Review of Mental Health Advocacy Services: A Summary

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This is a review of Mental Health Advocacy programs in other jurisdictions, including all US States and territories, Australia, New Zealand and four provinces in Canada. It was carried out via both a Web search and personal contact with Advocacy services. It defines advocacy, and mental health advocacy in particular. It summarizes the reporting relationships and roles of the programs that were reviewed. It also summarizes the key recommendations of the BC Ombudsman's original recommendation regarding the creation of a Mental Health Advocate for BC. Finally, it addresses implementation issues.

1. Definitions

Advocacy

... is a process by which a person or individual acting on someone else's behalf makes representation regarding rights, privileges, benefits and other issues pertinent to persons with a mental health problem. Advocacy on behalf of others is based on the individual's instructions, is respectful of the individual's rights and values, and maximizes the involvement of the individual.

— Listening: A Review of Riverview Hospital
Ombudsman of the Province of British Columbia, 1994

Mental Health Advocacy

Mental Health Advocacy is a well-established element of a progressive mental health service system. Recognizing that psychiatric patients are vulnerable to having their rights taken away and potentially subject to abuse and neglect, every state and territory in the United States as well as Australia and New Zealand has a Mental Health Advocate. Three other provinces in Canada (Alberta, Ontario and New Brunswick) also have formal programs.

Types of Advocacy

Advocacy can be informal (self, family, friends, caregivers) or formal. Formal advocates can do individual advocacy, helping an individual solve a problem, or systemic advocacy, addressing the policies that contribute to the problems. Because in all cases advocacy is informed by the person with the issue, systemic advocacy cannot exist independent of individual advocacy.

2. Qualities of Mental Health Advocacy programs in other jurisdictions

Reporting Relationship

Approximately three-quarters of the programs are established independent of the service system they monitor and are housed at arm's length from government services. The rest are internal special commissions or programs but still reporting independent of the service system they monitor. All services reviewed have some form of a public report detailing the types of complaints received and recommendations for improvements.

Role

All programs exist fundamentally to protect and defend the rights (legal, social, therapeutic) of psychiatric patients. In all cases, programs have formal protocols to investigate complaints. These protocols are established as memoranda of agreement between the service system and the advocacy organization or as part of the Mental Health Act. Where budget exists, the individual complaints are aggregated to produce systemic advocacy.

Current trends

The majority of programs were established to protect patient rights in the context of an institutionalized model of care. As care has moved to the community and provisions of extended leave under the Mental Health Act have been added to approximately two thirds of the service systems reviewed, most services are struggling with how to provide advocacy services in the context of community living. In addition to rights as citizens, the patients' need for access to housing, income support and community care mean that the scope of the advocacy job required to support living well in the community has increased. Now that more mentally ill people are residing in communities, addressing stigma against mental illness is a major task.

discrimination

3. The BC Ombudsman's Recommendations for the Provincial Mental Health Advocate

In 1994, the *Listening* report recommended the position be an internal advocate reporting directly to the Minister of Health. This was so he could be directly informed of how well the service system is supporting the needs of people with mental illness and enable him to prioritize mental health funding within the Health Ministry budget. The Ombudsman's recommendation was made recognizing the traditional organizational stigma associated with health programming. The aim was to let the responsible government agency be "Fair First".

The Children's Commissioner, the Advocate for Service Quality in the Ministry for Children and Families and the WCB Ombudsman are similar BC government models. Given that mentally ill people represent 20% of the population, the Children's Commission model is a more appropriate model than the Service Quality Advocate, who represents the approximately 1% of the adult population with a developmental disability who receive care from the Ministry for Children and Families.

Community advocates have called (and still do) for the Mental Health Advocate to be an independent officer of the legislature, as is the Child, Youth and Family Advocate, thinking this would hasten government commitment to the Mental Health Plan.

4. Implementation Issues:

The BC Mental Health Advocate's current situation

The current situation of the BC Mental Health Advocate as a contract co-managed by the Health Association of BC and the Adult Mental Health Division and reporting to an Associate Deputy Minister is unique among the advocacy services reviewed.

The contract will lapse on March 31, 2000. To proceed with an effective provincial advocacy service, government must address the following issues:

- *Principles for advocacy*

  The principles for mental health advocacy in BC were established in a lengthy process during the Ombudsman's Review of Riverview Hospital in 1992–1994. These principles form the basis of the current Riverview Advocacy program and should inform the design of the provincial Mental Health Advocate's Office.

- *Reporting relationship for the Mental Health Advocate of BC*

  The Minister must determine a reporting relationship that will enable independent advocacy—within or outside the Ministry of Health.

- *Providing information and referral to mental health patients and their families*

  Currently, government funds both the Mental Health Advocate and the CMHA (the BC Mental Health Information Line) to provide this service. To avoid confusion and increase efficiency, these two services should be merged.

- *Protocols with the regions*

  The Regional Health Authorities must articulate a complaints management process that recognizes the unique needs of mental health patients. They must also address how they wish to deal with individual advocacy within their region. Currently, 3 Regions have an individual advocacy service in place. These services are provided independent of the service system via community non-profit agencies such as the Canadian Mental Health Association. The Children's Commission model details a stepped complaint management mechanism that culminates in involvement of the Commission when all other mechanisms have failed.

- *Protocols for investigation*

  The Mental Health Advocate's Office must have protocols for investigation of serious incidents and deaths. These are basic to an Advocate's tool kit.

- *Protocols with other advocacy groups*

  The Ministry of Health funds almost two million dollars worth of programming for mental health advocacy and education with very little accounting of activities required. These funded groups* must be required to document whom they help with what issue and this information forwarded to the provincial Mental Health Advocate on a regular basis.

- *Right to advocacy*

  In the BC children's care system, people have the right to advocacy. In other jurisdictions, mental health patients have the right to advocacy. In the most progressive service systems this is detailed in a Charter of Patient Rights. Riverview Hospital has a Charter but this was constructed for patients in a tertiary care facility and something more basic to community living needs to be developed.

- *Access to advocacy*

  Currently, access to advocacy is not universal. If you are a patient at Riverview Hospital you can access an advocate; if you are a patient in the forensic system you have no access. Patients in the forensic system should have access to an individual advocate to assist with social and therapeutic rights (access to medications or provider of choice, etc.).

- *The person with the illness is the client*

  In all service systems, the client of mental health advocacy programs is the mental health patient. Decision-makers need to recognize that family members of seriously ill patients (who represent .4% of all those with a mental illness) may and should advocate for more coercive care strategies but that this cannot be the mandate of a psychiatric patients' advocacy service. Given that BC has just implemented revisions to the Mental Health Act advocated for by the family movement, it is

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* Canadian Mental Health Association, BC Schizophrenia Society, Mood Disorders Association, Alzheimer's Society of BC, Association of Awareness and Networking around Disordered Eating, Mental Health Empowerment Advocate's Program (income advocacy), Riverview Advocacy Program, Action Research and Advocacy Association

important that this trend be counterbalanced with strengthened supports for client-centred advocacy.

5. Conclusion:

People with psychiatric disabilities are some of the most vulnerable members of our society. The NDP government has taken a progressive step in deciding to implement a Mental Health Advocate's Office, but the current model does not provide the necessary independence to fulfill the function of mental health advocacy. Until this is addressed, the government can be criticized for creating an Office that is merely window dressing.

