM/SERVICE	AVERAGE WAITING PERIOD
_____	_____
_____	_____
_____	_____

26. A. Of the referrals received by your organization in the last year, approximately what percentage were appropriate (e.g., met your eligibility criteria)?

_____ %

B. Of those referrals that were appropriate, what percentage were accepted into your program/services?

_____ %

27. This is a two-part question.

A. To which services do you refer clients?

B. How often do you refer clients to these agencies?
1=less than once/month
2=one to two times/month
3=more than 3 times/month

Referrals made to:	Frequency of Referral
_____	_____
_____	_____
_____	_____
_____	_____

28. What referral agencies or services currently NOT available to your facility would be useful to your clients?

_____

_____

_____

_____

SECTION 4: NEED FOR ADDITIONAL MENTAL HEALTH SERVICES & RESOURCES

29. This is a two-part question. On the Master Response Sheet (at the end of this questionnaire) indicate:

A. The programs/services in which there is a need for MORE services and resources.

AND

B. The communities in which ADDITIONAL mental health services and resources are required.

30. One factor affecting the adequacy of mental health provision is the SETTING in which services are provided. On the Master Response Sheet, indicate the setting required to meet the additional needs you identified in Question 29.

CODING:
OPD = out-patient department
DP = day program
PPS = private professional setting
CH = client's home
R = residential
IP = inpatient
O = other (specify:_____)

31. Another factor affecting the adequacy of mental health service provision is the hours of operation. Indicate those mental health activities and expanded hours/days of services that are required.

MENTAL HEALTH SERVICES	DAYS	HOURS
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

32. List any groups within the community which you feel are not presently adequately served by the existing mental health services.

_____

_____

_____

At this point in the survey, you have identified a number of additional services needed to provide comprehensive mental health services in the industrial Cape Breton region.

33. Using the Master Response Sheet, rate the URGENCY of need according to the scale below:

URGENCY

a = within 1 year	d = 5 - 7 years
b = 1 - 2 years	e = 8 - 10 years
c = 3 - 5 years	f = Do Not Know

SECTION 6: SUGGESTIONS FOR COMPREHENSIVE REGIONAL MENTAL HEALTH SERVICES

34. In your opinion, does the framework of services we have been using represent a comprehensive range of mental health services?

_____ YES
_____ NO

35. What additional components should be included in a frame work of comprehensive mental health services for the Industrial Area?

_____

_____

36. List and describe ADDITIONAL organizations that could have a role in providing mental health services and resources.

_____

_____

_____

_____

37. List any features of your community which you feel has contributed to mental health problems of the residents.

_____ _____

_____

_____

38. Use the space below for any other remarks you wish to make regarding needs or gaps in existing services, planning for the delivery of mental health services in the Industrial Area, or for any other comments or suggestions you wish to offer.

_____

_____

_____

_____

_____

_____

Thank-you for assisting with this survey. Except for the program/service description, your responses will be kept confidential and will be used to assist the Cape Breton Mental Health Association to plan for comprehensive mental health services.

If you have further questions or comments about this survey, please contact Jim Ross, Mental Health/Cape Breton (539-3370 Ext. 171).

MASTER RESPONSE SHEET

MENTAL HEALTH SERVICE ACTIVITIES	24 Mental Health Services provided for clients	29A Need for more of the following services	29B Where Needed: S-Sydney NS-North Sydney SM-Sydney Mines GB Glace Bay NW-New Waterford O-Other (Specify)	30 Setting: OPD-Outpatients DP-Day Program PS-Private Professional setting CH-Client's Home IP-Inpatients R-Residential Other-(Specify)	31 Urgency: A- Within 1 year B- 1 - 2 years C- 3 - 5 years D- 5 - 7 years E- 8 - 10 years
1. PROBLEM IDENTIFICATION:					
1.1 Assessment/Evaluation/Diagnosis					
1.1.1 Psychological					
1.1.2 Psychiatric					
1.1.3 Family/Social					
1.1.4 Addiction					
1.2 Other					
2. COORDINATION AND DIRECTION:					
2.1 Inter-agency Referrals					
2.2 Case Management					
2.3 Follow-Up					
2.4 Other					
3. TREATMENTS/INTERVENTIONS:					
3.1 Crisis Responses					
3.1.1 Crisis Intervention					
3.2 Therapy					
3.2.1 Children					
3.2.2 Adolescents					
3.2.3 Family					
3.2.4 Adults					
3.2.5 Seniors					
3.3 Vocational Services:					
3.3.1 Vocational Counselling					
3.3.2 Vocational Assessment					
3.3.3 Training/Retraining					

MASTER RESPONSE SHEET

MENTAL HEALTH ACTIVITIES	24 Mental Health Services provided for clients	29A Need for more of the following services	29B Where Needed: S-Sydney NS-North Sydney SM-Sydney Mines GB-Glace Bay NW-New Waterford O-Other (specify)	30 Setting: OPD-Outpatients DP-Day Program PS-Private Professional setting CH-Client's Home IP-Inpatients R-Residential O-Other (specify)	33 Urgency A-Within 1 year B-1 - 2 years C-3 - 5 years D-5 - 7 years E-8 - 10 years F- Do not know
3.3 Continued:					
3.3.4 Transitional Employment Opportunities & Sheltered Workshops					
3.3.5 Job Search Training					
3.3.6 Job Placement Services					
3.4 Social/Recreational/Interpersonal Support Services:					
3.4.1 Social, Recreational/Leisure					
3.4.2 Life Skills					
3.4.3 Counselling Services					
FAMILIAL SUPPORT:					
4.1 Vacation Relief					
4.2 Counselling Activities & Mutual Aid					
4.3 Homemaking Services					
4.4 Other					
ACCOMMODATION:					
5.1 Cooperative Housing					
5.2 Supervised Housing					
5.3 Homes for Special Care Beds					
5.4 In-Patient beds in General or Psychiatric Hospital					
5.5 Subsidized Housing					
5.6 Residential					
5.7 Other					
TRANSPORTATION:					
6.1 Transportation Provider					
6.2 Transportation Facilitator					

MASTER RESPONSE SHEET

MENTAL HEALTH SERVICE ACTIVITIES	29	29A	29B	30	33
	Mental Health Services provided for clients	Need for more of the following services	Where Needed: S-Sydney NS-North Sydney SM-Sydney Mines GB-Glace Bay NW-New Waterford O-Other (Specify)	Setting: OPD-Outpatients DP-Day Program PS-Private Professional setting CH-Client's Home IP-Inpatients R-Residential O-Other (specify)	Urgency A - Within 1 year B - 1-2 years C - 3-5 years D - 5-7 years E - 8-10 years F - Do not know
7. EDUCATION:					
7.1 Public Education:					
7.1.1 Primary Prevention					
7.1.2 Mental Illness Awareness Programs					
7.1.3 Service Information Centres					
7.2 Professional Education:					
7.2.1 Staff Development					
7.2.2 Awareness of Community Resources					

8. Other (please list and describe any additional services or services that are needed but which are not included in this framework)

