

A Recovery/Resiliency Plan for Mental Health & Addictions in Saskatchewan

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POUR LA SANTÉ MENTALE

Introduction for the “Recovery/Resiliency Plan for Mental Health & Addictions in Saskatchewan A CONSPIRACY OF HOPE

Paradigm Shift:

Years from now the people of Saskatchewan will look back at this time in our province’s history and celebrate it as the beginning of a paradigm shift in mental health services. This new paradigm will lift us from the constraints of the medical model of treatment and guide us towards a system of services that are ‘recovery/resiliency-oriented’ – a new envisioning of how medical services and community supports should be provided to persons living with mental illness. This recovery/resiliency plan touches every area of service, from the acute hospital setting to the most independent consumer in the community. At its core, the promise of hope, healing and recovery are the focus of every intervention at every level of service.

Political Opportunity:

One may question what is so significant about our current political climate, and why is it important to make this the time for change. There are a number of answers to this which seem to be working together to create ‘a conspiracy of hope’. First, the federal Mental Health Commission has created the opportunity for all involved to re-examine mental health services and ask questions about what’s working, and what isn’t, within our current system. Also, the attention gained from a federal commission only comes around once every so often, so this is the time to put forward our big ‘one ask’ to government.

“Recovery” Evidence:

Another factor playing into this conspiracy is that the concept of ‘recovery/resiliency’ and ‘recovery/resiliency-oriented’ services has been well researched and the benefits of this shift in services have been well documented. Mental health service providers across North America have played leading roles in creating an evidence base, which has demonstrated that recovery/resiliency-oriented services are both effective and cost-efficient. The most significant example of this has taken place in Connecticut, where the entire behavioural mental health system, which includes both mental health and addictions, has successfully made the shift towards recovery/resiliency-oriented systems, beginning in the year 2000.

Disability Policy:

The concept of recovery/resiliency itself is borrowed from the addiction community and is heavily influenced by other cross-disability philosophies such as social inclusion and even civil rights. The mental health community has adapted these various principles and in the process of doing so, has translated them into the key features of a recovery-orientated system. This allows the concept of recovery/resiliency to be presented back to the community not just as a model for mental health service, but as a touchstone for disability policy on the whole.

Consumer & Family Knowledge:

The recovery/resiliency model demands an increased involvement of consumers and family members at all levels, who bring with them the experiential knowledge of the unique challenges and successes of living ‘in recovery’. This is a welcomed change from our current status quo, that rings true for anyone who has struggled with a disability over their life course. As quoted in an article on the systems transformation which occurred in Connecticut, “Revolutions begin when people who are defined as problems achieve the power to redefine the problem”.

Economic Investment:

The current economic conditions that Saskatchewan is benefiting from should allow the government to make a substantial investment in the future of mental health. As mentioned before, the cost-efficiency of the recovery/resiliency model will ensure that this is money well spent. While many people in this province are claiming a stake in this windfall, mental health has traditionally been waiting in line ever since the promise of adequate community support was made following de-institutionalization in the 1960’s.

Collaboration:

Finally, other parallel movements, such as the push toward collaborative health care, demonstrate that a wide group of professionals including psychiatrists, pharmacists, community mental health providers and even primary care physicians are ready to try something different.

Possibilities:

This document only hints at the possibilities this paradigm shift towards recovery offers consumers, family members, health professionals and governments. It outlines a system where all the stakeholders involved in a service benefit from changing how we do things.

A RECOVERY/RESILIENCY PLAN FOR MENTAL HEALTH AND ADDICTIONS IN SASKATCHEWAN

I A Leadership Vision is Required

It is over four decades since Saskatchewan was a world class leader in mental health. In its heyday, Saskatchewan attracted renowned psychiatrists and others to the province with creative and “cutting edge” models of care.

The barely implemented “Saskatchewan Plan” of the early 1960’s and the de-institutionalization model and regional psychiatric unit model it espoused were the outcome of a great deal of creative thought. Unfortunately, the community reinvestment and community-based and regional units it should have implemented were only partially realized at best.

It is, therefore, time for another bold vision leading to a proven model, which assists persons with mental health/illness and addictions to recover “in” rather than totally recover “from” their illness. Such a model is the “Recovery/Resiliency Model”, adopted by several other jurisdictions in Canada and the United States. It is more common to consider resiliency when dealing with child and youth issues, however, as outlined in “Recovery and Resilience in Children’s Mental Health: Views from the Field” - Barbara J. Friesen, Portland State University, published in the Psychiatric Rehabilitation Journal, 2007, Vo. 31, No. 1 38-48, there is more similarity than differences in the basic principles of “recovery” as it may apply to children and youth.

II What is the “Recovery/Resiliency Model”?

Defining Terms:

Recovery.....

Recovery refers to the ways in which a person with a mental illness and/or addiction *experiences* and *manages* his or her disorder in the process of maintaining and/or reclaiming his or her life in the community. Recovery does not necessarily mean cure or elimination of the effects of the illness/addiction, and may mean living with the effects of medications or accommodations required to function to the person’s full potential.

Recovery views illness or disability as *only one aspect of a person* who has assets, strengths, interests, aspirations and the desire and ability to continue to be in control of his or her own life. This includes reducing and eliminating symptoms through medication, therapy and support. Recovery requires access to suitable and adequate resources for necessities including income through employment or income support, housing, social support and inclusion in community as well as necessary health services.

Recovery assumes that persons who experience mental illness and/or addictions have the same civil rights as other citizens. Basic human rights enable the person to live with respect and dignity from others, and with self-respect and self-determination for themselves.

CMHAS, Practice Guidelines for Recovery-Oriented Behavioural Health Care, 2006

Recovery-oriented care.....

Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners ***offer*** in support of the person's recovery.

Recovery-oriented care assumes that the person has the right and the ability to make informed choices.

A recovery-oriented system of care ***identifies and builds*** upon each person's assets, strengths and areas of health and competence to ***support the person in achieving*** a sense of mastery over mental illness and/or addiction while maintaining or ***regaining his or her life*** and a meaningful, ***constructive sense of membership*** in the broader community.

The person in recovery needs ***information about the nature*** of his or her difficulties, ***education about the range of effective interventions*** available to overcome or compensate for these difficulties, ***access to opportunities to utilize these interventions*** in regaining functioning, and the ***supports required in order to be successful*** in doing so.

CMHAS, Practice Guidelines for Recovery-Oriented Behavioural Health Care, 2006

"Recovery/resiliency" refers to both internal conditions (i.e. attitudes, experiences and processes of change of individuals who are "recovering") and external conditions (i.e. circumstances, events, policies and practices that may facilitate recovery). Together these internal and external conditions produce the process called recovery/resiliency.

