



Featured Tool

Multnomah Community Ability Scale

In a study such as the CMHEI, which follows the progress of individuals over 18 months, we were interested in measures which could help us assess functioning over time rather than at a single point in time. The Multnomah Community Ability Scale (MCAS)* seemed to fit our needs. It was developed by a team in Multnomah County, Oregon, to assess impairments and abilities among individuals with severe mental illness living in the community. The measure assesses how the person has been doing, on average, for the past three months. By comparing ratings over time, we can tell whether the person has, in general, improved in functioning, remained more or less the same, or declined. Four subscale scores are produced, in addition to a total score, so that we can look at changes in functioning in specific areas - physical and psychiatric symptoms, daily living skills, interpersonal relations and daily activities, and behavioural problems.

Because the MCAS is not a self report measure, it is not being used in the consumer or family projects. It is usually completed by a provider familiar with the consumer. In this study, a research assistant completes the MCAS after speaking with the consumer's primary worker, meeting

with the consumer and reviewing his/her chart. The MCAS developers have prepared an information package which includes an administration manual, training video and normative data. These data describe average ratings for users of community mental health programs, subdivided into age and sex groupings. In psychometric tests performed by the Oregon team, the MCAS has performed well. In Ontario, several community programs are currently using the MCAS and find that it contributes useful information.

Examples of the 17 items that make up the MCAS are listed here. Each item is rated on a five-point scale. The full scale can be downloaded from the CMHEI website and the training package can be ordered from Sela barker at (503) 238 0769.

Sample Items:

- How successfully does your client manage his/her money and control expenditures?
- How frequently does your client initiate social contact or respond to others initiation of social contact?
- How extensive is the client's social support network?
- How frequently does your client experience episodes of extreme acting out?

*Barker et al. (1994) A community ability scale for chronically mentally ill consumers: PPart: Reliability and validity, Community Mental Health Journal, 30(4), 363-383.

Project News Goodbye and Hello

During the first two years of the CMHEI initiative, many of you may have spoken with Marie-Anik Gagne, coordinator of the initiative. Marie-Anik spent many hours ensuring that participating projects used a similar approach to collect and code data, and she established a detailed process to ensure data quality. Marie-Anik also worked with CMHA-Ontario staff to design and manage the initiative web site. Marie-Anik has left the project to work as a senior planner with the Durham District Health Council. We are sorry to see her leave and thank Marie-Anik for her efforts, and for giving the CMHEI project a solid foundation on which to grow. We wish her success in her new job and we certainly know where to go when good planning advice is needed.

Change often creates opportunity. We are delighted that Tess Sheldon, our CMHEI data analyst, has agreed to take on the coordinator position. Tess has also been very involved in the data collection process. She has designed more forms that she can count, she has developed scanning programs for data entry, and she has patiently modified the data base to accommodate coding and other changes in data collection. Tess will continue in these roles but will now also be responsible for web management, communications with in the project and with the field, and many of the coordination activities necessary to make the project run smoothly. She can be reached at (416) 535-8501 (4323) or at tess_sheldon@camh.net if you have any questions about CMHEI.

Community Mental Health Evaluation Initiative Project Newsletter No.2, May 15, 2000

About CMHEI

Welcome to our second newsletter! The Community Mental Health Evaluation Initiative (CMHEI) is a provincial evaluation project conceived by the Mental Health Policy Research Group, a consortium that includes the Ontario Mental Health Foundation, the Centre for Addiction and Mental Health, and the CMHA, Ontario Division. The purpose of the consortium is to research and advocate solutions for major issues and problems in the mental health arena, with funding support from the Ministry of Health.

Contact Information

If you have any questions or comments regarding this newsletter, have an idea for future issues to would like to receive a copy of our next issue, please contact:

Tess Sheldon, Community Mental Health Evaluation Initiative, c/o Clarke Site, Centre for Addiction and Mental Health, 250 College St. Toronto, ON. M5T 1R8, Ph: 416 535 8501,ext. 4323, fax: 416 979-4703, email: Tess_Sheldon@camh.net.

Website

For more information regarding the Community Mental Health Evaluation Initiative (CMHEI) visit the website. You will find project descriptions and proposals, the complete list of names and address of all individuals involved, and a copy of our press release and newsletter.

