TOGETHER INTO THE FUTURE:

A transformed mental health system for New Brunswick

The Hon. Judge Michael McKee

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INTRODUCTION

The history behind this report

In May 2008, I was asked by the Hon. Michael Murphy to lead a process that would guide the New Brunswick Department of Health in the development of strategic priorities for renewing the mental health system in the province. Throughout the gathering of information and developing recommendations, I was supported by Bernard Paulin and Joy Bacon. The information gathering took many different forms and resulted in responses from approximately 2,000 people. We consulted mental health experts from outside the province and reviewed best practices within Canada and beyond. At face-to-face meetings and through electronic feedback, we heard from a wide range of service providers, organizations, people with mental illness and their families. We were overwhelmed by the scope and sincerity of the response, which is reflected in some of the quotes interspersed throughout this document. People told us about their disappointments and struggles, perseverance and dreams, and gave clear direction about what works and what needs to happen to improve the system. We heard from the parent whose 23 year old son committed suicide at the same time his name was placed at the bottom of a waiting list. We heard about the 26 year old, discharged from hospital with only enough medication for twenty-four hours, no place to live , without a fixed address and unable to receive a health card from the Department of Social Development. We heard from some professionals that some of their colleagues seem to hide behind the notion of confidentiality which may not always be in the interest of the person with mental illness. We heard that the human dimension should be there in a way that it is sometimes not at the present time. Although all the specifics of the consultation results could not be included in this discussion, it is built on the themes, issues, gaps and suggestions we heard, and the values and vision behind them.

The groundswell of interest in the consultations demonstrated that mental health is everyone's business, and everybody has a part to play. The data bears this out. Approximately 20% of us will experience a mental illness at some point in our lives, and the remaining 80% will be affected by the illness of a relative, friend or colleague. In fact, no one

gets very far in life without experiencing fear, sadness or stress; and 3.5 million Canadians report severe stress. A report published in 2001[1] put the cost of mental illness to the Canadian economy at more than $14 billion per year, and the World Health Organization has predicted that by the year 2020 depression will be one of the leading causes of disability worldwide, second only to heart disease.

The guiding vision: this affects us all

Vision: mental health for all people is a government priority, and mental illness is accepted, understood and treated as any other illness.

Because we all move in and out of periods of greater or lesser mental health throughout our lives, there must be a system we can count on at every point: identifying the need for help and providing the right intervention at the earliest signs of a problem, preventing future problems, supporting and celebrating ongoing recovery, and optimizing wellness. The needs of the people must drive policy and program decisions and the effectiveness must be measured by the impacts on their lives. It is critical that the system's components work together seamlessly, supported by a network of connections amongst diverse groups, collaborating to "build bridges, not walls". The recommendations in this report address the need for change if we are to meet the needs of people and prepare for the future. They are grounded in the vision of a future where ***mental health for all people is a government priority, and mental illness is accepted, understood and treated as any other illness***, rather than the "poor second cousin".

Components of an effective system

Research findings about what works are consistent with this vision. Effective systems are based on a foundation of wellness. They have a single point of accountability with a protected funding envelope. They provide an integrated set of evidence-based services and supports for all ages and all degrees of severity: Primary (based in community), Secondary (delivered in general facilities) and Tertiary (delivered in specialty facilities). The services are accessible, coordinated across sectors and disciplines, and include information and knowledge transfer systems. A human resource plan ensures there are sufficient numbers of skilled staff to deliver the services.

[1] Stephens, T and Joubert, N. The economic burden of mental health problems in Canada. Chronic diseases in Canada, Vol. 22, no. 1, 2001, 1-10

Systems with the best results offer standardized assessments, crisis response, and case managers to support transitioning between services and community resources such as housing. For intensive care, there are Assertive Community Treatment teams to help people stay out of hospital, beds in hospital for those who need them, and treatments using the most appropriate and effective medications and psychological therapies. There are specific services for co-occurring mental health and addiction disorders and for people with mental illness in the criminal justice system.

Good outcomes are also associated with connections among services, as well as education and support for families, and initiatives run by people with mental illness. In addition, the system must raise awareness to decrease stigma and discrimination, engage communities in taking charge of their own mental health issues, and provide measures that support the entire population, including those with mental illness, to flourish with optimal mental health.

You have to decide whether to rebuild the house or just paint the living room.

Towards transformation

People want us to do more than tinker with the *status quo*; they want a transformed system. Transformation is based on seeing the world in a different way, with traditional relationships and ways of "doing business" replaced by new ways of connecting and working cooperatively. The starting place will not be the mechanics of the system, but rather what people need for recovery and good mental health. People have consistently told us that this includes provision for life's basic necessities such as housing and sufficient income, availability of mental health and social services, and engagement of those with mental illness and their families as partners in the solution. That is the starting place, but there is no defined end point. Transformation will be an ongoing process as all the participants in the system continue to listen and learn from one another. It will be crucial to ensure that there is an accountability framework that measures progress towards meeting the goals outlined; goals that will lead to a place where mental health is expected and mental illness is accepted, understood and treated as any other illness.

This report's set of goals and recommendations will get us started on the journey. As we join forces to follow the path laid out in the following pages, our province will move closer to the place described in the vision, a point of self sufficiency where all of us can participate fully in community life and achieve our potential for optimal mental health.

A note about the report's structure

This report is based on the totality of information gathered in the consultation process, distilled into consistent themes and organized under 14 strategic directions. *It is important to note that all the directions are interdependent; action in each direction supports outcomes in the others.* For each strategic direction, there is a description of the issue, a goal or sets of goals, and recommendations with timelines for each goal. Taken together, the goals paint a picture of the desired future; the recommendations suggest concrete steps for getting there.

Building Blocks of the System

The vision in the Introduction reveals a snapshot of a comprehensive mental health system of services and supports that meets people's needs. Its key elements have informed this report's 14 strategic directions and their respective goals and recommendations. These are the building blocks for realizing the vision. Such building blocks are necessary if vision is to be transferred into action. Some of the directions and actions identified require improving and applying what is already underway, others will require both practice and process change, while still others will require investment in additional resources.

