Original Research

Toward Benchmarks for Tertiary Care for Adults With Severe and Persistent Mental Disorders

Alain D Lesage, MD, MPhil[1], Daniel Gélinas, MSc[2], David Robitaille, MD[3], Éric Dion, MSc[4], Diane Frezza, RN[5], Raymond Morissette, MD[6]

Background: Scarce attention has been paid to establishing benchmarks for tertiary care for adults with severe mental disorders. Yet, the availability and efficient utilization of residential resources partly determines the capacity of a comprehensive system of care to avoid clogging ever-shrinking acute care bed facilities.

Objectives: To describe the actual utilization of and projected needs for residential resources, one part of tertiary care, in the catchment area of a psychiatric hospital in east-end Montreal. To compare results obtained against actual utilization and projected needs evaluated in other Canadian provinces and in other countries, with a view to establishing national benchmarks.

Methods: Two surveys were undertaken to establish the number of places in these facilities that were utilized and needed for adults aged 18 to 65 years with severe mental disorders, without a primary diagnosis of mental retardation or organic brain syndrome, and originally from the catchment area. A first survey ascertained the number of places utilized and of those needed for residential care among all long-stay inpatients and all adults in supervised residential facilities. A second survey identified the need for such long-stay hospitalization, nursing homes, and supervised facilities as an alternative or as a complement to hospitalization among acute care inpatients.

Results: The actual ratio of places in long-stay hospital units, nursing homes, and supervised residential facilities was 150:100 000 inhabitants. The ideal ratio, according to estimated needs, is 171:100 000. The figure breakdown is as follows: 20:100 000 for long-stay hospital units, 20:100 000 for nursing homes, 40:100 000 for group homes, 40:100 000 for private hostels or foster families, and 51:100 000 for supervised apartments. The needs of this urban, blue-collar population for supervised residential places hovered in the upper range of utilization and standards for European countries and within the proposed standards for Canadian provinces.

Discussion: Needs for long-stay hospitalization or for supervised residential facilities cannot be treated as absolute. For example, evaluation conducted in this hospital-led system of psychiatric care may produce higher estimates of institutional care. Comparing actual utilization and projected needs in this urban catchment area with current utilization in other jurisdictions in Canada and Europe should contribute to establishing sound national benchmarks within ranges.

Conclusions: It is possible to establish benchmarks that guide the development of supervised residential settings to best meet the needs of the population of adults with severe and persistent mental disorders. The methods used here to assess needs should serve as guidelines for future research, because they were designed to contain the bias of over- or underprovision of care in the current utilization.

(Can J Psychiatry 2003;48:485–492)

Information on author affiliations and funding appears at the end of the article.

Clinical Implications

- Within the dominant push toward supported housing rather than supervised residential settings in the community for patients who suffer from the most severe mental illness, the need exists for an array of supervised residential settings.
- Attention should be paid to the number of beds and to the availability and rates of community-based services, such as supervised residential settings.
- The need for nursing homes has been underestimated.

Limitations

- In the end, needs assessment rests on clinical judgment, even when systematically recorded, as is the case here.
- The perspective of consumers has not been incorporated.
- The current assessment was conducted in a catchment area with a system led by a psychiatric hospital organization, which may produce higher estimates of institutional care.

Key Words: *alternatives to long-term hospitalization, supervised residential settings, tertiary psychiatric care, supported housing*

The regionalization of health and social services in Canada, as in many other industrialized countries, has transferred the responsibility of assessing needs and obtaining budgets for required services from national authorities to more local planners and clinical decision makers (1). Thus, benchmarks for core services would be useful to these and other stakeholders. Unfortunately, such planning tools are sorely wanting.

A few years ago, for instance, a series of provincial mental health reform policy documents described service utilization and proposed some benchmarks, but only for hospitalization and the relative proportion of total budget to allocate to hospital and community care (2). More recently, an authoritative review of psychiatric tertiary care in Canada described needs but did not quantify standards for supervised residential settings (3,4). Similarly, in a recently completed study of alternatives to acute care admission, we managed to describe the needs for acute care beds, day hospital places, and intensive home care; however, the design did not allow us to measure the need for supervised residential settings (5).

The purpose of the present study is to contribute to benchmarking tertiary care; specifically, long-stay hospital units and supervised residential facilities. To this end, we describe the actual utilization of and needs for such facilities in the resource-rich catchment area of a psychiatric hospital in east-end Montreal, Quebec. Based on 2 successive surveys, the results are compared with utilization and benchmarks in other Canadian provinces and in European countries with comparable public mental health care systems (6,7).