If the BC Ministry of Health can resolve the issues discussed above, it can establish itself as a progressive model for other provinces to follow. Further, enabling a properly functioning provincial Mental Health Advocate's Office is consistent with the NDP's tradition as a party that advocates for the needs of the people, and will strengthen this perception in the public eye.

Comparison of MCF Service Quality Advocate and MOH Mental Health Advocate

Introduction:

Between the time of the recommendation of the Mental Health Advocate in the Ombudsman's 1994 Listening Report, the 1997-98 Working Group who created the job description and government's decision to fill the post in August 1998, there have been many different visions for the Mental Health Advocate's Mandate. It is clear that the Community wanted an advocate external to government while government felt comfortable with an internal advocate. The position that has been created is neither internal nor external and is in need of some problem solving. As Ministry officials frequently say they want an Internal Advocate like the MCF Advocate, I thought it useful to compare and contrast the two positions as they are indeed quite different.

Area of Mandate	MCF Service Quality Advocate	Mental Health Advocate
Term of Appointment	Government appointment by Order in Council; government position with usual terms of benefits, employment and termination.	Contract with Private Consulting Company. No benefits. Contract that can be terminated within 28 days.
Reporting Relationship	Meets with Minister of Children and Family 4 times per year; Meets with DM, ADMs on a regular basis.	Meets with Assistant Deputy Minister every month (approx); has met Minister once in 9 months. Has never met with DM or Assoc DM despite fact that most systems issues relate to care in acute sector.
Client Group	Adults with developmental disabilities within MCF Mandate	Persons living with a mental illness in BC who may or not be clients of the mental health system

Area of Mandate	MCF Service Quality Advocate	Mental Health Advocate
Relationship to Client	Acts as internal individual advocate with support of the provincial delivery system. Handles **60 individual cases per year**. Focuses on eligibility issues and portability of benefits within the context of Regional Quality Advisors. Can call up regional managers/front line workers and request they see clients and get back to her. Occasionally will be asked to do a service review for the Ministry. e.g. reviewed the closing of a group home after complaints came to DM's office; reviewed unexplained death of adult in care in Kamloops.	Acts as systems advocate within the context of no regional quality advisors. Fields ~~**60-70**~~ →160 **individual complaints per month** with no direct access to individual advocates and no feedback as to outcomes with individuals. Currently, sees issues escalate from complaints to suicide or from Advocate's office to Minister's office with no resolution and no feedback that issues have escalated or been resolved.
Principles and training for service delivery	Community Living Movement has clearly defined values and principles for client service that are agreed upon and reinforced in social worker training.	Community Living movement within Mental Illness has real divide between Recovery model and Medical model. Hospitals as a rule don't hire psychiatric nurses; general duty nurses with minimal training provide the majority of care. Most rural areas do not have access to skilled psychiatric care and staffing of mental health is limited though plans to build are part of the Mental Health Plan.
Context of Community Living movement	Struggle for deinstitutionalization well advanced with community supports in place. Academic leadership for capacity model through John McKnight.	Government commitment to community living movement mixed. Advocate appointed to monitor progress in implementation of multi year funding commitment. Current status of this commitment is under review. No Academic leadership; role of MECCHU and Best Practices groups in development. Still tension between service model and community capacity building model.

Area of Mandate	MCF Service Quality Advocate	Mental Health Advocate
Mandate for public education	None. Occasionally tours Ministry Regions to meet with staff.	Heavy commitment: 6 public events per month. Expected to tour regions to meet with family members, consumers, regional health authority staff and governors as well as mental health staff. People really need to see and talk to the Advocate given the shame and issues they face in recovery and the politics of regionalization with uncertain accountabilities.
Mandate for advocacy	Does no external advocacy to government but very important that independence within government is maintained.	Government says it wants an internal advocate but has located person outside of government. She is expected to work with external advocacy agencies to develop a network of individual advocates. E.g. Advocacy Review Project
Office Infrastructure support	Installed in MCF office building. Has telephone and security systems support from MCF; established on MCF Office Vision system.	Installed in market office building. Has gov't telephones but maintains own info and security systems support and email address.
Consultant Infrastructure support	Well established network of consultants: medical, legal, policy experts who provide support and action in dealing with client's needs. Also network of Ministry Regional Quality leaders.	No network of consultants. Staff are available to contact but no protocol for reporting back or managing cases. Clients not comfortable with confidentiality or complaints process at local level.
Vacation Replacement	Budgeted for relief for advocate and assistant.	No budget for vacation relief.
Participation on Ministry Committees	Does not serve on any Ministry Committees as stakeholders felt this might compromise her objectivity, but does review policy decisions in process.	Serves on Ministry Committees: e.g. Mental Health Plan Implementation Committee, Provincial Information Systems, Performance Monitoring Systems, MECCHU Advisory Board, Provincial Mental Health Advisory Council.

Area of Mandate	MCF Service Quality Advocate	Mental Health Advocate
Advisory Structures	Has $50,000 to support advisory group (families, regional MCF officials, non profits and private care agencies) that meets and advises on Advocate's caseload and systems strategy issues.	Has none. 6/99 Lillian Bayne suggests she has internal reference group.

Conclusion:

These two positions are vastly different. The MCF Advocate has a clear terms of reference within a supported infrastructure of government. Her mandate is limited to a small subset of individuals and her practice is office based. She stands at the end of a very well developed system for quality management. In addition, the services for folks with developmental disability are well supported by information systems to communicate on client progress.

The demands of the two populations are very different with the Mental Health Advocate dealing with 10 fold the number of clients. The Mental Health Advocate does not have a supportive infrastructure with consultant support that will report back. There are no designated quality managers within the field as say with Continuing Care or Cancer Care. The regionalization process makes accountability uncertain. In addition, the Mental Health Advocate has a number of additional duties such as public and professional education as well as the organization of an advocacy network. She is also expected to participate on committees as part of the Infrastructure development for Mental Health.

The Community Living movement and the Mental Health Reform movement are at very different stages in their history. The Community Living movement has a degree of maturity and funding support that the Mental Health community lacks. Wait lists of 2-3000 people for supportive housing does not exist in the Community Living movement. Nor is there the glaring lack of community support as what exists in the Mental Health service delivery system.

The Community Living movement has a well developed external advocacy system (BCACL & PLAN). BCACL is funded by member non profit agencies around the province. PLAN is funded by 800 parents and is an advocacy agency entirely at arms length to government. The Mental Health community fought for and still think they have an external advocate; the Ministry of Health thinks they have an internal advocate but does very little to support her in the way that the MCF Advocate is supported.

REVIEW OF REGIONAL MENTAL HEALTH ADVISORY COMMITTEES

OFFICE OF THE MENTAL HEALTH ADVOCATE OF BC

JANUARY, 2000

1. SUMMARY

This report reviews the current status of Regional Mental Health Advisory Committees (RMHACs) via a survey that was conducted by the Office of the Mental Health Advocate between August and December, 1999. Fifteen of the 18 Health Authorities have working RMHACs or are far along in the process of setting one up.

The RMHACS, begun at different points in time, are in various stages of development, but in general, the contact person for local groups expressed optimism about the developing capacity and accomplishments of their group. The groups have reported a variety of successes and challenges.

