CENTRAL AND SOUTH CARIBOO
MENTAL HEALTH SERVICES GAPS ANALYSIS

FINAL REPORT

Prepared for the Cariboo Regional District
By Kimberly Vance-Lundsbye, Researcher
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CONTENTS

EXECUTIVE SUMMARY:

The Cariboo Regional District, together with community partners including representatives from Interior Health, local Canadian Mental Health Association branches, Aboriginal health and social services, local government, policing, education, non-profit and government agencies, applied to the BC Healthy Communities Society and secured the Learn & Connect Grant. This grant was allocated to analyze gaps in mental health services in the Central and South Cariboo. This group of grant applicants will herein be referred to as "the stakeholders".

This analysis was conducted between August 2014 and December 2014 and consisted of an online survey distributed to mental health service providers. Service providers completed 52 surveys. A separate online survey was distributed via social media to the general community. Community members completed 33 surveys.

Both surveys explored key questions identified by the stakeholders as important in conducting the gaps analysis:

What are the services currently available?
How are they intended to work?
How do they actually work?
What are the roadblocks?
What is the experience of residents wanting help?
What are the gaps?
How can we work better collaboratively?
How can we increase the enrollment of vulnerable persons into healthy living initiatives?

Both service providers and community members identified gaps and barriers that can be organized under the following three major themes: **Waitlists**, **Geographical Constraints**, and **Navigating the "System"**. **Cultural competency** was identified as an important area of consideration for improving service delivery for Aboriginal people.

Both community member and service provider respondents identified the need for a localized after-hours crisis response and support navigating available services as gaps in current mental health services.

This study focused on identifying and analyzing gaps that that could be addressed by improving inter-agency collaboration. Thus, strengths of current mental health service provision and resources were explored along with barriers to inter-agency collaboration. The recommendations provided at the end of this report reflect that focus.

I-PROJECT BACKGROUND:

HEALTHY LIVING AND MENTAL HEALTH

Healthy living initiatives provided with intent to improve wellness and prevent illness can serve as a response to the impacts of mental illness and improve general mental health (Richardson, Faulkner, McDevitt, Skrinar, Hutschinson, & Piette, 2005). Comorbidities of physical illness such as heart disease or chronic pain can lead to increased functional impairment including loss of employment, social isolation, and financial hardship that cycles back to amplify barriers to improving mental health (Collingwood, 2010). Thus, access to and involvement in healthy living initiatives that promote wellness can prove effective in the treatment of those experiencing mental illness and for all community members to maintain mental health. Health promotion, chronic disease prevention, and participation in healthy activities are key components of creating and maintaining a healthy community (BC Healthy Communities, 2014). Agencies that provide healthy living programs such as food security, nutrition education, physical fitness, and social inclusion may serve as a first contact for community members who could benefit from accessing mental health services. Similarly, direct mental health service providers can refer clients to programs that promote wellness and healthy choices. Collaboration between multi-agencies is key in connecting clients with available services. Thus, identifying gaps in current mental health services and barriers to accessing available healthy living initiatives is a starting point to improve services through collaboration.

GAPS IN MENTAL HEALTH SERVICE PROVISION FOR RURAL AREAS

It is estimated that only a third of Canadians requiring mental health services are accessing them and that ”the situation is worse in northern, rural, remote and other underserviced areas” (Mental Health Commission of Canada, 2009). Gamm, Stone and Pittman (2010) identified several major inherent challenges to accessing mental health care in rural communities. These include geographic constraints, lack of local mental health specialists such as psychiatrists or inpatient psychiatric care, and a perceived lack of anonymity. General practitioners practicing in rural areas are more likely to be sole mental health care providers for patients than those practicing in urban areas. This can be attributed partially to the lack of local specialized mental health care, patient ability to travel to specialists, and long wait times to see specialists in larger centres. Time restrictions (short patient visits/case load and time for continuing education), insufficient mental health training or experience, and lack of specialized support are possible constraints for physicians providing mental health care in rural communities. Social workers, youth counselors, law enforcement and criminal justice workers, outreach workers, or family and friends are more involved in mental health care in rural communities than larger centres.

Gamm, Stone and Pittman (2010) also found there is some evidence to support that smaller centers may collaborate more effectively to provide care for a shared client due to a better knowledge of available services and personal contacts between agencies. However, gaps in essential services and distances between outlying communities and

services provided within those communities may contribute to a breakdown in linking clients with continued or enhanced care.

Specific populations have added challenges to receiving mental health care as there are limitations province-wide to meet the need. For example, as outlined by B.C.'s Representative for Children and Youth (2013) in the report *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C* there are limited options for youth with mental health issues and their families. Long wait times, and general lack of services and treatment spaces (e.g. assessment unit and respite), and missed support during transition into adult services are challenges provincially but are more severe rurally. Travelling several hours to attend an appointment with a psychiatrist is a major barrier for any person requiring such support but is more challenging for a youth who may not have family support or the family may have compounded barriers that restrict travel. The same added barriers may arise for other vulnerable populations such as seniors and persons with disabilities.

Providing mental health care for Aboriginal people in rural areas and reducing gaps in service comes with additional consideration and collaboration with health and social services offered within First Nations communities for First Nations people. Reading and Wien (2009) identify proximal determinants of Aboriginal health, including emotional, mental, and spiritual health. These determinants include health behaviours, physical environments, employment/income, education, and food insecurity. Though, these determinants may prove of similar significance in non-Aboriginal communities, their features are unique. The most important determinant of health amongst Aboriginal people is self-determination, which influences the aforementioned proximal determinants (Chandler & Lalonde, 1998). Mental health promotion and support from within the community itself to help navigate the general healthcare system can both empower and increase the likelihood of a client accessing services (Kirmayer, Simpson, & Cargo, 2003). A local example of this model at work is the role of the *Mental Health Navigator* for the Tsilhqot'in National Government's Health Hub. Their development of the Tsilhqot'in Mental Health Resource Guide (2014) is a tool that demonstrates collaboration with mental health and social services located in Williams Lake through shared information.

Maximizing the effectiveness of available direct mental health services such as healthcare and counseling, and community services that may benefit people with mental health issues such as programs offered through non-profit organizations and social services as well as collaboration between all service providers who come in contact with a community member requiring mental health care is imperative in rural areas (Gamm, Stone, & Pittman, 2010).

COMMUNITY DEMOGRAPHICS

This project aims to examine possible gaps in mental health services or service provision in both the Central and South Cariboo regions in Interior British Columbia.

The Central Cariboo, within this project, is defined as the City of Williams Lake and the outlying communities accessing mental health services located within the City of Williams Lake. The market area of the City of Williams Lake or the Central Cariboo for the purpose of this project is approximately 25,120 residents (The City of Williams Lake, 2014).

The South Cariboo, within this project, is defined as the District of 100 Mile House and the outlying communities accessing mental health services located within the District of 100 Mile House. The market area of the District of 100 Mile House or the South Cariboo for the purpose of this project is approximately 20,000 residents (District of 100 Mile House, 2014).

Typically, people living in outlying communities reside within a 1-hour drive from either centre.

Distance to larger centres that may offer specialized mental health care:

Prince George, B.C (241 km from Williams Lake, B.C)
Kamloops, B.C (196 km from 100 Mile House, B.C)
Vancouver, B.C (455 km from 100 Mile House, B.C / 547 km from Williams Lake, B.C)

DEFINITIONS

MENTAL HEALTH

The World Health Organization (2014) defines mental health as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

MENTAL ILLNESS

Mental illness refers to a range of conditions and disorders that affect mood, thinking and behavior. Mental health issues or concerns become illness when symptoms are ongoing and disrupt functional ability (Mayo Clinic, 2014).

RURAL HEALTH CARE

As 'rural' is a perspective and not easily defined, for the purposes of this project, this gaps analysis project accepts the concept of 'rural' as an identified social determinant in the Central and South Cariboo regions when accessing mental health care. This is decided based on the geographic market area of both service centres as well as the distance to regional hospitals offering specialized healthcare (Rourke, 1997).

II-METHODS:

STUDY DESIGN

The framework that was used to conduct this research involved both quantitative and qualitative methods. Base questions determining the general demographic of respondents were chosen for both the service provider and community member surveys. This was done to ensure there was an adequate representation of responses from both the Central and South Cariboo regions. Also, this allowed for exploration of the possibility of differing perspectives either regionally or dependent on scope of services for service providers. The development of two surveys, one for service providers and one for general community members was done to gather perspectives and also to identify any differences or similarities that may arise in data collected from the two groups.

The service provider survey included a majority of open-ended questions and opportunities to expand answers with intent to collect qualitative data. The expressed support of the project from the stakeholders and willingness to share information on the topic of gaps in mental health services led to this design.

