Working Together in New Ways

MENTAL HEALTH ACTION PLAN

2015-2020

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A message from the Mental Health Commission of Canada

The Mental Health Commission of Canada (MHCC) leads the development and dissemination of innovative programs and tools to support the mental health and wellness of Canadians. As a pan-Canadian health organization funded by Health Canada, the *Plan d'action en santé mentale 2015-2020*, originally published in French by the Government of Québec, has been translated into English in the spirit of facilitating access to information, resources and tools in both official languages.

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MESSAGE FROM THE MINISTER OF HEALTH AND SOCIAL SERVICES

Quebec was one of the first societies in the world to develop a mental health policy. This is a reflection of our values of inclusion and solidarity with the most vulnerable people among us. Indeed, Quebecers have long understood that mental disorders jeopardize the health and full development of the people who suffer from them and their families.

No one is immune to mental illness. It is estimated that in Quebec, 20% of the population will be affected during their lives. Many people will never be diagnosed. That is why we are so determined to implement the Mental Health Action Plan. It includes a set of concrete measures that will bring much needed help to people with mental illness and their entourage, in a targeted and coherent way, as quickly as possible.

This Action Plan is the result of a significant mobilization of all the partners working in the field of mental health. Its development is based on a remarkable interdisciplinary and intersectoral collaboration. This cooperation testifies to our commitment to reorganize the health and social services network to simplify people's experiences and improve their access to care and services. Through these changes and this plan, we hope to increasingly support the recovery process for people with mental illness.

With this in mind, I sincerely hope we can "work together in new ways." I also want to express my gratitude to all the teams that participated in the development of the 2015-2020 Mental Health Action Plan and the many partners who answered the call during our ministerial consultations.

Thank you to you all!

Gaétan Barrette

FOREWORD

Since 2005, the Ministère de la Santé et des Services sociaux (MSSS) has made mental health a priority. To further the work of the Plan d'action en santé mentale 2005-2010 – *La force des liens* (2005-2010 Mental Health Action Plan – *The power of relationships* [MHAP 2005-2010]), and the final report[1] and subsequent implementation assessment (Report on the Performance Appraisal of the Health and Social Services System: *Toward greater equity and results for mental health in Québec*),[2] published by the Commissaire à la santé et au bien-être (CSBE), the MSSS has produced a new action plan, the 2015-2020 Mental Health Action Plan – *Working together in new ways* (MHAP 2015-2020).

This Action Plan continues the work of the previous plan while mobilizing the health and social services network and its partners to "work together in new ways," by offering quality care, as always, but at the same time working to break down the walls that exist between services and to eliminate barriers to access.

On February 7, 2015, the Quebec National Assembly adopted the Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies.[3] This Act has resulted in the elimination of health and social services agencies and brings more health services and social services under the responsibility of a single institution, "to facilitate and simplify public access to services, improve the quality and safety of care and make the network more efficient and effective."[4]

The implementation of the Action Plan in this context undoubtedly represents a challenge of great complexity, but also a unique opportunity to "work in new ways." Indeed, regional integration will transform former partners into collaborators in an enlarged interdisciplinary team. People with concurrent disorders, such as a mental disorder and an addiction or a physical illness, will be even better served. This is, after all, the main motivation of all actors in the health and social services network.

It is important to emphasize that the Action Plan is consistent with and complementary to other government policies, strategies and plans that impact on the quality of life of people with a mental disorder. It is also a continuation of the changes made by the Act to Amend the

[1] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, Évaluation de l'implantation du Plan d'action en santé mentale 2005-2010 – La force des liens, Québec, Gouvernement du Québec, 2012, 83 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000380/.

[2] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, Report on the Performance Appraisal of the Health and Social Services System: Toward greater equity and results for mental health in Québec, Quebec, Government of Québec, 2012, summary accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Summary_MentalHealth2012.pdf.

[3] *An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies*, CQLR chapter O-7.2 [Québec], Éditeur officiel du Québec, 2015, accessible online: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2015C1A.PDF

[4] *An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies*, Explanatory Notes, [Québec], Éditeur officiel du Québec, 2015, accessible online: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2015C1A.PDF.

Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations.[5]

[5] *An Act to Amend the Professional Code and Other Legislative Provisions in the Field of Mental Health and Human Relations*, [Québec], Éditeur officiel du Québec, 2015, accessible online: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2009C28A.PDF.

ACRONYMS

1L MHT: First-line mental health team

AAOR: Service d'accueil, d'analyse, d'orientation et de référence des services sociaux généraux (general social services reception, analysis, orientation and referral service)

AHSSS: Act Respecting Health Services and Social Services

AQRP: Association québécoise pour la réadaptation psychosociale

CETM: Commission d'examen des troubles mentaux

CHU: Centre hospitalier universitaire

CISSS: Centre intégré de santé et de services sociaux

CIUSSS: Centre intégré universitaire de santé et de services sociaux

CLSC: Centre local de services communautaires

CPE: Centre de la petite enfance

CRD: Centre de réadaptation en dépendance

CRDI-TSA: Centre de réadaptation en déficience intellectuelle et en trouble du spectre de l'autisme

CRDP: Centre de réadaptation en déficience physique

CRJDA: Centre de réadaptation pour les jeunes en difficulté d'adaptation

CRMDA: Centre de réadaptation pour mères en difficulté d'adaptation

CSBE: Commissaire à la santé et au bien-être

CSSS: Centre de santé et de services sociaux

ID-ASD: Intellectual disability and autism spectrum disorder

DSM: Diagnostic and Statistical Manual of Mental Disorders

FMG: Family medicine group

FNQLHSSC: First Nations of Quebec and Labrador Health and Social Services Commission

GASM: Guichet d'accès en santé mentale (single-window access to mental health service)

INESSS: Institut national d'excellence en santé et services sociaux

INSPQ: Institut national de santé publique du Québec

ICT: Intensive community treatment

IUSM: Institut universitaire en santé mentale

JED: Jeunes en difficulté

MEESR: Ministère de l'Éducation, de l'Enseignement supérieur et de la Recherche

MELS: Ministère de l'Éducation, du Loisir et du Sport

MESRS: Ministère de l'Enseignement supérieur, de la Recherche et de la Science

MESS: Ministère de l'Emploi et de la Solidarité sociale

MHAP: Mental Health Action Plan

MJQ: Ministère de la Justice du Québec

MSP: Ministère de la Sécurité publique

MSSS: Ministère de la Santé et des Services sociaux

MTESS: Ministère du Travail, de l'Emploi et de la Solidarité sociale

NCEMH: National Centre of Excellence in Mental Health

NICS: Non-intensive core support

PACT: Program for Assertive Community Treatment

PD: Physical disability

PNSP: Programme national de santé publique

PPEP: Programme pour premier épisode psychotique

PSII: Plan de services individualisé et intersectoriel

RUIS: Réseau universitaire intégré en santé

SAPA: Soutien à l'autonomie des personnes âgées

SHQ: Société d'habitation du Québec

SIPPE: Services intégrés en périnatalité et pour la petite enfance

SVI: Support of varying intensity

WHO: World Health Organization

YPA: Youth Protection Act

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INTRODUCTION

In 1989, Quebec distinguished itself by developing one of the first mental health policies in the world. From the outset, the policy[6] responded to two sets of needs: the needs of people who are experiencing mental illness or whose mental health is threatened, and improving the mental health of the population beyond what could be done through the care and service network. The objectives and orientations of the Mental Health Policy are designed to ensure the primacy of the individual, enhance the quality of care and services, promote solutions that impact on the living environment of people with a mental illness and consolidate partnerships.

In 1998, the MSSS published a first action plan focused on the transformation of mental health services,[7] which targeted in a significant way the twin goals of intervening in the living environments of people with serious mental disorders and of children and youth with mental disorders, and diversifying the services offered to them.

In 2005, following extensive consultations, the MSSS published MHAP 2005-2010,[8] which was produced in the context of the modernization of the health and social services network. Its main objective was to provide for continuous access to various services, primarily through the implementation of first-line services within the context of health and social services centres (CSSSs) and through the introduction of new forms of collaboration between institutions and actors concerned. A number of the structural measures that were proposed were aimed to support the establishment and consolidation of services offered by CSSSs in the community, for people with both moderate and serious mental disorders.

Specifically, MHAP 2005-2010 introduced measures concerning the participation of service users and members of their entourage in the planning and organization of services, the fight against stigmatization, the promotion of mental health and the prevention of mental disorders; in addition to specifying the range of services offered to the general population, youth and adults with mental disorders, people who are at high risk of suicide as well as those with concurrent disorders. The Action Plan enabled the mobilization of actors concerned to improve services for people with mental disorders. To this end, the MSSS has organized, since 2006, annual Mental Health Days[9] in order to facilitate the mobilization of key actors concerned and partners as well as knowledge transfer.

As stated above, different projects that were carried out helped to bring the profile of services up to date and to determine Quebec's mental health priorities. To enrich its reflection on the

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[6] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Politique de santé mentale,* Québec, Gouvernement du Québec, 1989, 62 p., accessible online: http://www.msss.gouv.qc.ca/sujets/prob_sante/sante_mentale/download.php?f=0d4d1b073a10b132749dfd96039bc13a.

[7] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Plan d'action pour la transformation des services de santé mentale*, Québec, Gouvernement du Québec, 1998. 46 p., accessible online: http://publications.msss.gouv.qc.ca/ msss/document-000381/.

[8] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Plan d'action en santé mentale 2005-2010 – La force des liens*, Québec, Gouvernement du Québec, 2005, 97 p., accessible online: http://publications.msss.gouv.qc.ca/msss/ document-000786/.

[9] This event was first held every two years; it has been held annually since 2011.

services offered to youth and their mental health, the MSSS consulted with young users of mental health services, the members of their entourage, researchers and clinicians.[10] Other reports, consultations and work undertaken by the MSSS, expert groups and partners contributed to the discussion on orientations and measures to be included in MHAP 2015-2020.

To enrich its reflection and validate its choices, at the beginning of 2014 the MSSS consulted representatives from the mental health network, in addition to holding a province-wide forum on MHAP 2015-2020.[11] The comments heard during these two events confirmed the importance of considering mental health as a ministerial priority, of putting in place measures that would lead to improvements in meeting the needs of people with mental illness and to an evaluation of the performance of services and care in this sector, while promoting optimal and judicious use of financial, material and human resources.

The MSSS subsequently submitted MHAP 2015-2020 to extensive consultation. Thus, the comments and proposals for modification provided by a review committee, various divisions of the MSSS, several ministries and agencies with which the MSSS works in close collaboration as well as from key external partners contributed to the improvement of the document.

Without overlooking the population responsibility held by the integrated centres[12] and their partners, this Action Plan must be implemented based on an analysis of the met and unmet needs of the population served, resulting in measures adapted to local and regional realities. To this end, care and services must be adapted to the reality of service users, whether in terms of language (especially for English-speaking people),[13] culture, age or gender.

In addition, recognizing that gender is a factor that can cause different effects on mental health, and in accordance with government and ministerial orientations regarding gender-based analysis,[14] the approach to the development of this Action Plan sought to take into account the specific realities of women and men in terms of mental health.

“Working together in new ways” requires the mobilization of all partners in order to provide an adequate response to the needs of service users and members of their entourage as well as the establishment and maintenance of services supporting the full exercise of their citizenship. It is fair to say that interdisciplinary and intersectoral collaboration is the foundation for MHAP 2015-2020.

[10] This consultation is part of the Ministry’s ongoing internal work and has not been published.

[11] The National Forum on the 2014-2020 Mental Health Action Plan was held in Montreal on January 28, 2014, in the presence of Dr. Réjean Hébert, who was at the time the Minister of Health and Social Services and the Minister responsible for Seniors. The main partners of the mental health network were invited to comment on the priorities and orientations proposed by the MSSS and presented in a consultation document. Participants also had the opportunity to convey their thoughts and concerns in writing to the Mental Health Branch of the MSSS.

[12] The term “integrated centres” refers to both Centres Intégrés de Santé et de Services Sociaux (CISSS) and Centres Intégrés Universitaires de Santé et Services Sociaux (CIUSSS).

[13] *An Act Respecting Health Services and Social Services,* CQLR, section 15, chapter S-4.2, [Québec], Éditeur officiel du Québec, 1991.