Recommendations to help strengthen these committees include:

- The Ministry of Health make a RMHAC a standard for the Health Authority to receive mental health funding.
- The Ministry of Health negotiate with the Health Authorities to determine the potential relationship between the Provincial Mental Health Advisory Council and the Regional Groups.
- The Ministry of Health use some of the funds that were formerly available to the Family Advisory Council and the Consumer Advisory Council to hold macro regional meetings, provide advocacy training and subsidize travel costs for consumers and family members.
- The Ministry of Health provide community development support for regions where RMHACs are less well developed and assistance is requested.
- The Regional Health Authorities work towards having these groups chaired by a consumer or family member. Clerical assistance should be provided to community member chairs.
- The Regional Health Authorities continue to use diverse strategies to recruit new membership to these groups.
- The Regional Mental Health Advisories review the terms of reference of their Regional committees with a view to consider a variety of potential roles being adopted by their peers in other regions.
- The Office of the Mental Health Advocate continue to meet with these groups and support their development.
- The Office of the Mental Health Advocate conduct a provincial survey of peer helping programs so as to provide support regarding standards and policy issues for regional peer helping programs that are in development.
- The Office of the Mental Health Advocate repeat this survey in one year's time.

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REVIEW OF REGIONAL MENTAL HEALTH ADVISORY COMMITTEES

1. INTRODUCTION

This report reviews the current status of Regional Mental Health Advisory Committees designed to enable consumer and family participation in mental health reform in the 18 BC Health Authorities. The survey was conducted via fax-back form and then the data checked by telephone interview between August and December 1999 by the Office of the Mental Health Advocate. The Health Authority contacts who completed the survey are listed in Appendix 1.

Because the Advocate was aware that many of these groups were in development, a decision was made to contact the person responsible for developing the group. It was considered premature and inappropriate at this stage to directly survey group members.

The Advocate's Office undertook this survey for several reasons:

- The Ministry of Health had undertaken a revision of the Mental Health Advisory structures at the provincial level and had supported the development of Regional Mental Health Advisory Committees (RMHAC) so that consumer and family input could be maximized at the level of direct service delivery. It had funded each Health Authority to set up a group and supported the Chair of the Consumer Advisory Council to visit each Health Authority to promote adoption of this model. One year later a status report was necessary.
- With the restructuring of the Provincial Mental Health Advisory Council and the elimination of the Family Advisory Council and the Consumer Advisory Council, some citizens expressed concerns about having lost their voice in mental health reform. Some consumers and families had raised concerns about the functioning of these new structures and whether or not they were constituted in a fashion that would maximize input and partnership towards mental health reform. Others were concerned about the process for awarding the Consumer Family Initiative funds (a provincial total of $4.2 million in 1998) and whether these funds were being used according to the original purposes.
- Some Health Authorities expressed concerns about how to support the development of effective and timely consumer and family input. One Authority questioned the necessity of such a structure.

- The Mental Health Advocate noted that there were different levels of understanding as to what constitutes effective public participation and how to foster its growth. In addition, the Advocate saw the RMHAC as a touch point for accountability for mental health reform at the regional level. Strong collaborative groups giving input from their experiences would foster better care at the local level, and at the same time these groups would constitute a network of consumer and family contacts. These networks could be linked provincially, which would provide both feedback about policy initiatives and also peer contacts to support the work of information and referral coming from public contacts to the Advocate's Office.

A further purpose of this report is to prototype a "strategic survey" as an instrument for providing a provincial overview of regional implementation of a specific issue and inform further action from the Mental Health Plan leaders. Thus, it represents a format for process evaluation of a specific element of mental health reform. The intent is not to blame any one region for "failing" but rather to report on implementation status and share best practices from "leader regions". The survey database is constructed so the survey can be repeated at regular intervals if required.

This report reviews public participation in mental health reform in BC and elsewhere, summarizes the results of the survey of 18 Health Authorities and makes recommendations for follow up action. Although this survey is written for the Minister of Health, it will be presented to the Mental Health Plan Implementation Steering Committee and then circulated to the contacts in participating Health Authorities.

2. Public Participation in Mental Health Reform in BC and Elsewhere

> **"The renewed Mental Health Plan must produce changes that will have a positive impact on the lives of those who use mental health services and the quality of life in British Columbia communities. To achieve this, the plan must address a number of systemic issues of which ... Continuing to increase the involvement of Consumers and Families" is the first challenge listed.**
>
> *Revitalizing and Rebalancing British Columbia's Mental Health System*

> **"All services for those with a mental disorder should be consumer oriented and focused on promoting recovery"**
>
> *Mental Health: A Report of the Surgeon General*

Public participation in the planning, evaluation and delivery of services is a tenet central to mental health reform in BC. It is a principle of the 1998 Mental Health Plan as well as a principle set forth in the development of the regionalized mental health delivery system. While it is a principle, there is no statutory requirement or standard format that has been agreed upon between the Ministry of Health and the Health Authorities. The 1999 Best Practices Group on Consumer Initiatives described methods for fostering consumer participation, but assessed neither the current status of participation nor the strengths and weaknesses of different models.

In contrast to BC, New Brunswick has put public participation in mental health reform and Regional Mental Health Advisory Groups in revisions to its mental health legislation. Consumer and family representation in local regional planning processes is specified, and Regional Advisory Committees are required to approve mental health plans that are sent to the province for funding.

Consumer and family participation in mental health planning is also specified in US legislation. Consumers and family members lobbied the US Congress to ensure their voices would be heard, and this led to the creation of Public Law 102-321, which requires Mental Health Planning Councils in every US state. The Councils are required to have consumer and family members in order to receive federal money for mental health services. These Planning Councils make recommendations about state mental health budget allocations and so can be considered quite powerful. In addition to the planning function, twenty-seven US states have paid positions for consumers associated with their state Mental Health Authorities. Many have Offices of Consumer Affairs (Surgeon General, 1999, p.95).

Public participation in research (knowledge development) is a possibility yet to be realized in BC. In other jurisdictions, consumers are active participants in clinical research, respondents in survey research, partners in designing and conducting research projects and even as peer researchers who conduct their own research (Campbell et al., 1993).

3. Distinctions among Various Forms of Public Participation

There is an extensive literature on public participation. As stated in *Achieving Health for All*, "encouraging public participation means helping people to assert control over the factors which affect their health... By creating a climate in favour of public participation, we can channel the energy, skills and creativity of community members into the national effort to achieve health" (Epp, 1986, p. 3). Not only is public participation in health reform healthy with regards to mental health reform, it also serves to make the treatment system more relevant and effective to the patient and families needs, and it serves to bridge community actions from the treatment system to the community system as a whole. All jurisdictions, and most recently the US Surgeon General, acknowledge that educating the community at large about mental illness and addressing stigma are critical actions to support mental health reform (US Surgeon General, 1999).

When thinking about public participation the following distinctions can be made:

- True participation: the members of the community participate in defining the agenda and in making substantive contributions to the outcome of the planning, evaluation, service delivery, community support or education initiative.
- Consultation: the agenda is determined ahead of time by the service providers or administrators and public input is received around the specific issue presented for discussion.
- Pseudo consultation: the public is consulted on a predetermined agenda, but any input arising from the consultation does not affect the actions taken.

Supporting consumer and family participation in mental health reform is not without its challenges. The Consumer Movement represents a diverse group of perspectives ranging from anti-psychiatry to partnership approaches. Consumers and family advocates frequently find themselves on different sides when aspects of involuntary care are discussed. People may disagree because of differences in fundamental beliefs about human rights. Often people disagree because of the diversity of their experiences of mental illness. For example, a consumer with bipolar illness who is in recovery would have a different perspective on coercive treatment than would a family member of a person with schizophrenia who has little insight into their illness, is not receiving any treatment and is caught up in the criminal justice system.

