

# Discussion

## Introduction

The programs and strategies that have been described in this document provide convincing evidence of the range of innovative, excellent practice associated with mental health reform across Canada. We can not say, given the method of selection and evaluation that was used, that these examples are superior to the many other programs and strategies that exist. But it is clear that they provide valuable descriptions that illustrate how best practices can be implemented and disseminated. These applications represent a wealth of experience with new modes of delivering services and supports. It is hoped that this compilation will assist those involved with reform efforts by providing ideas, inspiration and practical information, as well as a contact for further information. In this final chapter a brief summary of the programs and strategies will be followed by an identification of what has been learned, a discussion of the characteristics of innovation and general considerations concerning the implementation of best practices.

## What has been described?

There is at least one application of best practice from each of the seven categories of core services in a comprehensive mental health system as defined in the Phase I literature review. Two programs in the situational analysis tackle important issues that were not covered in detail in the review of best practices, but were thought to be of sufficient relevance to warrant inclusion. The Dual Diagnosis Westview Program at Phoenix Residential Society targets a subpopulation of those with severe mental illness that is becoming increasingly prevalent and is particularly challenging to treat. The Inuvik Region Community Mental Health Pilot Project illustrates an innovative approach to outreach and community development in an under-serviced northern area. The only category of mental health system reform strategies that is not included is that of evaluation for which we received no nominations from the provinces. This probably reflects a tendency for this aspect of reform to be given relatively less and later attention. Four applications, two local program demonstrations and two system strategies, included site visits by members of the project team and are described in more detail. They were selected because they illustrate unique adaptations of best practices and have had a broad impact upon the systems in which they reside.

The Seven Oaks Project in British Columbia and Connections Clubhouse in Halifax both illustrate how elements of best practice that have demonstrated their effectiveness in research studies can be incorporated into the design of *innovative local programs*. The discharge of long-stay patients into community settings has been shown to provide a feasible and preferable alternative to institutionalization. The Seven Oaks Project has developed an alternative care model that demonstrates that even very behaviourally disturbed patients can be transferred to the community and that it is possible to provide tertiary care in relatively small facilities without undue cost. The latter

finding is of particular interest to geographic areas where distance and transportation difficulties mitigate against a centralization of specialized, tertiary services.

The provision of supported employment and supported housing are included as key elements of best practice. Connections Clubhouse has developed a capacity to provide these approaches combined with access to medical psychiatric consultation within a traditional Clubhouse program model. Provision of multiple services within one setting extends the range of clients whose needs can be met and provides for continuity of care through membership in a defined community.

The dissemination of program principles and models is illustrated by both these local programs. Two other Clubhouse programs have been developed in Nova Scotia and three other regions of B.C. are planning tertiary care programs based upon the Seven Oaks project. It is unlikely that they would have become role models without the concerted efforts that staff and management have taken to be visible and involved in their larger communities. A willingness to educate others about the principles and practice of psychosocial rehabilitation as well as the demonstration in practice of how such approaches succeed with even the most disabled clients characterize dissemination efforts in both programs. These are important ingredients of their broader influence.

The *two system strategies* that are described in greater detail are the Consumer/Survivor Development Initiative in Ontario and the Mental Health Commission of New Brunswick. Both have used policy, funding and governance mechanisms to achieve radical changes in the delivery of mental health services and supports. The CSDI is in keeping with research that supports an expansion of self-help, but it extends and refines the traditional self-help program model with original concepts and exciting variations in program design. Rather than focusing upon involvement of consumers in existing services it has emphasized the need for non-service alternatives and has developed operational guidelines that clarify how such initiatives differ from formal mental health programs. The New Brunswick Commission illustrates the implementation of a central concept of best practice regarding governance and funding, i.e. a mental health authority, in a Canadian context. Because the literature describing and evaluating mental health authorities is largely based upon U.S. examples, it is valuable to have an application within our health care system for examination.

The extent of the reform that has been achieved by both of these system strategies is impressive and has been documented by systematic evaluations. The creation of 36 viable projects with \$4 million of funding, which are, or soon will be, independent organizations, is a laudable outcome for the CSDI. It is complemented by changes in formal policy and informal attitudes concerning the rightful place of consumers within the system of care. Other provincial governments are also investing significant funds into building an infrastructure for consumer and family involvement, e.g. British Columbia has a Provincial Partnership Program with a budget envelope of \$4 million to support increased citizen involvement.

