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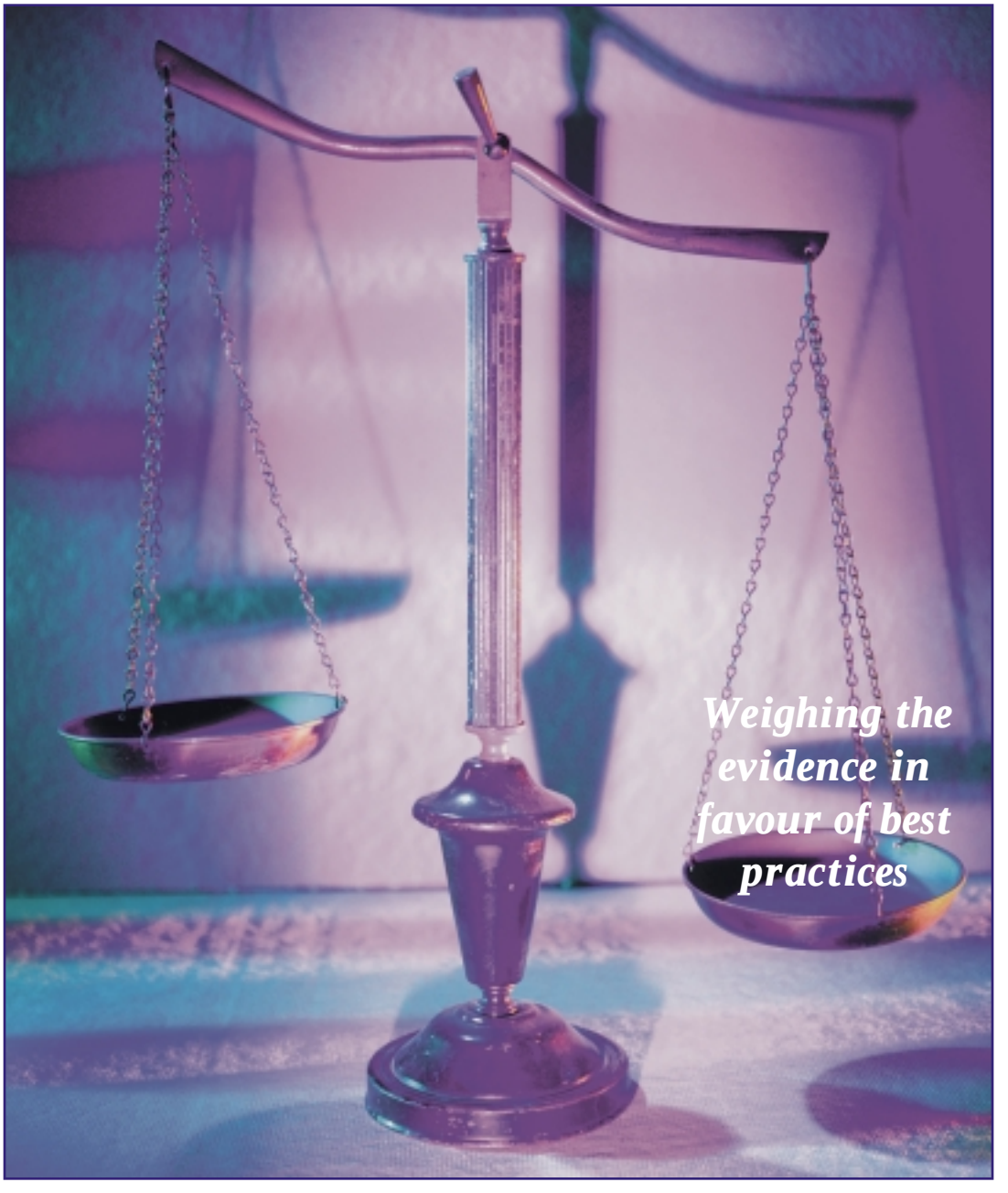

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ontario Division / Division de l'Ontario

IN THIS ISSUE:

Developing Best Practices

Implementing Best Practices

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CANADIAN MENTAL HEALTH ASSOCIATION
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OUR MISSION:
To provide leadership in advocacy and service delivery for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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CONTENTS

Collective Mental Health Under Assault…

BARBARA EVERETT, PH.D.
Chief Executive Officer

Shortly after the attacks in New York City and Washington, there was a lot of speculation that we had lost the capacity to be funny. Satire had died, the pundits said, at 8:48 a.m. when the first plane hit the World Trade Center. But even amidst the horror, one cartoon reportedly found its way onto the pages of a local newspaper. In it, an angry airport security guard questions a nervous traveller, "And just where do you think you're going?" The traveller replies, "I'd like to go to September the 10th."

The world has changed. Western society has suffered multiple losses, not the least of which has been a sense of safety and security. Our collective mental health has come under assault. At the Provincial Office, we have received many calls from worried journalists who want to tell their readers about the signs of posttraumatic stress disorder. What is depression, they ask. Are we OK?

Well, we're not OK. Witnessing horror has a profound effect on our well being. Our sleep is disturbed and our concentration reduced. We are consumed by news channels. We have altered our travel plans and we are worried. Worried and anxious in a low grade but all encompassing manner.

The Canadian Mental Health Association has been caring about, and for, people's mental health since the beginning of the last century. We have a unique body of knowledge and experience that the present world needs.

The clients we serve are rarely victims of terrorism or war and instead have come from torn homes, deeply unhappy childhoods defined by sexual and physical assault, lives of poverty, abandonment and neglect, and the humiliation of minds invaded by hallucinations and, sometimes, out of control behaviours that defy explanation.

Given the burden with which our clients' struggle, and the new world context of terror that threatens everyone's peace of mind, questions such as which mental health services work, which do not, and who gets to judge are essential. Best practices is an area of research that is trying to define systematically what sorts of mental health activities, interventions and programs are effective.

This issue of *Network* looks at what prominent researchers have to say about best practices, highlights some evaluative research projects in progress, features one person's struggle to get help for depression, and reviews programs that have proved to be beneficial. But we have entered the age of worry.. and I worry. Best practices, as with almost any topic in mental health and mental illness, is controversial. Some believe that only those programs with evaluation funding attached ever come to be known as "best", while many, just as worthy, programs are ignored simply because they are never studied and therefore do not enter the research literature. Others argue that this type of research perpetuates status quo thinking, meaning that only those programs that have attained the coveted attribution of "best practice" are replicated, interfering with funding for innovation and thus, the implementation of new ideas. Questions are raised such as: How do results that show a program doesn't work get reported? Who gets to say what is effective and what is not? Exactly why does the program or activity work? By what means are programs evaluated over time so that they remain effective? Who reports results on programs which worked only during the heady implementation stage, but lost their effectiveness as time wore on and excitement dimmed?