Perhaps because of the intensity of different experiences and the frustration in obtaining appropriate care, consumer and family participation can involve an element of emotionality. Processing emotional responses is difficult but essential, as typically in administrative forums rationality is prized and emotionality is considered bad manners (Church, 1996).

4. Results of the Survey of Regional Mental Health Advisory Committees

Appendix 2 lists the composition of the Regional Mental Health Advisory Committees. Fifteen of the 18 Health Authorities have working RMHACs or are far along in the process of setting one up.

The working groups, begun at different points in time, are in various stages of development, but in general, the contact person for local groups expressed optimism about the developing capacity and accomplishments of their group.

Success stories of the groups include:

- Reviewing and approving the Region's Mental Health Plan, reported by East Kootenay
- Facilitating consultations throughout the Region and developing the Region's Mental Health Plan, reported by North Okanagan
- Facilitating conferences: "Erase the Stigma", reported by Simon Fraser; "Patient and Family Rights", reported by East Kootenay
- Discussing new program initiatives such as reviewing a single intake system and discussing the Target Group Policy issue, reported by North West; reviewing the confidentiality requirements of the Provincial Mental Health Information system reported by Vancouver Richmond.
- Making policy recommendations: the Vancouver Richmond Population Advisory Group asked staff to approach the Ministry of Human Resources to exempt mental health consumers from attending compulsory orientation sessions in order to receive their benefits; they also organized a meeting between Pharmacare and consumer and family representatives about making Respiridone available as a first line medication.
- Making recommendations about funding for Consumer Family Initiative Funds or other special Regional Initiatives, reported by South Fraser and Vancouver/Richmond
- Involving people with experience with the forensic system to sit with providers on service planning committees, reported by Simon Fraser
- Helping people access services, reported by South Fraser

Challenges reported include:

- Reporting relationships: two of the groups (Vancouver/Richmond and North Shore) report directly to the Regional Health Authority. Further, these Boards have a designated member who "follows the Mental Health portfolio". This kind of a reporting structure allows consumers and families to have a direct input into policies, whereas groups who report directly to the Regional Mental Health Director are more oriented towards advising on the implementation of programs.

  In one region (South Fraser), there is an informal connection with the Health Board via circulated minutes to the Board and an informal Board liaison.

Most of the groups act as advisory groups to the Regional Director, which works well as long as the Regional Director doesn't also chair the group. A related potential conflict of interest is set up when a staff person who reports to the Regional Director is the chair of the group.

- Transportation costs: there is no single policy for reimbursement of travel costs among the groups. Some do and some don't'. While one-time funding of $5000 was provided by the Ministry of Health to establish these groups, ongoing support for travel costs has not been provided for and is essential to enable regular group functioning. The northern and rural Health Authorities are particularly challenged by these costs, as for example, in the North West, some people must travel and stay overnight to attend meetings in Terrace.
- Connections to the new Provincial Mental Health Advisory Council: people are uncertain as to whether they have a direct connection to the new Council.
- Group development and accountability: in some regions, it was reported that the number of individuals available to sit on committees is small and staff are reluctant to burn out the few active consumer and family members by asking them to attend multiple committee meetings. Further, when limited numbers of people are involved resentment can grow amongst the uninvolved as to why certain people are always asked to "represent" the consumer or family voice. Keeping these groups accountable to their peers was described as a challenge as well. The Capital, South Fraser, Simon Fraser, Vancouver/Richmond, Kootenay Boundary and North Shore regional contacts for this survey all described the importance of using a community development approach to facilitate consumer and family participation.
- Participation of service providers: most groups have a limited number of service providers on the committee, choosing to bring the various service providers together in some sort of regional management group. Concern was expressed that if service providers are too great in number, they will dominate the conversation. On the other hand, in two regions where there are more service providers at the table, consumer and family members indicated they felt comfortable with the partnership approach.
- Resources to support Consumer and Family Initiatives: some groups use the Regional Mental Health Advisory as a group to oversee the awarding of the Consumer Family Initiative Funds. Other regions have different processes, recognizing that the leaders on the Consumer and Family Advisory groups may also be leaders in Consumer and Family Initiatives and thus from a conflict of interest perspective may not be the best people to vote on their own appropriations. One region commented that despite increasing recognition of the value of consumer and family initiatives, these funds had not increased since 1994, and that available funds tended to go to the same valued programs (e.g. Peer Support, Income Assistance advocacy). There seems to be a question as to whether these funds are for one-time initiatives or to support ongoing programs such as Peer Support.

Status of group structure and function include:

- Fourteen of the reporting groups at the Regional level have met regularly enough to have minutes that are circulated.
- The Chairs of these groups are variously determined: ten regions have elected Chairs, four have appointed Chairs, and one group has not yet determined a process for selecting the Chair. Either a consumer or a family member chairs four of the groups, staff members chair 3 groups, community agency directors chair 3 groups and Regional Mental Health Directors chair groups in

four regions. In one region, a consultant chairs. In several situations, the Chair, though a consumer or a family member, is also an employee of the Regional Mental Health program, which could be problematical in dealing with contentious issues should they arise. On the other hand, staff chairing of meetings can also be seen as a first step in group development before the group becomes familiar enough to know its natural leaders.

- Twelve of the 18 Health Authorities report having subregional committees, usually at the level of a specific municipality, e.g. South Fraser has groups for Surrey, Langley, White Rock and Delta. All but one of the Health Authorities have representatives from these subregional groups sitting on the RMHAC.
- Ten of the 18 Health Authorities report having separate Consumer Councils.

Appendix 3 lists the summary reports for each individual Mental Health Advisory Committee.

Success stories that have built the capacity of these groups include:

- Advocacy training for groups members (e.g. the former Chair of the Vancouver/Richmond Advisory Group is a member of the Self Advocacy Program of the Kettle Friendship Society in the Downtown East Side; some members of North Okanagan, Thompson, Kootenay Boundary, and the Okanagan Similkameen Groups have participated in the CMHA Consumer Development Project). Advocacy training includes information on how to participate in meetings, conflict resolution, how the health policy process works, etc.
- Staff support: Simon Fraser, South Fraser, North Shore, Peace Liard, Cariboo, Vancouver/Richmond and Capital Regions all have designated staff persons to support consumer and family participation. This includes support to facilitate community meetings. For example, a group in Simon Fraser held a very successful community meeting to address stigma. They also used this meeting as an opportunity to recruit 17 volunteers to work on special projects. Staff support also includes logistical support for meetings (minutes, notice of meetings), research around identified issues and group membership development.
- An office and/or the provision of secretarial support with access to fax and email: the South Fraser Region offers support to their RMHAC and the subregional advisories through giving the executive members office space in the Mental Health Centre. The Kootenay Boundary Region is supporting the development of an RMHAC through building subregional groups and encouraging the use of the local Clubhouses as internet communication centres for these subregional groups.

5. Other Methods of Public Participation

In the course of the survey, many contacts suggested different methods to facilitate public participation in mental health reform, in addition to the RMHACs. These include:

- "Town Hall Meetings" at the local clubhouse (reported by Okanagan Similkameen South). In this situation the Regional Director goes to a setting familiar to consumers and lets them identify issues for discussion.
- Peer Support Programs. The variations on the theme of peer helping need to be documented and explored in a further survey, as many regions are grappling with how to foster such initiatives.