[14] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Analyse différenciée selon les sexes dans le secteur de la santé et des services sociaux, Guide-mémoire*, Québec, Gouvernement du Québec, 2010, 15 p.

Finally, the MSSS recognizes the fundamental impact of health promotion and disease prevention on the general health, both physical and mental, of the population. It also recognizes the equally real impact on individuals of the psychological distress associated with certain situations of everyday life, sometimes even threatening their mental balance and health. However, this Action Plan will primarily deal with measures to be provided to people who have a mental disorder or mental illness who use the services. These are the terms that will be used to designate the people to whom it is addressed.

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CONTEXT

MENTAL HEALTH AND MENTAL ILLNESS

The World Health Organization (WHO) describes mental health as a vital component of health, which is "[...] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[15] Mental health is determined by biological, socioeconomic and environmental factors. It is a state of well-being that allows a person to overcome the obstacles of life, to realize his or her own abilities, to be productive and to participate in community life.[16]

The concept of mental wellness is used in First Nations communities. It refers to "[...] a balance of the mental, physical, spiritual and emotional."[17] Mental wellness is supported by various factors including culture, language, the contribution of Elders, families and creation. To achieve their goal of promoting mental wellness, programs and services for First Nations must take into account the notion of cultural safety.[18]

As for the term "mental illness", it refers to all mental disorders that can be diagnosed. It means health conditions characterized by alterations in thinking, mood and/or behaviour, causing distress or impaired functioning.[19] The WHO and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)[20] include intellectual disabilities; autism spectrum disorders; behavioural disorders; neurocognitive disorders, including dementia; as well as addictions. Since these states or conditions are the subject of separate action plans and programs, they are not designated by the terms "mental disorder" or "mental illness" in this Action Plan.[21]

PREVALENCE OF MENTAL DISORDERS

In Quebec and Canada, it is estimated that nearly 20% of the population suffers from mental illness, whether or not it has been diagnosed. However, less than half of these people consult a

[15] WORLD HEALTH ORGANIZATION, "Constitution of the World Health Organization, Preamble," *Official Record of the World Health Organization*, no. 2, p. 100, entered into force on April 7, 1948.
[16] WORLD HEALTH ORGANIZATION, "Mental health: strengthening our response" (online), 2014, http://www.who.int/mediacentre/factsheets/fs220/en/ (consulted January 26, 2015).
[17] HEALTH CANADA, First Nations Mental Wellness Continuum Framework – Summary Report, Ottawa, 2015, p. 1.
[18] *Ibid*., p. 1-5.
[19] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Mental Health: A Report of the Surgeon General,* U.S. Public Health Service, Center for Mental Health Services, National Institutes of Mental Health, Rockville (Maryland), 1999, p. 5, accessible online: http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf.
[20] AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Arlington (Virginia), American Psychiatric Association, 2013, 947 pp.
[21] Throughout this document, the terms "mental illness" and "mental disorder" are used as synonyms.

professional.[22] Studies have reported that in the United States, about 1 in 4 adults has a mental illness and almost half will experience one during their lives,[23,24,25] suggesting that the Quebec and Canadian estimates are possibly under-represented.

In Quebec, from 1999 to 2010, the average annual prevalence of diagnosed mental disorders was 12%, of which 7.5% relates to anxiety disorders and depressive disorders (65% of all mental disorders) and 0.4% concerns schizophrenic disorders.[26] The diagnosed mental disorders, particularly anxiety disorders and depressive disorders, are more prevalent among women than among men.[27]

Although mental illness is present in all age groups, manifestations of it are typical at certain stages of life, including youth and old age. It has been demonstrated that 50% of mental disorders appear before the age of 14 years old and 75% before the age of 22 years old.[28,29] Mental disorders are also one of the main causes of hospitalization among people 15-24 years old.[30] The prevalence of mental disorders has doubled among young people under 20 in the last 10 years. In Quebec, this is partly explained by the increased frequency of diagnosis of attention deficit disorder with or without hyperactivity, especially in boys.[31] Suicide is the second most common cause of death for 15-19 year olds, after highway accidents.[32]

In older people, symptoms of mental illness are often coincident with the development of physical illness, cognitive impairment or, more broadly, the effects of aging.[33] Isolation, loneliness and stress related to the deterioration of physical health are factors that affect the mental health of older people.[34]

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[22] A. LESAGE and V. ÉMOND, "Surveillance des troubles mentaux au Québec: prévalence, mortalité et profil d'utilisation des services," *Surveillance des maladies chronique*, no. 6, Institut national de santé publique, 2012, pp. 1, 12.
[23] R.C. KESSLER *et al.,* "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62, no 6, 2005; pp. 593-602.
[24] R.C. KESSLER *et al.,* "Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62, no 6, 2005; pp. 617-627.
[25] R.C. KESSLER *et al.,* "The prevalence and correlates of serious mental illness (SMI) in the National Comorbidity Survey Replication (NCS-R)," in R.W. Manderscheid and J.T. Berry (eds.), *Mental Health United States*, 2004, Rockville (Maryland), Substance Abuse and Mental Health Services Administration; 2006.
[26] A. LESAGE and V. ÉMOND, *op. cit.,* p. 3.
[27] *Loc. cit.*
[28] R.C. KESSLER *et al.*, "Age of onset of mental disorders: A review of recent literature," *Current Opinion in Psychiatry*, vol. 20, July 2007, pp. 359-364.
[29] R.C. KESSLER *et al.,* "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62, no 6, 2005; pp. 593-602.
[30] HEALTH CANADA, *A Report on Mental Illnesses in Canada*, Ottawa, 2002, p. 18-19.
[31] M.C. BRAULT and E. LACOURSE, "Prevalence of prescribed attention-deficit hyperactive disorder," *Canadian Journal of Psychiatry*, vol. 57, no 2, 2012, pp. 93-101.
[32] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, La mortalité par suicide au Québec: 1981-2012 – Mise à jour 2015, Québec, Gouvernement du Québec, 2015, p. 6, accessible online: http://www.inspq.qc.ca/pdf/publications/1939_ Mortalite_ Suicide_ 2015.pdf.
[33] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, État de situation sur la santé mentale au Québec et réponse du système de santé et de services sociaux, Québec, Gouvernement du Québec, 2012, p. 12.
[34] PUBLIC HEALTH AGENCY OF CANADA, *The Human Face of Mental Health and Mental Illness in Canada 2006,* Chapter 1 – Mental Health in Canada (online), 2006 http://www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php (consulted April 10, 2015).

Knowing that older people are the segment of the population that will grow the most in the coming years, we must recognize the key role that will be played by the family physician, the general psychiatric and psychosocial first responders and specialized services in providing services to them. The increase in the number of cases arising from this demographic group requires a general increase in the specific skills of these interveners. To this end, specialized geriatric services will have to invest mainly in supporting other health care providers and ensuring the transfer of knowledge and skills to their partners, reserving their clinical expertise for the most complex cases.

DIRECT AND INDIRECT COSTS OF MENTAL ILLNESS

In Ontario, the burden of mental illnesses, including addictions, is greater than all cancers combined and 7 times greater than that of infectious diseases.[35] Mental illnesses exert strong pressure on public resources due to their high prevalence and the disabilities that result. Among the seven major health issues in Canada, mental disorders are the most costly in terms of direct services.[36] This is attributable to health care and health services, social support measures and legal actions relating to those affected.

Mental illnesses result in indirect costs associated with their impact on the economic productivity of affected individuals and their entourage, in addition to having a negative impact on their quality of life and life expectancy. Men with a mental illness live a little less than 8 fewer years, when compared to the average life expectancy of men from Quebec.[37] For women with a mental illness, the average reduction in life expectancy is 5 years.[38] A British study reports that the life expectancy of men with schizophrenia will be reduced by more than 25 years, and over 16 years for women.[39] This excess mortality associated with mental illness is explained by a higher number of suicides, the frequent association between mental disorders and certain lifestyle behaviours harmful to health (physical inactivity, smoking, excessive alcohol consumption, lack of sleep),[40] and the side effects of medication, but also by a greater risk of dying of certain other diseases.

Indeed, there is evidence that mental disorders affect the prevalence, evolution and treatment of many chronic diseases (cardiovascular diseases, diabetes, cancer, asthma). These diseases also have an impact on the prevalence and treatment of mental disorders. For example, an

[35] CENTRE FOR ADDICTION AND MENTAL HEALTH, Mental Illness and Addictions: Facts and Statistics (online), Toronto, World Health Organization, accessible online: http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx.
[36] COMMISSION DE LA SANTÉ MENTALE DU CANADA, Pourquoi investir en santé mentale contribue à la prospérité économique du Canada et à la pérennité de notre système de soins de santé, Fiche de renseignements – principaux faits, October 31, 2012, p. 1, (web page no longer available).
[37] A. LESAGE and V. ÉMOND, *op. cit.,* p. 6.
[38] *Loc. cit*.
[39] S. BROWN *et al*., "Twenty-five year mortality of a community cohort with schizophrenia," *British Journal of Psychiatry*, vol. 196, no 2, February 2010, pp. 116–121.
[40] CENTERS FOR DISEASE CONTROL AND PREVENTION, Mental Health Basics (online), Atlanta (Georgia), 2011, updated October 2014, http://www.cdc.gov/mentalhealth/basics.htm (consulted August 19, 2014).

estimated 60% of people with depression also have other chronic diseases, including diabetes and hypertension.[41]

People with mental disorders are also at greater risk of manifesting problems of alcoholism and addiction, and people who have a problem of alcoholism and addiction are more likely to eventually suffer from a mental disorder.[42] A U.S. survey estimated that the percentage of people with an anxiety disorder who will also have an alcohol problem or drug addiction is 24%. Concerning bipolar disorder and schizophrenia, the estimates climbed respectively to 56% and 47%.[43] This concurrence has many negative effects. Alcoholism and addiction can exacerbate mental illness, making it more difficult to diagnose, impair adherence to treatment and its effectiveness.[44] In addition, people with such concurrent disorders may experience more significant emotional, medical and social problems than people with a single disorder.[45] Given the frequent concurrence and interdependence of mental disorders and addictions, both health issues need to be addressed jointly and in an integrated manner.

Finally, it is estimated that 30% to 50% of people who are homeless are suffering from a mental disorder, including 10% with a serious mental disorder. More than half of adults who are homeless and suffering from a mental disorder also struggle with addictions.[46]

Any person may suffer from a mental illness at some point in his or her life. The characteristics of a person or their other health problems should not in any way constitute barriers to timely accessibility to adapted care and services in health and social services facilities and in the community. Unfortunately, service users are struggling to receive, in one place or continuously, services that meet all their needs, hence the need to work to strengthen the connections between actors concerned, institutions and partners. To this end, the ministerial Action Plan is focused on the development of an integrated vision of social services, mental health services and physical health services.

In order to improve the health of service users and members of their entourage and to improve organizational and clinical practices, the mobilization, collaboration and involvement of different partners, including community mental health organizations, is essential. For decades, they have participated in improving the quality of life and social participation of service users; contributed to the development of a range of diverse and adapted services, to the recognition of experiential knowledge and to the respect for the rights of people with mental illness and their entourage. Community organizations play a fundamental role in the recovery of service users, including through empowering them with a collective voice.

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[41] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, Report on the Performance Appraisal of the Health and Social Services System: Toward greater equity and results for mental health in Québec, Quebec, Government of Québec, 2012, summary accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Summary_MentalHealth2012.pdf.
[42] CENTRE FOR ADDICTION AND MENTAL HEALTH, Les troubles concomitants de toxicomanie et de santé mentale – Guide d'information, Toronto, 2010, p. 1, (web page no longer available).
[43] *Ibid*., p. 3-4.
[44] L. NADEAU, "Lorsque le tout est plus grand que la somme de ses parties: La cooccurrence de la toxicomanie et des autres troubles mentaux," *Santé mentale au Québec*, vol. 26, no. 2, pp. 7-21.
[45] CENTRE FOR ADDICTION AND MENTAL HEALTH, *op. cit.*, p. 8.
[46] L. ROY and A. CROCKER, Itinérance et santé mentale – Ampleur du phénomène (online), updated June 28, 2012, http://www.douglas.qc.ca/info/itinerance-et-sante-mentale (consulted January 15, 2014).

Moreover, as mental illnesses impact significantly on many sectors of activity and partners (schools, employers, housing, police, courts, correctional facilities, etc.), MHAP 2015-2020 aims to develop a vision and common goals, while facilitating concertation and the adaptation of practices.