Dr. Paula Goering and Dr. Elliot Goldner discuss some of these controversies and provide needed perspective. Their commitment to conducting effective evaluations and recognizing programs and interventions that work leaps off the page.. but still, I worry.

Gary Westover, who offers a consumer's point of view, begins to describe the kinds of questions that I worry may be missed in formal program evaluations. Researchers need methodologies that inquire about the things that matter to clients and their families: Am I treated with respect? Is my point of view listened to? Do I feel a part of my treatment plans? Am I treated as a whole person, with hopes and dreams, as well as problems and symptoms? It is here, in the quality of the relationship between clients and their mental health professionals where help is, or is not, delivered – where programs work, or don't work. The continued pursuit of knowledge through evaluation research is essential. But I believe that best practices are only at their best when they exhibit observable and measurable dimensions of human decency and respect. This is the best practice that the Canadian Mental Health Association, Ontario Division strives to embody.

Best Practices: Who Cares?

THE APRIL 2001, VOL. 37 NO. 2 ISSUE OF THE COMMUNITY MENTAL HEALTH JOURNAL DEALS WITH THE TOPIC OF MOVING COMMUNITY MENTAL HEALTH TOWARDS EVIDENCE-BASED PRACTICE.

THE LEAD EDITORIAL POSES THE QUESTION: "INTRODUCTION ASSESSMENTS, INTERVENTIONS, AND OUTCOMES: WHO CARES?".

From the interviews we conducted for this issue of *Network* with Dr. Paula Goering and Dr. Elliot Goldner, along with a consumer's viewpoint and comments contributed by Gary Westover, a Crisis / Community Support Worker with the Canadian Mental Health Association, Oxford Country Branch, it would appear that many people do indeed care, perhaps no one more so than consumers themselves, who are now providing input into what in fact is a best practice. Perhaps the simplest definition of 'best practice' is provided by Dr. Goldner when he states that "one of the critical components of defining a best practice is that the people who are using the service, or other kinds of components of health care such as housing for instance, define this as a better way of doing things." This issue of *Network* looks at some of the ways that 'better' practices can be identified, measured, evaluated and implemented. It also addresses the intriguing, and often hotly debated, question of whether innovation and best practices can go hand-in-hand – something both Dr. Goering and Dr. Goldner hold a definite opinion on.

To round out these interviews and viewpoints, we also take a look at a project undertaken by the CMHA to explore best practices in relation to home care and the knowledge gained through the *Putting Best Practices Into Action, Youth Suicide Prevention* program conducted in British Columbia. Finally, *Mental Health Works* –a joint project of the Global Business and Economic Roundtable on Addiction and Mental Health, the CMHA, Ontario Division, and the Ontario Ministry of Citizenship – is profiled. This project will aim to define best practices related to mental health issues in the Canadian workplace.

were happening. So we thought about best practices with regard to case management and community treatment; we thought about best practices with regard to in-patient and out-patient treatment. You can categorize them in different ways but there are a lot of different sectors that we have to attend to beyond just medical treatment – housing, social recreation, self help – in each of those arenas you would want to think about what are the best practices as we know them.

Once you have determined those best practices, how do they get implemented?

DR. GOERING: It's variable. One of the things that happened as a result of the reports we prepared for the Advisory Network was that they were widely circulated, and were of particular interest to people who were trying to plan and implement mental health reform in the various provinces. People used that material to help them decide what they should be putting in place in their policies and in their implementation plans. I think probably the province that used the material most seriously was British Columbia, because they structured their whole mental health reform implementation around best practices, and they included the concepts that we had highlighted in the report in their policy document. We have currently just completed a project that will shortly be available to the public called *Best Practices with Regard to Concurrent Disorders*. It's a look at what needs to be done to help individuals who have both a mental illness and substance abuse problem, and it's aimed more at the intervention level. It tries to summarize the information to be of help to people who are on the front line and are direct care providers. One of the questions we asked with regard to this report is, how do you help disseminate this, and how do you make sure it gets utilized? I think that to do that seriously you have to develop a whole systems change strategy that includes what policies need to be in place, what kind of training has to happen to give people the necessary skills, and how you get the key leaders at a local level knowledgeable and motivated to put these things in place. The group that worked on this latest best practices project has worked out what they think it would take in Ontario to try and get those best practices implemented and it's a pretty big project. We now have a proposal written and hope to get that funded – but this is just for one population and one kind of intervention. You really have to invest a lot, I think, to make it happen.

How are the views and opinions of those who will be at the receiving end of these best practices incorporated as you do your research?

DR. GOERING: It's very important that people

Review of Best Practices in Mental Health Reform

This project was developed and funded by the Federal / Provincial / Territorial Advisory Network on Mental Health (ANMH), which comprises government officials in Health Canada and in the provinces and territories, and addresses best practices in mental health policy and programs with respect to developing effective services and supports, components of a comprehensive community support system, and strategies to create the necessary conditions and incentives to foster their widespread implementation.

The project consisted of three phases:

Phase 1, Review of Best Practices in Mental Health Reform. This was a critical evidence-based review of the current state of knowledge about best practices relevant to mental health reform, with a focus on chronic and severe mental illness. The summary of best practices from Phase I provides the basis for a comprehensive checklist of the key elements that should be present within a reformed system of care for persons with severe mental illness. They tell us what should be done.

Phase II, Best Practices in Mental Health Reform: Situational Analysis consists of an analysis of mental health reform policies, practices and initiatives in Canada which approximated 'best practices'. These are descriptions of what can be done through innovative initiatives. Factors identified in this analysis that facilitate change include: skilled leadership and a committed group of expert staff, clearly articulated philosophy and principles, wide stakeholder involvement, infrastructure support and political will and a sustaining vision.