Appendix - F

Socio-Mental Health Professionals

	Name	Agency/Organization	Location
1	A.MacQueen-MacDonald	G.B. Hospital	Glace Bay
2	B.MacDonald	D.S.S.(adult protection)	Cape Breton
3	G.Gracie	Syd. Family Practice	Sydney
4	J.Aresenault	Helpline	Cape Breton
5	D.Munroe	Seaview Manor	Cape Breton
6	D.Jones	N.S. School Board	Northside
7	D.Roach	Calvin United Church	New Waterford
8	Cpt.	Harbour Lights Hostel	North Sydney
9	R.Schella	Dept. of S.S.	Glace Bay
10	T.MacPherson	C.B. Hospital	Cape Breton
11	F.Sampson	Family Services	Cape Breton
12	R.Aucoin	C.B. Addiction Center	Glace Bay
13	R.MacNeil	N.S. Legal Aid	Cape Breton
14	P.MacCormack	Syd. Boys & Girls Club	Sydney
15	Sr.Veronica	C.B. Mental Health Clinic	Sydney
16	K.Macdonald	N.S. Correctional Services	Glace Bay
17	B.Barrett	Private Practice	Glace Bay
18	B.MacLean	MemoriaL Jr. H.S.	Sydney Mines
19	D.Brown	C.A.S.	Northside
20	D.Natheson	N.W. Consolidated Hospital	New Waterford
21	J.Chisholm	C.A.S.	Glace Bay
22	A.Danrath	Town House	Glace Bay
23	J.Wezelkowski	CB Hospital	Cape Breton
24	R.Meahan	CB Mental Health Ass.	Cape Breton
25	B.MacInnis/C.Roberts	D.S.S.(Single Parents)	Cape Breton
26	B.Foley	CB Hospital	Cape Breton
27	M.MacMullin	Syd. City Police	Sydney
28	G.Andryshun	CBMHC	Sydney/NW
29	J.MacKeough	CB Hospital	Cape Breton
30	S.Irwin	Town Day Care	Glace Bay
31	C.Timmons	C.B.H.(day center)	Cape Breton
32	C.Currie	Salvation Army	Cape Breton
33	P.Boyd	Private Practice	North Sydney
34	E.Daynes	C.B. Hospital	Cape Breton
35	L.Smith	R.C.M.P.	Northside
36	R.Neville	Thompson Jr. H.S.	North Sydney
37	J.MacIssac	D.S.S.(Voc. ReHab.)	Sydney
38	C.Boutlier	Dept. Public Health	New Waterford
39	S.Hyde	C.B.M.H.C.	Cape Breton
40	L.Burke	Family Court	Cape Breton
41	D.Munroe	Sea View Manor	Glace Bay
42	D.Dalrymple	Childrens Aid Society	N. Sydney
44	B.MacIssac	Memorial H.S.	Northside
45	P.Mancini	N.S. Legal Aid	Cape Breton
46	P.Gow	C.B.H.	Cape Breton
47	D.Crowe/S.Dwyer	N.W. Police	New Waterford
48	P.Guy	Family Services	Glace Bay

Appendix - G

SOCIO-MENTAL HEALTH PROFESSIONAL INTERVIEW GUIDE

Your participation in completing this questionnaire is, of course, voluntary and you may omit or refuse any of the questions that you wish.

1) NAME: _____

2) YEARS EXPERIENCE: _____

3) NAME OF ORGANIZATION: _____

4) WHAT ARE YOUR PRIMARY JOB RESPONSIBILITY(S) WITHIN THE ORGANIZATION?

_____

_____

_____

_____

5) WHAT IS YOUR INVOLVEMENT WITHIN THE MENTAL HEALTH SYSTEM? (i.e., ARE YOU A SERVICE PROVIDER, REFERRAL SOURCE OR BOTH?)

M.H. SERVICE PROVIDER _____ REFERRAL SOURCE _____ BOTH _____

6) NO. OF REFERRALS MADE PER MON. TO AGENCY REASON

_____ _____ _____

_____ _____ _____

_____ _____ _____

7) DO YOU ENCOUNTER PROBLEMS MAKING REFERRALS TO ANY OF THE AGENCIES/ORGANIZATIONS OFFERING MENTAL HEALTH SERVICES? PLEASE ELABORATE.

_____

_____

_____

_____

8) IS THE WAITING PERIOD FOR MENTAL HEALTH SERVICES ACCEPTABLE? PLEASE ELABORATE. (ACCESSIBILITY)

_____

_____

_____

_____

9) ARE YOU SATISFIED WITH THE QUALITY OF SERVICES THAT CLIENTS YOU REFER FOR MENTAL HEALTH SERVICES RECEIVE? PLEASE ELABORATE. (ACCEPTABILITY)

_____

_____

_____

_____

10) WHAT FACTORS, IF ANY, DO YOU FEEL WOULD KEEP PEOPLE FROM SEEKING HELP FROM AN AGENCY THAT PROVIDES MENTAL HEALTH SERVICES? PLEASE ELABORATE. (ACCESSIBILITY)

_____

_____

_____

_____

11) ARE THERE OCCASIONS WHEN YOU MAKE REFERRALS TO AGENCIES OR ORGANIZATIONS OUTSIDE OF THE INDUSTRIAL AREA? PLEASE ELABORATE. (AVAILABILITY) YES NO _____

_____

_____

_____

_____

12) ARE THERE PARTICULAR GROUPS IN THE INDUSTRIAL AREA THAT ARE NOT ADEQUATELY PROVIDED FOR BY THE EXISTING MENTAL HEALTH SERVICES PLEASE ELABORATE.

13) COULD THE RELATIONSHIP BETWEEN YOU AND MENTAL HEALTH AGENCIES YOU MAKE REFERRALS BE IMPROVED? PLEASE ELABORATE. (ACCEPTABILITY)

14) IS IT CLEAR TO YOU WHICH AGENCIES HANDLE WHICH TYPES OF PROBLEMS? PLEASE ELABORATE.

15) ARE THERE FEATURES OF YOUR COMMUNITY WHICH YOU FEEL MAY CONTRIBUTE TO THE MENTAL HEALTH PROBLEMS OF THE RESIDENTS? PLEASE ELABORATE.

16) LIST ANY MENTAL HEALTH SERVICES AND OR RESOURCES THAT YOU THINK ARE NEEDED IN THE INDUSTRIAL AREA. PLEASE ELABORATE.

_____

_____

_____

_____

_____

17) ARE THERE OTHER AGENCIES OR INDIVIDUALS THAT YOU FEEL WE SHOULD TALK TO REGARDING THIS PROJECT?

_____

_____

_____

18) OTHER COMMENTS

_____

_____

_____

_____

_____

Appendix H

Consent Form

I, _____, give consent to James Ross, a graduate student, from Wilfrid Laurier University to use information from an interview designed to assess the mental health needs of Industrial Cape Breton. I willingly provided him with information and give him permission to use this information both in his Master's thesis and in a report for the Cape Breton Mental Health Association.

_____ _____
Date Signature

_____ _____
Date Signature

I understand that the results of the research will be available through the Cape Breton mental Health Association. However, I would like a written copy of the results to be mailed to my home. Yes( ) No( ) Please mail this information to: (please print clearly)

Name: _____

Address: City/Town - _____

Street - _____

Postal Code - _____
City/Town

Appendix I

Consumers Interview Guide

Your participation in completing this questionnaire is, of course, voluntary and you may omit or refuse any of the questions that you wish.

1) Tell me about any difficulties you encountered when trying to find the mental health service(s) you needed in industrial Cape Breton.

2) Tell me about the reasons you were satisfied or dissatisfied with the mental health service(s) you received.

3) Tell me what mental health services you think are missing or in need of more programs.

4) Tell me about any suggestions you have for mental health services in the Industrial Area.

