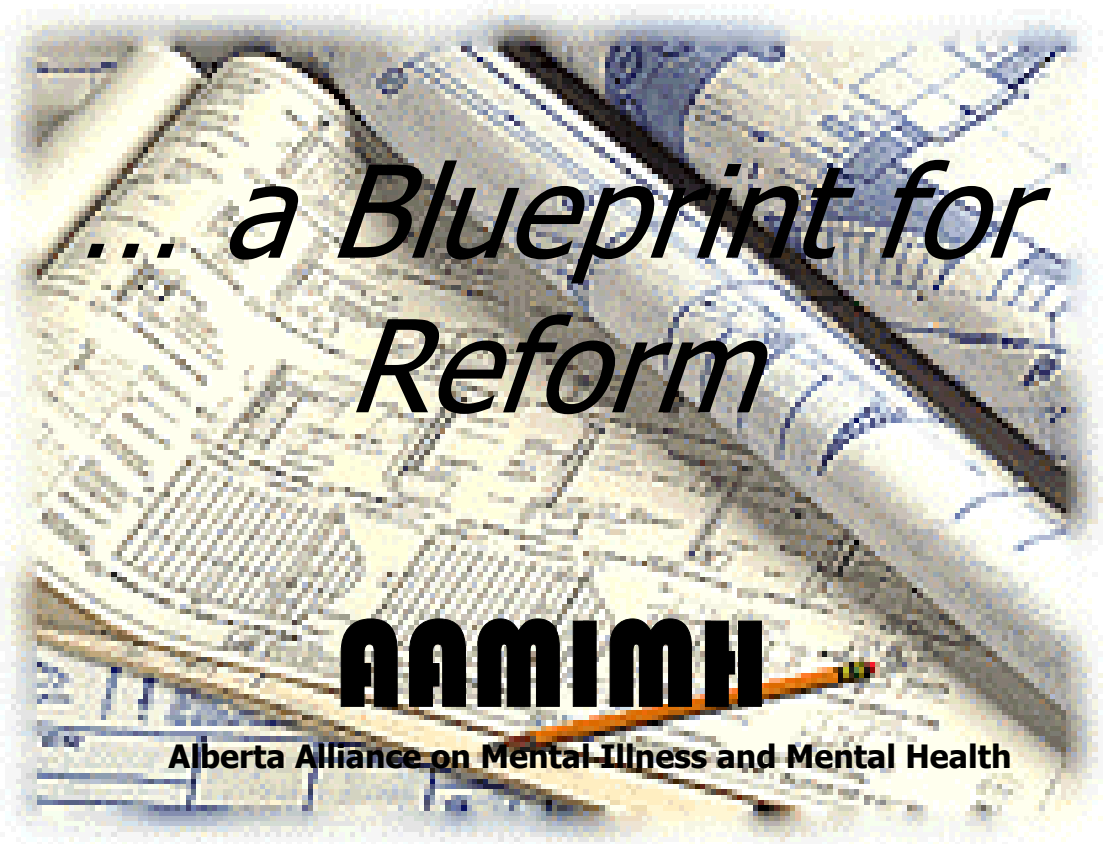


# Partnership, Participation, Innovation



*... a Blueprint for  
Reform*

**AAMIMH**

Alberta Alliance on Mental Illness and Mental Health

**MARCH 2003**



**WHAT IS MENTAL HEALTH?** A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

*World Health Organization, 2001*

**WHAT IS MENTAL ILLNESS?** A number of health conditions characterized by alterations in thinking, mood or behaviour (or some combination thereof) and associated with distress and/or impaired function.

*US Surgeon General, 1999*

**WHAT IS A MENTAL HEALTH SYSTEM?** A modern mental health *system* places the consumers/clients/patients of services central to all efforts, and includes a wide range of factors which influence lives. While recognizing the importance of treatment services, the approach also includes a role for family and friends, community services and supports, and consumers working together. It also acknowledges some fundamental elements to which every citizen should have access: housing, education, leisure activity, income and work.

*Alberta Alliance on Mental Illness and Mental Health, 2000*

- adapted from CMHA



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## EXECUTIVE SUMMARY

Since the publication of the Alberta Alliance on Mental Illness and Mental Health (AAMIMH) document *Good People . . . Good Practices . . . No System* in February 2000, the Government of Alberta has responded positively by initiating a reform agenda. The plan includes the divestiture of services to Alberta's Regional Health Authorities (RHAs), and defining a new role for the Alberta Mental Health Board (AMHB) – all as of April 1, 2003.

This *Blueprint for Reform* is intended as a guide and tool for all concerned with the reform and improvement of the mental health system. It also represents a commitment by AAMIMH member organizations to contribute leadership and expertise to the process of reform. This document offers statistical evidence regarding the prevalence of mental illness as a basis for establishing the timeliness and urgency of mental health reform.

The *Blueprint for Reform* contains a series of interrelated “units” that address key areas to consider in the design of a service system, by asking critical questions. The objective is to facilitate the development of plans reflecting best practices (that is, the latest information on successful mental health policies and programs).

