

## Relevant Coding Definitions

The original codes used to review interview transcripts were defined so that all reviewers would have a standardized understanding of when and how to use each given code. We added new codes as needed, when they emerged from the interviews, and then agreed upon definitions. Definitions for the codes most relevant to the final report are shared below, to aid the reader in assessing and understanding the language and themes used throughout.

### **Main Themes:**

**Quality:** the overall effectiveness and functioning of the MHA services landscape. Quality can be defined by factors such as the achievement of desired MHA outcomes, by positive relationships with care providers, or by efficient, equitable, timely, and person-centred service delivery. These factors are determined by the PLE, not by objective system indicators such as hospital admissions and recorded wait times

**Access:** the availability of services, the ability to locate those services, and the ease and facility with which one can access those services. In order to be 'accessible', a service must be available without creating too much of a financial or organizational burden upon the person seeking support and/or their caregivers

**Safety:** the actual or perceived physical, emotional, and cultural safety of the person seeking services, as well as the degree to which their confidentiality is protected.

- o Physical safety includes the actual use, or fear of: physical and chemical restraints, incidences of harm or adverse medical outcomes associated with treatments or medications, involuntary commitment, legal ramifications, etc.
- o Emotional safety includes the experience of, or fear that: services will upset, retraumatize, or otherwise exacerbate the mental health of the person seeking services due to a lack of care provider acceptance, understanding, or compassion
- o Cultural safety includes the experience of, or fear that: services will upset, retraumatize, or otherwise exacerbate the mental health of the person seeking services due to a lack of care provider acknowledgement and respect of PLE culture, nationality, language, religion/spirituality, ethnicity, etc.
- o Confidentiality refers to concerns about privacy (what information is requested, collected, or exchanged), and the impact that breeches to confidentiality (how that information is stored, protected, or shared) could have upon emotional, physical, and other types of safety



### **Sub-themes:**

#### Relationship with care provider

- Relationship: the way in which two (or more) people behave towards one another; the quality of that interaction
- Care provider: any person who administers or provides MHA treatment or services. This can include administrators, phone intake personnel, nurses and physicians, psychiatrists, psychologists, counsellors, social workers, addictions workers, peer-support networks...
- Note potential distinctions between asymmetrical relationships (care provider to patient) versus peer-support relationships (e.g. 12-step, CHANNAL)

#### Confidence in the system

- PLE expectations of what the services will be like and belief that the MHA system will work or not work
- This could include expectations of a practical nature, e.g. anticipating long wait times deters someone from seeking treatment; expectations of a philosophical nature e.g. the PLE is not comfortable with the particular approach (medical, spiritual, psychiatric, etc.) to MHA; expectations of a geographical nature e.g. believing services out-of-province are superior or those available in-province (pay special note as to *why*); trust issues related to how nepotism may dictate quality and access to services; or lack of trust that certain individuals or organizations are competent

#### Perceived stigma

- PLE perception that they are being or would be treated differently than other clients, due to gender, age, sexual orientation, class, race/ethnicity, religious beliefs, ability...
- PLE perception that they are or would be judged based on the type of challenge they are presenting with, their particular diagnosis, and/or the service(s) they are seeking
- PLE perception that they are misunderstood, disbelieved, or pathologized
- Impact of social norms and beliefs around MHA

#### Wait times

- Wait times for phone calls/returned calls (for central intake or making appointments, as well as access to immediate crisis phone line service or mobile crisis unit)
- Time between referral or application to initial assessment for services
- Time between initial assessment to service initiation
- Time between appointments/programs

#### Person-centred care

- Person-centred systems and services are those that are tailored to meet individuals where they are at, versus individuals needing to adapt to systems and



services as they are structured. It implies that structures have a level of built-in flexibility so that they can shift to fit people's various needs

- Services are culturally safe and adapted to individual unique needs vis-à-vis accessibility, language, etc.
- Services treat people holistically
- PLE and their caregivers are at the centre of decision-making and service delivery, they are presented with options and choices for treatment

#### Effectiveness

- PLE perception that the care/treatment worked or was useful to them
- Effectiveness as measured according to PLE-defined quality of life, versus other common system indicators (e.g. mortality/morbidity)
- Treatments and services are evidence-based/empirically proven based on experience (broadly defined) but selected according to individual needs

#### System navigation

- Entering the system: knowing where to go for what
- Practical aspects of locating and receiving care: phone calls, filling out applications, obtaining referrals, finding the address of services, etc.

#### Continuity of care

- Maintenance of care, over time, once in the system; transitioning between services
- Communications/cooperation between health care/MHA service providers
- Follow-up care and transitioning out of care

#### Community supports

- Community supports are non-provincial health authority services. They are non-institutional, i.e. accessed in-community, and involve a high degree of PLE initiative/ agency. For ex: NGOs, peer-support networks, and non-profits such as The Gathering Place, The Pottle Centre, CHANNAL, Stella's Circle, Choices For Youth, Women's Centre, etc.

#### Efficiency

- System/services are designed to avoid wasting opportunities, time, equipment, supplies, and energy

#### Voice/feeling heard

- PLE is asked for their opinion on quality of services

#### Power imbalance

- System policies and designs that underscore a power differential between service providers and patients/PLE

#### Self-advocacy

- PLE involvement in their own treatment plan, ability to exercise agency