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# Visions

## Approaches to Building Mental Health Accountability

**How do we know we are  
doing things right?  
Who do we include when we do  
research and evaluation?**

Guest Editorial • Dulcie McCallum

# Accountability in mental health: a glance at the past and a glimpse for the future

As Ombudsman, my investigation of Riverview Hospital was one of the major undertakings of 1993. A series of incidents led interested community groups and individuals to question the open-

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## Visions

Visions is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the Canadian Mental Health Association, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers and community.

In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association is grateful to the Ministry of Health, who has assisted in underwriting the production of this journal.

The Canadian Mental Health Association invites readers' comments and concerns regarding the articles and opinions in this journal. Please send your letter, including your name, address and phone number to: "Visions" Editor, Canadian Mental Health Association, BC Division, Suite 1200 - 1111 Melville Street, Vancouver, BC V6E 3V6 or e-mail to: [office@cmha-bc.org](mailto:office@cmha-bc.org)

*The opinions expressed are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its Branch offices.*

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ness of the hospital to listen to the voices of patients, their families and advocates. In the fall of 1992, after hearing from many of these people, as Ombudsman I decided to initiate an investigation.

The investigation represented the first systems review of a major psychiatric hospital by a Canadian or other Ombudsman. When deciding on the scope of the inquiry, the Ombudsman decided to cast the net broadly in order to encourage as many people as possible to share their views with us. The focus of the investigation was to discover the ways in which Riverview Hospital was, and needed to be, administratively accountable to the group it serves. However, I asked to hear the broad range of concerns of patients to see whether and where the hospital was falling short of meeting its public responsibility to listen to and address those concerns.

Two investigators from the Health Team spent many months of 1993 interviewing present and former patients, family members, members of community organizations working in the mental health field, Riverview Hospital staff and administrators, and Ministry of Health personnel. They considered the two key issues of responsiveness and advocacy. Interviews and group meetings were held in Campbell River, Prince George, Victoria, Penticton and Kelowna, in an effort to understand how this provincial hospital touches lives around BC.

*Listening* was released to the public in late May 1994. Many of the recommendations in *Listening* deal with how to foster and support advocacy by and for consumers of mental health services, particularly in a psychiatric hospital setting. In addition to advocacy, *Listening* addressed several ways in which Riverview Hospital needed to improve its internal processes for dealing with complaints made by patients and their families.

### Advocacy Recommendations:

- making it easier for family members of patients to advocate effectively on behalf of their loved ones
- encouraging staff persons to view advocacy for patients as a legitimate part of their role as professionals
- supporting patients in their efforts to advocate for themselves, regardless of disability
- establishing minimum standards governing the frequency and quality of ward meetings
- recognizing the legitimate role of a patient-run advocacy body independent of the hospital's governing authority.

### Internal Complaint Recommendations:

- adopting and implementing a draft Hospital's Charter of Patient Rights to serve as the foundation for creating a patient-centred culture at the hospital
- appointing a Patient Relations Coordinator at a senior level of administration to develop and promote mechanisms for responding to complaints
- permitting patients to request and receive a change of caregivers
- establishing a process by which patients can request and receive second medical opinions on treatment questions.

### Recommendations to the Provincial Government:

- proposed changes to mental health legislation to provide people who are involuntarily detained greater safeguards about giving consent to psychiatric treatment
- ensuring legislation gives people with mental illness the same right to pre-plan their medical care during periods of mental well being
- appointing a Mental Health Advocate for the province of British Columbia, with the following mandate: to report annually and as required to the public on the state of the mental health service system in BC, and on the issues being encountered by people who have a mental illness, service providers, advocates and those they support
- to provide a single information and referral source for advocacy resources in mental health services in BC

Riverview Hospital accepted all of the recommendations directed to it in *Listening*. The board, administration and staff collaborated on a comprehensive planning process to make change based on the recommendations a reality. As Ombudsman, I now felt that Riverview had in place a means of responding effectively to patients and family members with concerns about any aspect of hospital services.

Among the several recommendations made to the Ministry of Health, perhaps the most important was the recommendation that provided that the Provincial Government appoint a Mental Health Advocate for the Province of British Columbia. I considered having a Mental Health Advocate as one way to encourage government to engage in systemic advocacy aimed at improving the quality of life of people receiving mental health services.

The Minister of Health and Minister Respon-

sible for Seniors, in her 1998 Mental Health Plan, announced the creation of a Mental Health Advocate. In August 1998, Ms. Nancy Hall was appointed as the Province's first Mental Health Advocate. I expressed my appreciation to government for following the final outstanding recommendation from my report.

So where do we go from here? There are several things that those working in this field, people with a mental illness and families can think about in the coming year.

First, ensure that your local community caregivers, including hospitals that provide psychiatric services, are following the principles and intended outcomes recommended in *Listening*. The Ombudsman's Office will continue to use the report as a standard by which to measure services both in a hospital setting and, to the extent appropriate, in community settings, throughout the mental health care system now and in the future. With more and more individuals needing to find supports for the challenges facing them as people with a mental illness, we must extend the principles across the board of service delivery.

Second, promote the use of principles to guide provision of service to people who have a mental illness. Here is a sampling of the principles used as the framework for the *Listening* report modified to read generically:

- Every person is entitled to be treated with dignity and respect.

### Editor's message

Why is it that monitoring and evaluation are so current on everyone's mind? Perhaps it's a function of having limited human and financial resources, and trying to make the best possible use of these resources to achieve the most positive results for people using mental health services. It's important to be able to measure how well we are doing as individuals, organizations and as a mental health system. We will know how well we are doing, if we encourage consumers and family members to be involved in the development of measurements that are meaningful to them.

In this issue we explore a number of different ideas and approaches to accountability, monitoring and evaluating services as well as mental health research. We hope these ideas will spark the imagination of the reader so that we can build upon our strengths as a system to meet the needs of people with mental illness.

There are two consistent themes throughout. One is the need to develop standardized tools, methods and approaches on a local, regional and provincial basis, and the creation of one information system for collecting data that will enable us as a mental health system to make decisions based on evidence.

As consumers, family members and service providers, we all must be vigilant in creating a momentum for ensuring we are consistent and accountable.

Shelagh Turner

We are interested in receiving your comments about this and other issues of *Visions*. Send them to [dellery@cmha-bc.org](mailto:dellery@cmha-bc.org) or fax us at 604/688-3236.



Dulcie McCallum is the Ombudsman for the province of BC, appointed in August, 1992. Before this position, Dulcie worked as a lawyer and as legal affairs consultant with the Canadian Association for Community Living (CACL). While with CACL, Dulcie also taught advocacy to disability groups in the Caribbean.

- Every person has the right to be heard and listened to regardless of disability or method of communication.
- Every effort must be made to enable people to advocate on their own behalf and, where necessary, individuals and groups are to be provided with the necessary supports to make their wishes known and acted upon.
- Where decisions are made that affect the lives of those who are dependent on a service those responsible for making the decision must include those affected in the decision-making process regardless of any assessment of competency done for other purposes.
- All decision-making must be inclusive, accessible, understandable, responsive and expedient to those it affects including people who have a mental illness, friends, families and advocates.
- A complaint mechanism must be in place where individuals are being served by professional staff.
- Those responsible for the treatment, care and rehabilitation of people who are labeled mentally ill should demonstrate the optimum level

of respect, tolerance, understanding and affection for those they serve to set a standard for the community at large to emulate.

- Everyone has the right to self-determination. All legal and administrative mechanisms in place should, as a first principle, enhance the person's right to be self determining.

And finally, these principles can assist all of us to ensure that the person being served is at the centre of our service and that focus will be the paramount consideration in how we go about administering that service. Increasingly, mental health services are being delivered in the community with psychiatric facilities being but one end of a continuum. Key issues such as housing and employment need to be addressed to ensure that a holistic approach to maximizing the well being of people who have a mental illness.

We in British Columbia have a major challenge ahead of us to ensure that people who have a mental illness are enabled to find a safe, healthy and happy place in our community. This would be fair.

## BC Health Research Foundation identifies values of community-based research

Research isn't just something that happens in the ivory tower. "When research is happening in the community, people come to appreciate the value of the process of looking at things critically and seriously and then doing something to effect change." This comment from a leader of a grassroots community group captures the essence of community-based research. The BC Health Research Foundation has been committed to supporting this kind of research since 1990 when the Foundation created its first program to encourage community groups and health service providers to conduct research aimed at addressing health issues that community members identify as important.

Community-based research is one way to make health research more relevant to the day-to-day realities of both health care providers and consumers. The Foundation's efforts have been key to building the capacity of communities across the province to investigate critical health issues and take effective action. The community research grants program, the community-based research training program and other consultation and facilitation activities put the Foundation in

the forefront of the movement to find ways to build stronger links between health research and those who use that research: health care providers, consumers, community groups, and policy makers.

Community-based research is typically initiated by community members who believe they need to know more about a particular health issue in order to resolve it effectively. The community is actively involved in all aspects of the research process, from specifying research questions to implementing actions based on the results. Researchers and community members work as partners throughout the process of collecting and analyzing information and determining how to use that information to promote better health.

From the Foundation's experiences over the last several years, we can see that this kind of research produces unique benefits. Community-based research builds bridges among community members, researchers and policy-makers - people who have a stake in the health system, but who rarely have an opportunity to work together on specific issues. Having community members ac-

tively involved means that the research can be grounded in the knowledge and experiences of local people.

Community members contribute observations and insights that might have been missed if the research was conducted only through "outside observation." Including a variety of perspectives helps to ensure that local decision-makers see the research as credible and relevant. By doing this kind of research, a community can come to understand itself better and develop a sense of ownership of the problem and its potential solutions. And, in many cases, solutions are not only applicable to the communities that do the research. Many community-based research projects develop models for programs or services that can be applied by other communities facing similar issues.