Presented in question format, the “units” address the areas of policies, financing, legislation, quality improvement, organization of systems and services, and planning and budgeting. Each is designed in “checklist” form to serve as a status report of progress towards mental health system reform following the divestiture of services to the RHAs.

Finally, the *Blueprint for Reform* makes the following recommendations:

1. That the Government of Alberta endorse the principles in the *Blueprint for Reform* and commit to protecting mental health funding and improving financial allocations on a priority basis.
2. That the *Blueprint for Reform* be reflected in provincial and regional mental health business plans and utilized to guide the design and implementation of mental health system reform.
3. That the newly-mandated AMHB institute and maintain an annual “report card” to evaluate the results of action aimed at addressing the reform framework in the *Blueprint for Reform*.



# 1. INTRODUCTION

In February of 2000, the Alberta Alliance on Mental Illness and Mental Health (AAMIMH) published *Good People . . . Good Practices . . . No System*, a critique of mental health service delivery in Alberta. The report contained several recommendations for action, including the following five “needs” which were considered high priority:

- The need for a contemporary vision and strategic plan
- The need for adequate funding
- The need for regional psychiatric beds for acute care
- The need for improved community support services, including improved housing options
- The need to continue efforts to improve children’s mental health services.

Since that time, the Government of Alberta has responded positively and initiated the beginnings of a reform agenda that could serve as a model for the country. The plan includes the divestiture of services to Alberta’s Regional Health Authorities and they too are responding with a renewed interest in achieving a model system.

This *Blueprint for Reform* is intended as a guide and a tool for all concerned with the reform and improvement of mental health care. It also represents a commitment by AAMIMH member organizations to provide leadership and service to the process of reform.

This *Blueprint for Reform* may be useful for:

- the provincial authority (Alberta Mental Health Board) charged with system level governance, as it advocates, preserves the integrity of mental health resources, assists with planning, coordinates services, sets standards and evaluates reform progress,
- government officials and regional health authorities to plan and implement mental health system reform,
- service providers and community resources to plan and implement services consistent with best practices and the vision of a reformed system, and

- Alberta citizens, and in particular mental health consumers and family members, to further inform themselves about the best reform goals and processes so as to have more effective input into the planned changes to mental health care.

The *Blueprint for Reform* has been produced in order to facilitate the development of plans that the AAMIMH hopes will reflect best practices – the latest information on successful mental health policies and programs. The document is based on numerous previous reports, including the *Mazankowski* and *Romanow* reports, but relies heavily on the “Best Practices” work of the Federal/Provincial/Territorial Advisory Network on Mental Health and on the World Health Report 2001. Most significantly, the *Blueprint* mirrors, with permission, the *Mental Health Policy Project* of the World Health Organization (WHO). It also constitutes a consensus of a very broad range of stakeholders as reflected in the membership of the AAMIMH.

This *Blueprint for Reform* contains a series of interrelated “units” that address key areas to consider in the design of a service **system**, by asking critical questions. The units are contained in Section # 4 and include:

- Policies
- Financing
- Legislation
- Quality Improvement
- Organization of Systems
- Organization of Services
- Planning and Budgeting

## **2. MENTAL HEALTH AND ILLNESS – WHAT WE KNOW**

Worldwide, an estimated 450 million people suffer from mental illnesses, including depression, bipolar disorder, substance abuse disorders, dementias, post-traumatic stress disorder, obsessive compulsive disorder, panic disorder and schizophrenia<sup>1</sup>. Mental illnesses comprise five of the top ten causes of “years lived with a disability” – the measure of the societal burden of illness and disability.<sup>1</sup>

When substance abuse disorders are included the disease burden increases dramatically. The yearly economic cost in the United States alone is US \$148 billion, <sup>2</sup> with the burden attributable to illicit drugs (heroin and cocaine) estimated at between 0.4% and 4% of the total disease burden worldwide. <sup>2</sup>

And mental illness is a killer. Four thousand Canadians die every year by suicide, and the majority of these individuals are clinically depressed. Generally, an average of 450 people die due to suicide in Alberta. In 2002, the number of people who committed suicide in our province jumped to 477, making Alberta the province with the second highest suicide rate in Canada. Alcohol is responsible for 1.5 % of all deaths worldwide. <sup>2</sup> Thousands of additional people die from stroke, heart conditions, cancer and other illnesses where distress is a complicating factor.

