The Foundation

creating stable ground for change

Mental Health Services

Strategic Development Plan

February 2003

Interior Health

"The issue of culture has been consistently highlighted as the main determinant for the successful implementation of any developments within an organization.

Culture - the beliefs, values and customs of the organization - affects every part and function of the organization…

…Accomplishing this change in culture will require clear and strong leadership within the mental health sector and across the broader health and social care systems.

The leaders need to communicate a vision of the future system, engage key stakeholders across the system, and manage the organizational and structural changes required to reach the vision."

The Mental Health Policy Implementation Guide
National Institute for Mental Health in England

Central planning provides values, principles, and functional expectations.

Local planning provides the final form of services and the methods to achieve functional expectations.

IH Mental Health Leadership Team

CONTENTS

MENTAL HEALTH SERVICES VISION

The Interior Health Mental Health Service system will be guided by a set of vision statements that describe how IH sees its mental health services.

Vision *"best practice, in practice"*

Interior Health Mental Health Services will develop the most effective and most responsive mental health service system in Canada by putting best practice into practice.

Mission *"restore, preserve and promote mental health"*

The mission of IH Mental Health Services is to restore, preserve and promote good mental health through sustainable and accountable practices.

Values *R.A.R.E. Innovation*

Respect for individual worth, capabilities and rights.

Accountability for fiscal and clinical conduct to service providers, management, consumers, families and the citizens of IH.

Responsiveness to provide services when and where they are needed.

Excellence confirmed through evidenced based decision-making.

Innovation through creative design and delivery of services.

IMPACT OF MENTAL ILLNESS AND ADDICTIONS

The impact of mental illness and addictions is staggering in its overall cost to society. Although treatment has gained significant resources over the past two decades it is now clear that mental illness and addictions are one of the most prevalent and costly health and social issues facing citizens of the Interior Health Authority.

- Mental illness accounts for over 15% of the burden of disease in established market economies like Canada and the U.S.. This is greater than the disease burden caused by all cancers combined. *(World Health Organization, (2001) Mental Health: New Understanding, New Hope.)*
- The hospitalization rate for almost every major mental illness has increased significantly in the last decade. *(Health Canada (2002): A Report on Mental Illness in Canada)*
- From 1991-1998 there were an average of 1,509 alcohol-induced deaths per year in BC *(McLean M. (2000) Vancouver Drug Epidemiology and Crime Statistics 2000. Vancouver: Canadian Community Epidemiology Network on Drug Use).*
- 90% of people with both mental health and substance abuse problems had signs of mental disorders by age 11. *(BC Child and Youth Mental Health Plan 2003)*
- Mental illness represents the most frequent billing categories by general practitioners in Canada. (Health Canada, 2002. *The Economic Burden of Illness in Canada. 3rd. Edition(1998))*
- A 1996 study estimated the total annual cost of substance abuse in British Columbia at almost $2.3 billion. *(Single E, Robson L, Xie X, Rehm J. (1996) The Costs of Substance Abuse in Canada. Highlights of a Major Study of the Health, Social and Economic Costs Associated With The Use Of Alcohol, Tobacco and Illicit Drugs. Ottawa: Canadian Centre on Substance Abuse).*
- Almost 607,000 British Columbians over the age of 15 have made contact with the mental health system for a primary diagnosis of mental illness. *(BC Ministry of Health Services, 2001/2002 Annual Report)*
- Problem and pathological gambling has significant social and financial costs to individual gamblers, their families and society at large. Problem gambling takes its toll in the form of depression, multiple addictions, stress related physical ailments, family disruption and crime. Ultimately, these problems prove costly to taxpayers as they burden the health care system and tie up the courts. *(Henriksson LE. (June 1996) Hardly a Quick Fix: Casino Gambling in Canada, Canadian Public Policy 22:2.)*

EXECUTIVE SUMMARY

Mental Health service development in British Columbia has engaged in more than 7 different planning initiatives over the past 15 years. Each initiative has provided an additional piece of information to the effective delivery of mental health services in the province.

Plans relating to the redevelopment of the Riverview Tertiary site have provided guidance on the development of tertiary capacity – responsibility now transferred to Regional Health Authorities. Numerous Best Practice documents have provided guidance on leading edge program development and structuring of acute, clinical and community-based mental health services.

The ***Strategic Development Plan for Mental Health Services*** in Interior Health builds on the accomplishments of past planning initiatives and moves its strategic development into a new era.

This new era entails thorough examination of all mental health service within Interior Health at a Health Service Area level. It involves relevant stakeholders in a meaningful way to establish a mental health system that is sustainable, accountable and focuses on the needs of people with mental illness and addictions through good fiscal management and well-coordinated care.

Interior Health recognizes that mental health care is much more than formal mandated services. It includes all community services, long term care, public health, self-responsibility for health, community partners and others. Each part of the mental health system relies on the next. The ***Strategic Development Plan for Mental Health Services*** takes into account the interrelationship of emergency care, acute care, community-based service, community support services and self care, and coordinates it within the context of affordable and effective service delivery.

This document provides the principles and methods for continuing development of Interior Health's Mental Health Programs.

It is not meant to be an immutable blueprint to service delivery. There is a clear recognition that central planning is only one facet of the development of a comprehensive service system for mental health. There is an expectation resulting from the document that the principles and **functional outcomes will be addressed by each Health Service Area, moving toward common goals**.

The current development effort represents an opportunity to build on the stability now forming around Interior Health and pulls together mental health services – **to create Interior Health's Mental Health Service System as a Best Practice Service Delivery Model.**

This development process balances management's responsibility for financial and clinical accountability, against local service needs for autonomy, in the development of services to a form and manner that is valid for their social and environmental context.

The Directors of the Mental Health Service System recognize and champion the effectiveness and expertise of the existing mental health system currently offered by the staff of Interior Health and their community partners.