In order to encourage survey completion from community members via social media, the survey was designed to be shorter, 6-8 questions versus the 24 questions in the service provider survey, and included a majority of quantitative data collection methods.

Both surveys were offered in an online format and were able to be completed anonymously as no questions requested identifying information. Completed surveys were collected within an online server and not returned via an identifiable email. Respondents were not requested to offer emails or personal/professional names to complete the surveys.

This anonymous, online method was chosen to encourage respondents to provide input for this gaps analysis without persuasion or concern for subjection from other respondents, as in a group discussion model for example, and also to provide a structure for the input provided to keep data gathered on topic.

SURVEY DEVELOPMENT

Service Providers:

The service provider survey was titled *Mental Health Service Providers in the Central/South Cariboo: Gaps Analysis Survey*. It consisted of 24 questions that were designed using the online research tool development program *SurveyMonkey*. Refer to Appendix A to review a blank survey.

21/24 questions were created with a mandatory answer response that did not allow respondents to complete the survey without providing a response. Remaining questions

were left open as they pertained to specific Yes/No responses requesting further information dependent on the initial answer.

The survey consisted of a mixture of Yes/No, multiple and single choice selection, and text response questions.

The survey was developed by the researcher to answer the questions identified as important in this gaps analysis by the stakeholders.

What are the services currently available?
How are they intended to work?
How do they actually work?
What are the roadblocks?
What is the experience of residents wanting help?
What are the gaps?
How can we work better collaboratively?
How can we increase the enrollment of vulnerable persons into healthy living initiatives?

In addition, questions that required respondents to consider strengths in current mental health services in the Central and South Cariboo were included. This was done to ensure an expressed gap is truly a gap and not lack of awareness of a particular service, for example, and also to reveal potential resources to address identified gaps.

3 professionals who are working either directly or indirectly with people with mental health issues reviewed and provided input for the survey prior to completion and distribution. These reviewers work in healthcare, social services, and in community inclusion respectively.

Community Members:

The community member survey was titled *Let's Talk about Mental Health in the Cariboo.* It consisted of 6-8 questions and two streams of choice based on whether the respondent or their loved one has accessed services or supports or did not access services or supports for their mental health issue. This survey explored their experience accessing services and the reasons why services were not accessed. This survey was designed using the online research tool development program *SurveyMonkey*. Refer to Appendix B to review a blank survey.

This survey was developed using a mixture of Yes/No, multiple and single choice selection, scaling questions, and text response questions.

This survey was developed by the researcher to address the question regarding the experience of residents wanting help identified as important in this gaps analysis by the stakeholders. The first stream of this survey (A) included a scaling question with pre-set experiential statements about accessing mental health services. These statements were adapted from a similar Australian survey that was distributed online to measure clients'

experiences accessing mental health services (www.mhsa.aihw.gov.au). The second stream (B) offered pre-set choices for reasons services were not accessed with the opportunity to provide more reasons.

PARTICIPANT SELECTION

The service provider survey was distributed to 45 mental health service providers in the Central and South Cariboo via email with encouragement to share the survey with coworkers and partners. These service providers included a range of administrative and frontline workers, stakeholders and people unfamiliar with this project. Refer to Appendix A to review the email message that accompanied the survey request. 2 reminder emails were sent to the original list of 45 mental health service providers. There were no limitations on how the survey could be shared and to who as the survey was designed to easily remove responses provided by respondents from outside the scope of the project.

The community member survey was distributed on both 100 Mile House and Williams Lake specific *facebook* special-interest groups. These groups were general in nature besides their regional specification. The post *"If you or someone you know in the Cariboo has experienced a mental health issue, share your opinions on current services here:"* fronted the survey link in these groups. Though any member of these groups could respond to the survey, there were questions included that improved the chances their input be relative to the study. They had to identify themselves as someone living in the Williams Lake or 100 Mile House areas or "other" and specify. 54 community members began the survey and 33 completed it.

DATA COLLECTION

Data for both surveys was collected via the online research tool development program *SurveyMonkey*. This program collects and maintains the collected data. There are also some basic analysis tools inherent to the program.

Further qualitative data was collected on October 9th 2014 at a stakeholder meeting after the survey data was collected with intent to allow stakeholders to provide further input on select questions.

Online discussion within the social media groups was inspired from the request for input from community members via the survey and further qualitative data was gathered from these discussions.

Refer to Appendices C and D to review tables of relative collected data from both surveys. Qualitative responses have been included with only identifying factors removed and some grammatical and spelling errors corrected.

III – FINDINGS

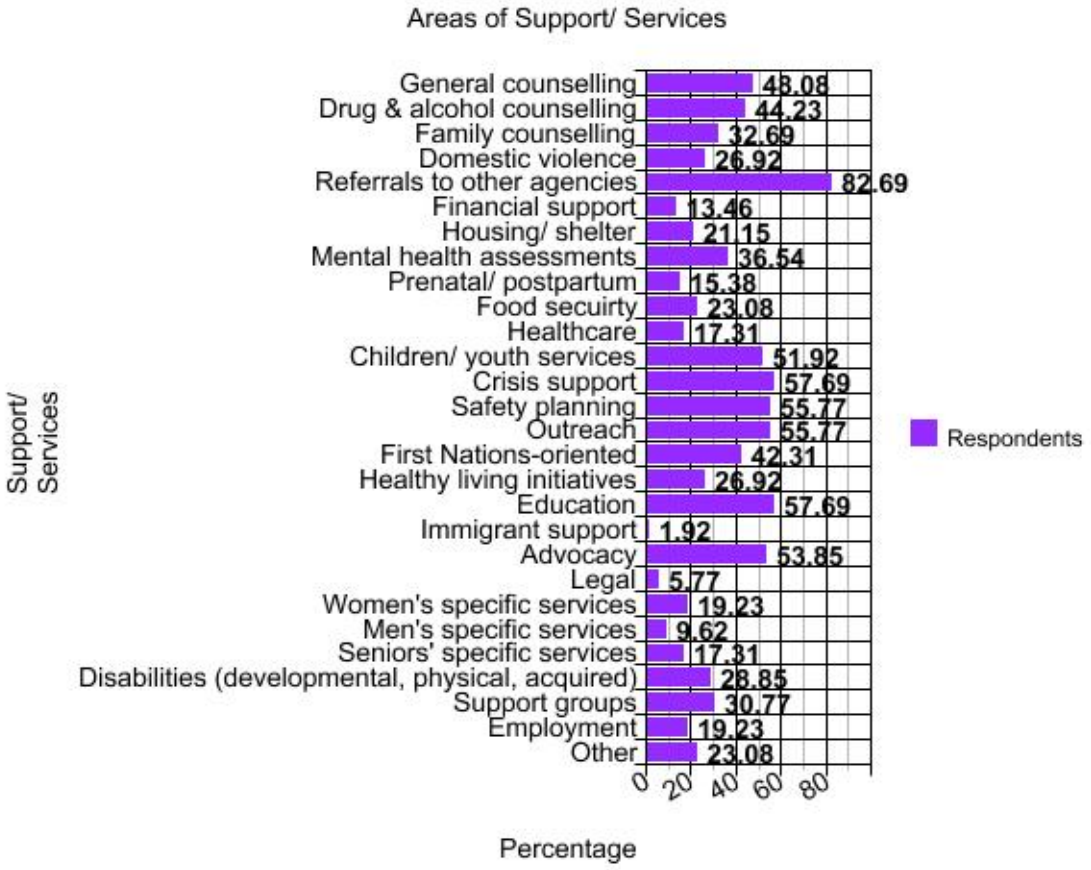
DEMOGRAPHIC CHARACTERISTICS

Service Providers:

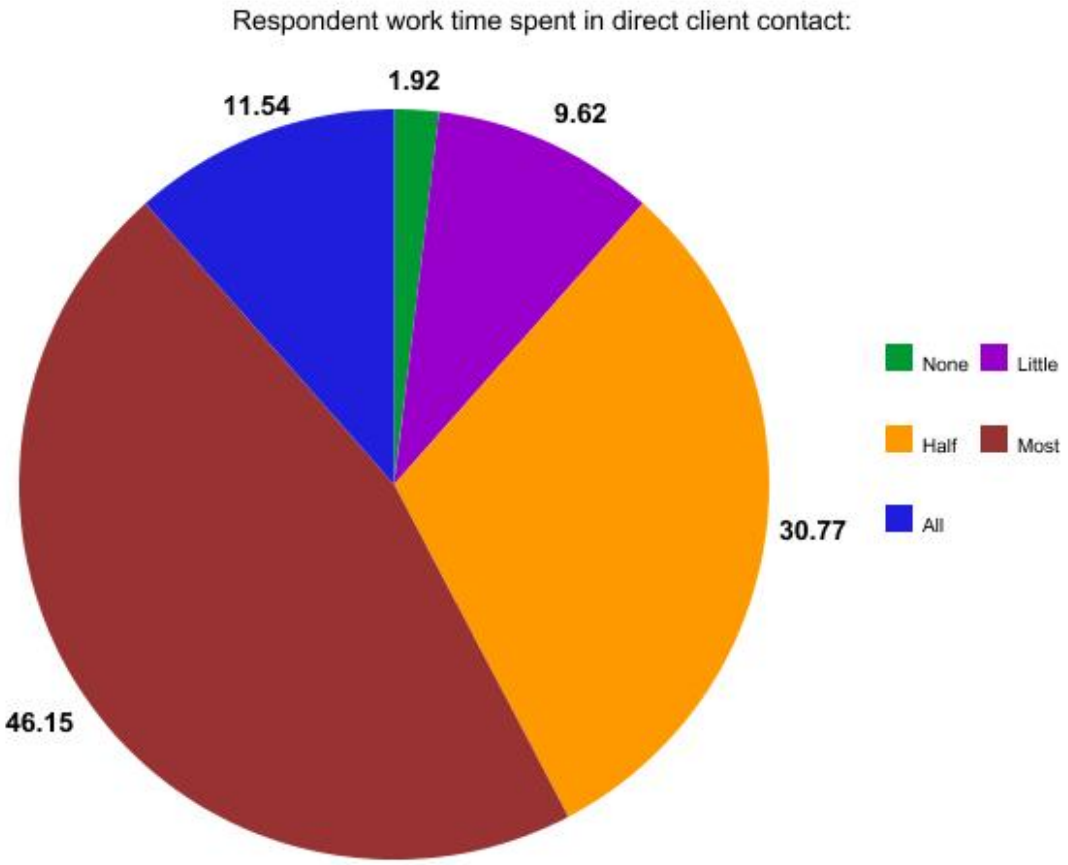
52 respondents completed the *Mental Health Service Providers in the Central/South Cariboo: Gaps Analysis Survey*. 37% of respondents were from the 100 Mile House area (South Cariboo) and 52% were from the Williams Lake area (Central Cariboo). Another 12% identified as "*Other*" with half of those working in rural outlying communities in either region and the other half working in both South and Central regions.

44% offered mental health specific services, 19% offered support services accessible by clients with mental health issues and others, and 37% offered both specific and support services.

The following graph represents the percentage of respondents working in the following reported areas of mental health support/services:

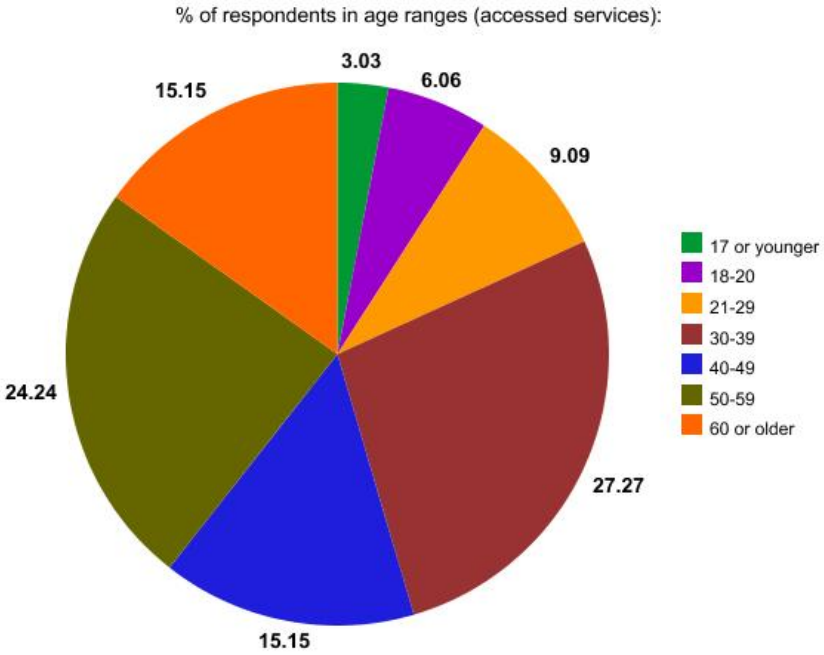


Other reported areas of mental health supports and services included: literacy, art therapy, cultural initiatives, transportation assistance, independence, hospice, parenting support, social services and child protection.

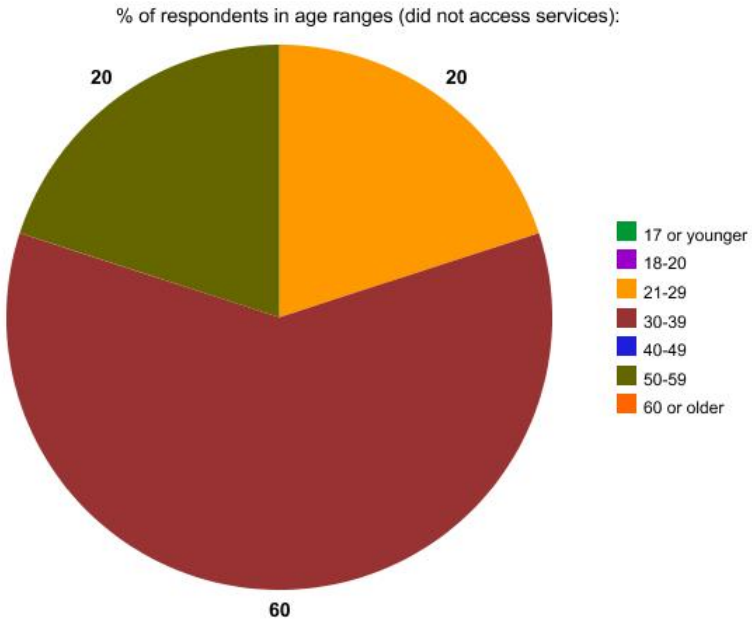


Community Members:

33 community members completed the *Let's Talk about Mental Health in the Cariboo* survey. 61% of respondents that did access mental health services lived in the Central Cariboo and 39% lived in the South Cariboo.



80% of respondents who did not access required mental health services lived in the Central Cariboo and 20% in the South Cariboo.



SURVEY RESPONSES & THEMES

Note: The collected data from both the service providers and community members was analyzed by region (Central and South) to identify if there were significant differences in responses and themes. There were no significant differences in responses noted so data was combined for this analysis.

Current Mental Health Services in the Central/South Cariboo

Service Providers:

In order to identify gaps in current mental health services, exploratory questions were asked in a variety of ways and with different wording to ensure respondents were given adequate opportunity to address the questions:

How are they (current services) *intended to work?*
How do they actually work?
What are the roadblocks?
What are the gaps?

According to respondents the usage of services by clients with mental issues compared to the current capacity (staffing, funding, resources) is often oversubscribed. While 54% felt their services were oversubscribed, 38% of respondents felt their utilized services are generally meeting capacity. There is potential that these percentages could be even higher as one respondent reflected "*the need is often higher than the utilization because utilization is not a good measure of need. It does not take into account client barriers to access, which is often poverty, discrimination, geographical barriers and ineffective or inappropriate services being offered."* Another factor that influenced how respondents answered this question was the weather. While some respondents commented that poor driving conditions in the winter lower the utilization of their services, others found that the summer months brought fewer clients. The common occurrence of waitlists for services was the predominant reason given for how respondents measured their services to be oversubscribed.

63% of respondents felt their services were working as intended to meet client needs and program goals. Program design and delivery, particularly support for clients while on a waiting list for other services, and collaboration with other service providers were key strengths identified by these respondents in achieving this. The main reasons offered by the 37% who reported that their services are not working as intended to meet client needs and program goals were: waitlists, geographical constraints, and a lack of specialized care providers. These statistics are supported by the high percentage (77%) of respondents who reported their agency to have a formal evaluation tool to track how and if client needs/program goals are being met. These tools are also in high use, according to respondents as 83% of those with evaluation tools used them "*often*" or "*always*".

Respondents identified the following specific populations with a low representation in their agencies' client demographic: LGBTQ, early childhood and children/youth, men, seniors, Asian and Indo-Canadians, and those with both low-incomes and high-incomes. The most common population named with a low representation by non-Aboriginal service providers was Aboriginal people. Urban Aboriginal people living off reserve were the most common population named with a low representation by Aboriginal service providers.