In Canada:

- Six million, or twenty percent of all citizens, will experience a mental illness in their lifetime. <sup>1</sup> Three percent will suffer a severe and persistent disability. <sup>5</sup>
- Six million, or 20% of the population, will suffer substance abuse disorder in their lifetime, <sup>4</sup> and as many as half of people with severe mental illness develop alcohol or other drug abuse problems at some point in their lives. Mental illnesses affect people of all ages, educational and income levels and cultures, although some groups are more vulnerable, i.e., the poor, women, the elderly and indigenous populations.
- In 1999/2000 over nine million hospital days were utilized by individuals with mental illness, and in 1998/1999 mental disorders accounted for 14% of total days of care in general hospitals. <sup>6</sup>
- The economic cost of alcohol amounts to approximately \$27.4 billion<sup>2</sup>
- Almost four percent of all admissions to general hospitals are for mental illnesses. <sup>7</sup>
- The economic burden of mental illness is estimated at \$14.4 billion, only slightly less than for cancer. <sup>8</sup>

In Alberta:

- Six hundred thousand people, or twenty percent of the population, will experience a mental illness during their lifetime. <sup>4</sup>
- The *Mazankowski* Report reveals that 39% of all general practice physician billings were mental health related. <sup>11</sup>

- Mental health problems constitute the top reason people consult their family physicians. 9
- One hundred and twenty thousand Albertans are addicted to alcohol and drugs. 4
- In 1999/2000, the most common dosage of a single commonly-used antidepressant was the third most prescribed drug. There are of course other dosages of that one drug and many other antidepressants. 9
- About \$500 million is spent on treating mental illness annually. 10

The burden of mental illness creates an enormous cost in terms of suffering, disability and economic loss – and trends indicate that as people live longer, the numbers are likely to increase in the future.

We also know that mental and physical health are inextricably linked. For example, personal attitudes of optimism, assertiveness and a belief that one can control his or her environment are associated with a lower incidence of both minor and major illnesses. Similarly, depression is frequently associated with and implicated in migraine headaches, asthma, back problems, gastrointestinal disorders, diabetes, AIDS, fibromyalgia, stroke, myocardial infarction and cancer. It has been demonstrated that major depression concomitant with illnesses like diabetes, heart disease and cancer lead to an increased severity of illness and also higher rates of mortality.

We know that most illnesses, mental and physical, are influenced by a combination of biological, psychological and social factors. We also know that most mental illnesses are very treatable. As noted in the 2001 World Health Report, “from the sum of our understanding, people with mental or behavioural disorders today have new hope of living full and productive lives in their own communities.”

Finally, we know that the factors which determine our overall health include “health” and “non-health” factors, the latter including, but not limited to, income and social status, social support networks, education, employment and working conditions, social and physical environments, personal health practices, coping skills, child health development, biology and genetics, gender, culture, and housing.

### **3. THE MENTAL HEALTH PRIORITY**

Mental illnesses comprise six of the leading disabilities (adjusted life years) – unipolar depression ranked #2, alcohol use disorders ranked #5, self-inflicted injury ranked #6, schizophrenia ranked #8, bipolar affective disorder ranked #9 and panic disorder ranked #20. <sup>1</sup> The portion of the global burden of disease is expected to rise from 12% in 2000 to 15% in 2020, <sup>1</sup> and as has been previously mentioned, mental disorders affect a range of outcomes in other physical health conditions.

Reform is also timely. Significant developments in our learning, new psychotropic medications, modern technology and the growth of the human rights and consumer movements has changed the manner and context in which people can be treated and supported. Decentralization of services is a trend across the world, providing an opportunity to integrate mental health into general health care.

### **4. MENTAL HEALTH REFORM: GOALS AND PRACTICES**

The goal of mental health reform is the development and implementation of a system of care that:

- reflects best practices in mental health care delivery,
- fully integrates mental health within health care and the broad range of community social supports, and
- improves and supports the mental health and well-being of all.

Such a system of prevention, treatment and care must provide clear and measurable outcomes including:

- easy accessibility,
- responsiveness and early intervention,
- culturally relevant alternatives, and
- a continuum of care that is balanced, coordinated, continuous and effective.

A significant outcome of such a system should be the promotion of the greatest safety, well-being, independence and true community integration of those experiencing even the most serious and persistent mental illness.

Achievement of the goals will be best met by:

- **Partnership** of government, health authorities, health providers and mental health consumers,
- **Participation** of mental health consumers, consumer-driven organizations, families and communities, and
- **Innovation** and a commitment to excellence and accountability in services, programs and system governance.

The goals will be best met by including the initiatives that involve consumers and their families in the design of mental health policy, programs and services<sup>1</sup>, and which give first priority to the people with the most severe and persistent illnesses. The goals of a reformed system must also include the provision of service to special populations with unique mental health needs, among others, women, children, older adults and ethno-racial groups.

Achieving the goals of mental health reform will require that special attention be given to the following practices.