Through provincial review efforts it is clear that some aspects of IH Mental Health Services lead the province in indicators of efficacy and cost containment. Thus the purpose of the development process is to **ensure IH remains the leader in areas in which it currently excels, and to improve other areas to best practice and leadership standards.**

The development process is an opportunity to provide stakeholders with the ability to **continuously monitor and improve mental health services in IH**. Continuous improvement will allow Interior Health to attract world class staff and support the *Employer of Choice* principles of the Interior Health's corporate mandate.

The new era of service development will allow IH Mental Health services to avoid the discontinuity created by moving from plan to plan. It will instead create an **organizational culture of quality assurance** that will effect continuous meaningful change within the service delivery system.

This document provides a framework to guide the work of the Health Service Areas in evolving their mental health care systems to help people with mental illness and their support networks access the services they require to restore and maintain optimal functioning and health.

Principle Goals of the Development Plan include:

- Achieve and exceed established Provincial Performance Targets:
  - Reduce mental health alternative level of care days by 4% by the end of 2005.
  - Conduct new research to identify causes of ALC days to further reduce inappropriate allocation of resources.

  - Exceed Provincial Performance Targets by reducing the time from discharge to follow-up from Provincial targets of 30 days to 7 days in IH by 2004.
  - Provide earlier intervention through reduced average age of referral and implementation of an adolescent unit in Kelowna, and creation of lead clinician positions in each HSA focused on children and youth transition and coordination.
  - Development of 150 Riverview tertiary care replacement units across IH completed in 2005.
- Review and redevelop all IH Mental Health Services to meet or exceed Provincial and National Best Practice standards before 2005, creating a single, coordinated system of mental health care across IH that includes addictions service, aboriginal mental health, concurrent disorders, and IH level coordination.
- Creation of population health strategies to prevent mental illness and reduce stigma and discrimination as a barrier to treatment, services and support.

IH MENTAL HEALTH STRATEGIC GOALS

1 Exceed established provincial performance targets

The Provincial Ministry of Health Services has established minimum performance targets for Mental Health Services which are enacted in the Provincial Performance Agreement (May 29, 2002). These targets were developed over the past 3 years from data provided to the Provincial Ministry of Health Planning through data amalgamation conducted by the Mental Health Evaluation and Community Consultation Unit in 1999/2000 (Mheccu). Upon release, investigation and provincial reporting, it is clear that provincial and IH data is insufficient to properly evaluate performance targets.

To comply with Provincial Performance Agreements the IH Mental Health Leadership Team has developed strategies to achieve or exceed all performance targets within established timelines and to establish electronic health records to reliably gather meaningful performance indicator data.

Increase in evidence based practice to:

1.1 Decrease by 4% over three years, the alternate level of care days (ALC) spent by mental health and alcohol and drug clients in hospitals once the primary need for inpatient care has completed.

Specific targets: 2002/03 0% reduction
2003/04 2% reduction
2004/05 2% reduction

2003

Standardize ALC day recording. (MCAP)

- Dedicate resources to standardize data collection throughout IH relating to definition of Mental Health ALC days.
- Train staff and physicians in each HSA in data point definition, recording and reporting practices
- Implement data collection practices in each HSA resulting in reliable electronic health records for ALC day causes.

Confirm principle causes for ALC days.

- Communicate principle ALC day causes and develop evidence-based intervention strategies.

Implement reduction strategies for known causes.

- Implement tertiary strategies for 2003.
- Implement adolescent inpatient unit (Kelowna General Hospital)

2004

Implement additional evidence based strategies targeted at reduction of ALC days for known causes.

- Implement tertiary strategies for 2004.
- Develop and Implement additional strategies as indicated by data.

Increase in evidence based practice to:

1.2 Improve continuity of care measured by the proportion of persons hospitalized for a mental health diagnosis that receive community or physician follow-up within 30 days of discharge.

Currently the Medical Services Plan and the CPIM are the data sets utilized to assess achievement of performance targets. Variability in data recording and analysis do not provide sufficiently accurate data.

2003

Establish and implement common IHA follow up protocol.

- HSA Directors create common IH follow up protocol through IH Mental Health Leadership Team.

Implement maximum 7 day follow up protocol for all patients following discharge from an acute care program.

- Allocate resources, and implement dedicated community follow up positions in each HSA.

Establish common reporting requirements across HSAs for capture of data demonstrating appropriate follow up.

- Coordinate with IT Division to include community follow up data as an electronic health record.
- Coordinate follow up initiatives through the Mental Health Leadership Team forum.

2004

Target further reduction in time to follow up from establish data relating to outcome of follow up.

- Evaluate and revise community follow up position based on evidence.

Increase in evidence based practice to:

1.3 Increase early intervention capacity as evidenced by the decrease in average patient age at first contact with a physician or health service provider for serious mental illness.

Increase in early intervention capacity may be evidenced by data other than decrease in average first contact age. Data also needs to be collected on report of onset date as a more accurate data point.

2003

Establish additional data protocol to more accurately reflect performance target.

- Coordinate with IT Division to create *date of illness onset* electronic health record.
- Train physicians and community health staff in data gathering and reporting strategies.

Implement current initiatives in early intervention.

- Implement an adolescent inpatient unit (Kelowna General Hospital).
- Implement Children and Youth transition protocol
- Develop and implement a human resource

plan in each HSA consistent with the transition protocol.

Establish protocol to coordinate service with the Ministry of Children and Family Development, Aboriginal Mental Health and Public Health.

- Dedicate staff resource to undertake coordination work with the Ministry of Children and Family Development, Aboriginal Mental Health and Public Health in each HSA.
- Coordinate HSA initiatives at the Mental Health Leadership Team forum.

2004

Review date of illness onset data to ensure appropriate reporting is established and new intervention strategies are developed.

1.4 Development of Riverview tertiary care replacement units in selected locations – to be achieved over the 3-year period (150 bed allocation).

2003

- 2 x 20 bed Tertiary Rehabilitation units operational in Kamloops facilities by March 31, 2003.

2004

- 44 Tertiary Acute beds operational in Kamloops facility by September 2004.