Not only does community-based research provide important outcomes, but also, the process is beneficial. The use of less traditional methods of research, better suited to exploration and description, provide a more interactive and collaborative atmosphere. The process contributes to growth and learning by everyone involved! Many people who have never participated in such projects call them "empowering". One coordinator of a Foundation-funded project described the project as "like a spider web - so many people were affected, some in big ways, others in small ways."

Community-based research faces many challenges. Forming partnerships between researchers and community groups can be difficult. Researchers and community members may have different expectations about how long a project should take or a different reason for thinking a project is worthwhile. It can take time for researchers and community members to build a common understanding of what the project should look like and to negotiate their respective roles and responsibilities. It can also be difficult to find the right balance between the need for the research to be owned by the community and the need for the research to be methodologically sound.

Community-based research is bona fide research: it is a systematic process designed to generate new knowledge. The users of such research need to have confidence that the results are accurate, valid and reliable, and that the data were obtained ethically and responsibly. This is not just a theoretical issue. Researchers can find themselves in ethical dilemmas if they feel that methodological standards are being compromised. Community members can feel frustrated and burned out if they feel the need for rigor is taken

too far.

Community-based research clearly has both strengths and weaknesses. In fact, some of its essential qualities are themselves double-edged swords. The involvement of community members makes research relevant and useful, but constrains the level of methodological rigor that can be attained. The focus on local issues and the involvement of local people make the research an effective change agent in the local community, but may limit its applicability to other settings.

Despite these challenges, community based research will continue to be an important part of the health research picture. As the health system struggles to find ways to involve stakeholders in health policy and planning decisions, community-based research is an effective way to give people a voice at the table. **As funding agencies respond to calls to be more relevant and accountable, community-based research provides a model for a different way of generating and using knowledge.**

Community-based research is still in the early stages of development. Not all questions are answered; not all the problems are resolved. But this kind of research has already demonstrated its merit and potential. Continued collaboration among researchers, communities, and policy-makers will further establish the spectrum of health research activities being undertaken here in BC.

Article provided by the  
BC Health Research  
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# Quantum mechanics of evaluation

**Max Shaw**

Evaluation of services can be a tricky endeavour. The skills needed may not be readily available to many organizations.

Evaluation is essentially a research project done to determine program effectiveness. The skills needed for designing, implementing and analyzing an evaluation are somewhat specialized. Finding someone with these skills, who can also make the findings understandable (and thus usable) may not be easy.

In addition, there's an anxiety that arises when an organization is told of an impending assessment. As a result, evaluators must have considerable charm to ease the situation and gain people's trust.

But these considerations should not put you off the effort. Mental health services will only improve if we can determine what works and how well.

Nelson recently embarked on an evaluation. It began with two consumers (Liz Dance and Max

Shaw) who had tired of hearing concerns about the inpatient unit at Trail Hospital's Daly Pavilion, where Nelson consumers are transferred for treatment. They concluded an evaluation was in order. With this in mind, the evaluators met with the director of the Nelson Mental Health Centre, Myrna Martin. Myrna had been playing with similar ideas, so the operation began.

Next, the Kootenay Boundary Mental Health Advisory Committee (KBMHAC) readily endorsed the concept and struck a subcommittee to do the work. The subcommittee included three consumers, two family members, a mental health centre director, Trail Hospital's quality assurance officer and Daly Pavilion's patient care coordinator.

With a small, irregular grant of \$5,000 from the Provincial Mental Health Advisory Council - far less than an evaluation of this dimension would normally require - the KBMHAC subcommittee developed a cost-saving strategy. They could use in-house resources, which made \$5,000 sufficient to assess all programs, including Adult Acute, Adult Community Support Services, Elderly Outreach and the Daly Inpatient unit.

A consultant was contracted to facilitate the project. The committee consciously chose a person with superior interpersonal and listening skills over candidates that might have had more evaluation experience, because they were determined the process be consumer-friendly and employ empowerment as a central value.

The evaluation subcommittee then set about designing an appropriate process and all the necessary interview guides and questionnaires to meet our assessment needs. In the Nelson case we wanted to establish a baseline of how the system was working for consumers and family members now, and to provide a guide for improving the system in the future. The basis for the research came out of concern and commitment to improving things. For this reason (and because it sounds less intimidating) the research report was called a *Progress Report* rather than an evaluation.

The final design included the following aspects:

- Surveys of consumers, family members and providers of both community and inpatient services,
- In-depth interviews of 18 consumers and 9 family members; some done by the facilitator while consumers were trained to do others,
- Focus group of front line workers such as counsellors, physicians, police, advocates etc.,
- Pre- and post-treatment outcome measures were conducted on all new mental health centre clients during a six month period. This caused considerably more paperwork for case-

## Best Practices in Evaluation and Monitoring

### A CRITERIA CHECKLIST - for monitoring and evaluation

- regular monitoring of all services and supports is the basis for program and system accountability, and for continuous quality improvement
- preset goals, performance measures and time lines are established
- an information system has common elements for system evaluation (provincial) and local elements for program evaluation (agency level)
- there is a sufficient, protected evaluation budget

*\*from Best Practices in Mental Health Reform Discussion Paper, 1997*

### KEY PRINCIPLES which should be observed in all future research and evaluation of mental health programs and services/supports\*:

- use methods appropriate to the program/service being studied
- use experimental or quasi-experimental designs with comparison groups whenever possible
- use participatory research and qualitative designs in the study of self-help groups and consumer/family initiatives
- clearly define and describe the nature of the experimental intervention, including all program elements
- provide clear descriptions of the outcomes to be studied in outcome evaluations and use standardized, reliable instruments
- when doing outcome evaluations, allow for longer follow-up times of at least two years
- include cost data in all research
- cost effectiveness data must take into consideration the perspectives of clients/patients, family, society and health systems
- meaningfully involve consumers and families in the design and delivery of the evaluations of programs/services

*\*drawn from Best Practices in Mental Health Reform discussion paper, 1997.*

workers but cooperation was good.

- Statistics from file audits, client registrations and other sources.

Notwithstanding the findings, the process in itself proved extremely useful. All the players got to know and trust each other as a result of the more frequent meetings.

It was also useful because the very act of evaluating raised provider awareness and added improvements. This is a consequence of what I call the 'quantum mechanics' of evaluation.

In quantum physics it is a well-established fact that the observer influences the experiment. This is Heisenberg's Uncertainty Principle: the very act of *looking* changes the course of the path of a particle of light (photon) as it hits an electron. This changes the energy outcome of that exchange.

By "looking" at mental health services, those very services are changed. For example, when counsellors started administering pre- and post-treatment measures their awareness was significantly increased, which undoubtedly informed their practice.

Another example occurred in the study when early returns indicated considerable dissatisfaction with discharge planning at the Daly inpatient unit. The staff there immediately began investigating alternative discharge planning.

In this way, the observers influenced outcomes positively even before any final report. This quantum aspect makes evaluation remarkably useful even beyond the quality of any findings. Every region in the province should undertake such an endeavour.

Max Shaw has an MSW and is a consumer activist living in Nelson.

## Evaluation of patient's rights identifies mental health consumers' experiences with involuntary detention and steps for change

**Barb Toews**

Patient rights. What are they? Are they protected? Do people know about them? In 1995, the Association to Eliminate Stigmas Oppressing People (AESOP) undertook a research project to determine the answers to these questions.

The first question, "What are patient rights?" is answered within the Mental Health Act regulations: a person has a right to be told that they are being involuntarily certified, why they are being certified, and that they have a right to have a review panel to determine if their detention is warranted.

The next two questions were not easily answered: "Are they [rights] protected?" and "Do people know about them [rights]?" To get these answers, AESOP decided that a survey of people who had been in hospital was the best way obtain these answers. AESOP located two volunteers who had no vested interest in the results of the survey (people who were not members of AESOP and were not involved in the mental health system), and sent these individuals out into the community and to our local hospital with a questionnaire. (One difficulty to note in conducting this survey was the small sample population - 18 participants. Due to the stigma of mental illness, and with involuntary detention being extremely stigmatized, people seem less willing to be identified and participate in this type of research). Despite the small sampling, the results of the survey were startling.

In answer to the question, "Do people know of their rights?" the majority of people (66.66%) were unaware of any rights they would have/have had while in hospital involuntarily. Further to this, most people did not find out from their doctor or nurse of their rights, but from other sources.

"Are patient rights protected?" Unfortunately, due to the ambiguous nature of mental health regulations which state that a person is to be informed of their rights as soon as they are "capable" of "comprehension," the protection of these rights is a difficult task.

The goal of this project was to determine whether or not people were aware of their rights. But more importantly, the goal was also to implement or encourage change that would ensure that patient's rights were protected. While direct advocacy (talking with specific stakeholders) is one way of implementing change, AESOP chose to undertake this part of their project in an indirect manner. AESOP released their findings during an open house, celebrating their third year of operations. Doing so, they were able to educate not just mental health consumers about their rights, but bring this issue to the attention of all people. Through the publicity is received through the media, AESOP believes that it has had a positive impact in the community. More and more review panels are occurring in our area, and increasing number of people are inquiring about their rights.

For copies of "Patient Rights Research Project" contact Barb Toews at the Prince George Branch of the Canadian Mental Health Association, Tel: 250/564-8644.

Barb Toews is the consumer advocate volunteer coordinator with the Prince George CMHA Branch.