Appendix K

Framework and Definitions of Mental Health Services In Industrial Cape Breton

The following framework outlines seven major program areas of mental health services provided within the Region of Waterloo. Included in the model are problem identification, coordination and direction, treatment/interventions, familial support, accommodation, transportation and education. These components reflect a continuum of programs designed to meet the prevention, treatment, rehabilitation, maintenance and educational needs of the individual, his/her support system and the community as a whole. Within each area, programs are provided in different settings and at different levels of care ranging from intensive hospital treatment services to community support services for individuals with limited mental health needs.

This framework was adapted from the Cohen model (Cohen, 1982) to reflect the range of mental health services in Industrial Area. The following model also incorporates concepts from Heseltine's interim report (Heseltine, 1982) and discussion paper (Heseltine, 1983). Each key program area and its service components are listed and described below.

1. Problem Identification

This program area refers to the series of activities that focus on the identification and detection of mental health problems. These activities can take place prior to entry into the mental health system or at any other point in time after an individual has accessed the system.

1.1 CASE IDENTIFICATION: The series of activities that revolve around the identification and detection of individuals who require assistance. These individuals may fall within the "high risk" category or may be individuals who require assistance but are either unable or unwilling to voluntarily seek help. Note: case identification does not include any form of treatment.

1.2 ASSESSMENT/EVALUATION/DIAGNOSIS: A series of activities that revolve around identifying the type, nature and extent of an individual's problems. These activities can take place as a pre-requisite to entry or potential entry into the mental health system or at any other point in time. Types of assessment include:

1.2.1. PSYCHOLOGICAL EVALUATION: Psychological or personality appraisal by a qualified practitioner (e.g., psychologist, M.S.W., family physician, psychometrist, psychiatric R.N.). or by someone working under his/her direct supervision.

1.2.2. PSYCHIATRIC EVALUATION: Appraisal of an individual's emotional/psychiatric condition by a qualified psychiatrist.

1.2.3. FAMILY/SOCIAL EVALUATION: Appraisal of family functioning and/or an individual's social interaction with the broader community by a qualified social worker, psychologist or other qualified individual.

1.2.4 ADDICTION EVALUATION: Appraisal of an individual's alcohol or chemical dependency by a qualified professional using generally accepted measurement devices.

1.3.OTHER: Additional, specific appraisals which can focus on: the client's physical status or occupational environment (excluding vocational assessment -- see 3.3) as they pertain/contribute to: mental health problems, his/her support system, home physical environment, or on the detection of mental health problems within larger groups (as opposed to the individual or family structure).

2. COORDINATION AND DIRECTION:

This program area refers to those activities designed to link the individual/client with the services required to meet identified mental health needs. Also included in this section are activities designed to promote continuity of care within the network of mental health services.

2.1 INTER-AGENCY REFERRALS: The formal or informal linkage activities between agencies, organizations and the hospitals that allow for the referral of individuals presenting with problems that one agency cannot deal with, to the most appropriate organization or institution.

2.2. CASE MANAGEMENT: On-going activities which facilitate the individual's movement through the network of mental health services so that, at any given time, client needs are matched by the services received. These activities ensure the coordination of service delivery by providing continuity of care within the service network. Other activities in this area may include interpreting the mental health network system to the client or acting on the individual's behalf in an advocacy role.

2.3 FOLLOW-UP: Activities designed to obtain/provide feedback on a client's/family's progress following a referral to a program or type of accommodation. Follow-up services may be undertaken by the original referring organization or by others delegated to do so (e.g., public health nurses or other field workers). It differs from case management which provides a more continuous, long-term monitoring of the individual's progress. Note: Follow-up services are provided on a short-term basis and differ from Case management which provides a more continuous long-term monitoring of the individual's progress.

2.4 OTHER: Additional activities that assist in determining needed referrals or directing the client to needed programs (e.g., personal planning services, discharge planning).

3.TREATMENT/INTERVENTIONS

Treatment refers to the series of planned activities that revolve around the reduction or alleviation of the problems or symptoms that are inhibiting the functional abilities of the individual and affecting the individual's to function at his/her maximum level. Interventions include rehabilitation or maintenance activities. REHABILITATION refers to the series of activities that are aimed at increasing an individual's level of functioning to his/her maximum potential following an episode of acute illness or following a broader range of emotional problems that have inhibited his/her functional ability. MAINTENANCE refers to those activities that are aimed at maintaining the individual at his/her fullest potential and/or preventing a deterioration in his/her condition.

3.1 CRISIS RESPONSES: Those activities available on an immediate but short-term basis.

3.1.1 EMERGENCY MEDICAL SERVICES: Assistance available to any individual on an immediate basis in a hospital setting (e.g., emergency department or unit in a general hospital). These services are NOT specifically oriented towards dealing with individuals presenting either psychiatric or psychosocial problems.

3.1.2 ACUTE CARE CRISIS SERVICES: Professional hospital services specifically oriented to individuals presenting with psychiatric and/or emotional emergencies. One of the distinguishing characteristics is the availability of beds within a psychiatric setting for immediate allocation if required.

3.1.3 CRISIS INTERVENTION: Services designed to provide individuals in need with immediate assistance to deal with problems of either a very specific nature (e.g., rape, suicide) or a more diverse set of problems.

3.2 THERAPY

3.2.1 PSYCHOLOGICAL THERAPY: Includes psycho-therapies which are directed to self-understanding and inducing or anticipating behavioral change. Also includes behavior therapies which are directed to a modification of external action by way of an "unlearning-learning" process. This type of therapy can directed at individuals, the family or a group.

3.2.2 PHYSICAL THERAPY: Chemical or physical means are used to provide relief of symptoms or make desirable behaviors possible and includes the use of medication, convulsive therapy and psychosurgery.

3.2.3 Other: Additional forms of planned, systematic interventions (excluding social and recreational programs -- see 3.4) based on scientific or psychological theories aimed at achieving specified change objectives.

3.3 VOCATIONAL SERVICES:

3.3.1 VOCATIONAL COUNSELLING: Those services that focus on attitudinal, motivational, emotional and physical impediments to job functioning.

3.3.2 VOCATIONAL ASSESSMENT: Those services that provide testing to determine the individual's capability, capacity and potential for employment, the most suitable occupations and type of training required.

3.3.3 TRAINING/RETRAINING: Those services that provide training or upgrading to increase either general or specific employment skills.

3.3.4 TRANSITIONAL EMPLOYMENT OPPORTUNITIES & SHELTERED WORKSHOPS: Those services that provide controlled or limited work environments for individuals who, due to their functional deficits, are unable to secure or maintain themselves in competitive employment. Through regular participation, the client is expected to become less isolated and acquires improved work habits and skills.

3.3.5 JOB SEARCH TRAINING: Those services that provide the individual with the skills necessary to seek and gain employment (e.g., resume training or interview skills.

3.3.6 JOB PLACEMENT SERVICES: Those services that provide assistance to the individual in finding the appropriate job that will meet their vocational goals and functional capabilities.

3.4 SOCIAL/RECREATIONAL/Interpersonal SUPPORT Services:

3.4.1 SOCIAL/RECREATIONAL/LEISURE SERVICES: Nontreatment services that either develop the individual's socialization skills or attempt to develop the skills of normal social functioning in isolated or withdrawn individuals (e.g., parties, outings, dances, games).

3.4.2 LIFE SKILLS: Structured learning opportunities which focus on personal coping skills (e.g., self-awareness, developing relationships, effective listening, dealing with anger) or basic life skills (e.g., budgeting, low cost cooking, using leisure time effectively, other home-making and daily living activities).

