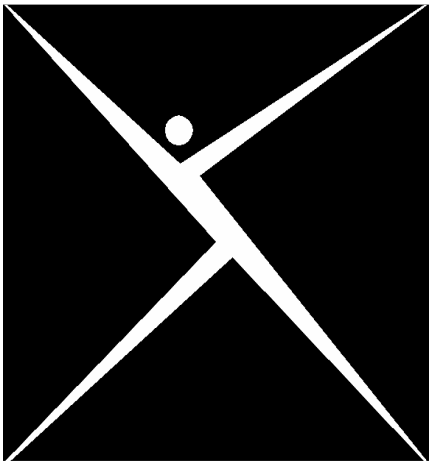
ACCESS

A FRAMEWORK FOR A COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEM

**CANADIAN MENTAL HEALTH ASSOCIATION,
ONTARIO DIVISION**



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CANADIAN MENTAL HEALTH ASSOCIATION,
ONTARIO DIVISION

EXECUTIVE SUMMARY

ACCESS: The Framework proposed in this paper is a continuous, integrated and seamless mental health system, which is designed to provide high quality service to consumers in Ontario's reorganized health system. This framework has the following qualities. It is an:

- **A**ccessible
- **C**ontinuous
- **C**omprehensive
- **E**ffective, and
- **S**eamless
- **S**ystem.

The paper is conceptually based on ***A New Framework for Support for People with Serious Mental Health Problems***, developed, in 1993, by the National Office of the CMHA, as well as the Values base articulated by the CMHA, Ontario Division in its ***1992-97 Strategic Plan.*** The CMHA recognizes the importance of a system of services and supports that has the qualities embodied in those documents. The CMHA also believes that such system qualities must be translated into daily service organization and delivery.

Leona Bachrach, a noted researcher, has been an advocate of mental health service systems that have the concept of "continuity" as their main feature. Bachrach has described "continuity" as a process involving the orderly, uninterrupted mobilization of the diverse elements of the service delivery system for the benefit of the person with serious mental health problems. She has also articulated nine interdependent principles that create "continuity" for people with serious and persistent mental health problems:

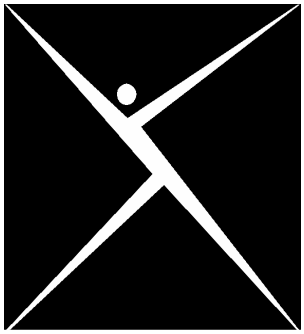
1. Administrative structures that promote access to the necessary services and supports;
2. Geographic, financial and psychological access (i.e. meeting the person "where s/he is");
3. Availability of a full array of services;

4. Individualized tailoring and regulation of services and supports;
5. Flexibility in the titration of supports and services;
6. Single point of coordination and accountability;
7. Continuity of relationship with the Community Support Worker;
8. Participation of the person receiving service in the process of planning for services and supports;
9. Cultural relevance.[1]

Functions that lend themselves to the concept of "continuity of care" are central to an effective system of community based mental health services. These functions include:

- the opening of doors to entitlements and the full range of mental health services,
- the individualization of service plans,
- the linking to and monitoring of the use of generic services,
- the facilitation of social networks,
- the development of communities (through which a detailed knowledge of community resources can enhance the range and quality of supports), and
- a fixed point of accountability and coordination in the close working relationships that the service, through its personnel, establishes with the person in need.[2]

The Canadian Mental Health Association, Ontario Division has developed a vision of how such concepts can be translated into day-to day practice in Ontario's reorganized health system. This Vision is detailed in the following Framework:



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[1] Bachrach, Leona L. (1993). Continuity of Care: A context for case management. In Harris and Bergman (Eds.) *Case Management for Mentally Ill Patients.* pp. 184-187.

[2] Ibid. pp. 187-189.

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INTRODUCTION

In the past several decades, since the dawn of the era of de-institutionalization, we have witnessed an ongoing effort to create services that meet the overall needs of people with serious and persistent mental health problems. There have been a number of advances in both the medical treatment of mental health problems, as well as in the creation and provision of psychosocial supports and services. The objective of service excellence has been and continues to be a vital endeavour as consumer/survivors and family members together with service providers strive to articulate how services and supports can best meet the multi-faceted needs of people who experience barriers to enhanced quality of life due to their mental health problems.

We know that it is not simply the presence of a mental health problem that makes effective service delivery a challenge. There are many other factors that militate against society's ability to work collaboratively with consumers and family members to assist with the achievement of improved quality of life. These factors, among others, include:

- the tendency of society and its systems to classify all people who experience significant mental health problems into one heterogeneous group with the concurrent assumption that one service delivery approach will suffice for all
- ongoing stigma and fear associated with people with mental health problems which leads to the tendency to create policy and service approaches that seek to control people rather than serve and support them within an atmosphere of respect, dignity and empowerment
- an imprecise awareness of and appreciation for the cyclical nature of mental health problems and the manner in which social and interpersonal factors impact on mental health
- a tendency to ignore the role of social supports, peer supports, and other determinants of health such as decent and affordable housing, employment, adequate income, etc., in the promotion of mental wellness especially among those who are most severely disabled by the mental health problems they experience
- the inability of services, in and of themselves, to deliver the right service/support, at the adequate level, at the right time, in order to adequately respond to changing and complex needs of people with mental health problems
- a lack of integration within the mental health system that does not permit a multidisciplinary approach to occur in a planned, integrated and accountable manner
- a lack of integration between the mental health system and other health and social systems in order that the overall needs of a person can be addressed in a planned, integrated and accountable fashion

- etc..

These issues are not new. The recent mandate of the Ontario government for District Health Councils to embark on the road of systems design, the adoption of the concept of mental health agencies as a governance structure, and the movement towards integrated health systems all begin to address some of these issues.

The Canadian Mental Health Association, Ontario Division has also long been aware of these issues. Through its policies and position papers, the CMHA has used a rigorous consultative process with consumer/survivors, family members, service providers from all disciplines, and policy makers, to address and advocate around these issues.

ACCESS, A Framework for a Community Based Mental Health Service System is the CMHA, Ontario Division's response to the many systems issues that have been identified over the years. The **ACCESS** document itself has had limited consultation (see "Acknowledgements" on page 56), but it is based on the aforementioned policy and position papers, and as such is based on years of consultation and discussion. Further consultation and refinement of the **ACCESS** Framework will be made possible through feedback based on implementation.

ACCESS has the potential to be implemented in conjunction with the systems designs recently created by District Health Councils (DHC). While DHC systems designs have recommended broad strategies in order to achieve integration, **ACCESS** provides some further detail regarding the implementation of such strategies.

ACCESS does not, however, provide precise detail regarding how the Framework is to be implemented in Districts and Regions across Ontario. There is a recognition that implementation must correspond to the strategies of local DHC systems designs, to the specific geographic, social and cultural issues to be found in various districts, as well as to the service structure already to be found therein. As such the **ACCESS** Framework needed to be flexible enough to be implemented in a wide variety of settings and situations, taking into account the diversity of our province. In whatever manner the Framework is implemented, *access* is paramount.

Nor does **ACCESS** prescribe any service delivery models. ACCESS attempts to move beyond the endless controversy regarding the efficacy of one service delivery model over another, and focuses, by preference, on functions that are to be delivered in an effective mental health system. The description of these functions which follow are based on "practice wisdom", accumulated by the CMHA from the input provided to it by consumers, family members, and service providers, over the years. However, because ACCESS does not adhere to one specific delivery model or another, it also lacks the empirical evidence that is associated with specific models. The empirical evidence that will be needed to ascertain whether ACCESS brings about the outcomes it seeks to achieve will result from rigorous research being applied to the implementation of its integrated functions in a variety of locales.

Furthermore, the various *functions* that are described in **ACCESS** should not be interpreted in a prescriptive fashion. Services that already perform, or have the capability to deliver, roles such as a "Resource Centre" or "Outreach" services in a

functionally equivalent fashion, need not re-name themselves, as the Framework focuses on functions and outcomes, without intending to be specific.

ACCESS is also lacking in detail in another pertinent area, that of system governance. While it may be the case that a particular organization becomes accountable for the implementation of the Framework in a given locale, it is equally possible to create a structure in which organizations can be jointly accountable. The governance of systems needs to reflect local considerations. Regardless of the structure used to ensure organizational accountability, the CMHA has long advocated for a strong voice of consumers and family members in all decision- making bodies that have the power to affect their lives.

Although **ACCESS** describes a Framework for a systems approach to the delivery of mental health services, its ultimate concern is for the achievement of desirable outcomes for people with mental health difficulties through service integration and service excellence. An important component of service excellence is the articulation of a solid conceptual and philosophical foundation on which the description of such an integrated system can be based. This is addressed in PART I. The description of the actual Framework is to be found in PART II. The Conclusion points out some considerations for implementation.

One final note: the achievement of outcomes through systems integration and service excellence is strongly linked to adequate financial and human resources. The proposed Framework calls for a range of professional expertise, with the training needed to deliver mental health services in community based settings. The multidisciplinary community mental health programs now being offered in a post-diploma/degree capacity at community colleges have made a small dent in the overwhelming need for such training. Of equal importance is the need to ensure that professional schools prepare their students for the delivery of mental health services through excellence in courses and through the provision of supervised practicums in the field. Finally, it is necessary for the various disciplines to develop an awareness of and an appreciation for the contribution of other disciplines--*including* the contributions of volunteers, other consumer/ survivors and the general public--towards the achievement of the outcomes that are desired by those who receive services.

Bearing these parameters in mind, the Canadian Mental Health Association, Ontario Division presents ***ACCESS: A Framework for a Community Based Mental Health Service System***.

PART I: CONCEPTUAL, PHILOSOPHICAL AND THEORETICAL BASE OF THE "ACCESS" FRAMEWORK

Experience in the delivery of community mental health services has demonstrated that none of the many uni-dimensional service approaches that have been implemented in the past 30 years have, by themselves, met all the needs of people with serious and persistent mental health problems. Focusing solely on any one area of need will not lead to satisfactory outcomes. With mental health problems, as with any complex situation, multidimensional problems require multidimensional approaches.

A sophisticated and organized systems approach to services and supports must recognize:

- the biopsychosocial complexities of mental health problems
- the various social/environmental/interpersonal factors that exacerbate or ameliorate the problem
- the myriad other difficulties that are often experienced by people with serious mental health problems

This paper proposes a continuous, integrated and seamless framework of community support services. This framework is the CMHA, Ontario Division's design for an:

- **A**ccessible
- **C**ontinuous
- **C**omprehensive
- **E**ffective, and
- **S**eamless
- **S**ystem.

The Framework, while promoting psychosocial supports, is intended to work collaboratively and in partnership with the medical services that are required by consumers of the mental health system. The CMHA recognizes and values the contribution of treatment services to the improvement of the quality of life of people with severe and persistent mental health problems. Through this Framework, the CMHA seeks to augment such vital services by focusing on the supports and resources that people need to achieve other outcomes, which are valued by consumers and which are further determinants of health: housing, income, education, leisure opportunities, employment, peer and social supports, etc.

THE NEW FRAMEWORK FOR SUPPORT

In 1993, the National Office of the Canadian Mental Health Association (CMHA) published ***A New Framework for Support for People with Serious Mental Health Problems***. The basic concepts of the ***Community Resource Base***, which formed part of the original ***Framework's*** policy (1984) are now widely accepted throughout Canada

and in countries abroad (Scotland, Northern Ireland, the United States, to name a few)[3] as the conceptual background for the development of mental health policy. ***Putting People First***,[4] Ontario's policy framework for the transformation of mental health services, used the ***Community Resource Base*** as a guiding framework for its *Vision* of a person-focused system.

The ***Community Resource Base*** is a paradigm for understanding the balance of services, supports, entitlements and opportunities that must work collaboratively to ensure that people with severe mental health problems live fulfilling lives in the community. While recognizing the importance of formal mental health services, the ***Community Resource Base*** emphasizes the role of family and friends, generic services and supports, and consumers working together on their own behalf. It also acknowledges the fundamental elements to which every citizen should have access: housing, employment, income, education, and other basic elements of citizenship. Symbolically, the ***Community Resource Base*** is represented as follows:

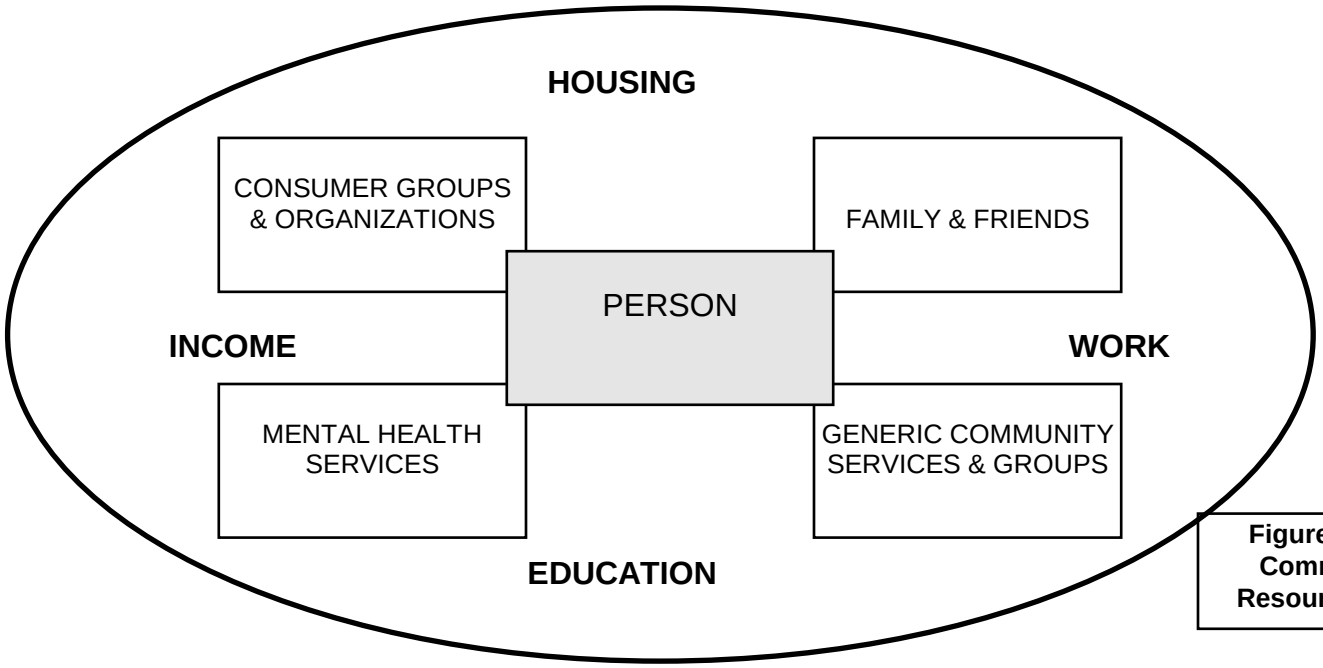

Figure 1: The Community Resource Base

The ***New Framework for Support*** also helps us to understand more fully what is meant by "community" when we speak of "community based" services. The concept of community implies interaction, identity, cohesion, mutuality, and shared values. Specifically, the concept reflects the following features:

- a strong, mutually supportive and non-exclusionary environment
- a high degree of participation in and control over decisions affecting one's life, health and well-being
- access to a wide variety of experiences and resources with the possibility of multiple contacts, interactions and communication

[3] Carling, Paul (1995) *Return to Community: Building Support Systems for People with Psychiatric Disabilities*. Guilford Press: New York. pp. 55-65.

