

REVITALIZING AND REBALANCING

*British Columbia's*

MENTAL HEALTH SYSTEM

THE 1998 MENTAL HEALTH PLAN

“**N**ow I sometimes feel I have hope that I can accomplish things in my life that are important to me. This is what I wish to celebrate: The survival of the spirit and soul, when the brain is not always a reliable friend. ”

- A consumer





The 1998 Mental Health Plan reflects the collective wisdom derived from the experience and reviews of mental health care systems during the last decade and addresses the current challenges that compromise quality care for people with mental illness.

Using the best available evidence and knowledge about effective clinical practices and support services, this updated plan will position the Ministry to work with health authorities, stakeholders and other ministries to support the development of comprehensive, integrated regional mental health care systems for British Columbians with the most serious and disabling mental illnesses, their families and the communities where they live.

Just over 10 years ago, following a province-wide consultation which resulted in the 1987 *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital*, the government of British Columbia approved the Mental Health Initiative, which committed to decentralizing institutional care provided at Riverview Hospital and to the development of regionally based, multi-level mental health / psychiatric care. Implementation of the Mental Health Initiative began in 1992, with an infusion of \$53 million to fund improvements in community services.

Between 1992 and 1995, transfers of Riverview Hospital patients and reinvestment of the associated funding into the community resulted in additional enhancements to community mental health care. In 1994, the Auditor General reported on the monitoring and successful outcomes of these transfers.

Despite these successes and the improvement of community mental health services, service pressures continued to mount. A significant portion of the \$53 million in funding was required to address pressures caused by inflation and demographic increases, leaving \$36 million for the development of new services in the areas of housing, emergency response, rehabilitation, clinical services, consumer/family services, child and youth services and alcohol and drug services for aboriginal people. While this augmentation provided a critical boost to the community mental health system and permitted the expansion of a broad range of services, it did not address the still inadequate supply of services relative to the needs of the most disabled individuals. Similarly, a number of fundamental problems were not addressed in an enduring way. Some of these include: the inconsistent interpretation and application of the *Mental Health Act*, as well as constraints within it; a continuing migration of people with mental illness to the Lower Mainland for services; a lack of admission and discharge planning between Riverview Hospital, acute care hospitals and community services; and less than optimal policy coordination between relevant social policy ministries.

This mental health plan builds on the existing strengths of services and planning, notably the continued redevelopment and decentralization of Riverview Hospital into community-based specialized care facilities. The plan builds upon previous planning by responding to systemic issues recently identified through public consultation, reports of the Ombudsman and Auditor General and coroners' inquests. It is consistent with the recommendations of the national document, *Best Practices in Mental Health Reform*, which represents the most current information about effective, evidence-based services and service models in the North American experience.



The 1998 Mental Health Plan is focused on a number of critical issues:

- an emphasis on adults with the most disabling functional impairment due to serious mental illness;
- an emphasis on early identification and treatment of individuals and related support for their families;
- implementation of best practices in mental health care to enable consumers to benefit from the most current knowledge about program and service design that produce positive health outcomes;
- more responsive services for individuals with multiple problems, who historically have been poorly served by existing services (e.g. people with a mental illness and substance misuse issue and/or who have been in conflict with the law);
- a shift in service delivery to better respond to individuals' complex needs through outreach, assertive case management and appropriate medical care in non-hospital settings wherever this is consistent with quality care;
- policy development and service planning coordination focused on the biological, psychological and social needs of people with serious mental illness;
- integration of forensic psychiatric services with other elements of the mental health system to provide improved community support and assertive case management services to low risk mentally disordered offenders and to reduce the number of people with illness who come into conflict with the law; and
- improved policy coordination with other ministries to better address income security, housing, training, employment and other social support needs.

This plan provides a framework to guide the work of health authorities in evolving mental health care systems which will help people with mental illness and their support networks access the services they require to restore and maintain optimal functioning and health. It includes a description of the service delivery structure and the accountability and human resource plan, considered essential tools for revitalizing and rebalancing British Columbia's mental health system.

The plan outlines the work which needs to be done with health authorities during a series of transitional phases in order to achieve relatively self-sufficient, regional mental health systems. This will require close collaboration with health authorities and stakeholders, including other government partners.



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## 1.0 PREAMBLE



In partnership with consumers, families and communities, the Ministry of Health and Ministry Responsible for Seniors is committed to working with health authorities to develop integrated, balanced and effective regional mental health service systems.

The 1998 mental health plan sets out the objectives and strategies for mental health reform that will promote the optimal mental health and participation of people with mental illness in British Columbia's communities.

Reform will be achieved by revitalizing and rebalancing the mental health care system, strengthening reform measures already in place and tackling critical systemic problems.

Responsibility for mental health policy development and service planning and delivery for children and youth has been transferred to the Ministry for Children and Families (MCF). The Ministry of Health and Ministry Responsible for Seniors will work collaboratively with MCF to support integrated planning and service delivery for young people who require early intervention, some of whom will later require services within the adult mental health system.

The 1998 mental health plan is primarily targeted to the 60,000 British Columbia adults with mental illness who experience a high degree of functional impairment. Generally, illnesses such as schizophrenia, major depression and bipolar disorder represent the most disabling mental illnesses; however, it is acknowledged that there are others who may not meet that diagnostic criteria, but for whom medical risk and level of impairment, regardless of diagnosis, determines their mental illness as "serious". It is also acknowledged that mental illness cuts across all lines of age, sex, ethnocultural background and economic status.

There is no question that society has significant responsibilities related to people with mental illness, both in human and financial terms. This is true whether people receive care in a hospital for long periods of time or in the community with appropriate clinical support, decent housing, adequate income assistance and meaningful day activities, including, where appropriate, employment. The mental health plan provides direction on how people with mental illness in British Columbia can be served with better health outcomes for the individuals, their families and friends and the communities in which they live. By the very nature of their illnesses, a portion of these individuals are at risk of continuing to spill into correctional facilities, emergency rooms, emergency shelters and the streets. Others will exhibit their illness in a less public way but will, nonetheless, experience a considerable erosion of social support, self-esteem and a limited ability to maintain responsibilities related to parenting, employment and other aspects of community participation.



“ The new mental health plan must be the centrepiece of a government social policy commitment to the mental health and well-being of the citizens of British Columbia. ”

- Jim Browne, Chair, Provincial Mental Health Advisory Council

## 1.1 Introduction

This document distills the experience of those involved in the mental health system over the last 10 years and draws upon the experience of other jurisdictions. It is also informed by the concerns that individuals have raised with the Minister of Health and Minister Responsible for Seniors; the Ombudsman's 1994 report, *Listening: A Review of Riverview Hospital*; the Auditor General's 1994 value-for-money audits on the transfer of patients from Riverview Hospital to the community and on psychiatrist services; and by coroners' inquests into the deaths of people with mental illness. The varied perspectives and expertise of consumers, families, service providers, planners, administrators and advocates have contributed to the continuing evolution of a more responsive mental health system in British Columbia. Particular attention has been given to the most recent analysis of the North American experience, *Best Practices in Mental Health Reform*, developed and funded by the Federal/Provincial/Territorial Advisory Network on Mental Health and Health Canada, in 1997. The best practices report provides a comprehensive framework and set of guidelines necessary for mental health reform to occur both at systemic and service levels.

This document summarizes accomplishments of the last decade related to the evolving mental health system, outlines the primary challenges to be addressed and describes a renewed mental health plan. The renewed plan describes a policy framework, a modified governance structure for the system, required changes in service delivery and the related accountability and human resource plan. A process for the subsequent review and renewal of the plan is also outlined.

A province-wide consultation was conducted between 1984 and 1987 to reach a consensus on the future of the mental health service system. This resulted in the 1987 *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital*. The "Blue Book", as it came to be known, set out 68 recommendations which formed the basis of the Mental Health Initiative.

“ Patients transferring from Riverview Hospital to the community need essentially the same range of services as was available to them at the hospital.... ”

- Auditor General Value-for-Money Audits 1993/94, *Transfer of Patients from Riverview Hospital to the Community*

In 1990, the government of British Columbia approved the Mental Health Initiative, which committed to a fundamental shift away from historical institutional care to a decentralized, regionally integrated mental health system. This commitment entailed replacing Riverview Hospital’s capacity with regional tertiary care facilities, enhanced acute care services and expanded community-based services. Implementation of the Mental Health Initiative began in 1992, following the infusion of \$53 million in new funding, an amount which exceeded the government’s original commitment of \$20 million in order to address service erosion and related inflation and population increases that had occurred since 1987.

## 1.2 Background

For nearly a century, Riverview Hospital has provided the province with specialized assessment, treatment, rehabilitation and long stay care to adults with serious and persistent mental illness.

This care capacity, that has historically been provided in the Lower Mainland, is being decentralized so that people with mental illness who live on Vancouver Island, in Northern parts of the province and in the Southern Interior, as well as those in the Lower Mainland, may access specialized care services within their own geographic region.

As a provincial tertiary treatment hospital, Riverview admits patients from acute care hospitals around the province (although predominantly from the Lower Mainland) who require highly specialized assessment, diagnosis, treatment and security that is beyond the expertise or capacity of the acute care hospitals. Patients receiving this care are treated for varying periods of time and discharged, ideally to the care of a general practitioner, a psychiatrist or a multi-disciplinary mental health team and the support of their families and other social networks. Historically, Riverview Hospital has also provided care to a number of patients who, due to the severity of their illness and related behaviors, have required long-term refuge or sanctuary. It is this

“Some people still need a more supportive environment - (we) still need a place for people to stabilize first before living independently.”

- Members, Riverview Hospital clubhouse

latter population that is being "deinstitutionalized". Planning for the replacement of Riverview Hospital capacity, therefore, requires careful attention in order to appropriately address these distinct needs.

At the outset of planning for the replacement of Riverview Hospital, two key assumptions were established:

- that a broad range of community support services, including housing and non-hospital based crisis intervention services would be further expanded; and
- that acute care hospitals would continue to provide a critical component of care for people with serious mental illness.

Between 1992 and 1995, the transfer of Riverview Hospital patients began, with associated transfer of hospital funding to the community and subsequent hospital bed closures. To date, this process has resulted in a reduction of \$13.2 million to Riverview Hospital and a reinvestment of the entire amount in regions to fund care for patients transferred as part of this process and to support enhanced community mental health care. Those transferred have been monitored and evaluations to date report successful outcomes. During this same period, the involvement of consumers and family members increased significantly in mental health service planning and delivery. Planning for the regional, community-based tertiary care facilities, which will provide medium to long stay specialized care, has proceeded to the point where functional programming is essentially complete.

By 1996, a variety of factors resulted in mounting pressures on the mental health service system in the Lower Mainland. Steadily, an increasing number of individuals appeared in the emergency rooms of hospitals, impacting a range of services, including police and ambulance. The acuity level of people with mental illness in acute care hospitals began to rise, necessitating longer stays and blocking access for ill people in the community.

“Some things are excellent, some average and some things definitely need to be improved.”

- Consumer and family member

The Minister of Health and Minister Responsible for Seniors suspended the reduction of Riverview Hospital capacity, with its associated patient and resource transfers, pending review of the community system requirements by a representative working group. The working group included members of the Provincial Mental Health Advisory Council and the British Columbia Mental Health Society, which operates Riverview Hospital.

The working group recommended the implementation of several management strategies and the addition of \$34 million in regional resources that were deemed necessary to resume Riverview Hospital patient and resource transfers and related reductions in capacity.

To facilitate development of an updated mental health plan, a consultation/discussion document, *Developing a New Mental Health Plan for British Columbia*, was circulated to mental health stakeholders. Province-wide feedback from consumers, family members, service providers, advocacy organizations and other stakeholders was received. Despite very short time frames, responses were thoughtful and broadly focused. A summary of consultation responses is located on pages 57 to 74.

### 1.3 Progress Report on Mental Health Reform

Reform of mental health care systems is occurring in virtually all jurisdictions. While there are minor variations across provinces and states - as governments seek ways to provide progressive, humane and cost-effective care for people with mental illness - a number of best practices criteria have been recognized:

- shift from hospital to community-based services to create a balance;
- specified, protected funding for an integrated mental health care system, including community, hospital-based and community-based tertiary care;



“ The process of inclusiveness of the client and family point of view...is appreciated and deserves to be emphasized again in the next 10 years.... ”

- Mood Disorders Association of BC

- single point of accountability responsible for the operation of an integrated mental health care system at the local level; and
- mechanisms for meaningful consumer and community involvement in decision-making.

Within British Columbia, mental health reform has been underway since 1992/93 and includes major initiatives consistent with best practices:

- decentralization of tertiary psychiatric care capacity;
- significant increases in community mental health resources/services (funding has more than doubled since 1987);
- development of consumer and family advisory committees and support services;
- integration of community and hospital-based mental health service components through regionalization;
- funding for development and operation of community services prior to reduction of Riverview Hospital capacity; and
- completion and evaluation of successful projects related to the transfer of institutional staff to community services.

Over the last decade, the focus for developing new services has shifted away from large-style residential care facilities ("boarding homes"), standardized and segregated rehabilitation services and predominantly hospital-based emergency services.

Services developed since 1992/93 reflect a shift toward more individually responsive and less institutionally focused care. Efforts to develop better coordination continued between mental health centres, hospitals and Riverview Hospital.



“ I managed to get a van (to live in). The police checked me out one day...and said, 'Find a place when you can.' It's been four years now. ”

- Roy, consumer whose story is described in *Nowhere to Live: A Report by the Lower Income Singles Task Group*

Clinical services were enhanced by 187.5 FTEs, emergency services in many communities were established or improved, psychiatric sessional funding substantially increased and 6,200 rehabilitation program spaces were created with an improved focus on psycho-social rehabilitation services.