1. Addressing Service and Support Needs for the Population

In order to meet the full range of people's needs, a comprehensive system must include effective, recovery-oriented services delivered by skilled mental health professionals, as well as supports outside the realm of formal services such as those provided by peers, families, educators, employers, and other resources in the community. For New Brunswick, a comprehensive system of services should include following the direction of the Provincial Health Plan for expansion of mobile crisis response services to Edmundston, Campbellton and Miramichi, and a pilot to test and evaluate Assertive Community Treatment, with eventual implementation depending on evaluation results.

Linking people to the necessary treatment, services and supports requires effective assessment and discharge planning by multidisciplinary case management teams. The plans should be developed with each person in a standardized way across the province, and built around people's unique requirements and goals for the various aspects of the recovery journey. It is important to involve a range of community partners in planning, and multi-disciplinary teams to work with each person and their family to develop and implement the plan. An integrated and responsive primary health care network where "every door is the right door" could be one of the mechanisms considered in moving forward. Such a system might serve individuals with any chronic disease including mental illness and addictions. Multidisciplinary and integrated approaches where all work towards recovery will pave the way for a successful return to community with reduced risk for homelessness, poverty, and re-hospitalization.

Goal 1.1 People have access to a full range of services

Recommendations

A clear plan

"Our daughter died searching for help."

- As a first step, consistently apply existing guidelines for optimizing equitable access to a comprehensive range of evidence-based services across the province.
  Timeline: 2009-2010
  Responsibility: Department of Health

Every door is the right door: integrated service delivery

- Building on the community health centre team approach currently in place in a few New Brunswick communities; create a province-wide network of holistically integrated service delivery models with a single point of entry.
  Timeline: 2010-2012
  Responsibility: Department of Health

Tertiary care

- Eliminate the current backlog in tertiary care facilities by ensuring availability of a range of housing options, with related treatment, services and supports for community living.
  Timeline: 2009-2013
  Responsibility: Departments of Health and Social Development

Co-occurring mental health and addiction disorders

- Move to integrated access and treatment in accordance with existing protocols.
  Timeline: Begin 2009-2010
  Responsibility: Department of Health

Goal 1.2 There is a comprehensive, skilled human resource pool

Recommendations

Training

- Create clear standards and policies for mental health professional education to ensure adequate and dedicated human resources at all levels across the lifespan.
  Timeline: 2 years, beginning 2009-2010
  Responsibility: Departments of Health and Post-Secondary Education, Training and Labour
- Institute regular in-depth staff training to enhance competencies for best practice interventions, based on a scan and gap analysis to identify human resource requirements in each region.

Timeline: Scan 2010-2011; Development and initial implementation of training to 2010-2013
Responsibility: Department of Health

Recruitment

- Revisit current policies, particularly for psychiatrists and psychologists, in order to maximize potential for recruitment.
  Timeline: 2 years, beginning 2009-2010
  Responsibility: Department of Health

People with mental illness triumph when professionals work as a team.

Particular disciplines

- Research strategies and create guidelines for appropriate deployment of particular disciplines such as psychologists and appropriate use of their specific expertise.
  Timeline: Research: 2010-2011. Guidelines: 2011-2012
  Responsibility: Department of Health

Goal 1.3 Assessment and discharge are consistent and recovery-oriented

Recommendations

A standardized recovery approach to needs assessment for all ages

- Develop a task group with stakeholder representation to review existing models.
- Develop standardized criteria for recovery-oriented assessment and referral tools and a common template for needs assessments based on the review. Use **multidisciplinary case management teams** to apply the template across the province.
  Timeline: Task group review 2009-2010; begin developing criteria 2010-2011; develop and begin utilizing template 2011-2014
  Responsibility: Department of Health

Discharge planning

Proper follow-up

A standardized recovery approach to discharge planning for all ages

- Develop a recovery-oriented approach to discharge planning based on existing models that include linkages to the community. Test, and then apply this approach across the province.
  Timeline: Research and development 2009; testing and implementation 2010-2013
  Responsibility: Departments of Health, Education, Public Safety, Social Development, and Post Secondary Education, Training and Labour.

Recovery is a team effort.

2. Addressing Service and Support Needs of Children and Youth

Childhood and young adulthood is a critical period of life for identifying problems and intervening early in order to minimize disruptions to schooling and social development, prevent further difficulties and mitigate the need for increased services down the road. Many consultation respondents asked for support for parents early in the help-seeking process, and mental health resources in schools for early identification, intervention, and referral to specialized services and supports. There are already some good models to build on: New Brunswick's *Link* program in schools, which helps young people with life challenges find the right kind of help, and the recovery-based approach of early psychosis intervention, currently in Fredericton, which should be made available in other areas of the province.

Can we do better where police are not the first to identify?

Focusing our efforts in the early years will result in improved outcomes for a significant number of young people, and ensure that the smaller number with more serious mental disorders will receive the appropriate assessment, services and treatments at the earliest possible point. The recommendations for equitable access to a full range of services in Section 1 are particularly critical for children and youth in need of help. At this stage of life, when time is of the essence, every door must be the right door.

If this direction is followed, most children and youth will receive the timely and appropriate interventions they need to get back on a positive life trajectory. However there will still be a minority who, even after the best and earliest interventions, will continue to require intensive support. *Connecting the Dots* recommends that the province develop and enhance residential treatment services for some of these children and youth with the most serious disorders. For others who may land in the criminal justice system after all possibilities for intervention and diversion are exhausted, there needs to be a Mental Health Court dedicated to children and youth, as a last resort.

Goal 2.1 School staff are equipped to identify problems and take appropriate action

Recommendations

- Build training programs for school support staff and teachers to provide basic skills, support, and competencies for timely, appropriate consultation.
- Establish school-based mental health teams.
  Timeline: Begin training program and development of teams 2010; teams in place 2014.
  Responsibility: Departments of Health, Education and Social Development

Goal 2.2 Interventions for identified problems are offered at the earliest possible point

Recommendations

My child in trouble with the law, referred by probation officer, was not seen until one year later.