[4] Ministry of Health, Ontario (1993). *Putting People First*. p.13.

The ***New Framework for Support*** recognizes that the basic determinants of health are central to the support of people with mental health problems. Unless these determinants, together with the features of community living, as described above, are the foundation for a coordinated system of services and supports, desirable health outcomes will not be satisfactorily achieved. For most citizens, access to such determinants of health is assumed. For those whose lives are complicated by disabilities and other barriers, however, a comprehensive effort to assist them to access entitlements and supports in a coordinated fashion is often necessary.

The ***New Framework for Support*** provides insight into the importance of a rich resource base for the community support of people with serious mental health problems. There is still, however, a need to articulate how the formal and informal services and supports that are required to promote the individual's health can be effectively and efficiently coordinated. As Ontario moves towards reduced reliance on in-patient services for those with serious mental health problems, the need for such a systematic framework has become acute. **Thus the CMHA, Ontario Division has developed ACCESS: *A Framework for a Community Based Mental Health Service System.***

AN ORGANIZED SYSTEM OF CARE

An Organized System of Care (OSC) is an integrated financing and delivery system for health care services. The aim of an OSC is to make high-quality health care available to all citizens, when necessary and at the required intensity, in a flexible and well-coordinated manner, while also reducing costs. Cost reduction is achieved because of the high degree of flexibility within the system. Services and supports are introduced and titrated as needed, at the intensity needed, and when no longer required are no longer purchased.[6]

For people with serious and persistent mental health problems, such flexibility is particularly important. The heterogeneity, the uncertain course, and the episodic nature of such problems indicate that the titration of services and supports in a timely and effective manner is crucial for stability and for the promotion of health.[7] In order to ensure that such supports are available when needed two options are available: either they are always available *or* they are purchased as needed. The cost involved in having a full range of services permanently available to any one individual would be prohibitive.

While flexibility is crucial, it must be balanced by the principles inherent in the "continuity of care" concept. Leona Bachrach, a noted researcher on the concept of "continuity of care" has described it as a process involving the orderly, uninterrupted

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[5] cf. Trainor, John, Pomeroy, Edward and Pape, Bonnie. *A New Framework for Support for People with Serious Mental Health Problems*, Canadian Mental Health Association. 1993. pp. 1-9.

[6] England, Mary Jane and Goff, Veronica V. Health Reform and Organized Systems of Care. *New Directions for Mental Health Services*. No. 59, Fall 1993. Jossey Bass Publishers. pp. 5-12.

[7] Kanter, Joel. Clinical Case Management: Definitions, Principles, Components. *Hospital and Community Psychiatry,* April 1989. Vol. 40 (4). p. 362.

mobilization of the diverse elements of the service delivery system for the benefit of the person with serious mental health problems. Bachrach has articulated nine interdependent principles that form the basis of "continuity of care" for people with serious and persistent mental health problems:

1. Administrative structures that promote access to the services and supports required;
2. Geographic, financial and psychological access: (meeting the person "where s/he is");
3. Availability of a full array of services;
4. Individualized tailoring and regulation of services and supports;
5. Flexibility in the titration of supports and services;
6. Single point of coordination and accountability;
7. Continuity of relationship with the Community Support Worker;
8. Participation of the person receiving service in the process of planning for services and supports;
9. Cultural relevance.[8]

Functions that lend themselves to the concept of "continuity of care" are central to an effective system of community based mental health services. These functions include:

- the opening of doors to entitlements and the full range of mental health services,
- the individualization of service plans,
- the linking to and monitoring of the use of generic services,
- the facilitation of social networks,
- the development of communities, through which a detailed knowledge of resources can enhance the range and quality of supports, and
- the identification of a fixed point of accountability and coordination in the close working relationships that the system, through its personnel, establishes with the person in need.[9]

Continuity of care and *flexibility of timing/intensity of services and supports* are therefore crucial to the efficient and effective community-based support of people with serious and persistent mental health problems. A re-organized system of health care in Ontario, which embodies these concepts, will ensure that:

- Community Support Workers have access to the services required by the people to whom they provide support, and that those services are available when they are needed and at the intensity required. Such access can be guaranteed through **purchasing power and / or through carefully delineated protocols with the providers of other needed services**. These mechanisms are available to the worker through his or her organization.

- The organizations which provide the structural and administrative support to front-line workers also need to be committed to the concepts that have been described above (i.e. the determinants of health and the components of community described

[8] Bachrach, Leona L. (1993). Continuity of Care: A context for case management. In Harris and Bergman (Eds.) *Case Management for Mentally Ill Patients.* pp. 184-187.

[9] Ibid. pp. 187-189.

in the ***New Framework of Support)***. Furthermore, they will possess a well-articulated values base which underlies such commitment and is reflected in a system of practice. Such a values articulation will guide the efforts of individual workers and ensure that administrative practices such as adverse selection and/or unnecessary reliance on more costly mental health services do not develop. Either can occur if concepts are not clearly articulated in well-defined principles of service. Managers in an Organized System of Care must always be vigilant to avoid adverse selection in order to ensure that those with the most significant need receive the services they require.

CMHA, ONTARIO DIVISION VALUES BASE

The Canadian Mental Health Association, through its 36 Branches in Ontario and through its Provincial Office, has articulated a strong Values Base, and a set of Principles of Service that govern our work. The **ACCESS** Framework is built on this foundation of values and service principles, which although strongly articulated and advocated for by CMHA, are shared by many community-based mental health services.

The following values and principles of service which have been articulated by the Canadian Mental Health Association have given CMHA the foundation necessary to provide services to those with mental health problems in a flexible and person-centered manner. The systems approach described in the **ACCESS** Framework is guided by the same philosophical foundation to ensure that systems as well as services continue to have the same commitment to those most disabled in a restructured health system in Ontario.

The philosophical foundation of the Canadian Mental Health Association, Ontario Division is made up of our **Vision**, our **Mission**, our **Organizational Values** and our **Service Principles**.

VISION

A society which values human dignity and
enhances mental and emotional well being for all.

MISSION

To advocate with and provide programs and services for people with mental disorders,
and to enhance and promote the mental health
of all individuals and communities in Ontario

The Canadian Mental Health Association, Ontario Division, is a provincial, charitable organization with a community focus. Our mission is achieved through public education, social action and advocacy, and research and policy development, as well as province-wide programs and services. Wherever possible, we carry out our activities in partnership and coalition with other organizations and individuals.

Certain fundamental shared values are at the heart of our mission[10]. They unite us and provide inspiration for the organization's goals and objectives. Those values are:

- **We value social justice**. We believe that social justice includes a commitment to a basic sense of fairness, a respect for differences among people, and that every human being deserves an equal opportunity in life.

- **We value individual and collective responsibility**. We believe that both individuals and society as a whole share in the tasks of informing the public, eliminating causes of mental illness, and caring for those individuals who need or want care.

- **We value access to appropriate and adequate resources/supports**. We believe that people require friendships and other natural supports. When formal supports are needed people should be able to choose the least intrusive option from a comprehensive range of appropriate mental health programs and services, without undue delay, and as close to their home community as possible.

- **We value self-determination**. We respect differences among people and the right of every individual and community to make choices and decisions based on unique individual beliefs and community norms. Basic to this right of self-determination is the need of people to be involved in decisions that affect their lives.

- **We value community integration**. Community integration of all people is an essential prerequisite to the development of healthy communities. We are committed to removing the barriers that prevent people, especially those with mental disorders, from fully participating in the life of the community.

- **We value integrity**. We believe that our day-to-day work must be true to our shared values and beliefs, and dedicated to promoting public trust and a sense of confidence within the organization.

- **We value partnership.** Partnership is dependent upon shared values and the cooperative efforts of all those working towards a responsive and accessible mental health system. One important partnership includes consumer/survivors, families, service providers and the community. We are committed to sharing, and view participation and partnership as essential to realizing our goals and objectives.

- **We value excellence**. We are committed to developing and maintaining the highest possible standards of management and operation to ensure that programs and services meet the needs and expectations of the community.

- **We value accountability**. We are guided by our shared mission, values, goals and objectives. As a publicly funded charitable organization we are committed to using our funds as efficiently and effectively as possible, and to being open to the highest standards of public scrutiny.

[10] CMHA, Ontario Division (1997). *Strategic Plan 1992-1997.*

- **We value creativity**. As an organization we must encourage innovative ideas and new ways of doing things that are responsive to changing attitudes and needs in the community as well as to ongoing organizational changes.

In 1994-1995, the Executive Director's Network of the Canadian Mental Health Association, Ontario Division undertook the establishment of a series of Service Principles. These principles, which were designed to provide structure and consistency to the community support services offered by the various Branches of the CMHA in Ontario, were built on the overall organizational values of CMHA, as well as the ***New Framework For Support*** [See above]. An inclusive process, in which service providers, consumers, and family members participated, was utilized to create these Principles of Service. That process was accompanied by a research project that described best practices which reflected these Principles. The Principles of Service are summarized here and will serve as a philosophical substructure for the work that follows.[11]

A. Self Determination: We believe that each person must have control and autonomy regarding his/her own life, and that supports must show respect for and responsiveness to each individual's preferences and needs.

B. Empowerment: We believe in all people having the opportunity to develop, recognize and act from a conviction of their own power, and that supports must foster and sustain the self-worth, abilities and growth of each community member.

C. Choice: We believe that each individual has the right, ability and responsibility to make decisions concerning his/her present and future, and that supports must offer all the knowledge, resources and encouragement necessary for people to make informed choices.

D. Citizenship: We believe that every person is entitled to equal access and opportunities to exercise and enjoy the rights and responsibilities of full citizenship, and that supports must incorporate and reflect these community values in their interactions with each individual.

E. Full Participation: We believe the participation of all people in the varied aspects of community life is essential to the well-being of each individual and to our society as a whole and that supports must foster and encourage the inclusion and contribution of every person.

F. Holistic Approach: We believe that the well-being of each person is best served when s/he is regarded and treated as a whole being, and that services must consider and include the physical, intellectual, emotional, spiritual, sexual and relational needs, wishes and abilities of every individual.

[11] cf. A Values Based Community Support Service System (DRAFT). CMHA, Ontario Division. 1995.

G. Mutual Interdependence: We believe that support relationships should be reciprocal, and that services are the most beneficial when they are based on mutual trust, collaboration and caring.

H. Respect for the Individual: We believe that every person offers unique and irreplaceable contributions to our society, and that supports must honour and advocate for the dignity of each individual, in order to support his/her sense of self-esteem as well as his/her value and respect in the community.

I. Excellence: We believe that the fulfillment of people's lives will be enhanced by supports that have an ongoing commitment to exceptional services, through integrity of values, responsiveness in relationships and effectiveness of action.

J. Innovation: We believe that people's preferences, needs and expectations alter throughout their lives, and that supports must meet this challenge through continued openness to change, flexibility, creative approaches and shared leadership.

These principles focus services to achieve outcomes that are valued by consumers: quality of life, community inclusion, recovery and empowerment. Moreover, these same principles have the potential to create a system which is both effective and cost-effective and, consequently, as attractive to funders as to consumers. ***By (1) focusing on the role of the community in providing supports and meaningful activities and (2) assisting users of mental health services to harness their own personal strengths and capacities, mental health organizations can assist in decreasing dependence on formal mental health services***. Although many consumers will require ongoing support, a focus on community integration and personal strength can decrease dependence on the formal service system.

The Principles of Service may be translated into practice through the adoption of the *Directional Statements* (see Appendix "A"), that flowed from them. The following ***Framework for a Community Based Mental Health Service System*** is a further elaboration of these principles and directional statements.

THEORETICAL FRAMEWORK

Paul Carling, in reviewing research that was completed on the experience of "Recovery" by mental health consumers, states

> "Studies...raise major questions about the level of expectations we should hold about the potential of individuals with psychiatric disabilities for community integration. These findings counter the pervasive beliefs that many people with psychiatric disabilities are too symptomatic or too "low functioning" to benefit from recovery and integration. To be sure many individuals are obviously in need of intensive assistance over an extended, or even lifelong period, if they are to take on employment, the independent management of a household, or other comparable productive activity. But this body of research strongly suggests that, with supports that are offered within the context of choice and

community participation, there is reason to hold hopeful expectations for any individual."[12]

Values, principles and conceptual frameworks can be implemented only when they are guided by sound theory regarding what is effective in assisting people who experience barriers. Theory is "an organization of assumptions, preconceptions, attitudes and rules which seeks to encompass the most important information and help us understand how and why we believe, or assert or claim the things that we do."[13] An understanding of theory enables us to effectively and intelligently structure interventions. The theory that is espoused in the *Ecological Perspective* (sometimes referred to as "Systems Theory") assists us to implement our belief that the community has a role to play in providing supports and meaningful involvements. *Strengths Theory* embodies our belief that mental health services must play a role in assisting people to harness their own personal strengths and abilities. These two theories complement each other, are logically consistent with the **ACCESS** Framework's espoused values and principles, and have been effectively implemented in models of community support designed to meet the needs of people with severe and persistent mental health problems. [14] [15] [16] [17].

An Ecological Perspective or Systems Theory studies the sensitive balance that exists between human beings and their environments, and the ways in which this balance can be maintained and enhanced. Carol Germain defines the ecological perspective in mental health practice as "... the science concerned with the adaptive fit of organisms and their environments and with the means by which they achieve a dynamic equilibrium and mutuality." If ecology is adopted as a metaphor for practice, then the unit of attention is the complex ecological system that includes the individual, the family, their environment, and the transactional relationships among these systems.

An ecological orientation dictates that the individual cannot be understood outside the context of the intimate environment, (i.e. the family); and that a family can be understood only in the context of its larger environment. The environmental perspective also emphasizes that there is a two-way, transactional relationship between the person and the ecological environment-- the family, friends, the neighbourhood, society and society's systems. This perspective helps us to see that when we analyse problems and difficulties, we need to do so in terms of deficits in the environment or as difficulties in adaptive strategies, rather than solely as a disease process within the individual. Efforts

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[12] Paul Carling, (1995) Return to Community*: Building Support Systems for People with Psychiatric Disabilities*. Guilford: New York. p.7.

[13] Freeman, David W. and Harris, Maxine (1993) The Philosophy of Science and Theories of Case Management: An Investigation into the Values and Assumptions that Underlie Case Management Theory. In Harris and Bergman (Eds.) *Case Management for Mentally Ill Patients: Theory and Practice*. Harwood Academic Publishers. p. 3.