Methods

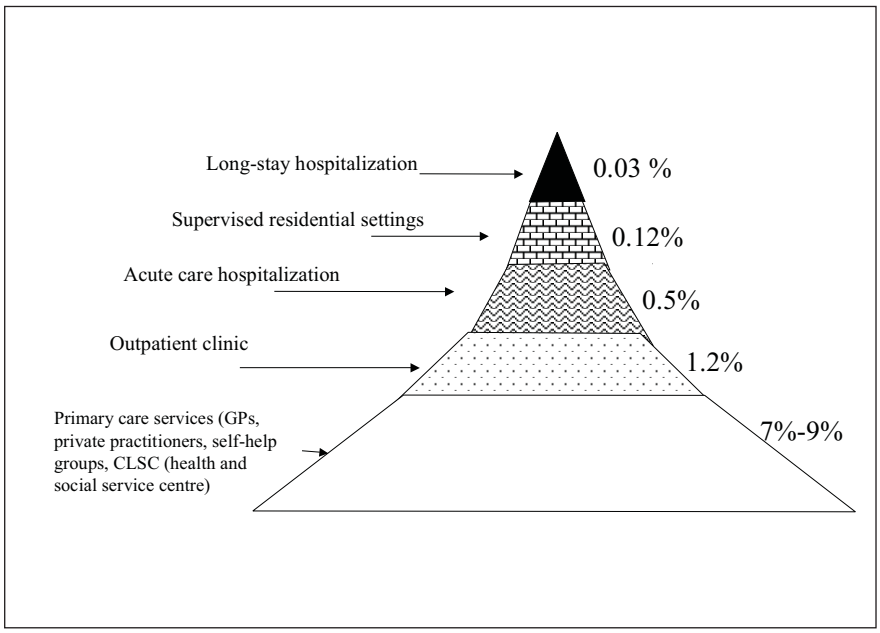
Conceptual Framework

The strategy used in the present study revolves around the concept of growing levels of needs among individuals with severe mental illness. Wing proposed a way to illustrate these levels, based on the services offered, on the number of people in need, and on the cost of services per person (8). The highest and costliest level of needs corresponds to the few people requiring long-stay hospitalization, followed by people in supervised residential settings, acute care inpatients, daycare users, outpatients, and primary care attenders. Figure 1, which was developed before the present study, illustrates the relative size of these populations in east-end Montreal. Casemix, too, is a key element in this model. According to this concept, patients are more likely to share the same level of needs with others in a given type of facility than with patients in other types of facilities. Under the proposed strategy, it was assumed that most people in need of long-stay hospitalization or supervised residential facilities actually resided in these facilities or had been admitted to acute care wards and were less likely to be found among outpatients or primary care attenders. Actual utilization, however, may not necessarily correspond to actual needs; an over- or underprovision of care may exist within any given type of service. Consequently, to correct this distortion, a needs assessment was carried out to weight the number of individuals who actually require a particular type of service in the catchment area.

Catchment Area Under Study: Background

Hôpital Louis-H Lafontaine, 1 of 7 psychiatric hospitals in Quebec, remains one of the largest in Canada. Downsizing at the hospital began in the 1960s, when its population reached almost 6000 inpatients. The hospital developed residential alternatives to hospitalization, beginning with hostels and foster families, followed by an array of supervised group homes, and in the past decade, supervised apartments, as well as supported housing and intensive home care. At the time of the study, the hospital had fewer than 800 inpatients but managed over 1300 patients in the various supervised residential settings. Occupational and social activities have also been set up. For a century, it was the psychiatric hospital where the

Figure 1 Percentage of the population using different types of services (rates indicative of our east-end Montreal catchment area (35,11)



French-speaking population of the Greater Montreal Area was referred for treatment, but over the past decade, admissions from outside its east-end Montreal catchment area have been sharply curtailed. Since the sectorization of psychiatric care in Montreal in the mid-1970s, the city has offered acute psychiatric and outpatient care to the 340 461 inhabitants in its catchment area. Each year, nearly 2000 patients are admitted at least once to its 150 acute care beds and to brief hospitalization units. In the same way, over 6000 outpatients visit its 7 community-based clinics staffed by multidisciplinary teams, its 3 specialized clinics, and its outpatient clinic for former long-stay inpatients. This catchment area lends itself well to epidemiologically based assessments of needs for mental health services for 3 main reasons: the mental health care system is entirely public, it is well developed, and sectorization ensures, in large part, that the population of the catchment area receives services there (9).