Key internal conditions that facilitate recovery/resiliency are:

- **Hope:** The individual's belief that recovery/resiliency is possible. Attitudinal components of hope are recognizing there is a problem, committing to change, focusing on strengths rather than weaknesses, and looking forward.
- **Healing:** Remembering that recovery/resiliency is not synonymous with cure, individuals "recover" their "self" by re-conceptualizing illness as only part of the "self", not as a definition of the whole. This re-connection with the self builds self-esteem and helps to counteract the stigma of the illness, which they may have internalized. The second part of healing is gaining a feeling of control over symptoms, usually by use of medication, appropriate social and counseling support and/or the reduction of symptoms by self-care practices.
- **Empowerment:** A sense of hope, healing and control leads to empowerment. Empowerment has three components – autonomy (or the ability to act as an independent agent), courage (a willingness to take risks, speak in one's own voice and step outside of safe routines) and responsibility (which speaks to consumer obligations for their own recovery/resiliency).
- **Connection:** Recovery/resiliency is a profoundly social process. The connection to the social world and roles to play in that world are critical to "recovery/resiliency".

External conditions start with human rights, or a "positive culture of healing" and recovery/resiliency-oriented services. Implementation of the principles of human rights in an organization results in a positive culture of healing. When applied to the culture of human services, this vision of a positive culture of healing begins with an environment characterized by mutual respect, listening, empathy, compassion, safety, trust, diversity and cultural competence. Service providers in a recovery/resiliency-oriented system must embrace the belief that every consumer can achieve hope, healing, empowerment and connection, no matter what his or her current status.

Key to a positive culture of healing is the development of collaborative relationships between consumers and providers. In contrast to a hierarchical model of service provision, the collaborative model allows consumers and providers to work together to plan, negotiate and make decisions about the services and activities the consumer will use to support his or her recovery/resiliency. Collaboration implies that the consumer is an active participant, that he or she is presented with a range of options and given the opportunity to choose from among them, and that providers allow consumers to take some risks with choices which may be other than those the provider might have chosen for them.

A recovery/resiliency model delineates four major consequences of severe mental illness: impairment, dysfunction, disability and disadvantage. Recovery/resiliency-oriented services address the range of these features and include services directed at symptom relief, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support and self-help.

What “recovery in” means for mental illness/addictions

Since the 1970's, a number of studies have been done to understand the long-term outcomes for people with serious mental illness. Generally speaking, these studies identified that approximately 25% of all people who experience serious mental illness achieve what is called *full recovery from mental illness*. The majority (75%) experience a broad range of *recovery/resiliency in their illness*. People with longer-term conditions must “work towards reclaiming control over their own lives and destinies while exploring ways to minimize the destructive effects of an enduring condition”. Following de-institutionalization, a consumer/survivor movement began to emerge among people living in the community who required ongoing access to treatment and also were determined to “live a safe, dignified and autonomous life given whatever they had been dealt by fate”.

This mental health consumer/survivor movement began by looking at other examples of communities that have experienced adversity, discrimination and marginalization. Three distinct movements were identified as creating the base for the “recovery in” ideology. The addiction community was the first to offer the concept of being “in recovery”, meaning that the person will “live their life and pursue their goals with dignity and autonomy in the face of the *ongoing presence of an illness and vulnerability of relapse*”. Independent living for persons with physical disabilities and the Civil Rights movements for persons who experienced discrimination and marginalization were two other models that focused on establishing a person's right to self-determination and highlighted the importance of social inclusion.

For example, the “Americans with Disabilities Act” or the “Canadian Charter of Human Rights and Freedoms” ensure that a person with paraplegia is not “required” to walk before having access to full participation in community life. Likewise, “psychiatric disability” can be understood as a long-term disability. For the mental health community, this concept of “recovery in” requires society to provide “accommodations and supports that enable people with psychiatric disability to lead safe, dignified lives in the community”.

The term and definition of “recovery in” is actually the most inclusive one available for mental health. This form of recovery/resiliency “speaks most directly and forcefully to the issues of civil rights and membership in society”. The “recovery in” definition demands that a person “with serious mental illness remain in control of their lives, unless, and only for a long as there are clear and convincing reasons, grounded in law, for their sovereignty to be handed over temporarily to others”. This civil rights based concept of “recovery in” is accessible to everyone, regardless of the severity of the disability, which clearly establishes it as the most inclusive definition possible.

A recovery/resiliency-oriented system does not prevent offering active treatments to reduce the signs and symptoms of mental illness, or rehabilitative interventions that could potentially restore functional impairments. Treatment, rehabilitation and support remain important elements of the medical interventions necessary in the treatment of any disability. Adequate resources in these areas work to reduce the barriers to community involvement and limit the impact the disability has on the person's life. However, under a recovery/resiliency model these “interventions and supports will be provided in ways similar to health care services for other health conditions. The people receiving these mental health services will continue on with their ordinary lives, recovering from the illness as much as possible. Where full remission is not yet possible, “recovery-oriented care offers access to the technologies, tools and environmental accommodations to incorporate the illness or disability as only one component of a multi-dimensional existence and multi-faceted sense of personal identity.”

This “recovery/resiliency plan” for people with serious and persistent mental illness is in no way prescriptive for other disability communities. The roots of the “recovery in” model are borrowed from other movements and as such, have required these broad principles to be applied and adapted to mental illness. The mental health community has successfully implemented these principles at broad systems levels in the U.S. and Canada. By doing so, there are some value and lessons that can be learned from mental health’s experience at building policy on the concept of civil rights and social inclusion.

Disability and Recovery/Resiliency

The disability community at large uses and has some reservations regarding the term “recovery”. Advocates for people with disability fear that the community will equate “recovery” with a “cure”. If there is an assumption that “recovery” means “cure”, the necessary resources and supports to allow full participation as citizens and adequate care for the illness/disability may be jeopardized.

What “recovery in” might mean for other disabilities

The recovery/resiliency model in mental health could suggest some policy standards for other disability communities. For example, other brain-based conditions such as Acquired Brain Injury, have particular interests in the “recovery/resiliency model”. After a brain injury the person can attain varied levels of functioning similar to those found in mental health. For the majority of people who experience a brain injury, a “cure” is neither possible nor realistic. The concept of “recovery in” speaks to this community well because despite all efforts to restore brain function, treatments have limited success and often restore a limited degree of functioning. The recovery/resiliency model ensures that where the success of these treatments ends, there are ongoing supports to assist the person in living a life with meaning and dignity, despite the remaining impact of disability.

The recovery/resiliency plan calls for some basic and fundamental building blocks that are relevant to other disability groups. The call for a distinct and adequate income security program, which would support people who struggle with any long-term disability, would work to reduce the negative impact of poverty on people’s lives. Access to employment and other productive activities will remain an important feature of the recovery/resiliency-oriented program; otherwise it would cease to be inclusive. This plan also calls for the support of other basic human rights such as access to shelter, which includes a range from supported housing, community residence and emergency housing to independent living. The need for these basic human services extends well beyond the mental health community and clearly touches multiple disability groups.