Phase III, Best Practices in Mental Health Reform: Discussion Paper 1997 summarizes and synthesizes the findings from Phases I and II, then addresses the implementation of best practices across entire systems of care. The benefits and timeliness of integrating mental health services are discussed, separation from the rest of health care is described as a necessary developmental stage and those best practices which should be given priority are identified.

who are going to be receivers have input in the development of best practices, as well as in their implementation. When we were doing the original project, as we developed our definitions, did the literature review, and identified the programs in Canada that were appropriate, we had the advice and input of consumer groups. They reacted to what we were proposing, gave us some new ideas, and told us when they thought we were off base. If you go to the literature and try to define the common definitions of best practices they usually involve two things. They involve a synthesis of the research literature, and an evaluation of that synthesis by experts. And I think that in the mental health field we increasingly recognize that consumers are experts and that they need to be a part of the evaluation of the evidence and a part of the decision-making.

How would you respond to the argument that best practices are opposed to, or stifle, innovation?

DR. GOERING: I would say that it depends on how the concept and the process is used. It is a risk if people think that best practices are the final answer, the complete answer. One of the things that we have suggested is that it would be a better term if we used the concept of 'better practices' instead of 'best'. Better practices would say that given what we know now, this is the better thing to do. It is very important for us to acknowledge that there are a number of areas where we just haven't done any studies and we don't have any evidence. So it isn't that they have been tested and found wanting, it's that there has been no testing of the approaches. So there's a lot we don't know and it would be really sad if people, when they looked at best practices, said okay, we've got the answers now let's do it, because there are a whole lot of things that we still need to be studying.

Should it be possible to incorporate innovation into best practices?

DR. GOERING: Yes. I think we should encourage it. One of the things you will notice as you read through the *Review of Best Practices in Mental Health Reform* is that in several areas, even though there have not been many studies done, for

Key Elements of Best Practice

As identified in the *Review of Best Practices in Mental Health Reform* prepared for the Advisory Network on Mental Health 1997. This document is currently out of print. Consult your local library if you wish to review the entire document.

At a provincial level key elements of best practice are:

- leadership which has an explicit and shared vision with all stakeholders for how the reformed system should be organized and what outcomes are desirable for people;
- a strategy that includes creating decentralized structures for managing local mental health care delivery;
- monitoring responsibility (e.g., through allocations, standard setting, audits);
- separate, single funding envelope that combines various funding streams for delivery of mental health care;
- legislation or policy directives to preserve the mental health reform strategy and envelope;
- capacity to develop joint initiatives with other government departments.

At a regional level and / or local level there is a mental health authority in place that:

- serves as a clear point of responsibility for people with serious mental illness;
- controls a single, combined envelope for funding mental health care;
- has responsibility for planning, organizing and monitoring services and supports, and dispensing funds;
- uses clinical, administrative and fiscal mechanisms to achieve more integrated delivery of care.

example family self-help groups, we really believe they work. If we want to convince funders of the value of that kind of activity then we need to be learning about it and that means both trying out what we are doing now and trying out some new ways. So every time we develop a 'better practice' we should also be saying that this is what we don't know and where we need to be doing more research and trying out new things.

Since working on the original report in 1997, you have co-chaired a National Conference on Best Practices and Mental Health Reform held in 1999. What came out of that conference?

DR. GOERING: Actually there have been two conferences. The one held in Toronto in 1999 and one in Vancouver last year. Through those conferences we were able to encourage people from across the country to talk about their experience with trying to make some of the best practices happen. They also told us about some things that haven't necessarily been studied yet. It was a mix of being able to talk about best practices and the realities of providing services. At the first conference we used a format where we identified programs, and then had presenters from several perspectives: consumers, someone who was providing or administrating, and finally someone involved as a policy person or evaluator. So we had multiple perspectives on various programs which made it a very rich and exciting format. There are still people who are critical of the best practices concept. I think the worry is that there is a certain kind of program and service orientation that will get promoted under this umbrella and other kinds, because they aren't as legitimate or as likely to come under investigation, will get left behind. One of the things that we've tried to do in response to that criticism is to make sure that there are more studies of things that aren't so easy to evaluate such as self-help and consumer survivor initiatives. We currently have a project that is ongoing in the Province of Ontario called the *Community Mental Health Evaluation Initiative* and we have seven projects that are funded to evaluate community mental health programming, two of which are in the self-help area. They are major projects, one of which is headed up by Dr. Geoffrey Nelson, a psychologist at Wilfrid Laurier University, which is looking at consumer survivor initiatives and self-help, the other one is an evaluation of family initiatives in Ontario headed up by Dr. Katherine Boydell. The Canadian Mental Health Association, Ontario Division is a partner in that initiative and their website describes these projects (www.ontario.cmha.ca). I am mentioning this because I think that there is some validity to people's concerns that not everything gets studied. My response to that is let's make sure we do a better job of studying everything. We are excited about these projects and I believe they are going to make some important contributions to the literature on best practices as they develop their results.

COMMUNITY MENTAL HEALTH EVALUATION INITIATIVE

The CMHA, Ontario Division, in partnership with the Ontario Mental Health Foundation and the Health Services, Research and Consulting Unit of the Centre for Addiction and Mental Health has formed a consortium: the Mental Health Research and Policy Group. Funding from the Ministry of Health's Community Reinvestment Fund is enabling the consortium to research and advocate solutions for major issues and problems in the mental health arena through the establishment of the Community Mental Health Evaluation Initiative. Six evaluation projects and one method study have been undertaken to conduct evaluation of community mental health programs in three priority areas:

Case management including housing support; Crisis Response; Consumer / survivor and family initiatives.

Detailed information on each of these projects can be obtained by visiting the CMHA website at www.ontario.cmha.ca. Future issues of Network will examine some of these projects, and their outcomes, in greater depth.

IMPLEMENTING BEST PRACTICES: *Identifying the Obstacles*

Dr. Elliot M. Goldner, M.D., M.H.Cs., FRCPC is the head of the Mental Health Evaluation and Community Consultation Unit. He is a psychiatrist and full-time faculty member in the Department of Psychiatry at the University of British Columbia where he also heads the Division of Community Mental Health. Following graduate training in health care and epidemiology, he developed Canada's first province-wide program for people with anorexia nervosa and other severe eating disorders. In addition to his work in this area, he has published articles on the implementation and teaching of evidence-based methods in psychiatry and mental health services. Research activities include development of measures to assess treatment outcomes, evaluation of mental health information systems, and assessment of patterns of mental health care to people with mental illness. Dr. Goldner served as the Conference Chair at the Second National Conference on Best Practices and Mental Health Reform held in Vancouver, April 5 - 7, 2000.

Dr. Goldner, when consumers are looking at programs or services, is there any way for them to know whether something has been evaluated and found to meet the criteria of best practices?