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MENTAL HEALTH PROMOTION AND THE PREVENTION OF MENTAL DISORDERS AND SUICIDE

The scientific community agrees that the mental health of a population is essential to its overall health and is closely linked to economic, social and human development.

It has been shown that intervening in promoting mental health and in preventing mental disorders and suicide is a premium investment in reducing the incidence of mental disorders and suicide and, by extension, the significant resulting costs to the health network and society. The factors, often called health determinants, which influence the mental health of a population, can be grouped into the following three categories:[47]

- structural factors, such as living environment, housing, employment, income level, transportation, education, supportive policies, social services and health services;
- social factors, such as the feeling of belonging to a community, social support, a sense of citizenship and participation in society;
- individual factors, such as lifestyle, genetic heritage, gender, emotional resilience, organization of life and ability to cope with stress or adverse circumstances.

Mental health is the result of the dynamic interaction between individuals, groups and the environment in general, throughout one's life.[48]

Approaches to promoting mental health and preventing mental disorders and suicide should cover the entire period of the life of individuals, whether or not they display the warning signs of a mental disorder or psychological distress. Policies, action plans and mental health services should take into account health and social needs at all stages of life, from early childhood to old age.[49]

In Quebec, several structural features, such as legislation, the health monitoring systems, the dissemination of provincial orientations and access to expertise, have been created to strengthen and reaffirm the will to act on the factors that influence mental health.

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[47] GOVERNMENT OFFICE FOR SCIENCE, *Mental Capital and Wellbeing: Final Project Report*, London, UK Department for Innovation, Universities and Skills, 2008, p. 76.

[48] P. MANTOURA, Framework for healthy public policies favouring Mental Health, Montreal, National Collaborating Centre for Healthy Public Policy, 2014, p. 2, accessible online: http://www.ncchpp.ca/docs/PPFSM_EN_Gabarit.pdf.

[49] WORLD HEALTH ORGANIZATION, Mental Health Action Plan 2013-2020, Geneva, 2013, p. 11, accessible online: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf.

The Public Health Act[50] awards a central place to the functions of health prevention and promotion and recognizes the impact of public policies on health. The Act is designed to include the creation of favorable conditions for maintaining and improving the health and welfare of the general population. It is in this Act that the development of a provincial public health program (*Programme national de santé publique [PNSP]*) is mandated.

The proposed approach to promoting mental health and preventing mental disorders and suicide in the PNSP is through comprehensive intervention, throughout the life of the individual, taking into account a number of factors. The objectives of the PNSP primarily target improving health, reducing health problems and psychosocial problems and taking positive action on determinants.

Although the MHAP is also directed at promoting mental health and preventing mental disorders and suicide, the PNSP remains the most effective means for dealing with these issues and can serve as a lever to support the implementation of the Action Plan. The actions proposed in the MHAP harmonize perfectly with those proposed by the PNSP.

[50] Public Health Act, CQLR, chapter S-2.2, [Québec], Éditeur officiel du Québec, 2001.

3 /

THE MENTAL HEALTH ACTION PLAN 2015-2020

MHAP 2005-2010 led to many advances, including the dissemination and gradual implementation of an approach oriented towards recovery, the development and implementation of the provision of first-line health services (particularly in the CSSSs) and the establishment of community-based support and monitoring. MHAP 2015-2020 introduces measures to facilitate the consolidation of the previous initiatives while promoting improved practices and timely response to the diverse needs of service users. In a context of limited resources, the most efficient, effective and promising measures are favored.

This MHAP is built upon the values and principles that follow.

3.1 VALUES

3.1.1 THE PRIMACY OF THE INDIVIDUAL

Following the ground paved by the Mental Health Policy of 1989, MHAP 2015-2020 reaffirms the importance of ensuring the primacy of the individual through respect for his or her personality, way of life, differences and the connections the individual has to his or her environment.[51] The primacy of the individual implies taking into account the perspectives and skills of individual service users while promoting their participation and that of their entourage, taking into account all their needs and their biopsychosocial situation. The promotion, respect and protection of rights are fundamental aspects.

3.1.2 THE PARTNERSHIP WITH MEMBERS OF THE ENTOURAGE

Recognition of members of the entourage as partners in the organization, planning and delivery of services as well as in the full exercise of citizenship of people who are ill, including those with a mental disorder, is decisive. Therefore, members of the entourage should be supported in their involvement and participation.

3.1.3 SHARED RESPONSIBILITIES

Mental health is everybody's business: the general population, the majority of government missions, municipalities, companies, etc. The mental health of the Quebec population, as well as the implementation and maintenance of measures introduced by the Action Plan, is based

[51] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Politique de santé mentale*, Québec, Gouvernement du Québec, 1989, p. 23, accessible online: http://www.msss.gouv.qc.ca/sujets/prob_sante/sante_mentale/download.php?f=0d4d1b073a10b132749dfd96039bc13a.

on a working partnership where, in full solidarity, all are involved in the creation of conditions that are conducive to individual well-being and the collective interest. Both in terms of development and implementation, an Action Plan requires the mobilization, involvement and concertation of different partners.

3.2 GUIDING PRINCIPLES

The MSSS is committed to ensuring that the planning, organization and delivery of health care and mental health services are guided by the principles described below.

3.2.1 CARE AND SERVICES ARE ORIENTED TOWARDS RECOVERY

Quebec bases mental health care and services on an approach oriented towards recovery. The MSSS reaffirms the ability of service users to take or regain control of their lives and their health and participate fully in community life.

An approach oriented towards recovery focuses on people's experience, and their journey towards a life they see as satisfying and fulfilling, despite mental illness and the persistence of symptoms.

Care and services oriented towards recovery differ from traditional services: beyond intervening to deal with the illness and the disability resulting from it, interveners provide hope and support, and are guided by the conviction that these individuals can:

- regain power over their life;
- determine their needs and strengths;
- develop their skills;
- act responsibly;
- use available resources as they deem necessary to meet their needs.[52]

Recovery is not a linear process. It may include periods of progress, stagnation and even steps back.[53]

3.2.2 CARE AND SERVICES ARE DIVERSIFIED AND PROVIDED IN A TIMELY WAY

People with a mental disorder or who are at risk of developing one must receive timely care and services that meet their needs in order to maintain their social roles and active lives. These services can be provided by institutions of the health and social services network or by their partners in the private sector or the community.

[52] ASSOCIATION QUÉBÉCOISE POUR LA RÉADAPTATION PSYCHOSOCIALE, *Les 5 étapes du processus de rétablissement,* training tool, Programme québécois Pairs Aidants réseau (unpublished).
[53] H. PROVENCHER, *L'expérience de rétablissement: Vers la santé mentale complète,* Québec, Faculté des sciences infirmières de l'Université Laval, 2013, pp. 3-4.

3.2.3 DELIVERY OF CARE AND SERVICES IS BASED ON COLLABORATIVE PRACTICES

Collaborative care is provided by interveners from different disciplines, sectors (public, community and private) and networks who work together to provide complementary services. Collaborative practices require the development of common goals, a well-defined and fair decision-making process as well as open and regular communication.[54]

Collaborative care is based on effective practices that evolve with the changing needs of the service users, the members of their entourage and available resources. There is no single model: collaborative care includes all the activities that enable people to work in effective partnership towards improving care and services.

The establishment of collaborative practices can involve:[55]

- strengthening the capacity to support people with complex problems (chronic and complex conditions, concurrent disorders, etc.);
- strengthening the professional and organizational capacities of the partners;
- improving the experience of care and satisfaction from the perspective of the service user;
- improved clinical outcomes;
- improved quality of care, services and performance of the health care network.

3.2.4 ORGANIZATIONAL AND CLINICAL PRACTICES DESIGNED TO IMPROVE THE PERFORMANCE OF THE CONTINUUM OF MENTAL HEALTH SERVICES

MHAP 2015-2020 requires all levels of management and all organizations providing or administering mental health services to attain the highest standards as regards the aspects of performance.[56]

This type of a change process starts with the establishment of a culture of measuring and evaluating services against the standard of providing an adequate response to the needs of service users, and a judicious use of available resources.

3.2.5 ORGANIZATIONAL AND CLINICAL PRACTICES ARE PART OF A CONTINUOUS IMPROVEMENT APPROACH

Particular attention is given to the establishment of favorable conditions for the development and maintenance of efficient and quality organizational and clinical practices. Continuous improvement consists of highlighting—systematically and continuously—strengths and weaknesses to ensure the methodical upgrading of processes as needed to establish and

[54] CANADIAN PSYCHIATRIC ASSOCIATION, "Joint Position Paper: The Evolution of Collaborative Mental Health Care: A Shared Vision for the Future," *Canadian Journal of Psychiatry*, vol. 56, no 5, p. 1-12.
[55] CANADIAN CENTRE ON SUBSTANCE ABUSE, *Collaboration for Addiction and Mental Health Care: Best Advice*. Ottawa, June 2014, 64 p., p. 2, accessible online: http://www.ccsa.ca/Resource%20Library/CCSA-Collaboration-Addiction-Mental-Health-Best-Advice-Report-2015-en.pdf.
[56] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *La zone de performance* (online), Québec, 2015, [website no longer available].

maintain the actions required to provide improved quality of care and services and adequate response to people's needs.

3.3 ORIENTATIONS

MHAP 2015-2020 is structured around the following four orientations:

- Promote the primacy of the individual and the full exercise of citizenship.
- Provide care and services adapted to youth, from birth to adulthood.
- Encourage clinical and management practices that improve the care experience.
- Ensure the performance and continuous improvement of mental health care and services.

4 /

PROMOTE THE PRIMACY OF THE INDIVIDUAL AND THE FULL EXERCISE OF CITIZENSHIP

The environment in which people evolve influences their ability to exercise full citizenship, that is to say, among other things, to assume the social roles they wish to undertake. This context has an impact on mental health, the appearance of mental illness and a person's recovery; it can help or hinder his or her development.[57] According to the WHO, the determinants of mental health and mental disorders include individual factors; but also social, environmental, cultural, economic and political factors. Social policies and the support available in the community influence all these factors.[58]

Since the adoption of the Mental Health Policy 1989, Quebec has achieved major advances, particularly in terms of the perception in the health and social services network—and more broadly, in society—of people with mental illness. A number of actors, including community organizations, participated in the promotion and defense of the rights of people with a mental disorder, of the recognition of the needs of members of their entourage and in the fight against stigmatization and discrimination concerning mental disorders and the people who have them.

MHAP 2005-2010 enabled taking a step in the right direction, particularly through the dissemination of a recovery-oriented approach, through awareness campaigns, by promoting the participation of service users and members of their entourage in the planning and organization of services and by integrating targets associated with support for housing, education and labor.

This first orientation of MHAP 2015-2020 is the establishment of a favorable environment for the recovery of service users. It includes measures that target the creation of conditions conducive to the full exercise of citizenship,[59] designed to have an impact both inside and outside the health and social services network.

[57] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *La santé et ses déterminants, mieux comprendre pour mieux agir*, Québec, Gouvernement du Québec, 2012, p. 9.
[58] WORLD HEALTH ORGANIZATION, Mental Health Action Plan 2013-2020, Geneva, 2013, p. 7, accessible online: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf.
[59] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Banque de documents de référence relatifs à la santé mentale*, Québec, Gouvernement du Québec, 2004, p. 8, accessible online: http://publications.msss.gouv.qc.ca/msss/document-001320/.

4.1 THE PRIMACY OF THE INDIVIDUAL IN THE HEALTH AND SOCIAL SERVICES NETWORK

Service users should encounter conditions that facilitate the full exercise of citizenship when they interact with the health and social services network. To this end, the MSSS requires the institutions responsible for providing mental health care and services to pay continuous attention to the respect of rights, to the fight against stigmatization and discrimination and to include the participation of these people and members of their entourage in the provision, planning and organization of services. These actions should be planned and evaluated.

MEASURE 1

So that service users may fully exercise their citizenship in the health and social services network and so that the members of their entourage are recognized in their status as partners, each institution responsible for providing mental health care and services will develop and implement an action plan on the primacy of the individual in the delivery and organization of services.

In order to facilitate this exercise and to promote the implementation, monitoring and evaluation of actions whose effectiveness is measurable, the MSSS will produce a model from which institutions can develop their plan.