#### 4.1 MENTAL HEALTH POLICY

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

|       |   | Yes | No | In Progress/<br>Comments |
|-------|---|-----|----|--------------------------|
| 4.1.1 | Is there an explicit mental health policy that gives high priority to mental health services? |     |    |                          |
| 4.1.2 | Is that policy endorsed at the highest level of the organization and of government?           |     |    |                          |

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.1.3 | Do the policies have guiding principles, which include: <ul style="list-style-type: none"> <li>• participation of the community,</li> <li>• deinstitutionalization and community care,</li> <li>• accessibility and equity,</li> <li>• integration through primary health care?</li> </ul>   |     |    |                          |
| 4.1.4 | Were the policies developed through a consultative process which included: <ul style="list-style-type: none"> <li>• the collection of information on population needs,</li> <li>• consensus building with stakeholders,</li> <li>• an international review of best practices, and</li> <li>• pilot projects to demonstrate the effectiveness of initiatives?</li> </ul>  |     |    |                          |
| 4.1.5 | Are policy objectives defined in terms of improving the health of the population?  |     |    |                          |
| 4.1.6 | Do policies specify action in the critical areas of: <ul style="list-style-type: none"> <li>• financing,</li> <li>• intersectoral collaboration,</li> <li>• legislation and human rights,</li> <li>• information systems,</li> <li>• advocacy,</li> <li>• research and evaluation,</li> <li>• quality improvement,</li> <li>• organization of services,</li> <li>• promotion, prevention, treatment and rehabilitation,</li> <li>• access to medication, and</li> <li>• human resources training?</li> </ul> |     |    |                          |
| 4.1.7 | Is information about the policies widely disseminated, promoted and understood by: <ul style="list-style-type: none"> <li>• government officials, and</li> <li>• the public?</li> </ul>  |     |    |                          |

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.1.8 | Do policies include an implementation plan including: <ul style="list-style-type: none"> <li>• objectives,</li> <li>• financial allocations,</li> <li>• monitoring,</li> <li>• evaluation, and</li> <li>• timeframes?</li> </ul>   |     |    |                          |
| 4.1.9 | Are policies driven by informed consideration of “best practice” evidence including: <ul style="list-style-type: none"> <li>• case management/assertive community treatment,</li> <li>• crisis response/emergency services,</li> <li>• housing,</li> <li>• inpatient/outpatient care,</li> <li>• consumer initiatives,</li> <li>• family self-help, and</li> <li>• vocational/educational supports?</li> </ul> |     |    |                          |

## 4.2 FINANCING

Adequate, stable and sustained funding is one of the most critical factors in the realization of a viable mental health system. Financing is the mechanism by which plans and policies are translated into reality. Financing creates the resource base for the actual operation and delivery of services, for the development and deployment of a trained workforce, and for the required infrastructure and technology. Without adequate, stable and sustained financing, objectives cannot – and will not – be achieved.

There must be proactive forward motion towards adequate funding for mental health at the provincial and regional levels.

|       |   | Yes | No | In Progress/<br>Comments |
|-------|---|-----|----|--------------------------|
| 4.2.1 | Is funding for mental health services equitable to funding for services of general health programs? |     |    |                          |

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.2.2 | Is funding for mental health services equal to the magnitude and burden of mental disorders present in the Alberta population?   |     |    |                          |
| 4.2.3 | Are the resources available for mental health consistent with the requirements of relevant legislation?  |     |    |                          |
| 4.2.4 | Are the resources available for mental health clearly detailed and protected within accounting systems for both: <ul style="list-style-type: none"> <li>• in-patient services, and</li> <li>• community services?</li> </ul> |     |    |                          |
| 4.2.5 | Is funding for mental health tied to a strategic vision?   |     |    |                          |
| 4.2.6 | Do financing mechanisms facilitate rather than impede access to required services?   |     |    |                          |
| 4.2.7 | Are resources specifically allocated to priority, underserved and at-risk populations (for example, people with severe mental disorders, women, children, older adults and ethno-racial groups)?                             |     |    |                          |
| 4.2.8 | Have provisions been made for special funding necessary during health services transitions to ensure that new services are firmly established before existing services are terminated?                                       |     |    |                          |
| 4.2.9 | Does health insurance promote parity between mental health and general health?   |     |    |                          |

Accountability for existing mental health resources should be a critical component of planning and budgeting.

|        |  | <b>Yes</b> | <b>No</b> | <b>In Progress/<br/>Comments</b> |
|--------|--|------------|-----------|----------------------------------|
| 4.2.10 | Is there a clear point of accountability?  |            |           |                                  |
| 4.2.11 | Are the resources available for mental health services and programs judiciously allocated to appropriate and effective services? |            |           |                                  |
| 4.2.12 | Are there information systems in place for monitoring expenditures and services to ensure quality, effectiveness and efficiency? |            |           |                                  |

Financing can shape the development and future of mental health systems through incentives and budget flexibility.

|        |   | <b>Yes</b> | <b>No</b> | <b>In Progress/<br/>Comments</b> |
|--------|---|------------|-----------|----------------------------------|
| 4.2.13 | Are policies in place to ensure the appropriate allocation and tracking of funds from institutions to community care? |            |           |                                  |
| 4.2.14 | Is there funding for quality, evidence-based services?  |            |           |                                  |
| 4.2.15 | Is there funding for workforce training and development?  |            |           |                                  |
| 4.2.16 | Are financial incentives available for health innovations?  |            |           |                                  |