DR. GOLDNER: I believe we are getting a little closer to having that level of information available for people, but there is still a long distance to go. What has happened with the information explosion is that there is now so much information available, but a lot of it is not reliable, or it is not available to people in a simple way. A consumer could do a literature search, they could go to the Internet to the bibliographic databases that exist and they could review the evidence – but that's a very complex and time-consuming thing to do. In my view there should be something that is much more easily accessible for people. There have been some attempts to develop that kind of information base, but most of those have been developed more for the research community than for consumers and their families – for example, the Cochrane collaboration is an international collaboration that provides high quality information and evidence about health services and practices. You could go to this database (http://hiru.mcmcaster.ca/cochrane/) and look through the list of things that have been reviewed and see if what you wanted information on was there. Another website is the Centre for Evidence Based Mental Health (www.cebmh.com) set up by the University of Oxford in England. This is geared more towards clinicians, researchers and practitioners, but there is no reason why a consumer or family member couldn't also get information from that kind of a site.

Is that information specific or generic? In other words, is it information which tells you, if you are looking at a program or service, that certain kinds of things should be in place as opposed to judging individual programs?

DR. GOLDNER: I think you are right in that generally they are more broad based and do not get into specifics, however it does depend on the topic. For instance if you were struggling with depression and you were interested in finding out what the best type of treatment for you would be, because you've heard about four different types of treatments you could choose from, you could go to this site and it would tell you what kind of evidence there is for each of those treatments, although it's not developed yet, I believe, to the best level possible. Ideally there would be a place where consumers and families could go that would help answer those specific questions.

Do you think that is the direction we are moving towards?

DR. GOLDNER: Yes I do and I believe we are moving quite quickly.

Developing Best Practices

Dr. Paula Goering is the Director, Health Systems Research and Consulting unit, Centre for Addiction and Mental Health. Dr. Goering was the principal investigator on the Best Practices in Mental Health Report project and the Co-Chair of the first-ever National Conference on Best Practices and Mental Health Reform held in Toronto April 30 - May 1, 1999. Dr. Goering is also a recipient of the C.M. Hincks Award, the highest award for contribution to the field given by the Canadian Mental Health Association, National Office.

Dr. Goering, how do you define best practices in relation to mental health?

Dr. Goering: In the project commissioned by the Federal / Provincial / Territorial Advisory Network on Mental Health that we did for the Advisory Network on Mental Health, we defined best practices as activities that are in keeping with the best possible evidence about what works. I think that definition still serves fairly well. It's a little bit different than some of the definitions on best practices that you might find in other health care sectors. Sometimes people restrict the term to practices that have the backing of an experimental study, so they would say that unless you have a randomized control trial, or series of trials which support the directions that you are taking, you don't necessarily have a best practice. We thought that definition was too restrictive in terms of mental health. Our interest was in applying the concept to organized programs that care, and that had an organized system of care. You can also use the concept to talk about what kind of care should be delivered, and it's in that context that you would not recommend a drug for use unless you had randomized trials which proved its efficacy. In that sector, it makes sense to be strict about the nature of the scientific evidence. But we knew that when you are talking about what works, in terms of programs and in terms of systems, there would be hardly any evidence to look at if we were too restrictive in the definition. We also think that the way in which we learned and what we know in those areas isn't as neatly described in terms of a particular kind of research design, so for us it was important to broaden the definition. We have consistently said that in order for something to be a best practice it's important that it is not just solely endorsed by research. You have to look for applications, to know that things can really work in a normal kind of situation, rather than just relying on a specially-funded demonstration project to give direction. So when we talk about evidence about what works, we are usually saying something that has the best possible empirical evidence from research and which also has examples of applications of that approach.

So this would be how you would evaluate and measure best practices?

Dr. Goering: Well, you can evaluate and measure by looking at research studies. You can also look for examples of where similar approaches have been applied in contexts which were non-research to see whether this is actually do-able.

What are some of the key elements that make up best practices?

Dr. Goering: It depends on what arena you are in. I think it's ideal to think of best practices at different levels. You need best practices that define the nature of the particular interventions or types of care that you are providing. You need best practices that tell you more about how to organize and deliver those interventions and services in the form of programs, and then you need best practices for setting up systems of care that will encourage programs that provide the best interventions. It's important to think in terms of levels. When we were trying to summarize the evidence with regard to the severely mentally ill, we divided it up into the sectors in which things

Do you think that consumers themselves are becoming a lot more educated about what is out there and want to have more input into the kind of treatment and type of program they experience?

DR. GOLDNER: Unquestionably. I also think this is a huge step forward in the way the health care system is currently working. Consumers and family members are becoming quite expert and knowledgeable and are therefore pushing the system forward to respond to the kinds of very important questions which are of concern to them. Before, researchers and professionals had to guess what kinds of things would be most important to consumers and family members to know about, now consumers and families speak, I think, with a very strong voice about the information they want to receive. If we are able to open channels so that consumers and families can have that voice, it helps the system to move forward at a more rapid rate.

Obviously there is a lot of research that goes into determining best practices. Will implementing the changes that best practices necessitate be another long road that has to be travelled?

DR. GOLDNER: It's not only a long road but a difficult road. Unfortunately there are often significant obstacles associated with implementing best practices, or changing policy. There are many reasons for that. One is that systems are hard to change; people are set in their ways and are used to doing things a particular way so it can take a long time to retrain and change the way that problems are approached. Also we know that systems are often very rigid, so making changes to the way a hospital or an out-patient program or a community service is managed and structured takes time. A good example of that is that for years we have known that, wherever possible, it is much preferable to provide services that are not based in in-patient hospital units. Services that can be provided in a community are preferable, but to actually move outside of hospitals has been a very slow process. It has often been very difficult to maintain services once they get out into the community.

Does implementing best practices also come with a price tag?