4.1.1 THE PROMOTION, RESPECT AND PROTECTION OF HUMAN RIGHTS

4.1.1.1 Respect for human rights in the health and social services network

In 1975, the Quebec National Assembly adopted the Charter of Human Rights and Freedoms, in which it is stated that every person has the right to full and equal recognition and exercise of rights and freedoms including the prohibition without distinction of discrimination or exclusion due to social condition or handicap.[60] The 1970s and 1980s also marked the rise of community and alternative mental health resources, followed by the emergence of movements of defense of the rights of service users. Mental Health Policy 1989 established the promotion, protection and respect of rights as concerns of the health and social services network. Moreover, all Quebec health regions were required to have a group at the regional level for the promotion and defence of rights, whose mandate is outlined in the *Cadre de référence des groupes régionaux de promotion et de défense des droits en santé mentale* (Reference framework of regional groups for the promotion and protection of mental health rights—French only).[61]

In spite of everything, sometimes rights are ignored, misinterpreted or ignored in the health and social services network.[62] Organizational constraints (e.g., the inadequacy of physical space,

[60] *Charter of Human Rights and Freedoms*, chapter C-12, chapter I.1, section 10, [Québec], Éditeur officiel du Québec, 1975.
[61] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX and ASSOCIATION DES GROUPES D'INTEVRENTION EN DÉFENSE DE DROITS EN SANTÉ MENTALE (AGIDD-SMQ), *Cadre de référence pour la promotion, le respect et la défense des droits en santé mentale*, Québec, Gouvernement du Québec, 2006, p. 11, accessible online: http://publications.msss.gouv.qc.ca/msss/document-001199/.
[62] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Informer des droits et sensibiliser aux responsabilités en matière de santé, Un avis du Commissaire à la santé et au bien-être, Consultation et analyse*, Québec, Gouvernement du Québec, 2010, p. 28.

lack of interprofessional collaboration or the institutional culture) enable the persistence of practices that run counter to respect for certain rights and established standards. This includes non-compliance or incorrect interpretation of the rights to information, confidentiality and consent; inadequate use of control measures (isolation, physical restraint and chemical substances)[63,64] and problems related to applying the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others (P-38.001).[65]

Every citizen enjoys rights and a person with a mental illness is no exception. Like any other service user, he or she must, if necessary, be supported by institutions and by the actors concerned in the exercise of rights and remedies. The health and social services network and its personnel must promote the maintenance of an organizational culture and practices that systematically support the respect and exercise of rights.

MEASURE 1.1

To ensure the promotion of human rights and to foster respect, each institution responsible for providing mental health care and services will include, in its action plan on the primacy of the individual in the organization and delivery of care and services, actions and monitoring mechanisms concerning the awareness, education and training of managers, interveners, service users and the members of their entourage on the rights of service users as well as the exceptional recourse to legal measures.

4.1.1.2 Fighting stigma and discrimination against people with mental illness

All mental illnesses are accompanied by stigma,[66] although stigmas can be more pronounced for certain diagnoses or when the behaviour adopted by the person differs from what is recognized as the norm.[67] The suffering caused by stigma may be greater than that caused by the symptoms of the illness.[68,69]

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[63] ASSOCIATION DES GROUPES D'INTERVENTION EN DÉFENSE DES DROITS EN SANTÉ MENTALE DU QUÉBEC, *Non aux mesures de contrôle! Isolement, contention et substances chimiques, Plus de dix ans après les orientations ministérielles: manifeste pour un réel changement de pratiques,* January 2014, 40 p., accessible online: http://www. agidd.org/wp-content/uploads/2014/01/manifestejanvier2014.pdf (accessed August 26, 2014).

[64] QUÉBEC OMBUDSMAN, Annual Report, 2012-2013, Québec, 2013, pp. 82-83, accessible online: http://www.myvirtualpaper.com/doc/protecteur-du-citoyen/2013-annual-report/2013091204/#0 (accessed August 28, 2014).

[65] The subjects of the application of the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others and mental health services in prisons are discussed in section 6.4 on correctional and forensic psychiatric services.

[66] CANADIAN PSYCHIATRIC ASSOCIATION, "Stigma and Discrimination – Position Paper," *Canadian Journal of Psychiatry*, vol. 56, no. 10, 2011, p. 2, accessible online: http://publications.cpa-apc.org/media.php?mid=1221.

[67] ASSOCIATION QUÉBÉCOISE POUR LA RÉADAPTATION PSYCHOSOCIALE, *La lutte contre la stigmatisation et la discrimination associées aux problèmes de santé mentale au Québec, Cadre de référence,* Groupe provincial sur la stigmatisation et la discrimination en santé mentale (GPS-SM), Québec, March 2014, p. 6, accessible online: http://aqrp-sm.org/wp-content/uploads/2014/04/cadre-de-reference-GPS-SM.pdf.

[68] H. STUART, "Fighting stigma and discrimination is fighting for mental health," *Canadian Public Policy*, vol. 31, no. s1, pp. 21-28.

[69] B. SCHULZE and M.C. ANGERMEYER, "Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionnals," *Social Science & Medicine*, vol. 56, no. 2, 2003, pp. 299-312.

Stigma can take many forms: social stigma, stigma-by-association, self-stigma and structural stigma.[70] Some people have to deal with dual or multiple stigmas because of their minority background (cultural or religious minorities, sexual minorities, etc.); the fact that they suffer from another state, disorder or condition (physical or mental deficiency, HIV-AIDS, etc.) or concurrent disorders (alcoholism, drug addiction, other addictions, etc.); they have criminal records, are homeless or impoverished.[71] In the health and social services network, stigma can take the form of prejudice, discriminatory words or behaviours, or limited access to services.[72] The experience of stigma in the health and social services network can have a negative impact on a person's future willingness to go to the hospital or to call on other agencies when needed, or to consent to treatments or services.

The government conducted a number of information and awareness campaigns on the topics of depression and anxiety disorders after the release of MHAP 2005-2010. In addition, the work of the provincial panel on stigma and discrimination in mental health[73] led to the creation of a reference framework on this subject.[74] The framework is clear that the maintenance, over time, of changes in attitude and behaviour is encouraged by positive interpersonal relationships with people with mental illness whose condition is revealed, which is referred to as "contact strategies."[75] In this regard, the integration of peer helpers into the nursing teams is a powerful lever in the fight against stigma. This measure has the advantage that it primarily targets health and social services network personnel.

The peer helpers network in Quebec is the first program of peer helpers in the French-speaking world. Peer helpers are people who have or at one time had a mental disorder and whose personal and professional skills, along with their training as a peer helper, make them a positive recovery model for the health care team and for the service users. Peer helpers are integrated into the workplace as members of the staff. They represent a source of hope and recovery of the power to act, and among other things, provide social support by breaking down social isolation, enabling the recognition of the service user's experience, participating in reducing the

[70] The different types of stigma and the best strategies to counter them are described in the reference framework, *La lutte contre la stigmatisation et la discrimination associées aux problèmes de santé mentale au Québec*, published by the GPS-SM and accessible online at: http://aqrp-sm.org/wp-content/uploads/2014/04/cadre-de-reference-GPS-SM.pdf.

[71] Aboriginal people, immigrants or members of a visible minority or gender may also be stigmatized. The stigma surrounding mental illness can also be amplified by sexism or ageism.

[72] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Rapport d'appréciation de la performance du système de santé et de services sociaux 2012 – Pour plus d'équité et de résultats en santé mentale au Québec*, Québec, Gouvernement du Québec, 2012, pp. 56-57, accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Rapport_Appreciation_SanteMentale_2012.pdf.

[73] This is a group of partners from the public and community mental health networks that aims to reduce the stigma and discrimination faced by people who have or have had a mental disorder and members of their entourage. The group is coordinated by the Association Québécoise de la Réadaptation Psychosociale (AQRP).

[74] ASSOCIATION QUÉBÉCOISE POUR LA RÉADAPTATION PSYCHOSOCIALE, *La lutte contre la stigmatisation et la discrimination associées aux problèmes de santé mentale au Québec, Cadre de référence,* Groupe provincial sur la stigmatisation et la discrimination en santé mentale (GPS-SM), Québec, 2014, p. 11, accessible online: http://aqrp-sm. org/wp-content/uploads/2014/04/cadre-de-reference-GPS-SM.pdf#zoom=100 (accessed January 25, 2015).

[75] *Ibid*., p. 6.

number of hospitalizations, and facilitating the maintenance of the person in the community while enhancing the quality of care and services.[76]

Moreover, the involvement of a peer helper in the training of health and social services professionals as well as in research activities plays an important role in improving the quality of care and services.

The health and social services sector has been repeatedly identified as a priority sector for the fight against stigma and discrimination.[77] Organizations and individuals that work with people with mental disorders and their entourage must actively participate in the fight against stigma and discrimination and to change the behaviour of different actors of society.

MEASURE 1.2

To fight against stigma and discrimination around the subject of mental illness and towards people who have or at one time had mental illness:

1. the MSSS will continue conducting information and awareness campaigns;
2. each institution responsible for providing mental health care and services will include in its action plan on the primacy of the individual in the organization and delivery of care and services, activities to fight against stigma and discrimination against people with mental disorders, primarily targeting interveners working in health and social services facilities. These actions will build on practices whose effectiveness is recognized, by promoting contact strategies;
3. each institution responsible for providing mental health care and services will ensure that mental health service users, members of their entourage and actors from the public network and community actively participate in the planning, organization, implementation and evaluation of these activities.

4.1.2 THE PRIMACY OF THE INDIVIDUAL IN SERVICE DELIVERY

4.1.2.1 The individual as main actor in their own care and services: the establishment and maintenance of care centered on recovery

The provision of care and services oriented towards recovery proceeds from the recognition of individual service users and the members of their entourage as full members of the care team. As recovery is greatly nourished by hope,[78] service users need to be supported in strengthening

[76] PROGRAMME PAIRS AIDANTS RÉSEAU, *Les bénéfices apportés par le pair aidant,* p. 2, 2013, accessible online: http://aqrp-sm.org/wp-content/uploads/2013/06/pa-benefices.pdf (accessed October 30, 2013).
[77] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Rapport d'appréciation de la performance du système de santé et de services sociaux 2012 – Pour plus d'équité et de résultats en santé mentale au Québec,* Québec, Gouvernement du Québec, 2012, pp. 60-61, accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Rapport_Appreciation_SanteMentale_2012.pdf.
[78] H. PROVENCHER, *op. cit.,* pp. 3-4.

their skills, in achieving the goals or projects they have set for themselves. Without in any way diminishing the importance of professional advice, providing care and services oriented towards recovery sensitizes the actors concerned to the risk of underestimating the potential of service users. The role of these actors is to encourage service users to take advantage of opportunities for change and growth, to become aware of their responsibilities and to determine the risks they are prepared to undertake.[79]

To go further in providing care and services oriented toward recovery, the network of health and social services and its partners, including community organizations, residential resources and professional bodies, should promote changes in practices requiring the adoption of this approach. To this end, various resources are available to people in practice settings (training activities,[80] including on medication management, self-management and rights, reference materials, tools, indicators) for monitoring the adoption and implementation of this approach in care and service settings as well as by interveners.

Since people with mental disorders frequent other services than those in the mental health sector, the dissemination and adoption of this approach among partners in the health, social services and other sectors must be ensured, by providing training courses and continuing education to these interveners.

MEASURE 1.3

So that mental health service users become the main actors in the care and services which concern them, and so that recovery-oriented care is established and maintained in the health and social services network, each institution responsible for providing mental health care and services will include in its action plan on the primacy of the individual in the organization and delivery of services, specific measures concerning the adoption of a recovery-oriented approach in the institutions, among managers, health professionals (including psychiatrists) and interveners as well as the development, evaluation and maintenance of services focused on recovery and its maintenance.