3.4.3 COUNSELLING SERVICES: Individual, group or any other type of client-centered listening/talking relationship that provide an outlet for the individual and provide assistance and support to the client in coping and learning to deal with problems.

4. FAMILIAL SUPPORT

This program area includes services that assist the family to cope with the emotional and financial concerns sometimes associated with the long-term caring for individuals attempting to increase their level of functioning.

4.1 VACATION RELIEF: Providing supplemental personnel to allow family member(s) short-term, temporary respite from the necessary care of the mentally ill individual. Care or supervision may be provided in the individual's place of residence or at a facility with the necessary physical and human resources.

4.2 COUNSELLING AND MUTUAL AID Activities: An interactive relationship which provides an outlet for individual family members or the family to discuss issues related to coping with mental illness. These activities may occur on a one-to-one basis or in a group setting but involvement of health professionals is not necessary. In addition, these groups may assist or support families in learning to cope with associated problems (e.g., making applications for financial support, problem-solving common concerns, sharing experiential knowledge, education re home therapies or interventions).

5. ACCOMMODATION

This program area refers to any supportive living arrangements that provide food, shelter, support and/or treatment to the ex-psychiatric or psychiatric patient or other individuals with varying mental health needs.

5.1 COOPERATIVE HOUSING: A supportive group living arrangement for individuals who lack the requisite skills or emotional stability to manage living in less supportive environments. The group living experience itself (rather than overt therapeutic programs) is the process by which residents increase skills and gain emotional stability.

5.2 SUPERVISED HOUSING: A supervised housing arrangement that provides individuals with more explicit therapeutic programs and a greater level of on-site staffing than cooperative housing (e.g., halfway houses).

5.3 HOMES FOR SPECIAL CARE BEDS: specially designated beds in nursing homes or Homes for the Aged or ex-psychiatric beds. A rehabilitative component must be included.

5.4 IN-PATIENT BEDS IN GENERAL OR PSYCHIATRIC HOSPITAL: Specially designated beds in the hospital environment whose purpose is to provide the environment and treatment specifically aimed at rehabilitation and re-integration of the individual into the community.

5.5 SUBSIDIZED HOUSING: Specially designated rent subsidized housing for ex-psychiatric patients.

5.6 OTHER: Additional forms of accommodation for those with varying mental health needs, e.g., group homes, alcohol treatment homes, emergency hostel, rehabilitation center, retirement home, nursing home, residential domicidal care facility.

6. TRANSPORTATION

This program area focuses on facilitating the client's access to needed mental health services.

6.1 TRANSPORTATION PROVIDER: A service which provides the actual means of conveyance or transportation needed to reach or return from mental health services. This service may also be used by individuals who -are functionally unable to provide their own means of transportation due to psychiatric disability.

6.2 TRANSPORTATION FACILITATOR: A service that makes arrangements or referrals to obtain needed transportation but does not actually provide the transportation vehicle.

7. EDUCATION

This program area includes a range of activities aimed at increasing the awareness, knowledge and/or understanding of mental illness, the application of psychological intervention concepts, the prevention of mental illness or availability of mental health services. Programs may be targeted at individuals, the community or at health care professionals.

7.1 PUBLIC EDUCATION:

7.1.1 PRIMARY PREVENTION: Educational programs aimed at increasing the awareness, understanding and/or behavioral application of principles of mental health (e.g., physical fitness, employee health promotion and stress management)

7.1.2 MENTAL ILLNESS AWARENESS PROGRAMS: Educational services designed to promote an increased awareness and understanding of specific forms of mental illness and their attendant concerns.

7.1.3 SERVICE INFORMATION CENTERS: Provides information about the scope of mental health programs available in the community. This service does not make actual referrals to available programs (see 2.4).

7.2 PROFESSIONAL EDUCATION:

7.2.1 STAFF DEVELOPMENT: Programs, workshops or other activities providing health professionals or other mental health care workers with opportunities to increase their understanding and application of principles of mental health and psychological or psychiatric interventions and treatments.

7.2.2 AWARENESS OF COMMUNITY RESOURCES: Activities aimed at increasing the awareness of available mental health care services to professional service providers.

7.3 OTHER: Additional educational activities focusing on mental health concerns, (e.g., program development and evaluation, research related to program efficacy, utilization or accessibility).

*** This appendix was reproduced here with the permission of the Waterloo District Health Council

Appendix L

Agencies and Organizations which Returned the Administrators Questionnaire

1 Resi-Care - 880 George St., Sydney
2 North Sydney Mental Health Center- North Sydney
3 Cape Breton Mental Health Day Center - Sydney River
4 Boys Residential Center - New Waterford
5 Sharon Unsworth: Private Counselling
6 New Waterford Consolidated Hospital (Social Work Department)
7 Family Service of Northside - Sydney Mines
8 Glace Bay General Hospital (Social Work Department)
10 Family Service Counselling Center of Sydney - Sydney
11 University College Cape Breton (Counselling Center)
13 Family Services of Eastern Nova Scotia - Glace Bay
14 Child and Adolescent Services Cape Breton Mental Health Center
15 Department of Community and Social Services (Vocational Rehabilitation Program)
16 Sydney City Hospital (Social Work Department) - Sydney
18 Glace Bay Mental Health Clinic - Glace Bay
19 Department of Community and Social Services (Single Parents Program)
22 Children's Aid Society of Cape Breton - Sydney
23 Dr. A. Kumar - Sydney
24 Resi-Care Association, 70 George St.- Sydney
27 Sydney Hospitals Crisis Program - Sydney
28 Salvation Army Cape Breton Resource Center - Sydney
30 Children's Aid Society - Glace Bay
32 Native Alcohol and Drug Association - Membertou
33 Sydney Community Health Center (Social Work Department)-Sydney
34 Child Welfare Service - Sydney
35 Children' Aid Society Northside Office - North Sydney
36 W. Zisserson Private Counselling and Consultation Services
38 N.S. Community College (AVTC)
39 Howard House Association of Cape Breton - Sydney
40 Cape Breton Hospital (Occupational Therapy Department)
43 North Sydney Private Counselling

Appendix M

Services Provided by Agencies/Organizations

* Refer to Appendix C-1 for key to interpreting coding i.e., which number corresponds with agency/organization

1. Problem Identification

1.1 Assessment/Evaluation/Diagnosis

1.1.1 Psychological - 2,3,10,11,12,13,14,15,16,18,20,21,22,26,27,28,29, 30,35

1.1.2 Psychiatric - 2,3,11,13,14,18,21,22,23,26,28,29,35,42,45

1.1.3 Family/Social - 1,2,3,4,6,7,8,9,10,11,12,13,14,16,18,19,20, 21,22,23,24,27,29,30,32,33,34,35,36,37,39,41,42, 43,44,45

1.1.4 Addiction - 6,18,26,28,29,32,36,39,45

1.2 Other - 40 (occupational performance), 36 (divorce mediation)

2. Coordination and Direction

2.1 Inter-agency Referrals - 1,2,4,5,6,7,8,9,10,11,12,15,16,18,19,20,21, 22,23,24,26,27,28,29,30,32,33,34,36,37,39,40,41,42,43 44,45