[14] cf. Bebout, R.R. (1993) Contextual Case Management: Restructuring the Social Support Networks of Seriously Mentally Ill Adults. In Harris and Bergman (Eds.) op. cit. pp. 59-82.

[15] cf. Drake, Bebout and Roach (1993) A Research Evaluation of Social Network Case Management for Homeless Persons with Dual Disorders. In Harris and Bergman (Eds.) op. cit. pp. 83-98.

[16] Rapp. C.A. and Wintersteen, R. (1989). The Strengths Model of Case Management. Results of Twelve Demonstrations. *Psychological Rehabilitation* 13, pp. 23-32.

[17] Rapp, Charles A. (1993) Theories, Principles and Methods of the Strengths Model of Case Management. In Harris and Bergman (Eds.) op. cit. pp. 143- 164.

for change are directed to the interaction between systems or subsystems, the goal being the enhancement of the relationship between those systems.[18]

The role of the practitioner in this theory is focused on:

- assisting with adaptedness by assisting the person to find the best fit between him/herself and the social situation;
- decreasing stress through advocacy and through other influences of the social environment, such as increasing the quality and quantity of the social network;
- assisting the entire social network to cope effectively, by supplying information, resources and various forms of education.[19]

The **Strengths Theory** is based on two assumptions regarding human behaviour:

1. First, people are successful in everyday life when they use and develop their own potential and when they have access to the resources needed to do this. Many people who experience significant mental health issues lose sight of their strengths, skills, talents and goals. Many lack self-confidence. Many do not even have the resources required to obtain the day-to-day necessities, let alone the resources needed to become a full participant in the community.
2. Secondly, human behaviour is largely a function of the resources available to individuals. People who have significant mental health problems need the same resources as anyone else. Individualized community support services assist the individual to obtain these resources. **In this context, the individual could view the Community Support Worker and other mental health services as an important environmental resource but only as one of the many resources that may be accessed. The community is viewed as a large pool of resources, not as an obstacle.[20]**

The focus of the practitioner who follows the Strengths theory is to assist the person to identify, secure and mobilize the range of resources -- both personal and environmental -- that are needed to live, play, and work in a normally interdependent way in the community. There is a focus on the creation of the individually tailored service plan designed to assist the person to meet his/her goals.

There is a logical consistency between the theory described here and the values, principles and conceptual framework espoused by the **ACCESS** Framework.

Logical consistency is crucial for the development of a clear understanding of the intent and ensuing practice of service modalities. It is also essential for purposes of research, financial management and outcome evaluation. Community support typologies are often constructed around the functions delivered or the structural components of service delivery. An **Organized System of Care,** on the other hand**,** necessitates greater precision of the service's purpose and intended outcome, so that comparative

[18] cf. Hartman and Laird (1983). *Family Centered Social Work Practice*. The Free Press. pp. 69-74.
[19] cf. Germain, Carol B. "The Ecological Approach to People-Environment Transactions." *Social Casework* (June, 1981), pp. 323-331.
[20] Rapp (1993) op. cit. pp. 146-147.

evaluations can be completed and provider selection can be informed. This reflects an increasing demand by society to understand the effectiveness of service delivery based on administrative criteria such as:

- cost-containment through utilization management, as a result of which only services that are deemed appropriate and necessary are delivered
- cost-effectiveness measurements based on a comparison of resource consumption to outcomes achieved
- provider accountability through financial and information management processes which capture and use information about needs, utilization, quality, outcomes and resource allocation/consumption.

The conceptual and theoretical frameworks described above can be compatible with a society's need to contain costs for the following reasons:

1. The focus on utilizing the resources of the community, including informal supports, self-help groups, volunteers and generic resources to meet such needs as housing, leisure, vocational pursuits and education, can promote cost-sensitivity.

2. The focus on assisting consumers to achieve interdependent relationships with support networks that can provide the emotional and social buffers necessary to mitigate against the vicissitudes of mental health problems, and a collateral focus on supporting such networks, can reduce the need for the use of expensive interventions.

3. A focus on environmental intervention, with the functions of education, advocacy and community development, rather than an exclusive concentration on clinical, cognitive and behavioural improvements, is often more engaging for consumers, and will more readily achieve desired outcomes.

4. The outcomes that are sought through such a framework, (those of independent living, finding employment or other meaningful activities, maintaining good health through the achievement of health determinants, and the achievement of other quality of life indicators) will reduce the need for ongoing professional and expensive interventions for many. Although there will always be those who require ongoing services and supports, achievement of health through self-care and community support can greatly reduce costs.

5. The ongoing focus on consumer satisfaction will also be an indicator of achieved outcomes.

A summary of the Framework for a Community-Based Mental Health Service System, envisioned by the Canadian Mental Health Association, now follows.

PART II: DESCRIPTION OF ACCESS: A FRAMEWORK FOR A COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEM IN ONTARIO

The Canadian Mental Health Association has long advocated for a community-based system of mental health services and supports in Ontario. There are, however, many debates about what characteristics constitute a "community" based system. Deena White of the Université de Montréal notes that:

> There seems to be a near consensus in the West regarding the need to strengthen the community base with respect to care for people with mental health problems. One of the reasons for this interest lies with the realization that medication in and of itself has not effectively managed the social problems associated with the deinstitutionalization of people diagnosed as mentally ill. Indeed, as an isolated strategy for dealing with this population, a strictly medical form of intervention has proven to carry social consequences...
>
> However, there is no consensus with respect to the objectives and characteristics of a community-based mental health system. The anchoring of the mental health system in the community has been extolled as an empowering strategy for a stigmatized and marginalized population; as an efficient and economical means of dealing with chronic illness; as a professional, reasoned and assertive response to community needs; or as a part of a larger strategy to incite individuals and families to rely less on costly public services and more on their own resources. Given the segmentation of contemporary Western Societies, all of these objectives may coexist, and not always harmoniously...
>
> Within a single society, the various agencies, organizations, professions and social groups implicated in the mental health field in one way or another all claim to favour the transition to a community based-system, and to incorporate a community-oriented approach into their programs. Simultaneously, they pursue contradicting ends and develop competing strategies.[21]

White suggests that a "community-based" system incorporate three dimensions:

1. **Community as Locality: (Systems Planning)**
2. **Community as Civil Society: (Service Organization), and**
3. **Community as Gemeinschaft: (Intervention Strategy)**

[21] White, Deena (1993). The community-based mental health system: What does it mean? *Canadian Review of Social Policy*, 31, pp. 31-32.

White also proposes that the characteristic differences between the community-based and institutional-based dimensions of planning, organization and intervention exist on a set of continua. Characteristics of any particular service or system (which might be designated as "community-based" due to its presence outside of the institution proper) can be placed on such continua to indicate whether it more closely reflects a community focus or an institutional mentality. Because planning and system design is beyond the scope of a service description, which is the focus of this section, this discussion will be limited to the continua as they relate to the *mode of intervention*. **Table 1** summarizes these:

Table 1
Continua of Community-Based/Institutional-Based Intervention Practices[22]

Community-Based Practices		**Institutional Based Practices**
Centred on Life-World	⟷	Centred on Service System
Experiential Knowledge Base	⟷	Scientific Knowledge Base
Consumer Controlled	⟷	Professional Controlled
Objective: Empowerment	⟷	Objective: Management

White contends that any model of intervention that is truly community-based must be sensitive to the cultural and social variables (which are more essential to the helping relationship than are standardized diagnostic and treatment procedures) and must be resistant to the type of professionalism that implies a controlling relationship[23]. She argues that the mere location of a service outside hospital walls does not constitute such an approach.

Ontario's system of services and supports must be flexible enough to meet the complex and changing needs of people who experience a wide variety of disabilities and barriers as a result of their mental health problems. It must be prepared to deal with early identification and prevention, and must focus on outcomes, while being cost effective.

As indicated in the Ministry of Health's definition of the "priority population" for mental health reform, a clear understanding of the level of disability experienced by a person is a key element in determining the appropriate level of supports and services needed to achieve the desired outcomes. This multifaceted approach to understanding mental health problems has been described as the **"vulnerability-stress-coping-competence" model**.[24] In this Framework, it is recognized that personal vulnerability due to mental health problems is compounded by:

- Stressful life circumstances, such as poor housing, lack of activities, inadequate income, etc.

[22] Ibid. p. 43.
[23] Ibid. pp. 42-3.
[24] Anthony, William A. & Liberman, Robert Paul (1992). Principles and Practice of Psychiatric Rehabilitation. InR. P. Liberman (Ed.) *Handbook of Psychiatric Rehabilitation*. Macmillan: New York. p. 1-29.

- Isolation, loneliness and the loss of extended social networks. Although nuclear family members often remain involved, extensive and flexible social networks are also necessary.
- Stigma and the loss of opportunities in which it results.
- Difficulty in coping with a myriad of demands.

Anthony and Liberman also indicate that the exacerbation of disability results from the experience of **"handicap",** ***which occurs when disabilities and the perception of differentness place individuals at a disadvantage relative to others in society*****.**[25] Handicap can be the result of discrimination or stigma. It may also reflect the lack of those accommodations that would assist people with mental health problems to live, work, learn and socialize in society's settings. The authors draw a comparison between the kinds of accommodations which assist people with physical disabilities to be community members (wheelchairs, ramps, etc.), and those which would allow for people with mental health problems to utilize their personal interests, abilities and strengths to become full members of society.

In order to achieve a full understanding of a person's need for supports and services, assessments result in a clear understanding of the situation by taking into account a variety of issues. An understanding of these issues must:

- be based on the person's own perception of his/her needs and the barriers experienced;
- incorporate the many dimensions of life in which the person is involved in or needs to be involved;
- focus on the availability and/or unavailability of informal supports from which a person can draw;
- be flexible enough to allow for the changing nature of a person's situation and ability to cope with constantly changing stressors and levels of distress over time.

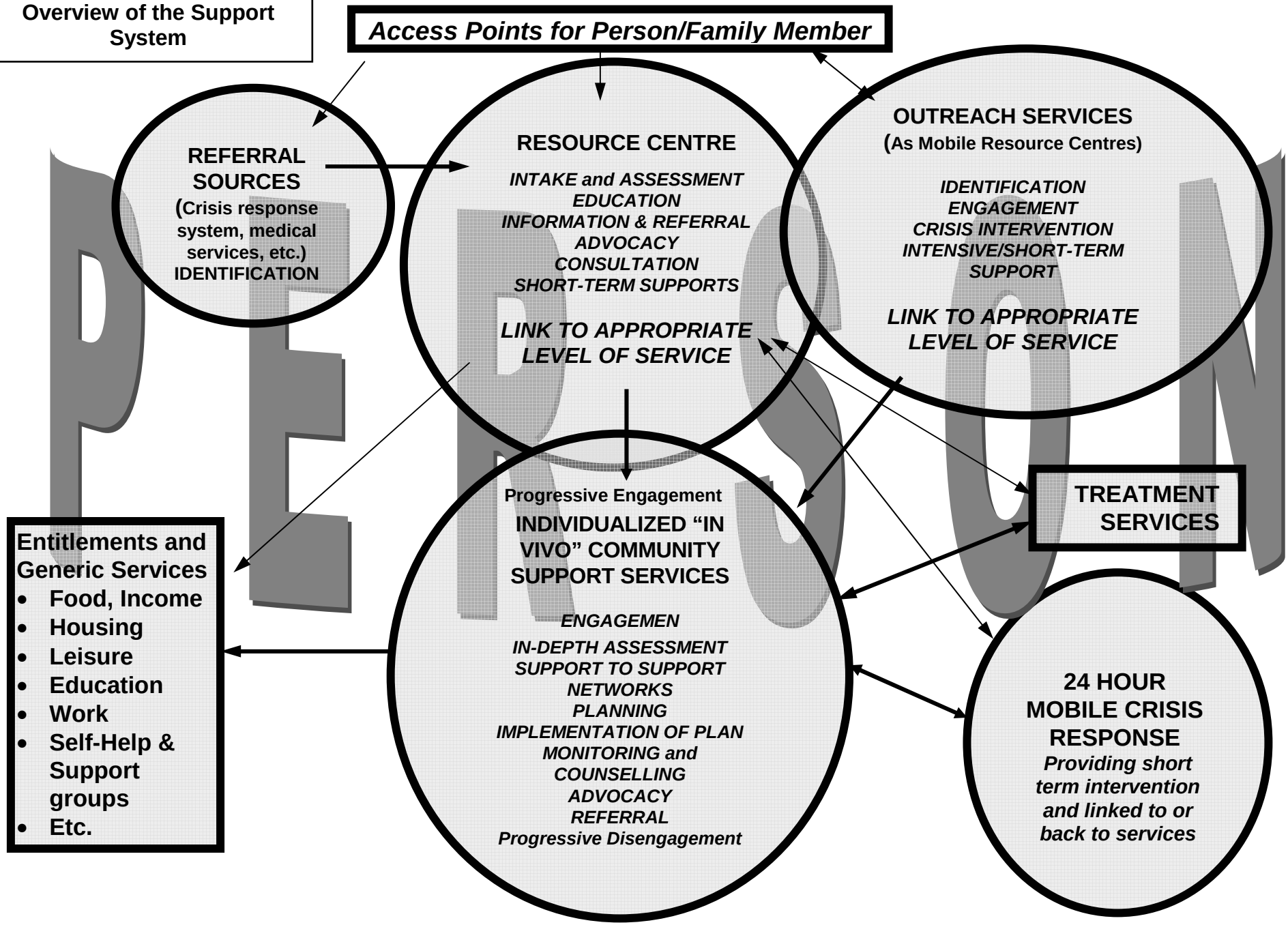
The identification of an appropriate level of service must be based on the individual's experience at any time and titrated to their changing needs over time. The flexible, continuous, and integrated system that would support the smooth movement from one level to another as required, is graphically represented below in Figure 2.

Table 2 describes a flexible scale of supports for people with severe and persistent mental health problems. This framework permits movement to a more or less intensive level of support, as needed. Utilizing such strategies as the "Extended Support Team" and "Case Mixing" (both described below) a person can move between levels of individualized, "in vivo" community support without needing to become reacquainted with a new worker or team of workers. Such continuity is in keeping with the concept of "continuity of care" articulated above.

It should be noted that each increasing level of support also incorporates the less intensive level(s) above it on the scale.

[25] Ibid. p. 9.