- Consumer Run Initiatives. This is a new area which uses community economic development as a strategy to support recovery in contrast to the more traditional rehabilitation approaches (Church, 1997). Consumer Run Initiatives are in the early stages in BC.
- "Bridges" and "Family to Family" Programs. The BC Schizophrenia Society trains volunteers to deliver these education programs.

The Capital Region purposely chose not to recreate their former Regional Advisory Committee. The region reported that this committee had token consumer and family participation, and the management had reported no relevant consumer-related outcomes. Health Authority staff noted that the discussions were very agency-dominated. Instead, the Health Authority created a Consumer Family Support Program that has the responsibility of getting consumer and family input on a variety of emergent policy and program issues. This Consumer Family Support Program has a Consumer Advisory Council with representatives from all of the communities in the Capital Health Region (Sydney, Gulf Islands, Victoria and surrounds). A focal point of the Consumer Family Support Program is the REES Centre, which is a consumer and family run research and evaluation centre. Consumers and family members have been trained to evaluate and review residential and psychosocial rehabilitation facilities. The Consumer Advisory Group works with the REES Group to survey and gather information to advise the Health Region. Many programs (e.g. the Consumer Business Training Centre) have a consumer advisory group as well.

6. Conclusions and Recommendations

The majority of Health Authorities have taken significant steps to establish a forum for consumers and family members to advise the Regional Mental Health Director in planning mental health reform. Two regions have groups with a direct reporting relationship to the Health Authority Board. These are above and beyond direct advice that consumers and families may give to specific programs.

One region has made a specific policy of not establishing a regional advisory. Another region has used the Regional Advisory as a structure to bring together the Community Health Council reps and CEOs to work in a collaborative manner, but the Committee has currently no consumer or family representation.

In regions where there are active groups, these groups have served as a point of contact for individual and systemic advocacy by the provincial Mental Health Advocate. These connections have enabled the Advocate to:

- Exchange policy issues for discussion
- Establish direct local links for advice and referral of individuals who are seeking help from consumer and family members in a similar circumstance

These groups can also serve as a point of contact for the new Provincial Mental Health Advisory Council to communicate information about provincial initiatives and focus-test proposed policy changes related to Mental Health reform. In addition, it is a local source of information for all consumers and families in the region.

While the Advocate has received reports of frustration from some consumers and families about the speed of development of these groups, it needs to be mentioned that this kind of work takes time. Rather than surveying the consumers and families about their concerns about their Regional group, the Advocate chose to canvas the Regional Directors who have responsibility for establishing a group

about the current status and challenges of the group. In some cases, the Regional Director referred the surveyor to the Committee Chair for more detailed information. A further survey might involve direct contact with consumers and families in the Region or direct contact with the community chairperson of said groups. The fact that several Regional Directors or staff people chair these groups may be considered an interim stage of group development, and in the short term does not merit criticism.

This process of developing effective structures for consumer and family participation at the regional level could be strengthened by the following actions:

- The Ministry of Health make a RMHAC a standard for the Health Authority to receive mental health funding, as it is in other jurisdictions in Canada and the US.
- The Ministry of Health negotiate with the Health Authorities to determine the potential relationship between the Provincial Mental Health Advisory Council and the RMHACs. As things are currently structured, there cannot be a one to one relationship because every Regional group will not be represented on the Provincial Advisory. But other relationships are possible. For example, it could be that there is no official line of accountability between the provincial and regional groups but that information about provincial initiatives and minutes of the Provincial Advisory group is circulated to the regional structures and vice versa. Further, assuming the new provincial Council will hold a limited number (2 per year) of community consultations, connecting with the Regional Mental Health Advisory could be a way of partnering to obtain optimal input and support ongoing community development.
- The Ministry use some of the funds that were formerly available to the Family Advisory Council and the Consumer Advisory Council to hold macro regional meetings so that the various RMHACs can gather to network and focus on skill development. As requested by several regions, the Ministry could also use some of these funds to develop an advocacy training package that can be repeated across the province. There are several advocacy training programs already developed (CMHA, Central Vancouver Island; Pentiction Advocacy Centre) which could be used. Finally, in the rural and remote regions, designated travel grants could be provided to enable reimbursement of transportation costs where distances are great.
- The Ministry of Health provide community development support for regions where RMHACs are less well developed and assistance is requested. It may be appropriate to provide some one time funding to the regions to do this community development work locally rather than at a distance.
- The Regional Health Authorities work towards having these groups chaired by a consumer or family member rather than by the Regional Director of Mental Health or a staff person. Community volunteer chairs should be provided with clerical assistance.
- The Regional Health Authorities continue to support diverse strategies to recruit new membership to these groups and widen the base of participation using other methods such as focus groups and surveys. As these groups become stronger and more at arms length from the Mental Health Director, they may want to consider taking over the function of administering surveys on consumer and family satisfaction, such as are currently being developed by Canadian Mental Health Association BC Division and the BC Schizophrenia Society.
- While recognizing that each region is geographically different and has different structures to support planning and evaluation, the Regional Mental Health Advisories could review their terms of reference to consider a variety of roles being adopted by their peers in other regions.

These roles include:

- providing policy advice on current "hot" issues or initiating new policy action
- raising new issues of concerns regarding service delivery, access to care or community supports
- providing advice regarding mental health services and supports representing diverse perspectives of the community (women, ethno-cultural groups, First Nations, youth and elders).
- providing input and/or developing the Regional Mental Health Plan
- providing leadership around strategies to address stigma in the local communities
- encouraging consumer and family participation in evaluation and accreditation processes in the Health Region.
- approving/commenting on recommendations for Consumer and Family Initiative funding in the region

- The Office of the Mental Health Advocate conduct a survey of peer helping programs so as to provide support regarding standards for regional peer helping programs that are in development.
- The Office of the Mental Health Advocate has a role to play in developing and meeting with these groups, supporting their development and receiving information about systemic issues for change that may come to light in the Committee's work.

APPENDIX 1: REGIONAL CONTACTS WHO COMPLETED THE SURVEY

REGION	*CONTACT PERSON*	*PHONE*
CAPITAL	s.22	
CARIBOO		
CENTRAL VANCOUVER ISLAND		
EAST KOOTENAY		
FRASER VALLEY		
KOOTENAY BOUNDARY		
NORTH OKANAGAN		
NORTH SHORE		
NORTH WEST		
NORTHERN INTERIOR		
Okanagan Similkameen Central		
Okanagan Similkameen South		
PEACE LIARD		
SIMON FRASER		
SOUTH FRASER		
Sunshine Coast		
THOMPSON		
UPPER ISLAND CENTRAL COAST		
VANCOVER/RICHMOND		

