Consultation paper
Spring 2001

SECTORIZATION:

CURRENT STATUS
and

POSSIBLE SOLUTIONS

FOR GREATER ACCESS TO PSYCHIATRIC SERVICES

RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

Michel Roberge
Services de santé mentale
Direction de la programmation et coordination

Roger Brosseau
Service conseil et aide à la clientèle
Direction des relations avec la communauté

Avril 2001

CONSULTATION PAPER

SPRING 2001

SECTORIZATION; CURRENT STATUS and POSSIBLE SOLUTIONS

April 2001

Table des matières

Preface 5

Acknowledgements 5

Summary 6

1. Introduction 7

2. Current Status of Sectorization 7
- Background 7
- Objective of Sectorization 7
- Rules for Sectorization 7
- Sectorial Breakdown 8

3. Initial Facts 8
- The Issue 8
- Percentages of Non-Sector Users 9
- Recommendation by the Regional Board's Service conseil et
- aide à la clientèle and Position of the Public Complaints Commissioner 10

4. Consultation Process 11
- Objective 11
- Interviewees 11
- Findings 11
  . Problems arising from the current implementation of sectorization 11
  . Service-management problems of a more general nature 12
  . Apprehended problems resulting from changes in or withdrawal of sectorization 12
  . Advantages of sectorization 12
  . Reasons for stringently enforcing sectorization 12
  . Possible advantages to adjusting or withdrawing sectorization 13

- Suggested solutions 13
  . Establishing local and regional access mechanisms with clear rules 13
  . Informing users and personnel 14
  . Improving equity 14
  . Improving access to a variety of services and approaches 14
  . Coordination, follow-up, and assessment 14

5. Summary Action Plan Proposal 15

6. References 16

Preface

Some will say that sectorization means not being able to receive psychiatric services anywhere but at the place determined by your postal code: "No care for outsiders!"

Others consider that users have a right to obtain unrestricted services at different locations and to move around as they choose: "Wherever and whenever we want!"

These two extremes are opinions expressed by partners in the health and social services system on the subject of sectorization. Over the last few years many people have shown dissatisfaction and taken issue with sectorization.

There is therefore reason to ask whether sectorization, which was intended to provide access to psychiatric services, has become outdated and whether it should be eliminated or changed.

If we are to arrive at solutions that are distinct from both extremes, we must understand the viewpoints, issues, difficulties, advantages, and disadvantages related to sectorization. Above all, we need forward-looking solutions that will guarantee both respect for user rights and accountability in the use of services, both efficient management and equitable resource distribution.

We therefore needed a profile of the current situation so that partners concerned with access to services could share their opinions and find possible solutions.

Acknowledgements

We would like to thank the many people who provided us with their opinions on sectorization and who helped us to understand its different facets and the issues related to it:

Doctors Edward Naltchayan (CH de St-Mary), Michel Filion (CHUM), Paul Beaudry (CSUM-Royal-Victoria), and Pierre Assalian (CSUM-Montreal General); Ms. Marie-Andrée Dionne (RACOR); Mr. André Chandonnet (CHUM) and Mr. Pierre-Antoine Baril (Action Autonomie); and those in charge of hospital complaint departments.

SUMMARY

This paper is intended to support discussions with partners in the mental-health system on the relevance and, if needed, on adjustments to the means by which sectorization of psychiatric services is conducted within the region of Montréal-Centre.

Our foremost goal is to ensure respect for the right of users to have access to psychiatric services, as provided for in An Act respecting health services and social services and without exclusion due to sectorization.

This paper begins by providing some context on the state of psychiatric-service sectorization in the region: background, objectives, rules, and sectorial breakdown.

Secondly, it presents certain facts that clarify initial perceptions of this issue. The problems generally expressed are specified, and some statistics are presented on percentages of users from each institution's sector. After that, the situation of users who have complained to the Board is described, as are the recommendations from both the Board's Service conseil et aide à la clientèle and the Public Complaints Commissioner for Health Services and Social Services in Quebec.

Thirdly, the findings of the consultation on problems with sectorization are presented along with possible solutions. The consultation process has examined six aspects of these problems:

(a) Problems arising from the current implementation of sectorization;

(b) More general service-management problems of a more general nature;

(c) Apprehended problems resulting from changes in or withdrawal of sectorization;

(d) Advantages of sectorization;

(e) Reasons for stringently enforcing sectorization;

(f) Possible advantages to adjusting or withdrawing sectorization.

