

B.C.'s Mental Health Reform

**CONSUMER
INVOLVEMENT
AND INITIATIVES**

BEST PRACTICES



**BRITISH
COLUMBIA**

Ministry of Health and
Ministry Responsible for Seniors

This report is one of seven mental health best practices reports. The reports reflect the efforts of 44 industry representatives who formed the best practices working groups. Following literature reviews and consultation, they documented what they collectively recognized as services and strategies that produce positive health outcomes for individuals.

The Ministry of Health is grateful for the expertise and diligence these mental health consumers, family members and service providers brought to the work.

The reports on Best Practices for B.C.'s Mental Health Reform are:

- Housing
- Assertive Community Treatment
- Crisis Response/Emergency Services
- Inpatient/Outpatient Services
- Consumer Involvement and Initiatives
- Family Support and Involvement
- Psychosocial Rehabilitation and Recovery

**BEST PRACTICES FOR BRITISH COLUMBIA'S
MENTAL HEALTH REFORM:**

CONSUMER INVOLVEMENT AND INITIATIVES

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Important note

The principles of psychosocial rehabilitation form the philosophical foundation for all best practices in mental health. These principles emphasize both consumer involvement in developing and realizing personal care and life goals and treatment and supports that help consumers manage their symptoms and build on their strengths.

EXECUTIVE SUMMARY

The involvement of consumers, or persons with mental illness, as active participants in reforming and improving the mental health system is a core value affirmed in British Columbia's 1998 Mental Health Plan. This involvement needs to be a key feature of regional and community systems for mental health.

According to the "best practices" research into consumer self-help and consumer initiatives, findings consistently show that participation by consumers is associated with:

- reduced hospitalization
- reduced use of other services
- increased knowledge, information and coping skills
- increased self esteem, confidence, sense of well being and of being in control
- stronger social networks and supports.

For consumer involvement to be most effective, there needs to be:

- meaningful involvement, not just "tokenism"
- democratic decision-making processes that value and actively include the views and opinions of a variety of consumers
- training, education and support for consumers
- advocacy and outreach to give a voice to those without a voice, and to involve more of them meaningfully.

In order to develop comprehensive mental health services and supports, the Community Resource Base Concept, which places the consumer at the centre of all services, has been suggested. While recognizing the importance of mental health services, it also acknowledges fundamental elements of community life, to which all consumers should have access: housing, education, relationships, income and work. Supports such as income, work and self-help, which are not usually provided by the mental health system, are exactly the supports consumers say are most important to them.

Over the last three years, she has established herself in an apartment, learned to drive a car again, joined a service club, become a volunteer with the Canadian Mental Health Association, taken computer courses....

—Margaret Manning, from *Moments: Stories About Special Moments in People's Lives*, CMHA, BC Division, 1995

Suggestions for health authorities that would support consumer involvement include:

- providing infrastructure for consumers' use (e.g., office space and in-kind supports such as telephones, faxes, photocopying, etc.) in regional offices or mental health centres
- hiring consumers to work in the mental health field in jobs such as peer support workers, mental health workers and advocates
- encouraging consumer representation on regional boards and committees
- consulting effectively with consumers in the planning, budgeting, monitoring and evaluation of mental health services
- providing adequate expense and travel allowances in advance, to encourage effective participation at meetings and conferences
- providing orientation, training and information to consumers
- facilitating and supporting the establishment of consumer networks within the region, and links to consumers in other regions.

Since 1992, the Ministry of Health has funded Consumer and Family Initiatives, also known as Consumer, Family, Community or CFC Initiatives. More funding should be provided for these initiatives, and others that have proven fruitful should be funded out of core mental health funding, thus freeing up available Consumer and Family Initiatives funds for new initiatives.

The use of CFC funding should be tracked and monitored both regionally and provincially. Each health region should provide an annual report detailing the use of these funds, including some details of contracts such as descriptions of the projects, budgets and evaluations. These reports should be available through the Ministry of Health and a summary should be reported annually to the Provincial Mental Health Advisory Council.

For allocation of the Consumer and Family Initiatives Funds, each health region needs to designate a committee, made up of at least one third consumers, which would be responsible for advertising the availability of these funds and awarding them to successful applicants. This committee could be made up of an existing consumer advisory group in the region, or a new committee could be struck by consulting a broad range of consumers in the region.

Fifteen years ago a planning meeting in the mental health field would have looked quite different than one today. Back then, there may have been a diverse group at the table, but the diversity would have been among various professionals such as psychology, nursing, social work and psychiatry. Today we are more apt to see faces at the table from outside the professions, because we have recognized that there are different kinds of expertise. There is the traditional professional expertise that comes from study and practice, but there is also the experiential expertise that comes from navigating the mental health system as a consumer/survivor. We now know that both kinds of expertise are important and necessary if we are to develop effective and humane mental health policy and programs.

—Scott, Pomeroy and Pape, *Tools for Consumer Participation*,
Canadian Mental Health Association, 1995

1. INTRODUCTION

“Include me and I will understand”

—Chinese proverb

1.1 Goals and Objectives

Recent “best practices” research into consumer self-help and consumer initiatives consistently shows that participation by consumers is associated with:

- reduced hospitalization
- reduced use of other services
- increased knowledge, information and coping skills
- increased self esteem, confidence, sense of well being and of being in control, and
- stronger social networks and support (Clarke Institute, 1997, p.11).

1.2 Inclusion of people with mental illness in planning, delivering and evaluating mental health care

The involvement of consumers, or persons with mental illness, as active participants in reforming and improving the mental health care system is a core value affirmed in British Columbia’s 1998 Mental Health Plan. This involvement needs to be a key feature of regional and community systems for mental health. By using and acknowledging the wisdom and experience of consumers, the care delivery of mental health services is improved.

The Ministry of Health has agreed to ensure that mental health consumers are involved in the planning, delivery, management, evaluation and reform of mental health services. As well, the ministry will work with health authorities to ensure the participation of mental health advisory committees and the availability of a range of consumer initiatives that support involvement, information, education, training, self-help, mutual aid and peer support programs.