DR. GOLDNER: The obstacles we've talked about so far are not to do with finances, but yes it is also about shifting finances and resources within the health system. There is always competition for those dollars, and sadly mental health does not always have a high priority in the system. Health Canada developed a Health Transition Fund whereby the Federal government provided funding in 1997 for four years for projects to be undertaken that sought to implement things like community treatment or new housing or home care based treatment. These are all things that had been identified as best practices in mental health and a number of communities across Canada agreed to have these implemented and evaluated. Around 150 projects were funded in the health sector with approximately 25 of these being directly relevant to mental health. I have been asked to write a synthesis of these 25 projects, which I am currently in the process of doing. I can tell you that one of the issues that arose with these projects was the difficulty, in many cases, of implementing them in the community. This was partly because the community wasn't fully prepared for this new practice and partly because the innovations strained the system in a particular way or there were other kinds of activities or problems that had not been anticipated: all the things that happen in the real world that don't always show up in research. It's quite fascinating to see all of the issues that arise around something we consider to be a best practice or innovation, because it does help to teach us, for the future, some of the things that we can do that will improve the likelihood of these things taking hold and doing well. The other thing that has come out of these projects is the fact that each community put a little bit of a different spin on a new practice. That 'best practice' had to fit into the local context, and that might be somewhat different in British Columbia to what it would be in Newfoundland or Ontario. Recognizing these kinds of factors is very important when you start implementing a best practice.

The National Canadian Mental Health Association undertook a study, supported by a financial contribution from the Health Transition Fund, Health Canada, to explore issues related to home care for adults with serious mental illness and make recommendations for practice and policy. Objectives of the study included: Identifying home care needs of adults with serious mental illness; Evaluating existing home care services for adults with serious mental illness across Canada; and Piloting and evaluating model programs in three national sites by forming working partnerships. Ten recommendations were made and policy implications were addressed. A full copy of the report can be obtained by contacting Barbara Neuwelt at bneuwelt@cmha.ca or visiting the website at www.cmha.ca and clicking on "Projects" and then "Home Care".

IMPLEMENTING BEST PRACTICES: IDENTIFYING THE OBSTACLES

You mentioned innovation in the same sentence as best practices, do you believe the two are tied together?

DR. GOLDNER: My own understanding of the best practices concept is that it is about innovation. That it's meant to denote more innovative practices that have now reached such a level of evidence that it has been demonstrated that these have some advantages over other kinds of practices. Generally what best practices denotes in my mind, and I know that there is some controversy about the meaning, is that they are an innovative practice that now has developed an adequate evidence base so that the community can have some level of confidence that these are improved practices.

What other key elements do you think make up best practices?

DR. GOLDNER: To me there are really only the two: the fact that they are innovative and that they are evidence based – constantly being refined and changed so that the best practice of today is unlikely to be one in a few months time.

How do you measure and evaluate best practices?

DR. GOLDNER: The standard is to use scientific methodology; to use research evidence; studies that have been undertaken that show there is some advantage to the consumer. This should either be that people are getting better outcomes, an improved quality of life for the same level of investment or energy or service, or that there is some improved efficiencies, so that people are getting the same quality of service but in a more efficient, less expensive way, or in a way that is more comfortable or brings other kinds of advantages. One of the critical components of defining a best practice is that the people who are using the service, or other kinds of components of health care such as housing etc., define this as a better way of doing things.

Do you think mental health issues are beginning to get a higher priority and that we are on the cusp of seeing some major changes take place?

DR. GOLDNER: There are certainly some indicators that that may be the case. For example, work that was done by the World Health Organization and the World Bank highlighted the level of disability and stress that is caused by mental disorders. Also I think in many communities and in many countries, people are realizing that it is in fact mental health related problems that are responsible for so much difficulty and disability and stress that people encounter on a daily basis. In the workplace, people talk about taking a mental health day because they feel stressed out. Business leaders are a lot more aware of the impact that mental health issues have on industry and on our day-to-day activities. But we must also realize that there is still an enormous stigma that is attached to mental illness, and that in fact we are still a very long way from being a society that fully accepts and understands mental health problems.

Centre for Evidence Based Mental Health

The Centre for Evidence Based Mental Health promotes and supports the teaching and practice of evidence based mental health care. The Centre is a non-profit organization located within the University of Oxford Department of Psychiatry, based at Warneford Hospital in Oxford, England.

Evidence-based medicine harnesses developments in technology and clinical research to provide readily accessible high quality information. The Centre for Evidence Based Mental Health is working with Minervation, a company which produces web-based knowledge systems for health care organizations, to produce a world-class, evidence-based Electronic Library for Mental Health (ELMH). The library, and derivatives from it, will be made accessible to users worldwide via Internet, Intranet, and CD-ROM solutions.

There is an online discussion forum for people who wish to get involved in the production and development of the ELMH, either as authors, reviewers or translators. The Centre for Evidence Based Mental Health website also includes education events and initiatives and is home to a number of electronic resources. It aims to support all mental health professionals in their everyday practice, providing a portal to high quality evidence-based mental health information, as well as a range of teaching materials. The website also seeks to destigmatize mental health through the dissemination of user-friendly evidence-based patient information.

Visit the Centre for Evidence Based Mental Health website at http://cebmh.com.

MENTAL HEALTH WORKS:
Developing Best Practices in the Workplace

Mental health problems have personal, social and financial consequences for Canada. While the health and social service systems address the immediate medical and personal problems, the resolution of workplace productivity issues has been left to managers, consultants, and ultimately market forces.

There are few resources for employers and employees on how to deal with mental illness in the workplace and there is very little guidance available to help businesses create a workplace that sustains or helps to restore mental health.

In addition to the economic impact of mental health problems, the lack of accommodation in the workplace has come at a considerable personal expense to people who have experienced serious mental health problems.

Unemployment rates associated with mental illness are commonly in the range of 75-85 percent. This is despite the fact that up to 80 percent of people with mental health problems could return to work in flexible work environments.

Mental Health Works is a joint project of the Global Business and Economic Roundtable on Addiction and Mental Health, the Canadian Mental Health Association, Ontario Division and the Ontario Ministry of Citizenship.

This project will assist employers and employees by providing information about the impact of productivity losses from mental illness in the workplace and specific advice and tools to help improve that picture. *Mental Health Works* is founded on the belief that raising awareness about mental health issues in the workplace will benefit employers and employees alike.

Over the next two years, *Mental Health Works* will develop strategies, a public awareness plan, and resources and tools that are directly applicable to the Canadian workplace. Research and strategies will focus on as many varieties of workplace settings as possible: office, retail, service industries and factories, urban and rural. Pilot testing and evaluation of these tools will be conducted on site by participating businesses.

Mental Health Works is expected to produce benefits for employees and employers by:

- Improving the ability of employers to respond to workplace mental health issues.
- Providing relevant, specific information on methods to reduce costs associated with lost productivity, burnout, absenteeism, turnover and disability insurance claims.
- Helping people return to productive work after an absence caused by mental illness.
- Creating tools and resources to create healthier and more productive workplaces.