Among the supervised residential facilities offered in the catchment area, nursing homes admit adults who experience a loss of autonomy and who require daily care and help with daily living skills because of a medical condition or a brain disorder. They are publicly funded and are not specifically intended for individuals with mental disorders. In 1998, there were 727 places in nursing homes in Quebec per 100 000 inhabitants (10,11). Hostels and foster families are privately operated under contract with hospitals or social services. Hostels accommodate an average of 10 to 20 residents, and foster families accommodate up to 9 but on average 4. Both services provide room and board and supervise daily activities. Professional staff visit weekly, and leisure, rehabilitation, and occupational activities may be arranged for residents. Group homes are operated by hospitals or by nonrofit organizations, and they are staffed 24 hours daily by professionals, nurses, or mental health workers. These homes offer individualized rehabilitation programs to enhance daily living skills, helping residents move toward less supervised settings. Supervised apartments cover an array of settings, some with staff on hand 35 hours weekly and others visited by professionals daily. These should not be confused with existing intensive home care programs, wherein over 30 mental health workers visit over 300 outpatients at home, offering intensive treatment and rehabilitation.

The sampling frame for the 2 studies was defined as patients with mental disorders, aged 18 to 65 years, without a primary diagnosis of mental retardation or organic brain syndrome, and originally living in the east-end Montreal catchment area. On a given day, these subjects were in long-stay wards or in supervised residential settings connected to Hôpital Louis-H Lafontaine, or they had admitted at least once in the span of 1 year to an acute care bed at the hospital.

Design and Instruments

Two epidemiologic surveys were conducted to measure the actual utilization of resources, and correction strategies were subsequently employed to estimate actual needs. The first study aimed at establishing how many places in long-stay wards and supervised residential settings were occupied and whether there was an over- or underprovision of care for these individuals. The second study aimed to evaluate the needs of acute care inpatients, including an alternative to hospitalization, (specifically, supervised residential facilities).

The opportunity for the studies arose in the spring of 1997, when the Montreal Health and Social Services Board conducted a survey to assess needs for all its psychiatric hospitals and supervised residential and acute care facilities. The instrument used for the purpose was the Levels of Care Survey (LOCS), a 140-item questionnaire completed by staff for each inpatient or resident, covering physical problems, psychiatric symptoms, daily living skills, and dangerous and embarrassing behaviours (12,13). Researchers from Quebec's Laval-Robert-Giffard Research Centre upgraded the instrument to include specific questions about hospital and supervised residential facility needs. The instrument was applied to

Table 1 Actual provision and estimated needs in the Louis-H Lafontaine catchment area for adults with severe mental disorders: 1997 survey

	Actual utilization rate per 100 000 inhabitants	Estimated needs based on study 1 of existing places per 100 000 inhabitants	Estimated needs for additional or fewer places based on study 2 of acute care bed users	Best estimate of needs per 100 000 inhabitants
Psychiatric hospital long-stay ward	34	15	5	20
Nursing homes	3	12	8	20
Hostels	21	20	–6	14
Foster families	40	36	–10	26
Supervised group homes	21	27	13	40
Supervised apartments	31	34	17	51
Total	150	144	27	171

all hospital inpatients and to all residents in supervised settings, except those in foster families, of whom a random sample of only 20% were surveyed. In all, 2036 persons were surveyed. Nursing homes were treated differently. In fact, only 1 facility was specifically geared to psychiatric patients: the Gouin-Rosemont Nursing Home, which housed nearly 400 residents and was, until 1989, under the jurisdiction of Hôpital Louis-H Lafontaine. Consequently, we asked the home's managers to flag all residents who might fit our inclusion criteria, and their case notes were reviewed. We identified 9 residents who were included as nursing home residents and in need of such facilities.

The second step in this first study consisted of establishing the total number of service users aged 18 to 65 years who were not diagnosed with mental retardation or with organic brain syndrome among the 2036 persons. This was achieved using the sociodemographic data garnered with the LOCS. The third step included estimating how many were originally from the catchment area. We selected a random sample of 20% from all the assessed cases in the service categories indicated in the first column of Table 1. A senior social worker and a senior nurse duly trained for the purpose reviewed the case notes for these patients. We defined residents' original address as the last known address where the individual had lived independently for at least 6 months; this was generally their own apartment, but it could also be a relative's, a spouse's, or a friend's place. These steps reduced the original number of 2036 long-stay hospital and supervised residential facility attenders to 500. The fourth step entailed weighting these numbers based on the results of the 1997 survey, which served to measure needs for the various types of facilities relative to their actual utilization. It showed, for example, that the need for long-stay hospital beds was 45% of the current utilization and that one-fourth of these users would be better off in nursing homes (14). Thus, actual need for long-stay beds was estimated at 45% of current users, as assessed in the third step. The final step included producing population-based ratios for these estimates of the number of patients aged 18 to 65 years from the catchment area. We used the 1996 total population census estimate for the catchment area of 340 461 inhabitants (15). Results appear in Table 1, column 2. The total population was used, rather than the more appropriate total population aged over 18 years (the numerator would then have emerged directly from the denominator), because most international figures are presented this way.