Specific infrastructure supports can facilitate planning and budgetary objectives.

|        |  | <b>Yes</b> | <b>No</b> | <b>In Progress/<br/>Comments</b> |
|--------|--|------------|-----------|----------------------------------|
| 4.2.17 | Are management and purchasing structures in place? |            |           |                                  |
| 4.2.18 | Are information systems in place?                  |            |           |                                  |

|        |   | Yes | No | In Progress/<br>Comments |
|--------|---|-----|----|--------------------------|
| 4.2.19 | Do contractual arrangements facilitate attainment of planning and budgetary objectives? |     |    |                          |
| 4.2.20 | Has provision been made for evaluation and analysis of cost-effectiveness?              |     |    |                          |
| 4.2.21 | Are key stakeholders involved, and is information sharing encouraged between them?      |     |    |                          |

Considerations of detail may eclipse the more obvious factors in developing serviceable planning and budgeting models.

|        |  | Yes | No | In Progress/<br>Comments |
|--------|--|-----|----|--------------------------|
| 4.2.22 | Has high priority been assigned to mental health services and programs?  |     |    |                          |
| 4.2.23 | Is the effectiveness of medications and services in the management of mental disorders well understood?                                      |     |    |                          |
| 4.2.24 | Have vested interests of certain stakeholders in preserving the status quo of existing structures and services been appropriately addressed? |     |    |                          |
| 4.2.25 | Has the importance of organized constituencies adequately representing people with mental disorders been fairly considered?                  |     |    |                          |

### **4.3 LEGISLATION**

Legislation in mental health is an important aspect of policy and service development. Legislation can provide longer-term consistency and continuity to policy directions which otherwise might be altered with changes in government.

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.3.1 | Does legislation facilitate the articulation of the fundamental principles, values, goals and objectives of mental health policies and programs?   |     |    |                          |
| 4.3.2 | Does legislation provide a legal framework to ensure that critical issues are addressed, such as: <ul style="list-style-type: none"> <li>• early access to care,</li> <li>• high quality of care,</li> <li>• integration of people with mental disorders into the community, and</li> <li>• mental health promotion</li> </ul>   |     |    |                          |
| 4.3.3 | Does legislation: <ul style="list-style-type: none"> <li>• protect and promote the rights, needs and interests of people with mental disorders, and</li> <li>• tackle the stigma and discrimination they experience?</li> </ul>  |     |    |                          |
| 4.3.4 | Does legislation promote quality of care by: <ul style="list-style-type: none"> <li>• supporting minimum standards for access to services and quality of services?</li> <li>• allocating resources for underserved populations?</li> <li>• promoting training, research and evaluation?</li> <li>• enforcing accreditation for providers and organizations?</li> <li>• requiring periodic reports on the mental health status of the general population and the access, quality, cost and impact of care for specific sub-populations?</li> <li>• providing resources for infrastructure development and maintenance?</li> </ul> |     |    |                          |

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.3.5 | Is legislation consistent with the <i>Canada Health Act</i> and the <i>UN Principles for the Protection of Rights of Persons with Mental Illness and the improvement of Mental Health Care</i> (1991)?   |     |    |                          |
| 4.3.6 | Is legislation the product of a consultation process involving all relevant provincial, regional and community stakeholders through: <ul style="list-style-type: none"> <li>• publication of legislation,</li> <li>• solicitation of written responses and</li> <li>• holding consultative meetings or public hearings?</li> </ul> |     |    |                          |

#### 4.4 QUALITY IMPROVEMENT

An emphasis on the quality of mental health policies and services is fundamental to effective stewardship and accountability. Quality improvement can result in effective policies that promote mental health, provide appropriate services, and enhance the likelihood of positive outcomes for people with mental disorders. A “quality orientation” results in optimal use of limited resources, and can reduce overuse or misuse of services. Ongoing monitoring provides an in-built mechanism to improve continually the effectiveness and efficiency of services.

Planning and budgetary processes influence the quality of mental health care.

|       |   | Yes | No | In Progress/<br>Comments |
|-------|---|-----|----|--------------------------|
| 4.4.1 | Do planning and budgetary processes specify the availability and quality of services for various sub-populations, such as people with severe mental disorders, women, children and adolescents, the elderly, different ethnic groups or people residing in specific geographic areas? |     |    |                          |

|       |  | <b>Yes</b> | <b>No</b> | <b>In Progress/<br/>Comments</b> |
|-------|--|------------|-----------|----------------------------------|
| 4.4.2 | Do planning and budgetary processes specify the minimum acceptable levels of quality for different settings (such as hospitals and the community), and for different services? |            |           |                                  |
| 4.4.3 | Do planning and budgetary processes specify the resources available for the infrastructure needed to implement quality management systems and feedback mechanisms?             |            |           |                                  |
| 4.4.4 | Do planning and budgetary processes specify the resources needed for the current and future development of a trained workforce?  |            |           |                                  |

Quality results from a partnership of policy makers, purchasers, providers, consumers and family members.