Project Goals:

- Reduce workplace barriers for persons with mental health problems.
- Increase employer and employee awareness of mental health issues.
- Build the capacity of organizations to address the needs of persons with mental health problems and to better manage mental health issues.
- Make workplaces more mentally healthy.
- Provide employers with services and resources to meet their needs.
- Reduce the stigma attached to mental health problems in the workplace.

For more information on this project, or to become a sponsor or active participant contact Miriam Ticoll, Project Director, Mental Health Works, CMHA, Ontario Division (416) 977-5580 ext. 4120 or e-mail: mticoll@ontario.cmha.ca

Mental, neurological and behavioural disorders together make up the single largest cause of years lost to disability and death. What impact does this have on our economy? In established market economies one quarter of all years lost to disability and injury result from neuropsychiatric conditions. Alcohol-related disease affects an estimated 5 to 10% of our population worldwide. In Canada alone, the cost of mental illness represents an astounding $16 billion a year in lost productivity. In the words of Tim Price, Chairman, Trilon Financial Corporation and inaugural Chairman of the Canadian Business and Economic Roundtable on Mental Health, "Mental illness is a business issue and we simply must know more about it."

A Different Way of Doing Things

A Consumer's Viewpoint

Gary Westover's vantage point as both a consumer and provider of mental health services makes him an ideal spokesperson for the consumer's point of view in this whole area of what constitutes a best or better practice. Mr. Westover is a Crisis / Community Support Worker with the Canadian Mental Health Association, Oxford County Branch. His experiences with what he terms the "trials and tribulations of depression" address not only the issue of stigma which is still being battled, but the right of the consumer to have input in decisions that are being made that will affect their day to day life. Dr. Goldner *(see page 12 of this issue of Network)* defined best practice as one which "the people using the service or other component of health care define as a better way of doing things." In the following article, Mr. Westover explores a "different way of doing things".

Though it has visited many times before, I am always taken aback by its arrival. Sometimes it stays for weeks, other times months. For as long as I can remember, depression has insinuated its gloomy presence into my life and, despite my best efforts to ward it off, I often find myself benumbed and immobilized by its cold, suffocating embrace. My longstanding search for relief has been as exasperating and defeating as the illness itself.

An important theme when dealing with depression, or any kind of illness, is acceptance. Unfortunately, the social stigma surrounding mental illness dissuades many who are so afflicted from accepting and attending to their condition. Understanding, tolerance and non-judgmental treatment of persons with mood and other psychiatric disorders have been a long time coming. And we still have a ways to go. Many people's sense of belonging (including my own) can be severely compromised by depressive illness and their inability to accept and love themselves consistently or at all. Matters are made even worse for these individuals when, for one reason or another, diagnosis and effective treatment are delayed, avoided or simply unavailable.

"I think people often pay lip service to the notion that consumers should be listened to. The reality is when a community psychiatrist is serving 1,500 or 2,000 clients he really doesn't have a whole lot of time to listen."

"In my role as a social worker in supporting people with mental illness, their complaint seems to be that 'this person doesn't have any time for us'. If there are 25 people in the waiting room you don't have to be all that astute to know that this doctor isn't going to have a lot of time to talk about what's ailing you. I am afraid that this contributes to a pill-pushing environment – and this kind of treatment focus has taken on a life of its own."

Not long ago, children who exhibited signs of depression were seen as "moody". Adolescents who presented with depressive symptoms were labelled "temperamental". For these reasons, coupled with the fact that men have not traditionally been encouraged to admit to, let alone seek assistance for, problems of a psychological nature, I did not receive any kind of treatment until I was 28 years old. At age 18 I did momentarily overcome my self-consciousness to ask my doctor to refer me to a counsellor to help sort out a few things. He responded by angrily instructing me to "forget about such nonsense" and "pull myself together." A decade passed before I again sought help.

Since my introduction to therapy, I have also experimented, albeit reluctantly, with a slew of anti-depressants. My inclination to abandon drug trials prematurely, i.e. before it is clear whether or

"It's easy to get lost in the system and that's even worse with seniors. They are less able to advocate for themselves, they have less people around them who will speak up on their behalf. I have a client just like that. The family doctor doesn't know what the psychiatrist is doing because they are in different communities. This person is in the middle and it's just sheer luck that nothing untoward has happened to her."

not a particular medication can offer any relief, has not helped my cause. One thing that has not helped assuage my ambivalence toward pharmacology is the way general practitioners and psychiatrists dismiss or minimize their patients' concerns, apprehensions and bodily discomfort in reaction to taking psychotropic medication. Physicians could do a better job educating and empathizing with their patients about the effects of taking substances designed to alter one's neuro-chemistry. All it takes is a little time and understanding.

A recent study conducted among family physicians in London, Ontario, found that the patients of doctors who take a few minutes to talk to, and better yet listen to, them recover more quickly from their illnesses than the patients of doctors who dispense medical advice and / or medication in a cursory and detached manner.

Another problem with mental health care providers is their oft times singular treatment focus. At one point I asked the psychiatrist whom I last consulted what he thought about referring me to a support group because I was feeling rather isolated and discouraged with the lack of results. For one reason or another he didn't support this idea, and in the twenty minutes or so he afforded me each visit he continued to focus exclusively on medication. I eventually told him that I needed a drug holiday and the good doctor and I parted company, but my depression and I did not.

I have also dealt with non-medical therapists who treat severely depressed individuals without ever referring them to a physician for a medical or psychiatric consultation. At best this is a narrow therapeutic approach, at worst it is irresponsible and dangerous. It would seem that even the most capable and seasoned professional helpers may need to be reminded from time to time to accept the limits of their expertise.

On a positive note, I am pleased to report that I have found a family doctor who is knowledgeable about the treatment of depression and has a warm, friendly interpersonal style. He also has a sense of humour (hallelujah!) and seems open to any insights I may have pertaining to my own well being and plan of care. Not only does it feel good to be listened to and heard, but it only makes sense that my point of view be solicited. After all, who knows more about how I feel, what works, and what doesn't than me? To date, we still haven't found a medication that works for me. Nonetheless, I'm feeling more hopeful these days which, as anyone who has experienced depression knows, is no small thing.

"It's paradoxical that on the one hand we are encouraged to be more open – it's maybe a little less of a taboo to acknowledge mental illness – but there is a dearth of people, including psychiatrists, to address the issues. With the recent disaster in New York City we could now see a situation that will overwhelm the mental health system. People whose anxiety was below the surface, and who were dealing with life on a superficial level, have now had their underlying anxiety brought to the fore. Mental health professionals have already been seconded from Canada to go and deal with the disaster in the U.S. – and we don't have enough people to deal with our own issues."