- Expand Early Psychosis Intervention services beyond Fredericton program.
- Establish Youth Concurrent Disorder Teams as per Health Plan.
- Establish Child and Youth Mental Health Courts.
  Timeline: For each of the above recommendations, begin research and development 2009-2010; begin implementation 2010-2011
  Responsibility: Departments of Health and Justice

Goal 2.3 Children and youth have access to in-province assessment and treatment

Recommendations

- Develop mechanisms to ensure equitable access to holistic assessment and treatment across the province that includes psychiatric plans for children and youth, close to where they live.
- As recommended in *Connecting the Dots*, ensure a range of treatment options including residential treatment capacity for children and youth with most the complex needs.
  Timeline: Mechanisms in place 2010-2011; treatment options by 2014
  Responsibility: Departments of Health, Social Development, Education and Public Safety

3. Addressing Service and Support Needs of Seniors

While the system of community services works well to maintain older adults in their own homes, those with mental illness need access to additional specific home-based services by providers who understand their needs and to beds in hospitals or nursing homes when more

intensive care and support is needed. Regardless of the setting, seniors' mental health is enhanced when they can participate in decision-making about their care and maintain linkages to the natural community. Strategies that support people with mental illness in their homes, such as daily outreach from hospitals, and those that enhance social involvement, such as links to community supports and programs, buddy systems, pairing youth and seniors and hospital day programs, are all good starting places.

It can be challenging for nursing homes or long-term care facilities to meet the needs of seniors with mental disorders in their care. Because staff may lack the expertise to deal with their issues, these patients can end up shuttled back and forth between the facility and hospital emergency rooms. Not only do staff require specialized training to understand the needs of the psychogeriatric population, but facilities must also have adequate physical capacity to meet the demand, and specialized beds to serve clients with dementia.

Goal 3.1 There are appropriate effective home and community supports for seniors

Recommendations

- Strengthen collaboration between mental health programs and Healthy Aging programs.
- Develop a plan for recruitment, training and incentives to increase supply of trained human resources by building collaborations with home care and primary care sectors, identifying training models, and providing specialized training for home support workers.
  Timeline: Begin collaborations 2009-2010; implement training 2010-2012
  Responsibility: Departments of Health and Social Development

Goal 3.2 There are appropriate and effective seniors' services in hospitals and long-term care settings

Recommendations

- Develop more defined mandates for tertiary and secondary care facilities that care for seniors.
- Develop distinct regulations and programming requirements to deal with complex mental health needs of people living in residential homes.
  Timeline: Begin all above strategies 2010-2011
  Responsibility: Departments of Health and Social Development

4. Fostering Collaboration and Coordination

The needs of people with serious mental illness are complex. Addressing them requires attention not only to medical/clinical factors, but also to social factors such as income and housing, education and training, and, in some cases, public safety and criminal justice. Because these policies are managed by different government departments, each necessarily focused on its own bottom line, responses are fragmented, and responsibility for outcomes can be avoided. Senior government staff in different departments have the will to work together so that people will not fall through the cracks. However, good will is not enough. Mechanisms are needed to translate this will into action and replace silos with new approaches. That requires strong leadership from the top but with accountability and the expectation of collaboration, it can happen. Breaking down silos is a prerequisite for system transformation, and must be seen as a priority by government. We need to be building bridges instead of walls.

It should not be up to the person with mental illness or the family to request better cooperation or coordination among professionals.

Silos also exist amongst professional disciplines such as nurses and doctors, psychologists, social workers, and rehabilitation therapists. Accessible, continuous care in a unified system will not be possible until there is service integration with clearly designated responsibilities for all aspects of care. This will require collaboration. Collaboration across disciplines can help ensure that people receive the right service or support from the provider(s) with the most appropriate skills, where and when needed. Linkages amongst different health and social service providers have consistently been shown to have a positive effect on outcomes.

There continue to be silos among government departments and professionals, and people continue to fall through the cracks.

Goal 4.1 Government departments work collaboratively within a coordinated system

Recommendations

- Establish an interdepartmental committee of Ministers as the point of accountability for the Mental Health Strategy, led by the Minister of Health and including Ministers of the other key departments named below.
- Establish an ongoing interdepartmental coordinating committee (recommended in *Connecting the Dots*) in order to support linked policies and integrated service delivery.
- Establish accountability mechanisms for interdepartmental collaboration, such as performance appraisals based on partnerships and outcomes for joint clients.

Timeline: Establish committees 2009-2010; begin implementing incentives 2010-2011; accountability mechanisms complete 2011-2012
Responsibility: Departments of Health, Social Development, Education, Justice, Post-Secondary Education, Training and Labour, Public Safety and Aboriginal Affairs Secretariat.

Goal 4.2 Service providers collaborate across disciplines

Recommendations

- Implement interdisciplinary case management teams with authority to meet people's needs.
- Develop collaborative guidelines for practice across disciplines and with community groups.
- Create incentives and strategies, such as integrated data systems and appropriate "front-end" consent processes to expedite the sharing of information across disciplines and settings.
- Continue to develop primary care networks that incorporate shared care strategies in processes involving intake; telephone back-up; consultation; discharge planning and follow up; transmission of reports; education; or video-based services.
- Explore strategies for better integration of psychiatrists within CMHC teams.

  Timeline: Begin first phase for all above strategies 2009-2011; all phases complete by 2014
  Responsibility: Department of Health

We need a justice system where being sick is not a crime.

