

Needs-Based Planning for Mental Health and Substance Use Services: Application in British Columbia

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Introduction

- A large gap in mental health and substance use (MHSU) treatment services exists in BC, as the high percentage of people in need of services surpasses current resource capacity [1]. In Canada, the disease burden of mental and substance use disorders is usually underestimated [2].
- Health system and services planning has traditionally followed utilization-based approaches that rely on previous utilization trends to estimate future requirements [2].
- Needs-Based Planning (NBP) is a systematic, quantitative planning approach for MHSU services and supports that estimates required capacity based on the needs of the whole population and considers all levels of severity and complexity of need, adjusting for comorbidity.
- Application of the NBP model to British Columbia (BC) aims to not only build a picture of existing services (i.e., capacity, location) but also facilitate the subsequent development and implementation of key care pathways through the system, as well as perform a gap analysis.

Objective

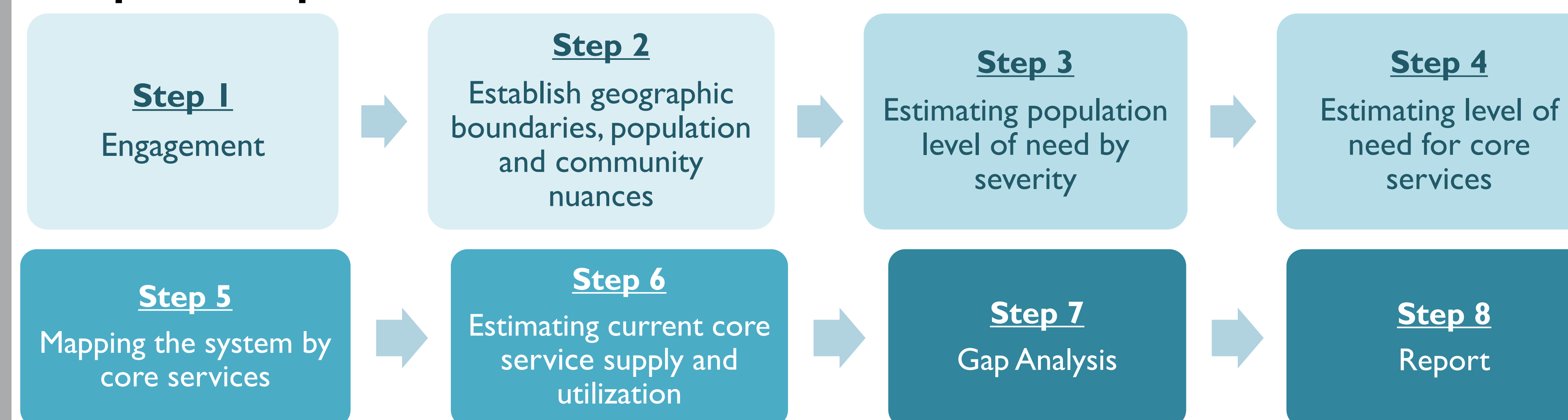
- Partner with the BC Ministry of Mental Health and Health Authorities across BC to:
 - Map local services (all Health Authorities)
 - Estimate the level of need in the population (all Health Authorities)
 - Perform a gap analysis (Interior Health)

Methods

- Utilized an NBP model that combined a BC-specific NBP model with the national substance use model
 - Expansion of the National Advisory Committee
 - Estimation of disorder-specific 12-month prevalence through a meta-analysis of representative community-based international data and sub-threshold mental health needs derived from Canadian data [3]
 - Development of a national core service framework building upon the BC model [2] and previous national work [4]
 - Identification of ideal resource requirements for each disorder and severity level, utilizing expert consensus through a Delphi-like process [4]
- Structured process for estimating population level of need and mapping local services according to the Core Services Framework was undertaken for all Health Authorities
- Gap analysis was conducted to quantify supply and service gaps (number of individuals in need, required FTEs and beds) for Interior Health Authority

Results

Steps for Implementation of NBP Model



Output of Step 5

Inventory of Services Mapped onto Core Service Categories

Organization	Name of Program or Service	Basic description of Program or Service	Service delivery options - virtual, in-person, or combined	Health Service Delivery Area where Program or Service is located	Local Health Area where Program or Service is located	Geographic area served by the Program or Service	Funding Source	Data Source	Is the core mandate of this Program/ Service focused on people with mental health and/or substance use health challenges?
Core Service Platform			Does this Program/ Service provide case coordination specifically for people with mental health or addiction challenges?	If "YES" using accompanied definitions provided to categorize into: <ul style="list-style-type: none"> Coordination by an Assertive Community Treatment (ACT) Team OR Intensive Case Management (ICM) team Coordination by a Community Mental Health or Addictions Team Coordination by a case manager Coordination by the primary care provider 		Please provide a few details about the Case Coordination / Case Management services you provide		Criteria for acceptance into the service / program (e.g. Age, Gender, Certain kinds of challenges, Certain Referral Sources)	

Output of Step 6

Gap Analysis Example Output Table (For illustrative purposes only)

ICM, FACT & ACT for Mental Health and Substance Use	Current Capacity	Projection from NBP Model	Gap
ICM, FACT & ACT for Mental Health and Substance Use	16 Full Time Equivalents	54 Full Time Equivalents	Gap of 28 Full Time Equivalents
	154 Patients	599 Patients	Gap of 445 People

First Nations Community Engagement

Challenges

- NBP model was not built from an Indigenous perspective, e.g. core services, level of need, perspective on strengths and solutions

Planned Approach and Objectives

- Inclusive engagement process including, local service providers, planners, community leaders, elders, and individuals/families affected by mental health and substance use health challenges
- Conduct community consultations (in-person and virtual) to:
 - Gain insight and co-produce knowledge focusing on First Nations priorities for mental health and substance use health needs and strengths
 - Understand community members' experience with existing services and focus on enhancing service accessibility and delivery

Discussion

- NBP allows for the needs of the whole population to be addressed in an integrated manner, bringing mental health and substance use issues together while remaining data-driven and going beyond previous service utilization trends.
- Analysis of the current system of services conducted through service mapping can inform development and implementation of key care pathways through the system by describing not only types of existent services but also distribution across other required core service categories.
- Mapping out and understanding what services exist, their capacity, location, and any other relevant information required to complete the other work streams creates a 'living tool' that can be used to track and evaluate the system on an ongoing basis and support future investment and policymaking.
- Process of bringing key stakeholders together allows for common definitions, sharing of information, set the stage for creating more consistent frameworks within and across Health Authorities for service planning and delivery.
- Gap analysis can identify significant gaps in the treatment continuum with a stronger evidence-base that facilitates planning and resourcing a more equitable balance of resources.

Limitations of the NBP Model

- NBP should be supplemented with other community input and needs assessment information.
- Those living in homelessness, First Nations populations living on reserve, and institutionalized populations are inconsistently included in the population health data (but are represented in the final required treatment capacity estimates as these are projected for the total population of the region).
- The survey data do not reflect the needs of children and youth under the age of 15.
- Limitations in gap analysis projections due to unknown access to private substance use and mental health services.

References

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