The second study aimed to project how many places in each type of facility were needed as an alternative to hospitalization for patients admitted to acute care wards over a period of 1 year. It was derived from a larger acute care study that investigated needs for alternatives to admission, such as intensive home care, day hospital services, and supervised residential settings (5). A mixed, 3-part sampling method was employed to obtain a clear picture of both the acute care bed numbers that were required at any time and the needs for alternative resources on a yearly basis. Part 1 covered all 212 acute care inpatients, either hospitalized or awaiting admission on a given day, conveniently chosen to be October 23, 1996. Part 2 covered all 125 new admissions to acute care wards or to the crisis-beds unit between November 13 and November 27, 1996. Part 3 covered all 1926 patients who were admitted to acute care wards or to the crisis-beds unit in 1996. The treating physicians of the Parts 1 and 2 samples completed an adapted version of the questionnaire used in the Nottingham Acute Beds Use Survey (NABUS) (16).

The number of places in various long-stay hospital or residential facilities deemed necessary for cases assessed in Parts 1 and 2 was subtracted from actual utilization and distributed according to the length-of-stay category, a proxy of casemix. It was then projected for each casemix level over the 1-year sample (from Part 3) to assess the total number of places needed over a 1-year period. This was based on utilization of these facilities by the group of patients who were in acute care facilities at least once over a 1-year period. The next step was to ascertain whether subjects were originally from the

catchment area. As the last address at admission for the samples in Parts 1 and 2 was recent, this information was garnered from the Louis-H Lafontaine electronic admission system. A total of 72.4% proved to be from the Louis-H Lafontaine catchment area. The third step identified persons aged 65 years or under: 21% of the samples in Parts 1 and 2 (and 50% for nursing home needs). The final step produced population-based rates that applied the same population base as in study 1. Table 1, column 3, presents the results.

Adding the results of studies 1 and 2 yielded the best estimate of needs for long-stay hospital, nursing homes, and supervised residential facilities for the catchment area population, illustrated in Table 1, column 4.

Results

Table 1 provides the actual utilization rates for long-stay hospital, nursing homes, and supervised residential facilities for adults aged 18 to 65 years without mental retardation or organic brain syndrome. Table 1 also shows the needs estimated in study 1 among current attenders of these facilities and the additional or fewer places required as identified in study 2 among acute care ward attenders over a 1-year period. More places, for example, would be required in supervised group homes and fewer would be needed in foster families (the latter involving acute care ward admission of patients who were in foster families and who were deemed in need of other types of facilities). The final column indicates the best estimate of needs for these various facilities. The total number of places required was higher than the actual utilization, mainly owing to the need for additional places in supervised apartments, group homes, and nursing homes. Needs for places in hostels and foster families, however, were below actual supply and utilization, because an overprovision of care existed among current attenders assessed in the 2 studies. Finally, needs for long-stay beds were also below actual supply and utilization.

Only one-quarter of current tertiary care users and supervised residential facilities surveyed were counted for the present study. This does not mean that the other users were not in need of these facilities; in fact, they did not meet the age, diagnostic, and area-of-origin criteria. These figures illustrate the provincial and regional functions of this psychiatric hospital; that is, it admits patients from outside its catchment area, patients who have aged, and patients had or have developed other diagnoses, such as mental retardation or organic brain syndrome. Further examination of the figures by type of facility also shows how admission has progressively been limited to a local sectorized area over the past 4 decades, during which time different types of supervised residential settings have been successively introduced. If we consider the diachronic development of long-stay beds, hostels, foster families, group homes, and supervised apartments, the relative ratio of Louis-H Lafontaine catchment-area residents estimated in study 1 for each of these types of services is 38.3%, 51.9%, 56.3%, 53.8%, and 75%, respectively.

Sectorization is purely an administrative measure that does not impede individuals from 1 catchment area from using services in another; these are often individuals who began attending a facility when resident of 1 catchment area and later moved to an adjacent one. Because this potential situation works both ways, we checked with social services at Hôpital Maisonneuve-Rosemont. It covers the nearest catchment area and most likely has in its facilities patients who were originally from the Louis-H Lafontaine catchment area. We found 10 foster-family residents and 5 supervised apartment residents who were originally from the Louis-H Lafontaine catchment area. Assuming that these facilities actually fit their needs, our corresponding best estimates would rise by 4 and 2 places per 100 000 inhabitants, respectively, which is unlikely to significantly affect the results described in Table 1.