2.2 Case Management - 1,2,4,6,7,8,9,10,12,14,18,19,20,21,22,23,24,26, 28,29,30,32,33,36,37,39,40,41,42,44,45

2.3 Follow-Up - 2,6,7,8,9,10,12,14,16,18,19,20,21,22,23,26,27, 28,29,30,32,33,34,37,39,40,41,42,44,45

3. Treatment/Interventions

3.1 Crises Responses

3.1.1 Crisis Intervention - 2,3,6,8,9,10,11,12,14,16,18,19,20,21,22, 23,26,27,28,29,30,32,33,35,37,39,41,42, 44,45

3.2 Therapy

3.2.1 Children - 6,7,10,12,13,14,16,22,30,35,37,40,41

3.2.2 Adolescents - 4,6,7,8,9,10,11,12,13,14,16,22,23,26,28,29,30,
33,35,36,37,40,41,42,44,45

3.2.3 Family - 1,2,5,6,7,8,9,10,12,13,14,16,20,21,22,23,24,26,29,
30,32,33,35,36,37,39,42,43,44,45

3.2 4 Adults - 1,3,5,7,8,9,10,11,12,13,18,20,21,22,23,24,26,29,
30,32,34,35,36,37,39,40,41,42,43,44,45

3.2.5 Seniors - 2,5,6,7,8,10,12,13,16,18,20,23,24,35,36,39,40,42,45

3.3 Vocational Services

3.3.1 Vocational Counselling - 1,11,15,19,22,24,28,29,30,35,37,38,39,40

3.3.2 Vocational Assessment - 11,15,19,29,38,40

3.3.3 Training/Retraining - 15,19,24,38,40

3.3.4 Transitional Employment Opportunities &
Sheltered Workshops - 15,19

3.3.5 Job Search Training - 15,19,38,39,40

3.3.6 Job Placement Services - 15,37

3.4 Social/Recreational/Interpersonal
Support Services

3.4.1 Social/Recreational/Leisure - 1,2,3,4,18,19,21,24,39,40,45

3.4.2 Life Skills - 1,2,4,14,15,19,21,22,24,26,30,35,36,38,39,40,41,44,45

3.4.3 Counselling Services -1,2,3,6,7,8,9,12,14,16,18,19,21,22,
24,26,30,33,34,35,36,37,38,39,40,41,43,44,45

4. Familial Support

4.1 Vacation Relief - 22,30,35,37

4.2 Counselling Activities & Mutual Aid - 4,8,9,16,22,23,30,33,34,35,37,
39,42,45

4.3 Homemaking Services - 22,30,35,37

4.4 Other -

5. Accommodation

5.1 Cooperative Housing -

5.2 Supervised Housing -

5.3 Homes for Special Care Beds -

5.4 In-patient Beds in General or Psychiatric - Hospital - 26,45

5.5 Subsidized Housing -

5.6 Residential - 1,4,24,25,39,41

5.7 Other - 35 (negotiation for improved housing)

6. Transportation

6.1 Transportation Provider - 4,18,22,30,35,37,39,41

6.2 Transportation Facilitator - 3,4,15,18,19,22,24,30,35,37,39,41

7. Education

7.1 Public Education

7.1.1 Primary Prevention - 2,7,8,9,10,11,12,14,21,22,30,33,35,37,
39,41,44,45

7.1.2 Mental Health Awareness Programs - 2,7,8,14,16,21,22,29,30,32,
34,35,36,37,41,44,45

7.1.3 Service Information Centers - 8,9,15,16,19,29,33,37,39,44,45

7.2 Professional Education

7.2.1 Staff Development - 1,3,4,5,67,8,9,10,12,13,14,15,16,18,19,20,21,
22,24,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,43,44,45

7.2.2 Awareness of Community Resources - 1,3,7,8,10,12,14,16,22,24,29,30,
32,33,34,35,37,38,39,41,43,44,45

Note: #31 Ann Terry Outreach Project is not included in the above data

Self-Help Groups appear on the next page

Self-Help Groups

Agoraphobia Support Group
Alcoholics Anonymous
Alzheimer Support Group
Association for Learning Disabled
Family Services of New Waterford
Friends of Schizophrenia
Head/Brain Injured Children Adults
Spina Bifida Association
Support Group for Battered Women
T&L Group of Emotions Anonymous

Appendix N

Setting of Services Provided

Outpatient	2,6,8,14,16,18,32,33,40
Day Program	3,32
Private Professional	7,10,13,15,22,34,35,36,37,43
In-Patient	8,16,33,40
Residential	1,4,24,28,32,39
Clients home	8,13,15,18,22,32,35,37,40,43
Other	11

Appendix O

Hours that Services are Provided

9:00 am - 5:00 pm	2,3,4,5*,10,11,13,15,16,18,22,33,35,36,37,40
5:00 pm - 9:00 pm	10,13,36,43+
24 hr. Standby	4,24,39
Emergency, on call	22,35,16
No Response	1,7,8,14,21,28,34

* Monday, Wednesday, Friday
\+ Two nights per week

** Refer to Appendix C-1 for key to interpreting coding i.e., which number corresponds with agency/organization

Appendix P

Agencies Operating Capacity

Could handle larger case load - 3,27

Have appropriate caseload - 1,2,6,10,15,16,18,22,24,28,32,34,36,39,40

Caseload too large - 4,7,8,10,11,13,14,22,33,35,36,37

** Refer to Appendix C-1 for key to interpreting coding i.e., which number corresponds with agency/organization

Appendix Q

Average Waiting Period for Services

Less than one week - 3,6,8,11,16,18,22,27,32,34,35,39,43

One to two weeks - 2,7,8,15,22

Two weeks to one month -11,40

More than one month - 10,13,14,18,36,39

No response - 1,4,24,28,33

** Refer to Appendix C-1 for key to interpreting coding i.e., which number corresponds with agency/organization

Appendix R

Raw Frequencies with which the Administrators Indicated the Need for Mental Health Services

	G.B.	N.W.	Syd.	N.S.
Problem ID	25	19	25	26
Co-ordination	15	16	12	18
Treatment/Intervention				
Crisis Responses	7	6	7	9
Therapy	39	26	32	45
Vocational	32	33	39	34
Social/Rec.	14	12	14	17
Familial Support	21	18	18	23
Accommodation	28	30	35	31
Transportation	7	10	9	10
Education				
Public	17	20	15	19
Professional	14	16	14	16
Totals	219	206	220	248
Percent	25	23	25	28

Appendix T

Frequency of Response - Administrators Questionnaire

	*No. Id.	Setting							Urgency				
		IP	DP	OPD	PPS	R	CH	Other	1	2	3	4	5
1. PROB. ID.													
1.1.1	16	2	6	18	8	4	4	0	15	3	1	0	0
1.1.2	12	6	6	14	8	4	2	0	13	3	0	0	0
1.1.3	11	2	2	12	8	4	4	0	8	2	0	0	0
1.1 4	5	4	4	4	8	2	0	0	4	0	0	0	0
1.2 (Occ. Ass.)		0	2	4	0	0	0	0	1	0	0	0	0
2. COORDINATION													
2.1	6	0	0	4	8	0	0	0	6	1	3	0	0
2.2	7	0	4	2	4	0	0	2	6	1	1	0	0
2.3	9	0	2	4	4	4	0	12	8	1	1	0	0
2.4	0												
3. TREATMENT/INTERVENTIONS													
3.1 Crises													
3.1.1	8	2	1	2	2	1	5	0	7	1	0	0	0
3.2 Therapy													
3.2.1	15	3	0	8	4	3	4	0	8	2	1	0	0
3.2.2	19	5	2	8	4	4	4	0	12	2	0	0	0
3.2.3	11	0	0	8	8	0	1	0	8	4	2	0	0
3.2 4	7	1	12	8	8	0	0	0	6	2	6	0	0
3.2.5	11	3	9	6	4	2	6	0	10	2	1	0	0