4.1.2.2 Recognize, promote and support the involvement of members of the entourage

The members of the entourage are often the main source of support and shelter for people living with a mental illness.[81] The manifestation of mental illness and the announcement of a psychiatric diagnosis in a loved-one can be destabilizing, lead to shock and feelings of grief and guilt. The adoption of roles and responsibilities in a family unit varies. It depends on each

[79] G. SHEPHERD, J. BOARDMAN and M. SLADE, *Making Recovery a Reality,* Sainsbury Centre for Mental Health, London, 2007, pp. 5-6.
[80] Training on recovery was established in the wake of MHAP 2005-2010 by the Association Québécoise de Réadaptation Psychosociale (AQRP).
[81] H. PROVENCHER, *op. cit.,* p. 3-4.

person's strengths and limitations, and on the culture and environment within which the family functions.[82]

The members of the entourage of a person suffering from mental illness experience a higher degree of psychological distress than the general population.[83] They have many needs that must be recognized, particularly with regard to information about mental illness, available services, the support they can get (psychosocial interventions, information, training, accompaniment, mutual-support groups, respite care, etc.) and on the strategies to adopt to deal with this new reality. [84,85]

Despite the recognition of the importance of their role, members of the entourage of people with mental disorders still do not feel able to fully participate in the responsibilities they must assume.[86] While exercising their role as providers of accompaniment, members of the entourage are held at a distance from the care team and interveners, making difficult the communication of information or observations that can be helpful in assessing the clinical state of the person receiving care.[87] It seems that some interveners refuse to listen to members of the entourage, justifying this behaviour on the grounds of confidentiality. However, listening compromises in no way the rights of the service user. In addition, the Code of Ethics of Physicians of Quebec, like those of other health professionals, refers to the obligation to work with the relatives of patients or with any other person who shows significant interest in them.[88]

The involvement of members of the entourage contributes to a decrease in their psychological distress while reducing the number of relapses in the person with a mental illness.[89] This involvement must be promoted and encouraged in the institutions responsible for providing mental health care and services. To this end, the interveners must be made aware of the importance of the contribution of members of the entourage and informed about the different ways to promote and support their involvement, while respecting the will of the person receiving care.

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[82] FÉDÉRATION DES FAMILLES ET AMIS DE LA PERSONNE ATTEINTE DE MALADIES MENTALE, "Rôles et responsabilités," *De la détresse émotionnelle à l'actualisation du potentiel des membres de l'entourage,* series 1, no. 2, 2010, p. 2, accessible online: http://www.ffapamm.com/wp-content/uploads/2010/09/Fascicule2150.pdf.

[83] J.P. BONIN *et al.,* Optimisation de la collaboration avec les familles et les organismes communautaires au sein des transformations en santé mentale, IRSC, FRSQ, March 2012, p. 5, accessible online: http://www.iusmm.ca/documents/pdf/Recherche/Recherche/rapport%20Projet%20Famille_Version%20%20finale.pdf.

[84] INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE DE QUÉBEC, *Guide d'information et de soutien destiné aux membres de l'entourage d'une personne atteinte de maladie mentale,* February 2012, p. 4, accessible online: http://www.institutsmq.qc.ca/fileadmin/publications/guide-soutien-membre-entourage.pdf.

[85] J.P. BONIN *et al., op. cit.,* p. 5.

[86] *Loc. cit*.

[87] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Rapport d'appréciation de la performance du système de santé et de services sociaux 2012 – Pour plus d'équité et de résultats en santé mentale au Québec,* Québec, Gouvernement du Québec, 2012, p. 44, accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Rapport_Appreciation_SanteMentale_2012.pdf.

[88] *Code of ethics of physicians*, chapter V, section 59, [Québec], Éditeur officiel du Québec, accessible online: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/M_9/M9R17_A.HTM (accessed February 10, 2015).

[89] Y. MOTTAGHIPOUR and A. BICKERTON, "The pyramid of family care: A framework for family involvement with adult mental health services," *Australian e-journal for the Advancement of Mental Health,* vol. 4, no. 3, 2005, pp. 210-217.

In addition, members of the entourage should be informed about community resources available to them and be directed to them where needed. Particular attention should be given to children whose parent (sometimes both) is suffering from a mental disorder, so that these children can receive support and adequate accompaniment.

MEASURE 1.4

To recognize the distress of members of the entourage of a person with a mental disorder, and to encourage and support their involvement in their role of providing accompaniment, each institution responsible for providing mental health care and services:

1. will include in its action plan on the primacy of the individual in the organization and delivery of services, actions and follow-up procedures on the involvement of members of the entourage of service users in the clinical process, in respect of their rights. These actions will pay particular attention to the updating of the concept of confidentiality and solicit the active participation of service users and members of their entourage;

2. will establish a mechanism to systematically inform the members of the entourage about the associations of families and friends of people with a mental illness, whose mandate is to provide them with psychosocial intervention, training and information, support groups and respite care;

3. will put in place a systematic referral mechanism for members of the entourage to associations of families and friends of people with a mental illness when a need for their services is determined. Particular attention should be paid to children of people with a mental disorder so that these children receive the necessary support.

4.1.3 THE PRIMACY OF THE INDIVIDUAL IN THE PLANNING AND ORGANIZATION OF SERVICES: THE ACTIVE PARTICIPATION OF SERVICE USERS AND MEMBERS OF THEIR ENTOURAGE

Over the years, health systems have come to regard the patient as an active partner in planning and improving services. In particular, this transformation was carried out in relation to the delivery of care and services to people with chronic diseases, because they evolve over a long period of time and require a close and equal partnership between the health professionals and the users of those services.[90]

There have been an increasing number of opportunities for service users of the health and social services network in Quebec to participate over the last thirty years: regional and provincial concertation tables, boards of directors, user committees, etc. MHAP 2005-2010

[90] A. BOIVIN *et al.,* "Involving patients in setting priorities for healthcare improvement: A cluster randomized trial," *Implementation Science*, vol. 9, no. 24, February 2014, 10 p., accessible online: http://www.implementationscience.com/content/9/1/24.

resulted in an increase in the participation of service users in various committees and local and regional structures of concertation. Community organizations organized groups of service users in certain regions, which played a fundamental role in terms of the dynamics of participation[91] and should be maintained.

Despite this progress, opportunities for participation could be more often actualized, since the participation of users does not always result in a real opportunity to influence decision-making bodies, and varies greatly from one region to another. Moreover, the involvement of service users and the evaluation of this participation suffer from the absence of monitoring processes.[92] In many areas, the relevance of the involvement of representatives of the families and other close relationships has yet to be discussed within the health and social service network.

To be a positive and constructive experience for all actors concerned, participation of service users and members of their entourage must be coordinated, sustained and adjusted in response to the results achieved and the obstacles encountered.

MEASURE 1.5

To support the active participation of service users and members of their entourage in the planning and organization of services:

1. The MSSS will support the institutions responsible for providing mental health care and services through the distribution of a guide for the participation of service users and members of their entourage in the planning and organization of services.

2. Each institution responsible for providing mental health care and services will include in its action plan on the primacy of the individual in the organization and delivery of services, specific actions designed to maintain, monitor and evaluate the participation of users and members of their entourage in the planning and organization of services.

4.2 ESTABLISHMENT OF CONDITIONS ENABLING THE EXERCISE OF FULL CITIZENSHIP

Various individual characteristics (personal and social skills, habits and behaviours, socioeconomic characteristics) and the living environment (family, daycare and school, workplace, housing and shelter, local community and neighborhood) influence the health status

[91] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Évaluation de l'implantation du Plan d'action en santé mentale 2005-2010 – La force des liens,* Québec, Gouvernement du Québec, 2012, p. 15, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000380/.

[92] M. CLÉMENT *et al., État de situation sur la participation des personnes utilisatrices suite au plan d'action en santé mentale 2005-2010,* ARUC-Santé mentale et citoyenneté, 2012, p. 34, accessible online: http://racorsm.com/sites/racorsm.com/files/uploaded-documents/articles/2012/11/09/2102etatdesituationparticipationpersonnesutilisatricespasm05-10.pdf.

of an individual and a population.[93] Some of these factors can be influenced through the interaction of various measures and thus support service users in improving their health, well-being and quality of life.

This section discusses the MSSS's commitment to supporting service users in fulfilling their social roles and in improving their living conditions and social participation. Since these goals require the contribution of a variety of professionals, the MSSS advocates an approach of intersectoral collaboration. Intersectoral work requires the development of a common language and objectives. Achieving the desired results depends in particular on collective mobilization maintained over time and the concertation of partners from the public and private sectors, and the community. The MSSS has elaborated measures concerning services that promote social participation, including housing, education, social involvement and the work of people who now have or at one time had a mental disorder.

4.2.1 HOUSING THAT MEETS PEOPLE'S NEEDS

Being housed is fundamental to the recovery, integration and social participation of a person with a mental disorder.[94] In addition, residential stability is a key factor when a person wishes to regain his or her power to act.

The MSSS promotes a formula of independent housing with appropriate community support[95] (non-intensive core support, support of varying intensity, intensive community treatment). However, given the diversity of the needs, abilities, preferences and aspirations of service users, a full range of residential resources must be established and maintained in all regions, in collaboration with partners from the public and private sectors, and community, health and housing organizations.[96] People should be referred to a resource or suitable accommodation that responds to their preferences and an assessment of their needs for accompaniment and service intensity, while ensuring their age and the judicious use of available resources are taken into account.

The Regulation Respecting the Classification of Services Offered by an Intermediate Resource and a Family-Type Resource, adopted in January 2012, introduced a new approach to the determination and classification of support services and assistance offered to users by intermediate resources and family-type resources, in accordance with the Act Respecting Health Services and Social Services.[97] The reference framework entitled *Les ressources intermédiaires et les ressources de type familial* (*Intermediate resources and family-type resources*—French only), published in April 2014, lists and defines the ten professional

[93] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *La santé et ses déterminants, mieux comprendre pour mieux agir,* Québec, Gouvernement du Québec, 2012, pp. 8-9.
[94] M. PIAT et al., "Les préférences résidentielles des personnes souffrant de troubles mentaux graves: une étude descriptive," *Santé mentale au Québec,* vol. 33, no. 2, 2008, pp. 247-269.
[95] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Lignes directrices pour l'implantation de mesures de soutien dans la communauté en santé mentale,* Québec, Gouvernement du Québec, 2002, p. 11, accessible online: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2002/02-844-03.pdf.
[96] M. PIAT *et al., op. cit.*
[97] *An Act Respecting Health Services and Social Services,* CQLR c S-4.2, section 15, [Québec], Éditeur officiel du Québec, 1991.

monitoring activities required by a person entrusted to an intermediate resource or family-type resource of a responsible institution.[98] These ten activities enable needs-based responses to people entrusted to an intermediate resource or a family-type resource.

The quality control process for services rendered by the institution and by the resource is part of these activities.

MEASURE 2

In order to facilitate access of the population served to a full range of residential resources or to housing that meets the needs and preferences of the service user while making judicious use of available resources, each institution responsible for providing mental health care and services will reorganize its offer of residential resources.

In Quebec, government interventions in the field of social housing are mainly handled by the Société d'habitation du Québec (SHQ), whose mission is to support access to adequate housing conditions.[99]

It is important to provide adequate support to the managers of social and community housing who count among their tenants people with special needs who wish to live in a quality home and environment. In this spirit, the *Cadre de référence sur le soutien communautaire en logement social*[100] (*Reference framework on community support in social housing*—French only) is a milestone in the essential collaboration between the health and social services network and social housing.

It is imperative that people who wish to live in independent housing have the opportunity to do so and are adequately supported. Several challenges hinder the ability of people with a mental disorder to live in self-contained units, including financial insecurity, scarcity of clean and affordable housing, stigma and constraints to accessing community support. Different programs can reduce these obstacles, including:

- AccèsLogis Québec is a financial assistance program that promotes the creation of social and community housing units for households with low to moderate incomes, or for clienteles with special housing needs. It enables housing cooperatives, housing

[98] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Cadre de référence – Les ressources intermédiaires et les ressources de type familial,* Québec, Gouvernement du Québec, 2014, 207 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000168/.

[99] M. LABERGE and C. MONTMARQUETTE, *L'aide au logement au Québec,* CIRANO, June 2010, p. 31, accessible online: http://www.cirano.qc.ca/pdf/publication/2010RP-09.pdf.

[100] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX and SOCIÉTÉ D'HABITATION DU QUÉBEC, *Cadre de référence sur le soutien communautaire en logement social - Une intervention intersectorielle des réseaux de la santé et des services sociaux et de l'habitation,* Québec, Gouvernement du Québec, 2007, 57 p., accessible online: http://www.habitation.gouv.qc.ca/fileadmin/internet/centredoc/NS19808.pdf.

authorities, housing organizations and nonprofit buying companies to develop social and community housing projects with a contribution from their milieu.[101]

- The Rent supplement program in the for-profit private sector enables households to inhabit an apartment by paying a rent equivalent to 25% of their income. This funding formula promotes diversity and social inclusion, as well as allowing more tenants to choose their place of residence.[102]

Accompanied by community support of the appropriate intensity, these programs promote access to housing and the recovery of service users.