Furthermore, the consultation process offers possible solutions along five avenues:

(a) Clarification of rules;

(b) Information for users and personnel;

(c) Greater equity among departments;

(d) Improved access to a variety of services and approaches;

(e) Establishment of mechanisms for access and for local and regional coordinating and of follow-up procedures.

Finally, an action plan is proposed as a means to continue this work.

1. Introduction

The Regional Board, in collaboration with its partners in the mental-health system, is examining the relevance of psychiatric-service sectorization and the possibility of making adjustments. The goals of this process are the following:

1. To guarantee users access to psychiatric services - sectorization shall not be a cause of exclusion - as provided for in *An Act regarding health services and social services* [6];
2. To see that the administrative measure known as sectorization is respected.

In this paper we will first deal with the current situation, meaning the objectives of sectorization, the rules governing its implementation, its breakdown, and frequently stated problems. We will then move on to the results of the consultation process, providing information on the people interviewed and the advantages of sectorization for both users and institutions. Finally, we will propose possible solutions.

The objective of this paper is to report on the 1999 regional consultation process that examined problems related to the sectorization of psychiatric services as well as the identification of possible solutions. The consultation process was intended to clarify the issue of sectorization, to better identify regional objectives, and to begin the preparation of an action plan.

This paper is also intended to serve as a means for supporting further meetings among partners so that regional policies on the sectorization of psychiatric services can be finalized.

2. Current Status of Sectorization

Background

Short-term psychiatric treatment for adults in the Montréal-Centre region has been sectorized since the late 1960's. This means that all hospitals involved with this treatment have a territorial responsibility regarding the provision of services. The Regional Board has since adopted the principle of sectorizing psychiatric services along territorial lines and defined it in different documents: in 1983 [3], 1987 [2], and 1996 [7].

Objective of Sectorization

Although all in a similar way, different documents have specified the objective of sectorization. In the latest document on the review of sectorization [7], it is stated that "... this administrative measure was and remains necessary in order to facilitate access to client services. Its purpose is to ensure that there will be a place where clients may go if the preferred professional or institution is unable to follow up on their requests."

Historically speaking, this measure was adopted to "allow for the best possible rational use of available resources by means of a more equitable distribution of interinstitutional responsibilities so as to ensure access to and continuity of care." [3, p. 5]. This document [p. 65] nevertheless stressed that the free choice of beneficiaries or their families, as established by law, was to prevail over the administrative measure.

Rules for Sectorization

Different documents have established rules for the implementation of sectorization [2, 3, 4, 7]. The current rules are to be found in the 1996 review of sectorization for adults [7]:

1. Each institution is responsible for delivering specialized, short-term services to people living in its sector and wishing to be treated by it.

2. Respect for the free choice of users, as established by law, remains in effect, whatever the reason may be (distance due to a change of residence, a preference for a specific institution or means of care, etc.).

3. In no way does sectorization apply to emergency cases. The hospital centre where the person arrives has a responsibility to provide the required emergency care.

4. The hospital centre retains its responsibility for hospitalization for a period of six months following its last intervention, regardless of where the user is living at that time.

5. Users may be transferred only after they - or their representatives - and the institution where they are to be transferred have stated their agreement with the transfer.

Sectorial Breakdown

The defining characteristic of the 1996 sectorization review [7] was its adjustment of the territories covered by psychiatric departments so that they would coincide with those of CLSCs. With the exception of Côte-des-Neiges, Lachine, Ahuntsic, and St-Michel, all departments cover one or more CLSC territories, and no CLSC territory is covered by more than one department. The above exceptions have resulted from difficulties in balancing the needs of the population living on CLSC territories with the resources available in psychiatric departments.

The current document on sectorization [7] describes the sectorial breakdown on the basis of municipalities and postal codes. In addition, a computerized file [8] specifies sectorial breakdowns solely by postal codes, a simple system for identifying a person's sector.

3. Initial Facts

The Issue

User advocacy organizations, institutional complaint services, and the Montreal Regional Board's Service conseil et aide à la clientèle have received complaints from users who have been refused access to the psychiatric services provided by their chosen institution or professional.

Different documents and communication with institutions reveal that most staff members see sectorization as an obstacle to accepting non-sector users. The present use of sectorization seems to force users to go the institution located in their sector, whereas sectorization should require that institutions deliver services to the clients who live in the sector assigned to them and who wish to receive those services. In other words, the responsibility has been transferred from the institutions to the users.