Overall, the most common gaps and barriers identified by service providers are gathered under the following three themes:

1. **Waitlists**

Many respondents described waitlists as a major challenge in meeting program goals and client needs. Reasons offered for the common occurrence of waitlists included: funding constraints and understaffing ("burn-out", funding, and a lack of qualified applicants for existing positions). Waitlists for specialized care such as psychiatric services was reported as the most problematic for meeting client needs. "*Over 20 youth to 1 worker; counsellors are booking 6 weeks in advance; we cannot meet demand; 6-9 month waiting list*".

2. **Cultural Competency**

A lack of Aboriginal service providers working within service centres and a lack of diversity in general amongst service providers were reported by respondents as barriers for clients to access required services. Clients with language barriers were reported to be at a greater risk. Respondents felt that services following a medical model do *"not fit everyone"* and that "*First Nations families do not always subscribe to western models of service delivery"*. Respondents expressed that there is a lack of non-Aboriginal service providers with cultural competence training and a lack of opportunities for further training or education.

3**. Geography-Rural**

Respondents reported that their clients travel up to 4 hours to access services. Transportation options, cost, time off work to travel, childcare, and weather conditions all were given as factors that inhibit people's ability to access services.

The challenge of providing care in a crisis was a factor in all three main themes. Respondents questioned an individual's safety while on a waitlist. Hesitance in referral to agencies due to a lack of cultural competency was noted and the distance of residents living in outlying communities to specialized care was expressed as especially concerning during a crisis.

These themes are explored further as well as a list of other identified gaps and barriers by service providers in Appendix C.

Client Experience

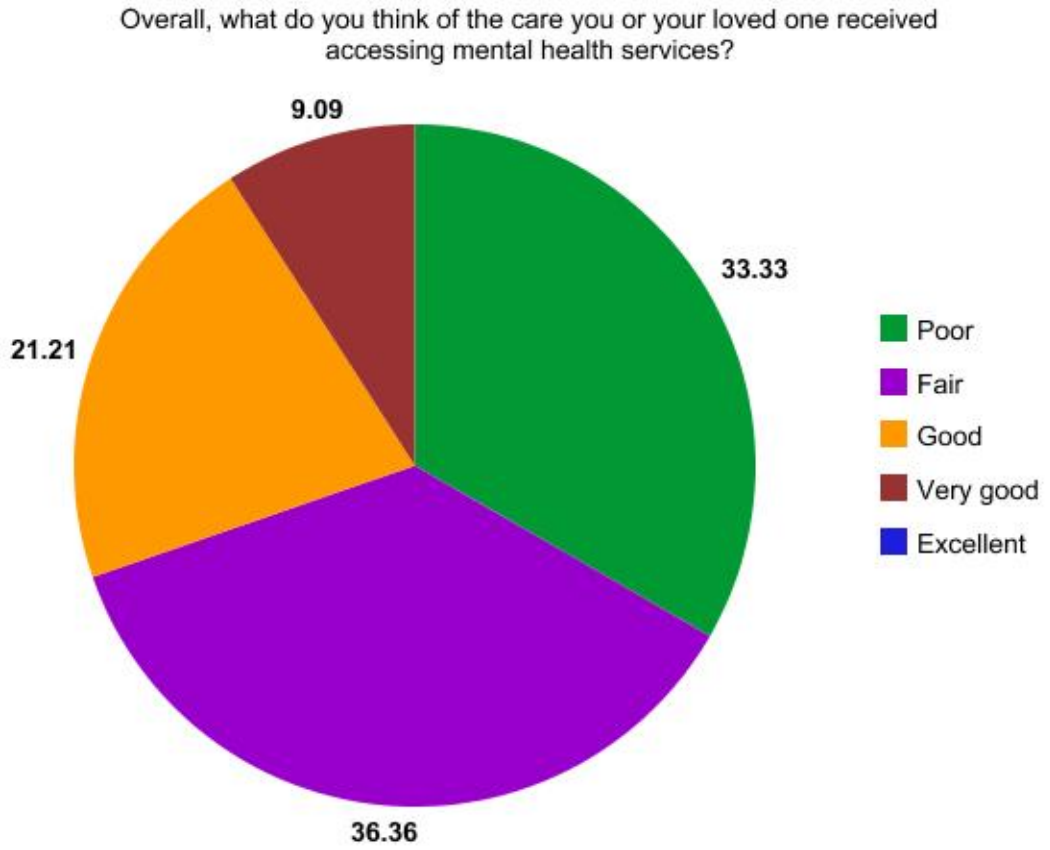
Service Providers & Community Members:

Service providers were asked to comment on their impression of their clients' experience accessing their services and other services within the community. The majority of service providers felt that the people who accessed their services had a positive experience and saw an improvement in their mental health and/or quality of life after accessing services. They reported that they had heard client's describe their agencies as "*welcoming*" and "*nonjudgmental*". The most common word used to describe mental health service providers by community members was "*caring*". Some service provider respondents relayed that their clients had expressed they had a negative experience when accessing services at another agency. These experiences were described largely as negative due to the client feeling "*judged*". Community members most often described service providers that were not familiar treating their particular mental health issue/illness as an aspect of what they "didn't like" when accessing mental health services in the Cariboo.

Community members were asked to rate their experience accessing mental health services using a series of pre-set statements:

	Needs LOTS of improvement.	Needs SOME improvement.	Needs NO Improvement.	N/A
How easy it is to get the services and supports I/they need…	40.63%	**50%**	9.38%	0%
How easy it is to get help in a crisis…	41.94%	**48.39%**	6.45%	3.23%
How easy it is to see a doctor/counselor/ worker when I/they needs to…	**50%**	43.75%	6.25%	0%
How well this person listens…	25%	**43.75%**	28.13%	3.13%
How much time this person spends with me/my loved one…	28.13%	**56.25%**	15.63%	0%
The level of respect this person and other staff on site show me/my loved one…	28.13%	31.25%	**40.63%**	0%
Opportunities for me to have a say in my/their own care…	**37.5%**	25%	31.25%	6.25%
How safe I/they feel when accessing mental health services…	25%	**40.63%**	34.38%	0%
The amount of information I/they get about my mental health issue and treatment…	**37.5%**	28.13%	28.13%	6.25%
Information about my/their rights and responsibilities…	**37.5%**	**37.5%**	21.88%	3.13%
Information about other mental health and community services…	**46.88%**	34.38%	15.63%	3.13%
Information about how to maintain my/their mental health…	28.13%	**62.5%**	9.38%	0%
Information about who to contact in a crisis…	**46.88%**	40.63%	12.5%	0%
The amount of information I/they get about different types of treatments available…	37.5%	**53.13%**	9.38%	0%
The choices I/they have in the treatment I/they receive…	**43.75%**	34.38%	15.63%	6.25%

The following graph shows how community member respondents rated the overall care they received accessing mental health services (values in percentages):



Refer to Appendix D to review all of the comments provided by community member respondents.

Healthy Living Initiatives

Service Providers:

Only 13% of service providers felt that healthy living initiatives are often utilized by individuals with mental health issues in their community. Another 58% reported they felt these initiatives are somewhat utilized by this group. However, many of the strengths identified as successes in meeting program goals for clients included these initiatives. Examples given by respondents included recreation and cultural activities, art therapy, food security, life skill development, positive parenting, literacy programs, employment readiness, and programs that encouraged social inclusion.