MEASURE 3

To develop housing and accommodation options that respond to people's situations, needs and ability to pay, the MSSS makes reference to the commitments outlined in the *Plan interministériel en itinérance 2014-2019* (2014-2019 Interministerial action plan on homelessness—French only):

1. The SHQ will reserve 500 units from the 2014-2015 AccèsLogis program and a minimum of 10% of each year's units from 2015-2019, for people who are homeless or at risk of homelessness as well as people with a mental disorder;

2. The SHQ will increase the use of the Rent supplement program to serve people who are homeless or at risk of homelessness as well as people with a mental disorder.

4.2.2 SUPPORT FOR PURSUING AN EDUCATION FOR YOUNG PEOPLE SUFFERING OR AT RISK OF SUFFERING FROM A MENTAL DISORDER

Health and well-being are factors that have a great influence on the educational success of all children, adolescents and young adults. Levers have been created and projects are underway that already promote concertation among the ministries involved in the educational success of young people, especially those with a mental disorder or who are at risk. Effective harmonization between networks can overcome the difficulties faced by these young people and adults, in addition to equipping the educational system and individual schools through the implementation of interventions, adaptation measures (extra time to complete exams, tutoring, etc.) and favorable environments for the health, well-being and development of students.

[101] SOCIÉTÉ D'HABITATION DU QUÉBEC, *Espace partenaires – Présentation d'AccèsLogis* (online), Québec, 2014, http://www.habitation.gouv.qc.ca/espace_partenaires/groupes_de_ressources_techniques/groupe_de_ressources_techniques/programmes/acceslogis_quebec/developpement_dun_projet/presentation_dacceslogis.html (accessed 26 novembre 2014).
[102] SOCIÉTÉ D'HABITATION DU QUÉBEC*, Espace partenaires – Programme supplément au loyer (PSL),* (online), Québec, 2014, http://www.habitation.gouv.qc.ca/espace_partenaires/municipalites/municipalites_acceslogis_quebec/programmes/acceslogis_quebec/participation_financiere_de_base/programme_supplement_au_loyer_psl.html (accessed November 26, 2014).

This section initially deals with the harmonization of networks and their professionals who serve people pursuing their education, and the implementation of housing and accommodation for young post-secondary students with special needs.

4.2.2.1 The ability of different networks to work together during the school years

Early intervention with young people who have or are particularly at risk of having a mental disorder is paramount, especially during certain critical periods of transition. During the passage from childcare to primary school, the risk factors can make the transition difficult for some children: difficulties in establishing warm relationships, disabilities, a difficult social situation, etc. In this regard, the Ministère de l'Éducation, du Loisir et du Sport (MELS), now the Ministère de l'Éducation, de l'Enseignement supérieur et de la Recherche (MEESR), the Ministère de la Famille and the MSSS have jointly developed a guide entitled *Guide for Supporting a Successful School Transition*, which is designed to provide childcare services and schools with information on what constitutes a quality transition, allowing them to analyze, improve and implement practices to aid the transition between the different environments where children live and receive services.[103]

The beginning of primary school is marked by the development of many skills. This period influences in many ways the coping skills and mental health of children.[104] It can be characterized by anxiety, adjustment difficulties, and learning or developmental delays.

The transition to secondary school is, in turn, characterized by the expression of a need for independence, the influence of peers as well as by the development of identity and sexual orientation.[105] A guide entitled *Ensuring a Smooth Transition from Elementary to Secondary School*[106] has been developed on this subject. Adolescence is characterized by many hormonal, physical, psychological and social changes. Moreover, it is during adolescence that young people are increasingly exposed to certain risk factors for mental health and physical health (alcohol, drugs, violence, etc.). Some manifest their first signs of anxiety, depression, eating disorders, psychosis, substance abuse or self-harm during this period.[107]

To support youth and families throughout the school years, the agreement for the complementarity of services between the education network and the health and social services

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[103] MINISTÈRE DE L'ÉDUCATION, DU LOISIR ET DU SPORT, *Guide for Supporting a Successful School Transition,* Québec, Gouvernement du Québec, 2010, p. 3, accessible online: http://www.mfa.gouv.qc.ca/fr/publication/Documents/GuideSoutenirPremiereTransScolQualite_a.pdf.

[104] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux,* Québec, Gouvernement du Québec, 2008, p. 49.

[105] *Loc. cit*.

[106] MINISTÈRE DE L'ÉDUCATION, DU LOISIR ET DU SPORT, *Ensuring a Smooth Transition from Elementary to Secondary School,* Québec, Gouvernement du Québec, 2012, 18 p. accessible online: http://www.reussiteeducativeestrie.ca/dynamiques/biblio_ens_prof/Anglo/Guide_ensuring_a_smooth_transition_from_elementary_to_secondary_school.pdf.

[107] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux*, Québec, Gouvernement du Québec, 2008, p. 49.

network entitled *Two Networks, One Objective: The Development of Youth*[108] aims to "[...] achieve a common, global vision of the needs of youth and their families as well as to define the specific and common responsibilities of partners, from a perspective of continuous and coordinated interventions. The partners of both networks must therefore deploy together the resources needed to ensure that all young people have timely access to the services they require [...]."[109] In the particular concern of carefully examining the needs of young people with difficulties or disabilities, the framework developed for managers and interveners of the two networks, entitled *Framework for Developing and Strengthening a Continuum of Integrated Services for Young People at the Local and Regional Levels*, clarifies the continuum of services tailored to young people by taking into consideration their specific needs, especially in times of transition.[110] The term "continuum of services" means access, continuity and complementarity of services required by a clientele. It takes into account service trajectories, the student assistance process and all the resources in place to meet the needs of a clientele.[111]

The continuum of integrated services includes, in addition to educational services, services to promote the health and well-being of all children and young people,[112] prevention services for those at risk of developing problems, assistance and rehabilitation services for young people with difficulties, adaptation, rehabilitation and social integration services for those with impairments and disabilities as well as support and accompaniment services for families.[113]

Concerning children and young people identified as having complex problems, the establishment of a continuum of integrated services is particularly supported by the creation of an individualized intersectoral service plan. The individualized intersectoral service plan is a planning and concertation process involving the two networks that improves the quality of response to the needs of a young person. It provides for the collaboration and active participation of the various actors, parents and the young person.[114] This approach enables schools to prepare the arrival at the school of youth with special needs, to establish optimal

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[108] MINISTÈRE DE L'ÉDUCATION, DU LOISIR ET DU SPORT and MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Two Networks, One Objective: The Development of Youth. Agreement for the complementarity of services between the health and social services network and the education network,* Gouvernement du Québec, 2003, p. 2, accessible online: http://collections.banq.qc.ca/ark:/52327/bs43769.

[109] *Loc. cit.*

[110] MINISTÈRE DE L'ÉDUCATION, DES LOISIRS ET DU SPORT and MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Framework for Developing and Strengthening a Continuum of Integrated Services for Young People at the Local and Regional Levels,* Québec, Gouvernement du Québec, 2013, p. 42, accessible online: http://www.education.gouv.qc.ca/fileadmin/site_web/documents/dpse/adaptation_serv_compl/Entente_MSSS_MELS_cadre_EN.pdf.

[111] *Ibid.,* p. 5.

[112] The theme of promoting health and well-being in schools will be further discussed in the next chapter, which focuses on young people.

[113] MINISTÈRE DE L'ÉDUCATION, DU LOISIR ET DU SPORT and MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Two Networks, One Objective: The Development of Youth. Agreement for the complementarity of services between the health and social services network and the education network,* Gouvernement du Québec, 2003, p. 6, accessible online: http://collections.banq.qc.ca/ark:/52327/bs43769.

[114] MINISTÈRE DE L'ÉDUCATION, DES LOISIRS ET DU SPORT and MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Framework for Developing and Strengthening a Continuum of Integrated Services for Young People at the Local and Regional Levels,* Québec, Gouvernement du Québec, 2013, p. 43, accessible online: http://www.education.gouv.qc.ca/fileadmin/site_web/documents/dpse/adaptation_serv_compl/Entente_MSSS_MELS_cadre_EN.pdf.

conditions for continuing their educational program as well as to establish a transition plan in collaboration with partners to assist the transition from school to entering the workforce. The partnership between the two networks can, for example, be facilitated by the holding of joint training activities that enable the development of relationships between people working in the two networks and the acquisition of a shared vision, through the support and commitment of managers as well as the establishment and dissemination of clear service trajectories.[115]

MEASURE 4

To support young people in their education, the MSSS and the MEESR will continue their efforts under the agreement for the complementarity of services between the education network and the health and social services network, in particular by supporting the development and strengthening of an integrated continuum of services for young people, at the local, regional and provincial levels.

MEASURE 5

To support youth and young adults aged 16-24 who continue their education in vocational training programs and through general adult education programs, institutions of the health and social services network and those of the education network will develop, in collaboration with their partners, agreements to improve access mechanisms and service trajectories to respond in a timely way to the needs of students with a mental disorder or who show indications of having a mental disorder.

4.2.2.2 The support of post-secondary students

The number of post-secondary students benefiting from accommodation measures because of a mental disorder, a learning disability or attention deficit disorder with or without hyperactivity has grown steadily over the last 10 years.[116] Since 2005, the work of the Ministère de l'Enseignement supérieur, de la Recherche et de la Science (MESRS) – now MEESR – has enabled challenges to be identified, including problems of access to professionals qualified to assess mental disorders. These problems have had the effect of delaying the implementation of accommodations by higher education institutions and have thus jeopardized the educational success of these students.

Further work and experiments have led to the development of practices in support of education through concertation between educational institutions and mental health services in addition to supporting student retention. Support programs for education set up in several regions of Quebec also help to highlight obstacles faced by students with a mental disorder, including stigma, lack of knowledge of people in the educational milieu of available resources, as a well as lack of access to adequate health care and services.

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[115] *Ibid.,* p. 16.

[116] COMMISSION DES DROITS DE LA PERSONNE ET DES DROITS DE LA JEUNESSE, *L'accommodement des étudiants et étudiantes en situation de handicap dans les établissements d'enseignement collégial,* 2012, p. 5, accessible online: http://www.cdpdj.qc.ca/publications/accommodement_handicap_collegial.pdf.

Under the populational responsibility entrusted to the integrated centres and their partners, these institutions must work to maintain and improve the health and well-being of the people in their territory, including through the establishment of concerted actions. Thus, the health and social services network and higher education institutions must collaborate in the establishment of conditions for post-secondary students who require accommodations to continue their education.

To this end, the institutions concerned must facilitate access to a mental health assessment by a qualified professional, in accordance with the Professional Code and other provisions of the law in the field of mental health and human relations.[117] Furthermore, as mentioned in the *Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes de santé mentale de première ligne en CSSS* (Orientations on the organization of care and services to adult clients by CSSS first-line mental health teams—French only), certain professionals in educational institutions may make referrals to the single-window access to mental health service of the first-line mental health team.[118]

MEASURE 6

To support youth and young adults in their schooling, integrated centres will be required to develop and implement a memorandum of understanding that meets the needs of individual institutions of higher education within their territory. This protocol should define access mechanisms, service trajectories and the procedures for referral to ensure access to diagnostic-type assessments to students who demonstrate indications for a mental disorder.

To guide them in this process, the institutions concerned can use as an example the memorandum of understanding presented in the *Cadre de référence pour soutenir la collaboration entre les centres de santé et de services sociaux (CSSS) et les collèges publics du Québec* (Framework to support collaboration between health and social services centres [CSSS] and Quebec public colleges—French only.)[119]

4.2.3 PROMOTING SOCIAL INVOLVEMENT, SOCIO-PROFESSIONAL INTEGRATION AND THE CONTINUED EMPLOYMENT OF PEOPLE WITH A MENTAL DISORDER

Social involvement and work can exert a great influence on the health, quality of life and recovery of people with a mental disorder. Although the MSSS promotes socio-professional integration and the maintenance of regular employment, MHAP 2015-2020 recognizes the

[117] OFFICE DES PROFESSIONS DU QUÉBEC, *Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé mentale et des relations humaines – Guide explicatif*, Québec, Gouvernement du Québec, December 2013, 94 p., accessible online: http://www.opq.gouv.qc.ca/fileadmin/documents/Systeme_professionnel/Guide_explicatif_decembre_2013.pdf.