2. INVOLVEMENT AND INITIATIVES

Consumers are people who have direct and personal experience of a mental health issue and who have used or are using the resources available through the private or public mental health system.

Consumer involvement can include key elements such as mutual support, advocacy, cultural activities, knowledge development and skills training, public education, education of professionals and economic development (Clarke Institute, 1997, p. 82). This list is in no way complete. We must not forget board and committee involvement, and utilizing the knowledge of consumers in the key areas of planning, budgeting, monitoring and evaluating mental health services.

Although people in British Columbia are most familiar with consumer initiatives as being those programs or moneys that allow for the development of the items listed above, we must recognize that consumer involvement is much more complex and all-encompassing. In defining consumer involvement, we need to look at the following factors.

2.1 Meaningful involvement

Consumers should be meaningfully involved in all aspects of their lives—for example, treatment plans, medications, discharge plans, housing, recreation, education and employment.

Consumers need to be involved in a manner that has meaning for them. “Tokenism,” or the placement of consumers in key positions for the sake of having a consumer present, is not “real” involvement. Mental health care will be improved by “...recognizing this fundamental fact and using consumers in a meaningful way to provide checks and balances in the design, delivery and evaluation of services...” (World Health Organization, 1993).

2.2 Democratic decision making

Tied closely with meaningful involvement in the mental health system is democratic decision making. Consumer involvement cannot be true consumer involvement until a decision-making process occurs that values and actively includes the views, opinions and wishes of a representative group of individuals. Consultation with a select group of consumers, which is the method used in some areas, cannot be seen as an effective decision-making process.

In Ontario, the Consumer Survivor Development Initiative has been a forerunner in the development and support of the consumer involvement/initiatives movement. The success of their many funded projects, which ensure that consumers are effectively involved (through support and training, employment opportunities, etc.) makes them good examples of the importance of democratic decision making. Without this important component, we revert back to consumers simply rubber-stamping bureaucratic programs without exercising their right to state their own opinions and make their own decisions.

2.3 Training and support

This is one of the most important components of consumer involvement. All too often, consumers are expected to readily become “involved” as the current social trend toward participation dictates. However, without adequate training and support, the consumer is at risk of burn-out and disempowerment. There is no real involvement without ensuring that consumers are provided with the needed skills, training and supports to develop their skills.

“Consumer initiatives are supported through funding, consumer leadership training, education of professionals and the public about consumer initiatives, and evaluation using appropriate methods.” (Clarke Institute, 1997, p. 11)

“Consumers can benefit from brief pre-training courses that focus on the skills needed to effectively participate in committees.” (World Health Organization, 1993, p. 7)

2.4 Advocacy

Advocacy is a right that all consumers are entitled to. This can include:

- self-advocacy
- peer advocacy
- instructed advocacy
- systemic advocacy
- legal advocacy.

Advocacy can make enormous differences in the quality of life for consumers by helping them obtain necessary services and resolve issues.

2.5 Outreach

The mental health system and consumers have a responsibility to reach out to people who currently do not have a voice and are not involved. This should include:

- consumers with a dual diagnosis
- homeless people
- all age groups
- those in acute or chronic phases of their illness.

Peer support is helpful for reaching those who have difficulty participating.

3. THE BENEFITS OF CONSUMER INVOLVEMENT

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

- consumers speak from experience and can offer new ways of looking at things from that vantage point
- consumers' input is as valuable as that of professionals and family members
- consumers get the attention of politicians and funders
- consumer involvement will make policies, activities and processes more relevant and rooted in reality
- expertise in organizations is more diversified with consumer involvement
- the present mental health system needs improvement, and new expertise can help
- consumers are a credible voice—involving them is in keeping with both federal and provincial governments' conviction that people with disabilities can and should speak for themselves.

Two reports published since 1986 by the federal government outline a new vision for health as an essential dimension of the quality of our lives (Achieving Health for All, 1986, and Mental Health for Canadians, 1988). This vision recognizes freedom of choice and emphasizes the role of individuals and communities in both defining what health means, and acting to improve it. Equally important to professional services are other types of programs designed to build the capacity of consumers to help themselves. The social factors these programs address are of critical importance in mental health.

A good example of this is the mental illness of schizophrenia. The World Health Organization's international pilot study of this illness produced the startling conclusion that outcomes of people with schizophrenia are significantly better in some developing countries than in industrialized countries. Mental health experts have suggested the apparent reason for this is that "although people in traditional settings receive little medical treatment, their social position remains intact. In Canada and other western countries, the exact opposite is the case." (World Health Organization, 1979)

Furthermore, "the recognition of the limitations of treatment oriented medical services and the resulting need for a more comprehensive approach has been brought sharply into focus by the fiscal crisis in health. Governments and health care providers now have little choice but to search for alternatives to expensive professional services." (Trainor, 1996, p. 19)

In order to develop comprehensive mental health services and supports, the Community Resource Base Concept has been suggested (Trainor, 1996, p. 19). This concept "assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors." (Trainor, 1993, p. 11) These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends, and generic community services and groups.

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

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

Organized in groups, and with adequate resources, consumers can do many things for themselves which were formerly thought to be the sole domain of the formal service system. Self help/mutual support is perhaps the most obvious of these functions. Self help groups are an important and growing resource for people who have been through the mental health system. They not only provide the opportunity for people to share emotional and tangible support, but they make use of people's own strengths and capacities as sources of help for others. Self help represents a fundamental tool for people to work together and take charge of their own lives. (Trainor, 1993, pp. 12-13)

In 1995, the Canadian Mental Health Association published *Tools for Consumer Participation*, by Pamela Scott, Ed Pomeroy and Bonnie Pape. This package, quoted in the following text, provides some tips, strategies and approaches that have proved beneficial to consumer involvement. (It is more completely represented in Appendix A of this report.)