5. Dealing with Mental Illness in the Justice System

There is general agreement from both mental health and justice sectors that many people with mental illness are misplaced in the criminal justice system, when what they really need is treatment, not jail. However, services are not easily available in a timely and coordinated fashion. There needs to be a comprehensive accessible community-based system of services and supports, with diversion programs to keep people with mental illness from entering (or returning to) the criminal justice system, and mental health services available in prisons to those who require them. The right mechanisms can ensure continuity of service from community to institution and back, through systematic information sharing between service providers in correctional facilities and the community, and a discharge planning process implemented in collaboration with community partners. Also needed are proactive alternative approaches - such as victim/community/offender

reconciliation, self-help groups for ex-offenders with mental disorders, half-way or transition houses, Aboriginal Healing Lodges for access to traditional healing - and interdepartmental collaborations for implementation.

A promising model that includes a diversion approach is Mental Health Court, currently in Saint John. This is a community-based, community-driven partnership between the judiciary, and public and private agencies, to deal with individuals with mental illness or intellectual disability and who are in conflict with the law. It requires the community in place to support people. The accused is held accountable for their behaviour, and provided with the least restrictive intervention in the least restrictive environment, with an emphasis on treatment rather than incarceration.

Goal 5.1 A full range of effective services is available in community and correctional facilities

Recommendations

- Ensure that protocols for delivery of mental health services in the provincial jail system are in place.
  Timeline: Services in place by end of 2010-2011
  Responsibility: Departments of Health and Public Safety.
- Make mental health training and education mandatory for police and frontline staff in correctional services.
  Timeline: Begin 2009-2010
  Responsibility: Departments of Health, Public Safety, Social Development, Education and Post Secondary Education, Training and Labour

Goal 5.2 Diversion and alternative measures are widely available

Treatment is more effective than jail.

Recommendations

- Define, develop and pilot approaches for diversion and other alternatives.
  Timeline: Begin research 2009-2010; begin piloting 2011-2012
  Responsibility: Departments of Health, Justice and Public Safety

Goal 5.3 All people across the province have access to Mental Health Courts

Recommendation

- Develop a plan to ensure access to the Mental Health Court process for every youth and adult in each region of the province.
  Timeline: Plan in place by 2012-2013

Responsibility: Departments of Health, Justice and Public Safety

6. Combating Stigma and Discrimination

The negative image of mental illness relative to physical illness creates problems and inequities at many levels. One of the strongest themes from the consultations was the need to address the stigma surrounding mental illness. Stigma is persistent and pervasive, in schools, workplaces, courts, and even within the health care system itself. Government departments can and must show increased leadership by ensuring that policies do not inadvertently lead to stigma and discrimination based upon a diagnosis of mental illness.

Stigma continues to show its face in the negative stereotypes associated with mental health conditions, and in the myths and misinformation held by the public, such as the notion that mental illness dooms people to isolation and dependency, with no hope for quality of life, let alone recovery. Negative attitudes and misperceptions subject people with mental illness to discrimination, rudeness, and rejection; denying them equal participation in family life, social networks, and employment. This naturally makes them reluctant to self-identify, creating impediments to timely treatment and support.

Overheard at the Emergency Room:

"Work at the ER wouldn't be so bad if we didn't have those crazy people."

Public education should address both beliefs and behaviours, and raise the mental health literacy level of the population. This can be accomplished through a two-pronged long-term, ongoing education/ media campaign, with one component focused on mental illness and the other on wellness for the whole population. It will be important to build on success stories, use champions and deliver messages that counter the myths and stress the importance of getting help early, continually evaluating and adjusting along the way. Stigma and discrimination should also be addressed by supporting community advocacy efforts and strategies that promote inclusion of people with mental illness**.**

Goal 6.1 There is public awareness and understanding of mental illness

Recommendations

- Build on, and partner with the Mental Health Commission of Canada's anti-stigma initiative to create a campaign targeting children, youth, schools, and mental health professionals.
  Timeline: Prepare for major campaign 2010-2011; implement campaign 2011-2014
  Responsibility: Department of Health and Department Wellness, Culture and Sport

Goal 6.2 There is public awareness about mental health and wellness

Recommendation

- Partner with community groups and organizations to develop awareness initiative to educate population about skills for mental wellness such as resiliency and managing stress.
  Timeline: Begin 2009; campaign span: 5-7 years
  Responsibility: Department of Health and Department Wellness, Culture and Sport

Goal 6.3 Communities are engaged to fight stigma and discrimination

Recommendation

- Partner with community groups and organizations to support their advocacy efforts in regard to stigma and discrimination and foster strategies that raise awareness about mental illness among educators, employers, and community at large to promote inclusion.
  Timeline: Begin 2010-2011
  Responsibility: Department of Health

7. Linking to Community Resources

What people with mental illness say they need for their recovery is not that different from what anyone needs for good mental health: a place to live and belong (with privacy, choice and control), adequate income, connections with people who understand us, a way to make a contribution, and purpose and meaning in life. A comprehensive system recognizes the importance of social cohesion and inclusion for the mental health of all people, particularly those with mental illness who are at risk for poverty and marginalization. For this population,

As Mother Teresa said, "Loneliness is the most terrible poverty."

For this population connections to the community are essential to transcending the identity of "patient".

connections to the natural community through housing, income, education, employment, recreation, spirituality and leisure are an essential key to inclusion, recovery, and transcending the identity of "patient". Case managers in multidisciplinary teams, along with families, peers, and others, are a necessary element to provide support and create links to the various community resources. Such connections will also be strengthened by mechanisms to facilitate and sustain information sharing between community resources (including families) and mental health services, as part of planning processes at all levels.

Goal: 7.1 People with mental illness are connected to the natural community

Recommendations

- Increase number of rent supplements available for people with mental illness.
- Develop a range of affordable, housing options based on effective models that promote independence and control for people with mental illness.

Partnerships - we all have a role to play.

- Create or strengthen partnerships with community resources in business, education and other sectors to foster inclusion of people with mental illness.

  Timeline: Rent supplements and Housing options; partnerships for community inclusion; 2009-2014

  Responsibility: Departments of Health and Social Development

- Build on Worksafe NB model for physical disabilities to implement a system that offers training, retraining and job placement for those recovering from a mental illness.
- Explore other models that support employment for people with mental illness in NB such as BUILT Network and Let's Work (CMHA Fredericton), and the potential for expansion of these models.