### Shifting Focus in Bed Development

Bed Resources*	1987/88	1996/97
Riverview Hospital	1,220	808
Regional Tertiary		
<i>Actual</i>	0	12
** <i>Planned</i>	550	663
Acute Psychiatry	725***	717***
Crisis Residential	10	83
Supported Housing	279	2,352
Residential Care	1,733	1,755
Family Care	133	158
Emergency Shelter	70	132
<b>Total</b>	<b>4,170</b>	<b>6,017</b>

A map showing changes in bed development between 1987/88 and 1996/97 is located on page 53.

\* This is not a comprehensive table.

\*\*Planned regional tertiary beds (not included in total)

\*\*\*Of these, 52 are designated for children and youth

“ Schizophrenia claimed our son recently. He was 29... a member of MENSA with a B.A...taught ESL in Japan...a gentle and sensitive young man with great potential.... ”

- Parents whose son committed suicide

#### 1.4 Challenges for the 1998 Mental Health Plan

The renewed mental health plan must produce changes that will have a positive impact on the lives of those who use mental health services and the quality of life in British Columbia communities. To achieve this, the plan must address a number of systemic issues:

##### *Continuing to Increase the Involvement of Consumers and Families*

Historically, the perspectives of consumers and families have not been fully acknowledged during treatment and care planning nor at levels where broader service planning occurred. Confidentiality requirements, clinical practice and economic stressors may limit the involvement of people with mental illness and their families in decisions regarding services, treatment and system planning.

##### *Implementing a Bio-Psycho-Social Approach to Care*

While there is broad support for a model of care that responds to individual needs, there is ambivalence on the part of some health care providers and other stakeholders to acknowledge the interaction and impact of biological, psychological and social health determinants; perhaps because treatment organizations are not typically able to support intervention at the societal level. These determinants of health are known to differently impact designated populations — women, seniors, aboriginal people, members of minority ethno-cultural groups and people with disabilities.

##### *Improving Access to Medical/Clinical Care*

Timely access to well-trained physicians and other clinical staff can prevent individuals' relapse and re-hospitalization. This does not always occur due to inadequate numbers of physicians and other professionals in rural areas, gaps in service during a 24-hour period, inflexibility in the delivery of clinical care and poor exchange of clinical information between care providers.

“ Focus on...a preventive mental health system...on relapse prevention, wellness promotion and recovery...and creation of a "no reject" system of care.... ”

- Canadian Mental Health Association, BC Division

### *Improving Mental Health Legislation and its Application*

Various provisions of the *Mental Health Act* have been inconsistently interpreted and applied. Current legislation is insufficient for mandating treatment where it is required in a way that minimizes unnecessary detention. This frequently results in insufficient supervision, interspersed with unnecessary infringements on the liberty of people with mental illness. Because hospital services are under pressure, seriously ill people are sometimes prematurely discharged with little or no supervision. In too many instances, this results in people abandoning their medication, becoming acutely psychotic and being involuntarily re-hospitalized with a still poorer prognosis. Where appropriate, a form of committal that does not involve detention in a hospital, but which allows for the supervision of medication - such as extended leave with involuntary treatment - can provide an alternative for treatment and adequate supervision.

### *Promoting Public Awareness and Understanding of Mental Illness*

Public attitudes have been influenced by stereotypes of people with mental illness in the media and the entertainment industry and by publicity about the failures of deinstitutionalization in other jurisdictions. Due to the nature of mental illness, some individuals with mental illness — both those receiving support and those not — tend to be more socially visible. Their presence in the community often leads the public to believe they are not receiving support or that they are to be feared. These public attitudes contribute to individuals' isolation and reluctance to seek help early for themselves or those they care about.

### *Bringing Together the Elements of the Mental Health System*

Elements of the mental health service system have evolved with minimal or no coordination and accountability for the overall coordination of care and evaluation of outcomes has lacked focus. Similarly, policy development across social policy ministries has not been well coordinated for sustained periods. This has diminished the impact which would be derived from more thorough, consultative and inclusive interministerial planning.

“ Many psychiatrists and others wrongly...cite dangerousness as the threshold criterion for involuntary committal, rather than 'requires care, supervision and control' as stated in the Act.... ”

- Family member

### *Ensuring People with the Most Serious and Disabling Mental Health Problems Have Priority Access*

In some communities, people with the most disabling mental illnesses have not always received priority for services. There are many pressures on the mental health care system and there are places in the province where people with less disability have no alternative but to use the services of mental health centres. It is important that regions have the flexibility to deal with these legitimate needs of people. Nevertheless, one of the purposes of the mental health plan is to ensure that, in allocating mental health funding, people with the greatest degree of functional impairment are given the highest priority.

### *Fostering Flexibility in Programs*

Programs and services have historically been developed in ways that do not easily accommodate complex or changing consumer needs. This has been particularly evident in programs requiring significant capital expenditure and flexibility (e.g. staff deployment, scheduling and program location) and in service coordination for individuals with complex needs. As an example, an estimated 50 per cent of people with serious mental illness have substance misuse issues, yet services tend to be delivered in isolation from each other.

Because of traditional practice models, service delivery has often been confined to an office-based model. This approach to care does not typically maximize contact with consumers' social networks, thereby failing to reach many of those who are in need of care. Similarly, limited office hours have not been responsive to crises or other emergencies in people's lives.



# 2.0 POLICY FRAMEWORK



## 2.1 Vision for the British Columbia Mental Health Care System

The province of British Columbia envisions a health care system where people with mental illness have access to necessary care as easily as to physical health care, with priority for specialized services based on medical risk or extent of disability resulting from a serious mental illness. Care will be provided in a timely, respectful way with sensitivity to age, gender, ethno-cultural background, geographic location and lifestyle.

Comprehensive, regionally and locally integrated programs and services will be based on an objective of optimum recovery that respects individual's strengths, life circumstances and capacity to recover. Early identification and intervention in the course of illness will prevent or mitigate long-term disability.

Service consumers, families and professionals will work together to lead the evolution of their community and regional care systems, based on a collective commitment to service evaluation and continuous improvement.

Mental health policies and services will reflect a partnership of public agencies. The impact of socio-economic, environmental, physical, biological and behavioral determinants on individuals' mental health will be recognized. Policy coordination will be improved to better address the income security, housing, training, employment and other social support needs of adults with serious mental illness.

“ **A** concise definition of the target population is fundamental. No serious planning can be undertaken in the absence of a clear definition. ”

- Forensic Psychiatric Services

## **2.2 Target Populations and Priority**

Target populations for the public mental health system are:

- those who experience serious long-term mental illness and disability; and
- those who experience acute, episodic serious mental illness.

This includes people with serious mental illness who do not voluntarily access care, as well as those who present with additional conditions (e.g. substance misuse, developmental disabilities, positive HIV status).

Priority for service will be based on medical risk, degree of functional impairment or disability associated with mental illness.

## **2.3 Mental Health Mission Statement for Ministry of Health/Health Authorities**

The Ministry of Health/health authorities' shared mission is to put in place integrated, comprehensive, accessible and effective mental health services. Utilizing the knowledge and experience of consumers and families, as well as care and service providers, these services will restore, preserve and promote mental health for adults with serious mental health problems.



“Mental disorders account for more than one-tenth of all days spent in hospital...only cardiovascular disease causes more bed-days.”

- *Provincial Health Officer's Report, 1996*

## 2.4 Mental Health Mandate for Ministry of Health/ Health Authorities

The mental health mandate for the Ministry of Health and health authorities is to provide core mental health services that include:

- emergency response and short-term intervention services;
- intensive case management;
- outreach services;
- clinical services (assessment, diagnosis, treatment and consultation);
- preventive measures (research, education, early identification and intervention);
- psychosocial rehabilitation;
- case management and social supports, including respite care for family caregivers;
- residential services; and
- where required, assistance in accessing housing, income assistance and rehabilitation services and benefits.





“ We need to find a way to coordinate and link (between mental health and other service deliverers) ...to ensure a comprehensive... 'seamless' system of mental health care. ”

- Youth Team, Regional Support Division, Ministry for Children and Families

## 2.5 Interministry Coordination

To ensure service coordination, the Ministry of Health and Ministry Responsible for Seniors will strengthen its working relationships with the social policy authorities within government:

- Ministry of Attorney General, regarding offenders with mental disorders;
- Ministry of Municipal Affairs and Housing, regarding access to and provision of safe, affordable housing for people with mental illness;
- Ministry of Women's Equality, regarding the identification of barriers that impede the access of women with mental illness to appropriate services;
- Ministry of Human Resources, regarding eligibility for income support and disability benefits for people with mental illness;
- Ministry of Education, Skills and Training, regarding education to support early intervention and identification, as well as supported education and employment to assist in the rehabilitation and recovery of people with mental illness;
- Ministry of Children and Families, regarding the early identification and treatment of serious mental illness in youth; service transition requirements for older youth with serious mental health problems; services for people with mental illness and substance abuse issues; and support services for parents, particularly women with mental illness whose children are in care or at risk of coming into the Ministry's care; and
- Ministry of Aboriginal Affairs, regarding the provision of mental health care to First Nations people with mental illness.

## 3.0 GOVERNANCE AND RESPONSIBILITIES



### 3.1 Ministry's Responsibility

The Ministry of Health and Ministry Responsible for Seniors is responsible for ensuring that high standards, quality care and the values of Medicare are maintained for health care throughout the province. With regard to regionalized services, including mental health, the Ministry is responsible for:

- maintaining the policy, legislative and organizational framework for health services;
- funding the health care system;
- defining core programs and services to be provided;
- ensuring coordination on system-wide or inter-regional issues;
- tracking and auditing, from a provincial perspective, the quality and accessibility of care, consumer satisfaction and waiting times for required treatment; and
- providing information management standards and guidelines for the collection and sharing of information.

### 3.2 Health Authorities' Responsibility

Health authorities are responsible for:

- establishing a plan for health services and facilities in the region (based on Ministry policy and identified needs);
- developing regional policies and standards and setting priorities;
- budgeting and allocating funds to health programs within the region for the delivery of specific health services;

“The best way to promote provision of services...is by creating and maintaining partnerships with the people who are using the service....”

- West Kootenay Boundary Region

- employing staff for all amalgamated agencies and staff transferred from the Ministry of Health and planning for required human resources; and
- governing the delivery of administrative, support and health services to the region according to provincial standards and specified services, either directly or through working agreements and contracts with funded agencies.

### 3.3 Advisory and Advocacy Structures and Relationships

Mental health advisory committees have been established and will continue to provide advice to Regional Health Boards, Community Health Councils, Community Health Service Societies and the Ministry regarding the performance of the mental health system. These committees are composed of consumers, families, mental health service providers and other stakeholders.

Advocacy associations, such as the Canadian Mental Health Association, British Columbia Schizophrenia Society and the Mood Disorders Association of British Columbia, will continue to advocate for improved services and access that are on par with physical health care services. The provincial family and consumer advisory councils will continue to be responsible for coordinating and linking with regional consumer and family advisory councils.

The Provincial Mental Health Advisory Council, with representation from provincial family and consumer advisory councils, advocacy organizations, organized labor and professional associations, will continue to advise the Minister of Health and Minister Responsible for Seniors on the performance of the provincial mental health care system and will work closely with the Provincial Mental Health Advocate (*see next section*). The council will engage in a reciprocal membership with the newly established Health Association of British Columbia, which represents health authorities.

“ There appears to have been a continuing erosion of responsibility of government and institutions...leaving... care to a somewhat nebulous entity... 'the Community'. ”

- BC Schizophrenia Society, Provincial Office

### 3.4 Provincial Mental Health Advocate

Programs and services to support people with mental illness are provided by many ministries and agencies, health authorities and providers (e.g. family physicians, mental health teams, hospitals, community agencies). Systemic advocacy is required to monitor the performance of the various elements of the service system, particularly at their boundaries, to ensure that services are integrated, coordinated and non-discriminatory.

To support this, the Minister of Health and Minister Responsible for Seniors will appoint a Mental Health Advocate for the Province of British Columbia, as recommended by the Ombudsman in her report on Riverview Hospital (May 1994):

*That the Provincial Government appoint a Mental Health Advocate for the Province of British Columbia, with the following mandate: report annually and as required to the public on the state of the mental health service system in B.C., and on the issues being encountered by consumers, service providers, advocates and those they support; and provide a single information and referral source for advocacy resources in mental health services in B.C.*

### 3.5 Governance of Riverview Hospital

Currently, Riverview Hospital, the provincial long-stay psychiatric hospital, is operated by the British Columbia Mental Health Society (BCMHS). The BCMHS and the Ministry have joint planning responsibility for overseeing the development of regional services that will replace the capacity of Riverview Hospital. While the benefits of a provincially coordinated regional planning process will need to be preserved, the governance of Riverview Hospital needs to reflect the regionalized health service structure. The governing body of the BCMHS will be altered to provide strong representation from the new health regions.

“ There is not only a gap between forensics and mental health, there is a canyon. Each department simply does not deal with the other.... ”

- Cariboo Regional Mental Health Consumer and Family Council

### **3.6 Governance of Forensic Psychiatric Services**

The need for better coordination of the Forensic Psychiatric Institute (FPI) and the province's six community forensic psychiatric clinics with other elements of the mental health system has been broadly acknowledged due to a high number of people with mental illness coming into conflict with the law and, therefore, the forensic psychiatry system. For many of these people, adequate community support - including case management where required - can prevent or reduce their involvement with the criminal justice system. Those already engaged with forensic psychiatry services due to minor offenses will be able to access mental health services from which they have often been excluded. High risk offenders will continue to be served within the FPI. To support this, the FPI will be brought under the operating responsibility of the BCMHS and responsibility for the forensic community clinics will be transferred to health authorities, with a strong policy linkage maintained with the FPI.