The proposed Crisis/Emergency Response component of the plan, borrowed from a best practice model in B.C., would create a needed service that could be utilized by all groups of disability who experience crisis. The suggested continuum of services may be successful in stabilizing many people, regardless of their disability, in the community with minimum interventions to ensure that only those who require access to the highest level of support (i.e. hospitalization) receive it.

Finally, consumers/survivors, families and a full range of health and other services have key roles in the recovery plan. At many levels stakeholders, who have been traditionally overlooked in the processes of care, would now have a new role to play in the system. The support of “consumer involvement and initiatives” allows empowerment of the individuals to demand and implement services in ways that are groundbreaking for any disability community. The concept of “shared care”, which formally involves other professionals in the delivery of care, both increases the range of supports being offered and better utilizes the scarce health professionals available in this province. The more formal role of “family support and involvement” in the system may not be entirely new to some disability groups, but nonetheless is still a welcome system standard for any disability policy.

As mentioned before, this plan is not prescriptive for other groups. Various disability groups will need to extract what works, and re-tool what doesn’t, from the recovery/resiliency plan to ensure a good fit for their own community. However, the foundation of the “recovery in” ideology grew from the influence of many cross-disability movements. For this reason, it remains a relevant policy perspective for groups who encourage people to cope and to manage their disability over the life course. It is also important to remember that people with brain-based conditions do utilize many of the mental health services described in this plan. For example, people with intellectual disability need a broad range

of housing supports; people with brain injuries need access to crisis services. Although not cross-disability by design, this plan will clearly have a positive impact on people well beyond the area of mental illness.

Source: Davidson, L. et al (2006) The Top Ten Concerns about Recovery Encountered in Mental Health System Transformation, *Psychiatric Services* 57,5

Source: Davidson, L and Roe, D. (2007) Recovery From versus Recovery In Serious Mental Illness: One Strategy for Lessening Confusion Plaguing Recovery, *Journal of Mental Health*, 16(4), 459-470

What we need, then, is a *vision of a client-centered system providing a continuum of care that links facility-based and community-based care in a recovery/resiliency-oriented service delivery system.*

Source: Adapted from "What is Recovery? A Conceptual Model and Explication", *Psychiatric Services*, April 2001, Vol. 52, Jacobsen and Greenley.

III Key Guiding Principles for the Organization of Mental Health Services

- **Protection of Human Rights:** Services should respect the autonomy of individuals and empower them to make decisions. The focus should be on the least restrictive treatments.
- **Accessibility:** Services should be available locally; a lack of local services acts as a barrier to obtaining services, especially in rural areas.
- **Comprehensiveness:** Services should include all facilities and programs required to meet the needs of the population.
- **Coordination and Continuity of Care:** Services should work in a coordinated manner to meet a range of social, psychological and medical care needs.
- **Effectiveness:** Evidence of effectiveness should be used to develop services.
- **Equity:** Access to services should be on the basis of need. Vulnerable individuals are less likely to demand services meeting their needs.
- **Efficiency:** Evidence on cost-effectiveness should be taken into account in developing services and making decisions on resource allocation.

Source: Adapted from WHO, 2003.

IV Components of a Recovery/Resiliency Plan for Mental Health in Saskatchewan

The following is a non-exhaustive, but representative list of the various needed components of a well-thought-out and planned mental health and addictions "system", as opposed to the current "patchwork" of semi-connected agencies, ministries and services.

- a) Inter-Ministerial Coordination to ensure that there is a coordinated, seamless transition for all required needs for individuals and their families. For example, the life of a person with mental illness/addiction can interact with social services, labour, justice, education and other government services as well as health. There are various models, such as Deputy Ministers Forums, which could assist in this purpose. Whatever is chosen, the current fragmented and uncoordinated system is simply not what the citizens of this province deserve when they or their loved ones require assistance with a mental health/addictions issue.
- b) Wait Time Benchmarks for Patients with Serious Psychiatric Illness are absolutely critical to a responsive and patient-centered, recovery/resiliency-oriented system. It helps little in individual circumstances to have services

if wait times preclude timely access.

The Canadian Psychiatric Association, in their 2006 “Wait Time Benchmarks for Patients with Serious Psychiatric Illnesses” have the following recommendations:

Definitions: Urgency Levels for Access and Sentinel Illnesses

Urgency Levels

For the illnesses outlined in these benchmarks, the CPA identified three general urgency levels for access. They have been chosen to equate to the categories described in the report issued by the Wait Time Alliance for Timely Access to Health Care. The CPA has tried to ensure that levels of pain and disability experienced by patients with psychiatric illnesses are categorized in a manner equivalent to the pain and disability levels described by our surgical colleagues.

1. Emergent

Traditionally, this implies danger to life, limb or organ within a very short time frame, hours or days. Behaviourally, the most obvious example might be the person with active suicidal ideation. However, there are others. Acute mania may put a person at immediate risk (within the next few hours or days) by affecting his/her judgment in driving, in interpersonal judgments, and in sexual activities to the extent that he/she cannot appreciate the dangers in his/her behaviour.

The response to this level of urgency would be best facilitated by hospital-based evaluation and urgent referral (or its equivalent).

2. Urgent

This category includes clinical conditions that are unstable, with the potential to deteriorate quickly and result in emergency admission. While waiting, such patients will need monitoring of their clinical condition by their practitioner. If the course proves fluctuating, with significant changes either in symptomatology or their level of adaptive functioning, it may require that the patient be moved up the referral list, or lower, as appropriate.

The response to this level of urgency would be best facilitated by an expedited consultation within two weeks, such consultation being best facilitated by a program of care with ready access to inpatient resources, if necessary.

3. Scheduled

This category involves stable symptoms, with tolerable disability or dysfunction in the roles of everyday life, one that is unlikely to deteriorate quickly and where the person has adequate and appropriate social support in the community.

Recommended Benchmarks			
Indication	Emergent	Urgent	Scheduled
<i>Access to family practitioner</i>			
Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 hours	Within 1 week
<i>Access to psychiatrist after referral by family physician</i>			
First Episode Psychosis	Within 24 hours	Within 1 week	Within 2 weeks
Mania	Within 24 hours	Within 1 week	Not generally applicable
Hypomania, with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Post-partum severe mood disorder or psychosis	Within 24 hours	Within 1 week	Within 4 weeks
Major Depression	Within 24 hours	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (including consultations for child and geriatric conditions not otherwise noted above)	Within 24 hours	Within 2 weeks	Within 4 weeks.

Qualifiers

The recommended benchmarks are representative only. Within a patient-centered approach to care, there will be many identifiable wait times. Waiting to be seen by a specialist may just be the start. The wait time for admission to hospital, or to a rehabilitative program of therapy, among others, should also be identified and tracked. In an organized system of care, it is as important to manage each of these as it is to manage the wait until the first visit.