Table 2 illustrates the comparisons with other jurisdictions in Canada and in Europe. Because the types of services vary from country to country and in their descriptions in the literature, all supervised residential settings were grouped under 1 category to simplify matters. Nursing homes shown in Table 1 were not included in this table because figures were not readily available from other countries. The results indicated that the need for supervised residential places in this Montreal urban catchment area (131:100 000 inhabitants) was twice as high as in Trieste (the flagship of the Italian Psychiatric Reform) and fell in the high range of the benchmarks that were established in the UK at the beginning of the 1990s (8). It was close to the range of utilization that was observed by Elliot and others in 8 urban areas in the UK (17) and within the range of utilization in the 5 European urban catchment areas part of the European Psychiatric Services: Inputs Linked to Outcome Domains and Needs (EPSILON) study (18). Needs for long-stay hospital beds were well within the range for all jurisdictions. Finally, in British Columbia and Ontario, utilization rates and benchmarks were close to the present study's assessment of needs on an epidemiologic basis.

Discussion

Although needs for supervised residential facilities in our east-end Montreal catchment area may appear high, they do not represent the highest level reported in the literature. The first study of actual utilization indicated that a certain overprovision of care occurred in these facilities and that users could be moved to settings that allowed for more autonomy. This would be congruent with current psychosocial rehabilitation values and would support housing practices; in fact, individuals prefer, and stand to benefit from, living in

Table 2 Comparison of actual utilization of and needs for long-stay beds and supervised residential facilities in this study with selected studies in Canadian provinces and European countries (rates per 100 000 inhabitants all ages)

	Current study (use circa 1997)		Wing (8)	Dell'Acqua and others (32)	Elliot and others (17)	Becker and others (18)	British Columbia Mental Health Plan (33)	Clarke Institute Consulting Group (34)
Type of study	Use	Needs	Benchmarks	Use	Use	Use	Use	Benchmarks
Country	Canada (Montreal, Quebec)	Canada (Montreal, Quebec)	UK	Italy (Trieste)	UK	Netherlands, Denmark, UK, Spain, Italy	Canada	Canada (Province of Ontario)
Geographical level concerned	Urban catchment area	Urban catchment area	Regional	Regional	Urban catchment areas	Urban catchment areas	Provincial (supraregional)	Provincial (supraregional)
Long-stay beds (mean)	34	20	20 (10–30)	na	na	48 (9–75)	21	na
Supervised residential facilities (mean)	113	131	92 (58–126)	64	113 (54–116)	77 (4–176)	122	103

their own accommodations with the necessary support (19). This overprovision of care, however, was offset by unmet needs for the same among acute care attenders and hospital inpatients. The clinicians who assessed the needs of these acute care attenders considered alternatives to hospitalization and support in the community: the study found unmet needs for assertive community treatment, day hospital services, and supervised residential facilities alone or in combination with other alternatives to hospitalization (5).

As shown in our studies, the need for long-stay hospital beds remains in the mid range of other Canadian and European jurisdictions. An earlier local study of long-stay inpatients in the past decade supports these results: in-depth individual needs assessment revealed that 50% of patients who are currently hospitalized could be transferred to existing supervised residential settings, 15% to nursing homes, and 35% to a tertiary care facility similar to a "hostel ward" for intensive treatment and rehabilitation (20). The present study also revealed the need for places in nursing homes for older patients with severe mental disorders and with severe physical disabilities, but not necessarily over age 65 years. So far, this dimension has been overlooked in the literature. Again, the earlier, local study confirmed that placing these individuals in nursing homes would be appropriate (20). This is congruent with the growing recognition of the greater physical problems and disabilities of aging patients with severe mental illness (21).

To establish valid benchmarks for other Quebec, Canadian, and international jurisdictions, it is necessary to point out the limitations of the present research before trying to generalize results from this east-end Montreal catchment area. First, the needs assessment approach has been criticized from the outset for being at risk of mixing facts with value judgments. Although the needs assessment procedures used in both our studies have been systematized and have relied on extensive information gathering, and notwithstanding that the procedure has proved reproducible in controlled research conditions, in the end, treatment plans and the appropriateness of interventions amount to a clinical judgment and a hypothesis (22). One might think that values held by the staff or physicians in psychiatric hospitals who completed the needs assessment would be more inclined toward supervised residential settings (23). On the contrary, qualitative research in the same organization has shown that psychosocial rehabilitation values are present and practised (24). Moreover, a wide variety of supervised settings and intensive home care services are known and are used in this catchment area. A second limitation is the incomplete assessment of the nursing homes in the catchment area for other potential cases. A third limitation relates to the static structural nature of the present design and results, which provide no information on the dynamics of these facilities, that is, no proposed length of stay (LOS) or standards for LOS.