## 4.0 SERVICE DELIVERY STRUCTURE



### 4.1 Models of Care

#### *Best Practices*

The Ministry will require health authorities to maintain mental health core services in each geographical area. Where practical, these services will be expected to follow the nationally recognized best practices framework. The service components required within a best practices framework are described below.

#### *How the Service Model will Change*

Implementation of the best practices in mental health care will support the development of regionally integrated mental health services with tertiary care provided in smaller, community-based facilities. These smaller facilities will bring a level of security and supervision not previously available outside the Lower Mainland. The development of smaller facilities for tertiary care marks a significant shift from historic psychiatric hospital planning which commonly results in systemic dependency on large scale institutions.

Services will be improved in specific areas that individuals and their families will be able to appreciate personally and qualitatively as more responsive care. These changes will result in increased or improved outreach; care provided in the home or where people are, wherever feasible; intensive case management; early intervention; education (of the public and service providers, including physicians); services based on best practices; services based on the bio-psycho-model of recovery; and services that are responsive, accessible and respectful of individuals.

“  
...as socio-economic and environmental standards  
(decline), so go mental health levels....”

- Douglas M. Leach, member, Queen Charlotte Islands Community Health Council

### *Consumer-Centered Model of Recovery*

Recovery involves developing new meaning and purpose in order to grow beyond the disabling effects of mental illness. A mental health system is recovery oriented when it:

- ensures the availability and accessibility of formal and informal personal supports;
- looks beyond relief of clinical symptoms and the meeting of basic needs to outcomes such as self-esteem and self-determination; and
- includes people who have mental illness to guide and inform the process of examining each service for its ability to facilitate recovery.

A service delivery model that promotes recovery must be sensitive to the unique needs and circumstances of each individual it serves. It must be accessible, providing effective treatment that respects the whole person.

### *Bio-Psycho-Social Intervention Model*

The bio-psycho-social model recognizes and addresses the biological, psychological and social aspects of illness and disability.

The most serious and typically persistent mental illnesses are biological in origin and require medical intervention. Frequently, the disabling effects of the illness are seriously complicated by social factors such as unemployment, poverty, trauma and inadequate housing. These place people at increased risk for accompanying medical conditions, such as substance misuse and communicable diseases, including HIV.

“Lack of gender sensitive services causes the majority of mentally ill women to stay either isolated or to accept services which do not address their needs.”

- Mental Patients' Association

### *Services and Planning that Address the Needs of Women*

While both women and men with mental illness share many common experiences related to their illness, mental health programs need to acknowledge the fundamental differences in women's and men's experiences. These differences are reflected both in patterns of service utilization and in the life experiences of consumers. To meaningfully acknowledge these differences will require a shift away from gender neutral service and system planning, thereby planning services according to individuals' needs. This key service principle will benefit all mental health consumers. Mental health services will better serve women with mental illness when:

- services are planned and evaluated with the involvement of women consumers and allied women's agencies;
- services and planning recognize consumers' diversity in terms of ethno-cultural ancestry, aboriginal heritage, age and sexual orientation;
- the impact of trauma / violence in the course of mental illness is acknowledged;
- services sensitively and respectfully address issues related to sexuality, pregnancy and parenting;
- the benefits of women-centred services are recognized, including housing and therapeutic settings, where a woman's privacy, security and social support needs may be better addressed;
- the distinctive ways in which women experience dual conditions of mental illness and substance abuse are appropriately addressed;
- the particular needs of women with mental illness who have been in conflict with the law are sensitively and appropriately considered in planning; and
- appropriate primary medical care is accessible for all aspects of physical health.



“ We need to think about consumers in a holistic way and to consider their social, personal and family histories and needs. ”

- Chatterbox Mental Health Advisory, Salmon Arm

### *Services and Planning that Respond to the Cultural Diversity of Communities*

The planning and delivery of mental health services need to be culturally appropriate for the communities in which they are based. Service providers need to be sensitive to and representative of their communities' composition and service strategies need to respond in a manner that is appropriate for the values and beliefs of community members, including those who are of aboriginal or other non-European ancestry.

Services also need to support the improved coordination of interjurisdictional (federal, provincial and aboriginal governments) policy development and service provision that will promote access to quality mental health care across reserve boundaries for First Nations people and for those who are living off reserve.

## **4.2 Early Identification and Intervention**

The services individuals receive during their first episodes of mental illness are critical to the way they respond to and deal with subsequent periods of illness. Early recognition of symptoms, respectful provision of the most effective treatments, appropriate support and follow up and timely access to accurate information all improve the likelihood that the individual will experience minimal secondary disability and associated handicaps and will, therefore, be able to achieve a higher quality of life in the long term.

The Ministry will work with other ministries to support the development of policies related to the early identification and response to potentially serious mental health problems.

The Ministry will work with health authorities to develop protocols with other health and social agencies, schools and other public services to support the early identification of potentially serious mental health problems.

“ This disease/illness (schizophrenia) has torn apart my family and leaves me heartbroken and very worried about my mother's future.... ”

- *Families Sharing the Caring*, Task Force Report, 1993

### 4.3 Treatment

Psychiatric diagnosis and treatment are core elements of mental health care. The three primary therapeutic agents for the treatment of mental illness are medication; psychotherapy, of which there are many forms; and various kinds of social supports. The objectives of mental health services are to:

- accurately diagnose the individual's illness;
- comprehensively assess the person's needs; and
- develop an appropriate and flexible therapeutic plan that will effectively treat or manage the individual's disorder and improve health and well being.

For acute phases of major mental illness, such as schizophrenia, bipolar disorder and major depression, medical intervention is critical for stabilizing the individual. Accurate diagnosis and appropriate medication are essential elements of intervention in the acute phase. Once the patient is stabilized, to prevent future relapse and long-term deterioration, it is vital the care system support the person to remain in treatment.

Treatment will be provided using a multi-disciplinary model of care, within a bio-psycho-social service model. Mental health professionals will provide the care and treatment consistent with evidence-based practice guidelines.

Particular attention is required in diagnosing people with mental illness who also have substance misuse issues, as the two conditions are interactive and will, therefore, profoundly influence the choice of appropriate treatment.



|||  
...access to regional beds is extremely difficult.  
Reliance on 'squeaky wheel' access is not conducive  
to effective care and places all involved at risk. |||

- Linda Coles, CEO, Kitimat General Hospital

For many people with mental illness, their general practitioner is the primary provider of treatment. The Ministry will ensure a service delivery model and continuing education in treating mental illness that builds upon the current knowledge and skills of all professionals, including general practitioners.

#### **4.4 Acute Psychiatric Care**

Due to the nature of mental illness, inadequate support and, for some, an unwillingness to continue medication, many individuals experience episodic periods of acute illness. There is, therefore, a need to ensure quick and responsive access to acute psychiatric care in hospital when community treatment alternatives are no longer sufficient. The purpose of a hospital psychiatric inpatient unit is to provide care, supervision and control within a medical environment for the purpose of treatment. This level of care is a key component of an integrated, comprehensive regional mental health system.

The Ministry will work with health authorities to ensure that every region in the province has, as a minimum, an appropriate secure room and protocols to coordinate emergency room staff with a mental health worker, as part of first line intervention. The Ministry will also ensure that every region has access to regional or cross-regional referral resources for individuals whose treatment requires specialized resources.

#### **4.5 Treatment and Housing Continuum**

Safe and appropriate accommodation is a basic issue for people with serious mental illness. Some people require housing with on-site treatment and care. Many others prefer and are able to live with lower levels of support in more independent settings. Without adequate housing, recovery and maintenance of mental health is not possible.

“The “Seven Sisters” project...will be particularly sensitive to First Nations needs....This will be reflected in building design, programming and staffing.”

- Northwest Regional Mental Health Advisory Committee on proposed Riverview replacement facility

### *Regionally Integrated, Community-Based Tertiary Care*

Some individuals have such severe or complex illnesses that community and acute care services are unable to effectively care for them. Care for such individuals has historically been provided by Riverview Hospital. The planned care model will have these specialized services provided in relatively small regional and community facilities, designated under the *Mental Health Act*, and integrated closely with other regional mental health care services.

The Ministry and health authorities will develop regional and/or community-based tertiary care, consistent with planning that has already occurred related to the replacement of specialized capacity of Riverview Hospital.

### *Supported Housing*

Decent and affordable housing options are a fundamental component of community care. Many people with mental illness prefer supported housing, where they can live independently with a range of flexible support services that are appropriate to their degree of disability. Services are needed to monitor individuals' well-being and to support the development and maintenance of skills that are essential for successful daily living, including personal care, home management, relationship building and accessing community resources. For these to succeed, effective communication and protocols need to be developed and maintained among the consumer, family, support staff and the mental health centre case manager. A provincial housing partnership, which has been recognized as a best practice model, and is being expanded involves the Ministry of Health and Ministry Responsible for Seniors, Ministry of Municipal Affairs and Housing, BC Housing, non-profit housing societies and the co-operative housing sector. The partnership was established to support increased availability to ensure decent, affordable housing and appropriate support services for people with mental illness.

“What is needed is more street outreach workers...to refer women to local services and resources, provide one-on-one support, peer counselling, crisis/suicide intervention....”

- *The Place to Start: Women's Health Care Priorities in Vancouver's Downtown Eastside, Core Women Care*

#### 4.6 Responsive Outreach Service Approach

A responsive outreach service approach is intended to actively engage clients within their familiar environments and provide the services necessary to maintain optimal health. Key features include:

- care provided where the client is, rather than being clinic-based;
- emphasis on early intervention; and
- in-home assessment and treatment, wherever possible.

The Ministry will work with health authorities to ensure, where practical, the development of an outreach capacity that is available 24 hours/seven days a week as a part of the regional service continuum.

#### 4.7 Case Management/Assertive Community Treatment

The team case management approach has consistently been shown to be effective in reducing re-hospitalization, resulting in better health outcomes for people with serious mental illness. Case management is a process that addresses the multiple aspects of a person's life which impact on his/her health and well-being. Care is typically taken to the location of the client rather than being clinic based. Clients who have histories of repeated hospitalizations respond well to an intensive case management approach as they are monitored to ensure medication compliance and other aspects of clinical treatment, which generally enables them to enjoy a higher quality of life through participation in activities including employment or supportive employment and access to a larger number of social relationships.

The Ministry will work with health authorities to ensure that a variety of case management approaches are available, including case management for individual support and rehabilitation and assertive community treatment services for individuals who require intensive support.

“ It would have been beneficial if the emergency room medical personnel had obtained collateral information from other care providers.... ”

- BC Coroners Service Inquiry, March 1997

#### **4.8 Crisis Response/Emergency Services**

**C**risis response and emergency services must be in place to help people resolve crises with options that respect their circumstances and capacity for self-determination. These services include crisis lines, crisis response teams, hospital diversion/rapid return to hospital programs, community or hospital-based day and evening programs and emergency/short stay residential facilities.

The Ministry will work with health authorities to ensure that a variety of appropriate designated and non-designated (as provincial mental health facilities are under the *Mental Health Act*) response and emergency services, including hospital emergency services, are available to promptly assist individuals when they need urgent help.

#### **4.9 Consumer/Family Involvement**

**B**ritish Columbia has taken a lead role in recognizing the value of involving people with mental illness and family members as active participants in reforming and improving the mental health care system. The wisdom and experiences of those who use mental health services is improving care delivery for people with mental illness, their families and their communities. The involvement of consumers and families is a core value underlying mental health reform; it needs to be a key feature of regional/community mental health systems.

The Ministry will work with health authorities to ensure that mental health consumers, family members and caregivers in each region are involved in mental health services planning, delivery, management, evaluation and reform.

The Ministry will work with health authorities to ensure the participation of mental health advisory committees and the availability of a range of consumer and family initiatives which support involvement, information, education, training, self-help, mutual aid and peer support programs.

|||  
...clients who receive long-term support keep their  
jobs longer.... |||

- *Best Practices in Mental Health Reform, Discussion Paper, 1997*

#### **4.10 Vocational/Educational/Personal Life/ Leisure/Rehabilitation Continuum**

**A** comprehensive psycho-social rehabilitation program provides a range of personalized services, advocacy and community education that address needs related to personal life, leisure, education and vocation. Services that focus on personal life are directed towards assisting the individual to gain or regain practical skills in the areas of personal care, home management, relationships and the use of community resources. Leisure plays an important role in both the maintenance and restoration of health. Choices of leisure opportunities need to be available.

Educational services and supports make it possible for individuals to determine their educational goals and undertake educational programs of their choice. Vocational services are those that support participation in a workforce, including the development of work skills and habits, opportunities for volunteer work, work experience, supported employment and coaching and mentoring to help maintain individual's employment.

The Ministry will work with health authorities to develop psycho-social rehabilitation services that assist individuals to live with the greatest level of independence, consistent with their capacities, through participation in events and activities with others and management of their lives in ways that respect individual choices.

In keeping with psycho-social rehabilitation objectives, and with the principle of community integration, health authorities are encouraged, wherever feasible, to use mainstream educational, recreational, skills training and employment services.

“ **A** common language, portable data base and standardized comprehensive assessments will go a long way to enhancing integration and coordination.... ”

- Werner J. Pankratz, Chief, Department of Psychiatry, Lions Gate Hospital

#### **4.11 Support for Families and Other Unpaid Caregivers**

For many people with mental illness, family members provide most of their care. The majority of caregiving is provided by women. Families will be supported in their caregiving roles by ensuring they have current information about the mental illness affecting their relative and will have access to improved respite care.