Several hypotheses may be used to explain this situation:

1. a lack of knowledge regarding sectorization rules and means of implementation

2. a scarcity of resources for dealing with "out-of-sector clients"

3. the need to continue the therapeutic process with users who tend to "escape"

4. forms of opposition, which should be identified

Percentages of Non-Sector Users

There is no system that would enable us to arrive at an exact figure for the number of service requests refused as a result of sectorization. The number of complaints (institutional reports on complaints and reports by the Regional Board) provides an indication, but it could constitute an underestimation, given that some users may accept a decision made by a department without filing a complaint.

A different approach is to conduct a department-by-department examination of percentages of non-sector hospital users. This approach does not provide an accurate means of measurement because factors other than the refusal of non-sector clients might be at the origin of a low percentage. One such factor could be the distance from other institutions. However, the departments with the lowest percentages of non-sector users could also be the strictest in resorting to refusals due to sectorization.

The following table presents 1998-1999 statistics on percentages of non-sector users and of first-admission non-sector users. Users may be accommodated in homes outside the sector, but any subsequent hospitalization will be in the hospital where they are receiving care. This means that, in such cases, they are listed as non-sector users. Users admitted for the first time (within the 1993-1998 time period) are not subject to that restriction. Therefore, the second column of figures probably reflects an institution's position on the admission of non-sector users more accurately than does the first.

In summary, despite certain opinions to the contrary, sectorization does not constitute an impenetrable filter. Non-users account for an average of approximately 30% of all admissions.

Table 1: ***Percentages of Non-Sector Users***

Institution	% of Non-Sector Users (1998-1999) *	% of Non-Sector User (1998-1999) First Admission*
Louis-H. Lafontaine	20 %	n.d.
Maisonneuve-Rosemont	36 %	30 %
Notre-Dame	49 %	25 %
Saint-Luc	46 %	19 %
Jean-Talon	32 %	29 %
Général de Montréal	53 %	64 %
Royal Victoria	59 %	44 %
Général Juif	22 %	19 %
St-Mary	40 %	25 %
Douglas	18 %	15 %
Lakeshore	10 %	9 %
Fleury	18 %	9 %
Sacré-Cœur	14 %	17 %
AVERAGE	**29,3 %**	**30 %**

* Based on residence within a CLSC territory

Recommendation by the Regional Board's Service conseil et aide à la clientèle and Position of the Public Complaints Commissioner

The Montreal Regional Board's Service conseil et aide à la clientèle regularly receives complaints related to the sectorization of psychiatric services. Users complain that they are unable to obtain from the institution of their choice the services required to meet their health needs. The response from the institutions is usually to the effect that the users should take their requests to the hospital located in their sector. In some cases the institution even claims that it must refuse the user's request because sectorization forces it to do so. Users have reported that the first question asked when they contacted an institution to request services was "what is your postal code?"

These practices are contrary to the right of users to choose the professional and the institution from whom and which they would like to receive services, as stated in An Act respecting health services and social services [6]. These practices are also contrary to the current rules applicable to the implementation of the administrative measure called sectorization [7]. These rules include the following:

Respect for the free choice of users, as established by law, remains in effect, whatever the reason may be (distance due to a change of residence, a preference for a specific institution or means of care, etc.).

Every year the Service conseil et aide à la clientèle must intercede with institutions in order to guarantee respect for users' rights and compliance with the rules related to sectorization. This has continually led the Service to recommend that the Montreal Regional Board take measures to remind institutions what these rights and rules are [9, 10].

The Public Complaints Commissioner for Health Services and Social Services [1] has also been addressed with complaints of this nature, and she has adopted a position very similar to that of the Montreal Regional Board's Service conseil et aide à la clientèle. She has recommended that there should be respect for the users' choice of an institution from which they would like to receive the services required to meet their health needs. However, she has also recommended that users be previously informed of the existence of the sectorization of psychiatric services and of the possible advantages of receiving care from an institution in their own sector so that they can make a well-grounded decision.

The following is quoted from the recommendation made by the Public Complaints Commissioner to the Regional Board:

... to remind all hospital centres providing psychiatric services in the region of the following:

An Act respecting health services and social services recognizes that every person is entitled to "choose the professional or the institution from whom or which he wishes to receive health services or social services". (s. 6)

Despite the sectorization of services, the right to choose means, among other things, that the person's choice must be respected even if that person does not have a file at the institution in question and that said person cannot be transferred from one institution to another unless he or she has consented to the transfer.