There is much to be gained from the sharing of information and advice about these initiatives. The New Brunswick Commission has accomplished a large shift of resources from institutional to community care in a short period of time. Many of the structural changes (such as a protected mental health envelope, central leadership, decentralization to regions, and broad community involvement)

that have occurred will be preserved in the new Mental Health Services Division which has recently replaced the Commission. As much of the rest of Canada struggles with the issue of whether mental health services can be successfully integrated, there will be continued interest in seeing if the progress and gains made by the separate governance structure in New Brunswick will be sustained.

## What has been learned?

A number of positive conclusions about mental health reform arise from reviewing these various examples. Some of the most striking are described below:

*It is clearly possible to successfully reallocate funds and personnel from institutional to community care.* Many of the innovative programs that have been described are funded with dollars that have become available through the downsizing of inpatient care within provincial hospitals. For example, both the Seven Oaks Project and the Housing/Mental Health Partnership Program in British Columbia draw upon funds that are available because Riverview has in the first four years of a 10-year plan transferred 200 patients and \$13.2 million dollars in annual funding. It is encouraging to note that in many cases, the staff of the best practice programs are those who have previously worked within institutions. With enlightened program managers and appropriate opportunities for training, hospital clinical and support staff can become excellent community workers. Programs such as the Assertive Community Rehabilitation Program in Ontario and Connections Clubhouse in Nova Scotia demonstrate that provincial hospital staff can make the transition to community-based care with very rewarding results. Manitoba has a province-wide commitment to retraining that recognizes the need for new skills and orientation as a component of system reform.

*The value of collaborations that involve ministries and agencies beyond health is demonstrated repeatedly.* The Crisis Response service in Manitoba illustrates how health and social service agencies can combine forces (and resources) to develop a system of interconnected components. The Inuvik Region Community Mental Health Project is partially funded by the Beaufort-Delta District Board of Education. Lethbridge Community College and Human Resources Development Canada are partial sponsors of the Skills Development Training Program in Alberta. When health involves other types of agencies, it becomes possible to better address the broad range of needs among those with severe mental illness. It also expands the resource base that is available for community support and allows persons with severe mental illness to participate in a broader range of community activities. Building and maintaining such interorganizational linkages requires skill and effort, but creative new initiatives make such collaborations worthwhile.

*The influential role of the Canadian Mental Health Association is evident across the provinces.* As is described in the section on A New Framework for Support, CMHA\_ National Office has provided concepts and principles that give a common thread through the diverse provincial mental health reform efforts. The roots of the New Brunswick Commission lie in the advocacy and policy activities of the local CMHA. Provincial divisions are visibly present initiators and sponsors of such innovative programs as the vocational program in Lethbridge. Partnerships between mental health and other health and social service agencies are developing in recognition of the range of supports and

resources that all citizens need. Every best practice program and strategy includes an emphasis upon consumer involvement in planning, management and evaluation. The evolution of this dramatic change has been facilitated by CMHA activities and resources.

*With concerted action, stigmatizing attitudes can be changed and resistance to change overcome.* It is encouraging to hear from the BC Housing/Mental Health Partnership Program about how acceptance of residents with mental health problems in public housing has grown as a result of education and support interventions. These reports parallel those of Connections Clubhouse and CASDT about the changes in perception and attitude among employers who have provided jobs for their clients. Ami-Quebec has demonstrated that professionals can learn from family members that some modes of practice need to change. The ACRP describes how skepticism about the placement of long-stay patients in the community was initially expressed by professional staff, as well as families and community members. When it was demonstrated that even the most challenging clients could be successfully treated and maintained, these negative attitudes were transformed into endorsements. Positive experiences with the integration of persons with severe mental illness in the community are a powerful means of reducing stigma and promoting reform.

### What facilitates innovation?

There are certain common factors which characterize the programs and strategies that have been described. Although none of the factors below are unfamiliar as dimensions of effective change, it is useful to remind ourselves about some of the preconditions for reform.

The combination of *skilled leadership and a committed group of expert staff* seems to characterize all of the programs that have been profiled in this situational analysis. Although it is not always explicitly stated in the program descriptions, the enthusiasm and dedication of the people who make them work is obvious in the actions they have undertaken and successfully completed. Program Directors are not only good managers, they have demonstrated willingness to take risks and ability to inspire and lead others makes innovation possible. In some programs, we are told that professionally trained staff are an essential component of success. In other situations we see that trained non-professionals are taking lead roles. The expertise that comes from the experience of being a consumer or a family member is a critical ingredient in the staffing of several of these programs.

*Clearly articulated philosophy and principles* typically underlie the specific innovations that have been implemented. There are different sources of these underlying principles. Psychosocial Rehabilitation offers a value and attitudinal base for many of the programs that have been described. Training in psychosocial rehabilitation seems to assist clinical programs and systems to move toward community-based care by providing a common ground for all the different disciplines involved and stressing the importance of client-centred care.