# Experiencing an accreditation process from a local agency perspective

**Gail Simpson**

No rehabilitation worker gets out of bed in the morning and says, "I'm going to do the worst job I can today." Everyone is committed to carrying out the most effective activities with the best possible outcomes for the person with mental illness, who is the focus of the rehabilitation (rehab), program.

## What is CARF?\*

CARF - the Rehabilitation Accreditation Commission (CARF) is a private, not-for-profit organization that originated from medical and vocational rehabilitation agencies' need to promote quality programs and services. CARF develops and maintains practical and relevant standards of quality for rehabilitation programs. These standards are applied through a peer review process to determine how well an organization is serving its consumers. The standards are developed by the rehabilitation field, which is defined as the persons served, rehabilitation professionals and purchasers.

## CARF'S Values

We believe:

- In continuous improvement in both organizational management and service delivery.
- In conducting accreditation, research and education with the utmost integrity.
- That people served by rehabilitation organizations should be treated with dignity and respect.
- In the empowerment of people with disabilities and others in need of rehabilitation services.
- That people with disabilities should have access to quality programs and services that achieve optimum outcomes.
- In being cognizant of the needs of all constituents, including consumers, providers, purchasers and others in the field.
- In the value of diversity and cultural sensitivity to the constituents we serve.

## Applying standards\*

Although CARF'S standards are responsive to the unique needs of specialized programs in behavioural health, certain fundamental principles apply to all programs. These principles serve as the foundation for all CARF standards. An organization seeking accreditation for a behavioural health program must demonstrate the following through policy and practice:

- Service design and delivery that focus on the needs of the persons served.
- A service delivery process that uses an interdisciplinary approach.
- Program accessibility and assignment of qualified staff members to provide behavioural health services.
- Partnership with the persons served in the development of goals.
- A system of accountability that measures the success of the behavioural health programs through evaluating the outcomes achieved by the persons served.

\*Sources: CARF 1997 Sourcebook and CARF's "A Foundation for Quality."

Accreditation is a process that allows you to see your program from many perspectives ("with new eyes") and to plan, in consultation with many stakeholders, how to enhance the program. The focus is on commending the areas that work and recommending improvements where needed.

## Background

A few years ago, the Ministry of Health formed a Mental Health Services' provincial evaluation committee. The purpose was to plan for and choose an accreditation process for BC's mental health programs and services. The committee explored two accreditation organizations, one of which was CARF - the Rehabilitation Accreditation Commission (or simply, CARE. See more about CARF in the accompanying article).

It was decided that 6 out of 12 organizations would act as pilot sites for the CARF process, and our agency was one of the six chosen.

Forty-two years ago, Victoria Branch of Canadian Mental Health Association received its charter. At first all services, including public education, social rehabilitation and housing, were provided through the branch. In 1979, a sister agency, Capital Mental Health Association "spun off" to carry out the direct service rehabilitation programs while the indirect services (public education, advocacy, information and referral) remained the mandate of the branch.

It was the rehab programs of Capital Mental Health that were to be reviewed by CARE.

## The Process

Looking back, it was the year-long preparation for the survey which was the most important phase. Program participants, board members, and administrative and line staff formed the Steering Committee to develop a review and action plan for the agency and its eight semi-autonomous rehab programs. Each program site also reviewed its own actions needed and made recommendations based on its self-study survey. All of us found the CARF standards to be relevant, practical, explicit and easy to understand. Our self-study concentrated on what areas of our work needed to be addressed, in order to conform with the standards.

The collaboration and joint initiatives among the programs created new opportunities for team-building and strategic planning. There was a sense of excitement felt around the whole organization as the December survey team visit neared.

The two-person team visited all six of our program sites over three days. They consulted clients, family members, board members, several



staff and other people who work with us (such as the Chief of Psychiatry of the local hospital and the Executive Director of the United Way). They reviewed minutes of Board meetings, financial information, critical incident reports, client files and outcome management reports. It was a very thorough process. We were all surprised at how comprehensive their areas of interest were and at how aware they were of the essence and "heart" of each program. During the exit interview, they offered details of their observations and everyone present felt the agency's values and operations had been observed, understood and fairly represented.

Two months later we received a comprehensive report with the exciting news that we had been granted the maximum three-year accreditation as the first non-profit psychiatric rehabilitation agency in Canada to receive such a designation.

### **CARF in Canada and the world**

Currently, CARF accredits over 2900 organizations which represents 117,685 programs and services at over 8,000 sites. Of these, 1923 programs are in the mental health field.

CARF conducts approximately 1,000 surveys each year. In Canada, there are 79 behavioural health programs accredited so far, most in BC.

With the report we received recommendations for improvement. We have developed an action plan to address these areas and in February, 2000, when our next survey team arrives, those areas will be the first discussed.

The board and staff of Capital Mental Health Association have been pleased with the CARF accreditation process and encourage other, similar agencies to consider becoming involved. It is very rewarding to undertake such a thorough review which focuses on effective service for our clients and program participants.

Gail Simpson is Executive Director of the Capital Mental Health Association, and of Canadian Mental Health Association, Victoria Branch

## **Client-centered accreditation program ensures province-wide quality of services**

**John A. Higenbottam**

Most publicly-funded health services in Canada participate in the accreditation program of the Canadian Council on Health Services Accreditation. This is a non-profit, national body which is committed to continuously improving the quality of health services provided by its participating organizations.

Participation in the accreditation program means that organizations must provide quality services which are client-centered as well as being committed to continuously improving the quality of services to clients. Participating in the accreditation program means that organizations must meet national standards. Compliance with these standards is evaluated through accreditation surveys where, approximately every three years, an organization is evaluated by a peer review team.

The Canadian Council on Health Services Accreditation has been in existence for fifty years and has been responsible, not only for improving the quality of health services across the country, but also for assuring that services are maintained at a high level across the country. Clients receiving services in Newfoundland or Manitoba can be assured that the services are at least the same quality as those provided in BC or Ontario.

Participation in the accreditation process is voluntary. However, a majority of Canadian health care organizations now participate as a commitment to providing quality, client centered

services. A certificate of accreditation displayed in health care organizations is an assurance to clients of the organization's commitment to continuously improving the quality of its services.

For many years, a majority of the health care organizations participating in the accreditation program have been hospitals. This has changed very significantly in the past ten years. Increasingly, community health services and now health regions have begun to participate in the program.

In mental health, acute hospital psychiatric units and psychiatric hospitals have traditionally participated in the program. In recent years, community mental health services have also begun to participate in the program. In BC, while the hospital based psychiatric units such as Lions' Gate and the provincial psychiatric hospital, Riverview, have long participated in the program, only Greater Vancouver Mental Health Services has participated among the community mental health organizations.

In BC, the Ministry of Health has made a policy decision that all community mental health services in the province will be accredited. As a start, a number community mental health programs and services were surveyed on a pilot basis by the Canadian Council on Health Services Accreditation. The pilot project demonstrated clearly the benefits of participating in the accreditation program in terms of service improvements and greater client focus.

Participating in the accreditation program has become even more important with regionalization. Although regional management of health services has served clients "closer to home," it creates the possibility that there will be significant differences among regions in the quality of mental health services being provided. Participation in the accreditation program assures clients that the mental health services in all regions meet the accepted national standards of the Canadian Council on Health Services Accreditation.

What is the client centered approach? Simply put, mental health organizations are expected to make serving clients their top priority. Obviously, most clients will be mental health consumers. However, other clients may include agencies, government or mental health advocacy organizations. In each case, the focus of the accreditation standards is to know who the clients are, what their needs are and how these needs can best be met. The standards require that clients be directly involved in the assessment of their needs and the planning and evaluation of services.

Dr. John Higgenbottom is presently Vice President, Clinical Services, Continuing Care, Psychiatry and Rehabilitation CPU's, Vancouver Hospital and Health Sciences Centre.

Other standards focus on evaluating the effectiveness of service in terms of client outcomes including not only improved mental health, but quality of life and satisfaction with services.

In addition to the services received directly by mental health clients, the standards also require the organization to evaluate the needs of its community and to demonstrate objectively that the identified community needs are being met.

In addition to being client-centred, the approach to quality also reflects the concept of continuous improvement. In other words, there can never be "just enough" quality. Mental health organizations must strive to continuously evaluate and improve the services they provide to clients.

In summary, the client centered accreditation program is key to providing quality mental health services. The participation of the community mental system in BC, together with the traditional participation of the hospital-based components of the system, is a major step forward in improving and maintaining the quality of mental health services within BC.

## Accreditation as a process: good or bad for mental health services?

**John Russell**

The prominent civil servant who toured the province in recent years saying, "process is for cheese," would not have had much time for accreditation. That is because the accreditation standards developed by the Canadian Council for Health Facility Accreditation is heavily weighted on process and has become increasingly so with changes to the standards that have been made since the early 90's.

The emphasis on process has, in my opinion, made the standards and accreditation increasingly useful for community mental health services.

My experience with accreditation goes back to 1985. As the relatively new Executive Director of Greater Vancouver Mental Health Services (GVMHS), I was responsible for guiding that organization through its second accreditation. The standards at that time were highly focused on organization structure and the minutiae of policies and procedures. It was a time when hospitals would hire consultants to come in for the six months prior to accreditation to get all of the paperwork in good order for the surveyors.

It was also a time when GVMHS found itself questioning whether accreditation was worth the effort. The effort was considerable. It was hard for us to see that preparing for the survey, the visit of the surveyors, and the subsequent report had any beneficial impact on the services that we provided to our clients.

Was it really going to make a difference, for instance, if committee chairs signed all meeting minutes?

The standards required a hospital model for staff in general and especially for physicians. GVMHS had a multi-disciplinary model without discipline heads and did not have the medical staff bylaws that hospitals have. It seemed to work well, and changing to the accreditation standard we felt would be counterproductive.