From here, you can also download all of the questionnaires that we are using in this multisite project and the manuals to assist you in understanding and using these forms.

www.ontario.cmha.ca/cmhei/

Featured Project Number 2 in the Study

Evaluating Intensive Case Management for Persons with Severe Mental Illness who are Homeless

A research team lead by Tim Aubry at Ottawa University is studying the Community Support Services program of the Ottawa-Carleton branch of the Canadian Mental Health Association (CMHA). This program offers individualized, practical support to persons with severe mental illness living in the community who are homeless or at risk of being homeless. Using a true experimental design, the study is comparing clients receiving case management services to a similar group only receiving outreach services. It is expected that people who receive the long-term, intensive support will likely do better on a range of outcomes, including severity of illness, adaptation to community living and quality of life.

In addition to being part of the first multi-site study in mental health in Canada, there are a number of innovative characteristics of this project that make it particularly exciting. First, thanks to the co-operation of the Ottawa-Carleton CMHA, the project is able to use a true experimental design, in which participants are randomly assigned to either receive intensive case management or to continue with a short-term housing outreach service. This means that the researchers will be able to attribute any differences between the two groups to the influence of the program, which is a rare opportunity in community-based research!

Second, this research project is planning to follow participants for two years, which is a little longer than most studies of case management. We are also collecting comprehensive information about the costs of providing services to this population, and are looking at the process of case management (i.e., how the program is actually implemented), in addition to participants outcomes. In doing this, we are hoping to be able to explain why the treatment group is doing better than the control group, if in fact it is.

Finally, we appreciate the opportunity to have so many consumers and students involved in the research project, as research assistants, program staff, Advisory Group members, Research Team members, etc.. While this is becoming more typical of community-based research, it seems clear to us that the involvement of consumers is making this a better, more relevant project, and we're appreciating the chance to train up-and-coming researchers and practitioners in community mental health.

To date, we have received consent from 86 people to become participants in the research, and have had 72 people assigned to one of the two study groups (i.e., treatment or control). We have conducted 63 baseline interviews, and 33 follow-up interviews. These interviews are held in community settings of the participant's choice, such as drop-ins, community centres, coffee shops, etc. and have generally been quite interesting for both interviewer and participants.



(From left to right) Gary Holmes, Heather Smith Fowler, Brad Cousins, Doug Angus, Dave Erickson, Marnie Smith and Tim Aubry. (Missing from the picture, Bob Flynn)

Featured Project

A Longitudinal Study of Family Initiatives in Community Mental Health In Ontario

Brief Project Description

Families represent the largest group of community caregivers for those with serious and persistent mental illness. This study, led by Dr. Katherine Boydell and John Trainor, is examining family self-help/mutual aid initiatives from both an individual and systems level. The first objective is to measure the impact that family initiatives have on individuals in terms of their experiences of such things as coping, empowerment, caregiving burden, support, hope, and stigma. The second objective is to examine systems-level impacts. The differing systems-level activities related to education, advocacy and outreach will be monitored as well as resulting organizational changes. The barriers and limitations to system reform will be documented and recommendations will be generated. Both qualitative and quantitative methods will be used to examine the individual and systems level impacts.

to keep track of this, participant's involvement in the organization is measured every three months with a tracking form.



In the first row (seated) are Vivien Del Valle, Caroline O'Grady, and Katherine Boydell. In the second row are (left to right), Joanne Philpott, Dorothy Pearson, Joan Scott, Patricia Parks

Family Initiative Partners

There are three Family Initiative Partners in this project. They are the Family Association for Mental Health Everywhere (FAME), the Schizophrenia Society of Ontario (SSO) and the Mood Disorders Association of Ontario (MDAO). Although these organizations have many differences, they are similar in that they provide services for family members who have a mentally ill relative. These services include education, support, and advocacy.

Research Assistants

Seven family research assistants have been hired to help recruit and interview the participants. While these research assistants come from quite varied backgrounds, they are all family members who have a relative who has been diagnosed with a mental illness. Research meetings take place every month to discuss the challenges and strategies of recruiting and interviewing. Family research assistants have found this open forum to be very helpful.