Entitlement to the services of the professional of one's choice is limited by the freedom of "a professional to accept or refuse to treat a person" (s. 6). This freedom does not exist in an emergency situation.

The choice of the professional may also be predetermined by the choice of the institution. Within the institution and in accordance with internal regulations, the person may make a choice from among those professionals authorized to practice in that institution.

The Régie (Regional Board) should take all necessary measures to inform users of legal and regulatory provisions concerning their right to receive services from the professional and institution of their choice.

The above recommendation was well received by the Regional Board, which took different ensuing measures, including the production and wide distribution of a pamphlet designed to inform users of their rights and of the objectives of the sectorization of psychiatric services.

4. CONSULTATION PROCESS

Adult psychiatric sectorization was reviewed in 1996, when some institutions were closed. At that point, however, there was not enough time for any in-depth thinking about the relevance of sectorization as a tool to promote greater access to mental-health services in our region and an equitable allocation of resources.

Since then different health institutions, community organizations active in the field of mental health, and the Montreal Regional Board have been questioning the need to maintain sectorization in its present form. In preparation for discussions and a sharing of ideas with partners, it was advisable to better document the situation from the standpoint of those involved.

Objective of the Consultation Process

The objective of the consultation process was to better understand the advantages and disadvantages of sectorization, to ascertain its relevance, and to identify possible solutions. This process is a preliminary stage on the way to a broader discussion with the different partners in the health and social services system.

Interviewees

The following people were interviewed during semistructured meetings jointly facilitated by Mr. Michel Roberge and Mr. Roger Brosseau, both from the Regional Board:

- Dr. Edward Naltchayan, St-Mary's Hospital Centre (April 12, 1999)
- Dr. Michel Filion and Mr. André Chandonnet, hôpital Notre-Dame of the CHUM (May 4, 1999)
- Heads of hospital-centre complaint departments (at their meeting on June 3, 1999
- Ms. Marie-Andrée Dionne, RACOR , and Mr. Pierre-Antoine Baril, Action Autonomie (June 8, 1999)
- Dr. Paul Beaudry and Dr. Pierre Assalian, CSUM (June 9, 1999)

Findings

Problems arising from the current implementation of sectorization

The way in which sectorization is presently implemented is problematic due to the following:

1. It results in an infringement of users' legally defined rights to choose an institution or professional.

2. Some users are looking for a particular therapeutic approach that may not be offered in their sector. They may therefore tend to "shop around" at different hospital centres.

3. Some users are treated at a hospital centre for physical health problems. If they also have a psychiatric disorder, they are asked to go to the institution located in their sector.

4. Users wishing to be treated by people who share their mother tongue or have an excellent command of it may not find a suitable response to their request. For example, some English-speakers living in French-speaking areas would like to be treated in a more Anglophone area. The opposite may be true for Francophones living in predominantly English-speaking areas.

5. Users dissatisfied with their care or with the relationship between therapists and themselves may feel as though they are the captives of the professionals or their institution.

6. Users who would like to obtain a second opinion have little access to another institution.

7. Users are sometimes transferred to the institution located in their sector without their consent and despite their refusal.

8. Restricted access for non-sector clients compromises access for the target clienteles of psychiatric specialization, thereby preventing the optimization of service quality and of training for specialists.

9. Each institution's complaint department must deal with approximately ten complaints related to sectorization every year. This leads to problems that are always difficult to solve.

10. It is difficult for general practitioners to refer their clients to the institution located in the same sector as their office. Their clienteles come from several sectors, and sectorization rules force them to increase the number of partners with whom they must deal.

Service-management problems of a more general nature

Some people have mentioned more-general problems about the way that services are managed:

1. There is little availability of services, and restrictive criteria are significant. This situation compromises access to services.

2. Often available services are limited to a medicinal approach, while people are looking for a varied psychotherapeutic approach. The latter is rarely available, and, if it is, the user must wait several months for treatment.

Apprehended problems resulting from changes in or withdrawal of sectorization

The following negative impacts could result from the withdrawal of sectorization:

1. Some institutions might see an increase in the number of users of psychiatric services, including patients with serious and persistent disorders. If no new resources were added, there would be congestion and overload, which would have a negative effect on the administration and quality of care.

2. "Shoppers" with personality disorders or other pathologies might request services at several institutions. The effect on institutions would be increased congestion, and the impact on these users could only be antitherapeutic.