In the 80's, a lot depended on the accreditation surveyors. Some had a breadth of relevant knowledge and an ability to look beyond standards to results. Some seemed to come fixated on their own particular "hobby horse."

In contrast, the last accreditation that I prepared for in 1996 was much more positive and staff, for the first time, saw it as a useful exercise.

So what was different about the 1996 standards?

The standards are still built on the essential policies and procedures needed for a sound and effective organization. The standards, however, rather than being prescriptive, focus on the need

to have policies and procedures that are consistent with objectives and understood by all involved. The real change is the requirement that the self-assessment that precedes the survey be completed by a team made up of a cross-section of staff from the organization as well as some representatives of the clients served and key organizations in the community that work closely with the organization.

As a process, accreditation ensures that people from across an organization participate in the self-assessment. This means that the assessment team on clinical standards, for instance, has participants from client groups and outside organizations, support staff from finance and human resources as well as clinicians.

### **The process is not perfect.**

Organizations make their own decisions about the individuals who will participate on the self-assessment teams. Organizations obviously want a positive accreditation outcome and are not likely to put individuals on their self-assessment teams who are really going to challenge practices. Surveyors are more carefully selected and trained as well as being better-matched to organizations. They still have limited time to do justice to a wide variety of programs spread across a large region.

The Canadian Council for Health Facility Accreditation now subjects its own standards and procedures to constant review. Their goals for change include implementing **standards for regional health authorities** and introducing **outcome measures**.

Standards for Health Authorities should permit more attention to the critical issues of service coordination and continuity of care. On the other hand, given that health authorities are large and complex organizations accreditation may run the risk of becoming superficial.

More focus on outcome measures could also be positive, but clients and families will have to be vigilant to make sure that outcomes defined by organizations actually serve the needs of clients. The current focus in acute care on length of stay, for instance, has not always been positive for people with a mental illness.

### **Is accreditation an evaluation?**

No. Accreditation ensures that an organization has a documented plan and objectives, that it is organized to meet its objectives and that it is able to provide sound stewardship of its resources. It does not ensure, however, that the objectives are actually achieved.

John Russell is the former Executive Director of the Greater Vancouver Mental Health Service (GVMHS).

## **The Community Resource Base: a foundation for a system progress report**

**Catharine Hume**

### **Background**

The *Salmon Arm System Progress Report* was sponsored by the Consumer Development Project, a project of the Canadian Mental Health Association (CMHA), BC Division. The idea to do a system level progress report came from discussions at the Thompson Okanagan Kootenay Regional Consumer Council. Council members were interested in developing a way for people who have received mental health services to have a direct and meaningful voice in the evaluation of mental health services in their communities.

### **Approach**

The "Community Resource Base" from CMHA National's *A New Framework for Support*, was used as the basis for the development of the progress report. The Community Resource Base states that one of the roles of mental health services is to support people to connect to, and build other areas of support in their lives. In turn, this

reduces dependency on the formal mental health system.

The Community Resource Base supported the development of a progress report that was based on the way mental health systems are experienced by consumers and families rather than on the way mental health systems are conceptualized by managers and planners. This made a fundamental difference in our approach. We made a real shift from focusing on the number of beds and staff in each of the services that made up the system to looking at the system as one piece that is intended to support people with mental illness to live more fully in the community. This shift allowed us to ask key questions both about how the services within the mental health services "box" worked with each other to accomplish this goal and how this "box" of services worked with others in the community to accomplish this goal.

This approach also broadened our thinking about the kinds of people we needed to hear from

in order to get an accurate picture of the way the system was working. The committee identified groups of people to gather information from, including consumers, families, service providers and a wide range of external groups. These external groups included family physicians, the RCMP, clergy members, on-reserve Native people, drug and alcohol workers, the local Ministry of Children and Families and financial aid workers.

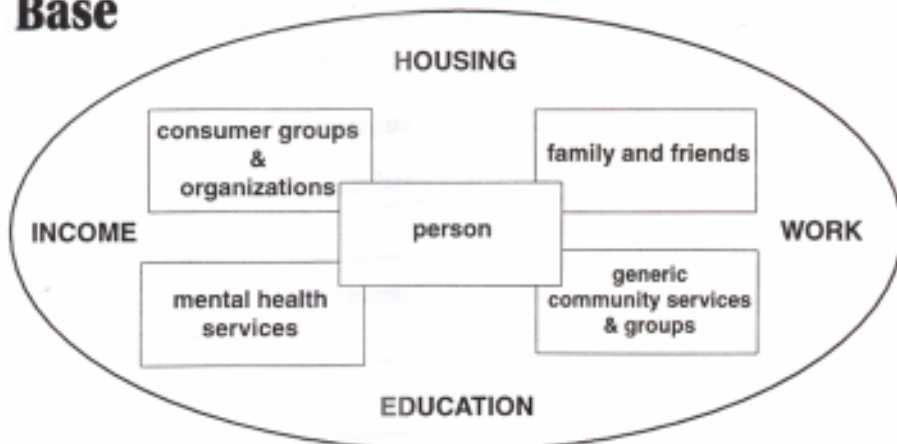
By broadening the sources of information we were able to collect 121 completed questionnaires from community members including:

- 46 people who have received adult mental health services
- 21 community mental health service providers
- 17 family members of people who have received adult mental health services
- 13 hospital-based mental health service providers
- 8 family doctors
- 6 RCMP and probation workers
- 6 workers from other Ministries (Children and Families and Human Resources)
- 2 local Native Bands
- 1 member of the clergy
- 1 Salvation Army employee.

For information, reports or questions, contact: Catharine Hume, Project Coordinator at CMHA, BC Division, Tel 604/688-3234, or Shelagh Turner at CMHA Consumer Development Project, Tel 250/868-9611

By using the Community Resource Base as the foundation for the Salmon Arm Progress Report we were able to fill out the picture of how the system is currently functioning and being experienced by a wide range of people within the community. This approach provided valuable insights into areas that are working well and areas that require more attention.

## CMHA's Community Resource Base



## Initial Impacts

To date, initial findings have been widely distributed and a final report, outlining recommendations, has been developed. The local system has already begun to address some of the initial findings in the areas of family member and family physician involvement. The local system is committed to prioritizing and working on the recommendations that have been developed.

By basing the Salmon Arm progress report on the Community Resource Base we were able to pull together information and experiences from a wide range of stakeholder groups both internal to, and external to, the formal mental health system. In turn this helped to encourage people within the system to recognize the importance of connecting to a broader base of individuals and organizations within their communities. This is a key component of mental health system reform.

## Salmon Arm evaluation: a mental health centre director's perspective

### Lyle Petch

You want to evaluate our mental health services? My first reaction to this notion was a mixed flow of thoughts and emotions. What a great idea! Best practices as the criteria? That's logical, but yikes!—how will we fare with that as the guide? What if we fail? What if we're really bad? Man, could we learn a thing or two! This could be a very useful process.

My initial jumble of mixed emotions notwithstanding, I never really doubted that this was a good idea and a rare opportunity to find out how we are doing. Within minutes of hearing the question, I was enthusiastically discussing how this evaluation would be conducted and what we had to gain.

Thankfully, I never felt particularly challenged in deciding to participate in this process. But then, I've long since concluded that our mental health services are imperfect and need improvement. On the other hand, I feel comfortable most of the time with my own efforts and those of the mental health service staff. I believe our intentions are sound even if the end product is short of the mark. I know there are issues we don't see or don't handle. And that's okay.

Implicit in my initial jumble of mixed emotions was the part of me that sensed a threat in an

evaluation of this type. This is a very personal reaction. Can I continue to feel good about myself even if the evaluation shows that I am directing a service that fails the grade? How closely is my self-esteem tied to the evaluation outcome?

Fortunately, as I considered the underbelly of that question, I realized that I would feel good about having the courage to participate, and excited about the new directions that could emerge from the evaluation.

I saw an immediate benefit to participating. I liked the fact that the initiative and direction came from outside our service. The neutrality was attractive, as was the fact that someone else was taking the lead and organizing the work! Admittedly, there was considerable local effort put forth by the broad-based steering committee that helped develop the evaluation questionnaires, but the energy required to drive the project to completion came from outside the community.

Developing a list of people to receive the survey, including service providers, family members and consumers from our area was relatively simple. Stuffing the envelopes with the invitation to participate in the evaluation was not! Thankfully, that chore went to someone else.

The gathering of responses to the evaluation questions, either through questionnaires or by interview, went smoothly. Within a few months, we were hearing about some of the initial findings. That's when the potential benefits began to emerge.

We heard what we do well, and are pleased that there are several areas that found approval. Of more interest, though, are those areas needing improvement. Some surprised me, others did not. Physician unhappiness with our communication procedures, family member concerns about our way of engaging with them, and our need for better community education strategies are a few key items.

There are others. What matters is that each of these areas provides a basis for targeted action. We have another opportunity to bring together consumers, family members, and service providers to make some plans, put them into play and see what happens.

We have already started to make some changes. I look forward to the pleasure to be found in the process of working together, hearing ideas, and sharing the responsibility and the satisfaction in doing our work a little bit better than before.

Lyle Petch is the director of the Salmon Arm Mental Health Centre.

## The experience of being a consumer on the Salmon Arm mental health system evaluation steering committee

**Kim Bramble**

As President of Salmon Arm CMHA Branch and a member of TOKO Regional Consumer Council, I have had a lot of experience being on boards and committees. As a member of the TOKO Regional Consumer Council I was in on the idea of a consumer-oriented survey program at the very start. I have been fortunate to be able to follow the process all the way to written reports on the findings of the survey, the *Salmon Arm Progress Report*. Learning by being involved in the process of developing research programs has been my most valuable experience.