[118] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS,* Québec, Gouvernement du Québec, April 2011, p. 27, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000672/.

[119] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX and MINISTÈRE DE L'ÉDUCATION, DU LOISIR ET DU SPORT, *Cadre de référence - Pour soutenir la collaboration entre les centres de santé et de services sociaux (CSSS) et les collèges publics du Québec,* Québec, 2010, 28 p., http://publications.msss.gouv.qc.ca/msss/document-000735/.

diversity of backgrounds, needs and ways to contribute socially. Thus, participation in the socio-professional and social spheres can take different forms: social involvement, including volunteering; studies; part-time or full-time work; day-to-day activities, adapted internships and workshops, etc. The contribution of people with a mental disorder does not solely depend on their individual will. The community, its leaders and its institutions have a responsibility to establish conditions that promote the mobility, social diversity and social involvement of these people.[120]

In this section, we will first look at the question of support for social and professional integration and job retention. The role played by the health and social services network in the professional integration of people who are or were at one time suffering from a mental disorder, including the promotion of mental health and employment practices, will then be discussed.

4.2.3.1 Socio-professional integration or employment integration

Socio-professional integration is an important aspect of the rehabilitation of people with a mental disorder.[121] Despite the decrease in the number of people with a severely limited capacity for employment, from 2008-2013, the representation among beneficiaries of financial assistance of last resort of people with a mental disorder, like that of people that have an autism spectrum disorder, has increased significantly, both in number and percentage. Yet nearly 34% of these beneficiaries have obtained a high school, college or university diploma. This finding reflects the difficult transition to entry into the labor market and the unmet needs for the adaptation of the professional environment.[122]

Over the years, various programs have been implemented by the MSSS, the Ministère du Travail, de l'Emploi et de la Solidarité sociale (MTESS) and by community organizations to support people with a mental disorder in their efforts to find employment. To meet the needs and preferences of these people, several models promoting social and professional integration or employment integration must coexist (psychosocial rehabilitation through labor, employment support services and pre-employment programs, including specialized labour services for people with disabilities, employment support such as "individual placement and support," etc.), to the extent that they adequately support people's efforts towards recovery. The MSSS has also mandated the Association Québécoise de la Réadaptation Psychosociale (AQRP) to review practices in psychosocial rehabilitation through work and to assess the impact of interventions on the re-establishment of service users.

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[120] L. RODRIGUEZ *et al., Repenser la qualité des services en santé mentale dans la communauté – Changer les perspectives,* Presses de l'Université du Québec, 2006, p. 130.

[121] M. CORBIÈRE *et al.,* "Le maintien en emploi de personnes souffrant d'une maladie mentale," *Santé mentale au Québec,* 2006, vol. 31, no. 2, pp. 215-235.

[122] MINISTÈRE DE L'EMPLOI ET DE LA SOLIDARITÉ SOCIALE, *Phase II de la stratégie nationale pour l'intégration et le maintien en emploi des personnes handicapées 2014-2018 – cahier de consultation,* Québec, Gouvernement du Québec, 2013, p. 9, accessible online: http://www.mess.gouv.qc.ca/publications/pdf/ADMIN_strategie_handicapes_cahier_consultation.pdf.

To meet the commitments made in the *National Strategy for Labour Market Integration and Maintenance of Handicapped Persons*[123] and the *Plan d'action gouvernemental pour la solidarité et l'inclusion sociale 2010-2015* (*Government action plan for solidarity and social inclusion 2010-2015*—French only),[124] the MTESS and MSSS have since 2012 conducted regional experiments to find better approaches to increasing social participation, integration and job retention. These experiments were designed to establish and consolidate intersectoral liaison mechanisms to optimize the efforts and progress of people with a mental disorder or with intellectual or physical disabilities through the services available in both networks. They have also attempted to leverage the complementarity of services delivered to these clienteles by the two networks in addition to enabling the identification of strengths and weaknesses of the current continuum of services.

With the collaboration of the MTESS, the MSSS hopes to improve services for the integration and continued employment of people with a mental disorder. To this end, regions need to establish a model of collaboration between the employment network and the health and social services network (especially in the intensive community treatment teams and the support of varying intensity teams as well as with partners from community organizations, to promote the integration and continued employment of service users as well as providing accompaniment in the workplace.

MEASURE 7

To promote the integration and continued employment of service users, and in light of the findings from the experiments they have conducted, the MSSS and the MTESS will establish models of collaboration between the actors working in mental health in the health and social services network, particularly in the intensive community treatment and support of varying intensity services, and the services offered by the employment network and community organizations, in order to provide better support to service users and employers.

4.2.3.2 Mental health and employment: towards an exemplary health and social services network

One of the great challenges of mental health and employment policies is to support people with a mental disorder so that they remain employed and maintain their productivity. To meet these challenges requires actions for monitoring and managing the illness, and a mobilization of businesses and employers to provide working conditions and management promoting mental health.[125] It goes without saying that timely access to first-line mental health services can promote the integration and continued employment of service users.

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[123] MINISTÈRE DU TRAVAIL, DE L'EMPLOI ET DE LA SOLIDARITÉ SOCIALE, *Stratégie nationale pour le maintien en emploi des personnes handicapées – État de la mise en œuvre et premiers résultats,* Québec, 38 p., accessible online: http://www.mess.gouv.qc.ca/grands-dossiers/strategie_nationale/publications.asp (accessed April 16, 2015).

[124] MINISTÈRE DU TRAVAIL, DE L'EMPLOI ET DE LA SOLIDARITÉ SOCIALE, *Plan d'action gouvernemental pour la solidarité et l'inclusion sociale 2010-2015 – Le Québec mobilisé contre la pauvreté*, Québec, Gouvernement du Québec, 2010, 52 p., accessible online: http://www.mess.gouv.qc.ca/grands-dossiers/plan-action/index.asp, (accessed April 16, 2015).

[125] ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), Sick on the Job?: Myths and Realities about Mental Health and Work, OECD Publishing, Paris, March 2012, accessible online: http://dx.doi.org/10.1787/9789264124523-en.

As an employer of nearly 7% of Quebec's workforce,[126] the health and social services network must set the example and establish working conditions that promote mental health, the return to work and the hiring of people who have or have had a mental disorder. The health and social services network must ensure compliance with the standards and laws relating to employment practices and ensure that people who have or have ever had a mental disorder are not discriminated against.

Sections 10 and 16 of the Quebec Charter of Human Rights and Freedoms prohibit employers from discriminating at the time of hiring because of a handicap.[127] The protection against discrimination because of a handicap refers to actual functional limitations as well as limits that are perceived or based on stereotypes, which have nothing to do with the actual capacity of an individual to perform his or her work.

Moreover, section 18.1 of the Charter prohibits collecting, on an employment application or during a job interview, information relating to the grounds provided for in section 10.[128] This protection extends to pre-employment medical tests, including questionnaires on health status. In this regard, the Commission des droits de la personne et des droits de la jeunesse states that an employer may not require information on the health status of a person unless the employer can prove that the information refers to aptitudes or qualifications required for employment (section 20 of the Charter).[129]

MEASURE 8

To qualify as an exemplary employer, every institution in the health and social services network will develop an action plan on mental health at work adopted by its Board of Directors and composed of effective actions on:

1. the promotion of mental health at work, the establishment of working conditions and organizational practices that promote the mental health of the personnel;
2. prevention of mental disorders, employee assistance programs and resources;
3. a process supporting recovery and the return to work for employees who have experienced an episode of mental illness;

[126] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Comptes de la santé 2012-2013 2013-2014 2014-2015,* Gouvernement du Québec, 2015, p. 29, accessible online: http://publications.msss.gouv.qc.ca/msss/document-001016/.
[127] *Charter of Human Rights and Freedoms*, chapter C-12, chapter I.1, sections 10 and 16, [Québec], Éditeur officiel du Québec, 1975.
[128] *Charter of Human Rights and Freedoms*, chapter C-12, chapter I.1, section 18.1, [Québec], Éditeur officiel du Québec, 1975.
[129] COMMISSION DES DROITS DE LA PERSONNE ET DES DROITS DE LA JEUNESSE, Application and Interpretation of Section 18.1 of the Charter of Human Rights and Freedoms, 2011, 21 p., accessible online: http://www.cdpdj.qc.ca/Publications/forms_employment.pdf.

4. the development of responsible attitudes towards discrimination in the workplace and in the hiring of people who have or have had a mental disorder.

In order to facilitate this exercise and to promote the implementation, monitoring and evaluation of actions whose effectiveness is measurable, the MSSS will produce a model from which institutions can develop their own plan.

5 /

ENSURE CARE AND SERVICES ADAPTED TO YOUTH, FROM BIRTH TO ADULTHOOD

The first signs of mental disorder often occur early in life. Indeed, 50% of mental illnesses appear before the age of 14.[130] The first manifestations of a mental disorder among young people are often confused with normal disruptive behaviours of children and adolescents, delaying access to adequate treatment and the services required. The consequences of this delay can include that the illness impacts on academic or professional performance; results in personal, social and family difficulties; diminishes the person's quality of life; becomes chronic; affects the person's lifestyle; adds to the impacts caused by other health problems; resulting in a decrease in life expectancy and the quality of life of the person affected.[131] Thus, the social and economic impact of mental disorders among young people is enormous and is even greater when stigma and discrimination are taken into account. Mental disorders are also considered the primary group of chronic diseases among children and adolescents, in the way that cardiac and metabolic diseases affect adults.[132]

This section, entirely devoted to youth, includes measures relative to these critical periods of their life course and service trajectories. The first measures are to be continued or undertaken to support the optimal development of children. The next measures will be aimed at the adaptation of care and services over the evolution of a young person's development, from childhood to adolescence and the transition to adulthood. Finally, measures will be directed to the provision of services for young people with a mental disorder who receive services under the YPA, and services directed towards young people experiencing a first psychotic episode.

5.1 SUPPORTING OPTIMAL CHILD DEVELOPMENT: A SHARED RESPONSIBILITY

A child's development depends on biological and environmental factors and the interaction of these factors. It is during childhood that the circuits of the brain that regulate emotions, attention, stress and self-control are developed based on the interaction between genes and the child's experiences. The well-being and optimal development of preschool children is a shared responsibility between the parents and family, the community and the government.[133]

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[130] R.C. KESSLER et al., "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, vol. 62, no. 6, 2005, pp. 593-602.
[131] MENTAL HEALTH COMMISSION OF CANADA, *op. cit.*
[132] T.R. INSEL and W.S. FENTON, "Psychiatric epidemiology, it's not just about counting anymore," *Archives of General Psychiatry*, vol. 62, no. 6, pp. 590-592.
[133] MINISTÈRE DE LA FAMILLE, *Favoriser le développement global des jeunes enfants au Québec – Une vision partagée pour des interventions concertées*, Québec, Gouvernement du Québec, 2014, p. 5, accessible online: http://www.mfa.gouv.qc.ca/fr/publication/Documents/Favoriser-le-developpement-global-des-jeunes-enfants-au-quebec.pdf.

Supporting the optimal development of children requires actions that take place in their living environments.

To this end, MHAP 2015-2020 sets out universal measures aimed at improving the health and well-being of and promoting the mental health and prevention of mental disorders among all Quebec children and families. It will also provide measures that target families and children who have multiple and concurrent vulnerabilities.

5.1.1 SUPPORTING THE OPTIMAL DEVELOPMENT OF ALL CHILDREN IN QUEBEC THROUGH UNIVERSAL MEASURES

Schools are environments where the promotion and prevention actions aimed at all young people are particularly effective because of the amount of time that young people spend there and the missions of the organizations that operate there. When interventions promoting social and emotional skills in schools are at a high level, their effectiveness is widely recognized.[134] They especially help children to recognize and control their emotions, to set and achieve constructive goals, to consider the perspectives of other people, to establish and maintain interpersonal and social relationships as well as to make responsible decisions.[135] Even though these interventions are universal, they have a particularly positive impact on children and young people who are vulnerable or who live in communities facing multiple socioeconomic adversity factors.[136]

Educational childcare services, the first stage of the educational process, contribute to the development of emotional, physical, motor, social, moral, cognitive and language skills in children, while promoting autonomy and the adoption of healthy lifestyle habits.[137] Quebec has adopted policies regarding these services, which are governed by the Educational Childcare Act.[138] These services play a key role in the development of vulnerable children.[139] The Quebec government has introduced various measures to promote access to educational childcare for all children, including childcare services with reduced parental contributions. Accessibility, in terms of availability of spaces, geographical proximity and related costs remains a challenge for Quebec. Kindergarten for four-year-olds living in disadvantaged areas is another way to contribute to their overall development.