The Framework for Support has broadened thinking about the components of community support and the capacities of consumers. It has guided community development activities and accorded a rationale for a wide range of innovations. In the literature describing best practices, there is an emphasis upon specific structures and activities associated with each approach, e.g. assertive community treatment, day hospitalization, etc. It may be taken for granted that these practices are more likely to be initiated and sustained in certain environments. This survey of the field supports the importance of having articulated a common language and set of values as a basis for major change.

*A wide range of stakeholders are meaningfully involved* in the planning and operation of innovative programs. Reports of extensive linkages with other constituencies and high levels of consumer involvement demonstrate that these are not closed systems. An openness to input from multiple perspectives increases opportunities for collaboration and problem solving and fosters creation of an *explicit vision of the future which is shared by various stakeholders*.

On a national level, the development of the vision articulated in *Mental Health for Canadians: Striking a Balance* (1988) has provided a complementary context for provincial reform efforts. At the provincial level, the official planning documents and descriptions of radically reconfigured services and supports inspire local innovators to pursue their agendas for change. Although achieving a shared vision requires skilled leadership and extensive consultation, it is an essential component of systems change.

*Infrastructure support* is another type of connection with powerful consequences. Many of the innovations described could not have happened without the active assistance of the larger organization within which the program resides. Champions in various program and system areas such as a sympathetic supervisor, a senior manager who is willing to modify procedures, a ministry that provides additional fiscal or human resources; all of these were identified as key elements of what made new initiatives possible. Several system strategies were facilitated through existing organizations which span multiple locales.

Most of the factors which facilitate innovation are common to both local program demonstrations and system strategies. *Political will is a special dimension of system change*. In order for radical, widespread changes in funding and policy to occur and be maintained, it is critical that elected governments endorse and support the reforms. There are a number of ways in which influence can be exerted. Advocacy groups applying pressure, professional groups issuing position papers, academics communicating research findings, senior ministerial staff writing plans and briefs that convince successive politicians of the value of reform; all of these are means of supporting system change. The personal experiences and convictions of an elected official have also often played a key role in assigning priority to mental health.

## How do best practices get implemented?

Judging from the examples that have been described, there is seldom an exact correspondence between program models that are rigorously evaluated and described in the literature and the best practices found in day-to-day life. There are definitely adaptations that take place as elements of best practice are borrowed from the program descriptions and put into action in various settings. The advantage of this approach is that implementation is tailored to local circumstance and is more likely to be accepted by those in the situation. The risk is that modifications may weaken or entirely omit those program components that contribute to effectiveness.

There are two ways in which such risks can be reduced or eliminated. One is for research program evaluations to pay increasing attention to the structure and process of providing care in different settings so that the critical ingredients of effectiveness can be specified and their relationship to outcomes better understood. The other is to build accreditation reviews and the monitoring of process and outcome into routine program delivery, so that information supporting or questioning the value of the interventions is readily available. Occasional examples of both of these types of evaluative activity have been described, e.g. the formal evaluation of Assertive Community Treatment in Brockville and the interactive database system in the Capital region of British Columbia. Still, on the whole, program and system evaluation appears to be weak and in need of attention across the provinces.

As expected, we have seen that best practices can be implemented through bottom-up and top-down processes. Sometimes an excellent local demonstration is the stimulus for change that then gets disseminated to the broader system. Other times there is a macro-level system strategy that filters down into the creation of multiple local initiatives. We are impressed with the amount of activity in both directions with regard to some of the core services. In particular, supported housing, consumer and family initiatives, and the diversion and transfer of long-stay patients are evident in many jurisdictions.

There is less evidence from the nominations submitted for this situational analysis of systematic implementation of assertive community treatment, supported employment and alternatives to acute inpatient admissions. Because this is not a comprehensive or exhaustive review, we cannot say with certainty that these are under-utilised best practices. We can, however, raise concerns about this possibility; concerns that are amplified because there is strong research support for the efficacy of these approaches.

Despite some misgivings about how best practices are being implemented, the overall impression that is gained from this situational analysis is quite positive. This document contains many interesting and exciting approaches. Some aspects are unique and may prove to be central in the next generation of best practices. This collection also reflects a much wider number of innovative programs and strategies which also merit special recognition but could not be included due to restraints of time and space. Taken as a whole, the work which is underway provides encouraging news about the progress of mental health reform in Canada and extensive possibilities for an improved quality of life for persons with severe mental illness.