The Ministry will work with regions to implement policies so that families are supported and involved - where this is consistent with quality care - in their relatives' treatment planning, maintenance and rehabilitation.

#### **4.12 Quality On-Line Management Information System**

The Ministry will support the development of a provincial, consumer-centred, outcome focused information system which:

- is an integrated health records system supporting appropriate and timely case management across care providers for follow up evaluation, research and quality improvement initiatives;
- provides sufficient information regarding service utilization to support decision making, including planning, funding and managing the care system; and
- in compliance with the *Freedom of Information and Privacy Act*, safeguards the privacy of individuals and their records.

The Ministry will immediately support appropriate provider access to the Client Patient Information Management (CPIM) system.



“ It is essential that education be aware of the changing nature of work expectations in order that programs can be reviewed and revised to meet field needs. ”

- Douglas College, Department of Psychiatric Nursing

### 4.13 Education, Research and Training

An education program, designed to meet the information and knowledge requirements of general practitioners, teachers and post secondary instructors, school counsellors, clergy, community centre coordinators and property managers is required to foster better awareness, understanding and response to mental illness in adolescents and adults. The program will focus on improving people’s understanding of mental illness and knowledge of available treatments and services.

The Ministry will work with health authorities, in partnership with consumers, families and advocates, to provide public education in communities.

Continuing education is essential for health care professionals and the full range of care and service providers to ensure they have current knowledge of clinical best practices, appropriate policy and applicable legislation and guidelines. Health authorities are responsible for the provision of continuing education for mental health staff.

To ensure advances in mental health care are promoted, effective treatment practices must be encouraged and innovative therapies evaluated. The Ministry will establish partnerships with universities to establish outcome research and evaluation capacity that is sensitive to, and in some cases focused on, designated populations (women, seniors, aboriginal people, people with multiple health risks and members of minority ethno-cultural groups). These partnerships will also provide a forum for the promotion of best practice models.

Similarly, the Ministry will work with health authorities to support the development of multi-disciplinary education programs for professionals in the area of community psychiatry.

## 5.0 ACCOUNTABILITY



One of the principal activities in achieving accountability is measurement. What the mental health system chooses to measure reflects the established health system priorities, communicates its values and expected outcomes and assists in planning service delivery.

### 5.1 Ministry Accountability Framework

The Ministry of Health is currently developing an accountability framework for British Columbia's health system which will reflect an integrated approach to health care delivery. The accountability framework will contribute to a shared understanding of health system stewardship and will assist the health sector to develop an approach that can be used to determine whether a component of the system, an organization or program is performing well and in alignment with specific goals and objectives.

The proposed framework involves four sequential processes, linked in a recurring cycle of planning, allocation, reporting, evaluation and adjustment or realignment of objectives.

The Ministry will develop policies, standards and performance measures that will establish performance expectations for health authorities and address the Ministry's accountability requirements.

“ **R**eliable valid evaluation cannot be done without clear, measurable behavioral objectives, that is: expected outcomes. ”

- Myrtle Macdonald, member, Provincial Mental Health Family Advisory Council, Chilliwack

## **5.2 Utilization Management**

The objective of utilization management is to determine whether the appropriate services are being provided at the right time to the people who most require them. Utilization management overlaps with other management activities, including outcome evaluation, information management and continuous quality improvement and is applicable to the entire range of health interventions, from prevention to treatment to rehabilitation. Population growth, aging, service frequency, patient care levels, technological and treatment changes are factors considered in determining appropriate and achievable utilization targets within available resources. Health care decisions are based on evidence of effectiveness, efficiency and appropriateness.

The Ministry will work with health authorities to develop effective utilization management activities for mental health services. Resource material and consultation will be available. The Ministry will work with regions in developing utilization management committees to improve resource management.

## **5.3 Joint Monitoring of Standards and Outcomes**

The Ministry and the health authorities will be developing outcome indicators and measuring outcomes at the individual, program and regional level. Data collected at these three levels will be used to establish performance standards for the mental health system, assess the effectiveness of services and identify areas requiring improvement.

At the individual level, clinical and functional outcomes that include client satisfaction with the care provided will be measured. At the program level, outcome measures will assess how effective and efficient a particular program is in carrying out its objectives and in sustaining

“ **P**riorities should be established with regional input and the unique characteristics of each region should be considered. ”

- Fraser Valley Health Region

coordination with other activities and programs. At the system level, the performance of clients, hospitals and programs and health outcomes for clients is measured to determine how the system is performing. To improve effectiveness and efficiency, consumers, family members and major stakeholders will be involved in reviewing outcomes at all levels.

#### **5.4 Complaints Management Process**

The Ministry will work with health authorities to implement a complaints management process. Communication about the process will describe the location and level at which complaints will be lodged and the expected review process and timing for response. Protections to guard against retribution, false accusations and frivolous complaints will be developed. The complaints process will be monitored for effectiveness, efficiency and responsiveness.

#### **5.5 Accreditation**

The Ministry will encourage third-party accreditation for regional mental health services to ensure consistent, high quality services across the province. Accreditation assures the public that a mental health service meets generally accepted standards set by government, consumers and families, providers and the mental health system. Recent testing of the standards of two accrediting organizations on 10 mental health pilot sites, through the Canadian Council for Health Services Accreditation and the Commission on Accreditation of Rehabilitation Facilities, has confirmed that accreditation will improve and validate the value and quality of programs.

The Ministry will seek a shared understanding with health authorities on the development of accreditation requirements and selection of accrediting organizations.

“ Treatment interventions (such as income support and housing) are...important...however, without medical diagnosis and treatment, (they) will, in the long term, fail. ”

- British Columbia Medical Association

## 5.6 Service Model Research

Historically, mental health services in British Columbia have not been systematically evaluated. Evaluative research is required to determine the relative effectiveness and value of different clinical approaches and service models. The Ministry will work with British Columbia's universities to develop an independent applied research capacity to conduct service model research. The Ministry will work with health authorities to ensure that new service models are evaluated as they are developed.



## 6.0 HUMAN RESOURCE FRAMEWORK



The staff involved in delivering mental health services ultimately determine the quality of care provided. The success of mental health service strategies depends upon an adequate availability of knowledgeable, motivated and skilled people to work with people with mental illness.

**H**uman resource planning is a formal process designed to ensure an adequate supply of competent personnel necessary to deliver programs. It is intended to:

- provide a framework to guide strategic decision making regarding program needs and human resource allocation;
- assess future conditions likely to affect relative supply and demand for different types of skilled human resources capacities (e.g. nurses, physicians, psychologists, social workers, home support workers);
- match human resource requirements with organizational goals; and
- achieve the most effective use of relatively scarce, specialized personnel.

“With enlightened program managers and appropriate opportunities for training, hospital clinical and support staff can become excellent community workers.”

- *Best Practices in Mental Health Reform, Discussion Paper, 1997*

## 6.1 Human Resources Plan

Although significant progress has been made in staffing the mental health care system, more clinical staff are required to provide programs that effectively reach those who are seriously ill and require individualized services (for example, intensive case management and outreach).

In conjunction with the local health authorities and other branches of government, the Ministry will:

- sponsor a dialogue with employer associations to address the supply and utilization of skilled mental health personnel across health services;
- develop a coordinated strategy to ensure that staff with specialized mental health/psychiatric expertise are available to those individuals in need; and
- sustain a labor adjustment strategy which will provide continuity of employment for existing Riverview Hospital staff by providing placement opportunities in newly developing replacement facilities or community settings.



## 7.0 FISCAL FRAMEWORK



### 7.1 Specified, Protected Mental Health Funding Envelope

In keeping with best practices and what has been learned from the experiences of other jurisdictions, the Ministry will set policies that define the scope and conditions for a comprehensive mental health services funding envelope.

### 7.2 Resources to Complete the Mental Health Initiative

In 1996, the Provincial Mental Health Advisory Council Working Group recommended that \$34 million be invested in the community mental health system for emergency response services, housing, community clinical staff, rehabilitation programs and other services.

A preliminary review of existing services indicates that the proposed increase would not bring services up to the current provincial planning guidelines in all regions. The planning guidelines have been developed and validated based on experience in other jurisdictions and substantiated in some areas by British Columbia's experience.

In order to ensure that sufficient resources are committed to enable successful completion of mental health reform, a fiscal plan has been developed to support implementation over a seven-year period.

#### *Housing*

Housing is the single highest priority for service for people with serious mental illness. Resources are required to provide up to 2,600 supported independent living units. Under the terms of an established agreement, the shelter component for these units will be administered by BC Housing Management Commission, while the care component will be provided through health authorities.



“**M**y son...once said to me that 'no one cares about crazy people like Dad and I.' This was a very heartaching statement from a boy who was only 14 years old.”

- Maureen E. Fantillo, New Westminster

### *Case Management*

Resources are required to provide intensive or assertive case management at a 20-to-one caseload for up to 8,200 clients with serious and persistent mental illness. Intensive support is necessary to enable these individuals to live successfully in the community and limit their need for re-hospitalization. Assertive case management will provide care for many individuals not receiving services because they are unable or unwilling to attend community clinics and who tend to have repeated hospitalizations.

### *Respite Care /Support for Family Caregivers*

Resources are required to provide respite care and education for 12,000 British Columbia families caring for a relative with mental illness. Frequently, the family caregiver is without significant support from others. When the caregiver has a medical emergency or otherwise “burns out” from care responsibilities, both the caregiver and client may end up in care.

### *Crisis Services*

Resources are required for the establishment or expansion of hospital diversion and after hours crisis services in 30 communities with acute hospital psychiatric units. This would provide for clinicians to respond to crises after normal clinic hours, assess people in acute phases of mental illness, ensure that they are connected to appropriate care and work closely with other emergency and police services.

### *Day and Evening Hospital Programs*

Resources are required to expand day and evening hospital programs at 30 acute hospitals. These programs would provide a full range of services annually to 1,800 clients temporarily requiring more intensive intervention than community programs generally provide without

“ **B**ritish Columbia has enough psychiatrists overall. However, significant problems exist with their geographic distribution in the province.... ”

- Auditor General Value-for-Money Audits 1993/94, Psychiatrist Services

requiring clients' overnight hospitalization. Day and evening programs have proven to be a viable alternative to inpatient care, both as a substitute or as a follow-up after early discharge.

### *Community Emergency Care Beds*

Resources are required to increase the availability of emergency / acute non-hospital beds. These new beds, which may be designated under the *Mental Health Act*, will improve the flow of clients through acute services now operating beyond capacity. The additional beds will assist in reducing the number of individuals being kept in emergency rooms for lengthy periods.

### *Additional Psychiatry Sessions*

Resources are required to raise the level of community psychiatry or program-based physician services to the standard currently provided in Vancouver / Richmond. The current allocation of physician sessions has been based on historic patterns of psychiatrist availability. These are neither appropriate nor sufficient.

### *Physician Training*

Resources are required for the training of general practitioners in underserved areas. Training programs will improve general practitioners' effectiveness in recognizing and effectively treating individuals with mental illness. Because recruiting sufficient numbers of psychiatrists to rural communities is a challenge, providing adequate training and support to general practitioners is key to ensuring that effective diagnosis and treatment of mental illness is made available in all communities.



“ To assist in the transition...additional community resources and replacement services, and...psychiatry capacity (prior to tertiary/acute reductions would help). ”

- Simon Fraser Health Region

### *Demographic Adjustment to Tertiary Care*

Resources are required to operationalize 113 additional tertiary beds due to population growth. Functional planning has been based on British Columbia's expected population in 2001. Resources are also needed to provide the additional funding that will be required for the operation of smaller scale facilities. These facilities have proven to be effective in the treatment and rehabilitation of individuals with very serious mental illness. Because of a loss of economies of scale, small facilities cost more to operate.

### *Transitional Funding*

A commitment to one-time transitional funding is required to operate the new tertiary facilities for up to one year before the corresponding Riverview Hospital capacity is reduced.

### *Residential Care for Specialized Care Needs*

Resources are required to increase the allocation for residential facilities for a small group of people with severe neuropsychiatric disorders and very challenging behaviors. Many of this group now receive care at Riverview Hospital, but their care entails a commitment of resources, which will require augmentation in community care settings.

### *Specialized Psychiatry Services for Women*

Resources are required for a specialized program of training and consultation to improve the quality of care provided to women with serious mental illness associated with or related to pregnancy and pre- and post-partum care planning. This is an under-recognized service component that addresses an important medical issue for women with mental illness.

It will be complemented by related policy and service coordination between the Ministry of Health and the Ministry for Children and Families.

“ Consumers and families have consistently identified the need for rehab programs, which promote opportunities for training and possible return to work as central to recovery. ”

- Greater Vancouver Mental Health Service Society

### *Rehabilitation Services*

Once basic housing and clinical needs have been addressed, rehabilitation services are an essential component of individuals’ recovery process. Resources are required to expand the rehabilitation capacity of current mental health services. Up to 750 half-time spaces in therapeutic and supported employment spaces are also included in the plan.

### *Demographic Increases*

Resource adjustments to accommodate demographic changes are essential to maintain the mental health care system's capacity. The mental health community is vigilant about service erosion due to unfunded inflation and demographics.

### *Provincial Mental Health Advocate*

A commitment is required to support the establishment of a Provincial Mental Health Advocate. The advocate will monitor the performance of the total mental health care system and provide systemic advocacy where elements of the system are not operating effectively for people with serious mental illness.