- 39 Adult Tertiary Residential units established by March 2004.
  Distribution:

East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo
5	5	19	10

- 10 Geriatric Tertiary Residential units established by March 2004.
  Distribution:

East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo
1*	1*	5	3

* to be developed in conjunction with other collateral services

2005

- 17 Tertiary Rehabilitation units established by March 2005.
  Distribution:

East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo
3	3	11	n/a

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2 Create a well coordinated mental health system within Interior Health that reflects unique qualities of each Health Service Area and assists with overall IH mental health standards and policy.

The creation of Interior Health provided an amalgamation of 4 previous Health Regions each with differing standards, protocols and operations. In addition, the merger of addictions programs with mental health programs has created a strong need for review and integration. Coordination of services across IH is necessary to avoid duplication, maximize available resources and create an easily accessible IH Mental Health System.

2.1 Standardize service functions across Health Service Areas based on best practice.

2003

Establish IH Best Practice guidelines

- IH Mental Health Leadership Team review Best Practice standards from national and provincial standards documents and create IH Best Practice service checklist.

Implement services based on Best Practice standards across IH.

- Stakeholder-based service review teams established and resourced in each HSA.
- Format for IH level coordination of review established.
- Best Practice Service inventory complete.
- Business case for service level change delineated and budgeted.
- Create new IH performance targets based on Best Practice Service Review
- Electronic health record established to provide meaningful data related to IH performance indicators.

Establish consistent IH clinical standards for specific populations.

- IH Leadership Team select clinical standards areas to be established. Each HSA will assume leadership for different clinical standards areas to provide concurrent development of consistent clinical standards across IH over the next 3 years.
- Clinical review teams are established to review content area and determine best practice clinical standard for 2 practice areas each year.

	Establish unique approaches / services at HSA level (2 year development profile) • Communicate standards and performance indicators relating to standards to other HSA teams through IH Mental Health Leadership Team. **2004** **Continue to establish consistent IH clinical standards for specific populations.** • New services / delivery approaches implemented resulting from Best Practice Service Review. • Development of clinical practice standards continues. • Coordinate HSA initiatives at the Mental Health Leadership Team.
2.2 Develop Tertiary Service Delivery/Care Continuum	**2003/4/5** **Ensure tertiary beds are utilized in the continuum of services as a resource throughout IH through the Best Practice Service Review.** • Mental Health Leadership Team coordination of 15 specialized provincial beds in the lower mainland, tertiary residential beds, tertiary rehabilitation beds and community-services.
2.3 Integrate Addictions and Mental Health Programs into a single mental health system.	**2003** **Create a coordinated single program.** • Standardize contracting protocol and templates across HSAs. • Consistent policy on service resource allocation is developed. • Co-leadership transition teams implemented to coordinate aboriginal services, child and youth services and public health prevention services. **Increase access to specialized services for people with concurrent disorders and reduce ALC days for people with concurrent mental illness and addictions disorders.** • Cross-training providing minimum competency standards for both addictions and mental health staff implemented. • Establish baseline for concurrent disorders from existing electronic health records.

	• Develop and coordinate services consistent with national policy *"related to the continuum of care approach is a stepped-care model, whereby clients are first engaged in the least intrusive level of care and then "stepped-up" or "stepped-down" on the basis of results from ongoing outcome monitoring;"* *Health Canada Best Practices: Concurrent Mental Health and Substance Use Disorders, 2002.* • Coordinate HSA initiatives at the Mental Health Leadership Team forum.
2.4 Create a single information system for IH Mental Health that will collect meaningful data for decision making in each HSA.	**2003/4** **Achieve minimum data set for all HSAs required to meet performance targets and for management information requirements.**
2.5 Coordination of IH Mental Health Services *IH wide coordination is required on specific issues.* • *Riverview Redevelopment / Tertiary resource allocation and residential continuum coordination.* • *Tele-psychiatry and IT involvement.* • *Strategic Plan implementation.* • *Standards development and implementation.* • *Development and recommendation of common mental health program policy.* • *Achievement of Provincial Performance targets and definition of concrete, measurable targets for development.* • *Monitoring performance at an IH level.* • *Liaison to ensure continuity of mental health services across IH.* • *Single point of contact for mental health services and information relating to:* - *corporate IH structure,* - *Provincial Health Services Authority,* - *Ministry of Health Services,* - *Ministry of Health Planning,* - *Minister of State for Mental Health and* - *Minister of State for Community Care.*	**2003** **Recommendations to Senior Executive Team regarding format for the coordination of IH Mental Health Services – September 2003.**

2.6 Inclusion of aboriginal mental health issues in IH mental health services

Aboriginal cultural identity with service delivery will be respected. Issues need to be included in the development of a single coordinated system that recognizes and includes aboriginal people in new ways of delivering mental health services:

- *Cultural considerations impact the efficacy of mainstream interventions.*
- *Inclusion of culture-based approaches have a strong possibility of augmenting the effectiveness of mainstream interventions and provide new / innovative directions for development.*

2003

Full involvement of aboriginal mental health and social service entities in the Best Practice Service Review process.

2.7 Cultural Diversity Awareness and Needs

Acknowledgement of differing cultural issues will assist in the development of new ways of delivering mental health services to different populations.

2003

Full involvement of existing cultural entities in the Best Practice Service Review process.

2.8 Concurrent Disorders

Many people with mental health problems experience concurrent disorders which complicate treatment. Concurrent disorders may present a barrier to accessing mental health services.

2003

Increase access for all concurrent conditions including those clients experiencing marginalization and limited contact with formal service systems.

- Establish methods for coordination with existing community services supporting concurrent disorder populations as evidenced by community agency inclusion in Best Practice Service Review and number of partnership initiatives developed.

Establish baseline rate of people experiencing concurrent disorders.

- Establish electronic health record for reliable data to demonstrate evidence of increased rate of concurrent disorders.