If there are not enough primary care practitioners to identify the need in the first place and to provide clinical monitoring while a patient is waiting; if there are not enough psychiatrists to whom family physicians can refer patients in need of specialized care so that referrals are not even attempted; if there are not enough supports within treatment and follow up programs so that once a diagnosis is made, curative treatment and rehabilitation can be instituted, then these recommendations might seem out of place.

To think so, however, would be wrong. The clinical need of the individual patient is independent of the resource availability. The whole underpinning of the “10-Year Plan to Strengthen Health Care”, an agreement signed by the First Ministers in September 2004, recognizes that the necessary first step for improvement is to establish what the key benchmarks should be. These recommendations constitute that necessary first step.

- c) Assertive Community Treatment – This is an essential part of responsive and appropriate care for persons with severe and persistent mental health issues.

Typical components are:

- small caseloads (a team of about 10 core staff members assigned to about 100 patients);
- continuous services (operating 24 hours a day, 7 days a week);
- medication delivered by team members daily if necessary;
- potential for service users to graduate to less intensive interventions;
- team approach, drawing on the contributions of psychiatrists, nurses and other professionals;
- service-user finances arranged or directly managed by the team;
- target for 80% of team activity to take place in the community.

Does it work?

- For people with severe psychotic disorders, assertive community treatment can reduce hospital admissions and acute inpatient days, but overall it does not reduce costs.
- It contributes to improvements in living arrangements and work status.
- It improves service-user satisfaction.
- It may offer fewer advantages if existing services already provide high-quality continuity of care.

Source: Thornicroft & Tansella, 2003

- d) Adequate Income Security

Foundational to an adequate community-based mental health system is the need for adequate income support. Those with a severe and persistent psychiatric disability, as all other disabilities of this nature, live with the support of a welfare system that never was designed for their long-term needs.

There must be inter-ministerial coordination to implement a “disability pension” model, which provides income up to the “LICO” or Low Income Cut Off amount for those living in the province. This will go a long way towards ensuring that, after stabilization in hospital, adequate and dignified income will allow the individual to enjoy a basic level of housing, diet, recreation and employment to the level possible to support “recovery/resiliency” as defined above.

Any income support plan must have provisions that make paid employment a viable option to supplement the pension while allowing seamless movement back and forth, depending on ability to work, and which does not jeopardize the basic pension income support.

e) Housing Needs

The need for adequate housing is critical, especially in our climate and with the distances traveled in our province.

There are several types of housing needs which include:

Supported Housing (rent subsidized)

- supported apartments
- block apartments
- satellite apartments/mobile homes
- congregate housing
- group homes
- supported hotels

Residential Housing

- range of support services provided
- community residence (fully staffed)
- community residence (partially staffed)
- family care (unlicensed)
- step-down home (short-term housing for individuals leaving hospital)

Emergency Housing

- shelter/hostel accommodation
- short stay crisis/residence

Residential Housing for Persons with a Mental Illness and Substance Misuse

- staff trained in both mental illness and alcohol/drug treatment

Intercultural Focus Housing

- Housing for persons with organic brain syndrome/acquired brain injury
- Housing for elderly with a mental illness as opposed to, or in addition to, those with psychiatric concerns
- Housing for persons with mental illness involved with the Criminal Justice System.

f) Mental Health Crisis/Emergency Response

Principles of mental health crisis/emergency response

1. *A system of mental health crisis/emergency services must provide a broad range of crisis response options to address the widely varying manifestations of acute mental health disturbance. Despite the diverse etiologies of mental health crises, and the widely varying manifestations of acute psychological disturbance, assessment and triage services provided within hospital emergency rooms remain the primary response available for most individuals affected by a major mental health crisis. The authors of *Review of Best Practices in Mental Health Reform* (1997) observe that “Mental health reform has forced practitioners and institutions to question sole reliance on this service delivery approach and to re-examine the methods most hospital-based psychiatric emergency services use to assess and treat people in crisis.”*
2. *Key services should be arranged as a continuum. Clients differ in their need for external monitoring and control and in their need for services only available in hospital settings. Service options should be arranged in a continuum reflecting need for increasing protection/security of clients or others and the extent to which services*

are removed from the client's own environment. More intensely resourced emergency services (e.g. hospital-based emergency rooms) should be reserved for individuals who require that level of care.

3. *Crisis response/emergency service providers should conduct assessments that identify and integrate the multiplicity of factors (biological, psychological, and/or social) that may produce mental health crises and they must be able to provide an appropriately broad range of crisis interventions.* No single discipline possesses the full complement of diagnostic and treatment skills necessary to meet the diverse needs of the target population for crisis/emergency services. Consequently, a crisis/emergency response service requires members functioning effectively as an interdisciplinary team.
4. *There must be efficient exchange of clinical information among components of the mental health system.* In order to ensure clear and concise communication of pertinent clinical information, a common language is required. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), multi-axial system is an example of such a common language for documenting and communicating clinical information. Furthermore, there must be an integration of CR/ES data to avoid duplication.
5. *Service providers must be well-acquainted with those provisions within the Freedom of Information and Protection of Privacy Act (FOIPPA) that pertain to the flow of information from one service provider to another.* On the one hand, this will ensure that client confidentiality is maintained where it is appropriate. On the other hand, this will ensure that client care is not adversely impacted by a service provider's failure to recognize those situations in which information may be communicated to third parties.
6. *Risk Management is an over-riding concern in crisis response.* This involves assessing and taking any necessary steps to reduce the likelihood of outcomes such as suicide, assault on others or dangerously impaired self-care.
7. *CR/ES systems have very limited ability to exclude clients.* In order to preserve their capacity to respond appropriately to those individuals who present for service, a CR/ES system must have ready access to a range of follow-up care providers. To ensure continued movement of clients from the emergency end of the service continuum to other services, planning of the mental health system as a whole should be done in an *integrated* manner, approaching the mental health system as one overall treatment program with integrated components, rather than as a collection of independent programs. The coordination of goals, entrance/admission criteria and termination/discharge criteria among components must not be left to chance. Rather, coordination should be ensured by assigning each component to fulfill specific functions in relation to overall mental health system goals.

Core components of a CR/ES system

In the Review of Best Practices in Mental Health Reform (1997), five core components of a system of crisis/emergency response services are outlined. These components satisfy the fundamental requirements for a system of crisis/emergency.

The five core components of a CR/ES system are:

1. **Crisis lines** – A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.
2. **Mobile crisis outreach** – A service in which first-line responders provide outreach to individuals in the community with acute mental health crises.
3. **Walk-in crisis stabilization services** – A setting where individuals can present with a mental health crisis and receive appropriate assessment and access to follow-up care or can be referred to an appropriate service.