## **7.3 Capital Funding for Community-Based Tertiary Care and Specialized Housing**

The replacement process for Riverview Hospital has now determined that planning and facility acquisition is required for 663 community-based tertiary treatment beds, including secure care, in regional and community facilities. Required as well are community residential facilities and acute/ crisis facilities, built over the next seven years.

|||  
(Seven Oaks') client-centred approach and efforts to integrate services with community agencies and residents' significant others are worthy of special mention. |||

- Canadian Council on Health Services Accreditation

One of the key principles of the Riverview Hospital replacement project is that community-based, specialized tertiary care will be developed, where practical, using existing or purpose-built facilities at the lowest practical capital costs, consistent with licensing standards and security requirements to provide quality care.

Cost estimates range from \$110,000 annually per bed for community residential and crisis facilities up to \$260,000 per bed for community-based tertiary care facilities such as Seven Oaks\*. This compares with \$283,000 in large, institutionally-based settings.

#### 7.4 Transition Funding

Most other jurisdictions outside of British Columbia have not fully developed and operated an adequate, regionally integrated mental health system prior to the closure of psychiatric hospital beds.

As well as capital and operating funds, transitional operating funds that enable the operation of new facilities for a period of time before the old facilities close are critical to ensure that there is no service gap in the transfer of patients to community-based, less institutional, tertiary care.

\*Seven Oaks is a 12-bed community-based tertiary facility in Victoria. It is the first Riverview Hospital tertiary-level replacement facility and has successfully provided care for some former Riverview patients with relatively high care needs.

## 8.0 PLANNING, IMPLEMENTATION AND REVIEW OF THE MENTAL HEALTH PLAN



### 8.1 Ministry Responsibility for Planning, Implementation and Reporting

The Ministry will lead the development of an implementation plan to rebalance and revitalize the mental health care system based on government approval of this plan. In partnership with the Provincial Mental Health Advisory Council and the advice of the Provincial Mental Health Advocate, the Ministry will establish a process to periodically review the progress of the implementation, to report on that progress and to adjust the strategy based on progress and outcomes.

### 8.2 Activities Related to Transition towards Regional Self Sufficiency

The plan foresees a series of activities and phases necessary for transition to relatively self sufficient regional mental health care systems:

- establishment of a mechanism for working with health authorities for the implementation of best practices and other service strategies related to mental health reform;
- the integration of Riverview Hospital and Forensic Psychiatric Institute services;
- the transfer of planning for replacing Riverview Hospital geriatric division services and Riverview Hospital neuropsychiatry division services to Acute and Continuing Care Programs (Ministry of Health and Ministry Responsible for Seniors), in consultation with the Adult Mental Health Division;
- the replacement of Riverview Hospital with a series of smaller regional and community facilities; and
- the closure of Riverview Hospital in about seven years, following the complete development and operation of regionally integrated, community-based specialized care facilities (which, in the case of the Lower Mainland, could be situated on a portion of the existing Riverview Hospital land, but will not be in a large facility).

“  
...this mental health plan must be regarded not as an accomplished end, but as a fountain from which flows a developing process.”

- John Forsyth, Hazelton

### 8.3 Periodic Review and Revision of Mental Health Plan

The Ministry will:

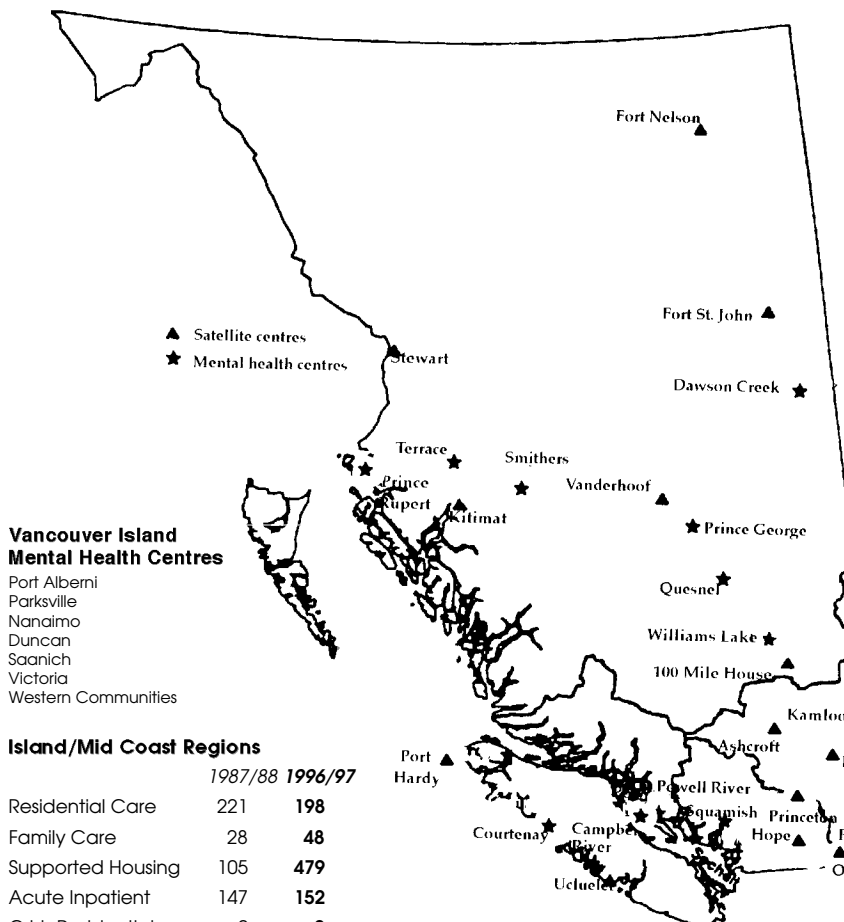
- partner with regional authorities, consumers, families and providers to continually monitor the performance of the mental health care system;
- utilize a provincial client-centred information system for:
  - clinical support,
  - utilization management,
  - outcome evaluation, and
  - system performance evaluation;
- report annually to the legislature through the annual report on the status of the Riverview Hospital Replacement and re-investment project;
- report every two years on progress towards achievement of vision and outcomes;
- update the Mental Health Plan periodically; and,
- account for the performance of the mental health care system utilizing:
  - the Ministry of Health accountability framework,
  - the Provincial Mental Health Advisory Council, and
  - the Provincial Mental Health Advocate for British Columbia.

# *Appendices*



# BED DEVELOPMENT 1987/88 TO 1996/97

(WITH PLANNED TERTIARY BEDS)



## Vancouver Island Mental Health Centres

- Port Alberni
- Parksville
- Nanaimo
- Duncan
- Saanich
- Victoria
- Western Communities

## Island/Mid Coast Regions

	1987/88	1996/97
Residential Care	221	198
Family Care	28	48
Supported Housing	105	479
Acute Inpatient	147	152
Crisis Residential	0	2
Emergency Shelter	0	46

<b>Tertiary</b>	100*	116**
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(12 in place)

## Lower Mainland Mental Health Centres

- Abbotsford
- Burnaby
- Chilliwack
- Delta
- Langley
- Maple Ridge
- Mission
- New Westminster
- North Shore
- Sunshine Coast
- Surrey Central
- Surrey North
- Tri-Cities
- White Rock/South Surrey

## Satellite Centres

- South Delta

## Lower Mainland Regions

	1987/88	1996/97
Residential Care	1,180	1,253
Family Care	51	46
Supported Housing	174	1,528
Acute Inpatient	403	407
Riverview Hospital	1,220	808
Crisis Residential	10	48
Emergency Shelter	70	80

<b>Tertiary</b>	300*	376**
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## North Regions

	1987/88	1996/97
Residential Care	16	27
Family Care	17	10
Supported Housing	0	91
Acute Inpatient	50	54
Crisis Residential	0	17
Emergency Shelter	0	6

<b>Tertiary</b>	50*	54**
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## Interior Regions

	1987/88	1996/97
Residential Care	316	277
Family Care	37	54
Supported Housing	0	254
Acute Inpatient	125	104
Crisis Residential	0	16
Emergency Shelter	0	0

<b>Tertiary</b>	100*	117**
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\*Tertiary, or specialized long-term care, beds planned according to the 1987 initiative to replace Riverview Hospital (approved in 1990/begun in 1992).

\*\*Tertiary beds in planning during 1996/97 and approved in the 1998 mental health plan. These beds will be developed for 2006.

Note: Additional housing requirements identified in the 1998 mental health plan will include 2,600 supported housing units and 35 emergency care beds (in addition to those represented in tables).

# PSYCHIATRIC FACILITIES/UNITS



*The following facilities are designated as Provincial mental health facilities under Section 3 (1) of the Mental Health Act:*

- Burnaby Psychiatric Services, Burnaby
- Forensic Psychiatric Institute, Port Coquitlam
- Jack Ledger House, Victoria
- Juvenile Services to the Court, Inpatient Assessment Unit, Burnaby
- Regional Psychiatric Centre, Abbotsford
- Riverview Hospital, Port Coquitlam
- Seven Oaks Provincial Mental Health Facility (Victoria Mental Health Centre)
- The Maples Adolescent Treatment Centre, Burnaby
- Willow Clinic (Woodlands), New Westminster

*The following hospitals are designated as psychiatric units under Section 3 (2) of the Mental Health Act:*

- British Columbia's Children's Hospital, Vancouver
- Chilliwack General Hospital, Chilliwack
- Cowichan District Hospital, Duncan
- Cranbrook Regional Hospital, Cranbrook
- Dawson Creek and District Hospital, Dawson Creek
- Fort St. John General Hospital, Fort St. John
- Greater Victoria Hospital Society sites, Victoria
- Kelowna General Hospital, Kelowna
- Langley Memorial Hospital, Langley

- Lions Gate Hospital, North Vancouver
- Matsqui-Sumas-Abbotsford General Hospital, Abbotsford
- Mills Memorial Hospital, Terrace
- Nanaimo Regional Hospital, Nanaimo
- Peace Arch District Hospital, White Rock
- Penticton Regional Hospital, Penticton
- Powell River General Hospital, Powell River
- Prince George Regional Hospital, Prince George
- Prince Rupert Regional Hospital, Prince Rupert
- Richmond General Hospital, Richmond
- Ridge Meadows Hospital and Health Care Centre, Maple Ridge
- Royal Columbian Hospital, New Westminster
- Royal Inland Hospital, Kamloops
- St. Joseph's General Hospital, Comox
- St. Paul's Hospital, Vancouver
- St. Vincent's Hospital, Vancouver
- Surrey Memorial Hospital, Surrey
- Trail Regional Hospital, Trail
- Vancouver Hospital and Health Science Centre sites, Vancouver
- Vernon Jubilee Hospital, Vernon
- West Coast General Hospital, Port Alberni



The consultation document, *Developing a New Mental Health Plan*, was developed to focus input and solicit feedback on future directions for the mental health system.

It was developed in April/May 1997 by the Adult Mental Health Division, with the involvement of the British Columbia Schizophrenia Society; British Columbia Mental Health Society and Riverview Hospital; Canadian Mental Health Association; Mood Disorders Association of British Columbia; Provincial Mental Health Advisory Council; Provincial Mental Health Consumer Advisory Council; Provincial Mental Health Family Advisory Council and from the Ministry's Acute and Continuing Care Division, Clinical Services Unit and Planning and Evaluation Division. In May/June 1997, over 4,000 copies were distributed to agencies, groups and individuals. The provincial consultation was coordinated on a regional basis through the provincial advisory councils, Canadian Mental Health Association and the British Columbia Schizophrenia Society. More than 150 agencies and individuals responded. A list of consultation respondents is included on pages pages 75 to 79. Efforts have been made to accurately capture the dominant perspectives that were reflected in the responses.

## Vision, Mission, Mandate and Values

The majority of submissions suggested at least minor changes, generally additions, to the proposed vision, mission and mandate. These suggestions related to ensuring that people with mental illness are not abandoned or neglected; have a right to a timely and accurate psychiatric diagnosis and treatment; and that mental illness represents a diseased state of the human brain and not just disadvantaged social conditions.

" In the provincial mental health system of the future, mental health will be... an integral part of health, on par with physical health. Consumers, families and professionals will engage and lead their community mental health systems as partners.... "

- Draft vision statement,  
*Developing a New  
Mental Health Plan*

## Principles and Assumptions

Two sets of assumptions created the most controversy: the implied limitation of mental health services to the five per cent with the most serious mental illnesses (e.g. schizophrenia, bipolar disorder and clinical depression), thereby ignoring a higher number of individuals experiencing acute, and in some cases highly disabling, mental health problems; and assumptions related to the planning ratios for tertiary and acute psychiatry beds. The discussion related to the five per cent is expanded in the following section, *Target Populations*.

Some advocacy groups and a high proportion of stakeholders believe that the current ratios of tertiary and acute psychiatry beds for the population (15 acute beds per 100,000 persons and 22 tertiary beds per 100,000) are inadequate. This perspective is based on the observation that a fully resourced community care system is currently not in place and that planning needs to include beds necessary for treating children, youth and elderly people with mental illness. Others believe that with current pharmacology, other therapies and appropriate community development, it should be possible to reduce the need to use acute psychiatry and tertiary beds in the way that they are currently being used.

## Target Populations

The concept that mental health services should be prioritized or targeted to serve individuals with serious mental illnesses whose functional ability is most compromised had general support. Questions were raised about which diagnoses were included in the targeted five per cent figure (and included the term serious mental illness) and how individuals' functional ability would be measured. A few clinical respondents expressed concern that target populations should be identified by standard *Diagnostic and Statistical Manual of Mental Disorders* categories, both because this approach would dispel the illusion that people's conditions were purely social adjustment problems and to make it possible to do comparative analysis between demographic subgroups. Many others commented on the need to acknowledge and include individuals with other mental illnesses that pose serious medical risk and experience high levels of functional disability.