In recent years, the array of initiatives that consumers control by and for themselves has steadily increased. The concept of self help in the mental health field has expanded to include other activities. For example, there are consumer operated businesses, consumers training other consumers in skills development, and consumers developing a base of knowledge for themselves.

Fifteen years ago, a planning meeting in the mental health field would have looked quite different than one today. Back then, there may have been a diverse group at the table, but the diversity would have been among various professionals such as psychology, nursing, social work, psychiatry. And that's about it. Today we are more apt to see faces at the table from outside the professions, because we have recognized that there are different kinds of expertise. There is the traditional professional expertise that comes from study and practice, but there is also the experiential expertise that comes from navigating the mental health system as a consumer/survivor or a family member. We now know that both kinds of expertise are important and necessary if we are to develop effective and humane mental health policy and programs.

This package is designed to help groups tap the more recently discovered experiential expertise of consumer/survivors. Because mental health professionals have traditionally had the decision making process to themselves, that process has evolved into something with its own rules, procedures, language. Often professionals are not aware of how stylized their interactions are. Consumer/survivors, like all the rest of the population other than mental health professions, have not had much exposure to these rules and procedures, and often find them to be confusing, intimidating, and irritating. It is important to understand that these reactions are not "symptoms" or a result of having experienced the mental health system. Rather they are a reflection of the difficulties encountered by newcomers who have been invited to participate in a previously closed system.

It should go without saying that consumer/survivors have the same variety of skills as the general population. Some people are highly educated; others are not; some have sophisticated verbal skills; others more practical common sense skills. But, regardless of their talents, if people have no experience with formal mental health planning meetings, parachuting them into a process without preparation on both sides is a recipe for failure. In this package, therefore, many of the suggestions, such as those for simplifying language or informalizing procedures, are an attempt to make meetings more acceptable not just for consumers, but for any newcomer from outside the formal mental health professions.

Sometimes staff members or other volunteers may complain that the accommodations provided to facilitate consumer participation amount to an unfair advantage granted a specialized group of people. In reality, this is not the case. Accommodations level the playing field. Consumer participation asks people who carry special burdens and liabilities and cope with special stressors to take on more. The accommodations, if properly made, level the field, address power imbalance and allow us to use the special knowledge of those who use the mental health system. Meetings will work only when all the participants are on an equal footing. (Scott, Pomeroy and Pape, 1995)

4. GUIDELINES FOR HEALTH AUTHORITIES' SUPPORT OF CONSUMER INVOLVEMENT

1. Infrastructure—office space, in-kind supports (e.g., telephone, fax, photocopying and separate bulletin boards for matters of interest to consumers—should be made available in regional offices or mental health centres, or both.
2. Because employment results in higher self-esteem and a better quality of life for many consumers, the regions should hire consumers to work in areas involving mental health. An example of successful inclusion of consumers in the workplace is provided by the Greater Vancouver Mental Health Services Society (GVMHSS, 1998). The special knowledge and expertise of consumers needs to be acknowledged, respected and utilized. Health authorities should fund advocacy positions for consumers as well as mental health worker training courses for consumers. A broad range of vocational, educational and personal development opportunities needs to be provided in the regions. Workplace accommodations for consumers need to be provided as well.
3. Consumer representation on regional boards and committees should be encouraged. “Consumers can help create a better mental health care system... using consumers in a meaningful way to provide checks and balances in the design, delivery and evaluation of services introduces a validity to the system that can be achieved in no other way.” (World Health Organization, 1993, p. 3)
4. Consumers should be effectively and meaningfully consulted in planning, budgeting, monitoring and evaluation mental health programs in each region.
5. Expenses and unreceipted participation reimbursements should be provided to consumer volunteers so that they are able to participate in meetings and conferences, and as a way of acknowledging their expertise. “Sufficient moneys should be budgeted to cover the expenses incurred by consumer volunteers who participate in policy work... Moneys should be provided to consumers in advance for such fundamental necessities as travel and accommodation.” (World Health Organization, 1993, p. 7)
6. Regional health authorities should provide consumers with necessary background information and orientation, training and support for boards and committees, so they will have a knowledge base to draw on before entering meetings. “Consumers are usually not familiar with how committees are structured and how they work. Information that is critical includes: terms of reference, background on committee

members, rules of order, reporting structure of the committee, knowledge of who struck the committee, etc.”¹

7. “Some consumers would like to attend smaller meetings at first, or mock board meetings, to gain confidence and experience, and would like the opportunity to observe at a meeting before making a commitment. They would also like the materials to be given out before the meeting. They would like upcoming meetings to be more widely publicized, and to be encouraged more to attend. They point out that it is sometimes risky for consumers to speak out.” (Clarke Institute, p. 73)
8. Consumer networks are valuable in providing peer support, friendship and information sharing. Regional health authorities should encourage and facilitate consumers getting together, not just on committees and boards, but informally, socially and without a professional or bureaucratic presence. Consumers need each other, can nourish and advise each other, and not just in a self-help or clinical setting. Some good examples might include communication networks, leadership training and media relations workshops. “Self help is founded upon the principle that people who share a disability have something to offer each other which cannot be provided by professionals.” (Clarke Institute, p. 82)

¹ Laurel House Consumer Focus Group, Victoria, B.C., April 21, 1999.

5. THE RIVERVIEW HOSPITAL CHARTER OF PATIENT RIGHTS

In 1990, it was requested that Riverview Hospital develop a charter of rights for patients. The Ombudsman of British Columbia conducted an investigation into administrative fairness at the hospital and produced a report in 1994 (Ombudsman, 1994, pp. 2-10 to 2-13). The report stated:

[The] Hospital's Charter of Rights should not merely be seen as a list of rights whose violation carries with it various penalty like consequences. It should serve more as an institutional framework or strategic guide to demonstrate a commitment on the part of the entity to live up to certain norms of conduct. More will come from a positive commitment of that kind, than from the enforcement of violations of rights. (Ombudsman, 1994, p. 2-13)

After a lengthy consultation process, involving patients, hospital staff, mental health agencies and other stakeholders, a final version of the Charter of Patient Rights was approved in 1994.