APPENDIX 2: COMPOSITION OF THE REGIONAL MENTAL HEALTH ADVISORY COMMITTEES

Regional Committee	RMHAC	Subregional MHACs	Consumer Council	Members	Consumers	Family Members	Providers	Community Agency Members
CAPITAL MHAC			✓		s.22			
CARIBOO MHAC	✓	✓		12				
CENTRAL VANCOUVER ISLAND MHAC	✓	✓	✓	15				
COAST GARIBALDI MHAC		✓	✓					
EAST KOOTENAY MHAC	✓		✓	12				
FRASER VALLEY MHAC	✓	✓	✓	11				
KOOTENAY BOUNDARY MHAC	✓	✓		n/a				
NORTH OKANAGAN MHAC	✓	✓	✓	24				
NORTH SHORE MHAC	✓		✓	13				
NORTH WEST MHAC	✓			17				
NORTHERN INTERIOR MHAC	✓			21				
OKANAGAN SIMILKAMEEN MHAC		✓						
PEACE LIARD MHAC	✓	✓		12				
SIMON FRASER MHAC	✓	✓	✓	n/a				
SOUTH FRASER MHAC	✓	✓	✓	19				
THOMPSON MHAC	✓	✓		16				
UPPER ISLAND CENTRAL COAST MHAC	✓	✓		13				
VANCOVER/RICHMOND MHAC	✓		✓	16				

n/a: figures not available

APPENDIX 3: SUMMARIES OF EACH MENTAL HEALTH ADVISORY COMMITTEE

Report on the Regional Mental Health Advisory Committee:

CARIBOO MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 12 **Consumers** s.22 **Family** s.22 **Providers** s.22 **Community Agency** s.22

s.22

Status of the Chair: Staff Member **Chairperson's Name:**

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Quarterly **Last meeting:** 11/17/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:**
Travel expenses come from Consumer Fund; this is a big concern.

To whom does the MHAC report: RHB **If not RHB, comment:**

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:
Make recommendations to be presented to the Board

Success stories for this MHAC:
Just started meeting.

Issues this MHAC is dealing
- Consumers are concerned about loss of direct input at the local level.
- How will linkage occur?
- Who will define the role of the provincial committee at the local level?
- Because it is in its early stages, we may not have the input or access to make concerns known.

Recommendations from this MHAC:

Overall comments for this region:
Subregions/local committees: Williams Lake s.22 Quesnel (none), 100 Mile House, Bella Coola: unknown if have local committee

Report on the Regional Mental Health Advisory Committee:

CENTRAL VANCOUVER ISLAND MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 15 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Community Agency **Chairperson's Name:** s.22

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Quarterly **Last meeting:** 9/1/1999 **Next** 12/1/199

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:** Subregions fund their reps; no regional funding

To whom does the MHAC report: Other Not officially recognized **If not RHB, comment:**

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:
Considered a "watchdog"

Success stories for this MHAC:
Input into Regional MH Plan. Beginning to be recognized and taken seriously by RHB. Sends member to Regional MH Care team (being developed). Four subregional MHACs active and glad to now have a roll-up group at regional level.

Issues this MHAC is dealing
Major on MHAC's plate: housing, increasing psychiatric sessions, educational/workshop dollars, Consumer opportunities to input in decision-making process.

Recommendations from this MHAC:
The new provincial body is of concern due to lack of input at the local level; island representation may be decreased and concerns about isolation must be addressed. Nancy Hall should visit and speak with local and regional groups.

Overall comments for this region:
Subregional Committees: Nanaimo s.22 Duncan, Parksville, Port Alberni

Report on the Regional Mental Health Advisory Committee:

Sunshine Coast MHAC

This committee is at the subregional level

Members: 15 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Contractor w/RHB **Chairperson's Name:** s.22

How is the chair determined: **Comments on Chair:**
Elected s.22

Frequency of meetings: Monthly **Last meeting:** 11/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:**
small region; no travel expenses

To whom does the MHAC report: **If not RHB, comment:**
Other CHSS rep sits on Council. Proceedings are supposed to flow back to RHB through this rep

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:
Advisory only. Have put forth idea that a consumer/family member sit on CHSS board but will have no

Success stories for this MHAC:
-Input into regional strategic plan
-Member on hiring committee for new manager
-Got temporary vocational worker hired
-Got increase in psychiatric services

Issues this MHAC is dealing
-Input re designating hospital was turned down
- More consumer participation is needed.
- We need to get an ongoing acute care committee
- We need to promote independent living. Right now there are only 12 units in the community.

Recommendations from this MHAC:

Overall comments for this region:

Report on the Regional Mental Health Advisory Committee:

EAST KOOTENAY MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 12 **Consumers** s.22 **Family** s.22 **Providers** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** s.22

How is the chair determined: Appointed

Comments on Chair: MH Director acts as chair and takes notes

Frequency of meetings: Monthly **Last meeting:** 11/1/1999 **Next** 12/1/199

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: lunch is provided

Comments on expense coverage:

To whom does the MHAC report: Other

If not RHB, comment: CHSS has yet to figure out its committee and reporting system. Director acting as conduit.

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

If MHAC hadn't approved MH Plan, CHSS wouldn't have submitted it to Victoria

Success stories for this MHAC:

-2 patient/family rights conferences
-Approved MH Plan before CHSS did
-Watch dogs to make sure family support person hired
-Part of recruitment process for new psychiatrist

Issues this MHAC is dealing

-CHSS needs to figure out its committee structure and reporting process before MHAC can function completely

Recommendations from this MHAC:

Overall comments for this region:

Report on the Regional Mental Health Advisory Committee:

FRASER VALLEY MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 11 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency** s.22

Status of the Chair: Community Agency **Chairperson's Name:** s.22

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Bi-Monthly **Last meeting:** 11/1/1999 **Next** 1/1/1999

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: Travel **Comments on expense coverage:**

To whom does the MHAC report: Other **If not RHB, comment:** RHB staff sits in on meetings.

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:

Advisory only, and can only assume that staff member who sits on committee will take concerns back to RHB.

Success stories for this MHAC:

- Crest Facility, a 10-bed crisis stabilization unit, involved local and regional mental health services with active participation of family and consumers.
- Legacy of strong local committee (Abbotsford MAC) still with us

Issues this MHAC is dealing

- Is there a body picking up on concerns? No.
-What is the meaning of advocacy; who are we advising beyond the staff person who sits in?
-Before regionalization, felt truly advisory. Now, still sorting out what the committee is doing. How is the Committee useful to the RHB?
-Fear (partially realized) of reduction in community-based service delivery system where consumers/families had influence.
-Regionalization might mean switch to more medical/hospital model in facilities such as CRESST. Not a reflection on staff but on system.

Recommendations from this MHAC:

Overall comments for this region:

Subregions: Agassiz-Chilliwack, Abbotsford, Mission, Hope. Local advisories send 1-2 members to regional meetings.

Report on the Regional Mental Health Advisory Committee:

KOOTENAY BOUNDARY MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: nr **Consumers** nr **Family** nr **Providers:** nr **Community Agency:** nr

Status of the Chair: Staff Member **Chairperson's Name** s.22

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Quarterly **Last meeting:** 11/1/1999 **Next** 2/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: travel **Comments on expense coverage:**

To whom does the MHAC report: Other **If not RHB, comment:** MH Director is standing (non voting) member; MHAC chair is voting member of Management Table

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

Chair sits on Management Table. Vision: Management Table to manage acute, contracts and community sectors

Success stories for this MHAC:

-Putting together local and regional advisory committees composed entirely of consumers/families
-Goal is to have advisory structure co-manage all aspects of mental health system

Issues this MHAC is dealing

Recommendations from this MHAC:

Overall comments for this region:

Current RMHAC and Chair are interim. Terms of Reference being developed for a Regional Committee consisting entirely of consumers/family members from the subregional committees: Nakusp, Grand Forks, Castlegar, Trail, Nelson. Plan: regional committee will have standing member on Regional Mental Health Management Table. Director and/or other providers will attend RMHAC meetings to provide info/support only. Management Table will manage acute, community and contract sectors.