3 Promote prevention strategies and reduce discrimination regarding mental illness

Mental illness and addictions still carry great stigma. Stigma creates a barrier to accessing services in a timely fashion (Health Canada 2002, A Report on Mental illness in Canada, Ottawa Canada). This, in turn, creates increased need in mental health crisis and acute services - the most costly form of intervention.

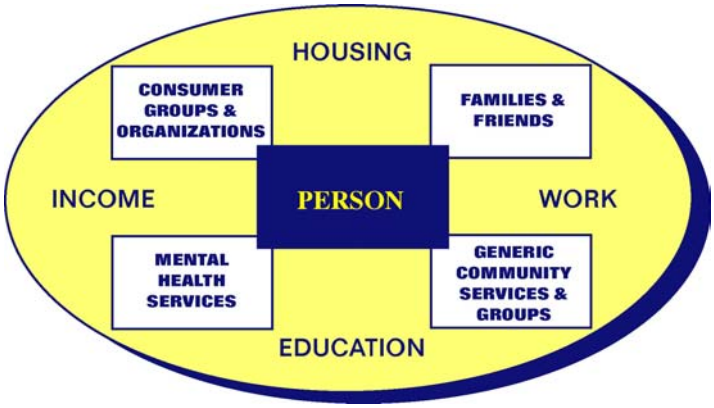
Additionally, changing attitudes about mental illness increases opportunities for community involvement (employment, social relationships, psychosocial rehabilitation involvement) for people experiencing mental health problems. This leads to a greater capacity for self care.

3.1 Develop a co-promotion strategy with the Population Health Group to create suicide prevention strategies. *Many people attempting suicide are not identified mental health clients.*	**2003** **Population health includes a strategy for suicide prevention/education in 2004 strategic plan.** • Partner with public health to coordinated approach to providing information and education about mental health services and mental illness.
3.2 Increase capacity through empowerment strateigies that encourages self direction..	**2003** **Include self care recommendations from existing provincial Depression Strategy and Anxiety Disorders Strategy in the development of clinical standards.**
3.3 Coordinate prevention and awareness efforts with community and academic partners.	**2003** **Number of effective partnerships increase evidenced from projects such as:** • IH staff involvement in National Mental Health Week, • National Mental Illness Week • Depression Screening and Education Day • Development of an internal IH Depression Screening Initiative. • Addictions Awareness Week **Provide detailed recommendations to IH Human Resources to provide incentive in contracting to agencies with demonstrated supported employment strategies.** **Develop detailed recommendations to IH Human Resources regarding an IH supported employment strategy**.

CONCEPTUAL FRAMEWORK

The Community Resource Base (CRB), from the Canadian Mental Health Association's, New Framework for Support, can be used as the basis for the IH Mental Health strategic development process as it provides a way of looking at the mental health system within the context of the whole community (see diagram).

Policy and planning efforts traditionally have dealt only with the organization of the formal mental health service system. Assumptions have been that formal mental health services can solve all problems of community life for people with mental illness and addictions if only we have enough services and organize these services properly.



The Community Resource Base helps planners shift from a primary focus of managing the service system to recognizing the essential roles that family and friends, consumer and community service organizations play in maximizing the independence and quality of life of people with mental illness.

The new emphasis in planning is to support individuals to connect to appropriate services within the mental health service system as well as build supports in other areas of their lives. It challenges everyone to invite involvement from people with mental health problems, family members and general social community agencies in a meaningful way.

The Community Resource Base illustrates that formal services are one of several important influences that affect people's lives. It provides a shift from a "service" paradigm to a "community development" paradigm.

The presence of four balanced sectors suggests that they work in partnership to support the person at the centre, who in turn, has the power to make choices about which resources to utilize. All the sectors need to be involved in mental health planning although not necessarily represented in equal proportions for all planning tasks.

PRINCIPLES OF STRATEGIC DEVELOPMENT FOR IH MENTAL HEALTH SERVICES

In order for the process of change to be understandable to all stakeholders, a set of common principles must be created.

These principles form the basic philosophy guiding the processes used for change.

The process gains legitimacy through IH senior management approval.	*Approval is clearly visible, ongoing and consistent as it relates to language, resources and participation.*
Central planning provides values, principles, and functional expectations.	*Local planning provides the final form of services and the methods to achieve functional expectations.*
The IHA and other service entities will provide the mandate, adequate resources and appropriate time to participants in the development process.	*Appropriate inputs to the development process are more likely to result in it being viewed as important, worthwhile and legitimate.*
Development is a process - not an outcome.	*All development is the result of best thinking in the context of the present time frame, knowledge base and resource availability. As these factors change so may the development goals. A development process should include methods for ongoing system assessment.*
Agreements relating to the development process will be honoured.	*Interior Health will gain acceptance of change by living up to agreed upon goals.*
A reasonable time line will be strictly adhered to.	*Discussions can go on forever without meaningful change. An informed decision will be made in regard to what an appropriate time allowance for discussion should be.*

Constructive comment is encouraged.	*Appropriate avenues for constructive comment will be created and maintained.* *Constructive comment is that which not only points to difficulties or barriers to effective treatment and support, but also that which provides realistic alternatives. Comment without suggestions for change are just complaint.*
Assessments of efficacy and need for change are reflective of the system as a whole – not of individual merit.	*Development efforts will meet with success if those involved perceive no possibility of personal loss. The development process will remain apart from clinical supervision issues.*
Development will not happen all at once - systems need time to change.	*If too much is attempted at the same time, systems become confused and difficult to understand. Many changes can take place – a few at a time.* *Any systemic changes should be viewed in a time frame of months and years, not weeks or days*

POPULATION SERVED

As outlined in the provincial Mental Health Plan, Interior Health provides mental health services to children, youth and adults with serious and persistent mental illness and addictions.

As well, IH provides services to adults with episodic mental illness, elderly persons with mental illness, residential facilities, hospital psychiatric services, and partners with the Ministry of Children and Family Development to provide mental health services to children and youth.