The charter is not law, but rather is a policy of Riverview Hospital. As such, the Hospital has made a commitment to give meaning to the rights contained therein.²

It is recommended that all psychiatric hospitals and facilities in British Columbia develop a similar charter of rights for their consumers.

² This has been done by the Hospital in developing policies that implement the rights established by the Charter of Patient Rights.

6. CONSUMER AND FAMILY INITIATIVES FUNDING

Since 1992, the Ministry of Health has had specific funding for Consumer and Family Initiatives, also known as Consumer, Family, Community or CFC Initiatives. These funds were originally designated for the following programs:

- consumer enterprises
- grants for community development in response to emerging/evolving mental health issues
- family support
- public education
- patient initiatives for change—involvement of consumers in service delivery, management and evaluation.

Consumers and their family members should be involved in evaluating the uses of this funding, and more funding should be provided for initiatives that have proved in practice to be fruitful.

7. GUIDELINES FOR ALLOCATION OF CFC FUNDING

1. Each community that receives funding needs to designate a committee to be responsible for the allocation of Consumer, Family and Community (CFC) funding, the monitoring of contracts, including participation in an evaluation process, and annual reporting.
2. The committee could be formed through an existing advisory group. Where such a group does not exist, a broad-based reference group not receiving funding should be formed through an open process. Consumers need to comprise a minimum of one third of the membership of this committee and, where possible, a consumer should chair or co-chair this committee. Committee members need to follow conflict of interest guidelines when deciding on applications for funding.
3. This committee has the responsibility for advertising the availability of CFC funding in the community. This should be done by distributing plain language materials to places where consumers and family members congregate. This information should become common knowledge among consumers in the community.
4. Terms of reference for the committee should include provisions for the involvement of new members and the turnover of membership.

Historically, in many regions, very little of the annual CFC funds are made available for new proposals, because funds are automatically re-allocated to those proposals funded in previous years. One way to get around this problem and free up funds for new proposals is to open the bidding process annually for all the funds and require that all proposals be re-submitted and re-allocated each year. Another recommendation is that where funded CFC proposals are seen to be successful, funding for them in subsequent years should come from core mental health operating dollars in each region, thus freeing up the CFC funds for more new proposals.

To ensure accountability, it is vital that the use of CFC funding be tracked and monitored both regionally and provincially. Each health region should provide an annual report detailing the use of these funds. This report should include some details of contracts, such as descriptions of the projects, budgets and evaluations. These reports should be available centrally through the Ministry of Health, and a summary should be reported annually to the Provincial Mental Health Advisory Council.

8. RECOMMENDATIONS FOR CONTINUOUS CONSUMER INVOLVEMENT

This list of recommendations details the necessary structures and means of communication that would ensure continuous and meaningful consumer involvement at a system level.

1. Mandate and support regional and local community mental health advisory committees.
2. Mandate and support a provincial mental health advisory council.
3. Provide the opportunity for elected consumer representatives for all regions to gather annually. This annual meeting would result in the production of an annual report card from consumers on the status of regional advocacy and the Provincial Mental Health Advocate's status report, as well as recommendations to the provincial mental health advisory council and government on emerging issues in mental health.
4. Elaborate and support a communications strategy, with funding for a communications officer, who could gather and distribute information to consumers in the province. A website (including a regional page) and a newsletter would be used for the exchange of information on a variety of issues and resources.
5. Support a network of regional consumer advocates that works with the Provincial Mental Health Advocate.

9. EXAMPLES OF BEST PRACTICE CONSUMER INITIATIVES

9.1 North Okanagan Peer Outreach/Mutual Support

This program has existed since 1997. Once secure funding from the Consumer Facilitation Funds had been negotiated, the steering committee developed job descriptions, hired two consumer coordinators, and opened an office. The coordinators, along with the steering committee, developed philosophy, mandate, objectives, goals and budget. The coordinators also developed guidelines for selecting suitable volunteers, as well as protocols on how clients are referred to the program. The policy and procedure manual was developed as the program spread into the hospital and began to interact with other agencies and professionals.

Training included communication and conflict resolution skills, crisis intervention, and grief management; there were also several panels of professionals and consumers. The first training program produced six volunteer candidates, as did the second; a third training session was recently completed. The training helped volunteers develop skills, self-affirmation, and feelings of self-worth, and realize how much effort is involved in putting a service program together and delivering it to consumers.

The steering committee includes several mental health professionals and service providers; the majority are consumers. The day-to-day operations of the program are run entirely by consumers. In the past year, the program has extended to Salmon Arm, helped develop a peer outreach program, and assisted Revelstoke in starting a mood disorder group. The program has also been asked to run week-long workshops in Nelson, Cranbrook and Trail.

9.2 The Kettle Friendship Society Advocacy Services

The Kettle is a drop-in and activity centre that serves the needs of people with a psychiatric disability in East Vancouver. It has a Self-Advocate Program that receives funding from the Consumer Initiatives Fund. Five consumers meet weekly and actively work together to create a supportive group dynamic, pursuing educational endeavours and facilitating workshops for the membership.

The Kettle Advocacy Service is a formal service that uses a model of self-empowerment and peer support. Four Mental Health Advocates provide resources, information and encouragement for individuals to address their own problems and concerns, or will assist in pursuing more difficult and complex matters and/or provide appropriate referrals.

9.3 Friends of Music Society

The Friends of Music Society was formed in 1989 by John Ferry, a social worker at the Victoria Mental Health Centre. The society seeks to involve musically inclined consumers as well as non-consumers in cultural activities and recreation with music. The first project was the Moodswing Orchestra, which plays swing and big band tunes. A choir by the same name was also formed, as well as a rock band called Pink Freud and a day program in which residents of boarding homes can learn musical skills. The society's groups perform many public concerts annually, and hold weekly sessions in the Eric Martin Theatre, where psychiatric patients often drop in from the wards.