  Timeline: Begin both employment strategies 2010-2012

  Responsibility: Departments of Health and Social Development

8. Working with People with Mental Illness

Many people with mental illness describe the elements most important to them for a good quality of life as "a home, a job, and a friend", ends often best achieved through connections to community resources outside formal health services. There are ways to provide services that

are amenable to recovery as well, with providers who believe in people's capacities, respect their goals and share their hopes. No one knows this better than people with mental illness themselves. The system needs them on the inside to share their experiential knowledge in all aspects of the service system.

"Nothing about us without us!"

Besides quality services and basic health determinants, people's positive outcomes are linked to opportunities for managing their own recovery journey, and support for creating alternative peer-support resources. It is important to provide new tools such as the Schizophrenia Society of Canada's peer-focused training, *Your Recovery Journey*, to strengthen these endeavours. It is also important to build on the proven self-help model that exists in the province. Activity Centres are a powerful testament to the capacity of those with mental illness to take charge of their situation and effectively address their own needs together, when given appropriate technical and financial supports. With additional resources, this empowering approach could achieve even greater impacts. Beyond the current mandate of Activity Centres, people who have experienced mental illness could educate peers, the public and providers, undertake participatory action research, create businesses, foster community inclusion in education and employment in accordance with a recovery vision, and develop support groups. This potential needs to be tapped.

Goal 8.1 The system welcomes input from people with mental illness

Recommendations

- Institute formal mechanisms, such as revitalizing community advisory committees, at all levels to foster the active participation of people with mental illness in system planning at all levels.
- Create formal mechanisms to promote active participation of people with mental illness in service provision, evaluation, and training of service providers.

  Timeline: Begin both processes 2009-2010; mechanisms in place by 2012

  Responsibility: Department of Health

Goal 8.2 Empowerment and capacity building are valued and supported

Recommendations

- Expand Activity Centres to encompass a variety of initiatives by, and for people with mental illness. Adjust their mandate and funding accordingly.
- Develop a plan for continuing support to local and provincial networks of people with mental illness and development of new networks.
  Timeline: Both strategies ongoing from 2010-2012
  Responsibility: Department of Health

9. Working with Families

Families have a vast reservoir of knowledge and experience that is necessary for the development of effective and appropriate services. They take a burden from the service system for their ill relative as providers, case managers, advocates, and more. But families too often feel isolated, shut out from their family member's treatment, uncertain about how and where to get assistance, support and information, and unaware that there are other people in the same situation.

Surprisingly some professionals are not able to see the value of involving the family in recovery.

Families make an invaluable contribution, not only to their family member, but also to one another in groups and organizations, sharing practical advice and help, information, and social validation. However, they cannot play their role effectively when overburdened and unsupported. Family groups must have adequate resources for collectively identifying their needs and supporting each other. To ease their burden, they must also have access to services such as information, training or respite care, and tools such as the comprehensive family resource guide from CMHA Moncton and the Schizophrenia Society's *Strengthening Families* Program. Families should be viewed as a resource; the system benefits when they can contribute.

Goal 9.1 Families are linked to system planning and government

Recommendations

- Ensure that families are appropriately involved in treatment and recovery plans for individuals, while still respecting privacy and consent issues.
- Create formal mechanisms whereby families can have input into service system planning at all levels.
  Timeline: Begin to develop mechanisms 2009-2010
  Responsibility: Department of Health

Goal 9.2 There is recognition and support for family groups

Recommendations

- Create a plan for sustaining and nurturing existing groups and supporting the development of new groups (such as for First Episode Families) where needed. Base the plan on a scan of family groups and organizations throughout the province, and their organizational requirements to carry out their role effectively.
  Timeline: 2010-2012
  Responsibility: Department of Health
- Partner with the Mental Health Commission of Canada in designing and piloting the Mental Health Family Link project.
  Timeline: Begin all above initiatives 2010-2011
  Responsibility: Department of Health

10. Removing Policy Barriers to Recovery

Many programs created for good policy reasons have the unintended consequences of creating stress, as well as disincentives for people to work, become self sufficient, and recover. Changes are needed that will make a difference in people's lives in regard to access to medications, income support, gaps in services for 16-19 year olds, and protecting security and autonomy.

Despite coverage of medication costs with a health card, problems accessing medication in community still exist. Patients receive 24 hours worth of medication at discharge, but can have a considerable wait before a new health card is issued. Upon getting a job, they must relinquish the card, but if the job is lost (not uncommon, given the episodic nature of mental illness) there is no financial support for medication while they are applying for a new card. The inadequate

Discharged with 24 hours medication, no fixed address, no medical card - 2 weeks later re-admitted to hospital.

amount for income support, policies that require receipts for particular expenditures, and complex application procedures are all additional barriers to rebuilding and taking charge of one's life. The reduced rate of income assistance upon employment and the cap on earnings create added disincentives to work. And the decrease in income assistance, if one moves in with a friend, discourages people from sharing space to minimize expenses and enhance social contact.

Young people between the ages of 16 and 19 are caught in the gap between child and adult service systems. For the purpose of social services, childhood is defined as under age 16, but many legal agreements associated with social supports, such as a rental lease, cannot be completed until age 19. There is no place mandated to provide this age group with needed social services such as housing and income support.

Although a feeling of control is a key ingredient for recovery, many people receiving mental health services are left without a sense of control over their lives. Legislative measures such as advance directives and provisions for consent to treatment are very tangible ways to support a sense of safety, autonomy and control.