4. **Community crisis stabilization services** – Community crisis stabilization services provide community-based support for individuals in a mental health crisis. Settings include: *Crisis residences* for crisis intervention and residential treatment, structure, supervision, intensive case management and connection to follow-up services; and *Home stabilization*, where mental health acute-care patients are provided treatment within their own homes by outreach nurses.
5. **Hospital-based psychiatric emergency services** – This includes a *psychiatric emergency service* which provides specialized emergency mental health assessment, treatment and management services via consultation to persons referred by a hospital emergency department and may provide 23-hour holding beds; and a *brief stay unit*, an inpatient psychiatric unit that specializes in the assessment and treatment of mental health emergencies. It maintains a brief length of stay (average length of stay is three to five days) and has the capability to detain and treat patients on an involuntary basis. The focus of the brief stay unit is on intensive management of psychiatric emergencies.

Source: Best Practices for B.C.'s Mental Health Reform

g) Inpatient/Outpatient Services

General Inpatient Program

The general inpatient program applies to all patients requiring psychiatric care who do not meet admission criteria for other specialized units (e.g., Psychiatric Intensive Care, adolescent, geriatric). All inpatient programs should be designated to admit involuntary patients under the *Mental Health Act*.

The general inpatient program provides concurrent, multi-disciplinary assessment and treatment for people with psychiatric disorders as one component of a continuum of care. Characteristics of the inpatient program for a specific community will be heavily dependent on the other services and programs available in the community.

Other patient populations that present special challenges in a general unit include those with eating disorders, head injuries and mental handicaps, as well as forensic patients.

Once patients can be managed in a less restrictive environment, they are discharged, unless it can be demonstrated that remaining in hospital leads to a better clinical outcome.

Psychiatric Intensive Care

The Psychiatric Intensive Care Unit (PICU) is a secure (locked) unit for patients requiring the highest level of observation and containment. Ideally, there should be at least one PICU for each region and protocols for admitting patients from other hospitals.

The PICU is intended to provide optimal clinical assessment and treatment of the most severely ill and aggressive patients, while preventing harm to themselves and others in a secure environment, until sufficient improvement has occurred to allow transfer to the general inpatient unit. The PICU generally includes the option of locked room within a locked unit and allows for greater mobility and socialization of confined patients than seclusion rooms.

Each larger region should have a Psychiatric Intensive Care Unit. Specialized units are required for adolescents and for geriatrics in acute care. Comprehensive treatment programs, including access to dedicated beds, are required for eating disorders and for mentally handicapped psychiatric patients.

Adolescent Inpatient Unit

Adult psychiatric inpatient units are not ideal for children and adolescents. Each health region, therefore, needs a residential assessment and treatment unit exclusively for adolescents and with programming specifically tailored to their

developmental needs.

Geriatrics

It is desirable to have a specialized unit, designed and staffed for the geriatric patient population, rather than mixing it with others. However, if there is a need to mix inpatient beds with another program in order to have a viable unit, geriatric medicine is preferable to most adult psychiatry because of the frail nature of this population.

Outpatient Services

There is no single detailed description of best practices for psychiatric outpatients. However, some principles can be identified:

- A system is needed for prioritizing referrals.
- Urgent referrals should be seen within 72 hours, others within 10 days.
- Where possible, group therapy should be emphasized. (There is evidence that the outcome from group therapy for the majority of clients is as good as from individual treatment.)
- Best practice outpatient treatment may include short-term active case management and/or short-term psychotherapy, for cases that are serious, but not persistent.
- Providing marital and family counseling may serve a preventive purpose and reduce the need for further service.
- More awareness of the importance of vigilance for possible first-break symptoms is needed.

Any treatment program should be describable and defensible in terms of its evidence base. In addition, every part of the mental health service should have a quality assurance program.

Other Services in the Continuum of Care

Partial Hospitalization

Partial hospitalization includes day hospitals, day treatment and day care. Partial hospitalization should not be compared with day hospitalization, but with intensive outpatient interventions.

Potential advantages of this approach include:

- potential to be consistent with best practices, in that they offer less restrictive environments than do inpatient programs
- better maintenance of autonomy and links with community
- reduced risk of institutionalization
- possibly lower overall treatment costs

Acute Home Treatment

Acute home treatment is an effective alternative to hospitalization for acute psychiatric illness and can reduce LOS for necessary admissions. Acute care is provided in the home for a limited period to treat acute psychiatric symptoms that would otherwise require inpatient treatment.

Tertiary Services

In this context, “tertiary” means specialized and long-term services. The goal of mental health tertiary services is to support the primary and secondary mental health system by providing:

- consultation
- education
- outreach services to secondary units
- acceptance of challenging patients from secondary units

- assistance in follow-up of discharged tertiary patients to secondary units
- research and dissemination of results to secondary units
- teaching of undergraduate and graduate students.

To date, tertiary services have developed unsystematically, with different terms of reference, funding bases, organizational affiliations, emphasis on service or research, etc. A systematic examination of the role, function and governance of these services is needed, with a view to providing some standardization and coordination. Recommended areas for provincial tertiary services include:

- eating disorders
- mood disorders
- refractory psychosis
- anxiety disorders
- early psychosis
- personality disorders
- mental handicap and psychiatric disorders
- neuropsychiatry
- substance abuse and psychiatric disorders
- disorders of the elderly
- child/youth disorders
- acquired brain injury and psychiatric disorders

Shared Care

Family physicians see a great many people with mental health problems, including high-acuity problems. The family physician plays a critical role in the early recognition, treatment and/or referral and follow-up management of clients with mental disorders. Fifty percent of people with mental disorders requiring mental health care receive that care primarily from their family physician.

Shared-care models allow for improvements in the expert support available to family physicians. “Shared care” refers to collaborative activities between family physicians and psychiatric services designed to improve mental health care for consumers by:

- improving communication and working relationships between psychiatrists/services and local family physicians
- establishing liaison relationships between psychiatrists/services and local family physicians
- integrating psychiatrists or other mental health clinicians into primary care offices.

Adapted from “Best Practices for B.C.’s Mental Health Reform

h) Consumer Involvement and Initiatives

The Benefits of Consumer Involvement

According to one report (Canadian Mental Health Association National Consumer Advisory Council, 1993), some of the reasons for involving consumers in all areas of mental health are:

- consumers speak from experience and can offer new ways of looking at things from that vantage point

- consumers must participate as paid “peer support” as a growing peer support movement shows the tremendous value this provides as an integral part of the recovery movement.
- consumers’ input is as valuable as that of professionals and family members
- consumers get the attention of politicians and funders
- consumer involvement will make policies, activities and processes more relevant and rooted in reality
- expertise in organizations is more diversified with consumer involvement
- the present mental health system needs improvement, and new expertise can help
- consumers are a credible voice – involving them is in keeping with both federal and provincial governments’ conviction that people with disabilities can and should speak for themselves.