Figure 2
Overview of the Support System



Increasing Levels of Support

Table 2 INCREASING LEVELS OF SUPPORT SCALE

FUNCTION	DESCRIPTION	INDICATOR	CORRESPONDING SERVICE	CHARACTERISTICS OF SERVICE
Information and Referral **Level 1.**	The person is relatively aware of his/her needs and is coping fairly well with his/her mental health problems. Information and Referral services assist him/her to identify and link with required services and supports.	Some people who are aware of their areas of need simply require information that will assist them to access community and therapeutic services to help them improve their quality of life.	The person receives information and referral to services and supports that meet his/her requirements (e.g. information and referral to support groups, self-help groups, psychiatric services, therapists, supported housing, supported education/employment; leisure or educational opportunities, etc.)	Service is offered in a community-based facility that is accessible by phone or through "walk-in". It is generally offered on a 9 a.m.-5 p.m. basis, and is staffed by volunteers and paid staff. Staff or volunteers are matched to the person based on the intensity of need or the complexity of the situation.
Information and Referral **Level 2**	More extensive exploration is needed to assist the person to identify the generic or specialized services and supports which will assist him/her to cope better with mental health problems, or to experience increased quality of life.	The person expresses a need for services or supports but is unsure of what is needed. The person and/ or family members may be experiencing distress due to the unresolved issue.	Service includes a detailed exploration of the situation and the barriers that may be experienced in resolving the problems identified. Suggestions are made regarding the range of services/supports that might meet the need, and assistance is offered to access them.	Service can be offered on a call-in or walk-in basis. Staff may also conduct a home visit if the situation requires that an assessment be done "in vivo".
Advocacy	Advocacy is provided on a singular or short-term basis to a person who is experiencing barriers in accessing basic needs or entitlements.	The person requires assistance in accessing basic needs or entitlements. Lack of supports at this time may result in an exacerbation of mental health problems or decrease in quality of life.	Staff advocate on the person's behalf to ensure that the basic need or entitlement is made available in a timely fashion.	Staff person is available to do what is necessary in order to meet the need and to reduce or avert a crisis situation. Service is offered in a facility or "in vivo" as required.

Table 2: Increasing Levels Of Support Scale (continued)

Increasing Levels of Support ↓

FUNCTION	DESCRIPTION	INDICATOR	CORRESPONDING SERVICE	CHARACTERISTICS OF SERVICE
Education	Through individual or group efforts, a person with a mental health problem receives education or skills training in a particular life domain in order to achieve increased wellness or greater independence.	The person requires education, life skills or self-care skills teaching, which are independent of larger goals, in one or more life domains. The lack of such service could exacerbate the minor or moderate problems that indicated such educational needs.	Education is offered to a person and/or family about diagnosis, treatment options, relaxation skills, coping skills, communication skills, and other related issues.	Group education is offered within a facility by staff or trained volunteer. A staff "in vivo" as circumstances dictate can offer individualized education.
Intermittent Consultation and Support	On an unscheduled basis, the person receives assistance face-to-face or over the phone to deal with interpersonal issues, budgeting, etc. The problem is often uni-dimensional and, thus, would not indicate more intensive service.	The person, often either not a candidate for more intensive services or a former recipient of more intensive services, requires intermittent supports to deal with distressing but non-critical issues; lack of such supports could exacerbate the situation.	Staff are available to problem solve with the person on an as needed basis around the particular problem.	Service would be offered by staff over the phone, in a facility or "in vivo" as circumstances dictate.
Outreach Services	Identification and support of persons with severe and persistent mental health problems, who, due to social or individual factors, would not seek services on their own and who, without some intervention, would be in serious jeopardy.	The person, often homeless or socially/geographically isolated, does not seek services on his/her own, nor does s/he have the natural supports that would seek out such services.	Staff identify persons unlikely to seek out assistance on their own and offer supports and services to them in a non-intrusive way. Basic needs are addressed prior to the exploration of more complex problems.	Staff is available in settings and situations in which such socially isolated people may be found, such as hostels, jails, drop-ins or the "streets". Generic service providers, police, etc can refer the person to outreach worker.

Table 2: Increasing Levels Of Support Scale (continued)

Increasing Levels of Support

FUNCTION	DESCRIPTION	INDICATOR	CORRESPONDING SERVICE	CHARACTERISTICS OF SERVICE
Individualized "In Vivo" Community Support **Level 1**	Meeting with the person in the community on a regular (biweekly or monthly) basis, a worker assists the person to schedule appointments, deal with non-critical issues, etc.	Based on a personalized plan it is determined that: The person needs assistance to coordinate services, communicate with service providers or deal with ongoing, distressing but non-critical personal problems, and/or The support network requires intermittent support to assist the person to coordinate services, communicate with service providers or deal with ongoing, distressing but non-critical personal problems.	A personal plan is created in collaboration with the person and with the services and supports that are required. Regularly scheduled meetings assist in the identification or anticipation of barriers and indicate the level of coordination necessary to overcome such barriers.	Staff person offers such a service "in vivo".
Individualized "In Vivo" Community Support **Level 2**	Brief but intensive supports to deal with specific problems. Approximately 1-10 hours of intensive assessment, planning and assistance in implementing the plan. Assistance is available through the support worker or through deployment to paraprofessional staff and/or volunteers.	Based on a personalized plan it is determined that: The person needs short-term supports to achieve goals in one life domain (For example, short-term but intensive supports to find new housing) and/or The support network needs brief but intensive support to assist the person to attain goals in one life domain.	Intensive but short-term supports are required to assist the person to access treatment, or search for housing, for example. If required, the person is assisted to determine preferences, and (s/he and his/her natural supports are provided with assistance to acquire such treatment or housing.	Provided "in vivo" by staff, at a time that corresponds with the need. Staff person ensures that the necessary support is still in place after the actual service is completed.

Increasing Levels of Support

Table 2: Increasing Levels Of Support Scale (continued)

FUNCTION	DESCRIPTION	INDICATOR	CORRESPONDING SERVICE	CHARACTERISTICS OF SERVICE
Individualized "In Vivo" Community Support **Level 3**	Incorporating all the functions of individualized community support services; this level of support necessitates the sole involvement of a Community Support Worker on a weekly basis.	Based on a comprehensive and personalized plan, it is determined that; regular assistance is required to achieve goals in one or more life domains and/or; The person needs regular assistance to ensure that basic life needs are met, access needed services and entitlements, keep appointments and learn skills related to such goals, and if; Existing support networks are able and sufficient to support the person in such an intensive fashion.	The person receives moderate levels of support to create a personalized plan that meets needs in one or more life domains (housing, treatment, education, employment, legal, income, etc.). The person requires weekly support and/or skills teaching to implement plan. Family members also receive intermittent supports, if indicated.	The staff person is available once per week (approximately), meeting the person wherever required (home, work, school, social setting) to provide the support necessary to implement the personalized plan. The worker is also available on a more intensive level if needed, titrating supports to life circumstances as required.
Individualized "In Vivo" Community Support **Level 4**	Incorporating all the functions of individualized community support services; this level of support would necessitate the involvement of a support worker on at least a weekly basis, with more regular, even daily assistance from paraprofessional staff and/or volunteers.	Based on a comprehensive and personalized plan; The person needs more intensive assistance to achieve goals in one or more life domains and/or; The person needs more intensive assistance to get basic life needs met, access needed services and entitlements, keep appointments, and learn skills related to such goals, and if; Existing support networks are unable/insufficient to support the person in such an intensive fashion.	The person receives more intensive supports and services in order to meet goals in various life domains. These life domains would include, but are not limited to, housing, treatment services, transportation, income, basic needs and entitlements, education, employment, leisure and recreation, and/or assistance in establishing and or enhancing support network. Support network also receives supports.	The staff person works extensively with the person to create a personalized plan to achieve needs and goals in more than one life domain. Staff person is also available on a more frequent basis as required. Paraprofessionals and/or volunteers work with the person and social network to implement this plan. This level of support is offered on a time limited and task specific basis.

Table 2: Increasing Levels Of Support Scale (continued)

Increasing

FUNCTION	DESCRIPTION	INDICATOR	CORRESPONDING SERVICE	CHARACTERISTICS OF SERVICE
Individualized "In Vivo" Community Support **Level 5**	Incorporating all the functions of community support services, this level of support would necessitate the involvement of a support worker on a daily basis, with assistance from paraprofessional staff and/or volunteers with an around-the-clock involvement if indicated.	The person's safety may be at risk due to inability to secure basic life necessities and/or; There is an extreme risk of exacerbation of mental health status and if; Existing support networks are unable/insufficient to support the person in such an intensive fashion.	same as Level 4	Supports are available on a 24 hour per day, 7 day per week, 365 day a year basis (24/7/365) as necessary. The support worker may be involved daily, with adjunct supports being offered through paraprofessionals and volunteers as indicated.
24-hour Crisis Response	24-hour crisis line, with mobile team availability. Mobile team can respond to immediate needs related to treatment, basic needs, or other immediately resolvable difficulty. Mobile team is involved usually for only short periods of time, with appropriate linking to other components of service system.	The person is in need of immediate crisis response service; Lack of such service will result in exacerbation of the situation with the potential of hospitalization, harm to self or harm to others, loss of housing, etc. If the person has an identified personal support worker, use of the crisis response team is indicated in crisis plan.	Whether by phone or through the involvement of a mobile team, short-term crisis response is based on a pre-established crisis plan if the person is already a recipient of support services from any aspect of the service system described above. The person is then linked back to this level of service, with, recommendations for increased supports, if indicated. If the person is new to the service system s/he and/or family members are linked to Resource Centre for more detailed assessment.	Crisis line or mobile team is available on a 24-hour per day basis to persons receiving any of the levels of support described above. Available on a 24-hour basis to persons newly identified by self or others as experiencing a crisis related to their mental health and needing immediate interventions.

Utilizing such a scale, and recognizing that people with severe and persistent mental health problems may require movement between less intensive and more intensive levels of support, allows for the matching of resources with identified needs and desired outcomes (i.e. a process of progressive engagement and progressive disengagement). Multifaceted approaches to understanding the person's situation must incorporate professional and personal evaluation of both need and desired outcomes.

The goals and objectives of this system are targeted to outcomes that correspond to the components of quality of life as described, for example, by Carling. [26]

The components of the seamless and integrated system of support are detailed in the next sections.

A. THE RESOURCE CENTRE

The **Resource Centre** acts as the central entry point to the mental health system in any District or Region, as population and geography demands. It provides a welcoming environment, accessible by telephone or by "walk-in", where staff and volunteers assist people with mental health problems and/or their family and friends, to access the wide variety of services, supports and resources that will contribute to timely, positive outcomes. The Resource Centre can be viewed as a "one-stop shopping centre" for a person's mental health needs.

The Resource Centre function needs to be implemented in a manner that reflects geographical needs and diversity. Other "centres" which may operate under a different name may provide a functional equivalent to the Resource Centre. The Resource Centre may not always be an actual place due to the population distribution in a particular region, but there should always be a clear method of access (e.g. by phone or other technological methods). In areas where population distribution and distance impede access to a physical centre, a strong Outreach function is indicated. As described below, the Outreach function has the capability of operating as a mobile Resource Centre.

The specific functions to be delivered within the overall function of the Resource Centre are:

INTAKE AND ASSESSMENT: The initial function of the Resource Centre is to assist the person to determine the level of support or service that corresponds with the presenting needs, and with the desired outcomes. This ***Intake*** process requires that an ***assessment***, which may take more than one visit depending on the complexity of the situation, be conducted with the person and his/her support network.

EDUCATION: Linking ***education*** to the intake process allows the person and members of the support network to make informed decisions about the course of action to be taken. A person coming to the Resource Centre on his/her own may have detected that there is a mental health problem early in its course. In this context, education can be preventative. If the person is referred from medical, in-patient or crisis response systems, s/he may have received a diagnosis. Education regarding this diagnosis and the lifestyles that can assist in dealing with

[26] Flanagan, J. C. (1978). A Research Approach to Improving our Quality of Life. *American Psychologist*, 33, 138-147. as quoted in Carling, op cit. p. 66.

and overcoming the related problems, either one-to-one, or together with family members or friends, can de-mystify what is often a frightening experience for all involved.

The Resource Centre can also play a role in ***public education*** and in keeping professionals up-to-date regarding interventions, theories and advances in their ongoing work. Public education efforts have made great strides over the decades in de-stigmatizing mental health problems and in creating an understanding and caring community for people. Much work remains to be done, however, and the successful support of people with mental health problems in the community will require *ongoing education* of the public. This **public education** function flows from the Resource Centre and informs the direct service and advocacy roles of the Centre. Finally, the role that education plays in ***prevention*** is vital in a health care system that has prevention and ***early identification*** as a high priority. Educating the public regarding the signs of stress, depression, anxiety and other more severe mental health problems can play a vital role in a re-organized mental health system in Ontario.

INFORMATION AND REFERRAL: Providing **information and referral** to people who are experiencing distress is not simply a matter of relaying phone numbers or addresses or even the names of contact people. The assumption that simply providing such information is sufficient is the weakness of the pure brokerage model of case management, often performed from behind a desk.[27] People who are experiencing severe disability as a result of a mental health problem need assisted or supported information and referral services, as do their distressed family members. Workers or volunteers in a Resource Centre will assist a person by:

- providing a range of options that will assist the person to meet his/her needs
- educating the person regarding the potential outcomes of any choice that might be made
- assisting the person to make a choice that reflects his/her personal preferences while achieving the desired outcome
- placing a telephone call on the person's behalf, if necessary
- accompanying the person to appointments, or to services and supports that might be difficult to access or intimidating to utilize
- assisting the person to fill out forms, and to deal with barriers.

Everything that is done in the Information and Referral function must be guided by a commitment to **Advocacy.**

ADVOCACY: Assisting people who are disabled due to severe mental health problems to access and sustain entitlements and to meet basic needs (such as housing, income, medical care, food, etc.) is extremely important from the perspectives of both service provision and prevention. Securing the resources necessary to meet basic needs can be an overwhelming task. Ensuring that people with mental health problems can access the various systems that they need to achieve the outcome desired is a vital role of any service. From a prevention perspective, assisting the person to get the right service at the right time to meet a pressing need may be all that is necessary to prevent relapse or deterioration of quality of life. Furthermore, as long as people with mental health problems experience stigma and misunderstanding, there will be a need for advocacy to ensure that equal access is guaranteed. Along with this basic **Advocacy** is the function of **Rights Advice**. People with mental health

[27] cf. Baker, F. & Intagliata, J. (1992) Case Management. In, R. P. Liberman, (Ed) *Handbook of Psychiatric Rehabilitation*. MacMillan: New York. p. 215.

problems and their families need to understand their legal rights and responsibilities under the various pieces of legislation that apply to them.

SHORT TERM SUPPORTS: As described in **Table 2**, the appropriate level of support for some people is that of ***Intermittent Consultation and Support*** either in person or over the phone. The ability to check in on a periodic basis can assist a person to sustain his/her quality of life without the intensive supports that a more comprehensive service would provide. Again, the absence of such support could eventually necessitate the provision of more intensive community-based service or even precipitate a crisis and a hospitalization.

LINKAGE TO APPROPRIATE LEVEL OF SERVICE: Linking to an appropriate service or support is a vital function of the Resource Centre. Linking could occur to a wide variety of services and supports available in the generic community, or to mental health specific or other specialized services. This function is made possible by the existence of a continuously updated database of generic and mental health resources that serves as a foundation for such referrals.