* Number of administrators responses identifying the need for this service

	*No. Id.	Setting							Urgency				
		I P	DP	OPD	PPS	R	CH	Other	1	2	3	4	5
3.3 Vocational Services													
3.3.1	10	5	3	5	8	3	4	0	4	5	1	0	0
3.3.2	10	5	3	5	8	2	2	10	4	5	1	0	0
3.3.3	11	5	3	2	2	0	1	15	6	4	1	0	0
3.3.4	8	0	3	0	1	0	0	10	4	6	0	0	0
3.3.5	10	5	3	0	3	2	1	5	4	3	0	0	0
3.3.6	10	0	0	0	2	1	0	4	3	4	0	0	0
3.4 Social/Recreational													
3.4.1	7	1	6	6	0	0	2	16	4	3	2	0	0
3.4.2	8	1	6	0	3	0	1	6	6	2	1	0	0
3.4.3	9	0	4	0	3	0	1	2	3	1	1	0	0
4. FAMILIAL SUPPORT													
4.1	9	0	0	4	6	8	40	0	12	2	0	0	0
4.2	10	0	0	0	0	8	15	0	4	4	0	0	0
4.3	9	0	0	0	0	0	15	0	3	1	1	0	0
4.4	accessible welfare, day care for day hospital												
5. ACCOMMODATION													
5.1	15	Not Applicable							11	4	5	0	0
5.2	19	Not Applicable							15	3	0	0	0
5.3	13	Not Applicable							10	4	0	0	0
5.4	19	Not Applicable							12	9	1	0	0
5.5	19	Not Applicable							9	5	0	0	0
5.6	13	Not Applicable							6	4	1	0	0
5.7	Negotiate for imp. housing, Hostel												

* Number of administrators responses identifying the need for this service

	*No. Id.	Setting							Urgency				
		IP	DP	OPD	PS	R	CH	Other	1	2	3	4	5
6. TRANSPORTATION													
6.1	9	Not Applicable							6	3	0	0	0
6.2	8	Not Applicable Victoria Co.							6	2	1	0	0
7. EDUCATION													
7.1 Public Education													
7.1.1	12	2	4	3	4	1	3	0	7	1	1	0	0
7.1.2	9	4	8	7	4	5	3	0	8	1	1	0	0
7.1.3	9	2	0	0	0	0	0	12 School, Community organizations	6	3	0	0	0
7.2 Professional Education													
7.2.1	6	4	1	4	0	2	2	0	4	2	0	0	0
7.2.2	8	4	1	4	0	2	2	0	4	3	1	0	0
8. OTHER		people to facilitate the setting up of self-help groups											

* Number of administrators responses identifying the need for this service

Note. 25 Administrators questionnaires are in this matrix

Appendix U

Features of the Community which Contribute to Mental Health Problems of the Residents

aging population
life style
family breakdown
for single parents
welfare mentality
government dependencies
lack of self-help initiatives
stigma of mental illness
lack of preventative programs
multi generational problems
no opportunities for PMI
inadequate housing
sexism
lack of support groups consumerism
lack of adequate information

"Government dependencies such as UIC and disability pensions - financial supports should not require that a person claim an inability to support oneself."

"No opportunity for the mentally ill to be a productive member of a society(systems problem too)."

Appendix V

Groups Identified as being Underserved by Soci-Mental Health Professionals

Group	* Percent Identifying Group
Child/adolescent	56
Senior citizens	30
Women	15
Those with chronic psychiatric problems	15
Low income/unemployed	13
Those with addiction problems	10
Families(parenting courses)	8
Micmacs	5
Adolescent females	5
Learning disabled	3

* N = 39

Appendix W

Community Forums

This appendix contains the raw data as obtained from those attending the community forums. The data is presented in ranked order. The number to the left of the identified need is the total number of votes that the need received.

Items Ranked Through the Nominal Group Process

Appendix W-1 Glace Bay

Number in attendance - 5 October 3, 1989

30- Steady employment

27 - Education on preventing drug abuse

26 - Values education taught in the schools

24 - Group counseling for mental health concerns in schools

20 - More suitable housing (general population)

19 - Mental health services to be more available on weekends

19 - Education to overcome stigma of mental illness

18 - Parenting program for parents of troubled adolescents

18 - More group homes for those with chronic mental health problems

17 - Emergency number for more immediate access to crises services

16 - Immediate access to qualified physician in crisis situation

10 - Better feedback on clients progress to referring agencies

9 - Education re available services

8 - Drop in center like Cardeil Place

8 - Ways to integrate clients back into the community

5 - One page listing of agencies in telephone book

3 - Setting other than institution for treatment of those with mental health problems

Appendix W-2 Sydney

Number in attendance - 10 October 10, 1989

54 - Preventative mental illness program for children

38 - Need for more mental health professionals in the field (maximum of 3 days for an appointment)

38 - Educational programs to educate physicians on mental health issues

37 - Examination and investigation of medical/legal issues of confidentiality (effects of the credibility of the client once labeled)

25 - Educational program for mentally handicapped children to assist them in dealing with inappropriate sexual behavior

22 - Research into self esteem in the community - programs to act on the research

19 - A mental health team to deal with community wide trauma and threats

14 - Inpatient assessment unit for youth in a secure environment

13 - More female psychiatrists

13 - Forums for public communication

13 - Need for services for men who batter

12 - Combined program of tutoring /counseling for disruptive children

10 - Distribution of positive information programs on mental health

10 - Examination of the issue of financial trusteeship specifically for people on fixed incomes

10 - Program for people with agoraphobia

10 - Actions to combat a general despair arising from chronic economic problems

9- Reorganizing existing agencies (specialization)

5 - Need for self-help/support groups for single parent families

4 - Reshaping of the blaming the victim philosophy
2 - Programs of response to minor community traumas
1 - Improved tapping of local strengths and dovetailing of them with local needs

Appendix W-3 New Waterford

Number in attendance - 6 October 17, 1989

43 - Better mental health services (full-time clinic)

41 - Positive education on mental health

26 - Removing the stigma attached to mental health i.e., treatment through a holistic medicine approach

25 - Improved admittance to the Cape Breton Hospital in crisis situations

24 - Funding for research

23 - Better liaison and communication with school personnel and the mental health clinic

21 - Team approach with clients in the community

19 - Better sharing of information among agencies

18 - Counselling for seniors in senior complexes

17 - Cape Breton Mental Health Clinic to provide counselling services to other agencies

15 - Need for a drop in center for those with chronic mental health problems in New Waterford

15 - Legislative changes in relation to admissions and discharges of patients at the Cape Breton Hospital

15 - Improved transportation services for patients going to the day hospital

9 - Resource people available in schools to students with emotional problems)

7 - Better liaison helping agencies working with seniors

6 - More follow-up on how the medication affects a client

4 - Steps to be taken to reduce the turn over in psychiatric staff

4 - Regular review of services

3 - Acknowledgement of the importance of psychiatric nurses

1 - Recognition of seniors over sixty-five with mental health problems as a group in need of services

Appendix W-4 North Sydney

Number in attendance - 8 October 24, 1989

58 - Central clearinghouse of mental health information

47 - Better coordination of efforts between existing helping agencies

39 - Develop more support systems for the post-mentally ill in the community including advocacy groups and improved service from family benefits workers eg. sharing of information re what services are available

35 - Vocational programs that will lead to gainful employment of the consumer

27 - Accommodations for the post-mentally ill - supervised and unsupervised homes and apartments

25 - Increase staff to help adolescents in crisis situations

25 - More self-help groups (to include a range of individuals with differing mental health problems e.g., emotions anonymous)

20 - More support for families with mentally handicapped adults (severe behavior disorders)

18 - More programs for people mentally ill & mentally handicapped (i.e., dual diagnoses)

15 - More follow-up information on discharged patients between agencies

15 - Volunteer services which use only the services of the consumer

14 - Facility that will offer programs for adolescents (eg. runaways)

13 - Secure funding for activity centers (i.e., Cardeil Place)

12 - Greater accessibility in rural areas for counselling services with youth

10 - More training programs and activities available for the mentally handicapped

10 - Transportation and easy access to and from buildings
5 - More positive education about mental illness - removal of stigma
2 - Baby sitting service for single parents

Appendix X

Groups Identified as being Underserved

Appendix X-1

The rank ordered list of mental health needs as identified by students at Breton Education Center in New Waterford. The number on the left is the number of votes the students assigned to the identified need.