Goal 10.1 People with mental illness have uninterrupted access to the most effective and appropriate medications

Recommendations

- Include a provision in discharge plans for uninterrupted access to the most appropriate, effective medication as determined by the case management team.
- Review process for health card exceptions through Prescription Drug Program.
  Timeline: Begin both above strategies within 6 months
- Institute quick turnaround for temporary coverage for medical card if a person leaves employment due to mental illness.
  Timeline: Begin work on revisions for temporary coverage 2009-2010 fiscal year
  Responsibility: Departments of Health and Social Development

Goal 10.2 People with mental illness have uncomplicated access to adequate income support and housing

Recommendations

- Review current process, and identify and address barriers arising from red tape, policies and applications with respect to income for people with serious mental illness.
  Timeline: Begin 2009-2010
- Conduct a review of rates and policies in order to ensure that people have access to a basic adequate income that will support their recovery in the community, including revisions to the Economic Unit Policy, and exemptions to the Household Income Policy.
  Timeline: Begin 2010-2011 fiscal year
  Responsibility: Departments of Health and Social Development

Goal 10.3 Young people age 16 to 19 have access to social services

Recommendations

- Address the service gap though an interdepartmental collaboration that starts by developing amendments to regulations in the Family Service Act, as recommended in *Connecting the Dots.*
  Timeline: 2009-2010
  Responsibility: Departments of Health, Public Safety, Social Development, Education, and Post Secondary Education, Training and Labour

Goal 10.4 Legislation to protect security and autonomy is up to date and accessible

Recommendations

- Review and update *Infirm Persons Act*.
- Educate public regarding Power of Attorney, and introduce advance directives in competency/power of attorney legislation.
- Create a process for determining competency to consent to nursing home placement (as is done in Ontario).
  Timeline: Begin above three strategies 2010
  Responsibility: Departments of Justice and Social Development

11. Facilitating Knowledge Exchange

Positive outcomes for people require practices that are guided by the best up-to-date evidence of what works. A systematic and sustained

knowledge exchange mechanism will help stakeholders keep abreast of new developments, as well as the many excellent and promising programs in the province to be identified and shared, all of which results in continuous improvement of the system. A knowledge exchange strategy must include the many kinds of knowledge that strengthen our understanding of mental health and mental illness, including medical/clinical knowledge, system factors such as coordination and integration, social factors such as poverty, the traditional knowledge of various communities, and of course the knowledge that comes from living with a mental illness as a person with the illness, or a family member.

Goal 11.1 A mechanism exists for knowledge exchange

Recommendation

- Develop Knowledge Exchange infrastructure in concert with the Mental Health Commission's work in this area.
  Timeline: 2009-2010
  Responsibility: Department of Health

Goal 11.2 Up-to-date, reliable data is available to inform planning

Recommendation

- Continue to update success indicators on an annual basis, linking process to existing New Brunswick Health Council report card.
  Timeline: Begin 2009-2010
  Responsibility: Department of Health

Goal 11.3 Research capacity in universities is enhanced

Recommendations

- Work with universities to strengthen mental health research capacity, building on existing programs such as post partum depression and early intervention work at UNB.
- Create partnerships with universities and Mental Health Commission of Canada to develop and support applied community-based research.
  Timeline: Begin both strategies 2009-2010
  Responsibility: Departments of Health, and Post-Secondary Education, Training and Labour

Understanding Aboriginal culture and values is key to effective treatment response.

12. Responding to Aboriginal People

Aboriginal people need access to appropriate services that are delivered with dignity and respect for their culture, as close as possible to where they live, regardless of where that may be. This is not just an expected courtesy, but a way to achieve optimal outcomes as well. Not only should service teams for Aboriginal communities include Aboriginal people, but Aboriginal people should be involved in training mainstream service providers in cultural competency and sensitive holistic approaches, and in customizing services accordingly wherever possible. Like other communities, they must also be supported to identify their own mental health needs, and plan and deliver the appropriate responses.

Goal 12.1 Aboriginal people have access to a comprehensive range of culturally safe services

Recommendations

- Create an agreement for delivery of mental health services similar to the existing tripartite model delivering child and family services on reserves.
- Work with Aboriginal people toward identifying ways for culturally safe services to be delivered on reserves, and for those services available only off reserve to be delivered with cultural competency and appropriate sensitivity.
- Improve access to video conferencing, teleforums and other electronic measures to ensure timely assistance when needed.
- Ensure Aboriginal input into system planning.
  Timeline: Begin work on all above strategies 2009-2010; complete by 2012.
  Responsibility: Department of Health and Aboriginal Affairs Secretariat

Goal 12.2 Aboriginal people have support to address their mental health needs

Recommendations

- Provide technical support and resources to Aboriginal communities to plan and deliver needed services and supports.
  Timeline: Develop plan and materials 2010-2011; Implementation 2010-2011
  Responsibility: Department of Health and Aboriginal Affairs Secretariat
- Build linkages for communication between services on and off reserves for a seamless system of care.
  Timeline: Create working group of providers on and off reserves 2009-2010
  Responsibility: Department of Health and Aboriginal Affairs Secretariat

- Continue to target university seats to train Aboriginal mental health workers.
  Timeline: Ongoing
  Responsibility: Departments of Health and Post-Secondary Education, Training and Labour

13. Supporting Rural Communities

The major issue facing New Brunswick's many rural communities is access to services. There are good initiatives underway but much remains to be done. There is some distance to go before there is any degree of equity in access to service for rural New Brunswickers. It will be important to build upon the good work already being done to help people find the services and supports they need, close to where they live. For example, there are telehealth videoconferencing sites that increase the reach of scarce resources. Similarly, all community mental health centres have some degree of emergency crisis response. These helpful approaches need to be expanded in order to be accessible to more people, especially in rural communities. Likewise, Activity Centres, present in urban centres as well as some rural regions around the province, are a valuable peer-support resource that should be accessible to *all* people with mental illness. Not only is it necessary to continue to bring services out to rural areas as much as is feasible, but these communities must also be provided with skills and resources to identify their own mental health needs and address them internally.

Goal 13.1 A comprehensive range of services is available in rural communities

Recommendations

- Design and implement strategies to strengthen outreach to smaller communities, including consultation models and collaborative approaches.
- Develop and implement strategies for broadening use of existing telehealth technology, especially for specialty consultants such as child and geriatric psychiatrists.
  Timeline: Begin developmental work for all above strategies 2010-2011
  Responsibility: Department of Health

Goal 13.2 Rural communities are empowered to meet their own needs

Recommendations

- Provide technical support and seed funding for community-controlled initiatives aimed at promoting mental health in rural areas.
- Explore models and provide training for volunteers (e.g. CMHA Helping Skills program) and paraprofessionals to work in remote communities.