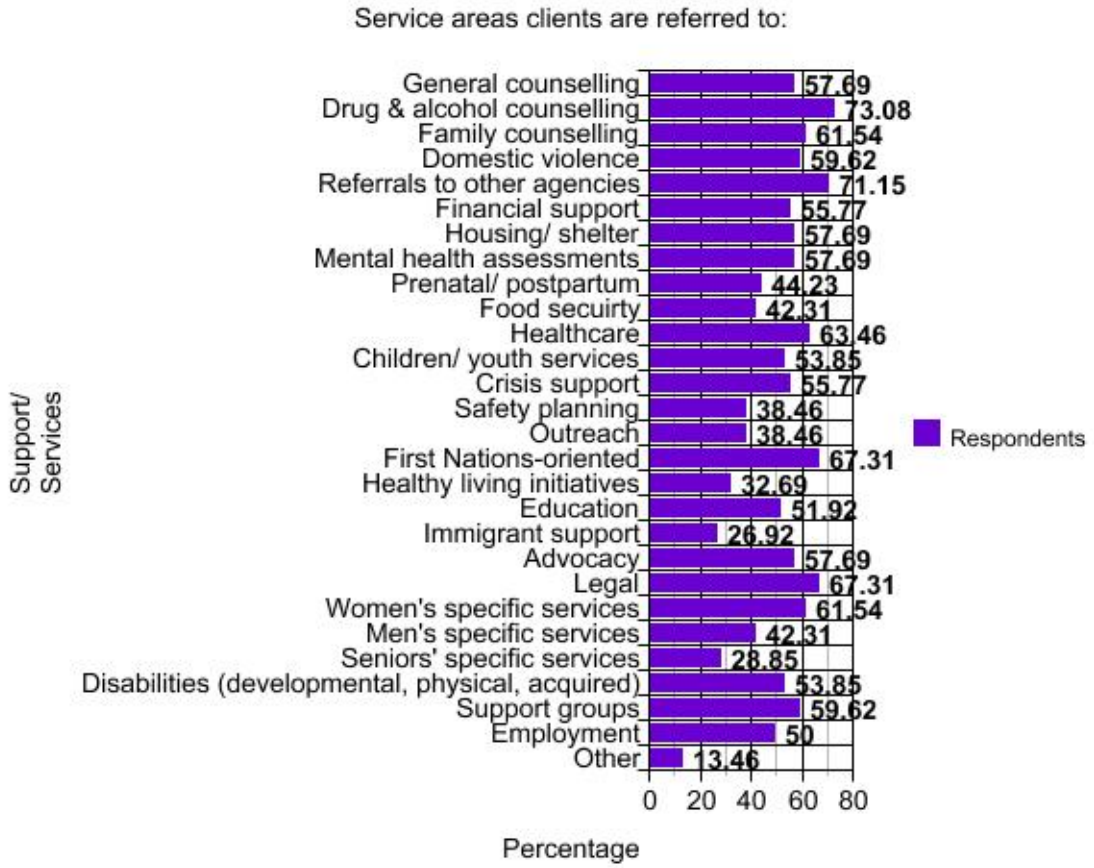
Respondents reported that there is a lack of work time available for preventative services such as healthy living programs. As one respondent stated, "*Due to staffing the most severe/acute cases get priority, which creates a situation where prevention work becomes virtually impossible.*"

Inter-Agency Collaboration

Service Providers:

96% of respondents reported that their agency had an established practice of referring clients to other agencies. This is supported by the 83% of total respondents that identified *referrals to other agencies* as a client support service offered by their agency. According to respondents, clients are referred to other agencies an average of 60% of the time.

The following graph represents the service areas where clients are most and least referred:



56% of respondents reported they felt very knowledgeable about other agencies' services that may offer different or additional support to their clients and felt comfortable making referrals accordingly. A further 27% were neutral to the statement provided to rate.

However, respondents reported some hesitance in referring out of agency. Reasons given were:

- A lack of awareness of what other services offer/fit for client.
- Long wait times for response from the referral recipient.
- Lack of cultural competence of the referral recipient.
- Services changing quickly due to changes in funding.
- A trend in referring to a few key agencies over and over without seeking new options.

Refer to Appendix C for a complete collection of respondent suggestions on how mental health service providers in the Centra/South Cariboo can improve collaboration.

IV: DISCUSSION

LIMITATIONS

The following limitations have been identified in this research project:

- The word "community" in the survey questions for service providers is a limitation. The survey did not encourage respondents to comment on inter-agency collaboration between the two Cariboo regions (Central and South). Most respondents referred to their respective regions only when providing input regarding "community".
- The majority of data collected was self-reported and can, therefore, not be verified.
- Though, a second stream was provided for community member respondents to provide input if they or their loved one did not access required mental health services, there were few respondents in this stream so the data was insufficient.

CONCLUSIONS

Overall, both service providers and community members reported a high client satisfaction from those that accessed the services they needed but also identified the same main gaps in client experience accessing mental health care/services in the region:

1. **Waitlists:**

Concerns over continuity of care were expressed by both service providers and community members – *"I still have no counselor access after 6 months"* and *"The psychiatrist cancelled both appointments…your file gets cancelled if you haven't made an appointment within a time frame."* Service provider respondents reported that some successes they have had in meeting client needs regarding waitlists was with the provision of support services, both 1-1 and group, for clients on waitlists for specialized care. Another strategy that has shown success, according to service provider respondents

was inter-agency collaboration that worked to support clients while waiting for specialized care.

2. **Geographical constraints:**

Community member respondents expressed frustration over the lack of local specialized care services. Waitlists to see out of town or travelling psychiatrists was identified as a barrier to accessing required mental health services as aforementioned. Primary care provided by a family physician as a response to the lack of local specialized care was reported to be helpful by some community member respondents and insufficient by others.

Cost, time away from work, transportation, and weather were identified as barriers to traveling to access services, both at local service centres (Williams Lake and 100 Mile House) and larger service centres (Prince George, Kamloops, and Vancouver) by community members. Service provider respondents shared this concern – *"Services are not accessible to those living in remote areas"* and *"difficult to drive the distance"*. People with mental health issues/illness are *"isolated"*.

3. **Navigating "the system":**

Service provider respondents reported clients' have expressed a difficulty accessing services due to being given *"the runaround"* and that clients have a lack of awareness about available services. Both community member respondents and service providers reported that clients had to make contact with several different service providers before accessing the appropriate service – "*I ended up going to the ER and finally got some help"* and *"When my spouse had a manic attack we couldn't get help and it was the weekend. This needs to change so that families are safe"* and *"I had to do my own research"*.

Both community member and service provider respondents identified the need for a localized after-hours crisis response and support navigating available services as gaps in current mental health services.

Though respondents clearly identified the lack of specialized care providers and mental health program funding as gaps, this study's focus was on identifying and analyzing gaps that could be addressed by improving inter-agency collaboration.

Several questions were asked to address potential gaps in working together collaboratively and also to explore current positive collaborations and collaborative strategies.

Key barriers for inter-agency collaboration identified by respondents were:

1. Limited funding - hours, coverage for time away from program.
2. Confidentiality constraints – policy, client unwillingness for information to be shared.

3. Lack of cultural competency.

Other noted barriers included: disinterest, lack of awareness/knowledge of other service providers and/or what they offer potential shared clients, agency politics, lack of support from administrators to attend meetings, policies and protocols, competition for funding, geographical distance between agencies, and a lack of an existing relationship or poor relationships inter-agency.

Respondents provided existing successful collaborations: tables, committees, and working groups to assist both specific clients and general service delivery. Conferences and events where service providers come together to share information with one another and the community were noted as current positive inter-agency collaborations.

"*Most agencies very welcoming and open to dialogue and change.*"

"*When we collaborate we can get a lot accomplished for our clients, everyone comes with interesting solutions."*

RECOMMENDATIONS

Inter-agency collaboration that strives to regularly take stock of current supports/services and allow for opportunities to meet to discuss mental health care in the Cariboo is a key starting point to improve inter-agency knowledge of one another's services. The continuation of or an evolvement of the mental health stakeholders group that encompasses representatives from both regions is recommended. This stakeholder group could develop and manage the following recommendation.

In order for this collected and updated knowledge of services to best serve the client in crisis and otherwise, the development of a "navigator network" wherein a service provider can be reached at all hours to provide information could address the gap identified in crisis care. The stakeholder group could determine the roles and responsibilities of these positions, appoint service providers to the network, and develop and maintain strategies for crisis care that would be shared by network navigators with first responders, family, and clients in a crisis. To address the cultural competency barrier, it is recommended that there is cultural diversity within this network. The existing Aboriginal health navigator/advocate roles were identified as strengths in current services and could work in conjunction with this new role or instead of when meeting the mental health needs of Aboriginal people. To address the rural communities barrier, it is recommended that there are navigators from both regions appointed to the network from varied agencies. Though appointed navigators would likely belong to or at least be affiliated to the stakeholder group, their role as navigator would be to provide information and after-hours options and safety strategies to those in crisis. As service provider respondents identified funding barriers to inter-agency collaboration and to the oversubscription of current services due to limited hours, it is recommended that the stakeholder group apply for funding to create and manage this network.

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APPENDIX A

SERVICE PROVIDER SURVEY

Email message that accompanied link:

Important Notice for Community Service & Mental Health Service Providers in the Cariboo:

The Cariboo Regional District was successful in obtaining a grant to complete an analysis of mental health services currently offered within the South & Central Cariboo region and identify any gaps in these services. This survey is one of several research techniques being used to collect data for this project. This e-survey tool allows for anonymity for respondents. All identifying factors that may arise from the text responses will be removed from the final report to protect anonymity.

Note: This email has been sent to typically one email address per agency that provides services that benefit people with mental health issues in the Williams Lake and 100 Mile House area.

Please do share this email and link within your office email database so that all staff that work with or interact with these clients can weigh in.

Please take time to answer the text responses with as much detail as possible. Results from this study have the potential to lead to the application for further funding to address some of the issues that arise so your input is important.

Follow the link below:

https://www.surveymonkey.com/s/CaribooMentalHealth

Input will be gathered until **September 30th 2014**.