However, I have never been involved in a research project the size and scope of the *Salmon Arm Progress Report*. Knowing most of the members of the steering committee made me comfortable from the very start, however, as the only volunteer consumer on the steering committee I was at first a little hesitant at the meetings because of the professional language and jargon being used. Nevertheless, I stuck to my guns and advocated for the use of plain language being used at all meetings.

The rest of the committee agreed with me and from that moment on I felt that I was an integral partner and contributor in the process of developing the survey. There was never any feeling of tokenism. I felt especially useful when it came to making the survey instruments user-friendly for the consumers. I felt validated and that my opinions were listened to and acted on.

I learned the difference between doing an opinion survey and a systems evaluation. Once we decided what information we were after it then became a problem of asking the right questions in order to get that information. Although I was a consumer participant and much of my focus was on the consumer perspective I felt that I have been an essential part of the overall project.

Kim Bramble participated on the steering committee which guided the Salmon Arm mental health system evaluation, and is an active consumer advocate in the Salmon Arm community.

# Consumer Advocacy Group's research projects document realities of living with mental illness

**Cindy-Lee Robinson**

ARA Mental Health Action Research and Advocacy Association of Greater Vancouver (ARA) is a non-profit, government-funded organization that provides direct advocacy services as well as research and evaluation of mental health services from a consumer/survivor perspective.

Previous research by ARA (under our previous name, Mental Health Action Research and Advocacy Association of BC) includes a community housing project, which evaluated the housing needs and circumstances of mental health consumers/survivors who live in the urban core of Vancouver. Also, our Consumer-Survivor Impact Project evaluated the effects of initiatives to include mental health consumer/survivors as participants on boards, committees, and councils at various levels of government and on community mental health agencies.

Currently, ARA is wrapping up an evaluation of Ministry of Human Resources services as they are provided to mental health consumer/survivors. In 1995, the Ministry of Human Resources announced they were going to move services for people with disabilities and seniors out of the welfare system. They acknowledged there was a stigma associated with welfare that was inappropriate for these two groups. (We can't resist pointing out here - it is inappropriate for anyone to be stigmatised because they require BC Benefits assistance.) Since then, seniors' benefits were transferred to the Ministry of Health, but people with disabilities receiving BC Benefits are still "on welfare."

Here is a sneak preview of our soon-to-be-published report, "Mental Health Consumer/Survivors and the Ministry of Human Resources: How Do They Do It?":

- Only 7 of the 70 respondents to the questionnaire who had been receiving benefits for more than 2 years were receiving the "Employable" (lowest) rate. Therefore, the Ministry of Human Resources implicitly admits the rest of the respondents must be in the "Disability" category. Despite the fact that many respondents have received these benefits "for at least two years or more" - one of the criteria to apply for full Disability benefits - less than one half of those re-

ceiving more than the Employable rate are receiving the maximum entitlement they are allowed under the Disability category.

- Most of the respondents were paying more than 50% of their income for shelter; they cannot afford to eat properly. The longer months of the year create even more difficulties for BC Benefits recipients to get proper nutrition.
- Though it is against their policy, many financial aid workers will give Crisis Grants for food, realizing many people can't afford to live on the allotted money from BC Benefits. Many more mental health consumer/survivors find it is too stressful to their mental health to go to the financial aid worker and request a food voucher.
- BC Benefits recipients are well aware of the fact that "too many" requests for Crisis Grants can easily lead to having benefits "administered." Even when Crisis Grants are refused it is a black mark in one's record. Administered means benefits are doled out in small portions throughout the month. It can often be demeaning, time consuming and can lead to further erosion of a sense of self-empowerment.

The next ARA research project, scheduled for late January, 1999, will document the lives of mental health consumer/survivors who are living in poverty. We do personal interviews with each respondent to our questionnaires and offer a small honorarium as this can take more than an hour and a half. If you would be willing to answer our next questionnaire, or have any ideas to offer on particular problems of poverty we should examine, or questions we should ask respondents, call with your name and a number where you can be reached.

For a copy of ARA research reports, or if you have any ideas for future research projects concerning mental health consumer/survivors, please contact the writer of this article at Tel 604/689-7938.

ARA's goal is to promote and facilitate services to encourage the healthy development of individuals in order to achieve a normal, productive life for mental health consumer/survivors. In addition to research activities, ARA provides direct advocacy services in an effort to enhance the quality of life of mental health consumer/survivors.

Cindy-Lee Robinson is a researcher with ARA Mental Health Action Research and Advocacy Association of Greater Vancouver.

# Building a more responsive mental health service: how to assess diverse needs in a culturally-diverse community

**Ron Peters**

What measures can be used to decide whether an equitable (or at least an improved) mental health service is being provided to the full range of people living in a region, including ethnic minorities? There is no one answer to this question.

At the simplest level various utilization measures are often applied. For example, if Aboriginals make up 2% of clients in the mental health system but comprise 4% of the regional population, you could say that Aboriginals utilize mental health services at half the expected rate, based on their representation in the population. In other words, their utilization rate was 50%.

Sometimes this is made a bit more sophisticated by comparing the utilization rate for a minority group with the utilization rate for Anglo Canadians. For example, if Anglo Canadians account for 80% of the mental health caseload but make up 65% of the population, their utilization rate would be 80/60, or 133%. The *relative* utilization of mental health services by Aboriginal clients compared with utilization by Anglo Canadians would be 50/133, or only 38%.

Using any of these measures involves making assumptions that may be questioned. For example, in the case of the Aboriginal community it is not clear how accurate the population statistics are, both because of ambiguities in how aboriginal status is defined and because some First Nations communities have resisted participating in the federal Census.

Using population size as the underlying indicator of need also forces you to assume that the need for mental health services is the same across all ethnic groups. Is it reasonable to assume that the mental health needs of people of Aboriginal or Chinese or South Asian descent are exactly the same, and that all of them have needs equivalent to those of Anglo Canadians? Epidemiological literature can be consulted to help test these assumptions, but appropriate studies only exist for some ethnic groups.

Sociological factors are also important. The need for certain kinds and amounts of mental

health service varies strongly with things like gender, age, social support, and poverty. If a certain ethnic community is made up of many women single parents living in isolation and poverty, is it reasonable to attribute a higher need for mental health services to their ethnic origin? If you then tried to address their cultural needs without addressing their need for income supports could you be missing the point?

Historical and political factors also play an important role within ethnic groups. Is it reasonable to assume that the need for mental health services is the same among recent refugees from mainland China as among fourth generation middle-class Chinese Canadians? Or, although they are all Latin American, should service needs be the same among professional, second generation Argentine immigrants versus recent Guatemalan refugees with a history of torture? Would all these groups require the same kinds of accommodations in order to make their services responsive to their needs?

In these cases, information systems need to include all of the pertinent factors before proper planning decisions could be made. Of course this assumes that you *have* an information system to begin with, and that it asks about ethnic origins, which some communities have been reluctant to do, believing that privacy is more important than a responsive service.

It is also crucial to be clear about what your service goals are in relation to your regional population. That is to say, you need to know what your goals and objectives are before you can properly decide what your indicators of success should be. A low utilization rate for a given community group might be good, bad or indifferent news. You need more information before you can decide if this is in fact a problem. Even then, knowing the utilization rate does not tell you what you should be doing to improve the situation.

This is where community consultation is irreplaceable. Meetings with cultural groups, open public forums, dialogue with community leaders, and focus groups with clients from various ethnic minorities are all useful. While no two communities will necessarily choose exactly the same indicators of local success, the one factor guaranteed to be necessary to success is community participation in planning, monitoring and improving services.

Ron Peters is Director of Planning & Evaluation for the Greater Vancouver Mental Health Service and he supervises the staff of the Multicultural Mental Health Liaison Program.

# Consumer participation creates more relevant research findings in housing and support services evaluation project

**Catharine Hume**

The table below is from *Participatory Action Research: Implications for Research and Evaluation in Psychiatric Rehabilitation, Psycho-social Rehabilitation Journal*, October 1994

In the spring of 1997, the Canadian Mental Health Association (CMHA), BC Division was contracted by the CMHA, New Westminster Branch to develop and implement an evaluation of their housing and support services. This project provided an exciting opportunity to develop a program evaluation rooted in consumer participation. While CMHA has long recognized the value of consumer participation in the development and evaluation of services, the value of this involvement has recently been given additional support by the *Best Practices in Mental Health Reform* materials. Best Practices states that: "just as con-

sumers and families must be involved in planning and delivering services/supports, so must they be meaningfully involved in the design and delivery of the evaluations of those programs/services."<sup>1</sup>

For this reason, we used a participatory action research approach. This approach to evaluation is based on the belief that when people who are directly affected by programs and services are involved in the development of the evaluation:

- the questions are more relevant,
- richer information is gathered, and
- recommendations are more likely to be acted upon.

We used a variety of approaches to involve consumers in the evaluation. The most significant approach was to invite and encourage people to become a part of the evaluation steering committee. We advertised this opportunity in the Branch newsletter and supported front line workers to identify and encourage people they thought might be interested. Five consumers identified an interest and became members of the steering committee in addition to one front line staff person.

Consumers on the steering committee were involved in developing the evaluation's overall goals and in defining both the approaches we would use and the specific questions we would ask. Consumer involvement at this level encouraged us to think more broadly about the lives of people with mental illness rather than staying focused on the narrower program issues alone. This involvement really kept us grounded on how programs were actually working as opposed to how they were theoretically supposed to be working and allowed us to probe in areas we might otherwise have neglected. At a more concrete level, steering committee members provided ongoing feedback on the wording of questions and helped us ensure that questions were clear, relevant and understandable.