"We need to look at mutual support groups instead of always looking to a psychologist or an overworked psychiatrist for the answers. That's not a small thing in terms of the support and the reduction in isolation it can provide. I really do believe that more and more we have to take better care of ourselves, and support each other, in addition to having professionals to go to. Our society in general has moved away from that kind of support, both within the family structure and the community, and now we are experiencing the backlash. If there is anything positive that has come out of the terrorist attack in the States, it's that people are realizing that they need each other. We are re-prioritizing what is important to us, and suddenly friends and family are becoming very meaningful. It's when we are faced with these kinds of calamities that we see there is something missing from our lives, hence this thirst for spirituality, for being part of a close knit family and community. We have maybe over-estimated our ability to function without these supports."

PUTTING BEST PRACTICES INTO ACTION

Youth Suicide Prevention in British Columbia

THE FOLLOWING IS A SUMMARY OF AN EVALUATION REPORT PREPARED BY JERRY HINBEST IN APRIL 2001, UNDER CONTRACT TO THE SUICIDE PREVENTION INFORMATION & RESOURCE CENTRE AT THE MENTAL HEALTH EVALUATION & COMMUNITY CONSULTATION UNIT (MHECCU) AT THE UNIVERSITY OF BRITISH COLUMBIA, AS PART OF THE PUTTING BEST PRACTICES INTO ACTION PROJECT FUNDED BY THE MINISTRY FOR CHILDREN AND FAMILIES.

The complete 84-page report can be found on the MHECCU website at www.mheccu.ubc.ca/publications/

Between May 1999 and June 2000, seven British Columbia communities, Powell River, Prince Rupert, Quesnel, Revelstoke, Richmond, the Stikine Region and Williams Lake, participated as demonstration sites for an innovative and precedent setting suicide prevention initiative. The *Putting Best Practices into Action* project was funded by the Ministry for Children and Families (MCF) and coordinated by the Suicide Prevention Information and Resource Centre (SPIRC), of the Mental Health Evaluation and Community Consultation Unit (MHECCU), in the Department of Psychiatry at the University of British Columbia.

The project's broad goal was to identify planning and communication requirements, local leadership characteristics, community-level partnerships, and infrastructure needs that best facilitate a comprehensive and community-wide approach to youth suicide prevention. It built upon work previously published by SPIRC: *Before the Fact Interventions: A Manual of Best Practices in Youth Suicide Prevention* (1998). The project also sought to help BC communities to begin the process of applying the best practices described in the manual, and to undertake original research that could improve understanding of what works, and in which community context.

Each of the seven participating communities implemented at least four of the fifteen best practices described in the manual. In total, eight of the best practices were addressed by project sites, with three done by all seven sites and a fourth implemented by all but one community.

The challenges faced and addressed by the seven participating communities were part of the rich tapestry of best practice implementation that the initiative was designed to develop and

BEST PRACTICE STRATEGIES:

Generic Skill-Building – enhancing young people's personal capabilities so that they can more effectively adapt and deal with daily tasks, challenges and stresses.

Peer Helping – selecting and training children and adolescents to become helping resources for their peers.

Youth Participation – active enlistment of young people in decisions that affect them and their community.

Suicide Awareness Education – providing the necessary attitudes, knowledge and skills to identify and help a potentially suicidal friend.

Gatekeeper Training – training individuals who typically come into contact with youth through their professional role or volunteer activities.

System-Wide Protocols – joint agreement between key agencies within a geographic area that reflects a coordinated response to youth-at-risk.

Community Development – coming together to identify common needs and concerns and making plans to meet those needs.

document. As such, even those planned activities that did not get implemented as part of the projects contributed to the local and community level learning that took place. The projects gained a great deal of hard-won learning through inspired efforts by many people.

In summarizing the learning gained, several broad observations stand out.

- A relatively small seed investment can have a strong impact in promoting a comprehensive and meaningful group of community-level suicide prevention activities.
- The one-year time frame for the phase one projects was too short to complete the implementation of many activities; too short to allow the quality and thoroughness of development that communities wanted; too short to fit well with organizational planning cycles and too short to implement evaluation efforts focused on effectiveness impacts.
- There was a great deal of turnover among project chairs, committee members and coordinators which contributed to burnout of remaining participants, and challenged continuity.
- In most communities participants finished their projects with a longer list of intended activities than when they started. Their understanding of the range of possible and necessary prevention activities has grown, and now encompasses activities far beyond the scope of their initial goals.
- Post-training surveys of peer helpers, those taking gatekeeper training and others involved with the projects, consistently showed high levels of satisfaction with the participation in suicide prevention activities. Most indicated clear increases in knowledge and appropriate changes in attitude towards helping those at risk of suicide.
- A key element of successful suicide prevention programs is the need for skill development and practice related to risk identification. The hands-on and practical side of the training was rated highly immediately after training and also after follow-up.
- The multiple best practice strategy approach had both positive and negative implications for those involved with the projects. Most tried to take on too many activities, but still found that working on several fronts at the same time provided certain efficiencies. Of more importance, activities served to support one another in many ways that were hard to predict in advance of the broader implementation.
- Finally, and perhaps most importantly, several communities noted the power of simply bringing youth suicide into the open as a topic appropriate for public discussion. Giving people permission to discuss suicide – something that virtually any of the best practice strategies can contribute to – can reduce tensions, facilitate communication, and help young people get the help they need. The process of facing suicide for a community thus appears to be very similar to what we know works for an individual. Asking the question and facing suicide directly does not increase the likelihood of its incidence. It decreases it.

The report concludes with a comprehensive discussion of future options and priorities for addressing youth suicide prevention in British Columbia. Twenty key ideas for consideration are offered related to the mandates of the Ministry for Children and Families and the Suicide Prevention Information and Resource Centre.

Saluting Our Members

CMHA Ontario Division's Membership Recruitment Drive

Congratulations to all the members of the Canadian Mental Health Association, Ontario Division, who, in the spirit of The International Year of Volunteers, recruited new members during the recent Membership Recruitment Drive May 7 - June 30, 2001. The membership drive has helped to give new energy and focus to the achievement of our common goals and we would like to acknowledge those who actively recruited new members.