The local needs that we assessed here may change owing to a series of factors. First, innovations and experiences may present the possibility of using less supervised settings. The types of settings may change. For example, "hostel wards" may be used as alternative tertiary care facilities rather than current long-stay hospital wards (25,26). Second, patients with psychosis may live with reduced handicaps today, relative to past decades, owing to earlier and more comprehensive treatment and rehabilitation interventions; intensive home care; and less supervised settings, where residents are encouraged to make greater use of daily living skills; greater community integration; and less use of long-stay wards. Third, Quebec's aging population means that, in the future, there should be fewer

new patients with psychosis and fewer adults aged 18 to 65 years who suffer from severe mental illness.

The ratios presented here are based on a more comprehensive method to assess needs than those used in the other studies reported in Table 2, which relied simply on utilization, good practice areas, or expert opinions. However, to serve as benchmarks for other regions, they must be placed into perspective. First, the relative needs of regions are influenced by socioeconomic factors that carry a weight of 1 to 3 (27,28). Such weights have long been used in the UK, which explains the range for the standards proposed by Wing (8), as seen in Table 2. In this east-end Montreal catchment area, the indicators place the area within the average for Montreal (29). Second, needs in urban areas may be higher than those in nonurban areas, because psychotic disorders are more prevalent in the former (30). Third, within urban areas, as across countries, the sociocultural fabric and social support that is offered may change the need for supervised settings, depending on the extent to which the family or extended family provides supported housing. Utilization of such facilities, for example, was much lower in Spain (4:100 000) than in Denmark (176:100 000), as reported in the EPSILON study (18). In the east-end Montreal area, a study comparing Italian-Canadian and French-Canadian service attenders with severe mental disorders showed the former less likely to be in long-term care with specialized services (31).

Based on these considerations and results, the projected needs established in this urban catchment area of Canada and comparisons with current utilization in other jurisdictions in Canada and Europe should contribute to the establishment of benchmarks with ranges. Establishing benchmarks for regions rests on planners at the appropriate level of organization, which in Canada is at the national or provincial level. It is important that planners recognize a range of needs, rather than an absolute ratio for all regions or subregions. The methods used here to assess needs should also serve as guidelines for replication in other areas of Canada. Similar studies elsewhere would help refine the ranges and one day help experts to propose benchmarks for tertiary care, particularly for long-stay hospital beds, nursing homes, and supervised residential facilities in Canada and in other countries (9).

Funding and Support

Dr Lesage is currently National Health Research Fellow for the Quebec Health Research Fund (FRSQ).

Acknowledgement

We acknowledge the essential contribution of the Hôpital L-H Lafontaine medical records and Chief, Mme Denise Champagne.