High School Students (New Waterford)

Number present 8 December 13, 1989

19 - More social/recreational activities for teens in New Waterford

18 - A T.A.D.D. program in our school

16 - Drug awareness program for teachers

13 - A social worker available in the school at all times to help the students

12 - An educational program to decrease the negative attitude about mental health

12 - An education program about drugs for parents

12 - Helpline in New Waterford

7 - More respect from teachers

6 - Teen counsellor to talk to teens during free periods

5 - A P.T.A. organization

5 - General survey to determine the needs of students

4 - Drug awareness program outside the school

1 - A drug awareness room in the school

1 - Physical therapy centers

Information from Jr. High School Students (North Sydney)

The information obtained from the junior high school students was gained with the assistance of a teacher who was briefed on the goals of the research. This information is presented as we received it.

Issues, Needs, Concerns

- Emotional - we know where the mental health clinic is, but we have fears and concerns about what is behind the doors;

"there's going to be a lot of crazy people running around there so I don't belong there it's for other people with problems."

"....can't go to the butterscotch palace etc."

- Addiction - Grade 9 students feel addiction education should be for grade seven's and lower.

Attitude to drug education. Students feel there is a real problem with drugs. Too much peer pressure, and some can't handle it. All seem to want help even those bragging about their exploits. Say they have to do what their friends expect of them.

- Needs - A place to go. - Hangout - Friday nights. A gathering place for teens with a positive image. i.e., no pool room etc.

- Problems - Pregnant - what is available? Usually don't know of options or what agencies to turn to for help.

Abused - Sexually and physically. Know of the CAS but often feel they're only there to remove the child from the home, although the image has improved.

Transition house - most know it is there for abused mothers but aren't clear about what happens to the kids.

Appendix X-2

The information obtained from the senior citizens is not ranked.

Meeting with Senior Citizens

Number in attendance - 5 December 18, 1989

- Education re all of the programs that are available to us
- Use of cable TV to reach those who are shut in
- Should be treated with respect - just because you're old doesn't mean you're stupid
- Care for alzheimer's patients
- Drop in center
- Feel abused by physicians, lack of respect, too much medication, reluctance to refer to specialist, or other discipline like social worker. They want to be only entry point into health system.
- Seniors being used as instrument of trial and error and experimentation with drugs
- Education re foot care, nutrition, adult day care etc. Take programs to the people. Involve professionals, establish a resource group of lawyers, tax experts, physicians etc. that we can consult with,
- Transportation committee, form car pools

"It seems that after you get to a certain age you're well it's not exactly that your not human but it's more like they don't feel that you should expect any more, hey don't want to listen to you they just give you a pill, as if that would solve your problems"

Appendix X-3

Single Mothers Living on Low Incomes - Dec. 5 Glace Bay

Education - on drugs, alcohol, nutrition, money management, child care

Issues of Respect and Dignity - how we are treated by Family Benefits workers and CEIC staff

Training - availability of, and how to get access to the programs that are available

Child Care - the need for accessible, affordable child care - if taking training is to be a realistic option

Need for increase in Family Benefits cheque

The importance of having support groups in local neighborhoods

Transportation is provided

Feel freer, more knowledgeable, more confidant

Appendix X-4

Ex-Psychiatric Patients - Sydney

Number in attendance - 18 October 26,1989

41 - Need more money! For transportation, recreation, telephone, television) -contributes to increased isolation. As well, we should have a clothing allowance.

33 - Need more places to socialize (eg. church sponsored organizations)

20 - Dental and eye care should be covered by the province

18 - Cheque should not be cut off because of long-term hospital care (over 4 weeks)

17 - Need direct transportation to the hospital

9 - Those with chronic problems are readmitted for to short a period of time

7 - Need direct admission to the Cape Breton Hospital, should not have go to a general hospital for a referral

7 - Need more follow-up care (social work, volunteers) - should have out reach social workers making visits to the home.

6 - To short of an examination period by psychiatrists. They should provide more emotional support

Ex-Psychiatric Patients - Glace Bay

Number in attendance - 8 November 29, 1989

- ** Need for an outreach social worker to be available for help in the community and to make home visits

- Difficult access to Day Center -must be up every day at 6:00 a.m. - need for improved transportation

- Need assurance that we will not lose our apartments if we are admitted to the Cape Breton Hospital for more than thirty days

- Need for a full-time drop-in center - exclusively for ex-psychiatric patients - as it is now we get swallowed up with ex-offenders

- Need for more education to help improve the attitude of general public regarding image of mental health and ex-psychiatric patients
- could bring students to one of meetings

Appendix X-5

Micmac's, Membertou Reserve

Number present 12 October 25,1989

96 - A liaison person from mental health clinic and all reserves (education)

75 - Counsellor [native or non-native (with specialized degree)] who will work with children and parents, individually or together

58 - Need for various support groups - including; youth, sexually abused, single mothers

51 - Need for ongoing, community workshops addressing problem areas

47 - Need for reserve based counsellors who are available in a crises (youth, family)-crisis line

37 - Need for shorter waiting periods with referrals at the mental health clinic

31 - Need for volunteer lay counsellors for youth

20 - Need for cultural camp to educate youth in their heritage

17 - Need for job training programs for adults

4 - Need for alternate transportation for medical appointments - ambulance is reluctant to transport those with mental health problems

Appendix Y

Special Interest Groups

Appendix Y-1

Presentation by Concerned Citizens in New Waterford

Number in attendance 8 December, 1989

- Full-time mental health clinic in New Waterford
- Improved liaison between mental health workers and visiting homemakers
- Educational, preventative programs for adolescents in the school system
- Outreach programs, including social workers, to visit clients in the clients homes
- Activity, resource center for those with chronic mental health problems
- Self help group for the post-mentally ill
- Supervised housing for those with ongoing mental health problems
- Simpler, less bureaucratic admissions procedures to the Cape Breton Hospital
- Inpatient assessment unit for children/adolescents
- Need for affordable, accessible transportation for clients from New Waterford to the Cape Breton Hospital
- Psychological assessment should be done in the community
- Less medication, and more one to one counselling
- Evening and weekend hours at the Cape Breton Hospital

Appendix Y-2

Meeting with Cape Breton District School Board Staff

Number in attendance - 8 December 8, 1989

- Directory of individuals in mental health services, with their qualifications, areas of specialty and telephone numbers

- More follow-up information on children we refer for mental health services. Regular system in place for them to get back to us. We send them detailed information, we would like to get the same in return. We would like to get recommendations so that we can work with the kid.