Report on the Regional Mental Health Advisory Committee:

NORTH OKANAGAN MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 24 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** s.22

How is the chair determined: Appointed

Comments on Chair: based on RMHAC discussion and recommendation

Frequency of meetings: Bi-Monthly **Last meeting:** 11/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered:

Comments on expense coverage: When requested. Honorariums and/or travel expense reimbursement.

To whom does the MHAC report: Other

If not RHB, comment: Regional Mgr, Community Programs

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

- Consumer and family initiative funding is at the local level.
- Consumers and families involved in decision-making process.
- A subcommittee of the RMHAC put together the N. Okanagan Mental Health Plan and facilitated a number of consultations throughout the region.

Success stories for this MHAC:

RMHAC Subcommittee put together the N.O. MH Plan and facilitated a number of consultations throughout region.

Issues this MHAC is dealing

Recommendations from this MHAC:

Overall comments for this region:

Subregions: Vernon, Salmon Arm, Revelstoke. Vernon and Salmon Arm have consumer councils

Report on the Regional Mental Health Advisory Committee:

NORTH SHORE MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 13 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Community Member **Chairperson's Name:** s.22

How is the chair determined: Appointed **Co-chair:** s.22

Comments on Chair:

Frequency of meetings: Monthly **Last meeting:** 11/1/1999 **Next** 12/1/199

Are minutes yes **Are minutes circulated:** Yes

Are expenses covered:

Comments on expense coverage:
Expenses as per Board policy are covered, including parking, childcare, etc. Members must submit receipts for

To whom does the MHAC report: RHB through s.22

If not RHB, comment:

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

They are an advisory group and therefore only make recommendations for Board's consideration.
- They have been involved in various planning activities for the region. In previous years, they voted on consumer and family initiative funds.
- As of this year, this fund has been combined with other pots of grant monies to come under community grants (health promotion partnerships).
- Advisory groups are involved in the development of policy and procedures re the allocation of community grants. A member of the group also sits on the review committee of the grant proposals. They advise senior management team of those that meet the criteria for community grants, including non-mental health promotion initiatives.

Success stories for this MHAC:

-Strong, actively involved and respected committee
-Good relationships with RHB, staff and community
-Details of successes published in quarterly reports

Issues this MHAC is dealing

Recommendations from this MHAC:

- Improved communications between doctors and mental health professionals. Consistent and standardized health records must be accessible throughout the continuum of care.
- Mental health awareness and promotion. Accessible, updated information on best practices must be available to physicians and health professionals. Media must be educated in order to avoid sensationalizing mental illness. Community education essential in order to recognize early warning signs of mental illness.
-Coordinated, timely, integrated services providing a model of care that includes a single-point entry and a continual case management. Programs should be provided in a seamless fashion to avoid duplication, costs and frustration on the part of providers and consumers. Better coordination between all levels of care will help mentally ill alleviate dependency on the system during periods of recovery.

- Enhanced services to children and youth, including a dedicated youth crisis response team providing after-hours emergency outreach; a psychiatric unit dedicated to children and youth; comprehensive eating disorder team; early childhood education and support programs; education and prevention programs for youth in areas such as violence, substance abuse, etc.; expanded continuum of housing to meet needs of mentally ill children and youth.
- Holistic approach that treats person rather than illness
- Mental Health Advocate should meet with providers, including front line professionals, on a regular basis to discuss systemic issues.

Report on the Regional Mental Health Advisory Committee:

NORTH WEST MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 17 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** s.22

How is the chair determined: Elected s.22 **Comments on Chair:** consumer, co-chair

Frequency of meetings: Monthly **Last meeting:** 7/1/1999 **Next** 8/1/1999

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:** MHECCU provides secretariat. Travel costs covered

To whom does the MHAC report: CHSS **If not RHB, comment:**

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:
Moving towards. CHSS needs to clarify position

Success stories for this MHAC:
Genuinely trying to better support MH Plan. Single intake system still in transition. Support target population concept

Issues this MHAC is dealing
-redefining resulting from restructuring
-how to get more consumers/family members because of great distances
-division of child/adult mental health a barrier in this region
-lack of resources: North shows the weaknesses in system because this region is the weakest link. If you bring up a problem, YOU become the problem
-Who does MHAC talk to?

Recommendations from this MHAC:
Higher profile for mental health advocate; need to address providers/communities/front-liners, etc.

Overall comments for this region:
Smithers, Prince Rupert, Kitimat, Queen Charlottes, Aiyanch/Nisga Valley, Stewart, Stikine/Deas Lake, Terrace, Bulkley Valley. Local MHACs not functioning now.

Report on the Regional Mental Health Advisory Committee:

NORTHERN INTERIOR MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 21 **Consumers** s.22 **Family** s.22 **Providers** s.22 **Community Agency:** s.22

Status of the Chair: Community Member **Chairperson's Name:** s.22

How is the chair determined:
Elected

Comments on Chair:

Frequency of meetings: Quarterly **Last meeting:** 11/1/1999 **Next** 2/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered:
Have applied for CIF money

Comments on expense coverage:

To whom does the MHAC report:
Other RMH Director

If not RHB, comment:

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:

Working to change role so their advice is heard and taken seriously. Current Director seems to be open to this.

Success stories for this MHAC:

-Partnership with MH Director starting to come together so that the Committee can actually function as an advisory

Issues this MHAC is dealing

-Concerns whether their input is really heard

Recommendations from this MHAC:

-MHAC should report to RHB as well as MH Director
-MHAC should have proactive input into mental health plan

Overall comments for this region:

Report on the Regional Mental Health Advisory Committee:

Okanagan Similkameen South MHAC

This committee is at the subregional level

Members: 15 **Consumers** s.22 **Family** s.22 **Providers** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** s.22

How is the chair determined: Appointed

Comments on Chair: Nominal co-chair (consumer) but inactive

Frequency of meetings: Monthly **Last meeting:** 12/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered:

Comments on expense coverage:

To whom does the MHAC report: Other

If not RHB, comment: Senior Management Committee

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:

Success stories for this MHAC:

-Identified funding priorities for MH Plan

Issues this MHAC is dealing

-Family concerns about communication/involvement, especial in Psych Unit

-Need to re-institute committee to set up procedural agreement regarding family rights, especially in the area of follow-up care planning. Former committee consisted of professionals, family members and consumers.

Recommendations from this MHAC:

Overall comments for this region:

Oliver, Osoyoos, Princeton, Keremeos, Summerland, Penticton

Report on the Regional Mental Health Advisory Committee:

Okanagan Similkameen Central MHAC

This committee is at the subregional level

Members: 12 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** s.22

How is the chair determined: Appointed

Comments on Chair:

Frequency of meetings: Monthly **Last meeting:** 11/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: no one has asked

Comments on expense coverage:

To whom does the MHAC report: Other

If not RHB, comment: Director of Mental Health Programs (= chair of MHAC) and Physician Director of MH Programs

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

Advisory. Decide how to respond to Ministry or Regional allocations or services.

Success stories for this MHAC:

-Consumers, family members and service providers all sitting at the same table

Issues this MHAC is dealing

-Committee structure isn't representative.