References

1. Thornicroft G, Tansella M, editors. The mental health matrix. A manual to improve services. Cambridge: Cambridge University Press; 1999.
2. Lesage AD. Canada. In: Thornicroft G, Tansella M, editors. The mental health matrix. A manual to improve services. Cambridge: Cambridge University Press; 1999.
3. Wasylenki D, Goering P, Cochrane J, Durbin J, Rogers J, Prendergast P. Tertiary mental health services: I. key concepts. Can J Psychiatry 2000;45:179–84.
4. Cochrane J, Goering P, Durbin J, Butterill D, Dumas J, Wasylenki D. Tertiary mental health services: II. Subpopulations and best practices for service delivery. Can J Psychiatry 2000;45:185–90.
5. Lesage AD, Bonsack C, Clerc D, Vanier C, Charron M, Sasseville M, and others. Alternatives to acute hospital psychiatric care in east-end Montreal. Can J Psychiatry 2002;47(1):49–55.
6. Freeman SJJ. An overview of Canada's mental health system. New Dir Ment Health Serv 1994;61:11–20.
7. Goldberg D. Community psychiatry in Europe: assessment and evaluation. In: Tansella M, editor. Making rational mental health services. Epidemiol Psichiatr Soc 1997; Monograph (Suppl 1):217–27.
8. Wing JK. Epidemiologically based mental health needs assessments: review of research on psychiatric disorders. London: Royal College of Psychiatrists; 1992.
9. Wing JK, Brewin CR, Thornicroft G. Defining mental health needs. In: Thornicroft G, Brewin CR, Wing JK, editors. Measuring mental health needs. London: Gaskell; 1992.
10. MSSS – Ministère de la santé et des services sociaux du Québec. Service de l'analyse statistique. http://www.msss.gouv.qc.ca/f/index.htm. August 1998.
11. Kovess V, Lesage AD, Boisguérin B, Fournier L, Lopez A, Ouellet A. Planification et évaluation des besoins en santé mentale. Paris: Médecine-Sciences Flammarion; 2001.
12. Furman WM, Lund DA. The assessment of patient needs: description of the Level of Care Survey. J Psychiatr Treat Eval 1979;1:40–2.
13. Côté J, Lachance R, Ouellet L, Pilon W. La concordance entre paires d'observateurs à 22 variables de l'Inventaire de niveau de soins et la stabilité de leurs observations. Module de recherche psychosociale. Québec: Centre de recherche, Université Laval-Robert-Giffard; 1989.
14. Comité plan de services des alternatives à l'hospitalisation. Les besoins de services rapportés à travers l'inventaire de niveaux de soins. Questionnaire complété en 1997 pour diverses clientèles de services psychiatriques de l'Hôpital Louis-H. Lafontaine. Prepared by Alain Lesage and Claude Lamarre; January 1998.
15. Statistics Canada. Intercensus survey. French Web Site Recensement statistique Canada 1996; 1996. http://www.santepub-mtl.qc.ca/Portrait.
16. Beck A, Croudace TJ, Singh S, Harrison G. The Nottingham acute bed study: alternatives to acute psychiatric care. Br J Psychiatry 1997;170:247–52.
17. Elliot P, Audini B, Knapp M, Chisholm D. The mental health residential care study: classification of facilities and description of residents. Br J Psychiatry 1996;169:139–47.
18. Becker T, Knapp M, Knudsen HC, Schene A, Tansella M, Thornicroft G, and others. The EPSILON study of schizophrenia in five European countries. Design and methodology for standardising outcome measures and comparing patterns of care and service costs. Br J Psychiatry 1999;175:514–21.
19. Carling PJ. Implementing supported housing: current trends and future directions. New Dir Ment Health Serv 1997;74:79–94.
20. Lesage AD, Morissette R, Fortier L, Reinharz D, Contandriopoulos AP. Downsizing psychiatric hospitals: I. Needs for care and services of current and discharged long-stay inpatients. Can J Psychiatry 2000;45:526–32.
21. Anderson J, Dayson D, Wills W, Gooch C, Margolius O, O'Driscoll C, and others. The TAPS Project. 13: Clinical and social outcomes of long-stay psychiatric patients after one year in the community. Br J Psychiatry 1993;162(Suppl 19):45–56.
22. Van Haaster I, Lesage AD, Cyr M, Toupin J. Further reliability and validity studies of a procedure to assess the needs for care of the chronically mentally ill. Psychol Med 1994;24:215–22.
23. White D, Mercier C. Coordinating community and public-institutional mental health services: some unintended consequences. Soc Sci Med 1991;33:729–39.
24. Bonin JP, Lesage AD, Ricard N, Demers M, Morissette R, Benoit D. Empowering the staff in long-stay wards. Can J Psychiatry 1998;43:1054–5.
25. Garety PA, Morris I. A new unit for long-stay psychiatric patients: organization, attitudes and quality of care. Psychol Med 1984;14:183–92.
26. Health and Welfare Canada. Best practices in mental health reform Phase II situational analysis. Chapter 2: Seven Oaks Project, Victoria, British Columbia. Prepared for Health Canada and the Advisory Network on Mental Health by the Health Systems Research Unit, Clarke Institute of Psychiatry. Ottawa: Health and Welfare Canada; 1997.
27. Lesage AD, Clerc D, Uribé I, Cournoyer J, Fabian J, Tourjman V, and others. Estimating local-area needs for psychiatric care: a case study. Br J Psychiatry 1996;169:49–57.
28. Smith P, Sheldon TA, Martin S. An index of need for psychiatric services based on in-patient utilisation. Br J Psychiatry 1996;169:308–16.

29. Roberge M, Lesage AD. Modélisation des besoins des services de santé mentale de la population de la région de Montréal-Centre. Québec: Régie Régionale de la santé et des services sociaux de Montréal-centre; 2000.
30. Marcelis M, Navarro-Mateu F, Murray R, Selten JP, Van Os J. Urbanization and psychosis: a study of 1942 1978 birth cohorts in The Netherlands. Psychol Med 1998;28:871–9.
31. Carpentier N, Dorvil H, Lesage AD. Utilization of out-patient services by first and second generation Italian immigrants and French Canadian patients with previous psychiatric hospitalizations. Santé Culture Health 1991;VIII(3):285–305.
32. Dell'Acqua G, Marsili M, Zanus P. L'histoire et l'esprit des services de santé mentale à Trieste. Santé Mentale au Québec 1998; XXII(2):148–70.
33. British Columbia Ministry of Health. Revitalizing and rebalancing British Columbia's Mental Health System. Victoria: British Columbia Ministry of Health and Ministry Responsible for Seniors; 1998.
34. Clarke Institute Consulting Group. Essential service ratios in a reformed mental health system: case management and housing support. Report to the Ontario Ministry of Health. Toronto: Clarke Institute of Psychiatry; 1993.
35. Lesage AD. Perspectives épidémiologiques sur le virage ambulatoire des services psychiatriques. Santé mentale au Québec 1996;XXI(1):79–96.