Mental Health utilization is estimated using Class 5 Diagnosis Codes (Health Records Coding for Mental Disorders) which includes senile and pre-senile organic conditions, psychoses – alcoholic, psychoses – schizophrenic, psychoses – affective, other psychoses, neurotic and personality disorders, alcohol dependence syndrome, drug dependence, mental retardation, and other mental disorders.

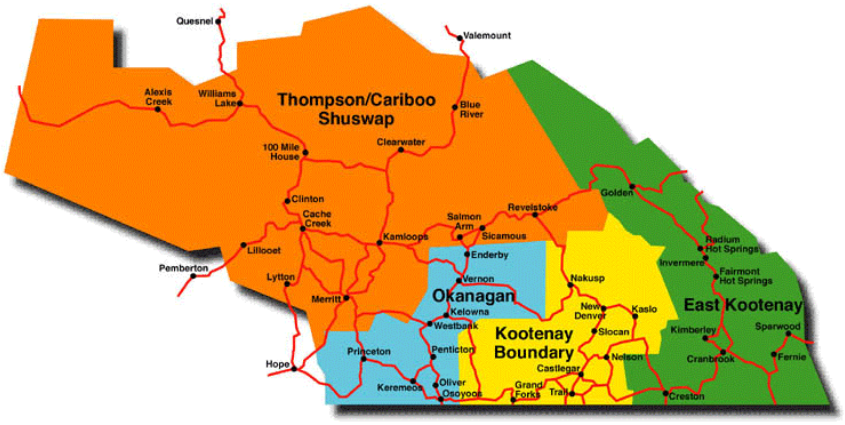
Differences are observable across HSA boundaries in relation to demographic and utilization trends data. (Source: *Interior Health - Health Services: Companion Document to: Interior Health Population Health Profile, and HSDA Health Status Vignettes*)

IH / HSA Population

	Okanagan	East Kootenay	Kootenay Boundary	Thompson Cariboo	IHA
Population	**356.777***	**78,860**	**79,903**	**172,161***	**687,701**
% of IH	**52%**	**11%**	**12%**	**25%**	
Growth est.(5yrs.)	**+6.8%**	**-0.3%**	**+0.5%**	**+2%**	

* Population figures are for mental health services only and may vary from other IH service data as some Shuswap residents are served by Okanagan mental health services.

Interior Health Authority - Health Service Areas



IH / HSA Mental Health Summary

A brief summary of population prevalence based on Class 5 Diagnosis Codes reveals some variance between HSAs which may be useful in assessing illness rates by HSA or data collection variances.

All data are 2000/2001 and drawn from the *Interior Health - Health Services: Companion Document to: Interior Health Population Health Profile*

	Okanagan	East Kootenay	Kootenay Boundary	Thompson Cariboo	IHA
Mental Health Hospitalizations / 100,000	**7.0**	**8.1**	**9.7**	**7.6**	**7.6**
Mental Health Utilization Days /1000	**54**	**64**	**69**	**67**	**61**
Senile and pre-senile organic psych. (cases 01)	**123** **52%**	**39** **16%**	**42** **17%**	**33** **13%**	**237**
Schizophrenia (cases 01)	**354** **49%**	**63** **9%**	**111** **15%**	**194** **27%**	**722**
Affective Disorders (cases 01)	**806** **51%**	**138** **10%**	**135** **9%**	**349** **24%**	**1428**
Personality Disorders / Neuroses (cases 01)	**193** **36%**	**101** **19%**	**82** **15%**	**156** **29%**	**532**
Alcohol & Drug Dependance (cases 01)	**199** **19%**	**62** **6%**	**74** **7%**	**705** **68%**	**1040**
Alcohol Psychoses, MR, Other (cases 01)	**693** **22%**	**639** **20%**	**329** **10%**	**1552** **48%**	**3213**

Source: Ministry of Health, PURRFECT 7.1

CONTINUUM OF MENTAL HEALTH SERVICES

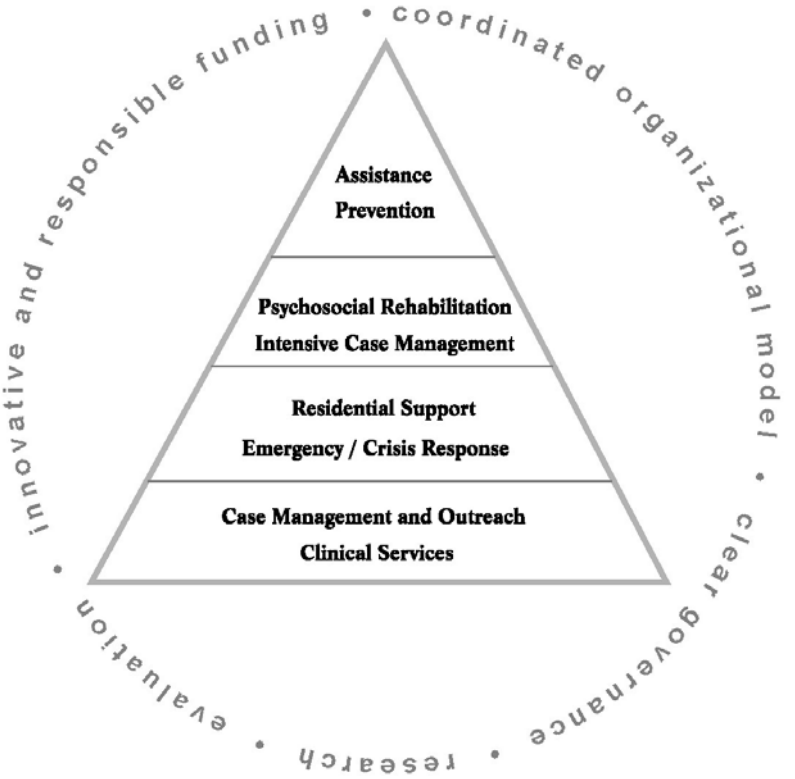
IH Mental Health Services is conceptualized in the following diagram as a continuum within a hierarchy of service needs.