|       |  | <b>Yes</b> | <b>No</b> | <b>In Progress/<br/>Comments</b> |
|-------|--|------------|-----------|----------------------------------|
| 4.4.5 | Have those responsible for developing policy at the provincial, regional and community levels encouraged and facilitated the establishment of appropriate non-governmental organizations through legislation and regulation? |            |           |                                  |
| 4.4.6 | Have those responsible for developing policy provided forums to develop a common understanding of various perspectives and to build consensus across diverse groups?   |            |           |                                  |

Specific mechanisms must be implemented at all levels to maintain, monitor and improve quality.

|        |   | Yes | No | In Progress/<br>Comments |
|--------|---|-----|----|--------------------------|
| 4.4.7  | Is there provision for accreditation of service providers and organizations?  |     |    |                          |
| 4.4.8  | Are there clearly-defined standards for treatment and care?   |     |    |                          |
| 4.4.9  | Are there clearly-defined clinical guidelines?  |     |    |                          |
| 4.4.10 | Is there a provision for performance measurement, including consumer and family member perspectives?                                      |     |    |                          |
| 4.4.11 | Is there provision to assure monitoring of outcomes?  |     |    |                          |
| 4.4.12 | Is there adequate provision for consumer and family education?  |     |    |                          |
| 4.4.13 | Is there sufficient information on treatment and care services, and adequate capacity in the system to analyse the available information? |     |    |                          |
| 4.4.14 | Is state-of-the-art knowledge readily available and appropriately shared?   |     |    |                          |
| 4.4.15 | Is there provision for adequate workforce development and training?   |     |    |                          |
| 4.4.16 | Is there sufficient consumer and community input into standards of care and quality assurance processes?                                  |     |    |                          |

## 4.5 ORGANIZATION OF SYSTEMS

A governance model that allows the government to develop province-wide policies, set system standards and seek overall outcomes for the enhanced mental health of Albertans should consist of:

- a *provincial entity* charged with system level governance (preserves the integrity of mental health funding, monitors and evaluates system performance and promotes accountability and standards),
- *Regional Health Authorities* having overall responsibility for providing, integrating and administering the full range of health and mental health services within broadly defined mental health programs that include community resources, and

- *Regional Councils* supporting the provincial entity and the Regional Health Authorities, made up of health, mental health, community and consumer representatives, and having responsibility for planning and advising on a range of services that best address local needs consistent with best practices and provincial standards.

The governance structure must be critically appraised on an ongoing basis to assure that it remains responsive, accessible and accountable.

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.5.1 | Does the provincial entity have the mandate: <ul style="list-style-type: none"> <li>• to protect mental health funding,</li> <li>• to articulate and hold accountable,</li> <li>• to evaluate and monitor, and</li> <li>• to ensure a clear, consistent, goal-driven, stakeholder-owned mental health policy is in place?</li> </ul> |     |    |                          |
| 4.5.2 | Are all programs and services administered regionally?   |     |    |                          |

## 4.6 ORGANIZATION OF SERVICES

The organization of services is a critical aspect of policy because services are the ultimate means through which effective interventions are delivered. Services in the community through to more specialized services need to be coordinated, allowing for referrals and back referrals at each level of the health system in order to promote continuity of treatment and care. Links between health services and the non-health sector (for example, housing, social services and law enforcement) must also be established. The exact mix of services will vary considerably according to the cultural, social, political and economic context.

There are advantages in delivering mental health interventions *through general health systems*, including:

- better geographical accessibility,
- reduced stigma through managing mental disorders in the same way as other illnesses,

- improved screening, detection and treatment rates of mental health problems,
- enhanced quality of care through the adoption of a comprehensive approach to improving health,
- better adherence and clinical outcomes for a range of other present disorders such as diabetes and heart disease, and
- cost-efficiency savings due to shared infrastructure.<sup>1</sup>

There are advantages in providing mental health services *based in the community*, such as:

- enhanced continuity and comprehensiveness of care,
- addressing the essential elements of a comprehensive psychosocial rehabilitation strategy that includes social reintegration, employment, housing and general welfare, and
- improved outcomes and cost-effectiveness of treatments, particularly when informal mental health services such as traditional healers, families, self-help groups and volunteer workers are given adequate direction, support and opportunities to develop.