Manuscript received September 2002 and accepted January 2003.

Preliminary results of this study have been previously published by Robitaille D, Morissette R, Lesage AD, Gelinas D, Dion E, Frezza D. Recursos Residenciales Protigidos En Quebec. Vertex Revista Argentina De Psiquiatria 1999;X:111–20.

[1]Research Professor, Department of Psychiatry, University of Montreal, Centre de recherche Fernand-Seguin, Hôpital Louis-H Lafontaine, Montreal, Quebec.
[2]Research Assistant, Centre de recherche Fernand-Seguin, Montreal, Quebec.
[3]Psychiatrist, Centre Hospitalier Régional du Suroît, Valleyfield, Quebec.
[4]Research Assistant, Centre de recherche Fernand-Seguin, Montreal, Quebec.
[5]Research Assistant, Centre de recherche Fernand-Seguin, Montreal, Quebec.
[6]Head, Medical Services, Rehabilitation and Residential Services, Hôpital Louis-H Lafontaine, Montreal, Quebec.
Address for correspondence: Dr A Lesage, Centre de recherche Fernand-Seguin, Hôpital Louis-H. Lafontaine, Unité 218, 7401 Hochelaga, Montreal QC H1N 3M5
e-mail: alesage@ssss.gouv.qc.ca

Résumé : Vers des repères pour les soins tertiaires des adultes souffrant de graves troubles mentaux persistants

Contexte : On a accordé peu d'attention à établir des repères pour les soins tertiaires des adultes souffrant de graves troubles mentaux. Pourtant, la disponibilité et l'utilisation efficace des ressources résidentielles déterminent la capacité d'un système de soins complet d'éviter l'encombrement des lits de soins actifs dont le nombre diminue sans cesse.

Objectifs : Décrire l'utilisation actuelle et les besoins projetés de soins tertiaires dans la zone desservie par un hôpital psychiatrique de l'est de Montréal, et comparer les résultats obtenus avec l'utilisation actuelle et les besoins projetés évalués dans d'autres provinces canadiennes et d'autres pays, dans l'optique d'établir des repères nationaux.

Méthodes : Deux sondages ont été entrepris pour établir le nombre de places utilisées et nécessaires dans ces installations pour adultes de 18 à 65 ans, qui provenaient à l'origine de la zone desservie et qui avaient de graves troubles mentaux sans diagnostic principal de déficience mentale ou de syndrome cérébral organique. Un premier sondage évaluait le nombre de places utilisées et celui des places nécessaires pour des soins résidentiels chez tous les patients hospitalisés à long terme et tous les adultes dans des installations résidentielles supervisées. Un deuxième sondage déterminait le besoin d'une telle hospitalisation de longue durée, de maisons de repos et d'installations supervisées comme solution de rechange ou comme complément de l'hospitalisation pour les patients hospitalisés des soins actifs.

Résultats : La ratio actuel des places dans les unités de longue durée des hôpitaux, des maisons de repos et des installations résidentielles supervisées était de 150 : 100 000 habitants. Le ratio idéal, selon les besoins estimés, est de 171 : 100 000. Ce chiffre se décompose ainsi : 20 : 100 000 pour les unités de longue durée d'hôpitaux, 20 : 100 000 pour les maisons de repos, 40 : 100 000 pour les foyers de groupe, 40 : 100 000 pour les résidences privées ou les familles d'accueil, et 51 : 100 000 pour les appartements supervisés. Les besoins de cette population urbaine de cols bleus en matière de places résidentielles supervisées oscillaient dans l'extrémité supérieure de l'utilisation et des normes pour les pays européens, et des normes proposées pour les provinces canadiennes.

Discussion : Les besoins d'une hospitalisation de longue durée ou d'installations résidentielles supervisées ne peuvent être traités comme un absolu. Par exemple, l'évaluation menée dans ce système principalement hospitalier de soins psychiatriques peut produire des estimations plus élevées de soins institutionnels. Comparer l'utilisation actuelle et les besoins projetés dans cette zone urbaine desservie avec l'utilisation courante dans d'autres territoires du Canada et d'Europe devrait contribuer à établir de solides repères nationaux à l'échelle.

Conclusions : Il est possible d'établir des repères qui guident la mise sur pied de cadres résidentiels supervisés afin de répondre au mieux aux besoins de la population des adultes souffrant de graves troubles mentaux persistants. Les méthodes utilisées ici pour évaluer les besoins devraient servir de lignes directrices aux futures études, parce qu'elles ont été conçues pour maîtriser le biais de sur-fourniture ou de sous-fourniture de soins dans l'utilisation actuelle des cadres résidentiels supervisés.