The ***Community Links*** Database developed by the Canadian Mental Health Association Branches in London-Middlesex and Waterloo Regions is an example of such an extended Resource Database. Through the use of this database people can be referred to:

- Self help groups, both mental health specific and those focused on other issues, such as single parenting, survivor groups, addictions etc.
- Support groups, led by professionals, for such problems as smoking cessation, anger management, post-partum depression, etc.
- Counsellors, therapists and psychiatrists, both private and publicly funded, with their various specialties,
- Emergency services such as shelters, food banks, etc.
- Other specialty services or mental health services designed to meet specific needs.

The ***Community Links*** database cross-references many fields to ensure that the service or support is appropriate to age, gender and need, and accessible, by cost, language and geography, and through such accommodations as wheelchair accessibility.

The use of technology would ensure that a true provincial system of mental health services and supports is established. Consumers and family members could utilize a single 1-800 number throughout the province, which would be electronically routed to the local Resource Centre, allowing for true access to services.

THE RESOURCE CENTRE AS INTAKE TO OTHER COMPONENTS OF THE SYSTEM: The Resource Centre performs an additional function in linking people to either the appropriate level of individualized community support services or to other components of the (mental health or generic social service) system, such as psychiatric services, housing, income and food, leisure opportunities, crisis response services, self-help and peer support groups.

Components of service that are of specific importance in the mental health system[28] are as follows:

[28] Palmer, Henry & Carling, Paul (1997). *Developing an Implementation Model for Community Support Services in Ontario: An analysis of Policy documents and Suggestions for Next Steps*. (unpublished document prepared for CMHA Ontario Division) The Centre for Community Change through Housing and Support: Burlington, VT.

- **Support Coordination:** Along with the generally accepted functions normally attributed to case management, support coordination also provides assistance in developing and maintaining relationships, promoting interaction with the wider community, promoting a large spectrum of involvements, and actively fostering interdependence. These concepts are consistent with the health determinants outlined in the CMHA National Office's ***Community Resource Base***.
- **Housing support**: The provision of "in vivo" housing supports, the development and implementation of home ownership options, and the provision of tailored interventions designed to promote the "goodness of fit" between a person and the housing of his/her choice are important considerations in providing this component of service.
- **Supportive Employment**: Increasingly, employment services are being provided in the generic vocational rehabilitation arena. Attempts to normalize job acquisition while recognizing and addressing the need for individualized support are being promoted. There is also recognition that employment outcomes should be more closely connected with quality of life indicators, than with data such as "number of days active in paid employment".
- **Supportive Education**: Progressive educational facilities have begun to develop attitudes and practices which recognize the capacity of individuals with psychiatric disabilities to thrive in educational programs which are of interest to them and which are connected with improved quality of life variables. Practices that promote inclusion in normalized educational settings heighten diversity while adding value to learning environments.
- **Access to Treatment**. Assistance to access treatment services, especially specialized services for those who have concurrent addiction problems, those who are survivors of trauma, the frail elderly, etc., is important. People who most need treatment services often have little awareness of what is available and/or have difficulty accessing them.
- **Treatment Education**: Family and consumer education programs developed in recent years focus on assisting people to receive up-to-date information about all aspects of care. An essential component of these educational efforts requires that people who use services and their families become familiar with their rights under the *Mental Health Act* and other pertinent pieces of legislation.
- **Crisis Prevention and Intervention**: This is focused on both individual service and systems initiatives. On the level of individualized service, crisis plans are utilized increasingly to assist in crisis prevention. On a systems level, the creation of 24-hour crisis response teams, partnership with other service providers, and the development of consumer-run alternatives will assist in effective and timely crisis intervention services.

Having a thorough understanding of the person's needs and desired outcomes provides for an uninterrupted transition into individualized community support services and other services, **when indicated**. Furthermore, if the service is not immediately available due to waiting lists, the Resource Centre ensures that the person is not unsupported. Immediate needs are addressed and urgent referrals are conducted through the Resource Centre so that the person is not left vulnerable to crisis.

B. OUTREACH SERVICES

The Ministry of Health's policy on the subject of effective outreach services to meet the needs of the homeless and socially isolated has recently underscored the importance of outreach to these groups. This policy reflects the recommendations forwarded by groups such as the Canadian Mental Health Association[29] and (in the United States) the Federal Task Force on Homelessness and Severe Mental Illness.[30] Among the many recommendations of such groups are those regarding **Outreach services** to individuals who are homeless or socially isolated and/or who would experience inordinate difficulty in identifying that they have needs and/or in accessing the resources required to achieve desirable outcomes in the fulfillment of these needs. Recommendations that focus on Outreach services include:

- The gathering of data on the extent of homelessness and mental health problems in communities
- The expansion of outreach efforts to ensure that benefits and services are available to such groups of people
- The review of eligibility and application processes for programs and services to ensure that they do not inadvertently exclude or discriminate against homeless people with severe mental health problems
- The review of existing laws, regulations, and policies and the modification thereof to ensure access of these groups of people to appropriate services and to eliminate unnecessarily punitive laws (which tend to increase resistance)
- The protection of and advocacy for the rights of such groups of people.[31]

In Ontario, we are also aware of the need to provide outreach services to people in the correctional system who experience severe mental health problems, as well as to people with mental health problems in rural and remote areas, many of whom experience similar accessibility issues.

Although both advocacy for and the creation of such outreach services are increasing, there is little knowledge about what constitutes effective outreach services. In this framework, **Outreach Services** are constituted as Mobile Resource Centres, providing all the services of a Resource Centre (***INTAKE and ASSESSMENT, EDUCATION, INFORMATION & REFERRAL, ADVOCACY, CONSULTATION, and INTENSIVE SHORT-TERM SUPPORTS)*** while paying specific attention to the functions that are characteristic of outreach services ***(IDENTIFICATION, ENGAGEMENT,*** *and* ***CRISIS INTERVENTION).*** Outreach staff persons rely on the Resource Centre for current and specific information about the resources available, allowing them to provide needed information to those who are homeless and socially isolated.

While traditional definitions of outreach services were focused on a brokering function, an increased awareness of the needs of and barriers faced by homeless and socially isolated people who have severe mental health problems indicates the need for a definition that recognizes such needs and barriers. One such definition recently identified in the literature on this subject defines outreach services as:

> *"Workers contacting homeless (socially isolated) people in non-traditional settings for the purpose of improving their mental and*

[29] Canadian Mental Health Association, Ontario Division (1997). *Position Paper Respecting Mental Health and Homelessness.*

[30] Leshner, Alan P., Chair of the Federal Task force on Homelessness and Severe Mental Illness (1992). Outcasts on Main Street. Washington.

[31] Ibid. p. 70.

physical health, social functioning and/or utilization of human services and resources."[32]

In this framework, the effectiveness of an outreach service is focused on the adaptation of various community support functions to meet the specific cultural and personal needs of people who are homeless or socially isolated. The values of "street culture" must always be a central consideration of outreach staff; the unilateral introduction of professional norms will not be accepted in a culture that is characterized by personal autonomy, self-reliance, caution and skepticism towards professional helpers[33]. Morse *et al*. [34]speak to various approaches and functions that are inherent in an outreach service and which are consistent with the **ACCESS** Conceptual and Theoretical Framework (described in Part I). These approaches and tasks are as follows: (NOTE: These functions do not necessarily follow in a consecutive manner, but rather are continuous and overlapping.)

Continuous Relationship Approach: Recognizing that neither a brokerage approach nor an approach that focuses on social controls is likely to be successful with people who require outreach services, **ACCESS**'s preferred outreach approach is that of establishing a continuous relationship. This approach recognizes that a labour intensive and often personally challenging relationship building process is key to overcoming the distrust and isolation often characteristic of the people in such groups, and to establishing the trusting and meaningful relationship that is required in order to achieve desired outcomes.

Contact and Credibility: Outreach services must be offered where people are. Credibility will be established only when outreach staff "blend into" the staffing patterns of non-threatening milieus such as drop-ins, soup kitchens, shelters, etc. "Blending in" must relate to cultural norms, comfort with such settings (with their cigarette smoke, noise, smell, etc.) and most of all, attitudinal proclivities.

Identification and Engagement: While paying attention to the more blatant behavioural manifestations of mental health problems (such as those based on delusions and hallucinations) is the simplest way of identifying need, workers must also be aware of behaviours that might mask mental health issues. These include withdrawal, chemical dependency and/or criminal activity. It is often necessary to spend time with people to determine whether there is an underlying mental health problem. For such people premature exclusion is a disservice. Many people who are homeless and have mental health problems have had negative experiences with the mental health system. Thus, engagement is often a challenging venture. A balance between focusing solely on assertive treatment, on the one hand, or on being too passive, on the other, can be achieved by assisting people to meet day-to-day needs, thus providing the foundation for a trusting relationship. That same focus on day-to-day needs must continue once the relationship is established. To do otherwise (to serve the more ambitious agenda of the support worker for instance), will result in repeated withdrawal on the part of the person.

In this light, the following principles should guide programs that offer Outreach Services:

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[32] Morse, Gary A. *et al*. (1996). Outreach to Homeless Mentally Ill People: Conceptual and Clinical Considerations. *Community Mental Health Journal*, 32, (3). p. 263.
Kline, J. D. (1993). Testing the Limits: Policy Modifications and Demands of Emerging Special Populations. In Harris and Bergman (Eds.) *Case Management for Mentally Ill Patients*. op. cit. p. 240.

[34] Morse et al. op. cit. pp. 263-273.

- a person's right to housing and other entitlements should never be tied to treatment compliance
- managers must assist staff to "shift the threshold of risk", and, as much as possible, respect personal choice while diminishing instances of unilateral interventions.[35]

Assessment and Planning: Informal assessment which flows from the engagement process and focuses on understanding the person's needs, preferences and outcomes as a base for planning is most effective. Thus, obtaining clothing or assistance with income may be more important for the person than undergoing a psychiatric assessment. People who are homeless or socially isolated will most often not engage in formal "pencil and paper" assessments. A focus on meeting immediate needs, intervening in crises, slowly establishing connections with others who could act as members of social networks and an emphasis on the incredible strength and resiliency of the person is indicated.

Ongoing Service Activities: The establishment of a trusting relationship is an ongoing process, and must be an ingredient in any service linkages that occur. Links to medical, psychiatric, income maintenance, housing, food and other entitlements, government offices for documentation, etc., must be undertaken with the person's permission and must often be done either with or on behalf of the person. Assisting him/her to overcome the bureaucratic hurdles to receipt of entitlements may take repeated efforts.

Special Considerations: The pursuit of services and resources on behalf of the homeless or socially isolated in this framework of outreach cannot depend on perceived readiness for services as would be judged by the possession of social or daily living skills. These issues must be pursued concurrently or subsequently with a focus on attaining the needed resource immediately upon the request of the person, whenever possible. Advocacy may be required to ensure timely access to a service without which the person's life or well-being may be endangered.

Other special considerations that must be built into all outreach functions include:

- The careful instilling of hope in a person who may have lost hope for the future;
- The promotion of autonomy on the part of the person and the careful creation of a support network that will assist in buffering against the stressors of life (Ecological Perspective);
- Organizational supports to outreach workers who are at risk of "burning out" in light of the incredible need to which they respond;
- The assumption of a long-term perspective, especially in the face of resistance to accepting help;
- The recognition that those who remain opposed to treatment can be helped in other important areas of their lives;
- The need to intervene concurrently with addiction problems, out of the recognition that substance abuse is often a way of coping with life stressors. The alleviation of some of the stressors can act as a motivation for behavioral change.

Although this description of **Outreach Services** has focused almost exclusively on those who are homeless and/or socially isolated, the provision of outreach services to other high needs groups is also indicated. Studies have demonstrated that the prevalence of mental health

[35] Rowe, Michael, Hoge, Michael A. & Fisk, Debbie (1996) Critical Issues in Serving People who are Homeless and Mentally Ill. *Administration and Policy in Mental Health*, 23 (6) pp. 555 - 565.

problems among inmates of correctional facilities is extremely high.[36] The need for culturally sensitive outreach services to other groups (especially to ethnic and racial minorities and those for whom English is not a first language) who may not, of their own accord, seek mental health services, is also very real.

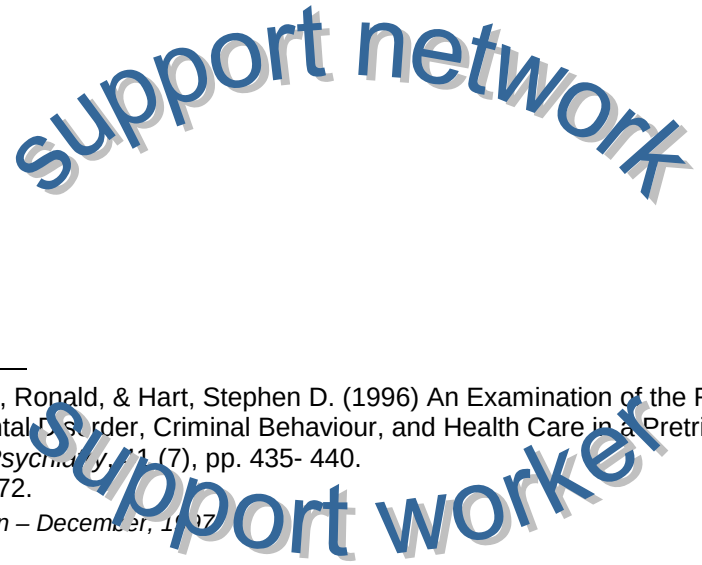
Linking to Follow-up Community Support Services: People who are initially served through Outreach services often require ongoing support. The following considerations must be taken into account when linking to long term, individualized ("case management") services:

- An expectation of eventual transition to long term individualized services early in the engagement process
- The active involvement of the person in the referral process, and attention to the personal concerns that could result in resistance to such a referral
- Initial assistance to the Community Support Worker in his/her attempts to engage with the person, through information sharing and technical and emotional supports;
- The provision of follow-up services on a gradually declining basis to both new staff and to the person receiving support.[37]

C. COMMUNITY SUPPORT WORKERS

Although there is increasing recognition that the labours of an unaided Community Support Worker may not be sufficient to address more complex needs, fidelity to the conceptual premise of *"continuity of care"* demands a single point of accountability through the assignment of responsibility to a single worker. Various strategies to extend the potential of community support services have been put forward in the recent literature. The concept of "continuity of care" provides an evaluative framework for measuring such innovations. In order to adequately respond to the needs of people with severe and persistent mental health problems, while satisfying the prerequisites of "continuity of care", **ACCESS**'s community support service framework includes the concept of an **Extended Support team**.

Although based on the firm belief that decision making power in the community support venture is to be found in the **CORE Team**, i.e. the *Person, his/her Support Network and the Community Support Worker*, it is also recognized that there may, nevertheless, be a need to involve other services, and other workers at a paraprofessional level and volunteers, in order to fully achieve desired outcomes. Other supports and services (the Extended Support Team) are held accountable through the CORE Team, graphically represented in Figure 3.



[36] cf. Zapf, Patricia A., Roesch, Ronald, & Hart, Stephen D. (1996) An Examination of the Relationship of Homelessness to Mental Disorder, Criminal Behaviour, and Health Care in a Pretrial Jail population. *Canadian Journal of Psychiatry*, 41 (7), pp. 435- 440.