APPENDIX A: TOOLS FOR CONSUMER INVOLVEMENT—TIPS AND STRATEGIES

(From *Tools for Consumer Participation*, by Pamela Scott, Ed Pomeroy and Bonnie Pape, Canadian Mental Health Association, 1995.)

The following is a compilation of tips and ideas for building consumer-friendly agencies, boards and committees. In addition, it addresses approaches related to consumer participation that have worked well for others.

1. Taking the first steps

Different agencies have moved along the path to consumer participation at different speeds. Agencies just beginning the journey face special challenges.

Choose your model

Agencies with boards and committees that have not had consumer members in the past need to do some preparatory work as they begin to include consumers. At the agency level they need to address the question of whether they are moving to consumer participation on existing committees or creating a consumer advisory council or both. Each has its own strengths and weaknesses but, in either case, consumer input should be sought and given high credibility in the decision-making process. If the choice is a consumer advisory group, the issues are how to support its operation. If integrated committees, then committee members need a chance to explore their own feelings and apprehensions. At this stage it may be useful to invite volunteers familiar with the consumer participation process to help the group adjust.

Reflect on your decision

When an agency decides to involve consumers, the process is enhanced not only by existing members being able to empathize with prospective consumer members, but also by their awareness of their own values surrounding consumer participation. Before contacting nominees, the group might want to ask itself a number of questions. The first logical inquiry would be about the motive: i.e., “Why do we want this?” and “Why now?” Other questions the group might want to address could be concerned with the purpose and scope. For example:

- What will the consumer role be? (Board member or a member of a separate advisory committee?)
- Will there be remuneration?

- How much control over policy decisions will consumer members have? (i.e., advisory role?)
- What will the committee structure be?
- How will candidates be chosen?

Inherent in answering these questions are feelings and attitudes towards consumers, all of which should be talked about and resolved to the best of the group's ability. Once the group is fully aware of its own position, it can be much more sensitive to the position of the new consumer candidates.

Do your homework

Planning for expanding consumer participation must be done carefully, because if it is not, everyone can become confused and disenchanted with the whole operation. As well as being conscious of its own position, a board/committee must also be empathetic to the position of prospective consumers. Becoming familiar with the experience of other board/committees and consumer advisory committees through reading, interviewing, etc., is a good place to start. This way, the problems and successes of other groups can be used as building blocks for the current project. In planning the operation itself, it is a good idea to build in the necessary supports and modifications to facilitate consumer participation right from the beginning.

Plan the process

As a process, consumer participation can be seen to function at two levels: the planning of programs, services, etc., and the planning of the process in which those decisions are made. At this stage the second function is the most important. Ideally, the new consumers should take part in the planning of the process in which they are about to become involved. When planning the process together, new and existing members should be encouraged to review the key factors of board/committees:

- purpose (i.e., mission statement), and
- terms of reference (i.e., degree of authority, budget, frequency and time of meetings, staff support, member responsibilities, member qualifications, etc.).

2. Recruiting consumers

Take a broad approach

Recruiting consumer participants requires a broad approach. You cannot assume that all consumers are exposed to the same notices, announcements or invitations. Spread the word in as many ways as you can.

Advertise

Don't be afraid to advertise for interested consumers in local newspaper publications, as well as cable TV bulletin boards, community centre and shopping mall bulletin boards, and counsellors' and doctors' offices.

Establish community links

Establish formal or informal linkages with consumer/survivor constituent groups in your region.

Identify consumers with initiative

Ask program staff to identify consumers who initiate action, and begin recruiting these people for boards and committees.

Keep building the resource pool

Continually focus on increasing the number of consumer volunteers.

Use consumer expertise

Work to develop the skills of people from the grass roots who have consumer expertise.

3. Creating consumer-friendly agencies**Do not define consumer participation too narrowly**

Think broadly. Consumer participation should not be narrowly defined. Be aware that agencies are actually very complex structures. There are boards, committees, task forces, and staff positions that can be filled by consumers. All these positions provide opportunities for consumer participation.

Reframe past roles

Professionals and consumers need to reframe past roles. Professionals frequently see consumers at their worst. Professionals need to de-emphasize illness and see consumers as people. For consumers, being around professionals who have judged them in the past makes it hard to relax.

Adopt the right tone

In terms of day-to-day operations, support does not imply on-the-spot counselling. Rather, it entails fostering a sense of belonging. Consumers need to feel that they are making a valid contribution and that their experience is valued. Most importantly,

through encouragement and listening, consumers need to feel that they can work with professionals and other members as partners on an equal footing. Closely related to this is sensing that the group is “safe” in terms of self-disclosure, and that the other members will still respect them regardless of their personal histories of mental illness.

Use consumers as liaisons

To involve less articulate or shy consumers, use more experienced consumers as liaison or buddies to build participation.

Build teams

Working on a task as a member of a pair is a building block for increased participation.

Formalize support

If consumers are not to be put at risk, support must be written into someone’s job description. This can help ease potentially threatening new situations.

Provide orientation

Make sure that consumers have an opportunity to learn about rules, responsibilities and their potential role on committees. A small setting that encourages questions is often preferred.

Sensitize the agency

Make the phrase “consumer participation” a living phrase in your agency. Make sure everyone understands the contribution of consumer participation to agency effectiveness, as well as its contribution to self-esteem, personal morale and empowerment. Ensure that the board as well as the staff is committed to enhancing consumer participation.

Be honest

Be honest with yourself about possible doubts and fears. Ask your staff to do the same thing. This can be achieved by allowing agency staff periods of frank discussion.

Offer sensitization training

Sensitization training which identifies barriers to participation and inclusion *must* be available to both staff and consumers.[emphasis added]

Deal with the threat

Professional staff sometimes see the call for consumer participation as criticism and a rejection of their expertise. It isn't that simple. Many consumers want and need support from professionals and non consumers but want to make these interactions more equitable. Working through this is powerful.