The second level of consumer involvement was the use of peer interviewers. The committee identified the following benefits of using a peer interview approach:

- creates an opportunity for peer interviewers to develop and/or build upon interviewing and research skills,
- increased comfort for people when they are being interviewed by peers, and
- the likelihood of more open and honest responses from those being interviewed.

Four peer interviewers attended a two day training session and were hired on contract to conduct a set number of interviews. Having four peer interviewers gave us the flexibility to increase

## Differences in emphasis between traditional research and research using Participatory Action Research Paradigm

### Traditional Research Paradigm

Emphasis is on "learning about" research subjects

Objectivity vis a vis research and subjects is valued

Researcher acts as "professional"

Research is best conducted by "outsiders"

Subjects have one role; that of research subject

Subjects are passive objects of study and so not contribute to the research process

Traditional paradigm lends itself to controlled experimental research studies

Subjects' involvement in research ends when data collection is complete

Research agenda shaped by professional and socio-political

### Participatory Action Research Paradigm

Emphasis is on "learning from and about" research subjects

Subjective experiences of subjects are also valued

Researcher acts as "consultant", "educator"

Research must have input from "insiders" i.e., those being studied

Subjects have dual roles both as subjects and as researchers

Subjects are actively involved in the conceptualization, design, implementation and interpretation of research studies

Participatory Action Research paradigm also lends itself to qualitative, ethnographic studies of the disability experience

Subjects act as "change agents" converting results of research into new policy, programmatic or research initiatives

Research agenda influenced directly by the concerns of many constituents, including the end-users of the system



or decrease the number of interviews each interviewer was responsible for completing and also provided interviewers with a peer group where they could discuss their observations and experiences.

Peer interviewers and steering committee members were then involved in making sense of the information we had gathered from consumers. Interviewer observations were also used to enrich the findings and helped make these findings come alive for the primary researcher, the steering committee, the Branch staff and the Board of Directors. Recommendations were developed with the involvement of peer interviewers and the steering committee. An implementation committee which will involve interested consumer steering committee members is also be-

ing developed to help ensure that there is action based on the key findings.

Perhaps the most valuable result of consumer involvement in this program evaluation was that it helped us to become more clear about how programs are actually being experienced. This understanding provides the Branch with an important starting place for the development of any ongoing program evaluation approach. In addition, this kind of consumer involvement offers people real and concrete opportunities to build on existing skills and use their own experiences and insights in tangible ways to improve programs for themselves and others.

For copies of the final report, contact the author at Canadian Mental Health Association, BC Division, Tel 604/688-3234.

<sup>1</sup> Health Systems Research Unit - Clarke Institute of Psychiatry (1997). Best Practices in Mental Health Reform Discussion Paper, p.36.

Catharine Hume is a project coordinator at the Canadian Mental Health Association, BC Division, and was the primary researcher in the CMHA, New Westminster housing evaluation.

## Methods used and outcomes measured in the Nelson mental health services *Progress Report*

Myrna Martin

### Overview

The purpose of the Progress Report is to establish a baseline of how the mental health service system is working now for consumers and family members and to provide a guide for improving the system in the future. The intention is to initiate an ongoing way of monitoring progress towards meeting the needs of consumer and family members in our region.

After exploring several options the Evaluation Committee of the Kootenay Boundary Mental Health Advisory Committee decided to do a multifaceted *Progress Report* of the Nelson Mental Health Services as a pilot for the whole region. The hope is that the *Progress Report* process will be improved and repeated in all areas within the region over the next few years.

### The Process

Each component of the *Progress Report* was developed and supported unanimously by the Advisory Committee. At times task groups were struck to complete certain parts and brought back to the whole committee for approval. This was an essential part of the *Progress Report* because the Committee wanted to ensure that the report was as complete as possible and would receive acceptance by all involved. It was essential that each member of the system - consumer, family member, provider, psychiatrist - had confidence in the objectivity and validity of the report.

### The Report

The focus of the report is in three major areas: access, appropriateness and outcome measures. Each of these areas will be explored in several ways.

#### Surveys:

A consumer survey for community mental health services and for inpatient services was developed by the Committee, using the consumer-oriented *Mental Health Report Card*. This is a tool developed by the Mental Health Statistics Improvement Program Task Force on a Consumer-Oriented Mental Health Report Card, April, 1996. In May and June of 1998 each consumer of these services was invited to complete a survey, anonymously.

Family members completed a survey questionnaire as well. These were circulated through family support groups, Journey of Hope groups as well as to families more directly involved with Nelson Mental Health Center.

Service providers, physicians and other referring agencies were also invited to complete a Services Coordination Survey in June, 1998.

#### Interviews:

An outside facilitator was contracted to conduct 10 in-depth consumer interviews and 5 family member interviews about their experiences with community-based and inpatient services. Two consumer peer interviewers and one family mem-

ber from outside the immediate community were trained in peer interviewing by the Women's Research Foundation. They conducted an additional 8 in-depth consumer interviews and 4 family member interviews. The interview guide was developed through the Committee and pilot-tested in the peer interview training by the consumers and the family member. The facilitator assisted the consumers and family members with the analysis and report writing.

#### **Focus Group:**

Front line staff service providers from contract agencies, the mental health centre, the inpatient unit, community agencies, physicians, police, advocates and consumer and family development project staff were invited to participate in a focus group in June, 1998.

#### **Pre- and Post-Treatment Outcome Measures**

Each new client between January 1998 and June 1998 completed a symptom distress scale (adapted from the SCL 90 and the BSI), an alcohol and non prescription drug use scale and an AIMS scale (drug side-effect scale), if appropriate. They also completed a form which records work, involvement with the criminal justice system, self help activities, sense of mastery, self esteem, socialization, hospital admissions, medical care, housing, and history of victimization. Each ongoing, long term client also completed these measures early in the report period. At termination or at the six month point these measures were completed again for the post-test results.

Myrna Martin is Director of the Nelson Mental Health Centre.

Article drawn from the report of the Kootenay Boundary Mental Health Advisory Committee's Evaluation Committee.

#### **Statistics from file audits, client registrations, and other sources**

Nelson Mental Health Center compiled statistical data for the *Progress Report* including:

- wait times for all programs,
- percentage of individuals who receive follow-up from community mental health upon discharge from the inpatient unit,
- percentage of involuntary admissions,
- percentage of individuals who receive a face-to-face contact within 7 days of discharge,
- readmissions,
- percentage of mental health consumers discharged on extended leave,
- percentage of suicides within 14, 30, 60 and 90 days of discharge from a psychiatric bed,
- hospitalization rates and length of stay due to mental illness compared to the provincial average (these will include discharges from Riverview as well as the Daly), and
- percentage of consumers and family members on Advisory Groups.

#### **The Report**

The *Progress Report* will be circulated widely and is expected to play a major role in continued improvement of the mental health planning process that will occur over the next several years. In turn, the report will help the mental health system to better meet the needs of citizens of the Kootenay Boundary Region experiencing mental illness.

## **CMHA, BC Division identifying BC's mental health research needs**

### **Eric Macnaughton**

CMHA BC Division, through the leadership of its Policy & Research Committee, has organized three events and produced a report on the topic of mental health research in BC. The first step was an exploratory workshop in January, 1997, with Dr. Dan Offord, primary author of the *Ontario Mental Health Survey*, and Dr. Julio Arboledo-Florez, an expert in the field of the epidemiology of mental illness and violence.

The original intention of this event was to gauge interest in a "made-in-BC" mental health survey, as it was felt that home-grown data is crucial to planning effective mental health services. At the end of the day, however, there was consen-

sus that the group needed to concentrate on building the funding base and infrastructure for all aspects of mental health research, including outcome evaluation of services and policies. Survey research would be one piece of the overall puzzle.

The next step was a conference in May, 1997, with keynote speaker Dr. Lee Robins, lead researcher for the first major mental health survey in the United States. The intention of this event was to pose the issues raised at the exploratory workshop to a wider group of people, including people with mental illness and family members, and more people from outside the Lower Main-

land. Another main purpose was to look at the issue of research infrastructure, and consider what types of resources would be needed to carry off mental health research on a more sustained, ongoing basis.

This event featured workshops on multicultural research issues, measuring quality of life, the link between sexual abuse and mental illness, and measuring the numbers and extent to which those with mental illness are "outside the system." The conference also featured a panel of consumers and families who spoke about their priorities for research, and about the need for the research process to meaningfully include stakeholders at all stages.

One of the key issues to emerge from this event was the need to develop a clear set of values on which research would be based. This includes the need to "level the playing field" so that more people with mental illness and their family members can be part of the process, and can play significant roles in the future. It was also felt that there was a need to look more closely at models

in other jurisdictions, to gain insight into how these issues had been successfully addressed and carried out in other parts of the world.

Subsequently, CMHA, BC Division contracted Duncan researcher, Laurie Williams, to look further into research models in other jurisdictions and to produce a report of her findings. Her other goal was to facilitate a process to help define the values on which any mental research infrastructure would be based. In the course of this project, Laurie talked to over forty people involved with mental health research projects or representing organizations conducting mental health research.

In June of 1998, CMHA hosted an event to discuss her findings, and to work through the issue of research values and principles. The discussions of that day are reflected in the initiative's final report, which is now complete, and being distributed to conference participants and other key stakeholders in the mental health research field in BC. The report's recommendations will provide direction as the Ministry of Health and advocacy groups move forward with their research agendas.

Eric Macnaughton is Coordinator of Policy and Research at CMHA, BC Division, and is completing a study focusing on initial experiences with the mental health system on first break (psychosis), as part of an Early Intervention initiative.