Some services are required as basic or foundation services which support the development of further services. The continual building of the system provides a comprehensive service continuum. It is recognized that all components of the system must develop concurrently, therefore all services in the continuum require and are allocated resources.

The circle encompassing the continuum represents components of the mental health system required to provide effective coordination of the service continuum.

These services are derived from *British Columbia's Mental Health Reform – Best Practices*, and *Revitalizing and Rebalancing British Columbia's Mental Health System, The 1998 Mental Health Plan.* A detailed description of Best Practice standards relating to each service area is available in Appendix A.

IH Mental Health Services Continuum Model



PRINCIPLES OF SERVICE DELIVERY

The principles of the service system place the person receiving services at the centre of development issues. The IH mental health service system recognizes that the people with mental illness and addictions participate as members of the broader community – with all the inherent rights and privileges accruing to all citizens.

The stated values are brought to life through the utilization of the following principles:

Relevant stakeholder groups will have an avenue for meaningful involvement in the development process.	Examples of stakeholder groups may include: ▪ people with mental health problems/consumers, ▪ family members and care givers, ▪ Family Physicians ▪ Psychiatrists, ▪ the RCMP, ▪ Aboriginal social services, ▪ criminal justice system, ▪ IH mental health employees, ▪ Employment Assistance Workers, ▪ Ministry of Children and Family Development staff ▪ residential service providers ▪ School districts ▪ Employee Assistance Programs ▪ others supporting people with mental health problems Stakeholders will have an informed and appropriate chance to contribute to the process of change. Meaningful involvement means; using language appropriate to participants, scheduling accessible meeting times, hearing and considering ideas that have not traditionally been a part of the service mainstream, include the use of mentors for those unfamiliar with system intricacies.
Service development supports the concept of functional equivalency.	Not all services need look the same. The same outcome can be achieved in different ways.
Services will be relevant to the group targeted for support.	That is they will address: ▪ geography, ▪ resource availability, ▪ distance from service, ▪ cultural differences, ▪ age appropriateness, ▪ lifestyle choices.
Services with evidence based validity will be supported.	Services which are known to be effective will be pursued over services which lack demonstrable outcomes. Services and methodologies which are innovative but do not have current demonstrable outcomes will have an appropriate opportunity to demonstrate effectiveness..
The safety of clients, caregivers, and the public is essential.	The safety of clients, caregivers, and the public is essential.

Services will be non-discriminatory.	Services will be equally available regardless of: ▪ ethnicity, ▪ religious beliefs, ▪ lifestyle values, ▪ sexual orientation, ▪ political beliefs or affiliation, ▪ stated opinion of health services ▪ or any other value-based difference
Services will be characterized by a high level of coordination and communication.	Joint work will be evidenced between institutionally-based mental health services, community-based mental health services and other community services. The broader community will be highly involved as a part of the development, treatment and support teams. The recognition of the importance of mental health on all aspects of life predicates the involvement of the broader community support system. Broad involvement may be promoted through the use of trans-disciplinary or multi-disciplinary teams.
Services will promote self-management of care and independence to greatest degree possible.	This may be accomplished through strong utilization of natural and informal supports, and self-help / peer support groups. Most mental health service needs last a lifetime. Natural supports (friends and families) are more likely to remain in people's lives than professional supports. Utilization of self-management tools and recovery focus to strengthen capacities of individuals.
Services will form a realistic continuum of care.	Services will have continuity throughout phases of illness/wellness and throughout life. Mental illness and addictions affect all aspects of life. Treatment will be multi-faceted and reflective of the patient's social reality. Treatment and support will be holistic and embrace a biopsychosocial model. The continuum of service will be composed of formal, funded services in partnership with non-formal supports.
The best staff are key to the best service.	The best employees are attracted and retained through accurate hiring, clear expectations, appropriate remuneration, up-to-date and current training and recognition based on merit. IH Mental Health service development should include best practice human resource management in order to attract and retain the best mental health staff in Canada.

Services will be accessible when and where they are required.	Accessibility does not mean all services will be available in all locations. Realistic application of resources will allow for appropriate levels of accessibility. Access may also mean availability through alternate methods such as: assisted travel, tele-medicine, remote consult, or use of non-formal services as bridging mechanisms. Often resources are concentrated in urban centres. As rural settings may not have sufficient population to reasonably warrant all professions or services practices will be established to allow the sharing of resources through creative initiatives (joint training, locum, “clinics”, or time limited group interventions). Although some resources will not be available in all locations, each Health Service Area will develop a range of resources.
Accountability will be built into all service components	Accountability will be evidenced through participation, open information sharing and adherence to standards.
Development of services must be sustainable within reasonable resources.	Interior Health and community service agencies have a limited resource capacity. The need for sustainable development within those resources is required.

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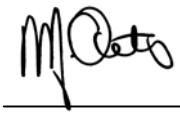
IH MENTAL HEALTH LEADERSHIP TEAM

Kim Marshall,
Mental Health Director
Okanagan Health Services Area

Dr. Don Duncan
Co-Manager
Okanagan Health Services Area

Mohamed Dhanani,
Mental Health Director
Thompson Cariboo Health Services Area

Dr. Shiraz Mohamed
Co-Manager
Thompson Cariboo Health Services Area



Martin Oets
Mental Health and Support Services Administrator
Kootenay Boundary Health Services Area

Dr. Sharman Naicker
Co-Manager
Kootenay Boundary Health Services Area

Kelly Madigan
Mental Health Director
East Kootenay Health Services Area

Dr. Stu Howard
Co-Manager
East Kootenay Health Services Area

APPENDIX A

The following tables are divided into 8 Best Practice service functions. The information has been derived from a number of sources and sets the standard by which mental health services in the Interior Health will be examined.