If you have any questions about this survey or about the project, please contact researcher Kimberly Vance-Lundsbye at 250-706-3143 or kimberlylundsbye@hotmail.com

Thank you in advance for your input and support of mental health services in the Cariboo.

Mental Health Service Providers in the Central/ South Cariboo:
Gaps Analysis Survey

1. I work in the:

100 Mile House Area
Williams Lake Area
Other:

2. My agency provides:

Mental health specific services (Example: counseling, clubhouse, etc.)
Support services accessible by clients with mental health issues and others (Example: food
security, affordable housing, etc.)
Both

3. My agency provides client support/ services in the following areas: (Check all that apply.)

General counselling
Drug & alcohol counselling
Family counselling
Domestic violence
Referrals to other agencies
Financial support
Housing/ shelter
Mental health assessments
Prenatal/ Postpartum
Food security
Healthcare
Children/Youth services
Crisis support
Safety planning
Outreach
First Nations-oriented
Health living initiatives
Education
Immigrant support
Advocacy
Legal
Women's specific services
Men's specific services
Seniors' specific services

Disabilities (developmental, physical, acquired)
Support groups
Employment
Other:

4. How much work time do you spend in direct client contact?
None
Little
Half
Most
All

5. Rate your agency's current (past 12 months to present) usage of services by clients with mental health issues compared to the current capacity (staffing, funding, resources).
Services are not utilized.
Services are rarely utilized.
Services utilized are generally meeting capacity.
Services are somewhat over utilized.
Services are very over utilized.

Comments:

6. Are your services working as intended to meet client needs/ program goals?

Yes
No (Please explain.):

7. Describe barriers for meeting client needs/ program goals. Specify if your program is under or oversubscribed.

8. Describe some of your agency's successes in meeting client needs/ program goals.

9. Does your agency have a formal evaluation tool to track how and if client needs/ program goals are being met?

Yes
No

10. If you answered "Yes" to Question 9, how often is the evaluation tool used?

Never
Half of the time
Often
Always

11. List specific populations that have a low representation in your agency's client demographic that could benefit from services offered at your agency. (Example: gender, age, ethnicity, socio-economic status, etc.)

12. Does your agency have an established practice of referring clients to other agencies?

Yes
No

13. If you answered "Yes" to Question 12, how many clients are referred to a service provider outside your agency?

Few
Half
Most
All

14. If you answered "No" to Question 12, explain:

15. Which services do you refer your clients to outside your agency? (Check all that apply.)

General counselling
Drug & alcohol counselling
Family counselling
Domestic violence
Referrals to other agencies
Financial support
Housing/ shelter
Mental health assessments
Prenatal/ Postpartum
Food security

Healthcare
Children/Youth services
Crisis support
Safety planning
Outreach
First Nations-oriented
Health living initiatives
Education
Immigrant support
Advocacy
Legal
Women's specific services
Men's specific services
Seniors' specific services
Disabilities (developmental, physical, acquired)
Support groups
Employment
Other:

16. I feel very knowledgeable about other agencies' services that may offer different or additional support to my clients and feel comfortable making referrals accordingly.

Strongly disagree
Disagree
Neither disagree nor agree
Agree
Strongly agree

Comments:

17. Describe barriers for inter-agency collaboration in the Central & South Cariboo in mental health services.

18. Describe some positive inter-agency collaboration experiences in the Central & South Cariboo in mental health services.

19. Share a few ideas on how these agencies could collaborate more effectively.

20. As a service provider, what is your impression of your clients' experience accessing your services and others? What are some comments heard from your clients?

21. To your knowledge how well utilized are healthy living initiatives by individuals with mental health issues in your community.

Initiatives are not utilized.
Initiatives are rarely utilized.
Initiatives are somewhat utilized.
Initiatives are often utilized.
Initiatives are over utilized.

22. Describe gaps in mental health services/ service delivery in the Central and South Cariboo region.

24. Describe strengths in mental health services/ service delivery in the Central and South Cariboo region.

APPENDIX B

COMMUNITY MEMBER SURVEY

Let's Talk about Mental Health in the Cariboo Survey

1. Choose the following statement that describes your experience.

I have accessed services/ supports in the Cariboo for a mental health issue.
My family member of friend has accessed services/ supports in the Cariboo for a mental health issue.
I did not access services/ supports for a mental health issue that I did/or currently have.
My family member or friend did not access services/ supports for a mental health issue that they did/ or currently have.

A Respondents: Accessed Services/Supports

2. I live in the:
Williams Lake Area
100 Mile House Area
Other:

3. What category below includes your age?

17 or younger
18-20
21-29
30-39
40-49
50-59
60 or older

4. Rate your (or your loved one's) experience accessing mental health services:

	Needs LOTS of improvement.	Needs SOME improvement.	Needs NO Improvement.	N/A
How easy it is to get the services and supports I/ they need…				
How easy it is to get help in a crisis…				
How easy it is to see a doctor/counselor/ worker when I/they needs to…				
How well this person listens…				
How much time this person spends with me/ my loved one…				
The level of respect this person and other staff on site show me/ my loved one…				
Opportunities for me to have a say in my/ their own care…				
How safe I/ they feel when accessing mental health services…				
The amount of information I/ they get about my mental health issue and treatment…				
Information about my/ their rights and responsibilities…				
Information about other mental health and community services…				
Information about how to maintain my/ their mental health…				
Information about who to contact in a crisis…				
The amount of information I/ they get about different types of treatments available…				
The choices I/they have in the treatment I/ they receive…				

5. Overall, what do you think of the care you or your loved one received accessing mental health services?

Poor
Fair
Good
Very good
Excellent

6. Describe what you didn't like when accessing mental health services in the Cariboo?

7. Describe what you did like when accessing mental health services in the Cariboo?

8. Are there mental health supports or services that you cannot access that you or your loved one need?

Yes
No

Comments:

B Respondents: Did Not Access Services/Supports

2. I live in the:
Williams Lake Area
100 Mile House Area

3. What category below includes your age?

17 or younger
18-20
21-29
30-39
50-59
60 or older

4. Why did you or your loved one NOT access supports/ services for a mental health issue you/ they did (or currently) have? Check all that apply.

Don't know about services available in my area.
Negative previous experience accessing services.
Transportation
Service needed is not available in my area.
Don't feel comfortable asking for help,
Process is too complicated.
Can't afford the service needed.
No childcare.
Can't take time off work.
Prefer to self-manage my issue.
Other:

5. Overall, how would you rate your (or your loved one's) mental health?

Poor
Fair
Good
Very good
Excellent

6. Share some ideas on how mental health services/ supports could improve or change in the Cariboo to better serve the community.

APPENDIX C

This table is an organized collection of identified *Gaps* or *Barriers*, *Strengths* or *Resources*, and *Collaboration Suggestions* derived from the collected data from both the Service Provider and Community Member surveys.

The top 3 most commonly identified gaps/ barriers and strengths/ resources by service providers are listed and expanded. Italic texts in this document are the words of respondents.