Paul Auger, CMHA Thunder Bay
Jim Biskey, CMHA Chatham-Kent
Michael Borges, CMHA Kingston
Dean Braunsteiner, CMHA Hamilton-Wentworth
Debra Brassington, CMHA Peel Region
Pat Cawker, CMHA Victoria County
Bob Chambers, CMHA Hamilton-Wentworth
Shirley Charron, CMHA Windsor-Essex
Marc Chevalier, CMHA Windsor-Essex
Lucette Chiasson Plourde, CMHA Windsor-Essex
Isabel Churcher, CMHA Nipissing Region
Susan Dennison, CMHA Windsor-Essex
Fran Edwards, CMHA Peterborough
Joy Ely, CMHA York Region
Jim Evans, CMHA Windsor-Essex
Marlene Fortin, CMHA Thunder Bay
Ted Gill, CMHA Elgin County
Peter Giokas, CMHA Hamilton-Wentworth
Mr. & Mrs. L. Gray, CMHA Windsor-Essex
Cathleen Harrison, CMHA York Region
Pam Hines, CMHA Windsor-Essex
Ivan Isenor, CMHA Thunder Bay
Naresh James, CMHA Victoria County
Bill Jesty, CMHA Windsor-Essex
Karen Jewell, CMHA Peel Region
Marilyn Karn, CMHA Windsor-Essex
Jon King, CMHA York Region
Lisa Leblanc, CMHA Nipissing Region
Kim Lewis, CMHA York Region
Kathy Massong, CMHA Windsor-Essex
Annette Matte, CMHA Windsor-Essex
Terry McCartney, CMHA Oxford County
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Susan Merilainen, CMHA Thunder Bay
Gulzar Molu, CMHA Peel Region
Jean Montgomery, CMHA Haldimand-Norfolk
Sylive Montpelier, CMHA Subdury
Paul Murdock, CMHA Sudbury
Marie Nesbitt, CMHA Windsor-Essex
Alison North, CMHA Brant County
Steve Oliver, CMHA Victoria County
Bertha Pierobon, CMHA York Region
Marion Quigley, CMHA Sudbury
Kathy Quinlan, CMHA York Region
Kristin Rimmer, CMHA York Region
Suzanne Robinson, CMHA Peel
Ann Sheldon, CMHA Waterloo Region
DJ Smale, CMHA Elgin County
Donna Speer, CMHA Victoria County
Richard Speirs, CMHA Thunder Bay
Rebecca Stewart, CMHA Windsor-Essex
Barbara Tammet, CMHA York Region
Lena Vander Heyden, CMHA Hastings & Prince Edward Counties
Karen Whitelaw, CMHA Oxford County
Donna Wigmore, CMHA York Region
Colleen Zakoor, CMHA York Region
Emma Zucchetto, CMHA Windsor-Essex

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NOVEMBER 18 – 20, 2001

INPUT '01 – The 14th Biennial Symposium on Employee and Family Assistance Programs in the Workplace – Chateau Laurier, Ottawa. This symposium offers a fresh and revitalized look at pragmatic programs and services that work, and an opportunity to meet the experts and practitioners. There will be 50 different workshops addressing a wide array of timely issues surrounding addictions and other personal problems that can affect productivity on the job, as well as treatment and prevention programs. For more information: Tel: 416-675-6622, Fax: 416-675-0135, Web: www.humberc.on.ca/~input.

MARCH 11 – 13, 2002

Fundamental Concepts in Mental Health – This course identifies health promotion strategies that address the stigma and myths surrounding mental illness. For more information: Tel: 416-595-6020; Fax: 416-595-6644; Web: www.camh.net/ets.

MARCH 25 – 26, 2002

12th Annual Rotman Research Institute Conference, Emotions and the Brain, Toronto, Ontario. For more information: Education Department, Baycrest Centre for Geriatric Care, 3560 Bathurst Street, Toronto, Ontario M6A 2E1. Tel: 416-785-2500 ext. 2363; Fax: 416-785-4215; Email: conference@rotman-baycrest.on.ca; Web site: www.rotman-baycrest.on.ca/

APRIL 18 – 20, 2002

State of the Hart - Habilitative Achievements in Research and Treatment for Mental Health in Development Disabilities A Canadian Report Card, Vancouver, BC. For more information: Interprofessional Continuing Education. Tel: 604-822-0054; Fax: 604-822-4835; Email: interprof@cehs.ubc.ca

Community programs run by the Canadian Mental Health Association are a vital part of Ontario's mental health system. In fact, increasingly, they are the only programs available in some communities! We need to rely on your support to be able to continue this essential work. Your caring donation will help the CMHA continue to provide these programs and services to meet the needs of individuals, and their family members, experiencing a mental health problem in the community. Please give generously today. Thank you.

To donate to the CMHA call 416-977-5580 ext. 4138, or 1-800-875-6213 or give on-line at http://www.ontario.cmha.ca/donate/donate.html

READERS' COMMENTS

Dear Editor:

I wanted to let you know how much I enjoyed reading the articles in the last issue of *Network* (Summer 2001). You've captured the essence of the stories told by members of the Dream Team as I have heard them. We are grateful to the Canadian Mental Health Association, Ontario Division, that these stories are being published, and so eloquently at that. Thank you for such great work.

GINETTE GOULET
Associate Director
ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH & ADDICTION PROGRAMS

This column is designed for you, our readers. Due to space limitations, letters may be edited. Please take a few moments to send your comments for publication to:
The Editor, Network,
Canadian Mental Health Association,
Ontario Division,
180 Dundas Street West,
Suite 2301, Toronto,
Ontario M5G 1Z8

or fax them to
(416) 977-2264.

Letters may also be e-mailed to:
division@ontario.cmha.ca

Emerging Into Light

A symbol of recovery and resilience for people who care about mental illness and health, this image is the original artwork of Jennifer Osborn, a consumer and young woman of considerable artistic talent who has recently returned to work after a period of recurrent illness. Jennifer created this image and donated it to the Canadian Mental Health Association because she wanted to share her story though art, creating a symbol that would be distinct, simple and convey the dignity of our ongoing battle against mental illness. In July 2000, the Canadian Alliance of Mental Illness and Health formally endorsed the symbol and agreed to act as custodian of the image. By endorsing a common symbol, we can help to build public awareness about the importance of mental illness and mental health issues. By adopting the *Emerging into Light* symbol, we are bringing mental illness out of the dark ages and into our community.

Visit the *Emerging into Light* Gallery at www.cmha.ca, a place dedicated to celebrating resilience and recovery.

Network

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