An immediate priority is to ensure that the large range of mental health services and programs is closely matched with population needs.

|       |   | Yes | No | In Progress/<br>Comments |
|-------|---|-----|----|--------------------------|
| 4.6.1 | Are resources invested in a reasonable balance between facility-based and community-based mental health services?   |     |    |                          |
| 4.6.2 | Are community support programs put in place before any reduction in institutional inpatient resources?  |     |    |                          |
| 4.6.3 | Are addictions programs fully integrated into other mental health and health services?  |     |    |                          |
| 4.6.4 | Has the service provision gap between rural and urban areas been reduced by extending the reach of general health services or establishing more specialized community mental health services? |     |    |                          |

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.6.5 | Has the training and continuing education of health care professionals moved from an emphasis on disease-based medical models to encompass psychosocial and alternative concepts of health care? |     |    |                          |
| 4.6.6 | Has the meaningful involvement of consumer and family organizations in service planning and delivery been encouraged and increased?  |     |    |                          |
| 4.6.7 | Do the provincial and regional entities demonstrate commitment to mental health consumers' involvement through all aspects of the policy and care continuum?                                     |     |    |                          |
| 4.6.8 | Have financial incentives and disincentives been considered and implemented to encourage the development of community services and regional in-patient facilities?                               |     |    |                          |

## **4.7 PLANNING AND BUDGETING FOR SERVICE DELIVERY**

Regional mental health services need to develop planning and budgeting tools for service delivery. Managers and planners in local mental health services need to plan services based on a thorough assessment of local needs, and in consultation with all relevant stakeholders in mental health. Planning and budgeting for local mental health services always involves:

- situation analysis,
- needs assessment,
- target setting, and
- implementation tasks.

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.7.1 | Do the planning and budgeting processes for service delivery incorporate such steps as: <ul style="list-style-type: none"> <li>• situation analysis,</li> <li>• needs assessment,</li> <li>• target setting and</li> <li>• implementation strategies?</li> </ul> |     |    |                          |

## 4.8 SERVICE DELIVERY

Local mental health services need to develop quality improvement mechanisms for mental health service delivery. Quality mental health care, based on the best available evidence, is essential in ensuring that service planning targets are attained.

|       |  | Yes | No | In Progress/<br>Comments |
|-------|--|-----|----|--------------------------|
| 4.8.1 | Has a quality improvement checklist or standards document been designed in consultation with all mental health stakeholders?                           |     |    |                          |
| 4.8.2 | Have accreditation procedures been developed according to the quality improvement checklist document?  |     |    |                          |
| 4.8.3 | When commissioning services, do contract specifications include indicators of quality mental health care?  |     |    |                          |
| 4.8.4 | Are quality improvement mechanisms used to monitor the mental health service?  |     |    |                          |
| 4.8.5 | Are there effective processes in place for recognizing services that have performed well, and for addressing services of an unacceptably low standard? |     |    |                          |

|       |   | Yes | No | In Progress/<br>Comments |
|-------|---|-----|----|--------------------------|
| 4.8.6 | Is there provision for reviewing, on a periodic but less frequent basis, the quality improvement mechanisms themselves to ensure that services are consistent with the latest evidence on best practices? |     |    |                          |

## 5. ADVOCACY, THE AAMIMH AND MENTAL HEALTH REFORM

“Advocacy in mental health” is a term used to describe a variety of different actions aimed at changing attitudinal and structural barriers to achieving positive mental health outcomes for the population. Strategies generally include education, raising awareness and lobbying. The goals of advocacy vary, but usually include improving government and institutional policies and practices, changing laws and regulations, protecting the rights and interests of people with mental illnesses and improving mental health services, treatment and care.

In August of 1999 the Canadian Mental Health Association invited senior representatives of all major provincial consumer, family, advocacy and professional organisations to a meeting (see section #7 for a list of the organizations). The purpose was to determine “stakeholder” views as to the adequacy of the government’s mental health reform progress. If dissatisfied, the organizations would be encouraged to develop a consensus on the issues, priorities and means for moving the reform agenda forward. From these meetings emerged a broad coalition of groups committed to the improvement and reform of mental health services in Alberta – the first such coalition in any Canadian province.

At the inaugural meetings, the AAMIMH members discussed matters relating to each of the usual goals of advocacy, but eventually identified five “urgent” issues relating to policies, funding and services. They then produced a report entitled *Good People . . . Good Practices . . . No System*, which acknowledged some progress over the years but chronicled 75 years of reform plans that were never realized. The report went on to identify

eleven key issues, including five which were identified as urgent as they formed the very foundations of mental health reform. They included:

- The need for a contemporary vision and strategic plan (URGENT)
- The need for adequate funding (URGENT)
- The need for regional psychiatric beds for acute care (URGENT)
- The need for improved community support services, including improved housing options (URGENT)
- The need to continue efforts to improve children's mental health services (URGENT)

The other issues considered important but less urgent, included:

- More research
- Reducing reliance on separate psychiatric hospitals
- Developing a human services plan
- Expanding full range of mental health services and choices for consumers and increased support for non-profit organizations
- Improving information technologies.