  Timeline: Begin developmental work for both above strategies 2010-2011

  Responsibility: Department of Health

Promote mental health and well-being

14. Enhancing Wellness for Everyone

Prevent Mental illness

Mental health issues touch everyone, whether through mental illness, difficulties with coping, or challenges and transitions of everyday life. That is why a mental health strategy must be grounded in a commitment to wellness for the whole population, with initiatives that help people flourish to the greatest extent possible, regardless of whether or not they have a mental illness. A general culture of wellness will promote mental well-being and help prevent disorder by enhancing mental health protective factors (such as social cohesion), decreasing risk factors (such as isolation), and working across sectors at all levels to influence social determinants of health.

Intervene early

Programs that engage communities, build capacity, and reduce inequalities can foster positive mental health across the various life stages and settings. For example, there is growing recognition of the importance of workplaces as settings for promoting the mental health of employees, whether through programs targeted at employee stress or policies that shift the workplace culture to enhance employee control over the design and organization of their work. It is also possible to build individual capacity and control by recognizing and supporting the ways people can take responsibility for their own mental health, whether through exercise, alternative therapies, holistic mind-body approaches, or self-help/mutual support.

Support Recovery

People in communities know their own mental health issues and collectively have the knowledge and experiences to address these issues. In fact, strengthening community action is a well-documented

strategy for health promotion. The CMHA NB Regional Community Worker program is a good example of a longstanding proven program for promoting wellness through education, information, and advocacy in communities; with more support its impact could be even stronger. Building partnerships with community groups and organizations and enhancing their capacity to take action on mental health and recovery will give New Brunswick a head start on implementing a strategy. With information, resources and support, communities will be critical partners in transforming the mental health system.

Given what we know about the positive impact of interventions for children and youth, it is vitally important to provide programs and resources with specific support and information to strengthen and reinforce the role of family. Programs that strengthen skills and competencies for high-risk parents or guardians can be effective in building resiliency, empathy, and respect. Wellness also involves recognizing problems early and knowing what to do about them, particularly for children and youth, when interventions can make a significant difference to outcomes (see Section 2), as well as people at risk for suicide, when interventions are critical. This area in general presents a clear example where minimal investment at the front end will reap significant payback benefits in the future.

Goal 14.1 A culture of wellness exists across the province

Recommendations

- Map existing programs that support mental health promotion and mental illness prevention, and build on these strengths to guide future action.
  Timeline: Begin 2009-2010
  Responsibility: Department of Health

Goal 14.2 Communities are empowered to take action on their own behalf

Recommendations

- Establish a pilot provincial self-help resource centre, building on models shown to be effective to provide technical support and assistance to self-help groups for the general population and enhance access to groups.
- Provide start-up resourcing through seed funding for innovative multi-sectoral community mental health initiatives such as youth engagement.

Timeline: Research 2009-2010 and pilot: 2010-2011; begin community initiatives 2010
Responsibility: Department of Health

Goal 14.3 The mental health of families and children is valued and nurtured

Recommendations

- Expand capacity to provide a national "Handle with Care" program to train daycare providers in mental health promotion for early childhood.
  Timeline: 2010-2012
  Responsibility: Departments of Health and Social Development
- Increase recognition and early diagnosis for post partum depression by providing information, education and links to existing services.
  Timeline: Begin development phases 2009-2010
  Responsibility: Department of Health

People experiencing a mental illness deserve a better life.

Goal 14.4 Resources and strategies are in place for prevention

Recommendations

Continue work already underway for taking a coordinated approach to suicide prevention for people at risk, including development of support groups. Invest additional resources in current suicide prevention committees.
Timeline: Begin 2009-2010
Responsibility: Department of Health

CONCLUSION

While the goals in this report represent an ideal future, the recommendations are feasible, and crafted to be achievable within a 5-year time frame. Some relate to directions that have already been identified in the Health Plan. Many can be started immediately, offering "quick wins" to a public that is anxious for change. Some, in particular, can be completed in the first year; these include collaborations between the Department of Health and other departments to deal with the fine points of policy barriers regarding medications, income support, and services for youth ages 16-19, and the research on care models with single points of entry. Most of the longer-term strategies start with a research/needs assessment/development phase that can also provide early preliminary results in the first year or two.

Many of the recommendations involve additional expenditures in the

short term, but these front-end costs will pay significant dividends. Spending smarter, serving people earlier and better, nurturing wellness and preventing difficulties will sow the seeds for transformation. With system transformation, fewer people will be inappropriately incarcerated or requiring long-term hospitalization, and more will be living productive lives in the community. Put simply, there will be less dependency and more self-sufficiency, which will ultimately cost less in some parts of the formal system. And herein lays the key to the success of the strategy: once savings start to accrue, they can be reinvested to sustain ongoing transformation. This will leave New Brunswick with a legacy of an increasingly effective, seamless system of services and supports that produces better and better outcomes for people, far into the future.

The same dynamic spirit that characterized the consultation process must now guide the implementation of a strategy. Mental health affects us all, and this strategy is everyone's responsibility; its energy will come from the continued engagement of individuals and communities, collaborating to "build bridges, not walls".

New Brunswick has a proud history of leadership in mental health reform in Canada. In the 1980s we became a model for reducing institutionalization and focusing on community, and broke ground in 1989 with the establishment of our own Mental Health Commission. Since then, there has been growing recognition worldwide of the impact of mental health and mental illness, particularly in these uncertain times. Mental health has recently been called "a sleeping giant" that is expected to become an even more significant public health issue in Canada over the next decade. Now is the time to take the next steps forward, working together to build a transformed, coherent system that promotes and protects the mental health of all of us.

We can all make a difference!