Historically, mental health policy has been based on what can be called the “service paradigm”. This paradigm assumes that the exclusive focus of policy should be formal services, and that it is these services which are the primary determinants of outcome. The service paradigm was developed by professionals and reflects their point of view. As a result, most policy makers come to their task with a map of the service system in their heads and a goal to develop policies which will deliver better services. By assuming this narrow focus, they are seriously limiting the range of options which could be considered if other kinds of resources and experiences were tapped.

In contrast, the Community Resource Base Concept uses a new approach called the “community process paradigm”. While recognizing the importance of mental health services, it also “acknowledges fundamental elements of community, to which every citizen should have access: housing, education, income and work”. All individuals, including mental health consumers, need these elements in order to live a full and meaningful life in the community. It should be noted that supports such as income, work and self-help, which are not usually provided by the mental health service system, are exactly the supports which consumers say are most important to them.

Organized in groups, and with adequate resources, consumers can do many things for themselves, which were formally thought to be the sole domain of the formal service system. Self-help/mutual support is perhaps the most obvious of these functions. Self-help groups are an important and growing resource for people who have been through the mental health system. They not only provide the opportunity for people to share emotional and tangible support, but they make use of people’s own strengths and capacities as sources of help for others. Self-help represents a fundamental tool for people to work together and take charge of their own lives. (Trainor, 1993)

Adapted from “Best Practices in B.C.’s Mental Health Reform”

i) Family Support and Involvement

Mental illness in the family creates a crisis that affects all members. The chronic stress family members experience in their new role as primary caregivers dealing with mental illness often undermines their own health, financial resources and ability to cope. This negative effect on the family unit can also hinder the stabilization and rehabilitation of the person with mental illness.

Training in coping skills, communication, information and support reduces the level of crisis in families, as well as reducing the relapse rate of the patient. In addition, the way families are treated and supported can contribute to the rehabilitation of the patient.

The 1993 report of the Task Force of Families of People with Mental Illness, *Families Sharing the Caring*, noted that unrealistic expectations were placed on family members, who were often expected to advocate and provide services that

should be provided by the system. Confidentiality was cited as a frequent barrier to effective communication and support.

The task force recommendations form the basis for best practices in family support and involvement, which have been endorsed by family groups throughout the province. Best practices for family support and involvement include:

- Provision of professional counseling for family members in need, including assistance in accessing services – Case Managers should provide family members with information, support and coping skills.
- Partnerships among families, consumers and professionals in the treatment plan – Families must be informed and aware of the treatment plan and discharge planning should focus not only on the individual's personal functioning, but also on the family's ability to care for the client.
- Training opportunities and resources to support self-help – Self-help models have great potential when skilled facilitators and resources are in place and family support groups are a cost-effective way to provide support to families who, in turn, can provide needed support and care to their mentally ill family member.
- Diversified respite care – Families have identified a strong need for flexible programs that will provide ongoing support through outreach, home care and activities for the family member who is ill.
- Inclusion of families in the planning and evaluation of services – Family members want opportunities for their voices to be heard and for input into planning and evaluation.
- Expansion of training to mental health professionals to include skills and competencies that would increase their understanding and improve their ability to meet the needs of families – A more comprehensive professional education program for mental health service providers will enhance support for families.
- Increasing public awareness of mental health issues through education and a variety of approaches – Better understanding and public awareness will reduce the stigma of mental illness, which increases the burden on family members.
- A coordinated approach to providing family members with support, information, resources, education and training – A designated position in each region will improve coordination between agencies, families and mental health services, and reduce families' difficulties in accessing services.

In order to implement best practices for family support and involvement, the partnership model, which allows the family voice to be heard by providing opportunities for input into planning and evaluating services, needs to continue and be enhanced.

The working group also recommends that a family and consumer forum occur twice a year for two days to review consumer and family issues that are systemic in nature. The forum could monitor implementation of the mental health plan using the best practices models.

Adapted from "Best Practices in B.C.'s Mental Health Reform"

j) Psychosocial Rehabilitation and Recovery

The Review of Best Practices in Mental Health Reform has demonstrated that people with serious mental illness have the capacity to work or return to school.

Experts in the field of vocational and educational supports for people with mental illness have recognized a quiet

revolution that is changing the way people with serious mental illness are perceived, either by themselves or by others. As more and more people return to school and gain or maintain jobs, previously held stigmas and perceptions are subsiding. People with mental illness want to gain new knowledge and to obtain and maintain meaningful employment that will enhance their quality of life.

Returning to school and preparing for or maintaining employment is a process that helps people in their recovery. It promotes the development of self-esteem and a new positive self-image. It counteracts the feelings of worthlessness that many people with serious mental illness have internalized because of the social stigma attached to their disabilities.

The practice of psychosocial rehabilitation, with a focus on early intervention and recovery, is the driving force behind this quiet revolution focusing on wellness, independence, self-determination, hope, personal capacity for growth and development, potential partnerships, seamless services based upon individual needs and ongoing evaluation as part of continuous improvement.

Psychosocial rehabilitation involves four life-related domains:

- personal life – services that help an individual gain or regain practical skills in the areas of personal care, home management, relationships and use of community resources
- leisure
- education
- work

Recommendations:

Provincial:

Create provincial leadership in the development and reform of psychosocial rehabilitation and recovery services by:

- Conducting a best practices initiative for personal life and leisure areas
- Promoting reform and advocating for evidence-based practice in rehabilitation and recovery services
- Funding best practices demonstration projects to test pre-employment, employment and supported education initiatives in rural and urban settings
- Establishing a provincial registry of rehabilitation practitioners
- Encouraging regional learning needs surveys among mental health professionals (rehabilitation and clinical staff) to develop provincial clinical standards, curricula and educational initiatives
- Organizing provincial best practices conference calls with experts in the field of rehabilitation and recovery services to provide health authorities with the latest information, as well as opportunities for answering questions and receiving guidance in the development/reform of these services.