-Organization has changed to Integrated Mental Health model; committee needs to redesign itself.

Recommendations from this MHAC:

-Proposed a committee consisting of 2/3 consumers/families, 1/3 providers meet on housing, another such on consumer/family issues, and another on psychosocial rehab, using Best Practices.

-Have proposed restructured MHAC; next meeting will discuss.

Overall comments for this region:

Report on the Regional Mental Health Advisory Committee:

PEACE LIARD MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 12 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Staff Member **Chairperson's Name:** s.22

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Bi-Monthly **Last meeting:** 10/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:** Professionals are encouraged to get agencies to cover travel

To whom does the MHAC report: CHSS **If not RHB, comment:**

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:

Advisory; watchdog that MH Plan is being followed.

Success stories for this MHAC:

-Input into very good MH Plan
-Helping establish services throughout large region
-Consumer/Family initiatives have increased as a result of Committee work

Issues this MHAC is dealing

-RMHAC trying to figure out structure
-Figuring out reporting relationships and accountability up and down.

Recommendations from this MHAC:

-CHSS should provide remuneration to help MHAC meet and function

Overall comments for this region:

Subregions: South Peace, North Peace, Ft. Nelson. Dawson and Ft. St. John have subregional committees; Ft. Nelson is in process of organizing one.

Report on the Regional Mental Health Advisory Committee:

SIMON FRASER MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 0 **Consumers** 0 **Family** 0 **Providers:** 0 **Community Agency:** 0

Status of the Chair: **Chairperson's Name:**

How is the chair determined: **Comments on Chair:**

Frequency of meetings: Bi-Monthly **Last meeting:** **Next**

Are minutes **Are minutes circulated:**

Are expenses covered: **Comments on expense coverage:**

To whom does the MHAC report: **If not RHB, comment:**
RHB Management Team

Is the RMHAC involved in the decision making process: No

Comments on the decision making process:
Advisory. Decisions to Board via Director

Success stories for this MHAC:
-consumers increasingly involved

Issues this MHAC is dealing
-major issue: reconstituting regional committee
-Terms of Reference being worked out
-inclusion of forensic people in committees; getting services for this population
- local committees very concerned with housing
-Ridge Meadows MHAC concerned with lack of resources

Recommendations from this MHAC:

Overall comments for this region:
Subregions: Burnaby, New West, Tri Cities, Ridge Meadows, all have local committees of varying size, composition and meeting frequency. Regional committee: being reconstituted. Meeting 11/30 to brainstorm (reps from local committees), terms of reference to be worked out by January. Vision: Bi-monthly, 20 people (each local sends 2 consumers, 2 family reps, 1 "line staff" plus Regional MH Director and Coordinator of Consumer/Family Initiatives as non-voting members. MHAC will report via Director to Board in advisory capacity.

Report on the Regional Mental Health Advisory Committee:

SOUTH FRASER MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 19 **Consumers** s.22 **Family** s.22 **Providers** s.22 **Community Agency:** s.22

Status of the Chair: Community Member **Chairperson's Name:** s.22

How is the chair determined: Elected **Comments on Chair:**

Frequency of meetings: Monthly **Last meeting:** 11/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:**

To whom does the MHAC report: Other MH Coordinating Committee **If not RHB, comment:**

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:
Chair of RMHAC sits on the Regional Coordinating Committee

Success stories for this MHAC:
We have taken an active role in issues such as moving staff of MHC. The office in MH centre has been beneficial. We are helping people access services.

Issues this MHAC is dealing
Difficulty in keeping group functioning, training, support for former members, etc.

Recommendations from this MHAC:
People need to be doing something. We must be more action-oriented.

Overall comments for this region:
Subregional committees in Delta, White Rock/South Surrey, Langley, Surrey Central, Surrey North. All send representatives to Regional Committee

Report on the Regional Mental Health Advisory Committee:

THOMPSON MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 16 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Community Agency **Chairperson's Name:** s.22

How is the chair determined: Elected **Comments on Chair:** BCSS Regional Representative

Frequency of meetings: Bi-Monthly **Last meeting:** 9/1/1999 **Next** 10/1/199

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: $5,000 budget **Comments on expense coverage:**

To whom does the MHAC report: Other **If not RHB, comment:** CHAC - a consumer group

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

Staff act as advisers; more input lately re restructuring; "Will be meeting bimonthly as changes move forward" [sic].

Success stories for this MHAC:

-Good representation throughout region, including a member from Lillooet Band
-Dedicated members functioning well
-Advocated strongly for and support crisis line, Step Up/Step Down facility
-Decided to meet more often and for longer because so many issues to deal with.
-Providing an educational on Best Practices within next 3 months so all members will have this knowledge to inform their ability to advise

Issues this MHAC is dealing

- Having to re-visit Terms of Reference so everyone knows what is and isn't possible and have a unified understanding of goals and visions

Recommendations from this MHAC:

Overall comments for this region:

Localities: Lillooet, Barrier, Lytton, Logan Lake, Merrit, Kamloops, Chase, Ashcrost, Clearwater. Only Lillooet has a functioning MHAC. CEO very receptive.

Report on the Regional Mental Health Advisory Committee:

UPPER ISLAND CENTRAL COAST MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:**

Members: 13 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Regional Management **Chairperson's Name:** Don Bruce

How is the chair determined: Appointed **Comments on Chair:**

Frequency of meetings: Bi-Monthly **Last meeting:** 11/1/1999 **Next** 1/1/2000

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: **Comments on expense coverage:**

To whom does the MHAC report: CHSS **If not RHB, comment:**

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

Success stories for this MHAC:

Supported and worked hard to get a Step Up/Step Down facility. This has been approved and negotiations with Finance are underway.

Issues this MHAC is dealing

MHAC as constituted long-standing; inherited by current MH Director

Recommendations from this MHAC:

MH Director submitting proposal at next meeting to add 1 consumer and 1 family member to MHAC and cover their expenses.

Overall comments for this region:

Report on the Regional Mental Health Advisory Committee:

VANCOVER/RICHMOND MHAC

This committee is at the regional level

Does this region have a Regional Mental Health Advisory Committee: yes **Consumer Council:** yes

Members: 16 **Consumers** s.22 **Family** s.22 **Providers:** s.22 **Community Agency:** s.22

Status of the Chair: Community Member **Chairperson's Name:** s.22

How is the chair determined: Elected Co-chair being nominated **Comments on Chair:**

Frequency of meetings: Twice a Month **Last meeting:** 11/1/1999 **Next** 11/1/199

Are minutes Yes **Are minutes circulated:** Yes

Are expenses covered: travel, child care, translations - MH funds **Comments on expense coverage:**

To whom does the MHAC report: Other **If not RHB, comment:** Population Coordinating Committee, which links directly to HB

Is the RMHAC involved in the decision making process: Yes

Comments on the decision making process:

Advisory: meant to look at key issues and provide voice for community.

Success stories for this MHAC:

- Organized a meeting between Pharmacare and consumer/family representatives which helped tip the balance towards Respiridone being designated 1st line drug.
- Human Resources has rethought compulsory orientation sessions.
- Consumers and family have advised MOH on inequities re drugs.

Issues this MHAC is dealing

- MHAC is concerned about housing, education, training, meaningful work and graduated work program.
- Consumer and family involvement require more education and training
-Integration of "inherited" committees

Recommendations from this MHAC:

Overall comments for this region:

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