Focus on the gains

Many professionals and volunteers view consumer participation as a zero sum game, meaning that any growth in the influence of consumers is a loss for them. This is not the case. There is a place for all of us to use our skills working in partnership. We all have something to give and gain.

4. Removing barriers within the agency**Provide reimbursement**

Many consumers are not in a position to pay for transportation to and from meetings. This should be taken into consideration and funds should be provided. Reimbursement should be made in advance. In general, consumers should be consulted about any special needs, financial or otherwise, that can be accommodated.

Use the buddy system

In order to provide support and encouragement to consumers learning the ropes, either a consumer or an understanding non-consumer member should be appointed to act as a "buddy", particularly during training and orientation periods, but also for as long as is desired.

Avoid professional jargon in manuals and meetings

A proper board manual, including the roles of the committees, rules of board procedure, etc., can be helpful, but only if free of acronyms and other jargon. The same is true for the things said at meetings. Reliance on acronyms and jargon in discussion often excludes all but those who work in the system.

Plan meeting times with the consumer in mind

Much important discussion and constructive work tends to go on in committee meetings that take place during working hours. Professionals in the field often attend these meetings as part of their job responsibilities; consumers often cannot. Consumers may rely on public transportation, which also speaks to scheduling of meeting start and stop times.

Encourage partnership through joint projects

Partnership among the different members of the community can be demonstrated and strengthened through joint projects. For example, consumers and professionals, consumers and family members, consumers and community leaders have successfully teamed up to present public education sessions.

One advantage to this is that after telling a story, the consumer has an opportunity to catch a breath while someone else talks. Another is that the non-consumer knows that the presentation is not just theory. Partnering like this is an important way of working with material that often has personal and emotional content.

5. Building a team: Groups that work instead of hurt

To any new representative, meetings can be lengthy affairs heavily laden with jargon that can be as confusing as Latin and can exclude the newcomer from the overwhelming task of breaking into the discussion. Nevertheless, most members continue to attend and put up with the inconvenience.

For consumers, often trying to cope with all the hazards of daily life, “sticking it out” through a tedious, formalized meeting can be toxic and not to be tolerated. Many of the suggestions that follow simply reflect the need to make meetings more humane, but the stakes involved in failure to do so are hugely different for the consumer.

Appoint more than one consumer to each board

Appointing more than one consumer to a committee or board takes the onerous burden off the shoulders of the lone consumer, and widens the perspective by increasing the number of voices.

Make opportunities available for the consumer

Make full use of consumers on boards by identifying their skills. Avoid recruiting “token” consumers by making sure that opportunities exist to influence the organization’s decision making and strategic planning processes.

Make consumers comfortable about speaking out

Instead of just the usual board business, pay attention to process and keep participation in mind. Professionals are often pretty comfortable with speaking out and able to look after their own issues. Often they dominate in ways that limit the possibilities. It is incumbent on the chairperson to see that there is balanced participation. For example:

Clarify when necessary

Enable members to break in, and make sure the group attends to what is said, not just to who said it. Be prepared to refocus personal stories to address the items on the table.

Minimize parliamentary procedure

Interesting and useful formats for accommodating consumers in meetings are being practiced by a number of groups, one of which is the Mental Health Advisory Committee to the Niagara District Health Council. One hour before the regular meeting is scheduled to begin, a pre-meeting is held where consumers get together to go over the meeting agenda. This is a useful procedure in that it familiarizes consumers with meeting material and members can plan their responses. As far as possible, the regular meetings themselves operate by consensus with a minimum of parliamentary procedure. Before tackling the business at hand, the members of this organization begin every meeting by going around the table and letting each speak briefly about their personal life. This brief sharing of good news/bad news sets an informal tone which carries forward into the meeting.

Make the agenda relevant

Time spent on routine matters needs to be curtailed if possible. Issues that touch on the reality of consumer's lives and draw upon the consumer expertise need to be central. Special strategies for dealing with routine material need to be developed.

Appoint back-up people

Back-ups or alternates are often desirable, and should be built into board practice; they can often participate as observers. The back-ups are to take over when acting consumer representatives cannot attend meetings. They should be recruited with the understanding that they may need to cover for persons who may be absent for extended periods of time.

Illness can affect anyone—treat everyone equally

If a consumer representative becomes ill, treat them as you would any other board member: send cards, flowers, and if necessary, the minutes of meetings. (Something is wrong if you involve people because they are consumers and then reject them for that very reason.)

Be aware of special needs

All members must be consulted about any special needs they may have that the committee should know about and accommodate.

Break meetings up

Consumers may find it difficult to remain in a meeting for prolonged periods of time as many medications create special needs. Take time for breaks. Great ideas are more likely to surface when everyone is fresh.

Arrange social activities

Arrange for and facilitate informal activities—i.e., dinners, picnics, retreats—outside the formal work environment. Encouraging interaction of this sort results in more congenial work relationships and helps break down existing barriers between providers and consumers.

Remain sensitive to members' economic situation

Meetings held in posh places, conversations focused on material pleasures, and unwritten dress codes that reflect affluence point to a life experience that is out of reach for the average consumer, and promote a feeling of exclusion. All are to be avoided.

Call in outside facilitators

It is advisable to call in facilitators from outside the organization occasionally. Outsiders can ensure that all members of the board are able to participate equally and can take an objective look at group dynamics and development.

APPENDIX B: RIVERVIEW HOSPITAL CHARTER OF PATIENT RIGHTS

PREAMBLE

The Board of the British Columbia Mental Health Society is pleased to endorse the Charter of Patient Rights outlined below as a framework for patient care at Riverview Hospital. In support of this Charter of Patient Rights, the Hospital will undertake all reasonable efforts to ensure these rights are exercised while recognizing the rights of others, and in conformance with existing legislation.