## Tracking patients transferred during Riverview's "downsizing"

Alex Berland

What happened to patients who were transferred during the "downsizing" of Riverview? Two approaches were used to find the answer to this question. One system asked mostly providers, the other asked families and the consumers themselves.

First, the Ministry of Health and Riverview Hospital established a "Tracking Program" to provide follow-up information on patients transferred during the downsizing. (Many other patients are discharged from Riverview Hospital on a regular basis. We did not include them in this report although we will be attempting to include such people in future.)

For now, this progress report provides information on the outcomes for 232 clients transferred during five (fiscal) years, starting in 1992/93. Fifty-nine per cent of the patients transferred had a diagnosis of schizophrenia, 12 per cent had mood disorders and 9 per cent had unclassified delusional/psychotic disorders. Average length of stay at Riverview before transfer for all patients was 8.3 years (range 1.6 to 11.1 years).

We transferred clients to a variety of community placements, including mental health residential facilities, family care homes, semi- and independent living, continuing care facilities, extended care units, residential tertiary care, and private treatment. (See Table 1.)

Most of the clients transferred have remained in the community.

Around six months after discharge, we used on-site interviews with care providers, patient chart reviews, and follow-up phone interviews to figure out outcomes for clients living in facilities. For clients in semi-independent or independent living situations, we also interviewed their case managers.

### What did care providers say about the transfer process?

Care providers for these clients have reported that the majority of client transfers (84%) from hospital to the community went smoothly. They were also able to identify some elements that are important to simplify a smooth transfer process. Most importantly:

- **Good communication between the hospital and the community is crucial to the patient transfer process.**

Most of the care providers reported that the client transfers went well. Some care providers said they wanted more specific information regarding

**Table 1. Snapshot Location/Status for Clients by Fiscal Year**

Location/Status	1992/93 4 years	1993/94 3 years	1994/95 2 years	1995/96 1 year	1996/97 6 months
In the Community	28 (52%)	23 (72%)	50 (83%)	58 (89%)	17 (81%)
In Riverview Hospital	5 (9%)	5 (16%)	4 (7%)	4 (6%)	2 (9.5%)
In Forensic Psychiatric Institute	0	0	1 (2%)	0	0
Deceased	18 (33%)	1 (3%)	3 (5%)	3 (5%)	0
Voluntary Withdrawal From Services	3 (6%)	0	0	0	2 (9.5%)
No Longer Part of "Downsizing" Project	0	3 (9%)	2 (3%)	0	0
<b>Total</b>	<b>54</b>	<b>32</b>	<b>60</b>	<b>65</b>	<b>21</b>

the client's psychiatric history, medical history, medication history, social and family history. A good history can make the difference in preventing a client's deterioration and return to hospital. Some care providers also expressed their appreciation for assistance from Riverview Hospital after we had transferred the client. Thus, communication before, during and after the transfer is important to the success of the transition from hospital to community.

- **Effective discharge planning is critical when transferring patients to the community.**

Again, most care providers said that the details of the transfer process were handled well. Some reported that they want more attention paid to the details. For instance, several care providers commented that the patients' clothing was inadequate for community living. A personal appearance that may have been acceptable in the hospital can stigmatize the client in the community.

There were several mechanisms in place to respond quickly to the issues that care providers identified. First, when we transferred the client, the coordinator of the Patient Placement Project

at Riverview telephoned care providers, asking about the placement process and outcome. Secondly, after the Tracking Program followed-up, they reported any information regarding transfer issues to the Patient Placement Committee. Thirdly, the Patient Placement Committee distributed questionnaires to patients, family members and facilities regarding their satisfaction with the transfer.

#### **What about readmissions to Riverview?**

Besides examining the number of people who had returned to Riverview Hospital at the designated "snapshot" periods, it is also interesting to consider how long patients remained in the community before their readmission to hospital. Table 2 provides detailed numerical information regarding the cumulative percentage of clients who were readmitted to Riverview Hospital.

#### **What about the consumers' perspective on the transfers?**

In 1996, we sent short questionnaires to 50 former patients. Generally these people said that they were satisfied with the discharge process and with their adjustment to the community. Some expressed concern about leaving Riverview because supports were less immediately available. On the whole, however, they were satisfied with their placements and their involvement while creating their new homes.

#### **What's next in tracking Riverview's outcomes?**

With changes in mental health services driven by the Mental Health Plan, the need for accurate client information will become even more apparent. As planners, managers and service providers, we must be able to answer the questions:

The author thanks Karen Nesbitt, Dr. Derek Eaves and John Fox for their significant contributions to this article. For further information or copies of the complete Tracking Report, please contact Alex Berland at Riverview administration offices, Tel 604/524-7850.

**Table 2. Cumulative Percentage of Clients Readmitted to Riverview Hospital by Fiscal Year Group and Time Away**

Time Away from RVH	Fiscal Year				
	92/93	93/94	94/95	95/96	96/97
< 6 months	15.1%	18.7%	6.7%	6.2%	9.5%
< 1 year	21.3%	18.7%	11.7%	9.4%	—
< 2 years	25.9%	21.9%	11.7%	—	—
< 3 years	28.2%	25.0%	—	—	—
< 4 years	33.6%	—	—	—	—

- What type of clients will be returned to the community?
- What type resources will be needed to sustain them in the community?
- What level of intensity of support will be needed?
- How should community agencies collaborate to meet client needs?

We are now working with Ministry of Health staff to develop an extension of the project to follow other patients discharged from Riverview. We will also be improving some outcome measures. Documenting client needs in order to develop a comprehensive and multi-agency community

strategy is especially important.

The Riverview Tracking Program shows the usefulness of good data collected to address specific issues. It was designed to collect only a few well-defined indicators such as location, type of facility, length of stay in the community, and number of re-admissions. Collecting clinical information was not its original purpose. We also need to improve the method for including consumer and family opinions. Nevertheless, the data has been useful in showing the overall outcome of transferring patients to their communities: that former Riverview patients are, overall, well cared for in the community.

Alex Berland is Public Administrator at BC's psychiatric hospital, Riverview Hospital.

## A View of the future of Mental Health Research in British Columbia

**Shelagh Turner**

Recently I read an article in the April 1994 edition of the Canadian Journal of Psychiatry by Dr. Ray Lam and Dr. Nady El-Guebaly entitled, "Research Funding of Psychiatric Disorders in Canada: A snapshot, 1990 - 1991." I was intrigued, as their thesis was that research funding for mental disorders in Canada, particularly in British Columbia is disproportionately low compared to the incidence of mental illness and the magnitude of direct mental health care spending. I spoke with Dr. Lam recently about his thoughts on mental health research funding.

Mental health research has lagged compared to other health-related research because funding agencies and the medical system are influenced by the same biases against mental illness as the general public, in Dr. Lam's opinion. Mental illness simply does not have the profile of other sectors of health care. The stigma associated with many mental disorders, which is perpetuated in the media and our daily lives, reaches its way into funding decisions for mental health research.

Within Canada, British Columbia has one of the worst records for supporting mental health research. Why does BC have such a poor record? Dr. Lam believes research in the mental health field has not been a government priority as they are not clear on the benefits of research and evaluation from a systemic perspective. It's a field that has not had the same degree of advocacy as is found in other health sectors. Although basic neuroscience research is well funded and may ultimately provide new treatments, more research specifically

about mental illness is required now. The same argument was used successfully by the AIDS and breast cancer activists to explain why they needed dedicated funding for these specific diseases - beyond general immunology or cancer research.

Dr. Lam suggests there must be more emphasis on analyzing the outcomes of services and service delivery. More and more often, policy decisions in the mental health system seem related to cost factors or ideology rather than whether a need is being met efficiently and effectively. In British Columbia, we need to make decisions that are based on evidence. However, we have been unable to do this in a comprehensive way, since we have no standardized system for collecting data. Without a standard, information is anecdotal and does not provide an adequate basis for decision-making.

It is essential for us to understand how effective our current mental is right now. The first priority must be to develop an effective, centralized information system throughout the province. Additionally, in order to determine how well we are doing as a mental health system, we need to develop standardized tools, methods and processes which will collect data on a local, regional and provincial basis. This will provide us with a basis for planning and refining the mental health systems of the future.

In this regard, Dr. Lam sees a value in the accreditation process. It provides a snapshot of where things are right now and helps to create a plan of how things should look. Its value lies in the use of agreed-upon benchmarks, which provide a basis for ongoing assessment. Benchmarks are only useful when they are based upon BC info, not on other systems or jurisdictions in Dr. Lam's opinion.

How do people with mental illness and their families fit in to mental health research? It is critical that consumers and family are actively in-

Dr. Lam is professor of Psychiatry at the University of British Columbia and Director of the Mood Disorders Clinic, Vancouver Hospital and Health Sciences Centre.

Shelagh Turner is the Coordinator of the CMHA Consumer Development Project based in Kelowna.

involved in the accreditation process in a way that moves beyond tokenism. They should be involved in the determination of which outcomes are relevant and develop meaningful ways to measure these outcomes. For example, involving people with mental illness and their family members would require a different set of questions and way of asking these questions, than if they were not involved.

The University of British Columbia Department of Psychiatry is interested in providing leadership in the area of outcome-based research. The UBC program CUPPL (Cooperative University Provincial Psychiatric Liaison) provides psychiatric service delivery, mental health service planning and professional training throughout the province. By using this province wide program, there may be an opportunity to train professionals in evaluation methods that would promote stronger, community-based mental health re-

search.