CLINICAL SERVICES

Service Function	Target Groups	Potential Methods	Best Practice Standards
CLINICAL SERVICES • Assessment, diagnoses, treatment and consultation provided in a variety of settings (inpatient and outpatient) to enable people to manage the disabling aspects of their mental illness and / or addiction. • Develop with the individual, care plans that enhance personal ability for secondary prevention and self care and reduce harm. • Patient education.	**CLINICAL SERVICES** • All people experiencing a severe and/or persistent mental illness or addiction. • All people experiencing an episodic or cyclical mental health problems.	**CLINICAL SERVICES** • Inpatient hospital based services. • Outpatient and day hospital services • Community based counseling and sessional services • Support to primary health care practitioner. • Group support oriented services • Short term residential transitional services	**CLINICAL SERVICES** • Range of services available from individualized counseling to group-oriented support services. • Treatment and support should be provided from a bio-psycho-social framework. • Should be well coordinated with primary health care providers. • Should be characterized by close working relationships between hospital based mental health services, community based mental health services and supporting community agencies. • Health care plans should promote self management or care. • Harm reduction model will be used in treatment planning.

CASE MANAGEMENT AND OUTREACH

Service Function	Target Groups	Potential Methods	Best Practice Standards
CASE MANAGEMENT / OUTREACH • Defined as 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.	**CASE MANAGEMENT / OUTREACH** • For all persons with a persistent mental health problem. • For people with a cyclical or episodic mental health problem.	**CASE MANAGEMENT / OUTREACH** • Multi-discipinary or trans-disciplinary team approach. • Formation of treatment teams around individuals with the case manager acting as the coordinator of multi-stream support.	**CASE MANAGEMENT / OUTREACH** • Consumer directed and driven by consumer needs. • Low staff to consumer ratio (1/40) • Support provided in the environment of the consumer's choosing. • Strong team orientation. • Support spans all aspects of the consumer's life. • Recognition that disability in any aspect of life can have a strong impact on mental health.

EMERGENCY / CRISIS RESPONSE

Service Function	Target Groups	Potential Methods	Best Practice Standards
EMERGENCY RESPONSE AND SHORT TERM INTERVENTION • provides consumers with support in a crisis situation that requires immediate intervention as outlined in the BC Mental Health Reform Best Practices document. • provides assessment, psychiatric consult / management, pharmaceutical interventions, • provides discharge planning with care plan and prevention strategies, • family / caregiver education and support	**EMERGENCY RESPONSE AND SHORT TERM INTERVENTION** • People with a severe mental illness or addiction. • People requiring detoxification services. • Experiencing an acute psychiatric crisis • People requiring immediate professional care. • People who are a danger to self or others	**EMERGENCY RESPONSE AND SHORT TERM INTERVENTION** • Hospital based Psychiatric Emergency Service • Mobile community crisis response teams • Crisis lines • Hospital diversion / rapid return to hospital programs • Community day and evening programs • Hospital based day and evening programs • Emergency short stay residential programs. • Adolescent Psychiatric and addiction services distinct from adult services. • Geriatric outreach services. • After Hours Outreach • Withdrawal management	**EMERGENCY RESPONSE AND SHORT TERM INTERVENTION** • There are a number of service alternatives that allow community and hospital based treatment. • Service should be provided in the least restrictive environment with the minimum disruption to daily life. • There is a fair clinical basis for priorizing referrals. • Urgent referrals are seen within 72 hours. • 24 hour – 7 day/week availability. • Active involvement of service user and family members. • Intervention is time limited without jeopardizing clinical outcomes. • Service supports and provides future crisis planning. • Sufficient exchange of clinical information between service settings. • Community caregivers work with hospital workers to plan admissions to hospital and re-entry to community. • Family physicians are well linked to mental health specialists.

RESIDENTIAL SUPPORT

Service Function	Target Groups	Potential Methods	Best Practice Standards
RESIDENTIAL • Service support the individual to acquire and maintain safe and affordable housing (short term / long term) which enhances their quality of life across the spectrum from private / supported / assisted living to residential care.	**RESIDENTIAL** • For all people living with the long-term effects of mental illness or addictions. • For people who require some level of assistance in acquiring and maintaining a supportive and safe residential environment.	**RESIDENTIAL** • Market housing, • Supportive group living • Supported Independent Living Programs (congregate housing) • Respite • Assisted living • Block apartments • Supported hotels with single room occupancy, leased owned and managed by non-profit societies. • Emergency housing for individuals requiring short-term stabilization but not hospitalization. • Housing registry / Home finder services. • Rental subsidies. • Specialized care facilities. • Supportive recovery models • Residential addictions treatment	**RESIDENTIAL** • Range and choice of options that are a match for client social realities. • The goals of service should be movement toward independent living. • Residential supports should be stable and permanent. • Consumers should be involved in design, development and management if possible. • Housing should not be a restrictive and severe financial burden. • Residential settings should be typical. • Residential settings should not form a concentrated “service ghetto”. • Outreach (or case management) staff should be readily available. • Consumers should be free to determine the level of support they will receive, free to make lifestyle choices and have materials residential support (phone, cable, etc.)

INTENSIVE CASE MANAGEMENT

Service Function	Target Groups	Potential Methods	Best Practice Standards
INTENSIVE CASE MANAGEMENT • Provides enhanced services to a specific population of consumers that require specialized treatment and support (includes ACT as described in the BC Mental Health Reform Best Practices document) • Develop meaningful and influential engagement with service user. • Increase stability in service users life. • Provide a more culturally responsive service environment. • Provide support to the service user and family for sustained periods. • Promote effective interagency coordination. • Provide more immediate and effective risk assessment and management. • Provides assessment. • Provides and supports the provision of training in activities of daily living. • Provides support and training to families and caregivers. • Supports medication interventions including the regular assertive monitoring of side effects. • Promotion of overall health status (nutrition, dental health, STD prevention) • Helps to develop use of local services, educational resources and vocational resources.	**INTENSIVE CASE MANAGEMENT** • Adults with a severe and persistent mental illness or addition. • History of high use of inpatient or emergency service (3 admissions within a 2 year period, more than 6 mores inpatient care in a 2 year period). • Demonstrated difficulty in maintaining consenting contact with available services. • Multiple or complex needs demonstrated by history of violence, self harm, poor response to previous treatment, co-existing diagnoses.	**INTENSIVE CASE MANAGEMENT** • Self-contained teams responsible for providing full range of Interventions • Development of multi-disciplinary or trans-disciplinary support teams. • Development of multi-agency partnerships to augment treatment team interventions. • Utilize cognitive behavioural therapy (CBT) • Utilize occupational therapy approaches to daily living skills.	**INTENSIVE CASE MANAGEMENT** • Consumer directed and driven. • Single primary care physician or psychiatrist responsible for support to each team. • Treatment is long-term. • Majority of support and intervention is provided in the community. • Support is provided by the team itself. • Emphasis of service is to build relationships (personal and service oriented). • Small caseload (10-15). • High frequency contact