PART I: QUALITY OF LIFE/SOCIAL RIGHTS

Social rights emphasize the rights of the patient rather than administrative/organizational convenience, and aim to avoid a system of control that may become dehumanizing. These rights are to be interpreted within the Hospital's responsibility to provide a safe and therapeutic environment for all patients within the available resources. These rights include economic assistance, privacy, confidentiality, security of person and property, recognition of individuality, access to religious services, freedom of social contact and communication in the language of choice.

Each patient has:

- The right to a safe and secure environment.
- The right to considerate and respectful care.
- The right to be treated with dignity and respect at all times. This right applies also to patients' family members, significant others and friends.
- The right to an appropriately prompt, reasonable and courteous response to requests for services or information.
- The right to an interpreter when needed.
- The right to be provided with sufficient, nutritious and palatable food, with consideration given to religious and medical requirements.
- The right to receive a written monthly statement, as well as at the time of discharge, of deposits, withdrawals and balance of account(s), and a written receipt and account balance for all deposits and withdrawals.
- The right to meet with clergy or other spiritual advisors, as promptly as possible.
- The right to privacy including during visits and in the sleeping environment provided this doesn't create a risk for the patient or others.
- The right of liberal access to family members, significant others and friends.

- The right to privacy for sexual activity between adult patients subject to capacity to consent and to engage in safe sexual practices.
- The right to education regarding communicable diseases including sexually transmitted diseases, and the right to confidential access to prophylactics to assist in the prevention of communicable diseases.
- The right to a quiet sleeping environment.
- The right to wear personal clothing at any time while hospitalized unless deemed to be an elopement risk.
- The right to uncensored and unobstructed communication by telephone, letter or in person with any willing party.
- The right to retain and use personal clothing, money and possessions with access to secure storage, unless this poses a risk to the patient or others.
- The right upon discharge:
 - to have two business days notice³;
 - to notify the person of choice;
 - to have appropriate help in finding suitable housing and community resources; and,
 - to be informed of follow up medical care and support and to have assistance in arranging it.
- When a patient agrees to a planned discharge, hospital staff will make sure such a discharge does not occur until issues of finance, housing and community clinical care are addressed.
- The right to choose and be provided with recreational and educational activities.
- The right of generous access to the out of doors daily. Normally, this will be no less than 90 minutes unless this puts the patient or others at risk or if staffing is not sufficient.
- The right of spouses to share a room if both spouses are patients, if both are agreeable, if a private room is available in an appropriate ward and if it is deemed to be clinically appropriate for both spouses.
- The right to be provided with all possible assistance in ensuring that financial support from appropriate agencies during hospitalization and upon discharge is obtained.
- The right to a volunteer, as promptly as possible.

³ Where the discharge is ordered by the Review Panel, two business days notice is not possible.

PART II: QUALITY OF CARE/THERAPEUTIC RIGHTS

Therapeutic rights emphasize the right of patients to be involved in treatment decisions. Patient involvement in treatment decisions involves the right to be fully informed of treatment options and for voluntary patients to give consent freely. This enhances the patient's ability to strive toward improved health and to make a commitment to a post discharge treatment plan.

This approach includes consideration of therapeutic alternatives, second medical opinions, choice of caregiver, clinical safeguards, information about treatment, access to caregiving persons, discharge plans and adequate supervision.

Each patient has:

- The right to receive prompt and appropriate care and treatment provided by appropriately trained staff.
- The right to know the full identity and professional status both of ward staff and other staff providing services at Riverview Hospital.
- The right to expect a reasonable continuity of caregivers.
- The right to choose caregivers and care environment where possible.
- The right to a second medical opinion and to have hospital staff facilitate the obtaining of this opinion.
- The right to be involved in discharge planning from the time of admission.
- The right to be fully informed of all reasons, benefits and risks involved in any proposed transfer.
- The right to be informed, upon discharge, of continuing treatment requirements, and to have every reasonable effort made to ensure these are met.
- The right to be fully informed by a physician and nursing staff about the following, prior to giving consent to any treatment, but in conformance with the *Mental Health Act*:
 - the nature and type of any treatment planned and how it may work;
 - the likely benefits of the treatment;
 - the common and likely side effects, adverse reactions or risks of the treatment;
 - the known and safe treatment options; and,
 - the potential risks and benefits of refusing treatment.
- The right to receive reasonably full and complete information concerning treatment in terms and language that can reasonably be expected to be understood.
- The right to be free from chemical and physical restraint, except in an emergency where it is necessary to protect the patient from injury to self or others. The physician must have authorized this restraint for a specified and limited period of time.

- The right to be free from experimental and/or controversial procedures unless informed consent is given.
- The right to give consent freely without any external pressure or coercion, unless otherwise mandated by law.

PART III: SELF DETERMINATION/LEGAL RIGHTS

When a person is admitted involuntarily to a psychiatric hospital, a number of civil and human rights may be taken away. An involuntary patient has a right to be informed of the reasons for detention and of the available review process. Self determination includes the right to be informed before giving consent, but in conformance with the *Mental Health Act*, access to clinical records, legal rights information, review of committal, access to legal services, incompetence determination when required, review of compulsory treatment and restraint.

Each patient has:

- The right not to be detained unless the rules of natural justice and fair procedure are followed.
- The right of access to free legal advice, counsel or advocacy on request.
- The right not to be impeded from choosing a lawyer to provide representation at review panels that consider the matter of involuntary detention.
- The right immediately upon admission, or as soon thereafter as the patient can reasonably understand, to be fully informed of the relevant Riverview Hospital rules and regulations, legal rights and the Charter of Patient Rights, including the right to a Review Panel or court hearing under the *Mental Health Act*. This information must be provided on an ongoing basis, at least every three months, and be presented in a manner and language that can be understood.
- The right to see his/her hospital record, to attach a statement of corrections and to have specific parts of the record copied, without charge, unless harmful to third parties or self.
- The right to have all communications and records pertaining to care while hospitalized shared only with persons directly involved with medical and psychiatric treatment of the patient, except where required under law.
- The right, if eligible, to vote in any municipal, provincial, or federal election, and to be fully notified of the date, time and place of enumeration and voting and to receive any necessary assistance in being enumerated and in travelling to the polling station, if on hospital premises.
- The right not to be subjected to any form of cruel and unusual treatment or punishment. This is guaranteed under the Canadian Charter of Rights and Freedoms and the United Nations' Universal Declaration of Human Rights.