[37] cf. Morse *et al.* op. cit. p. 272.

P E R S O N

Figure 3: The CORE Team

Although the task of supporting a person and his/her support network can be a shared responsibility of the Extended Support Team, there are certain functions that must be centralized in the Community Support Worker in order to guarantee "continuity of supports". These functions are as follows:

Engagement[38]: Engagement is seen as a separate function in this framework of community support. It is here that the relationship, so vital to any helping effort, is built. The Community Support Worker has three primary goals in this stage:

- First, the education of the newly referred person to the nature of this value based community support process.
- Second an effort to describe how involvement in the process could have impact on the life of the consumer, and on his/her capacity to achieve his/her needs and desires.
- Finally, the creation of an atmosphere that allows the participants in the process to get to know each other. This cannot be achieved if the emphasis is on completing forms or eliciting a psychiatric history. By sharing some personal information about him/herself (i.e. Rogerian Self Disclosure), the worker models an appropriate relationship skill.

Engagement is fostered by assertive outreach and strongly adheres to the value of self-determination. The worker will try to instil within the person being supported a commitment to leading the community support process. This approach is enabled by recognition of the person's strengths. Each initial meeting is unique, but first and foremost, Community Support Workers should convey to the person that they are truly committed to them. Engagement in **ACCESS'**s Framework of community support also includes meeting, engaging with and establishing supportive relationships with members of the support network, where one exists. This is based on the understanding of the CORE Team: that of the Person, Members of the Support Network and the Support Worker.

In the engagement period, meeting basic life needs and addressing other immediate concerns is essential.

Creating and/or Sustaining a Supportive Network of Family, Friends and Community members: The importance of increasing the social support network of people with severe and

[38] cf. Rapp, Charles, A. (1993) Theory Principles and Methods of the Strengths Model of Case Management In Harris and Bergman and (Eds.) *Case Management for Mentally Ill Patients*. op. cit. pp. 153-154.

persistent mental health problems, and of potentiating the supportive interventions and coping responses of the network is crucial to a successful outcome.

All too often the role of family and friends is ignored. The significant and irreplaceable contribution of family members to the support and understanding of the person must be a central focus of all assessment, planning and interventions. Family support groups have long advocated for a more direct role in the working relationship. However, this role must be *balanced,* with support workers attending to the needs of family members through information, advocacy, education, assistance, support and respite.[39]

Much of the isolation that family members experience can be ameliorated by inclusion in the helping process. The development of support networks that are sufficient in size and density, the availability of a wide range of supports in such networks, and the enhancement of complementary roles will also determine network success.

The role of the Community Support Worker in increasing and sustaining the support network is clear. For those people who have no support network, or whose network is exclusively made up of professionals, a more concerted effort is required.

The role of informal supports in the lives of people with disabilities has received considerable attention in the literature, but this attention is not often reflected in practice. A variety of innovative strategies for increasing the social inclusion of people with severe disabilities have been demonstrated as being effective (e.g. Support Clusters,[40] Circles of Support[41]). In order for workers to make use of such innovative strategies, however, they and the organizations for which they work must undergo attitudinal and operational change, including:

- the modification of schedules to accommodate family relationships,
- the encouragement of and practical support for activities in naturally occurring settings, and
- the exercise of flexibility in understanding what constitute important interventions and use of time.[42]

The utilization of volunteers and other naturally occurring associations in the achievement of social inclusion has also been documented[43] and is a central feature of the Extended Support team.

Personal Planning: The Community Support Worker has responsibility for the creation of a personal plan that is to be used as the blueprint for all interventions. As basic life needs and immediate concerns are addressed from the beginning of the engagement process, Personal Planning is focused on the identification of a desired future for the person. Ideally, Personal Planning is done, as much as possible, in conjunction with members of the support network whom

[39] cf. Zirul, Doris W., Leberman, Alice A., & Rapp, Charles A. (1989) Respite Care for the Chronically Mentally Ill: Focus for the 1990's. *Community Mental Health Journal*., 25 (3) pp. 171-183.

[40] cf. Naylor, Phil. (1993) *Final Report of the Support Clusters Demonstration Project*

[41] cf. Mount, Beth (1991) *Dare to Dream: An analysis of the conditions leading to personal change for people with disabilities*. Manchester, CT: Communitas

[42] cf. O'Brien, John and O'Brien, Connie Lyle (1992) Members of Each Other: Perspectives on Social Supports for People with Severe Disabilities. IN Nesbit, Jan (Ed) *Natural Supports in school, at work and in the community for people with severe disabilities*. Baltimore: Brooks Publishing Company. pp. 17-63.

[43] Reidy, Deborah (1993) Friendships and Community Associations. In Angela Novak Amado (Ed.) *Friendships and community connections between people with and without developmental disabilities*. Baltimore: Brooks Publishing Co., pp. 351-372.

the person identifies as being important. Personal Planning incorporates the function of assessment because a holistic portrait of the person's present situation, past interests and involvements and future dreams is a central feature of this approach. Personal Planning focuses on any life domain that appears to be directly related to successful community tenure and increased quality of life.

In **ACCESS**'s Framework of a community support system, all people who use services will have a plan on file. The plan will contain the specific objectives being pursued by the Community Support Worker at any one time. This could include plans for engagement, assessment, resource acquisition, service co-ordination, etc., and should contain estimated timelines. Ideally, all people with mental health problems receiving community support services will engage in a Personal Planning process which focuses not simply on maintaining community tenure, but on creating a desirable future for and with the person and the members of the support network. Community Support Workers are held accountable through such a plan.

Personal planning extends the notion of treatment planning by incorporating the fulfillment of service and support needs into a plan that is centered on achieving valued experiences such as:

- community participation
- contributing to society and to others
- inclusion and involvement in naturally occurring and meaningful settings and opportunities
- performance of valued social roles, and;
- making choices.

While such experiences may seem a luxury, they are consistent with the types of outcomes that are identified as desirable in the ***Framework for Support***. Their pursuit forces Community Support Workers to recognize that the outcomes that are desirable for a person with severe and persistent mental health problems are consistent with the quality of life desirable for any person in society. Valued experiences, such as those described above, would be unique to each individual. The Personal Planning process is aimed at identifying the components of a desirable future for a person through

(1) knowledge of their past interests, involvements and relationships;
(2) an understanding of their present situation, and;
(3) a vision of a desired future for the person based on their aspirations, strengths and ideas.

The Personal Planning Process is one that involves all members of the **Core Team**: the person, members of the support network (or designated others if members are not available) and the Community Support Worker***. The person receiving support is at the centre of the planning process. His/her desired outcomes, identified in light of his/her hopes, dreams, and strengths, form the basis of the plan.*** The person must be involved in the decision-making and planning, and frequently plays a role in carrying out certain aspects of the plan. The ultimate goal is for the person to become one (albeit the most important) member of his/her planning group.

The members of the support network are involved in the planning process with the person's consent. Family members and friends are there to listen, help, make suggestions, and, in some cases, to take responsibility in the implementation of the plan if they so choose. Family members and friends often know the person more intimately than staff members and their

contribution is unique and irreplaceable. Their involvement in planning lends energy to the process, and allows for commitment to the plan that is ultimately created.

Personal planning in mental health services is a burgeoning idea. In the State of Washington, it has been formalized by the creation of *"The Individualized and Tailored Care Planning Field Book: Adult Consumer Planning Guide"* (Washington Mental Health Division).[44] Miles notes that, in order for personal planning to be successful, basic values such as unconditional care, family centered support and strength based service creation, as well as access, voice and ownership must have already been integrated by the service providers involved".[45] [46].

Crisis Planning: A crisis plan is a collaboratively determined set of responses to an impending or potential crisis situation. This is an important aspect of personal planning in that early intervention can minimize the often-devastating effects of a crisis on established life roles. As with overall Personal Planning, the establishment of crisis plans involves the person, the Community Support Worker, members of the support network and other supports that might potentially be involved in responding to the crisis.

Crisis planning has as its outcomes, the following:

- The identification of specific stressors that have resulted in crises in the past
- The specific identification of behavioural and symptomatic cues that indicate the onset of a crisis
- The identification of desired supports and modes of interventions
- The enhancement of self-understanding and self-determination on the part of the person
- The enhancement of the person's and their support network's abilities to interrupt the crisis cycle early in its onset
- The creation of documentation regarding strategies and decisions that will serve as a reminder to all involved.
- The strengthening of accountability by all involved
- The increased effectiveness of crisis response
- The increased satisfaction of all stakeholders with the outcome of future crises.

The Crisis plan should have the following basic information:

- The critical stressors, triggers and situations that signify the onset of a crisis cycle
- The personal changes in behaviours/symptoms that signify the onset of a crisis
- The usual stages that a crisis has taken in the past, which could well indicate the course of any future crisis
- Self-management coping techniques that have been useful to the person

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[44] Miles, Patricia. (1996) *The Individualized & Tailored Care Planning Field Book: Adult Consumer Planning Guide.* State of Washington Mental Health Division: Portland, OR.

[45] Miles, op. cit. p. 1.

[46] In Ontario, the "Discovery" approach to personal planning was created by consumers, service providers and managers of services, in conjunction with consultants, at the Canadian Mental Health Association, Waterloo Regional Branch. This individualized process has proven to be very successful in achieving the desired outcomes of many people whom the rest of the system had identified as "untreatable" or "chronic". cf. Joyce, Susannah (1995). *Discovery: Personal Planning with People who Receive Support*. The Collective for Community Action: Kitchener, ON. and Joyce, S. (1995) *Discovery: A Facilitator's Guide*. The Collective for Community Action: Kitchener, ON.

- External supports which are available to the person, beginning with the least intrusive and moving towards more structured services, as well as information about hours of availability and back-up supports
- An intervention/action plan, detailing actions to be taken at each stage of the crisis
- Relevant names, phone numbers, etc.
- Any limits to intervention that the person wishes to place on the crisis plan and the conditions that would require that such limitations not be respected
- Ideally, the signature of the person, indicating consent.

Every person utilizing the community support service will have a crisis plan on the agency file. They, and members of their support network, will also have a copy. Ideally, the plan will be created in conjunction with the person and the support network. In the event that this is not possible, the Community Support Worker will develop a crisis plan, ensure that it is on file, and inform those responsible for its implementation, in order to ensure a consistent approach to crisis intervention. Crisis plans should be updated as needed and reviewed at least every six months. Should a crisis occur in which the crisis plan was not helpful, a careful re-examination of the plan should be completed and adjustments made to deal with the factors that were overlooked.

Implementation: Although the primary worker may not be the only person involved in the implementation of the plan, it is his/her responsibility to ensure that the necessary resources, including human resources, are available and put into place to implement the plan. In the Extended Support Team structure described below, the Community Support Worker either has the ability to purchase whatever human resources are needed to carry out the plan, or has such resources available through arrangements with other services, as outlined in pre-established protocols. The Community Support Worker must be in constant collaboration with the person and the support network to ensure that all barriers are being addressed and to monitor the usefulness of the plan.

Resource acquisition is a major part of the implementation of this plan. The resources and supports required should be documented in the plan, as should the timelines involved in acquiring such resources, and the outcomes of such efforts. In the **ACCESS** Framework of service, Community Support Workers would be able to rely on information to be found at the Resource Centre regarding services and resources available in the community for the implementation of the plan.

Monitoring through Collective, Continuous Support and Collaboration:[47] The ultimate aim of this function refers to the process of empowerment, helping the person (or family members) to learn how to monitor the implementation of the plan themselves. In order to assist in sustaining the efforts of the person in the implementation of the plan, a ***collective*** of supports and supporters needs to be developed. The efforts of this collective of supporters must be ***continuous***. ***Collaboration*** refers to the third part of the monitoring function; i.e. the combined efforts of the worker, the person and the collective of supporters to help sustain the plan. There is recognition of the value of each collaborator's input. In this model, the worker is responsible for ensuring that follow-up (through ongoing consultation and collaboration) is completed. The Community Support Worker many also need to oversee and co-ordinate **Advocacy** efforts that aim at ensuring that community opportunities resources are available, accessible, adequate and accommodating.

[47] cf. Rapp, C. A. (1993) op. cit. p. 157-8.

Counselling: Another central role of the Community Support Worker involves ongoing discussions with the person around such issues as hope for the future, motivating factors, barriers encountered, etc. (Counselling). In the community support process, counselling incorporates skills of empathic communication, active listening, advice giving, self-disclosure, sharing of information and personal experience. The focus is here-now and near term (next month or so), and involves a discussion of potentials and possibilities. In this Framework, specialized counselling is referred to therapists. For example, in circumstances where problems have been identified that relate to traumatic past events, or inordinate difficulties in thinking, feeling, and behaving, an effort will be made to assist the person to access a focused therapy process designed especially to address these issues.

Gradual Disengagement: Although some individuals require community support services over a long period of time, this function entertains the possibility of disengagement for all persons who use such services. It is the role of the Community Support Worker to identify how and when gradual disengagement can occur. This disengagement is possible because of the work that has been done to create and sustain an interdependent network of supporters. As individuals begin to achieve independence and stability, as well as their desired outcomes, in the various environments in which they participate, the level and intensity of the community support relationship may be reduced. People need to know, however, that, should community support services be required in the future, those services will be available to them. The notion of gradual disengagement is one that provides for the introduction of independence, while concurrently maintaining the personal connection that is essential if persons with severe and persistent mental health problems are to maintain a reasonably high quality of community life.

Gradual disengagement also includes the function of ensuring that other supports are able and willing to take over the role previously filled by the Community Support Worker.

D. DESCRIPTION OF THE EXTENDED SUPPORT TEAM

It is through the creation of an **Extended Support Team** that the supports and services required to sustain a person in the community (minimally) and implement the personal plan (ideally) will be put into place. ***The Extended Support Team is characterized by the fact that the full team only exists as needed. The Extended Support Team increases the social network around the person and brings in service providers on an as-needed basis, titrating such involvement according to changing needs. This approach is favourable to the achievement of integration and recovery while also reducing costs, because the continuity of support is not dependent on the permanent presence of all service providers. Cost effective and continuous 24/7/365 availability is possible through the members of the Extended Support Team in a manner that is chosen by the person and which promotes cost sensitivity.***

The Extended Support Team, as illustrated in **Figure 4**, is focused on the CORE Team: the Person, the Support Network and the Community Support Worker. They are the locus of decision making. The CORE Team may designate the Community Support Worker to be responsible for the implementation of decisions in conjunction with the person/support network or through the arrangement of services as needed. Alternatively, arrangements for services

may be implemented by the person him/herself or by family members, as desired by the CORE Team. In any case, the personal plan that is the basis of service and support decisions, provides the consistency that is needed.