APPENDIX

In addition to the information listed below, 450 individuals took part in the online consultation and 400 people met with the Task Group in regions around the province.

In all, approximately 2000 people met directly with the task group, while numerous others were represented by their associations or organizations

General Information Presentations

Centracare

Jacinthe Dufour, executive director, Alternative Residences Alternatives Inc.

Carol Steel, Executive Director, CMHA Moncton Region Inc.

Marg Milburn in conjunction with District 18

Judy Gorham, Leaning Specialist, School District 18

Community Planning Group

Johanne Cléroux, CMHC Campbellton

Community Advisory Committee Saint John

VON

John Howard Society

Schizophrenia Society - Saint John Chapter

Roots of Empathy

Ron Harris, Psychologist

CHMA

Canadian Mental Health Association - Fredericton/Oromocto Region Inc.

Luc Dubé and Dr. Siddartha

Independent Living Resource Centre Miramichi

Groups

First Nation Health Directors

Elsipogtog First Nations Health Services

Activity Centre Directors

Deputies Ministers and Senior Staff from Public Safety, Education, Social Development, Health, Wellness, Culture and Sport and Justice

Dr Stan Kucher

Dr Nicole Letourneau & UNB

Elizabeth Fry Society

John Howard Society

Mental Health Advisory Committee

Mirielle Lanouette-Beausejour

NB Association of Social Workers

NB Health Council

NB Senior's Federation

Premier's Council for the status of disabled persons

Primary Care Stakeholders Group

Psychiatric Patient Advocate Services

Rachel Brown

Rob Turgeon NBSPCA

L'Association acadienne et francophone des aînées et des aînés de NB

CHIMO Helpline

NB Seniors Federation

Independent Living Center - Miramichi

Atlantic Board of the Portage Group

Canadian Mental Health Association NB

Chiefs of Psychiatry

CLCC Implementation Committee

College of Psychologists

Dr. Celine Finn

Forensic Committee

Nère St-Amand

Staff Deputy and Staff from DPS

NB Medical Society

Nurses Association of NB

Schizophrenia Society of NB

Suicide Prevention Committee

Forensic Committee

NB Medical Society

Judge Brien, Mental Health Court

NB Association of Nursing Homes

NB Youth Advisory Council

Staff Groups

Miramichi

Edmundston

Campbellton

Bathurst/Peninsula

Moncton

Saint John

Fredericton

Letters and e-mails

Dr. Mubeen Jahagit (Child Psychologist)

Sharon Wells

Charles and Sandra LeBlanc

Wynne - Anne Pomar

Joan Sichel

Nicole MacNaughton, president of NBAOT

Lucie Robichaud, Canadian Mental Health Association - Fredericton/Oromocto Region Inc

Robert Buck

Roger Stoddard

Linda Duffett - Leger, RN

Michael McKenney

Dr. Gilbert Dru

Francine Morin

Yolande Cyr, directrice du centre d'activité La Source de Grand Sault

Bernadette Boucher

Charlotte Leblanc, Nutrition and Allergy Consultant

Robert Pert

Not signed

Eric Richard

Robert Boulter

Louise Boulter

Sharon Cameron

Fiona Williams, Coordinator, CPG

Stephanie Haines - Lacey, Clinical Social Worker

Émilienne Basque, Secrétaire, Regroupement des bénéficiaires en installations résidentielles

Aurélie Basque, Trésorière, Regroupement des bénéficiaires en installations résidentielles

André Duguay, Conseiller, Regroupement des bénéficiaires en installations résidentielles

Lisette Basque, Vice Présidente, Regroupement des bénéficiaires en installations résidentielles

Donat Comeau, Conseiller, Regroupement des bénéficiaires en installations résidentielles

Bernard Basque, Président, Regroupement des bénéficiaires en installations résidentielles

Strengthening Families Together 3rd Edition - Schizophrenia Society of Canada

Assertive Community Treatment Facts and Articles - Unsigned

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Proposal: **To develop an early psychosis program for AHSC Region 2 -** AHSC Region 2 Planning Task Force

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AHSC Strategic Direction - AHSC

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Actuellement: Les Services de Santé (Mentale er médical en général) - Unsigned

Soumission - Yves Hudon, président Le réseau des bénéficiaires en santé mentale du NB

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Annual General Meeting Agenda - CMHA Moncton

List of Board of Directors for 2009 - CMHA Moncton

Meeting Notice - CMHA Moncton

Living with Depression Support Group - Dr. Shirley Northrup, CMHA Moncton

Vivre avec la dépression report annuel - Hélène Hébert, Facilitator, CMHA Moncton

With Hope in Mind annual report - Emerise Nowlan, Facilitator, CMHA Moncton

ADHA Parenting Course annual report - Shirley Ross, Facilitator, CMHA Moncton

Daybreak Activity Centre annual report - Melody Petlock, Daybreak Director, CMHA Moncton

Our Place/Chez Nous annual report - Carmel J. Fitch, director, CMHA Moncton

Alliance Center annual report - Alice LeBlanc, Alliance Center director, CMHA Moncton

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Grief Therapy Group annual report - Dr. Shirley Northrup, CMHA Moncton

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***Pamphlet:* 10 Questions Caring Educators Ask -** Brenda MacLoon, Virtues Project Facilitator

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Position Statement - Diane Reid

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Position Statement - Unsigned

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Position Statement - Brenda MacLoon

Position Statement - Bertrand Collin

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Position Statement - Unsigned

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Soumission - Carole Gallant, Gestionnaire Programme enfant - adolescent CMHC Restigouche

Soumission - Serge Robichaud, Gestionnaire de Programme, CMHC Campbellton

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Presentation: **Housing Workshop -** Community Advisory Committee Saint John

Funding proposal for the establishment of a community residence for four current patients of Centracare - Nora Gallagher, regional manager, Centracare

Position Statement - Sharon Gronzik, CAC

Position Statement - Roger Stoddard

Position Statement - Robert Buck

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150 Years of Caring: The continuing history of Canada's oldest Mental Health Facility - David Goss

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