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
Service Providers		
1. Waitlists • Understaffed • Lack of funding • Too few qualified clinicians (i.e. psychiatrists) • Long waiting times between appointments – continuity of care • Staff "burn-out" • 54% of respondents felt their services are over utilized. – "*Over 20 youth to 1 worker; counsellors are booking 6 weeks in advance; we cannot meet demand; 6-9 month waiting list*". 2. Cultural Competency • Lack of Aboriginal service providers (off-reserve) • Aboriginal "*safe practices that include traditional healing*"	1. Collaboration with other service providers/ community partners • 96% of respondents have an established practice of referring clients to other agencies. The most common services referred to were reported as: drug & alcohol counselling (73%), legal (67%), and family counselling (62%) • Sharing information with clients about other services available • Referrals to other services while clients are on waitlist 2. Services for Aboriginal people available on reserve • Clients feel "*safe*", "*supported"* • Service is culturally appropriate	*"Advertising to promote programs more widely and to appropriate referral sources."* *"I would like to know about if there are other service providers offering similar or different service that could be beneficial for my clients."* *"I feel that (clients) should be able to access a bed anywhere in the province for timely assessment and care in a tertiary setting specific to mental health."* *"More forums with open invites. Things called 'Community Inclusion/ outreach etc.'"*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• Lack of diversity amongst service providers/ staff • Mental health services dominated by medical model – "*does not fit everyone*". • Language barriers • Lack of cultural competence training for non-Aboriginal service providers and trained/ informed non-Aboriginal service providers • Limited resources to travel to First Nations communities • "*Clients mistrust health providers off site, fear, racism, travel, difficultly finding certified staff willing and able to relate culturally/ socially.*" 3. Geography-Rural Communities • Clients travel up to 4 hours to access services • Lack of services in both outlying and central (WL & 100 Mile) communities • Lack of public transportation options/ service times • Financial cost to travel • Crisis care is not available immediately	• "*We are staffed by Tsilhqot'in speakers therefore are able to advocate for those that speak only Tsilhqot'in*" • Aboriginal staff • "*The Band enjoys a smaller population where everyone knows everyone and are better able to support, assist or refer.*" 3. Local programs/ support while on waitlist • Support groups • Counselling • One-on-one worker support Other identified strengths/ resources: • 63% (majority) of respondents felt their services are working as intended to meet client needs/ program goals • Cultural initiatives (within program) • Recreation activities (within program) • Wrap-around support service • Open-door policy • Client-centered approach	*"Mental Health could hold and Open House wherein they describe their services and introduce their staff at all agencies in a out of Williams Lake. Regular meetings could be held in Williams Lake or surrounding area. Continue with what is working well."* Collaborate more effectively *"through case management"* and *"build relationships and understanding of needs".* *"One referral form for all mental health services, an up tot date document outlining all mental health services."* Collaborate more effectively by having *"regular provider and leadership meetings to share best practices, upcoming initiatives, trends and gaps in the community."* Collaborate more effectively *"through an ongoing dialogue regarding current best practices. Presenting new information…ongoing relationship-building between the agencies."* *"More conferences, networking and specific gatherings."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• Weather conditions inhibit travel • Many people do not have a family doctor • Isolation • Difficult to meet with other service providers for collaboration Other identified gaps/ barriers: • 37% of respondents felt their services are not working as intended to meet client needs/ program goals – waitlists, geographical constraints, lack of specialized care providers • Lack of collaboration between service providers • Lack of awareness/ knowledge of available services by both clients and other service providers - 44% of respondents reported they do not feel very knowledgeable about other agencies' services • Lack of awareness/ knowledge of how services work and what is offered (i.e. client confidentiality, cost, etc.) • Stigma • Continuity of care	• Ability to travel to rural communities to provide service • Clients reporting satisfaction with service, skill improvement, quality of life improvement • Ability to be flexible for client's specific needs • Developed support groups for clients to attend while on waitlist for specialized care • Skill development programs (i.e. literacy, job readiness, life skills) • Efficient intake systems • Clients no longer requiring services is a measure of program success • "*Strength based and holistic assessment practices. Trauma informed service delivery. Family centered mental health initiatives an adherence to practice based evidence (not just evident based practice) as First Nations families do not always subscribe to western models of service delivery.*" • Clients' involvement in their own care plan/ goal setting	*"It always seems that the people involved in collaborations are the managerial staff members. In my opinion, the people involved in these committees should be the frontline workers, whose practice will be directly impacted by any proposed policy changes resulting from these collaborations."* *"Come to visit, help bridge the gap between our communities, meet face to face with services providers and potential clients, give avenue for making assessment and support long term."* *"Meet periodically to share knowledge, information, meet new staff, learn about programs, talk about barriers."* *"More regular meetings with management front line staff to know each other better and feel comfortable making referrals."* *"Cultural trainings, trainings about bias, trainings on ethics, hire First Nations service providers."* *"Information on the variety of programs and an up to date contact list for easy reference."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• Youth-specific services, especially crisis/ stabilization/ in-patient; children and youth in outlying communities most impacted • Community detox/ addictions treatment – "*Addiction is a huge issue and often, those with mental health issues use drugs and alcohol to cope. However, they are unable to receive mental health counseling until they get the addiction under control. However, the underlying root cause of the addiction is not being addressed. Thus, a vicious cycle is started.*" • Outreach (not enough outreach for specific populations i.e. youth, limited hours) • After-hours/ On-call mental health support • Children and youth mental health (CYMH) access inhibited by stigma of connection to Ministry of Children & Family Development (MCFD) • Competent trauma counselling • Lack of awareness • Confidentiality constraints	• 77% of respondents have a formal evaluation tool to track how and if client needs/ program goals are being met and reported that these tools are being well used (Often-50%/ Always-33%) • 56% of respondents reported they feel very knowledgeable about other agencies' services and feel comfortable making referrals accordingly. • "*Dedicated staff that do more with less*" • Qualified, well-trained, experienced staff • Good rapport with other service providers/ community partners • "*Our community and area are very generous donators and thus, we are able to do much with very little.*"	*"Make pamphlets available at one another's sites. Talk with clients directly about specific programs and possibly even do workshops or info sessions."* *"Open communication, tele-health, translators, support services."* *"Getting together a couple of times a year rather than just a couple of practitioners connecting."* *"Gov't agencies working together to support an individual rather than being an 'either or' mentality."* *"Using telephone conferences, or skype where there is internet support."* *"Centralized communication system."* *"We could improve by picking some goals to work on and developing sustainability for longer periods of time to see if we are really affecting change."* *"Annual cross functional service provider forum for info sharing and best practice development."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• Time limits on counselling sessions do not account for clients with special needs • Employment for people with mental health issues/ illness • Adequate crisis care; people are discharge from "*hospital without a sufficient safety plan*". • Lack of affordable housing or supported living environments for those with addictions and/ or mental health issues • Lack of funding – for staff hours – "*the most severe/ acute cases get priority, which creates a situation where prevention work becomes virtually impossible*", current services, and alternative services such as "*yoga; art/play/movement/adventure therapy.*" • Services for people with acquired brain injuries • Transitioning process – clients ageing out of current care • Lack of free counselling services	Successes in inter-agency collaboration: • The following specific collaborations were reported by respondents: Mental Health and CYMH quarterly meetings, meetings with Aboriginal agencies, visits from counsellors from other agencies, West Integrated Team meetings, TNG meetings, the Integrated Case Assessment Team, Counsellors Under Pressures, Communities that Care, Child and Youth Mental Health Collaborative, Suicide and Sudden Death Committee, Let's Talk About Mental Health in the Cariboo, Tsilhqot'in Mental Health forums, and multiple specific examples of two agencies meeting regularly given by respondents. • Conferences and events where service providers come together to share information with each other and/ or the community • Collaboration between "*mental health, family doctors, and the school to better support children and their families with mental health issues.*"	*"I would like to be able to share with any of the other agencies that we are here for (specific clients) and not here to pick up the slack from there department due to lack of their funds."* *"Try to be more creative within their boundaries, workshops put on together, share resources."* *"A board consisting of 1-2 members from each agency, who will represent his/her group. The goal would be to keep each group aware of common problems, issues, client troubles (with signed disclosure agreements) and new changes coming to each group. The board could meet once each quarter or more frequently, whatever is found to be more effective."* *"More staffing."* *"Having a person who can be on call during hours other than 9 to 5."* *"More time to collaborate - more counsellors to attend needs of community."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• Incongruence between how services are funded and client needs – "*We have a very little mental health budget and very little mental health training here. Yet, a high percentage of our clients have mental health issues.*" • Both voluntary and in-voluntary service models impact client engagement in care • Referral process for treatment – clients "*feel very uncomfortable going to ER department for doctor referral for admission to program*." • Client difficulty navigating "t*he system*" with "t*oo many different places to go before getting to the service they require*". • Respondents identified the following specific populations with a low representation in their agencies' client demographic: GLBTQ, early childhood – children/youth, Aboriginal, men, seniors, Asian and Indo-Canadians, low-income and high-income.	• "*Most agencies very welcoming and open to dialogue and change*" • Working around funding barriers to meet community needs – i.e. "*coming together and having some action work done*" with this project • In-services from other agencies • Other agencies are open and ready "*to help*" • "*When we collaborate we can get a lot accomplished for our clients, everyone comes with interesting solutions."*	*"Consider each service as valuable and put your personal biases about professional competency aside. Professional designation is only one component in provide effective services; have regular meetings with physicians, they are key people who need to know about services; combine tables/committees where we discuss the same thing; too many MH initiatives are currently run side by side; cut out the politics and get everyone on the same table; focusing on client centered approach and client's need rather than feeding our own egos and agendas."* *"Inviting First Nations to rather combine services than separate them."* *"Monthly reports if have shared clients, frequent updates etc."* *"A complete list and wallet size contact information card."* *"Taking the initiative and making the effort. It is amazing how many people who should know about our services have no idea we exist and what we offer."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
• 87% of respondents felt that community healthy living initiatives are somewhat utilized or less by people with mental health issues. • Some hesitance in referring out of agency – lack of awareness of what other services offer/ fit for client, long wait times for response from referral recipient, lack of cultural competence of referral recipient, services changing quickly due to changes in funding, trend in referring to a few key agencies over and over without seeking new options Barriers for inter-agency collaboration: 1. Limited funding; hours, coverage for time away from program 2. Confidentiality constraints – policy, client unwillingness for information to be shared 3. Lack of cultural competency.		*"Meet with community agencies more." More program hours being able to email each other.* *"More brainstorming sessions, getting together on a regular basis."* *"When a new employee is hired at one of the agencies I believe it would be beneficial for them to be given information on what the other agencies provide so that they can be ready to refer their client if the client has a need that the new employee cannot help them with."* *"We need to actually meet with each other in person and have updates on programs offered, or to be informed of changes to service."* *"Form a front line mental health staff collaborative as most collaborative initiatives are lead on the executive level and front line experience doesn't get the opportunity to inform change."*