The future of mental health research and evaluation in British Columbia is fundamentally linked to funding. Funding is required to develop a standardized system for collecting data as well as to design and implement standardized tools and processes for gathering information. Funding is required for training in research methods, development and analysis. Dr. Lam's vision is the creation of a dedicated government-based or partnered, *Mental Health Research Foundation* which raises and disburses seed money for mental health research projects throughout the province. Dr. Lam cited the Ontario Mental Health Research Foundation as an example of how this might work. A Foundation such as this could foster new partnerships within the mental health system, while significantly raising the profile of mental health and its research in British Columbia.

## Accountability in the mental health system ensures cost-effective and care-effective services

**Eric Macnaughton**

Accountability is a key issue in the health care system. In short, accountability is about making the best use of resources to achieve the best possible results for people who use mental health services.

This involves doing a number of things in partnership with consumers, family members, and service providers. First, it involves setting clear goals for what we want our mental health programs to achieve, and how we want them to accomplish this. Secondly, it involves looking at programs to see whether they measure up to expectations. Finally, accountability involves the ability to make the necessary changes to our programs and our mental health system as a whole, so that they *do* achieve the outcomes that people with mental illness want.

### Setting Goals

Clear goals should be expressed in terms of change, and in terms of who is expected to change, in what way, and in how much time. For example, some members of a clubhouse program might decide they wish to increase their job skills

by a certain amount over a six month period of time. Whatever the goals for change are, they must be meaningful in the lives of the people in the program.

Just as programs can set goals, so can the system as a whole. An example goal for the mental health system is to increase the amount of money spent on community supports, compared to spending on hospitals. Another measurable goal is to have a system that responds to individual needs.

### Measuring Goals

"Program evaluation" is a way to measure the success of a program. Evaluations can look at a number of different things. Evaluations can look at *how* the program works on a day-to-day basis (known as "process evaluation"). They can look at the organization or the bigger picture within which the program works (known as "structural evaluation"). And finally, they can measure outcomes—that is the extent to which program goals are met. For the clubhouse example given above, an outcome evaluation would measure how much job skills had actually improved after six months.

On an informal basis, programs can be evaluated by having good record-keeping. This can provide valuable feedback to staff about such things as who attends the program, and how and why they came into the program. Taking direct measures of consumer satisfaction, and ensuring ongoing user involvement for planning and improving the program are other important ways of keeping accountability.

One example of a system-level evaluation is called a spending analysis. The analysis looks at actual spending in terms of institutional and community resources, and then makes a comparison to an ideal standard. Model systems in other countries spend 60% of their dollars in the community, but many Canadian provinces and regions spend only 20%.

### Cost-effectiveness studies

A more complicated way of doing program evaluation is to measure "cost-effectiveness". Most such studies compare the effectiveness of community-based programs to hospital-based programs, in terms of outcomes and in terms of cost. Much of the research shows that properly set up community-based alternatives offer as good or better outcomes, at a lower cost than programs which are hospital-focused. These studies have mostly looked at an intervention known as "assertive community treatment" (or ACT). Some have also looked at supportive housing and consumer-run alternatives, and shown these to be cost and care-effective investments.

### Achieving Necessary Changes

Once a program is evaluated, stakeholders must work together to make necessary changes and improvements. At the system level, there must be incentives and ability to change the way resources are allocated. There also must be accountability to people whose needs go beyond a single program, or whose needs change over time. This is necessary to avoid people "slipping through the cracks".

Model mental health systems address these issues by having an agency called a "mental health authority." This group is given the ability and responsibility for making all spending decisions within the mental health budget. Because they have spending responsibility, these boards have an incentive to prevent unneeded hospitalization, which is the most expensive part of the continuum of care. They can also reallocate resource savings to community alternatives.

In addition to being accountable for costs, the mental health authority is also responsible for ensuring people get care when and where they need it, at all points in the service network. Often this responsibility is carried out by a primary community support worker. Although based in the community, the worker helps design in-patient rehabilitation plans should the person enter hospital, and engages the consumer in discharge planning as soon as possible after admission to hospital.

### Accountability to the Individual

It must be emphasized that for the concept of accountability to have meaning it must begin and end with the consumer. Planning and evaluation at the system level must include the consumer and his or her support network. At the program level, outcome goals should reflect the consumer's wishes about how rehabilitation and support should be arranged. The most fundamental issue, though, is that system, program, or individual supports should improve the consumer's quality of life, as defined by her or him. This is what real accountability means.

Eric MacNaughton is the Coordinator of Policy and Research at the Canadian Mental Health Association, BC Division

## Resource List

### Books

- Barnsley, J. and Ellis, D. (1992). *Research for Change - Participatory Action Research for Community Groups* (Contact: Women's Research Center 604/734-0485)
- CMHA, BC Division (1995). *Accountability Fact Sheet and Technical Paper* (Contact: CMHA BC Division 604/688-3234)
- CMHA, National Office (1995). *Discussion Guide on Mental Health Reform* (Contact: CMHA BC Division 604/688-3234)
- Ellis, D., Reid, G. and Barnsley, J. (1990). *Keeping on Track - An Evaluation Guide for Community Groups* (Contact: Women's Research Center 604/734-0485)
- Health Systems Research Unit, Clarke Institute of Psychiatry (1997). *Review of Best Practices in Mental Health Reform* (Contact: Publications Health Canada 613/954-5995)
- Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-Oriented Mental Health Report Card - Final Report (1996). *Consumer Oriented Mental Health Report Card* (Contact: Clearinghouse - 301/443-3343)
- The Research Committee of the International Association of Psychosocial Rehabilitation Services (1997). *Measuring Psychosocial Rehabilitation Outcomes* (Contact: International Association of Psychosocial Rehabilitation Services 410/730-7190)

### Workshops

- BC Health Research Foundation, as part of its community-based research training program, offers a series of four introductory level workshops:
- An Introduction to Community-Based Research
  - An Introduction to Methods for Community-Based Research
  - The Basics of Community-Based Evaluation
  - Writing a Research Proposal that Gets Results

These workshops will be held in Vancouver in January 1999. For more information, contact Chris Crossfield or Corinne Hof at BC Health Research Foundation: 604/436-3573 or toll free at 1/800/565-5994.

# Initial Thoughts on an Evaluation Framework for the Mental Health Advocate

**Nancy Hall**

The Mental Health Advocate for BC has the responsibility on reporting annually on the Mental Health system from the perspective of the consumer/survivor and family member. This report is meant to reflect on the current state and enable all to create action to improve the lives of people living with mental illness. In general, because my mandate is systemic advocacy, I am looking for broad patterns that repeatedly re-occur or are absent and can be altered with a positive benefit for the people who matter most.

Behind any evaluation there are always several assumptions and it seems at this point critical to name mine. They involve how I characterize the diversity of consumer/survivor and family voices and how I think about mental illness and mental health reform.

First of all, I am aware that the consumer/survivor lens has many different views in part because of the causes of mental illness but also because of cultural and diversity of life experiences. Some people consider themselves a mental health survivor meaning they enjoy relative good health but in no thanks to the quality of care provided by the formal system. I also assume that a variety of strategies will have to be used to find the consumer/survivor voice. We need to understand that given the power inequities in the consumer-provider interaction, it will be always be difficult for persons

with mental illness to express their needs and give feedback to service providers. We need to move beyond formal patient complaint systems.

The family lens is unique and different from the consumer lens. Many of the severely disabled mentally ill people have family care providers as their primary sources of help. These caregiver's experiences have value in and of themselves and need to be acknowledged and supported. It is important to state that I see mental illness as a chronic condition that with the right combination of community supports can enable the person to be an active member of society. I do not see consumer/survivors as passive recipients of service. As a systemic advocate, I will also bring to this evaluation several assumptions about mental health reform. While many will cry out for enhanced service capacity, from other jurisdictions we know that action is necessary on at least 2 levels besides the service system. We need to address the determinants of health as well as to enhance consumer participation in planning, service delivery and evaluation. I will measure progress towards the provision of adequate housing and improved access to income assistance. Recognizing the inherent value of the consumer/survivor's experience, I see there is a job to strengthen participation at all levels of the system. I will want to reflect on the quality of assistance and advice from all advocates within BC and support the development of a Network of Advocates for persons with mental illness. This network must work together towards a common vision as well as build the capacity of consumer/survivors around the province to take action in support of themselves and others.

At this point I am in the midst of developing a framework for evaluation and the purpose of this contribution to this edition of *Visions* is to seek input on this first draft of a framework. To begin with, I have chosen five basic areas to review:

**Community Context.** Are the basic supports in place to enable independent community living?  
**Money.** Are the resources, both new and old being spent in the most cost effective manner?

**Structures.** Are the systemic structures for working together functioning to enable consumer/survivor/family participation at the provincial, regional and local levels?

**Information systems.** Are the various aspects of the system able to communicate with one another in the most efficient form to enable effective care whilst maintaining patient confidentiality?

**Programs.** Do the programs and services that are offered around the province meet the standards of best practice? Do they maximize consumer participation and feedback?

## Glossary

*Don't let the big words scare you! Here's a plain language guide to words you'll find in this issue of Visions.*

**accreditation:** an official "stamp of approval" process, usually given by experts, or peers from a related field. This process ensures that an organization maintains certain standards of services and/or the way services are provided.

**epidemiology:** the study of how diseases occur in populations, how much or how often they occur, where they come from, how they spread and how they are controlled.

**methodology:** the methods used to do research and the process that is involved in doing the research. If research is "methodologically sound," it means the kinds of questions asked, the ways the questions were decided on and then asked, and the quality of the answers are considered very good.

**outcome measures/outcome evaluations:** measuring the end result of using a mental health, health, or any other service. Finding out if and how well a service/program/project did what it's supposed to do.

**utilization:** a measure of how much something is used, such as a mental health service or program