Advantages of sectorization

Some of the advantages of sectorization would lead us to preserve it:

1. Users, especially the seriously ill, derive greater benefit from the work of a team that is familiar with and connected to a specific sector's services and organizations. The proximity of caregivers in the neighbourhood or sector promotes partnership, whereas distance reduces the possibilities of cooperation and familiarity with a specific area. This familiarity with the user's environment is essential to rehabilitation and proper reintegration into society.

2. In a framework of complementarity between frontline and specialized services, contacts for the purpose of referrals and collaboration are easier to establish when people know each other.

3. With sectorization, there is a better balance between the demand for services and the available institutional resources.

4. Sectorization allows for better control over people who "abuse" the system. These are people whose illness often makes them want to contest norms.

Reasons for stringently enforcing sectorization

Certain factors seem to promote a strict enforcement of sectorization:

1. The predominant factor seems to be the issue of an equitable allocation of resources. When there is a perceived scarcity of resources with respect to demand, it becomes difficult for an institution to accept non-

sector users and thereby increase its case load, unless the available resources also increase. The situation is even more difficult when the institution sees itself as less advantaged from the standpoint of resources than the institution in the sector where the prospective user resides. Equity must be a matter of balance among different kinds of professional resources, including psychiatric staff and beds for psychiatric patients.

2. It is also important to maintain control over users whose illness causes them to be perpetually dissatisfied, to want to overstep established rules, to "shop around," etc. Allowing such users to go from one professional, service, or department to another will not solve their problems, and, to the contrary, it might even intensify them. Some families, seeing little progress in a patient's condition, will look elsewhere for more effective treatments when the nature of the illness is serious and the current treatment actually constitutes the best practice. They usually will not find better treatment anywhere else, although their shopping for it may prevent the needed therapeutic relationship from being developed.

Possible advantages to adjusting or withdrawing sectorization

Some advantages could be derived from adjusting or withdrawing sectorization:

1. In general terms, the problems caused by the implementation of sectorization would be eliminated or reduced in scope.

2. It would be possible to broaden the pool of target clients and thereby promote regional specialization. This would mean an improvement in the quality of services and in the training of specialists.

3. Shared care would be encouraged. It would therefore be easier for general practitioners to obtain psychiatric advice or to refer their clients from different neighbourhoods to the institution located in the same sector as their doctor's office.

4. Users would have easier access to a parcular approach or type of therapy that might not be available in their sector.

5. If they so requested and desired, users receiving hospital care for a physical health problem could also benefit from psychiatric services. This would mean better continuity in their care.

6. Users wishing to obtain a second opinion could have access to another institution.

Suggested solutions

Possible solutions fall into five categories:

Establishing local and regional access mechanisms with clear rules

1. Local and regional mechanisms still to be defined would be aimed at making the management of complex or contentious situations run more smoothly and at promoting personalized solutions and approaches that are respectful of users' needs and rights. Such mechanisms would be directed at roles and responsibilities related to psychiatric services, the management of waiting lists, priority criteria, intersectorial coordination, and the management of contentious cases. These mechanisms would include the following components as well as others.

2. Free choice for users is still the basic principle that must be respected. Sectorization can be used when no preference for a specific institution has been expressed.

3. All requests for changes in doctors or institutions should be considered on the basis of clinical, human, social, and legal factors. Reasonable justification for such changes may include language, the right to a second opinion, access to services not available in the user's sector, a preference for a specific kind of treatment, a change of residence, etc.

4. Users already undergoing physical health care should have access, if they so desire,

to mental health care at the same hospital centre, notwithstanding an important clinical contraindication.

5. General practitioners working in the same sector as the institution may refer patients to that institution, and said institution must receive those patients as if they resided in that sector.

6. Joint institutional mechanisms (rules, procedures) could be established for those wishing to transfer from one institution to another.

7. Dissatisfied users may also be referred to another doctor within the same hospital centre.

8. If justification is required, patients should be provided with a written explanation of why their request was refused.

Informing users and personnel

9. Information should be disseminated as broadly as possible to users, personnel, doctors, administrators, etc. One possibility would be to publish an explanatory pamphlet for general distribution throughout the system: hospital centres (including emergency rooms), CLSCs, community organizations, private clinics, etc.

10. We should obtain support from the heads of complaint departments.

11. It should be remembered that the objective is to provide access to services and that this includes the right to choose. In this sense, it is important to minimize the impact of limited resources, of administrative constraints related to sectorization, etc.

Improving equity

12. Resources should be adjusted to meet the demand. The budgets of psychiatry departments should be reviewed annually so that they can cope with their responsibilities and respond to the needs of users. There should be swift and flexible regional procedures; if not, the situation will remain unchanged.