PSYCHOSOCIAL REHABILITATION

Service Function	Target Groups	Potential Methods	Best Practice Standards
PSYCHOSOCIAL REHABILITATION • Provides a range of personalized services, advocacy and community education related to personal life, leisure, education and vocation. • Services focus on assisting the individual to gain or regain practical skills and independence. • Provides affiliation and relationship opportunities for individuals experiencing isolation.	**PSYCHOSOCIAL REHABILITATION** • For people with severe and persistent mental health problems. • People with mental health / additions problems who are currently unable to return to gainful employment. • People with mental health / additions problems who require minimal supports to live in the community.	**PSYCHOSOCIAL REHABILITATION** • Life skills programs. • Clubhouse-model programs. • Case management services through promotion and support in community involvement. • Pre-Employment services • Employment Services • Supported Employment programs • Supported Education programs	**PSYCHOSOCIAL REHABILITATION** • High level of consumer involvement and self-determination. • Focus is on assisting transitions from formal mental health services to natural community supports. • Support of peers may play a strong role in therapeutic outcomes. • A spirit of hope and gain (recovery) are cornerstones of support. • Service includes community development capacity to work with employers and community entities to provide education of mental health and to act as “gatekeepers” for people with mental health problems.

PREVENTION

Service Function	Target Groups	Potential Methods	Best Practice Standards
PREVENTION MEASURES • Research • Education • Early identification and intervention • Programs provide early recognition of symptoms, effective treatment, supports and timely access to information that serves to improve the likelihood that people with mental illness will experience minimal disability. • Community development which promotes healthy childhood development through an asset building model.	**PREVENTION MEASURES** • Service is for individuals who are at risk of developing mental health problems. • People who are experiencing early signs of mental health problems.	**PREVENTION MEASURES** • Collaboration in providing educational materials and presentations with Public Health Nursing, community mental health agencies, school districts, community service agencies and others. • Early identification and intervention, suicide prevention, eating disorder, anxiety prevention programs and substance use prevention.	**PREVENTION MEASURES** • Based on demonstrated prevention outcomes. • Utilizes known predictors of mental illness and addictions issues. • Provides primary level outreach and at different times in the life cycle. • Is highly collaborative with community agencies to provide early intervention upon detection. • Works on a model of strengthening capacities in individuals (self-esteem, coping skills, negotiating skills, parenting skills), and communities (increasing social inclusion, workplace health, community safety, schools supports). • Targeting factor known to influence mental health (family history, anxiety, perception of control, participation, social inclusion). • Utilizes an Asset Building Community Development Model

ASSISTANCE

Service Function	Target Groups	Potential Methods	Best Practice Standards
ASSISTANCE • Assist consumers to access services such as market housing (landlord / tenant issues), income support, legal and medical benefits delivered through many different ministries, agencies, and service providers. • Assist family members, caregivers and supports to understand mental illness and addictions issues.	**ASSISTANCE** • People with less intensive mental health and addictions care needs. • People who require minimal supports to maintain wellness.	**ASSISTANCE** • Consumer and family education services. • Peer Supports • Family Support and Education • Consumer and Family Advisory bodies. • Community Living Support Workers. • Respite support.	**ASSISTANCE** • Education and support efforts are focused on self care capabilities are increased. • Demonstrated belief in the ability to self manage illness. • Involvement of consumers and family members is facilitated and resourced. • A range of opportunities exist for participation in systemic issues. • Consumers and family members are involved as providers and educators.

SYSTEM NEEDS

Service Function	Target Groups	Potential Methods	Best Practice Standards
SYSTEM NEEDS • There is a freestanding mental health reform policy based on an explicit vision that is shared among the various stakeholders. • There is a planned strategy for implementing policy that preserves the mental health envelope, prevents losses due to downsizing institutions, and increases the proportion of funds spent on community care. • Regular monitoring of all services and supports is the basis for program and system accountability, and for continuous quality improvement. • Establishment of performance measures and timelines • Information gathering system • A clear point of accountability for system performance. • Promotes and manages cost containment and the transfer of resources to most appropriate use. • Assures mental health care is connected with the broader health system and generic services. • A detailed labour strategy.	**SYSTEM NEEDS** •	**SYSTEM NEEDS** • Coordinated Leadership / management team approach	**SYSTEM NEEDS** • Policy defines concrete, measurable targets for reform • There is an understandable methodology for monitoring and evaluation. • Goals, performance measures and timelines are pre-established and well understood by all components of the system. • An information system has common elements for system evaluation (authority level) and local elements for program evaluation (agency level) • There is a sufficient, protected evaluation budget. • At the regional/local level an organizational entity or mental health authority is identified as responsible for mental health care. • The authority uses sound clinical, administrative and fiscal mechanisms to promote cost containment and transfer. • Diverse funding sources are consolidated into a single funding envelope that can be used flexibly. • Funding allocations to a region or local area are linked with unique characteristics and needs of residents. • A consumer-centred information system supports decision making in planning, funding and managing the system. • Mental health care has demonstrable connections with the broader health system and generic services.