Most respondents felt that the way to reach a larger proportion of those with the most disabling mental illness was through outreach programs, assertive case management programs, new laws providing for community treatment orders, crisis response services, community education, peer support and friendlier, individually focused services.

Responses were varied regarding the responsibility of the mental health plan for the needs of the 25 to 30 per cent of the population, who, over time, have less disabling, treatable mental health problems. Concern was expressed that a broad focus on those with less disabling mental illness would compromise services to those most disabled by severe mental illness. Others expressed support for including the needs of the 25 to 30 per cent in the plan. Most respondents felt that it is necessary to assist individuals in the 25 to 30 per cent category, if only to prevent their conditions from becoming chronically disabling, through early detection and intervention and support with other existing or augmented services provided by a range of community agencies, general practitioners and others.

“ One of the worst offences in mental health is for the consumer to use I.V. drugs. Once it becomes known...all services begin closing down...rather than accepting the person for who they are and working with his/her needs. ”

- Mental health worker  
and family member

There were some suggestions that because of the multiple services that people with mental illness regularly access, the inclusion of a wide range of care and service providers (in addition to consumers and families) could lead to better utilization management and to better planning for the population served.

## Environmental Scan

“The historical lack of continuity between mental health and alcohol and drug services seems to be perpetuated and further divided on the basis of age.”

- Vancouver Hospital and Health Sciences Centre, Department of Psychiatry

There was widespread support for the use of contemporary information technology to support a province-wide client information and communication database system that would facilitate the timely exchange of clinical information, provided consumers'/patients' confidentiality was appropriately safeguarded. There was also support for public education through the media and the internet that would improve the public's access to accurate information about mental illness and would help to challenge negative stereotypes about people with mental illness which perpetuate stigma and social isolation.

A large number of respondents expressed frustration that new psychopharmaceuticals which demonstrate reduced side effects, increased compliance and potential reduced downstream costs, were not more readily available. A few respondents supported the use of alternative therapies in combination with the lowest drug dosages possible, consistent with effective care. The use of pilot studies to test new therapies and routine consideration of the experiences of other jurisdictions were supported.

A large number of respondents expressed support for significant service reform to implement new modes of support, specifically, shifting the patterns and styles of service from an office-based model to an outreach based community system with extended service hours. Providing alternatives to a purely hospital-based medical model of treatment, to one that recognizes the totality of individuals' circumstances, was commonly supported. Home based care was preferred by most, with recognition that some will require hospital based stabilization. Respondents supported

the strategy of focusing resources on front-end services that are accessible, accountable, responsive, give priority to individuals' greatest needs and concurrently provide care providers with adequate support and safety.

Strong support was expressed for the development of and broad adherence to evidence-based clinical standards, best practices, approved treatment protocols for specific disorders and other facets of outcome-oriented services. Respondents frequently expressed support for increasing the role of consumers and their families, in collaboration with support networks, in defining care needs and taking responsibility for their own care management (consistent with individuals' capacity and improved quality of life). Concern was expressed about the adequacy of support for families and other unpaid caregivers, who are predominantly women, and support requirements for those who are supporting the frail elderly with dementia.

### **System Management**

Strong support was expressed for integration of services, increased accountability, increased attention for individuals who have complex needs which are frequently difficult to address and who may be disinclined to access services, and improved relationships with other government agencies whose activities impact on the lives of people with mental illness. Those most frequently mentioned were the Ministry of Children and Families with respect to the need to maintain a coherent mental health system spanning all ages, plan for youth in transition and improve coordination between mental health and addictions services; Ministry of Municipal Affairs and Housing regarding the need for increased housing; Ministry of Human Resources regarding increased income support for people with mental illness; and the Ministry of the Attorney General regarding appropriate support and protocols before and after people with mental illness are in contact with police and the criminal justice system.

“...gender (the social experience of being a woman) is always a dynamic part of women's lives and thus, a woman's health, has to be examined from her perspective and her context.”

- Nancy Hall, Ph.D.,  
Chair, Minister's  
Advisory Council  
on Women's Health

“ Case management models and advocacy will be an integral part of increasing the coordination of service. Education to the community as a whole, as well as professionals, needs more emphasis so that clients receive the services they require in a timely fashion. ”

- **Central Vancouver Island Regional Health Board**

Concern was expressed that in many instances the structure of health care in rural and remote areas was not compatible with an integrated service structure. It was suggested that specific boards should be formed for the purpose of managing the full range of mental health needs from inpatient acute care through community services to support services such as housing, with a single administrative structure and single funding envelope.

Respondents noted that the existing system is not well organized and identified the following service elements necessary for the non-engaged population: mobile and flexible service strategies, outreach-oriented service models with extended hours, relevant services that are respectful of individuals' circumstances, increased service capacity and the legal authority to enforce treatment for those individuals who were too ill to make the choice whether to receive treatment. Greater education was highlighted as an area requiring further development. Education was identified as necessary for providing individuals and their families with accurate information about the symptoms of mental illness and the service options available, as well as necessary for a broader audience (i.e. the general public) to reduce stigma for those requiring treatment and to improve understanding about mental illness.

### **Progress in Mental Health Reform**

Mixed opinions were expressed regarding the number and configuration of beds for tertiary care and acute psychiatry. Although a majority of respondents felt that the planned tertiary beds should reflect population growth, possibly at a higher ratio of beds per 100,000 than current planning guidelines, a strong minority supported a more flexible approach based on service reform in the community, followed by needs assessment and a review of experience in other jurisdictions, preceding any decision on increasing the institutional infrastructure.



Many respondents were concerned about lack of access to acute hospital psychiatry beds, based on the fact that the alternative was referral to a regional centre or Riverview Hospital from their home communities and often this was not easily done. Some respondents expressed their concerns that many acute psychiatry beds are being used inappropriately due to inadequate community resources. Many noted that better utilization management and enhanced community services, including "step-down" and "step-up" facilities, could resolve some of the problems. Earlier intervention and adequately supported home care were cited as important alternatives that would reduce the need for acute psychiatry beds.

Coordination of services through community health centres (i.e. co-located public and mental health services) was supported by many respondents. Concerns were expressed about the concept of individualized consumer funding, for reasons related to cost effectiveness and unfamiliarity with the model. Intensive case management was seen as promising, particularly with low client ratios that permitted more than service brokerage functions.

There was overwhelming support for the increased availability of affordable, safe, secure and supportive housing for people with mental illness. A number of respondents identified the need for a provincial strategic housing plan. Respondents supported housing that encompasses a range of options that meet the unique needs of various consumer groups, with an emphasis on supported independence. Respondents identified as priorities the provision of highly specialized care such as services for people with organic brain syndrome and the development of care options for those who are typically hard to house because of their inability or unwillingness to comply with rules, their involvement with the criminal justice system or substance misuse issues. However, it was noted strongly that a continuum of housing alternatives cannot be a substitution for inpatient services necessary for stabilizing people with acute manifestations of serious mental illness.

“In many areas, community health centres are very accessible, offer a wide range of services and operate in a manner which is less threatening than many traditional health facilities....a 'store front' location operating within a subsidized housing complex will be more readily used by people with limited resources.”

- British Columbia  
Nurses Union

## Regional Mental Health Services

Respondents suggested that service integration be promoted through strong and active regional and local mental health advisory committees, clear policy direction from the Ministry, joint management of resources (among primary, secondary and tertiary) and streamlining individuals' entry into the care system. Once patients are ready to be discharged from inpatient psychiatric services, there must be community based services, especially housing, case management, medical follow up and rehabilitation available.

“There must also be a capacity within the regions to consistently stay up to date with new mental health service delivery developments, consult between regions, liaise provincially and ensure there is a policy base to produce (system-wide consistency), rather than pockets of excellence.”

- British Columbia  
Mental Health Society/  
Riverview Hospital

For smaller communities, a clear mandate and adequate resources to provide the full spectrum of primary and secondary services were seen as essential. In addition, there is a need for more training of primary care physicians, mental health staff (both those with professional designations, as well as community support staff), families and consumers.

Considerable interest was expressed in understanding how the Ministry of Health would work with health authorities regarding the implementation of policies related to mental health care reform.

It was clearly stated that the Ministry of Health should monitor disparities between regions, especially regarding access to acute and specialized care for people living in remote areas. There was mixed reaction to shifting resources between acute hospitals and community services. Most who supported a shift highlighted the need for transitional resources in order to develop community based alternatives before the closure of acute psychiatry beds. This was expressed by many Lower Mainland respondents who cautioned that the shortage of acute psychiatry beds should not be exacerbated by the closure of more beds.

## Mental Health Partners

A significant number of respondents identified the considerable role that ministries other than the Ministry of Health play in the lives of people with mental illness. Concerns about interministerial coordination were frequently mentioned.

A strong central policy role in the Ministry of Health was viewed as essential for interministry coordination. There was strong support for coordination through an inter-ministry committee, although some felt this approach had proven ineffective and that formal partnerships and written protocols were required.

Regional coordinating and inter-agency committees were identified as important by many respondents. Many expressed the view that a potent vehicle for effective coordination is an empowered case manager who can utilize resources from a variety of service providers and can work with and on behalf of a consumer without undue administrative interference.

## Core Services in a Comprehensive Mental Health Plan

There was strong support for the concept of best practices for core services including comprehensive assessment, timely access to psychiatric diagnosis and treatment and outcome oriented, evidence-based practice. It was recommended that the nationally recognized mental health practices be communicated through continuing education programs and by building these standards into accreditation processes.

“If change is to bring improvement, it must be targeted at the system's failures, and so avoid upsetting the system's successes.”

- Hassan Azim, MD,  
President, British Columbia  
Psychiatric Association

“We would like to see more explicit inclusion of relapse prevention as a guiding principle.”

- British Columbia Psychological Association

There was mixed reaction to the concept of providing higher levels of care in non-institutional settings. This reaction related primarily to concerns about the levels of resources that would be required to provide a similar quality of care that adequately provided for the safety of consumers and caregivers. In order for such an initiative to succeed, the availability of trained and skilled paraprofessionals, home care workers, as well as a range of nursing and clinical supports and prompt access to a hospital bed if required, were considered mandatory.

Early identification and intervention, as well as adequate crisis response and appropriate treatment, were identified as priorities with the potential to significantly reduce the degree of disability experienced by people with mental illness and to promote recovery. A single point of accountability for coordination of services and a continuous case management approach were supported. The importance of general practitioners and family physicians in primary care was emphasized by many. It was also mentioned that the dichotomy between hospital and community is frequently an artificial one.

The need for rehabilitation programs which promote opportunities for training and eventual employment, whenever possible, was identified as central to recovery. The need for other rehabilitation initiatives for those for whom work is not the primary goal, such as the elderly, was also noted.

The need to acknowledge the integral role of consumers and their families in the management of their own care, and in peer support and self-help groups that provide mutual care, was emphatically made throughout the responses. The need for consumers and their families to have meaningful input into decisions related to community supports and services, as well as the need to participate in broader systemic issues, was also widely supported.



The importance of decent, affordable housing and adequate income support were issues raised again and again throughout the responses. The lack of these supports was seen as a major contributor to the deterioration of individuals' conditions and frequency of mental health crises among people with serious mental illness.

## Specialized Services and Populations

There was mixed support for the use of existing services to better address the needs of groups who have specialized needs. Others felt that existing mental health teams should access special services, including cross disability and cross cultural agencies, to supplement their services.

Concern was expressed that the high number of individuals with mental illness in the criminal justice system was related to the lack of intervention and treatment in the mental health system. Timely and effective care and treatment, appropriate intervention for individuals, particularly when in a psychotic state, and the appropriate application of the *Mental Health Act* were seen as factors in better meeting the needs of this population. Some respondents assessed that, due to the unique set of skills required on the part of practitioners, the current forensic service structure should be maintained and separate facilities within the mental health system should be available for the rehabilitation of forensic clients.

Respondents expressed a need for better services for the population of individuals with head injuries.

A number of responses identified several groups that experience particular difficulty accessing care. Predominantly, these are individuals with complex needs who desire independence.

“Clients are afraid to accept their problem openly. If they accept their mental problem, they are scared it might affect immigration, jobs....”

- *Culturally Sensitive Mental Health Care: Communities Creating Change, Culture and Health 2000*

**"Mental health services need to acknowledge the belief system, whether religious or philosophical, of each individual and the role spirituality plays in support and recovery. "**

**- St. Joseph's Hospital**

Respondents identified the need for a shift in attitude from a system where individuals must comply behaviorally or face discharge from programs to a "no reject" system that flexibly responds to individuals' needs.

Reference was also made to the often poorly served needs of youth under 19 who are making the transition to the adult mental health system. Liaison with the Ministry for Children and Families is critical in order to ensure a successful transition.

There was substantial support for ensuring new and existing programs acknowledge the ways in which women's experience of mental illness differs from men's. Respondents highlighted the need to shift from a gender (and culturally) neutral mental health care system to one that considers the impact of trauma/ violence; issues related to parenting; benefits of female clinical staff and women-only housing; and one that acknowledges women's particular experiences of mental illness and substance abuse and criminal/justice systems.

A number of respondents identified concerns about the need for improved understanding, sensitivity and involvement of First Nations and other ethno-cultural groups within the mental health care system. The increasingly multicultural makeup of the province and the need to appropriately respond was highlighted by many respondents.



## Utilization Management

While there was strong support for system performance indicators that are related to clinical best practices, less value was placed on inter-regional comparisons, due to the differences in resource levels and program structures between regions. There was considerable support for jointly managed (i.e. primary, secondary and tertiary) resources with clear admission and discharge criteria at all levels from community to tertiary. Those with the greatest need were supported as priority for service; and, it was noted that people with serious, persistent mental illness are not necessarily always the patients with the greatest need. Access to inter-regional and provincial resources and information systems was considered important. Similarly, effective communication between service providers was identified as extremely important.