Other members of the Extended Support Team, including paraprofessional supports, volunteers, and purchased professional services are accountable to the CORE team either through the Person, members of the Support Network, or through the Community Support Worker as determined by the personal plan. Natural supports work in conjunction with the members of the Core Team, and are, as much as possible, supported in their efforts by the Community Support Worker. Professionals, paraprofessionals and volunteers are available as needed, with the members of the CORE Team being the constant factor. Some examples of these collaborative efforts include:

- The involvement of a paraprofessional with expertise in skills teaching, working on a scheduled basis with the person as they learn household management skills, or other skills that may be indicated by the personal plan
- The involvement of a volunteer for a determined period of time who can assist the person to become acquainted with and/or access the various leisure and recreation opportunities available within the community
- The involvement of a homecare nurse to assist with medication management or with the management of other health problems, for a period of time, as needed
- The involvement of a number of natural supports, volunteers, and/or paraprofessionals to support a person on a 24-hour per day basis, as indicated, during a time of crisis
- The arrangement of a generic educational opportunity for the purposes of upgrading or acquiring new knowledge or skills
- The regularly scheduled appointment with a counsellor or a psychiatrist for the purposes of psychotherapy or for the monitoring of the effectiveness of medication and its side-effects
- Etc.

The ongoing availability of the Community Support Worker provides the link from the CORE Team to the rest of the mental health system. ***This is a crucial concept. When family members or the person receiving support need to talk to a Community Support Worker about concerns, needs or changing life events, the presence of the Community Support Worker must be assumed. In order for this to be effective the Community Support Worker, or an identified member of the Extended Support Team, must be available to people on a 24 hour, 7 day per week basis, with clear delegation of responsibility when absences are required due to illness or vacation.***

The purpose of the Extended Support Team is to provide the supports and services that are needed to promote the recovery and community inclusion of the person and to improve his/her quality of life, as determined by the personal plan. Communication among members of the Extended Support Team is essential. Communication can take place in a variety of ways, and it should not always be assumed that the Community Support Worker would always speak on behalf of the CORE Team. While it may be the case that the CORE Team requests communication with the extended team be carried out by the Community Support Worker, it may also be the case that such communication becomes the responsibility of the person if he or she so desires.

In the event that the person decides to be the main communicator, they may also request support from other members of the CORE Team, or from peers, to do so. Family members

must also be encouraged to express concerns and ideas to the Extended Support Team. The consistency of such communication is found in the common articulation of the person plan.

More formal means of communication with Extended Support Teams may be indicated, such as the formal meetings that take place in the Support Clusters approach.[48] Because of the multiple service providers involved in the lives of people with both developmental and mental health issues, (the focus of the Support Clusters Demonstration Project), such formal communication was essential.

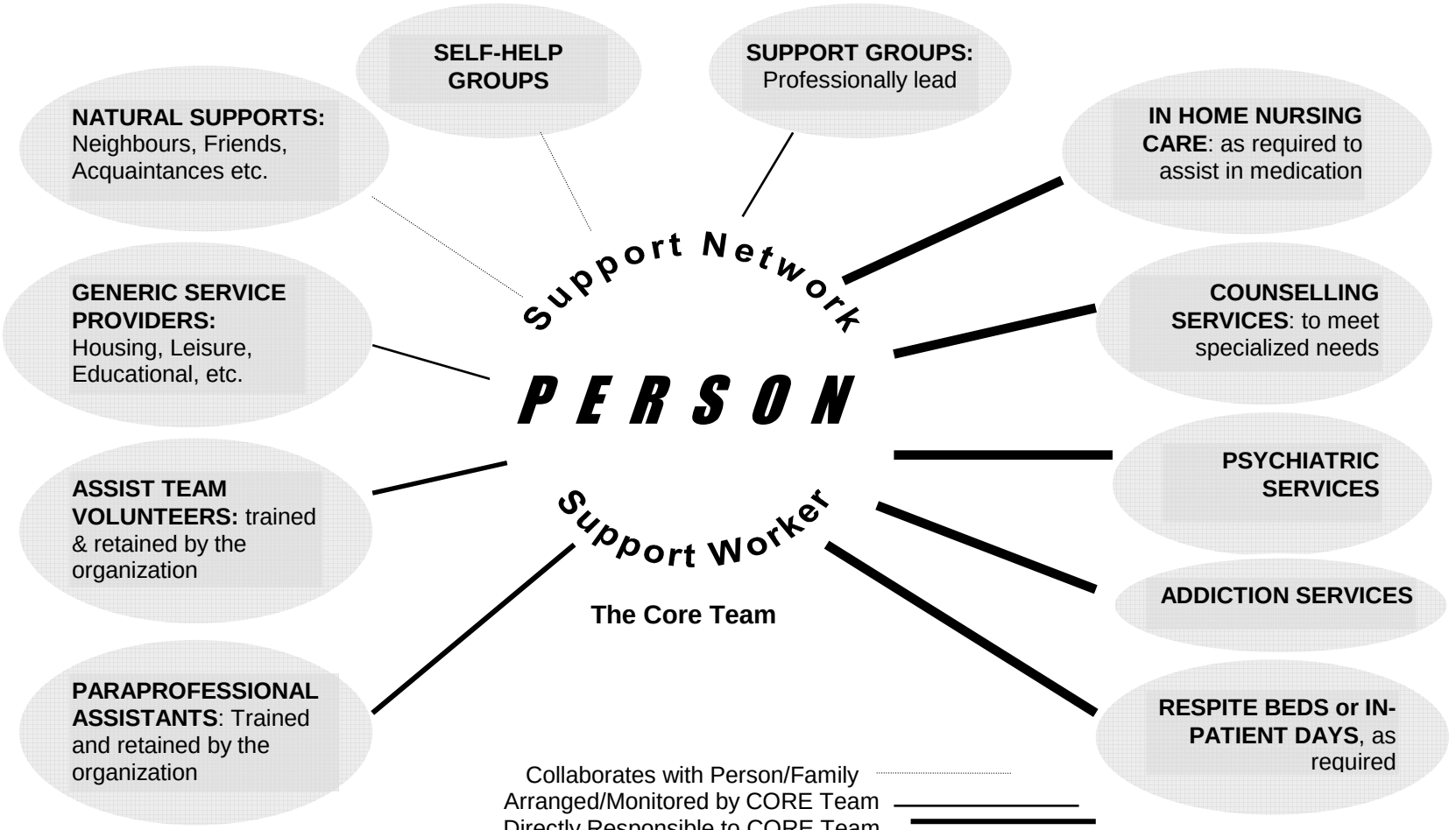
[48] cf. Naylor, Phil. (1993) *Final Report of the Support Clusters Demonstration Project*

FIGURE 4:
THE EXTENDED SUPPORT TEAM

SUPPORTS INVOLVED IN IMPLEMENTING PERSONAL PLAN

SERVICES MEETING SPECIALIZED NEEDS: MEDICAL, THERAPEUTIC

Increased levels of formality in support/service provision



OUTCOME: Community support and integration through the implementation of the Personal Plan: Work, Education, Leisure pursuits in the natural community.

OUTCOME: Medical and Emergency Maintenance with Restrictive Environments used only for brief stabilization

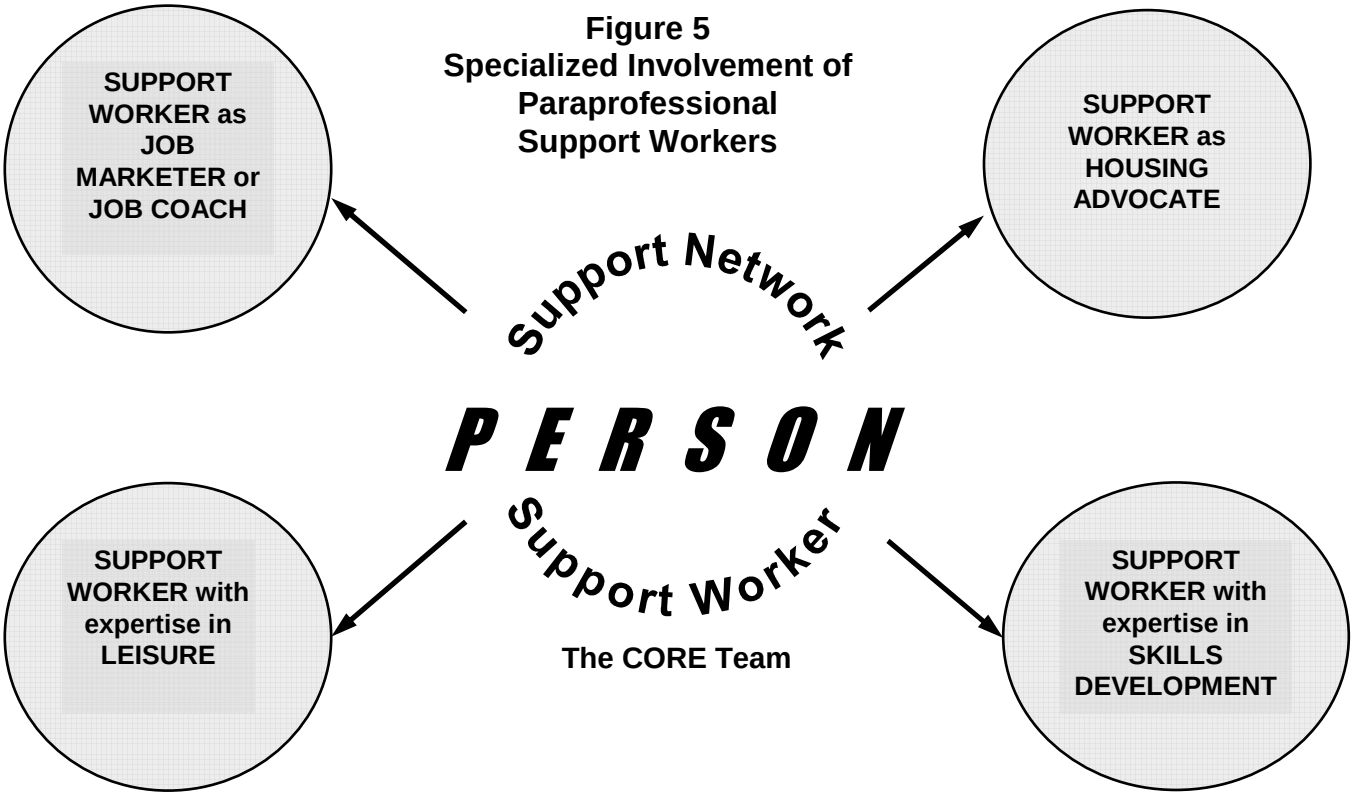
Paraprofessional Support Workers assist with day to day tasks, as assigned by the Community Support Worker. Such tasks could include providing transportation, assisting with housing searches, filling out applications, assistance with activities of daily living (such as shopping, cleaning, cooking, etc.) and support and skills teaching in various settings (home, work, school). As well, the support worker may be involved in the provision of respite services and round-the-clock supports when such are required.

The paraprofessional support worker is usually involved in a time-limited and task-specific manner, and reports back to the Community Support Worker a) if other needs make themselves apparent and b) with regards to the completion/ partial completion/ non-completion of tasks. The support worker must have the skills necessary to understand why the task could not be completed if partial/non-completion was due to barriers encountered by the person in the community.

Beyond the generic skills and knowledge required, support workers would have expertise in specific areas. In this approach, the Community Support Worker would be able to draw on such expertise to help meet the need identified in the Personal Plan, as indicated in **Figure 5,** below. Thus, in communities where housing stock is scarce and work needs to be done with landlords, a support worker with such expertise could be employed by the Community Support Worker to find and secure housing. The same may apply in areas of employment, recreation and skills teaching, etc.

Community Support Workers can also rely on the Resource Centre for its extensive information on appropriate community resources needed to implement the Personal Plan.

Figure 5
Specialized Involvement of Paraprofessional Support Workers



Assist Team Volunteers: Volunteerism has long been a tradition of mental health services. The complexity of needs presented by people with severe and persistent mental health problems who are now living in the community necessitates that volunteers be trained to

interact effectively and to detect difficulties. Volunteers may be asked by the Community Support Worker to be involved in the implementation of a personal plan when the goal requires the involvement of a person who can enhance community knowledge and comfort through his/her own experience in the community. Additionally, volunteers can play an important role in facilitating unobtrusive introduction to community opportunities and community members.

ACCESS encourages the involvement of consumers as volunteers, and recognizes that this is not only an important form of modeling for those utilizing services, but beneficial for consumer-volunteers on their own road to recovery.

The involvement of the volunteer is usually time limited and task specific. The Community Support Worker acts as back-up to the volunteer as needed, and the volunteer regularly communicates with the Community Support Worker regarding the completion of tasks. (Core competencies of the Assist Team Volunteer are described below.)

Purchased Services and Protocols: ***The use of purchasing power by Community Support Workers ensures access to needed services. It is the Community Support Worker, in liaison with the CORE team, who is in the best position to determine the person's needs for particular professional interventions and services***. While traditionally, Community Support Workers relied on advocacy to ensure access to services at the time that they were needed, purchasing power, *or at least, carefully delineated and enforceable protocols*, will ensure such access. Putting direct access to resources in the hands of the Community Support Worker will place resources as close to the person as possible while ensuring fiscal responsibility through the overseeing organization.

Through the exercise of purchasing power, Community Support Workers would have access, when necessary, to such services as:

- homecare nursing, for the purposes of dispensing medication,
- specialized counselling for those who could profit from individualized or group therapies,
- the full range of psychiatric services, including psychiatric consultation for medication adjustment and monitoring,
- addiction services, and
- respite beds or inpatient stay.

The worker, either through purchasing arrangements or through pre-established protocols, would access these services. Incentives could be created to ensure that the method used is the most cost effective and balances the need to utilize the least intrusive response with concern for the person's safety and good health.

The purchase of such services must be overseen by the organization, to ensure both fiscal responsibility, and the delivery of timely and effective interventions which ensure the person's safety and well-being. A values-based understanding of such purchasing power would be the primary requirement for organizational accountability.

DETERMINING SIZE AND RANGE OF "CASELOADS": Caseload sizes should range from 15 - 20 persons at any one time. Through ***"case mixing"*** the Community Support Worker should be able to provide services to some (30%) who require very intensive community support (Level 5 Individualized Community support services as described in **Table 2**), some people (40%) who

require mid-range intensive services (Level 3-4 Individualized Community Support Services) and others (30%) who require a less intensive community support service (Level 1-2).

> It is both positive and productive to mix caseloads with the aim of achieving some balance among those patients *(sic)* who require the most intensive interventions and those who make lesser demands on the Community Support Worker's availability.... Caseloads can be balanced even when the target population consists exclusively of long term mental patients *(sic)* for some of those individuals definitely require more attention than others.[49]

Through the assistance of the Extended Support Team members, such a caseload is both manageable and cost effective. In order to ensure manageability, there should be one Paraprofessional Support worker for every 4 Community Support Workers, as well as a substantial number of trained volunteers.

SUPERVISION AND MANAGEMENT ISSUES: Supervision of the Community Support Worker and members of the Extended Support Team, who are trained and retained by the organization, should focus on providing the direction, ideas, resources and support needed by workers to continue to be effective, feel energized and deal with difficulties. This necessitates that the supervisor has direct experience in the provision of community based support services to people with severe and persistent mental health problems.