13. Institutional financing should be based on both the population of the sector and the level of activity.

14. More financing should be allocated for the psychotherapy resources of ambulatory services.

15. Second- and third-line programs should be financed in a differentiated, swift, and flexible manner.

Improving access to a variety of services and approaches

16. There is a need to improve consensus building so as to encourage the development of a variety of proven psychotherapeutic approaches.

17. Mechanisms should be identified so as to ensure that those users with the most serious and persistent disorders will continue to benefit from the services that they require.

18. Departments should refocus their activities more intensely on clients needing specialized services. Consequently, they should work more closely on sharing care with family doctors and on basic mental health care.

19. There should be more consultation with frontline workers, who can provide an appropriate response in close contact with the user's environment.

Coordination, follow-up, and assessment

20. The Board would be responsible for enforcement of local mechanisms and would manage regional coordination. It would provide its board of directors and the institutions with feedback on an annual basis.

21. The Board will assess the impacts resulting from the implementation of these recommendations.

22. The term sectorization should be replaced by one that emphasizes access mechanisms.

5. SUMMARY ACTION PLAN PROPOSAL

1. **Validation of Report within the Regional Board**

   - Services
     - Mental Health, Conseil et aide à la clientèle
   - Departments
     - Programming and Coordination; Community Outreach
   - Correction of Report
     - On the basis of remarks from services and departments

2. **Validation of Report within the Health and Social Services System**
   - Hospital centres
     - Executive Director, Director of Professional Services, and department heads
   - Users and their representatives
   - Complaints
     - Heads of complaint departments and hospital centres and/or ombudsmen
   - Others
     - Regional Medical Commission, Regional Department of General Medicine, CLSCs, community organizations

3. **Approval of Final Report and Action Plan**
   - Review to follow up on reactions from the Health and Social Services System
   - Approval
     - Board of Directors

4. **Implementation**
   - Partners to be provided with information
     - Information pamphlet
     - Meetings to inform
   - Budget adjustments
   - Other factors on the basis of the approved action plan

5. **Follow-up and Assessment**
   - Follow-up on complaints
   - Assessment (study and evaluation service of the Regional Board)
   - Accountability mechanisms

6. References

1. Commissaire aux plaintes. [Réponse à un usager concernant le refus du Centre hospitalier Pierre-Boucher de donner des services de psychiatrie en raison du lieu de résidence, décision conséquente à l'application de la pratique de la sectorisation en psychiatrie.] Sous la signature de monsieur Rénald Gendron, délégué du commissaire. Le 23 juillet 1999.

2. Conseil de la santé et des services sociaux de la région de Montréal métropolitain (Janvier 1988). Nouvelle sectorisation des services de santé mentale de courte durée aux adultes. CSSSRMM. (Adopté par le conseil d'administration le 10 décembre 1987).

3. Conseil de la santé et des services sociaux de la région de Montréal métropolitain (Juin 1983). La responsabilité sectorielle des centres hospitaliers de la région de Montréal métropolitain [06A] quant à la dispensation des services psychiatriques aux adultes.

4. Conseil de la santé et des services sociaux de la région de Montréal métropolitain (Juin 1990). Plan d'organisation des services de santé mentale de la région de Montréal métropolitain. CSSSRMM.

5. Gouvernement du Québec (1991). Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives. L.Q. 1991, c. 42.

6. Gouvernement du Québec. Ministère de la Santé et des Services sociaux (1989). Politique de santé mentale. MSSS : Publication Québec.

7. Régie régionale de la santé et des services sociaux de Montréal-Centre (Juin 1996). Sectorisation des services psychiatriques de courte durée pour adultes - Selon la municipalité, le code postal et le CLSC - Région de Montréal.

8. Régie régionale de la santé et des services sociaux de Montréal-Centre (Oct. 1996). Sectorisation des services psychiatriques de courte durée pour les adultes, selon le code postal. Région de Montréal-Centre. Version électronique. ISBN: 2 - 921254 - 75 - 1.

9. Régie régionale de la santé et des services sociaux de Montréal-Centre (Jan. 1999). Rapport sur les plaintes des usagers - 1997-1998. Pages 156-158.

10. Régie régionale de la santé et des services sociaux de Montréal-Centre (Avril 2000). Rapport sur les plaintes des usagers - 1998-1999 et rétrospective. Pages 136-138.

NOTES

RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE
3725, rue Saint-Denis
Montréal (Québec)
H2X 3L9