While there is general support for utilization management techniques to optimize use of resources, respondents pointed out that utilization management cannot be a substitute for an adequate supply of resources. There was some indication that more resources devoted to early identification and intervention would reduce the utilization of higher cost resources.

## Human Resources

The need for highly trained professional and associated staff and continuing education for all workers were seen as a key element in service reform. Respondents identified training and appropriate recognition of knowledge, skills and abilities, as well as awareness of cultural issues as critical attributes of qualified staff.

It was suggested that in addition to providers, consumers and families should be supported in their participation to act as advocates, educators and as members of care teams (e.g peer support, outreach).

“...housing should fit within a program which provides graduate, cascading levels of support and autonomy to enable clients to seamlessly flow into the community - without precipitous drops of support and assistance.”

- **The Elizabeth Fry Society of Greater Vancouver**



**" Better training of mental health workers is required around addictions, sexual abuse, multiple grief and loss and suicidal ideation, as well as increased willingness to address these issues.... "**

**- Association of First Nations Women**

There was support for a provincial staffing strategy for psychiatric services based on a system of incentives for psychiatrists, more training for general practitioners, more use of psychiatric outreach and expanded roles for trained psychiatric nurses and other mental health professionals.

A majority of respondents felt that both the tertiary plan and the regional service plans had to be considered in developing a mental health human resource plan, given the level of knowledge and skill that existing Riverview Hospital staff can provide in the regional tertiary facilities. Developing flexibility and wage parity across union jurisdictions was identified as necessary to promote the successful redeployment of staff.

### **Research and Education**

There was widespread support for research, including many respondents supporting the formation of a Provincial Mental Health Research Institute. It was suggested that health research funds should be allocated in proportion to direct health care costs or to prevalence, be gender and culturally sensitive and should not focus exclusively on psychopharmacology. Wide communication of findings was seen as important.

Two streams of education were identified as necessary. The first stream was general public education to help identify early signs of mental illness and to reduce stigma. The second stream was the emphasis of mental health issues in professional education and inservice education of all professions likely to have contact with individuals with mental illness, ranging from teachers and lawyers to general practitioners, nurses and social workers. It was felt that attendance in continuing/in-service education should be publicly funded to encourage participation. Consumers felt they should have input/participation in professional education to provide professionals with personal insight/experience.



## Evaluation and Quality Improvement

Support was virtually unanimous for evaluation initiatives that included external accreditation, performance monitoring, program evaluation and client outcomes and satisfaction. To achieve this end, recommendations touched on two main themes. The first was the need for clear goals and provincial standards, with standard evaluation criteria, common clinical indicators and outcome measurement based on quality of life measures, and symptom reduction.

The second theme was the need for a comprehensive provincial client-centred information system that would both provide a provincially accessible medical record and would provide management information and evaluation data. Support for the province-wide distribution of the information technology required to access this information network was requested.

Strong mention was made of the need to include front line staff in the quality improvement process. In addition, the role of consumers and families in ensuring that the services they receive are provided in a timely, courteous and helpful manner was frequently emphasized as essential to the evaluation process.

### The Fiscal Framework

The fiscal framework was developed in 1994 to guide the allocation of resources from Riverview Hospital to regions in order to fund the operating costs of tertiary replacement facilities and community service enhancements as the hospital's capacity was replaced.

Respondents, specifically those from outside the Lower Mainland, supported the continued adherence to the principles and financial targets of the fiscal framework.

Respondents generally supported the concept that changes to the mental health system, such as service reform and community service enhancement, must precede or parallel the Riverview replacement process.

“...elderly persons are not just "old adults". They have unique mental health needs that require the specialized knowledge and approaches of a number of disciplines and services.”

- BC Psychogeriatric Association

Mixed feelings were expressed regarding an expansion of tertiary care over an expansion of community care. Most respondents felt both tertiary and community development were required. A strong voice was raised for priority going to community supports such as continuous case management, housing and rehabilitation that would provide better up-front service to people before they get extremely ill, thereby alleviating the pressure on acute, and subsequently, tertiary beds.

“ ...British Columbia does indeed provide better services for individuals with serious mental illnesses than any of the states...I caution, however, that such praise has more to do with the poor quality of services in the US than it has to do with BC having achieved a level of excellence by any cosmic standards. ”

- Fuller Torrey, MD, US consultant on mental health services in letter to Ministry of Health following a 1993 visit/review

### **Completing the Initiative/Conclusion**

There was general support for implementation of the recommendations made in the Provincial Mental Health Advisory Council and British Columbia Mental Health Society working group's report on resource increases and strategic management shifts required before downsizing of Riverview Hospital resumed, but within the context of a detailed implementation plan that would provide clear direction for service reform, system change and targeting of new resources.

The small number of respondents that considered community residential care for people with neuropsychiatric illness were nearly unanimous that the proposed \$4.6 million was not sufficient.

There was no consensus on the topic of tertiary service governance, with support polarized between those who felt it should be regionalized and those that felt it should remain a separate society responsible for provincial tertiary mental health services, at least for the balance of the redevelopment period. There was strong comment that the sooner the decisions around governance of Riverview Hospital occurred, the better off the system and the patients it serves would be.

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There were very mixed reactions as to whether the document described the respondents' aspirations for the mental health system of the future. Some professionals did not feel it respected either their participation in the consultation process nor their concerns for a safe working environment. A number expressed concerns that the target population was too narrow or too broad. Many gave their support conditional on community resources being in place before any adjustments were made in the institutional sector.

**"** These are investments in future prosperity... as gifted people lose functionality, our society loses the fruits of their creative potential. **"**

- Consumer

Many responses supported the necessity of a Provincial Mental Health Advocate.

Effective communication between the Ministry, the regional health authorities, consumers and families and service providers, including front line workers, was seen as vital. Clear leadership from the Ministry and a plan that was a living document, with actions, timeliness, budgets and outcomes and responsiveness to changes in the environment were identified as essential to the process.

Responses emphasized that the strengths of the current mental health care system need to be built upon, including the existing pilot programs for assertive case management, good housing models, early diagnosis and stabilization programs, peer support and the considerable expertise that consumers, families and those who provide care and service to people with mental illness can offer.

**"** This is not a reform process that can be conducted in boardrooms, ministry offices or hospital hallways. Rather, it is a process that must be ultimately evaluated in a public manner on the streets of our communities, in public institutions and in partnership. **"**

- British Columbia  
Mental Health Society/  
Riverview Hospital



## LIST OF CONSULTATION RESPONDENTS



The Ministry of Health and Ministry Responsible for Seniors thanks the people of British Columbia who contributed to the development of the 1998 Mental Health Plan. Because many individuals' thoughts were included in organizations' submissions, it is not possible to recognize everyone.

Affiliation of Multicultural Societies and Service Agencies of BC  
Association of First Nations' Women  
BC Ambulance Service  
BC Association of Clinical Counsellors  
BC Association for Community Living  
BC Association of Specialized Victim Assistance and Counselling Programs  
BC Government and Service Employees' Union  
BC Government Managers' Association  
BC Housing  
BC Institute on Family Violence  
BC Medical Association  
BC Nurses' Union  
BC Psychological Association  
Dan Bilsker, Ph.D., Psychologist  
Dr. George Blevings, Regional Manager, Tri-Cities Mental Health Centre  
Dr. Charles R. Brasfield, University of British Columbia

British Columbia Mental Health Society  
British Columbia Psychiatric Association  
British Columbia Psychogeriatric Association  
British Columbia Schizophrenia Society  
*Nanaimo Branch*  
*Provincial Office*  
*Kootenays Branch*  
Michael Butler, Victoria  
Canadian Association of Anorexia Nervosa and Associated Disorders  
Canadian Mental Health Association  
*BC Division*  
*Consumer Development Project, Kelowna Branch*  
*Consumer Development Project, Vernon Branch*  
*Dawson Creek Branch*  
*Delta Branch*  
*Duncan and Nanaimo Branch*  
*Victoria Branch*  
*White Rock/South Surrey Branch*  
Capital Mental Health Advisory Committee  
Capital Mental Health Association  
Cariboo Community Health Service Society  
Capital Region Mental Health Advisory Committee  
Cariboo Region Mental Health Consumer and Family Council  
Central Okanagan Mental Health Advisory Committee  
Central Vancouver Island Regional Health Board  
Chatterbox Mental Health Advisory, Salmon Arm  
Chilcotin Mental Health Advisory Committee  
Citizens Counselling Centre  
Cooperative Organization of University Teaching Hospitals, Psychiatry Group  
Courtenay Mental Health Centre, Adult Community Support Team  
Dease River Band Council, Good Hope Lake  
Donna DeLange, Duncan  
Dr. Paul Devlin, President, Medical Staff, Riverview Hospital  
Anne Dewar, Sunshine Coast Family Advisory Group  
Richard and Peggy Dolman, White Rock

Douglas College  
The Elizabeth Fry Society of Greater Vancouver  
D. Evans, Capital Health Region  
Maureen E. Fantillo, New Westminster  
Feminist Research, Education, Development and Action Centre  
Dr. Patricia Fisher, Clinical and Consulting Psychologist  
Forensic Psychiatric Services  
John Forsyth, Hazelton  
Fort St. John Mental Health Advisory Committee  
Fraser Valley Health Region  
Fraser Valley Mental Health Support Team  
Dawn Goodwin, Victoria  
Greater Vancouver Mental Health Service Society  
*Geriatric Rehabilitation*  
*Special Advisory Committee*  
Marguerite and Hershel Hardin, West Vancouver  
Margeurite Holgate, Courtenay  
Hospital Employees' Union  
Dr. B.C. Humphrey, Mobile Outreach Seniors Team, Nanaimo  
Dr. Martin K. Impey, Vernon  
Joint Project Building Committee, Riverview Hospital Replacement  
Dr. R. M. Jones, Chilliwack  
Journey of Hope Support Group, 100 Mile House  
Kamloops Mental Health Advisory Committee  
Kamloops Mental Health Centre  
Kitimat General Hospital staff  
Dr. Raymond W. Lam, submission to Temporary Advisory Subcommittee on Psychiatry (TASC)  
Langley Stepping Stones Rehabilitation Society  
Lions Gate Hospital Department of Psychiatry  
June Lister, Nanaimo Mental Health Advisory Council  
Myrtle MacDonald, Chilliwack  
Jean A. MacLeod, Duncan  
Pat McMahon, Richmond  
Mental Patients' Association  
Minister's Advisory Council on Women's Health  
Ministry of Aboriginal Affairs

Ministry of Attorney General  
*Victim Services Division*

Ministry for Children and Families  
*Community Living Branch*  
*Regional Support Division*

Ministry of Health and Ministry Responsible for Seniors  
*Office for Seniors*  
*Office of the Provincial Health Officer*  
*Women's Health Bureau*

Ministry of Human Resources

Ministry of Municipal Affairs and Housing

Ministry of Women's Equality

Mood Disorders Association  
*Dawson Creek Branch*  
*Mission Branch*  
*Port Coquitlam Branch*  
*Provincial Branch*

New Westminster Police Service Victim Assistance Unit

Winifred Norbury, 100 Mile House

Northern Interior Advisory Council

Northern Interior Consumer Advisory Council

Northern Interior Regional Health Board

North Peace Health Council

North Shore Health Region

North West Mental Health Consumer Advisory Council

Patient Empowerment Society, Riverview Hospital

Peace Liard Community Health Services

Peace Region Consumer Advisory Council

Penticton Mental Health Centre and multiple community responses

Powell River Mental Health Advisory Committee

Roderick Pringle, Vernon

Provincial Mental Health Advisory Council

Provincial Mental Health Consumer Advisory Council

Provincial Mental Health Family Advisory Council

Queen Charlotte Community Health Council

Queen Charlotte Island Health Care Society

Geraldine Quock, Telegraph Creek



John Revel, Prince George  
Richmond Consumer and Family Council  
Richmond Mental Health Advisory Board  
Riverview Hospital Clubhouse  
Riverview Hospital Family Advisory Group  
St. Joseph's General Hospital, Comox  
Salishan Pathways Human Resources Society  
Sandy Merriman House, Victoria  
W. G. Sawchen, New Westminster  
G. Scaletta, Capital Health Region  
Simon Fraser Health Region  
Julie Skippon, Executive Member, Provincial Mental Health Advisory Council  
Shawn Smith, mental health worker, Vancouver  
South Cariboo Mental Health Advisory Committee  
South Fraser Health Region  
South Fraser Valley Regional Mental Health Advisory Committee  
South Peace Health Council  
Stewart Health Centre  
Thompson Okanagan Kootenays Interregional Mental Health Planning Committee  
Thompson Okanagan Kootenays Mental Health Consumer Council  
Thompson Region Consumer Advisory Council  
United Native Nations  
Upper Island/ Central Coast Community Health Services Society  
Vancouver Hospital Department of Psychiatry  
Vancouver/ Richmond Geriatric Mental Health Coordinating Committee  
Vancouver/ Richmond Health Board  
Vancouver/ Richmond Mental Health Advisory Committee  
Vancouver/ Richmond Mental Health Network  
Western Communities Mental Health Advisory Committee  
West Kootenay Boundary Mental Health Advisory Committee  
A. Winn, Coquitlam  
Pat Yochim, Regional Manager, Parksville Mental Health Centre

## ANNOTATED LIST OF RELEVANT DOCUMENTS



Auditor General of British Columbia, 1993/94: *Report 5, Value-for-Money Audits, Ministry of Health, The Transfer of Patients from Riverview Hospital to the Community, Psychiatrist Services* (May 1994).