Group supervision can also create the culture of support that is required by Community Support Workers, who are often involved in difficult situations. Furthermore, it allows staff to get to know the details of the lives of the people being supported by other team members, which can be effective for coverage during absences resulting from illness or vacation. Finally, group supervision allows for expertise to be shared and for common problem solving to take place thus creating an ongoing learning environment for all of those involved.

Documentation and statistics, while necessary, should not be so burdensome as to detract from a Community Support Worker's availability to the people supported by the program. As much as possible, documentation and statistical processes should be seen as a tool to facilitate service enhancement, rather than as a way of monitoring the activities of staff.

Other management issues include[50]:

- The promotion of the values of the organization through interactions with staff and people who use the service, as well as in the community.
- The creation of office and community environments in which consumers are seen and treated as people with a future rather than patients with an insurmountable past.
- The creation of a learning environment, in which Managers and Community Support Workers learn from each other.
- Persistence in the ongoing quest to improve services through the creative use of resources and through a focus on empowering the worker. (The recognition here is that empowered workers will, in turn, be empowering to people they support).

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[49] Bachrach, op. cit. p. 191.

[50] Gowdy, Elizabeth & Rapp, Charles A. (1989) Managerial Behaviour: The Common Denominators of Effective Community Based Programs. *Journal of Psychosocial Rehabilitation*, 13 (2) pp. 31 - 51.

- Strong emphasis on outcome identification in planning services and on outcome achievement through the support and direction of staff.

PROMOTING COST-SENSITIVITY WHILE DIMINISHING ADVERSE SELECTION: One concern about the impact of efforts to be cost-effective, especially in a system where the purchase of service is limited through funding constraints or through some form of capitation, is that of adverse selection. "Adverse selection" describes a process whereby people who are seen as likely to consume more financial or human resources are refused service.

The focus of the **ACCESS** Framework is on the person. Community Support Workers, if they become caught up in worrying about financial expenditures, may either not admit people who are deemed to be high consumers of resources or may endanger the person because of a concern about the purchase of more expensive services.

The following describes the policy and practices necessary to counteract this tendency:

First, this Framework requires a ***"no-reject" policy***; i.e. no person would be denied service on the basis of concern over his/her potential use of human and/or financial resources. Second, certain practices should be adopted. These include:

- a partial distancing of the Community Support Worker from the financial accounting that will take place when capitation rates become the norm, so that intervention decisions are not based on financial concerns; and
- the managerial practice of ensuring that a certain amount of the budget is in flexible dollars, available to purchase whatever is needed to serve the needs of the person.

Furthermore, the system must advocate that a variety of means be adopted that will ensure that no person with severe and persistent mental health problems is under-serviced in a re-organized system of mental health services and supports.[51]

E. OUTCOME BASED EVALUATION

The focus on Outcome Based Evaluation is a burgeoning one, as organizations, funders and the public are increasingly interested in understanding the impact of services on the lives of people with severe and persistent mental health problems. Paul Carling, in his description of a service system that is moving towards a greater focus on community integration, notes that outcomes that measure whether a person has been "fixed" are no longer applicable. Rather this movement towards community integration asserts that in order to be effective:

> *"Such services must be controlled by their users, designed specifically to achieve integration outcomes, and be organized not primarily to "fix" the individuals, but instead to support those key foundations of a healthy life on which all citizens rely (the health determinants of the **Framework for Support**, to which he earlier refers): a home, a job, and connections with family, friends, coworkers and neighbours. Thus, this movement does not in any way ignore the nature or severity of an individual's disability. Rather*

[51] cf. CMHA, Ontario Division (1997). *Consultation Document on Integrated Delivery Systems: Implications for mental health services in Ontario.*

> *it approaches the person in a fundamentally new way -- as an equal, and as a valued "customer" whose growing empowerment, satisfaction and improved quality of life are the critical outcomes through which we can evaluate the success of a professional's work."*[52] *(Emphasis added)*

There are 3 critical elements to service evaluation which, according to Carling, must be incorporated in order to measure service impact in a manner that is logically consistent with the ***Framework for Support***. These 3 elements are:

1) the lived experience of disability as the major source of the research questions to be developed;
2) full participation of people with disabilities in all aspects of research and evaluation; and
3) an emphasis on the same outcomes that are of concern to all citizens, often described as an improved "quality of life".[53]

The evaluation tool to be used in **ACCESS**'s Framework of a community based service system for people with severe and persistent mental health problems is the **"Outcome Based Performance Measures"** developed by *The Accreditation Council on Services for People with Disabilities.*[54]

The *Outcome Based Performance Measures* is designed to examine the outcomes in the lives of people with disabilities that result from the provision of supports and services. Developed through individual interviews and focus groups, this tool is designed to measure service outcomes for people with a variety of disabilities.

The outcome measurement question asks; ***is the outcome present?*** The subsequent question, focusing on organizational process, asks, ***Has the organization developed and initiated a process that enables (or will enable) the person to overcome barriers and achieve the outcome?*** If the answer to this latter question is "yes" the next question is, ***What is this organizational process?***

The *Outcome Based Performance Measures* begins with the identification of goals, preferences, experiences and range of choices (consistent with the concept of Personal Planning) and concludes with questions regarding satisfaction with services and supports and satisfaction with personal life circumstances.

The *Outcome Based Performance Measures* is based on certain values which not only provide the context for evaluation, but which must be present in the delivery of services. These values are consistent with the Values Base and Service Principles of **ACCESS** Framework as described in Part I. The value base of the *Outcome Based Performance Measures* is as follows:

- The role of choice and decision making
- The role of rights and responsibilities
- The role of comprehensive planning for people

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[52] Carling, Paul (1995). *Return to Community*. op. cit. p. 22.
[53] Ibid. p. 65.
[54] Accreditation Council on Services for People with Disabilities (1993). *Outcome Based Performance Measures.* Towson, MD.

- Individualization
- Organizational Processes support Personal Outcomes
- Quality as defined by Outcome begins with the Design of Services.[55]

The *Outcome Based Performance Measures* is comprehensive, in that it is designed to measure 30 individualized outcomes. These outcomes are detailed in Table 3.

[55] Ibid. p. 8.

TABLE 3
OUTCOME MEASURES FOR PEOPLE[56]

PERSONAL GOALS	1. People choose personal goals. 2. People realize personal goals.
CHOICE	3. People choose where and with whom they live. 4. People choose where they work. 5. People decide how to use their free time. 6. People choose services. 7. People choose their daily routine.
SOCIAL INCLUSION	8. People participate in the life of the community. 9. People interact with other members of the community. 10. People perform different social roles.
RELATIONSHIPS	11. People have friends. 12. People remain connected to natural support networks. 13. People have intimate relationships.
RIGHTS	14. People exercise rights. 15. People are afforded due process if rights are limited. 16. People are free from abuse and neglect.
DIGNITY & RESPECT	17. People are respected. 18. People have time, space and opportunity for privacy. 19. People have and keep personal possessions. 20. People decide when to share personal information.
HEALTH	21. People have health care services. 22. People have the best possible health.
ENVIRONMENT	23. People are safe. 24. People use their environments 25. People live in integrated environments.
SECURITY	26. People have economic resources. 27. People have insurance to protect their resources. 28. People experience continuity and security.
SATISFACTION	29. People are satisfied with services. 30. People are satisfied with their personal life situations.

The methods used for measuring such outcomes are clearly delineated in the materials and include such means as interviewing the person, interviewing the support network members, observing environments, and checking files and documentation.

The second part of the *Outcome Based Performance Measures* is a comprehensive evaluation of the organization's capacity to assist people to achieve outcomes.

Table 4
PERFORMANCE MEASURES FOR ORGANIZATIONS[57]

[56] *Outcome Based Performance Measures*. (1993) op. cit. p. 11.

PERSONAL HEALTH, SAFETY AND WELFARE	31. The organization protects the rights of people. 32. The organization demonstrates a commitment to using positive approaches in all service and support activities. 33. The organization's service practices and staff demonstrate sensitivity and concern for personal dignity and respect. 34. The organization implements procedures for investigation and intervention in all instances of alleged abuse and neglect. 35. The organization owns, operates or leases buildings that comply with all applicable fire and health codes. 36. The organization implements procedures for meeting all emergencies such as fire, severe weather and health. 37. The organization implements employment-screening procedures that minimize unnecessary or unreasonable risk.
FISCAL MANAGEMENT	38. The organization has a budgeting and accounting system. 39. The organization has an independent audit of its fiscal activities annually. 40. The organization has separate accounting for funds managed for people.
HUMAN RESOURCE MANAGEMENT	41. The organization's personnel practices meet all applicable laws. 42. The organization provides opportunities for staff training and development. 43. The organization regularly evaluates and provides feedback to its staff on their performance.
PLANNING AND EVALUATION	44. The organization has a clear statement of its mission and purpose. 45. The organization conducts an ongoing evaluation of success in achieving desired outcomes. 46. The organization includes input and involvement from people served and others in its evaluation and planning activities. 47. The organization implements a program for ongoing quality improvement.

The *Outcome Based Performance Measures* briefly described here is a tool that is consistent with the values and principles of **ACCESS** and which corresponds to the conceptual/theoretical base, described in Part I, and the system description detailed in Part II of this paper.

Pilot projects for the application of this tool may be in order.

[57] Ibid. pp. 137 ff.

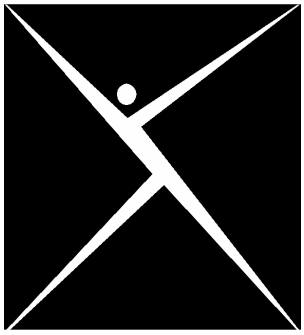
CONCLUSION

The Canadian Mental Health Association has had a proud tradition of advocating for and delivering values-based services in Ontario since its inception in 1918. As times have changed and as new societal demands have emerged, the CMHA has consistently risen to meet these demands in order to better serve those in need. The imperative to move beyond individual service or organizational excellence and move towards system quality, especially at this time of the re-organization of Ontario's health system, is the impetus that underlies the need for a system framework. The **ACCESS** Framework is the CMHA's vision of a mental health service system for tomorrow's Ontario.

In tomorrow's Ontario, the ongoing development of a province-wide mental health system is clearly a challenge. While the Canadian Mental Health Association, Ontario Division has taken a leadership role in articulating the **ACCESS** Framework, it is recognized that the full implementation of such a Framework must:

- Occur in a collaborative manner within a multidisciplinary and multi-organizational context;
- Take into account local and regional differences including the urban/rural dimension and the cultural distinctiveness of various parts of Ontario;
- Be subject to rigorous research and evaluation processes in order to provide a feedback loop to the concepts of **ACCESS** based on actual outcomes perceived in people's lives
- Require appropriate resources.

Moreover, it has been strongly recommended that the implementation of **ACCESS** first occur on a demonstration project basis. Such demonstration projects should be chosen to reflect the diversity of the province, so as to provide a range of experiences and feedback to the Framework described in **ACCESS**.



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APPENDIX "A"

DIRECTIONAL STATEMENTS

(From "A Values Based Community Support Service System" (DRAFT): *The Values Clarification Project of the Mental Health Reform Implementation Sub-Committee of the Executive Directors Network,* CMHA Ontario Division)

1) In order for people to take control of their lives and give them direction, organizations should build in formal and informal ways of assisting a person to express their preferences about how services will assist them in life, and then structure services accordingly.

2) In services that are more intensive in nature (i.e. providing and/or coordinating a wide range of supports and services, in order to improve the quality of life for the person), personal planning will be the basis of all work carried out with the person or on his/her behalf. Personal planning is characterized by:
   - its person-centred process
   - the inclusion of members of support networks in the planning and implementation process
   - its focus on the person's desired future (i.e. their dreams and aspirations)
   - the creation of comprehensive strategies for the fulfillment of the desired future and the effective surmounting of barriers
   - its focus on the person's strengths and talents
   - its holistic approach.

3) Services for the person should be structured around his/her needs and desires, as articulated in the personal plan. Services that are comprehensive in nature will be further characterized by their flexibility and portability, and will thereby reduce fragmentation of supports and services.

4) A person's support network plays a central role in his/her life and is closely involved in the personal planning process. Staff's role, although important in the facilitation and implementation of the plan, is secondary to that of the role of the support network.

5) Staff should be involved in the expansion and support of the person's support network to assist him/her to move from a position of exclusive dependency on formal services. Although the importance of formal services is acknowledged, the involvement of a wide variety of people in the support of the individual leads to interdependence. Organizations, while offering formal supports, should also focus their resources on the concurrent creation, facilitation and support of vibrant support networks.

6) Crisis support plans, which outline how the person chooses to be supported, and by whom, at the time of a crisis, are important components of personal planning. Crisis planning is all the more important when crisis limits choice, as these choices can be made and recorded at a time when self-determination can be exercised.

7) Staff are responsible for providing all the information a person needs to make choices regarding directions for his/her life, and the various strategies that could be undertaken to attain these outcomes.

8) When assisting the person to locate housing, employment, leisure opportunities, etc., generic services (i.e. services available to the whole community) should be utilized. Where access to such services does not exist, efforts should be made to establish them, rather than establishing specialized services.

9) Assisting people to attain valued roles through the acquisition of the housing, work, education and leisure opportunities that any community member would desire is central to the concept of community integration. These outcomes are indicators of quality of life; they increase self-worth, and should be the focus of formal services.

10) Self-help/mutual aid is acknowledged as a means for attaining a very specific and valuable type of support from and to others who have similar life experiences. The role of formal service vis-à-vis self-help initiatives is to be one of consultation and support rather than one of direct operation.

11) In order to foster attitudes of acceptance and responsibility on the part of the community, education and community development are vital to achieving community integration.

12) In order to ensure that services are able to meet the needs of the person, resources and decision making power (as this has to do with the delivery of service to that person) must be increasingly in the hands of those providing the direct service. This will require new approaches to accountability.

13) People receiving services should be strongly represented in the governance of the organization, as well as in the day to day operations of the organization.

14) The organization needs to ensure a seamless system internally, and will facilitate structures for the seamless linking of services with other organizations.

15) An organization should have a single point of entry into its support services. The single point of accountability to the person on behalf of the organization, and in its linkages to other organizations is established through the personal plan.

16) A major role of support services is the elimination of barriers that impede accessibility to the community and to the attainment of the desired roles in community life.

17) The organization should engage in a process of ongoing evaluation, in order to assess its adherence to service principles, its ability to achieve the outcomes desired by the person, and the consistency of the organization's efforts for and with people.

18) People who are supported will be fully involved in all aspects of the evaluation process. This includes determining what constitutes quality service (outcomes), the design of the evaluation process, its implementation and its interpretation. Members of personal support networks will also have significant involvement in these processes.

19) The evaluation should also focus on the organizational processes that either inhibit or assist in a person's freedom to make informed choices, its ability to facilitate personal planning, and the achievement of the outcomes outlined in such plans.

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