Regional:

Identify a designated contact in each health authority for promoting rehabilitation and recovery services to:

- Facilitate development/reform within the region through fair distribution of financial resources, to provide a range of rehabilitation and recovery services
- Establish regional/local rehabilitation advisory committees
- Participate in a provincial networking committee to collaborate on evidence-based resource development, consultation, consensus building, education and dissemination of information

- Review existing data and establish benchmarks for staff-to-client ratios in rehabilitation services (e.g. number of rehabilitation specialists in mental health teams/contracted agencies, leisure programs, pre-vocational programs, TEP, supported employment, supported work)
- Identify training needs of staff within the region
- Create a website to provide information and resources for mental health staff, consumers and family members in the regions
- Encourage regional health planners to distribute financial and human resources fairly to a range of rehabilitation and recovery services, to meet the needs of children and youth, adults and seniors, with consideration for gender and culture, by:
 - providing a range of programs/services in all areas of rehabilitation, i.e. personal life, leisure, education and work.
 - providing consumer access to all service levels, i.e. basic support, readiness, rehabilitation process and ongoing support.
- Hire at least one rehabilitation specialist in each region. In rural areas, two regions may need to consider establishing a partnership to ensure that rehabilitation services are available within a reasonable distance.
- Incorporate recovery concepts and PSR principles and practices into all mental health services:
 - integrate recovery concepts and PSR principles into clinical treatment
 - consider rehabilitation services as a primary intervention at the onset of illness
 - assess individual readiness to begin rehabilitation
 - hire at least one rehabilitation specialist on all assertive community treatment teams
 - hire a variety of rehabilitation specialists for mental health teams that utilize case management models where the case manager-to-individual ratio is higher than assertive community treatment team ratios.
- Encourage rehabilitation staff to take steps to ensure that language, age and culture will not be a hindrance in receiving needed rehabilitation services. Specifically, rehabilitation services should make appropriate efforts to determine consumer needs and develop pilot projects to address needs, e.g. training in English as a second language, leisure programming and vocational rehabilitation services.
- Sustain the development of supported education within each region by:
 - ensuring individual access to supported education within three months of referral
 - ensuring that coordination exists among mental health providers
 - providing training and education and working with college/university staff regarding the needs of the mental health population
 - reviewing current supported education practice and, where appropriate, developing and piloting adult services and early intervention approaches for children and youth
 - encouraging health authorities to develop a range of pre-employment and employment services:
 - Pre-employment:
 - ensure individual access to pre-employment services within three months of referral
 - ensure that coordination exists among mental health providers and between pre-employment and employment programs/services
 - develop working committees and partnerships with regional offices of provincial and federal ministries responsible for employment services
 - form local community advisory groups, which could create linkages and relationships to the business community and relevant non-profit agencies for developing a range of work experiences, work shadows, volunteer options, etc.

Employment:

- ensure individual access to pre-employment services within three months of referral
- ensure that coordination exists among mental health providers and between employment and pre-employment programs/services
- develop working committees and partnerships with regional offices of provincial and federal ministries responsible for employment services
- form local community advisory groups which could create linkages and relationships to the business community to provide access to employment options
- ensure that financial and human supports are available to assist the development and evaluation of consumer-run businesses/services.

- Establish accountability within each region by:
 - adopting recognized standards for practice and seek accreditation through organizations such as PSR Canada or other recognized accreditation agencies
 - implementing standardized data collection utilizing outcome measures
 - implementing consumer satisfaction surveys

- Each region allocate adequate financial and human resources to develop a range of consumer recovery services that will help consumers participate more fully in the mental health delivery system.

Adapted from “Best Practices in B.C.’s Mental Health Reform”

k) Children’s Mental Health Services

The Children’s Advocate Report of 2004 “*It’s Time for a Plan for Children’s Mental Health*” echoes the overall need for a mental health plan for the province and should be a big part of that plan.

Conclusions fo the Children’s Advocate Office include the following:

- Create a comprehensive data collection system that is consistent with a population health model and track and report on the status of child well-being and the prevalence of mental disorders in children and adolescents.
- Implement a more coordinated, integrated system across government departments, service delivery agencies, professional disciplines and administrative structures.
- Train, recruit and retain qualified mental health professionals.
- Make resources for child and adolescent mental health services a higher priority in the health care system.
- Continue to support public education, prevention and early intervention research and services.
- Fit the service to meet the needs of the child rather than focusing on fitting the child or youth into the existing service delivery system.
- Engage parents, children and youth themselves and other community members when plans of action are developed and implemented.

l) Therapeutic/Mental Health Court

It is well established that there is a need for a therapeutic/mental health court in the province.

The Canadian Mental Health Association, the Schizophrenia Society of Saskatchewan, and the Ministries of Health, Corrections and Public Safety and Social Services worked collaboratively and will be developing a model for this “court” in the near future, which suits specifically the needs of Saskatchewan.

m) Adequately Funded, Large Scale Public Education and Awareness

As noted in every major study on mental health/illness/addiction that has been released, the ignorance of mental health issues in the general population plays a major role in the stigma and the discrimination both systemically and individually that plague those with mental health issues and their families.

We require a well funded, large scale public awareness and education campaign to deal with this foundational issue. The campaign should include mainstream radio, television, billboard and public transit areas of dissemination.

n) System Accountability for Best Practice Service Delivery

An explicit mental health policy is necessary in order to give high priority to mental health services; describe the vision, values, objectives and strategies of governing bodies; serve as a “blueprint” upon which future action can be based; identify principle stakeholders and achieve consensus among them; designate clear roles and responsibilities; and specify standards that need to be achieved across the system. Policies should be endorsed at the highest level and applied consistently.

The following questions must be appropriately and positively answered to achieve an implemented mental health plan:

- Is there an explicit mental health policy that gives high priority to mental health services?
- Is that policy endorsed at the highest level of the organization and of government?
- Do the policies have guiding principles, which include:
 - participation of the community, including consumers and families.
 - deinstitutionalization and community care,
 - accessibility and equity,
 - integration through primary health care?
- Were the policies developed through a consultative process which included:
 - the collection of information on population needs,
 - consensus building with stakeholders,
 - an international review of best practices, and
 - pilot projects to demonstrate the effectiveness of initiatives?
- Are policy objectives defined in terms of improving the health of the population?
- Do policies specify action in the critical areas of:
 - financing,
 - intersectoral collaboration
 - legislation and human rights,
 - information systems,
 - advocacy,
 - research and evaluation,
 - quality improvement,
 - organization of services,
 - promotion, prevention, treatment and rehabilitation,
 - access to medication, and
 - human resources training?
- Is information about the policies widely disseminated, promoted and understood by:

- government officials, and
 - the public?
- Do policies include an implementation plan including:
 - objectives,
 - financial allocations,
 - monitoring,
 - evaluation, and
 - time frames?
- Are policies driven by informed consideration of “best practice” evidence including:
 - case management/assertive community treatment,
 - crisis response/emergency services,
 - housing,
 - inpatient/outpatient care,
 - consumer initiatives,
 - family self-help, and
 - vocation/educational supports?
- Is funding for mental health services equitable to funding for services of general health programs?
- Is funding for mental health services equal to the magnitude and burden of mental disorders present in the Saskatchewan population?
- Are the resources available for mental health consistent with the requirements of relevant legislation?
- Are the resources available for mental health clearly detailed and protected within accounting systems for both:
 - in-patient services, and
 - community services?
- Is funding for mental health tied to a strategic vision?
- Do financing mechanisms facilitate rather than impede access to required services?
- Are resources specifically allocated to priority, under-served and at-risk populations (for example, people with severe mental disorders, women, children, older adults and ethno-racial groups)?
- Have provisions been made for special funding necessary during health services transitions to ensure that new services are firmly established before existing services are terminated?
- Does health insurance promote parity between mental health and general health?
- Is there a clear point of accountability?
- Are the resources available for mental health services and programs judiciously allocated to appropriate and effective services?
- Are there information systems in place for monitoring expenditures and services to ensure quality, effectiveness and efficiency?
- Are policies in place to ensure the appropriate allocation and tracking of funds from institutions to community care?
- Is there funding for quality, evidence-based services?
- Is there funding for workforce training and development?
- Are financial incentives available for health innovations?