The first audit in this report examines how the Ministry of Health has planned the transfer of patients and funding from Riverview Hospital to community-based programs. The second audit assesses how the Ministry ensures that psychiatrist services are accessible to people with serious mental illness in a cost-effective way.

Federal/Provincial/Territorial Advisory Network on Mental Health, *Best Practices in Mental Health Reform*, Discussion Paper (1997).

The document completes a three-part project conducted by the Health Systems Research Unit, Clarke Institute of Psychiatry, for the Federal/Provincial/Territorial Advisory Network on Mental Health. It summarizes and synthesizes Phases I and II of the project, then addresses the implementation of best practices across entire systems of care. (Phase I was a critical, evidence-based review of the current state of knowledge about best practices relevant to mental health reform. Phase II was a situational analysis of mental health reform policies, practices and initiatives in Canada which approximated 'best practices'.)

Ministry of Health and Ministry Responsible for Seniors, *A Report on the Health of British Columbians, Provincial Health Officer's Report, 1995, Feature Report: Women's Health* (February 1996).

The 1995 annual report of the Provincial Health Officer includes a chapter on women and mental health, with British Columbia data.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division,  
*British Columbia's Mental Health Initiative, 1995 Report (1996).*

The document is a comprehensive report on the status of the mental health initiative with details on Riverview Hospital patient placement planning; monitoring of progress on patients transferred from Riverview Hospital; human resource and labor adjustment initiatives; the acute mental health strategy; tertiary program planning; fiscal framework and transition funding; and psychogeriatric programs.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division,  
*Elderly Services - Mental Health Planning Guidelines for the Province of British Columbia (February 1994).*

The planning guidelines estimate service capacity requirements based on population and prevalence. To validate the British Columbia estimates, the capacities have been compared with other jurisdictions.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division,  
*Families Sharing the Caring: Summary Report of the Task Force of Families of People with Mental Illness (1993).*

The report outlines issues of concern to family members and provides recommendations for better supporting families.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division,  
*Guide to the Mental Health Act (RSBC, 1996).*

The guide provides an overview of the *Mental Health Act* and clarifies issues related to admission; treatment; rights, renewals, review panels and the court; and other issues. It was developed to improve understanding of the Act among physicians, care and service providers, consumers and families.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division,  
*Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital (1987).*

The document summarizes extensive public consultation and outlines direction for mental health planning in 1987.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division, *Mental Health Planning Guidelines for the Province of British Columbia* (1994).

The planning guidelines estimate service capacity requirements based on population and prevalence. The capacities have been compared with other jurisdictions to validate the British Columbia estimates.

Ministry of Health and Ministry Responsible for Seniors, Adult Mental Health Division, Continuing Care, Hospital Care and Facilities, Planning and Construction, *Services for Elderly British Columbians with Mental Health Problems [A Planning Framework]* (July 1992).

Information and guidance for planners to assist them in meeting the needs of seniors with mental health problems and their caregivers.

Ombudsman, Province of British Columbia, *Public Report No. 33, Listening, A Review of Riverview Hospital* (May 1994).

The report is based on a year and a half investigation into the state of administrative fairness at Riverview Hospital. In the report, the Ombudsman makes many recommendations both to the Ministry of Health and to Riverview Hospital.

Provincial Mental Health Advisory Council/British Columbia Mental Health Society Working Group Report to the Minister of Health, *Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital Report* (June 1996).

Outlines challenges facing the mental health system and proposes strategic shifts in management that need to occur, as well as areas where additional resources are required.

Provincial Mental Health Family Advisory Council, *Building Partners in Mental Health*, (1996).

The pamphlet outlines steps for family members and mental health professionals to use in order to effectively communicate and work together.

***If you would like a copy of any of these documents, please contact the Adult Mental Health Division at (250) 952-1629.***

# GLOSSARY

## AS USED IN THIS DOCUMENT



### *Adult*

People 19 years of age and older.

### *Asylum*

A place of refuge and protection for people with long-term mental illnesses who do not require acute hospital treatment, but do require ongoing supervision, care and treatment in a community facility or institution.

### *Accreditation*

External, formal review of the performance and adherence to standards of an agency delivering care services. Certification by a national organization whose business is the evaluation of the compliance of service organizations (such as hospitals) with pre-set standards of care and/or service.

### *Acute Care (also referred to as secondary level care)*

Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

### *Acute Psychiatry (inpatient)*

Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit, which often entails emergency psychiatric care.

### *Bio-psycho-social Approach/Model*

Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including physicians, nurses, social workers, occupational therapists, dieticians and psychologists.

### *Capital Assets*

For purposes of this plan, pertains primarily to physical items of value expected to last a number of years. Includes buildings, vehicles, computers or other items but not leased assets.

### *Capital Funding*

Funding for physical items (see *Capital Assets*).

### *Case Management*

The coordination of a consumer's health care, housing, employment, training and/or rehabilitation services, usually by one person (the case manager) operating in a team environment who liaises with all others providing services to the consumer. Case management provides active outreach, coordination of personalized care plans and monitoring of mental health status.

### *Consumers*

People who use mental health services.

### *Crisis Stabilization Program*

Provides community-based, short-term treatment and stabilization services for individuals in psychosocial and psychiatric crises as an alternative to hospitalization. During the client's stay, a thorough assessment is completed, intensive brief crisis intervention services are provided and an immediate action plan for community re-integration is implemented.

### *Designated Facility*

A hospital or provincial mental health facility which may admit involuntary patients under the *Mental Health Act*.

### *Determinants of Health*

Factors that influence and determine health status. These include social, economic and physical environment, health services, biological influences and health behaviors and skills.

### *DSM-IV*

*Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*. The American Psychiatric Association's classification tool to assist health care practitioners in classifying mental disorders based on symptoms.

### *Dual Diagnoses*

Commonly used to describe the condition of people who have a mental illness and either a mental handicap or substance misuse issues.

### *Emergency Accommodation*

Facilities which offer short-term emergency accommodation in a supportive environment for people with marked behavioral and social problems associated with mental illness who have no other immediate housing options available to them, but who do not require care in a hospital or intensively staffed facility.

### *Family Care Home*

Care provided in approved homes to one or two adults with a serious and persistent mental illness who are unable to live independently. This style of care is not subject to licensing under the provincial *Community Care Facilities Act*.

### *FTE (Full-time Equivalent)*

FTE is the unit used to describe a full-time position. For example, two half-time positions equal one FTE.

### *Fiscal Framework*

The fiscal framework was developed in 1994 to guide the allocation of resources from Riverview Hospital to regions in order to fund the operating costs of regional tertiary replacement facilities and community service enhancements as the hospital's capacity was replaced. Essentially, it describes the resource requirements and allocation strategies to enable implementation of the plan.

### *Forensic*

Forensic Psychiatric Services provides assessment, diagnosis, treatment, detention and supervision of people with mental illness who are involved with the criminal justice system.

### *Functional Impairment*

An individual's ability to perform usual daily activities are reduced. A number of measurements exist which gauge a person's level of functioning (and level of functional impairment); the global assessment of functioning (an aspect of assessment that is part of the American Psychiatric Association *Diagnostic and Statistical Manual IV*) is one such tool.

### *Funding Envelope*

Funds granted to a health authority which are to be spent for a specific purpose, e.g. the mental health funding envelope.

### *Governance*

Refers to the authority to operate a health care program. Governing bodies, such as boards of directors or trustees, generally define the vision, mission and values of an organization and set goals, objectives and priorities for its operation.

### *Health Authorities*

Public bodies, mandated under the *Health Authorities Act*, responsible for governing, managing and delivering health services in a defined geographical area. It refers to either Community Health Councils (CHCs) or Regional Health Boards (RHBs) and, for practical purposes in this document, includes Community Health Service Societies (CHSSs) although these do not have status under the Act (and derive their authority from their constitution and bylaws, established pursuant to the *Society Act*).

- RHBs govern the delivery of all health services within a designated region.
- CHCs govern the delivery of acute and continuing care based services, such as hospitals and intermediate care facilities in areas of the province where there are no regional health boards.
- CHSSs govern the delivery of services which are broadly regional in nature - public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services - in areas of the province where there are not regional health boards. Collectively, the CHSS and the CHCs within a region govern the delivery of all health services in the region.



### *Health Status*

The evaluated state of health of a group or community, represented by universal epidemiological indicators such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

### *Individualized Direct Funding (Direct Consumer Funding)*

A model of funding whereby an assessed amount of funding is targeted to a client and the client or a designated agency directly purchases the services for the client.

### *Integration*

Organization of service entities along a continuum, ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures in order to ensure that client's needs are met in a coherent, unified, holistic and efficient manner.

### *Labor Adjustment Initiatives/Human Resources Planning*

A process designed to ensure an optimal deployment of existing personnel in a new service delivery system and an adequate supply of competent personnel necessary to deliver programs in the future.

### *Mandate*

An organization's mandate describes the scope of its responsibility.

### *Mental Health Act*

British Columbia's *Mental Health Act* was proclaimed in 1964. Its purpose is to ensure "...the treatment of the mentally disordered who need protection and care..." The main focus of the *Mental Health Act* is to provide authority, criteria and procedures for involuntary admission and treatment. The Act also provides protection to ensure these provisions are applied in an appropriate and lawful manner.

### *Multiaxial Assessment*

Involves an assessment on several axis, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axis included in DSM-IV:

Axis I	Clinical Disorders
Axis II	Personality Disorders
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

### *Operating Budget*

The amount of funding necessary to pay for the cost of running an organization.

### *Organic Brain Syndrome*

A psychological or behavioral abnormality associated with a temporary or permanent dysfunction of the brain due to disease processes, strokes or accidents.

### *Outreach*

Services are taken to the consumer (home, work, facility), rather than requiring the consumer to attend a clinic or hospital.

### *Performance Indicators*

Performance indicators measure how well things are done (e.g. the number of individuals graduating to more independent levels of care and remaining healthy).

### *Psycho-social Rehabilitation*

Psychiatric rehabilitation services designed to assist a person with a serious mental illness to effectively manage the illness and to compensate for the functional deficits associated with the illness. People who receive psycho-social rehabilitation services are significantly more likely to be able to return to work, school or resume a productive role in the community. The range of psycho-social services may include rehabilitation, case management, residential treatment and support, crisis services, social services, housing, vocational rehabilitation, substance abuse treatment, peer support and family support.

### *Psychotropic Drugs*

Any medication with a primary effect on the central nervous system with the intention of improving mood or thinking. The term "typical" psychotropic drugs refers to relatively old products. The term "atypical" refers to psychotropic drugs which are relatively new and are designed to treat a wider range of symptoms with fewer side effects.

### *Primary Care*

Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients and patients. Primary care may include referral to more specialized levels of care, e.g. secondary (hospital or specialist care). Family doctors are often referred to as primary care physicians.

### *Residential Care*

Residential care is provided in community-based licensed facilities which are staffed and provide full-time care, supervision and psycho-social rehabilitation for people whose social and/or mental functioning prevents them from living more independently. These facilities average 13 residents and are regulated by the *Community Care Facility Act* and the *Adult Care Regulations*. The facilities are subject to program standards, guidelines, policies and procedures.

### *Residential Care for Specialized Needs*

Augmented resources provided to community care settings to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviors.

### *Residential Program/Services*

An organized program which enables clients to have the best possible quality of life through a program integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate residential settings.

### *Respite*

Temporary, short-term care, designed to give relief or support to a family caregiver who has responsibility for the ongoing care and supervision of a family member with a serious mental illness. Respite could be provided inside or outside the home.

## *Secondary Level Care (see Acute Care)*

### *Serious Mental Illness*

Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illnesses; however, it is acknowledged that there are others for whom medical risk and level of impairment, regardless of diagnosis, determines their mental illness as "serious".

### *Stakeholders*

Representatives of the British Columbia mental health care community of interest (e.g. families, consumers, professionals, unions, health authorities).

### *Supported Housing*

Includes a variety of living arrangements (usually self-contained living units) for people with a serious and persistent mental illness able to live independently with the assistance of a range of support services and the provision of a housing subsidy.

### *Tertiary Care*

The care of people with serious, complex and/or rare mental disorders who, by reason of severe psychotic behavior or specialized staff or facility needs, cannot be managed by the resources available at the primary and secondary levels of care in the province. It also includes specialized services, such as child and adolescent, psychogeriatric, alcohol/substance abuse and forensic mental health services.

Tertiary mental health care includes specialized intensive acute care assessment and short-term treatment programs and both short-term (episodic) and long-term institutional care for severe chronic cases. It excludes long-term care that does not require daily access to the special clinical resources that are available only within the tertiary care programs.

### *Transition Funding*

Funding required to bridge change in service delivery from Riverview Hospital to community or shift from the old Riverview facility to new regional tertiary care settings. It provides for funding two similar services for a limited period of time in order to ensure that client care is maintained during the transition.

### *Utilization Data*

The information required for comparing the observed use of resources with the standards.

### *Utilization Management*

Process by which agencies decide on the efficient use of care resources, comparing the observed use of resources with recognized standards of appropriate, timely and cost-effective utilization targets. The objective of utilization management is to ensure the right services are provided to the intended consumers, when they most need them, at the least cost, consistent with quality care.

### *Values*

Values are the beliefs of an organization which underlie the principles and actions and form the basis for planning and operation of services.

### *Vision*

A vision statement describes how an organization intends to change and improve in the future.

“ I get my ideas (for my art) from my own instincts. I often do it by just looking down at the paper and paint sitting in front of me and thinking about being able to celebrate with nice people everything that has occurred in the year. Thank you for letting me try. ”

- A consumer