- More case conferences regarding our kids, particularly if child has been seen by one of our guidance counsellors. If they are seeing any of our kids it would likely be beneficial for us to be involved too.

- Some reluctance on part of families to go to mental health clinic. Efforts to reduce stigma.

- Coordinating body made up of Family Services, mental health clinic, CAS, and the school. Interdisciplinary committee for children by region.

- Some confusion regarding Family Services and mental health clinic. Education to help clarify this confusion.

Appendix Y-3

Meeting with CFOS

Number in attendance - 17 November 15, 1989

List of Concerns

Respect

- * Stigma is the biggest issue - (no privacy in waiting room in the clinic - dignity and respect)

- No respect! No psychiatric consultation with family members or police officer on admissions. How does psychiatrist know what person was like in the community?

- Hospital should call family members if person is admitted

- The patient or family have no choice in selecting psychiatrist

- The psychiatrist should consult family members regarding daily outings or at least family members should be told if family member will be in the community. It can be disturbing if you have a chance meeting with the patient when you don't know they are out.

Crisis/Admissions

- Differential treatment by examining physicians - some say yes, some say no re admissions

- Concerns regarding admissions policy - one patient admitted three times in three days, keeps getting released

- Improved crises intervention program and admission guidelines for chronic patients

Follow-up

- Need for follow-up or support in the community after the person is released

Treatment/Coordination

- Need for improvement in physician in the community and hospital staff communication - re release of patient, information on medication

- Better consultation or coordination between psychiatrists on different wards in the hospital - medication seems to get changed too frequently and for little reason

Education

- Need for primary prevention program on mental health in the schools

Assessments

- Need for someone to do in home assessments

CBH/Clinic

- Need for extended hours at the mental health clinic (evening and weekends)

- Need for psychiatrists to spend more time with the client/patient

- Stealing of clothes while patient is in the hospital

Appendix Y-4

Meeting with Coordinators of Homes for Special Care

Number in attendance - 6 December 8, 1989

List of Concerns

Accommodation

- Extreme shortage of beds for those over sixty-five in homes for special care, particularly for those with serious psychological problems

- Alzheimers, dementia and those with other types of psychiatric illness don't get along - need for appropriately designed buildings or more units for the elderly who have mental health problems. Sometimes we have to load them up with drugs to control them in our environment.

- Person are sent to Halifax to get classified, then where do they go. There is a shortage of appropriate housing in the industrial area.

Treatment/Assessment

- Need a psycho-geriatric unit for assessment and long-term care (have to be sent to Halifax for updated psych. assessment)

- Outreach and psychological support services for staff in nursing homes. (mental health clinic used to come to Breton Bay nursing home - used to be a team that went to nursing homes.)

- Sometimes we prefer to refer to the Nova Scotia Hospital. They are more responsive.

Communication

- Communication between the Cape Breton Hospital and the nursing homes needs to be improved

- Better sharing of information regarding clients who have violent histories. People will say anything to get those with histories of violence admitted.

- Clarification of admissions policy at the Cape Breton Hospital for those over sixty-five

- We send them to Cape Breton Hospital, they comeback loaded with drugs. The CBH will only keep them for thirty days.

Appendix Z-1

List of Individuals Selected to Receive Validation Form June 8, 1990

Administrators

Dr. John Campbell - Northside

Sandra MacNeil - Northside

Charles Coleman - New waterford

Lowell Blood - Sydney

Al MacLean - Glace Bay

Socio-mental Health Workers

Beth MacIssac - Northside - Memorial H.S

Greg Andruyshun - New Waterford

Frank Sampson - Sydney

Sgt. Mike MacMullin - Sydney

Patti Guy - Glace Bay

Barry Macdonald - Industrial Area

Consumer

M. Flynn - New Waterford

T. Usher - Sydney

Public

Ron Neville - Northside

Stewart Perry - Sydney

George MacDonald - GLace Bay

CFOS

Renylda Bruce

Youth

Ron Neville
George MacDonald

Women

Sandra MacNeil

Seniors

Dale Orychock

Community Friends

Marg Graham

School Board

Heidi MacLellan

Micmacs

Ruth Christmas

Appendix Z-2

Recommendation Feedback Form

Name _____ Agency/Group _____

Position _____

Do you believe that the recommendations contained in this summary offer appropriate and useful solutions to the mental health needs in industrial Cape Breton?

Yes ___ No ____

Please Elaborate (If commenting on a specific recommendation, please refer to it by its number.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

What would you suggest is an appropriate format to release the findings of the needs assessment survey to the community?

Public Forum ____

Executive Summaries Distributed to key individuals and agencies ____

Through the media ____

Other (please specify) _____

Would you be receptive to the idea of a coordinating and planning body for the delivery of mental health services in the industrial area of Cape Breton?

Yes____ No ____

_____

_____

_____

If "Yes", would you participate in such a body?

Yes ____ No ____

_____

_____

_____

If you agree with the idea of a coordination and planning body can you suggest an individual, agency or organization that would be appropriate to help establish such a body?

_____

_____

_____

Thank-you for your help.

Appendix Z-3

Dear

Further to our conversation of June 12, 1990, find enclosed a copy of a draft of the executive summary of a report I am in the process of preparing on behalf of the Cape Breton Mental Health Association entitled, A Mental Health Needs Assessment of Industrial Cape Breton. As the summary of the report is approximately 40 pages I thought it was appropriate to provide you with this brief overview of the project including the research goals, the methodology and the recommendations. A copy of the Summary and Discussion of the results of this survey is available through Ms. Rhonda Meahan of the Cape Breton Mental Health Association in Sydney. (539-3370 Ext. 125.) A final report will be available this fall.

As I indicated in our conversation I would appreciate receiving feedback regarding the recommendations from a number of stakeholders who participated in the survey. I recognize that only a few of recommendations may pertain to yourself, your group or your agency. Please feel free to comment on as many or as few of the recommendations as you wish. I intend to use the feedback as a validation mechanism to insure that the recommendations offered are both useful and appropriate for planning the delivery of mental health services in the industrial area. Your comments and suggestions will be both appreciated and helpful.

If you have any questions please don't hesitate to contact me. The attached form may be used to submit your comments. I would appreciate receiving your feedback by July ,1990.

I should mention that while I am completing this project on behalf of the Mental Health Association you should forward your comments and any questions relating to the research to me at the following address:

Department of Psychology,
Wilfrid Laurier University,
75 University Ave., West,
Waterloo, Ontario,
N2L 3C5
Tel. 519-884-1970 Ext. 2929
Fax. 519-886-9351

Thank-you for your assistance in this matter.

Sincerely yours,

James Ross

Appendix 2-4

Recommendation Number & Service Category		Number of times the Mental Health Recommendation was Referred to by Respondents
R1	Problem ID	3
R2	Problem ID	2
R3	Problem ID	3
R5	Coordination	4
R6	Coordination	1
R8	Coordination	2
R9	Crisis Response	5
R11	Crisis Response	3
R12	Crisis response	1
R14	Therapy	3
R15	Therapy	2
R16	Therapy	2
R17	Vocational	1
R19	Social/Recreational	3
R21	Familial Support	1
R23	Familial Support	1
R24	Accommodation	2
R25	Accommodation	3
R26	Accommodation	4
R27	Accommodation	1
R28	Transportation	3
R29	Transportation	4
R30	Transportation	1
R31	Transportation	1
R32	Transportation	5
R33	Education	6
R34	Education	1
R35	Education	2
R36	Education	1
R37	Education	1