- The right to be provided with a written copy of the Riverview Hospital Charter of Patient Rights and to have it posted in every patient dayroom and at every main building entrance.
- The right of access to an organization independent of Riverview Hospital to investigate alleged violations of these patient rights.

Nothing in this document prevents Riverview Hospital from recognizing patients' additional rights including those protected by the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights. This document will be reviewed annually through a consultative process involving patients, former patients, patient advocacy organizations, family members, staff and other stakeholder groups.

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GLOSSARY

accountability. The Management Team is responsible for defining expected outcomes and performance measures, a plan for monitoring service delivery, and activity reporting structure. The Ministry of Health is responsible for the expenditure of public funds.

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

acute care (also referred to as secondary level care). Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

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

adult. Person 19 years of age or older.

advocacy. The act of informing and supporting people so they can make the best decisions possible for themselves, or an act or acts undertaken on behalf of others when they are unable to act on their own.

ALOS. Average length of stay.

Assertive Community Treatment (ACT). An expensive alternative to other forms of community care, which should be targeted to the most appropriate clients (i.e., frequent users of the system, including inpatient care and forensic services). The 1998 Mental Health Plan addresses the two per cent of the population with serious and persistent mental illness, with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, up to 8,200 clients.

best practices in mental health. Descriptions of what can be done to facilitate change for the better in mental health policies, practices and initiatives. Factors that facilitate change include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in

stigma, enthusiastic leaders and skilled staff, and the Canadian Mental Health Association National Framework for Support.

biopsychosocial approach/model. Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including physicians, nurses, pharmacists, social workers, occupational therapists, dietitians and psychologists.

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

clinical practices guidelines. Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

community resource base concept. This concept "assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors." These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends, and generic community services and groups.

consumers. People who use mental health services.

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

decompensate. The psychotic symptoms return, or the person's ability to function is disrupted.

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

determinants of health. Factors that influence and determine health status. These include social, economic and physical environments, health services, biological influences and health behaviours and skills.

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

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

ECT. Electroconvulsive therapy.

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

empowerment. The capacity of choice. Includes the ability to define, analyze and act on problems one experiences in relation to others and in one's environmental living conditions. As a process, describes the means through which internal feelings of powerlessness are transformed and group actions initiated to change the conditions that create or reinforce inequalities in power.

epidemiology. Prevalence of a disease in a particular community at a particular time.

etiology. Pertaining to the science of the causes of disease.

evidence-based decision making. A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

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

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

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

functional impairment. An individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning (and level of functional impairment). The global assessment of functioning (an aspect of assessment that is part of the ASP *DSM-IV*) is one such tool.

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

guidelines. A suggestion or set of suggestions that guides or directs action. The purpose of a guideline is to provide additional information that assists service providers to comply with policy. Guidelines may be suggestions on how to carry out or implement

policy. Whereas health authorities and services providers must comply with Ministry policy, they do not have to comply with guidelines.

health authorities. Public bodies mandated under the *Health Authorities Act* to govern, manage and deliver health services in a defined geographic area. Refers to either Regional Health Boards (RHBs) or Community Health Councils (CHCs). Community Health Service Societies (CHSSs) are included here, although they do not have status under the act and derive their authority from their constitution and bylaws, established pursuant to the *Society Act*.

RHBs govern the delivery of all health services within a designated region.

CHCs govern the delivery of acute and continuing care-based services, such as hospitals and intermediate-care facilities, in areas of the province where there are no RHBs.

CHSSs govern the delivery of services that are broadly regional in nature—public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services—in areas of the province where there are no RHBs. Collectively, the CHSSs and the CHCs within a region govern the delivery of all health services in the region.

health status. A group or community's status of health, evaluated by means of universal epidemiological indicators such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

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

mandate. The scope of an organization's responsibility.

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

mental health crisis. An acute disturbance of thinking, mood, behaviour or social relationship that requires an immediate intervention; which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and may be defined as such by the client, the family, or other members of the community, including family physicians or police.

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

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

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

organic brain syndrome. A psychological or behavioural abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

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

partnership model in mental health. Services provided through individual care planning carried out in a partnership among, the Ministry of Health, service providers, local governments, family members, other unpaid caregivers and consumers, to meet the needs of consumers, in the context of all the roles and functions of all parts of the mental health system.

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

psychotropic drug. Any medication that has a primary effect on the central nervous system, with the intention of improving moods or thinking. The term “typical” psychotropic drug refers to relatively old products. The term “atypical” refers to psychotropic drugs that are relatively new, and designed to treat a wider range of symptoms with fewer side effects.

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

quality assurance (QA). An ongoing program to ensure that standards of service delivery are being met.

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

residential care for specialized needs. Augmented resources provided to community care settings, to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviours.

residential program/services. An organized program enabling clients to have the best possible quality of life, while remaining or becoming integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate settings.

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

secondary level care. (See *acute care*)

serious mental illness. Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illness. It is acknowledged, however, that there are others for whom medical risk and level of impairment—regardless of diagnosis—defines their mental illness as “serious.”

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

standard. An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared. Used by service providers to attain and maintain quality of care or service delivery, they state what consumers and the public can expect from a service. While a policy tells service providers what to do, a standard is a tool that allows a service provider to measure, monitor and compare actual performance against a benchmark.

supported education. An effective means of helping individuals with psychiatric disabilities to achieve success in accessing and pursuing educational opportunities of their choice.

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

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

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

utilization data. The information required to compare observed use of resources with recognized standards for use.

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

values. The beliefs of an organization that underlie its principles and actions, and form the basis for planning and operating services.

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