The report then detailed a contemporary vision and "best practices," ending with five recommendations relating to the AAMIMH priority issues. They were:

- that the government of Alberta declare its support of a contemporary plan for a community-based mental health system that is consumer-focused, decentralized, regionalized and integrated; and that provides a comprehensive range of psycho-social supports as defined within the "community resource base"; and that the plan be accompanied by a bold and aggressive implementation strategy,
- that adequate funding should be designated in 2000 - 2003 Alberta government budgets in order to alleviate the unacceptable chronic lack of access to psychiatric acute care beds (in RHA general hospitals) and within community-based services (such as outreach and housing services) in all Alberta health regions,
- that the Alberta (mental health) Hospitals Ponoka and Edmonton not be rebuilt without a clear definition of their role within a contemporary system of mental health care,

- that any funds spent to rebuild or refurbish Alberta Hospitals Ponoka and Edmonton should be matched on a 2:1 ratio with funding for enhanced and new community services (e.g. if \$1M is added to the capital budget for refurbishing, \$2M should be added to community services), and
- that the Alberta Mental Health Board should continue to demonstrate a policy and funding commitment to enhance the long-neglected area of children's mental health.

With funding from The Muttart Foundation and from the member organizations the AAMIMH opened an office, staffed a secretariat and began the task of advocating for change.

In early 2002 the Alberta government made a commitment to the decentralization and integration of mental health services, a move which has the potential to begin addressing the AAMIMH priorities.

The AAMIMH membership was pleased that by the fall of 2002, key Alliance recommendations were reflected in the positions articulated by the Alberta Health and Wellness Minister, the Honourable Gary Mar, and his Department; and by the Right Honourable Don Mazankowski and the Premier's Council on the Future of Health Care.

**NB:** A more detailed description of AAMIMH activity can be found in Chapter 16 of *Political Asylums* by Ron LaJeunesse.

## 6. RECOMMENDATIONS

AAMIMH makes the following recommendations:

1. That the Government of Alberta endorse the principles in the *Blueprint for Reform* and commit to protecting mental health funding and improving financial allocations on a priority basis.
2. That the *Blueprint for Reform* be reflected in provincial and regional mental health business plans and utilized to guide the design and implementation of mental health system reform.
3. That the newly-mandated AMBG institute and maintain an annual “report card” to evaluate the results of action aimed at addressing the reform framework in the *Blueprint for Reform*.

## **7. AAMIMH MEMBER ORGANIZATIONS**

### **Founding Members**

#### **Active**

Alberta Association of Registered Occupational Therapists  
Alberta Mental Health Self Help Network  
Alberta Psychiatric Association  
Canadian Mental Health Association  
Depression and Manic Depression Association of Alberta  
Psychologists' Association of Alberta  
Registered Psychiatric Nurses' Association of Alberta  
Schizophrenia Society of Alberta

#### **Supporting Organizations**

Alberta Committee of Citizens with Disabilities  
Alberta Disabilities Forum  
Premiers Council on the Status of Persons with Disabilities

### **Current Members (March 2003)**

Alberta Association for Community Living  
Alberta Association for Marriage and Family Therapy  
Alberta Association of Registered Occupational Therapists  
Alberta College of Social Workers  
Alberta Mental Health Self Help Network  
Alberta Psychiatric Association  
Boyle Street Co-op  
Calgary Dual Diagnosis Committee  
Canadian Mental Health Association  
Edmonton City Centre Church Corporation  
The Organization for Bipolar Affective Disorders  
Psychologists' Association of Alberta  
Registered Psychiatric Nurses' Association of Alberta  
Schizophrenia Society of Alberta

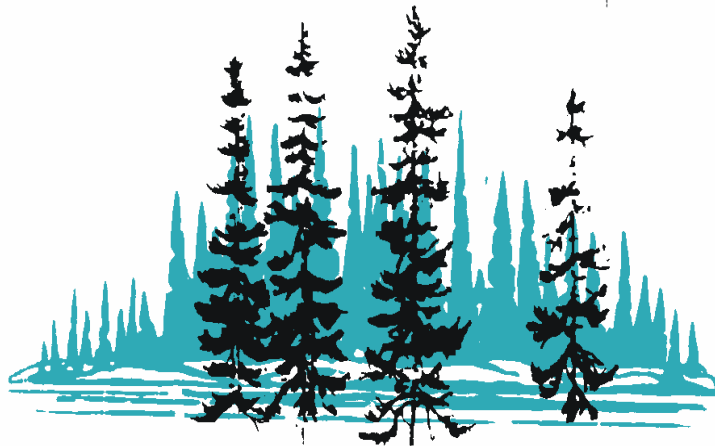
In addition, AAMIMH acknowledges the ongoing participation of the Premier's Council on the Status of Persons with Disabilities, recognizing its mandate as an objective liaison between community and government stakeholders.

### **Executive and Staff**

Peter Portlock – Director, Alliance Secretariat

Administrative support is provided by the staff of CMHA Alberta Division office: Ron LaJeunesse, David Allen, Eveline Royer, Jillian Dacyk and Sherryl Husereau

The AAMIMH wishes to acknowledge the financial contribution of



**The Muttart Foundation**

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without which progress in mental health reform  
would remain an elusive dream.

## 8. REFERENCE MATERIALS

### Footnotes

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“Consumers/users and their families really don’t care much about politics, economics, system complexities or philosophical differences. They care only about getting better. Their problem is that they suffer with a mental illness. That surely should be enough of a burden for anyone.”

*Political Asylums, 2002*