Research Participants

The project's goal is to interview 240 individuals who a) have a relative who has been diagnosed with a mental illness, and b) are members of one or more of the three family initiative organizations involved in the study. Some of these individuals are new members to the organizations while others have been involved for quite a while. The amount of participation in the organization appears to vary both among and within individuals -- that is some people use the services more than others, and/or some people use the services more at some times than at other times. In order

Preliminary Data

To date, 102 participants in total have been interviewed. This includes 47 individuals from FAME, 40 from SSO and 15 from MDAO. Family research assistants also call each participant every three months to keep in touch and to inquire about the participant's participation in their family initiative. 9 month follow-up interviews have also begun. The systems aspect of the study, which examines the organizations, is scheduled to begin this spring.

Sub-Study

Caroline O'Grady, PhD Student, will conduct a sub-study examining families of the mentally ill and the impact of participation in self-help/mutual aid support groups on perceptions of stigma.

Contact Information

If you have any questions, please do not hesitate to call us at the numbers below:

- * Darryle Jadaa at (416) 813-7166; darryle_jadaa@camh.net
- * Dr. Katherine Boydell at (416) 813-8469; katherine.boydell@sickkids.on.ca
- * John Trainor at (416) 535-8501 x 2071; john_trainor@camh.net
- * Caroline O'Grady at (416) 813-7166 caroline_ogrady@camh.ca

"This position has helped me to be more self-sufficient and has boosted my ego. I love doing the interviews and talking to other people."

Family Member Research Assistant

Cost-effectiveness analysis (CEA) is one of the most widely applied methods of economic evaluation for health care programs. The idea behind CEA is similar to what you likely do when grocery shopping - compare a variety of product options based on various criteria (e.g. quality, packaging) and costs. CEA links criteria (also know as outcomes or effects) and costs to create a clearer picture of a program's strengths and limitations in terms that are easily understood.

The mental health system is somewhat like your grocery basket- filled with different types of goods and produce to meet the various needs of your household members. At the very heart of the CMHEI project is the recognition that the mental health system cannot adequately meet the needs of the population with one type of program alone, but requires a mix of different types of services. Thus, the goal of the CEA piece of the CMHEI is to understand how, within the context of a constrained budget, different types of services and supports meet different needs and fit together to form a comprehensive picture. Towards this end, the CMHEI will examines a number of commonly used outcomes (e.g. reduced hospital stays, decreased symptoms, decreased days homeless, increased sense of empowerment) in the evaluation.

One of the greatest challenges associated with conducting a CEA is collecting information about costs. Part of the difficulty occurs when trying to decide on whose costs we should focus - the program's, the health system's, the government's. As we expand out from direct program costs, we enlarge the scope of the information that we need. While the use of ERs or GPs may not affect a program's budget, it will affect the health care system's and the government's. Because one of the mandates of the CMHEI is to give policy makers information that can be used for planning, we are collecting information about costs to the larger health system. Thus, in the multi-site protocol, we included instruments to gather information about GP use, ER visits, hospitalizations, community program use, and medication use.

Another challenge is that we need to assess costs using a measure that is relevant to both services and supports. In the end, we decided to look at time - time the consumer spends using the study program and using other services and supports. By associating a cost with each unit of time, we will be able to calculate the cost of service and resource use. The costing and outcome information will be combined into measures that can be used to describe how each program contributes to the mental health care system.

Data Quality Corner

You have all heard the expression "garbage in, garbage out".In this project we are always struggling to improve the quality of the data. A key challenge has been to train interviewers to code forms appropriately for our data scanners.

Diana Raymond, our lead person in data scanning, has asked us to remind the projects to: Use PEN, instead of pencil, so that the scanning device is able to read the forms.

The Coordination Centre doesn't want to develop a reputation for nagging, so we contracted with our CMHEI poet laureate Betty Lin (also a researcher in the HSRCU) to prepare a gentle reminder for project teams:

Here is Betty's response (in song):

**Pencils
(to the tune of Memories from Cats)**

Pencils,
They're no good with the scanner.
It refuses to read forms
that are filled out with lead.
When we scan them,
it acts as if there's nobody home,
and the answers
are never read.

Lonely nights
we spend rewriting
all those forms using ink.
Hours later
you hear muttered cursing.
We're so tired, we can't think.

Daylight.
There's a new batch of forms here.
I hope someone used ballpoint.
If they didn't, I'll scream!
Maybe some day the centres
will always use some pens?
That would be our
Fondest dream!