Gaps/ Barriers	Strengths/ Resources	Collaboration Suggestions
Other barriers: • Disinterest • Lack of awareness/ knowledge of other service providers and/ or what they offer potential shared clients • Agency politics • Lack of support from administrators to attend meetings • Policies and protocols • Competing for funding for programs • Geographical distance between service providers • Lack of relationship building between or poor relationship inter-agency		*"One is definitely getting rid of the 'us and them' mentality, break down the hierarchical structure that instills dominance over because of gender, socio-economic status, education level, race, etc.; level the 'playing field', respect difference and value diversity, expect all agencies to examine their own values around 'cultural safety', stop denying and challenge selves and others to be a better person."*

APPENDIX D

Gaps/ Barriers	Strengths/ Resources
Community Members	
Respondents were asked to rate from a list of pre-set experiential statements about accessing mental health services. The top 3 identified areas that "need lots of improvement": 1&2. Information about other mental health and community services. 1&2. Information about who to contact in a crisis. 3. How easy it is to get help in a crisis. Respondents were asked what they "didn't like when accessing mental health services in the Cariboo". The following are their responses: • 69% of respondents felt the care they/ their loved one received accessing mental health services was poor to fair. *"Can't get in to see people quick enough, back up and people have to wait too long to see Dr. and Specialists."* *"Having to wait."* *"Response time in a crisis."* *"Long waiting times."* *"Length. Of wait time."*	Respondents were asked to rate from a list of pre-set experiential statements about accessing mental health services. The top 3 identified areas that "need no improvement": 1. The level of respect this person and other staff on site show me/ my loved one. 2. How safe I/they feel when accessing mental health services. 3. Opportunities for me to have a say in my/their own care. Respondents were asked what they "did like when accessing mental health services in the Cariboo". The following are their responses: *"Easy access to everyone who needs help."* *"They can be sensitive at times."* *"My worker was easy to deal with."* *"Caring support workers."* *"Clean facility."*

"The Gateway program should be extended and more beds available. I have never accessed this program myself but the people close to me have and each one relapsed within days after leaving. I know it is designed to just be a resting place before you make a choice for Rehab, but I think it should be an actual Rehab facility." *"Waiting too long to see a professional."* *"Wait time."* *"The wait list is too long."* *"The office pushes for group work without any individual counselling first."* *"The wait time."* *"No one in town knowledgeable on certain mental health issues."* *"Long wait lists and access to services."* *"No knowledge, talked to as a weirdo. Acted scared of my anxiety. No understanding."* *"Very hard to get a hold of.* *Most easily accessed service is prescription drugs. Little in the way of counselling support and follow up."* *"Person was spoken to as if a very young child and as a result would not entertain the idea of further help."*	*"What I liked about visiting my loved one in gateway was they got their own room, the common eating area was peaceful and the small reading room had several different activities they could do."* *"They were warm and caring."* *"Availability of Gateway as an inpatient service. Although not terribly impressed that it has had to take on people with alcohol addiction problems."* *"My child's clinician is patient and very informative."* *"The counselor had great hand outs."* *"Friendly and supportive."* *"Caring staff."* *"It's getting better but improvement is needed."* *"Courteous and respectful help. Very friendly."* *"Not far to drive to the hospital."* *"I got lucky enough to find a practitioner who was willing to do research into a field outside of their expertise so that I didn't have to wait 6 to 8 months just for my 4th referral to go through and so I didn't have to travel to Vancouver."* *"That they call to make the appointments."*

"The wait time, no specialists so constant travel time, the amount one has to pay for medical care even though you pay the premiums is unreal. Universal care in Canada, my arse!" *"Finding help is easy, good help, impossible. Doing silly 10 step exercises, telling yourself bad things won't happen to you and so on is supposed to do what exactly? Waiting six month so far to see a shrink with no end to the wait in sight."* *"When my spouse had a manic attack we couldn't get help and it was the weekend. This needs to change so that families are safe."* *"The help offered was terrible. I had to do my own research."* *"I still have no counsellor access after 6 months. And I have to travel 4 hour round trip to see a psychiatrist & psychologist. Told to take a pill, little to not help from doctors for referrals."* *"There were too many assumptions about my condition. Not enough time was taken to listen to what I had to say therefore the assumptions."* *"There are very few non-clinical counselors. Parents don't have much of a say about their child's care or need for continued care. Every situation is dealt with at a office increasing stigma of mental health. Conversations are restricted because of a lack of client/ professional relationship. Personally I felt like I was being held responsible for the struggles my children were having even though I wasn't part of the root situation. I felt ignored and easily dismissed during and at the end of sessions....I could go on."*	*"The building is quiet."* *"I ended up going to the ER and finally got some help."* *"Increased pamphlets and information available in office...however this information also was restricted to just a few generalized groups."* *"That there is very little institutionalize treatment."* *"Things took off almost immediately in the right direction for my family member after seeking help. The counselling in conjunction with medication have helped tremendously the past couple years."*

"The waiting time and selection." *"The psychiatrist cancelled both appointments because she/he was coming from Kamloops. Your file gets cancelled if you haven't made an appointment within a time frame."* *"The psychiatrist, and the meds."* *"Called and called, tried to set up appointments and had nobody show up."* Respondents were asked if there were needed mental health supports or services they could not access. 64% reported that there were. These are their comments: *"Counsellor or someone to talk to who doesn't know all about the town, that is it is a small community & I don't feel its safe to talk."* *"No bus route where I live now."* *"More addiction treatment for non native."* *"Grief Counseling. There is no specialist in town that is fully trained in how to help people overcome grieving."* *"More psychiatrists."* *"Tame the worry dragon program, because my child is too young."*	

"I do not know what all there is to choose from." *"Adult ADD assessment."* *"Anxiety support because lack of services."* *"Anxiety therapy."* *"Small town, knowing the people who provide services in other aspects, makes me not want to let them know my mental health problems."* *"Psychiatrist or equivalent specializing in youth sexuality, totally nonexistent here. Also occupational therapists are nonexistent here and they are (again) insanely expensive."* *"A psychiatrist, Counsellors that will be what they should be instead of telling us, just say bad things will not happen to me."* *"Counseling. They say no one is available."* *"Cognitive therapy."* *"Non-Clinical counselling services...there is no public information about local counselors who help with everyday coping issues."* *"A time frame is put on your file if you haven't seen a psychiatrist within a time frame. Then you have to get referred again. Should have easy access when needed."*	

Community Suggestions/ Discussion
"Public Awareness of Mental Health Resources." *"More awareness and easier access to mental health support."* *"We need a detox."* *"Home visits would be ideal."* *"The Cariboo could GET some services. There are services for those that are low functioning, but there are no services that I know of for the average person with a mental illness. I moved here 9 months ago from a psychiatrist, a GP that specialized in mental health, and groups I could attend on cognitive therapy and to learn about my illnesses. There is NONE of that here. And if you have a crisis, you go to the hospital, they drug you up, then you're released. I was absolutely APPALLED to hear that there are padded rooms here for the mentally ill. It's not the 1940's anymore. This contributes to the stigma."* Comments Made in Online Discussion Inspired by Survey: *"The town needs a good detox."* *"I think a lot of addicts in this town would benefit from a detox. Travelling makes them avoid it."* *"I've had some extensive fun with an addict and I'm not sure I support the idea of detox. I think if someone wants to actually get clean, they should have to have the will power to do it at home for the 30-60 days, then head to treatment. Sorry, but I don't buy the disease claim. The system just kind of turns into a baby. We screw up when we are weak and the system is a crutch to keep you weak. It's not about "support" or "compassion" or "empathy" it's about wanting to change. My ex was like an infant, because of all the detox and counseling brain washing he had. All you need is a healthy purpose...I see detox centers a junkie haven. nothing more..."* *"I think in many ways you are right (reply to above statement) but some addictions, like a dependence on alcohol or heroine require medical attention hence the need for detox."*

"Another gap in mental health services is suicide prevention/ intervention for men…who commit suicide 4 times more than rest of population…and 8 times higher when dealing with divorce…custody family court. All suicide prevention currently is only focused on youth. Men should not be so undervalued by mental health service providers. "

"This town has many addicts and not many avenues for help."

"Services? What services?"