- Are management and purchasing structures in place?
- Are information systems in place?
- Do contractual arrangements facilitate attainment of planning and budgetary objectives?
- Has provision been made for evaluation and analysis of cost-effectiveness?
- Are key stakeholders involved, and is information sharing encouraged between them?
- Has high priority been assigned to mental health services and programs?
- Is the effectiveness of medications and services in the management of mental disorders well understood?
- Have vested interests of certain stakeholders in preserving the status quo of existing structures and services been appropriately addressed?
- Has the importance of organized constituencies adequately representing people with mental disorders been fairly considered?
- Does legislation facilitate the articulation of the fundamental principles, values, goals and objectives of mental health policies and programs?
- Does legislation provide a legal framework to ensure that critical issues are addressed, such as:
 - early access to care,
 - high quality of care,
 - integration of people with mental disorders into the community, and
 - mental health promotion?
- Does legislation:
 - protect and promote the rights, needs and interests of people with mental disorders, and
 - tackle the stigma and discrimination they experience?
- Does legislation promote quality of care by:
 - supporting minimum standards for access to services and quality of services?
 - allocating resources for under-served populations?
 - promoting training, research and evaluation?
 - enforcing accreditation for providers and organizations?
 - requiring periodic reports on the mental health status of the general population and the access, quality, cost and impact of care for specific sub-populations?
 - providing resources for infrastructure development and maintenance?
- Is legislation consistent with the *Canada Health Act* and the *UN Principles for the Protection of Rights of Persons with Mental Illness and the Improvement of Mental Health Care* (1991)?
- Is legislation the product of a consultation process involving all relevant provincial, regional and community stakeholders through:
 - publication of legislation,
 - solicitation of written responses and
 - holding consultative meetings or public hearings?
- Do planning and budgetary processes specify the availability and quality of services for various sub-populations, such as people with severe mental disorders, women, children and adolescents, the elderly, different ethnic groups or people residing in specific geographic areas?

- Do planning and budgetary processes specify the minimum acceptable levels of quality for different settings (such as hospitals and the community), and for different services?
- Do planning and budgetary processes specify the resources available for the infrastructure needed to implement quality management systems and feedback mechanisms?
- Do planning and budgetary processes specify the resources needed for the current and future development of a trained workforce?
- Have those responsible for developing policy at the provincial, regional and community levels encouraged and facilitated the establishment of appropriate non-governmental organizations through legislation and regulation?
- Have those responsible for developing policy provided forums to develop a common understanding of various perspectives and to build consensus across diverse groups?
- Is there provision for accreditation of service providers and organizations?
- Are there clearly-defined standards for treatment and care?
- Are there clearly-defined clinical guidelines?
- Is there a provision for performance measurement, including consumer and family member perspectives?
- Is there provision to assure monitoring of outcomes?
- Is there adequate provision for consumer and family education?
- Is there sufficient information on treatment and care services, and adequate capacity in the system to analyze the available information?
- Is state-of-the-art knowledge readily available and appropriately shared?
- Is there provision for adequate workforce development and training?
- Is there sufficient consumer and community input into standards of care and quality assurance processes?
- Does the provincial entity have the mandate:
 - to protect mental health funding,
 - to articulate and hold accountable,
 - to evaluate and monitor, and
 - to ensure a clear, consistent, goal-driven, stakeholder-owned mental health policy is in place?
- Are all programs and services administered regionally, recognizing that there is a need in the overall continuum of services for a provincial hospital such as Saskatchewan Hospital at Battlefords to manage long-term, difficult to manage and forensics patients?
- Are resources invested in a reasonable balance between facility-based and community-based mental health services?
- Are community support programs put in place before any reduction in institutional inpatient resources?
- Are addictions programs fully integrated into other mental health and health services, realizing and recognizing the additional training and methods of treatment necessary for adequate dual-diagnosis treatment?
- Has the service provision gap between rural and urban areas been reduced by extending the reach of general health services or establishing more specialized community mental health services?

- Has the training and continuing education of health care professionals moved from an emphasis on disease-based medical models to encompass psychosocial and alternative concepts of health care?
- Has the meaningful involvement of consumer and family organizations in service planning and delivery been encouraged and increased?
- Do the provincial and regional entities demonstrate commitment to mental health consumers' involvement through all aspects of the policy and care continuum?
- Have financial incentives and disincentives been considered and implemented to encourage the development of community services and regional in-patient facilities?
- Do the planning and budgeting processes for service delivery incorporate such steps as:
 - situation analysis,
 - needs assessment,
 - target setting and
 - implementation strategies?
- Has a quality improvement checklist or standards document been designed in consultation with all mental health stakeholders?
- Have accreditation procedures been developed according to the quality improvement checklist document?
- When commissioning services, do contract specifications include indicators of quality mental health care?
- Are quality improvement mechanisms used to monitor the mental health services?
- Are there effective processes in place for recognizing services that have performed well, and for addressing services of an unacceptably low standard?
- Is there provision for reviewing, on an periodic but less frequent basis, the quality improvement mechanisms themselves to ensure that services are consistent with the latest evidence on best practices?

Adapted from "Partnership, Participation, Innovation...a Blueprint for Reform" – Alberta Alliance on Mental Illness and Mental Health, March 2003

CONCLUSION

The above are some components of a well-developed plan for mental health. It should be noted that we have several best practice "models" in the province, but they are locally implemented only and must be replicated in strategically located areas of the province to appropriately provide access to the services required.

Recovery/resiliency oriented outcome measurements must be implemented at all levels of the system.

The plan will require real increases to the mental health budget and should be implemented incrementally over a five to ten year period of time.

We look forward to working with the Ministry of Health and other appropriate Ministries to move towards implementation of a much needed and overdue "Plan for Mental Health in Saskatchewan"

Next steps

The Canadian Mental Health Association and the Mental Health Coalition would like to work with other disability groups through the Provincial Interagency Network on Disability (PIND), the Disability Income Support Coalition (DISC) and other individual agencies who might be interested in developing a true recovery/resiliency-oriented philosophy and programs to meet needs in our province. Because of our limited population and resources, working together will ensure that all persons with disability, who require crisis and long-term services, will have access to a continuum of alternatives to meet their needs as they seek to live with their illness or disability, while serving as fully as possible as citizens in our communities.