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[134] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux,* Québec, Gouvernement du Québec, 2008, p. 54.
[135] M. KNAPP, D. MCDAID and M. PARSONAGE (eds.), *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, London, Department of Health, 2011, p. 9, accessible online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf.
[136] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux*, Québec, Gouvernement du Québec, 2008, p. 53.
[137] MINISTÈRE DE LA FAMILLE ET DES AÎNÉS, *Programme éducatif* (online), http://www.mfa.gouv.qc.ca/fr/services-de-garde/cpe-garderies/programme-educatif/programme-educatif/Pages/index.aspx (accessed March 26, 2014).
[138] *Educational Childcare Act*, chapter S-4.1.1, [Québec], Éditeur officiel du Québec, 2006.
[139] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux*, Québec, Gouvernement du Québec, 2008, p. 39.

MEASURE 9

To support the optimal development of children in Quebec, the MSSS, the MEESR and the Ministère de la Famille will continue their collaboration and concertation in the development and deployment of effective promotion and prevention actions in the schools, including preschools.

The *Healthy Schools* program encourages public and private elementary and secondary schools, in concertation with their partners, to plan actions to promote the health, well-being and educational success of young people. The approach is based on the interaction of key factors, including self-esteem; social skills; healthy lifestyles; and young people's family, school and community environments, which have important effects on their academic achievement, health and well-being. To equip schools in the selection and prioritization of health promotion and prevention actions to be implemented according to the needs of their students and the reality of their environments, the MEESR, the MSSS and the Institut national de santé publique du Québec (INSPQ) work together to designate the skills to develop in young people and the activities to initiate in their living environments.

MEASURE 10

To support the optimal development of young Quebecers, the MSSS and the MEESR will continue to work in concertation to deploy effective promotion and prevention actions in the schools, in continuation of the *Healthy Schools* program.

5.1.2 TARGET INTERVENTIONS TOWARDS CHILDREN AT RISK OF DEVELOPING A MENTAL DISORDER

The family environment plays a crucial role in all spheres of development. It affects the skills, behaviours and the present and future health of the child.[140] A significant number of young people are subject to multiple sources of stress, whose impact is cumulative. This has a direct influence on childhood stress-related disorders (adjustment disorder, attachment disorder and post-traumatic stress disorder), on the onset or worsening of other mental disorders as well as on cognitive development.[141]

Children who are repeatedly exposed during the first years of life to certain forms of adversity (family poverty, inadequate parenting, abuse, parental mental disorders) are more at risk of encountering difficulties (difficulties in school, physical and mental health problems, adoption of risk behaviours, delinquency, crime)[142] that may entail serious consequences for themselves as well as substantial costs to society.

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[140] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *La santé et ses déterminants, mieux comprendre pour mieux agir*, Québec, Gouvernement du Québec, 2012, p. 9.

[141] R. FELDMAN and A. VENGROBER, "Posttraumatic stress disorder in infants and young children exposed to war-related trauma," *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 50, no. 7, 2011, pp. 645-658.

[142] CANADIAN ACADEMY OF HEALTH SCIENCES, *Early Childhood Development – Executive Summary*, Royal Society of Canada / Canadian Academy of Health Sciences Expert Panel, Fall 2012, 3 p., accessible online: http://rsc-src.ca/sites/default/files/pdf/ECD_3_FINAL.pdf (accessed February 20, 2014).

Moreover, the presence of a mental disorder in a parent influences the onset of mental illness in the child.[143] This influence is caused by genetic and environmental factors, but also by the stressful situations experienced by these families.[144] In addition to experiencing difficulties related to the illness of one or both parents, these families can be dealing with family separations and disruptions.[145] These risks and negative consequences can however be counteracted by family stability and support,[146] hence the importance of providing accompaniment to interveners in the acquisition of skills related to the adaptation of interventions to this reality. Interveners working in various programs or schools can be confronted with this situation, including those who provide protection and rehabilitation services in an integrated centre.

In a number of countries, programs have been developed to provide accompaniment for families living in vulnerable situations, to promote the optimal development of children and to limit the impact of risk factors. In Quebec, the MSSS has developed the integrated perinatal and early childhood services (*services intégrés en périnatalité et pour la petite enfance* [SIPPE]) for families living in vulnerable situations. This program brings together professionals from health and social services and interveners from community groups and childcare services, to provide support for future parents and families during the pregnancy and when the baby arrives, until the child reaches the age of 5 years old.[147]

A neglect intervention program has also been developed to meet the needs of children living in situations of neglect or high risk of neglect and those of their parents.

To improve the ability to respond to the needs of families and to enhance existing programs, community and school programs as well as teams and interveners in integrated centres offering protection and rehabilitation services to troubled youth and their families must benefit from the expertise and support of interveners from first-line mental health teams. Organizational and clinical practices must promote a comprehensive response to the needs of children and screening for mental illness and addictions, among both parents and children.

MEASURE 11

To complement and improve the service offering for families who require them, to promote mental health and to prevent the onset of mental disorders, the MSSS

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[143] W.R. BEARDSLEE *et al*., (2003), cited in INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux*, Québec, Gouvernement du Québec, 2008, p. 79.

[144] M. RUTTER, "Developmental psychopathology: A paradigm shift or just a relabeling?," *Development and Psychopathology*, vol. 25, no. 4, November 2013, pp. 1201-1213.

[145] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC. *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux*, Québec, Gouvernement du Québec, 2008, p. 79.

[146] P.M. ELLIS and S.C.D. COLLINGS (1997), cited in INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *Avis scientifique sur les interventions efficaces en promotion de la santé mentale et en prévention des troubles mentaux,* Québec, Gouvernement du Québec, 2008, p. 79.

[147] AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE MONTRÉAL, *Portail Santé Montréal – Services intégrés en périnatalité et pour la petite enfance (SIPPE)* (online), http://www.santemontreal.qc.ca/vivre-en-sante/sante-des-tout-petits/services-integres-en-perinatalite-et-pour-la-petite-enfance-sippe/ (accessed November 26, 2014).

reaffirms the commitments outlined in the *Plan Interministériel en Itinérance 2014-2019*:

1. The MSSS is committed to maintain and improve the SIPPE program for vulnerable families in all regions of Quebec.

2. The MSSS is committed to continuing the implementation of the neglect intervention program offered by the integrated centres, and to make it available throughout Quebec. This program is for children who live in a context of neglect or who are at high risk of neglect, and their parents.

3. The MSSS is committed to continuing the implementation of the crisis intervention and intensive community treatment program,[148] as defined in the ministerial orientations of the Jeunes en difficulté program. This service is offered by the integrated centres throughout Quebec. The program is designed to prevent the removal of young people from their family environment during a crisis situation.

4. The MSSS is committed to intensifying the detection of addiction and mental health problems among the parents targeted by the aforementioned programs and their referral to appropriate services, calling upon the services of responding mental health professionals and addiction interveners when necessary.

5.2 RESPONDING TO THE NEEDS OF YOUNG PEOPLE ACCORDING TO THEIR STAGE OF DEVELOPMENT

Mental illness affects people of all ages. The median age of onset of the disease varies according to the mental disorder. It is 6 years old for anxiety disorders, 11 years old for behavioural disorders, 13 years old for mood disorders and 15 years old for addiction problems.[149] The early age of onset for all psychiatric illnesses is associated with their chronicity and seriousness. From the clinical point of view, the child psychiatric clientele presents a number of characteristics that require the development and promotion of this expertise, particularly in terms of adapting treatments and interventions focussed on the development of the child or adolescent and his or her family situation.

Young people known as “emerging adults,”[150] who are passing through the transition from adolescence to adulthood, constitute an age group in which we can observe that the burden of

[148] This measure concerns the crisis intervention and intensive community treatment program, as defined in the ministerial guidelines of the Jeunes en difficulté program. This program should not be confused with intensive community treatment model, which is intended to provide monitoring in the community of people with a serious mental disorder, and which is also the subject of a measure in this Action Plan.

[149] R.C. KESSLER, *National Comorbidity Survey: Adolescent Supplement (NCS-A), 2001-2004,* Ann Arbor (Michigan), Inter-university Consortium for Political and Social Research, 2013.

[150] C. MUNSEY, “Emerging adults: The in-between age,” *American Psychological Association*, vol. 37, no. 6, June 2006, accessible online: http://www.apa.org/monitor/jun06/emerging.aspx (accessed April 14, 2015).

disease is largely attributable to mental illness. According to the INSPQ, mental and behavioural disorders are responsible for 90% of years lived with disability among 15-29 year olds.[151] Except in a handful of countries, health systems have developed few services for this age group. In addition, the current organization of services does not facilitate the consideration of this epidemiological reality, since services oriented towards young people end when they reach the age of 18. This arbitrary cut-off based on the attainment of majority does not respond to the social reality or the neurological development of young people. Chronological age and stage of development do not necessarily correspond. Some young adults may need close supervision and proximity to their living environments while others develop a great deal of autonomy at an earlier age.

Upon reaching the age of majority, many young people find themselves without any monitoring because of constraints on access to services for adults, or stop attending mental health services. This disruption of services can have serious consequences, especially for young people who receive services under the YPA. Without a family or social network, these young people are particularly at risk of homelessness.

As studies have shown, support during the transition from youth services to adult services is important, especially if it encourages the concertation of all relevant disciplines in the planning of this transition.[152,153] Whether they are offered in schools, communities, hospitals, or in programs in integrated centres that offer protection and rehabilitation services for young people with adjustment problems, mental health services must be integrated so that young people and their entourage benefit, as necessary, from appropriate interventions that meet their needs. To this end, some regions have developed practices to facilitate harmonization of the transition and to reduce disruptions to services.

MEASURE 12[154]

To support young people in the transition to adulthood, each institution responsible for providing mental health care and services will ensure continuity of service by adapting the services offered to the needs and life stages of children, adolescents and young adults, regardless of age.

MEASURE 13

To foster the deployment and maintenance of best practices in services for young people, in particular in relation to adaptation to development and stages of life, the

[151] S. MARTEL and C. STEENSMA, *Les années de vie corrigées de l'incapacité: un indicateur pour évaluer le fardeau de la maladie au Québec*, Institut national de santé publique du Québec, 2012, p. 17.
[152] CENTRE FOR ADDICTION AND MENTAL HEALTH, "Effective Transitions in Child and Youth Mental Health and Addiction Services: Protocols, Pathways and Partnerships," *SISC Evidence Briefs*, no 1, 2014, 4 p., accessible online: http://eenet.ca/wp-content/uploads/2012/11/Transitions-Evidence-Brief.pdf.
[153] ONTARIO CENTRE OF EXCELLENCE FOR CHILD AND YOUTH MENTAL HEALTH, *We've got growing up to do – Transitioning youth from child and adolescent mental health services to adult mental health services*, May 2011, p. 2, accessible online: http://www.excellenceforchildandyouth.ca/sites/default/files/policy_growing_up_to_do.pdf (accessed August 18, 2014).
[154] This measure corresponds to measure 3.3 of the Plan d'action interministériel en itinérance 2015-2020.

MSSS will develop and disseminate ministerial orientations on mental health services for children and youth transitioning to adulthood.

MEASURE 14

In order to intensify early detection and intervention for young people with problems that can be associated with homelessness and to ensure a smooth transition of these young people to adult services, the MSSS reaffirms the commitments outlined in the *Plan Interministériel en Itinérance 2014-2019*:

- integrated centres will ensure increased detection of youth at-risk for addictions in the places they frequent, and provide appropriate intervention.

In a broader perspective, the MSSS requires the health and social services network and its partners to rethink the offer, organization and delivery of services. In order to adequately meet the needs of youth and make contact with young people who are not followed in the health and social services network and who could benefit from services, the network would do well to learn from innovative models and practices developed in our province, elsewhere in Canada and in other countries.

To this end, transformational research for adolescents with mental illness appears to be a promising avenue. Overall, transformational research is a reconstruction of the approach to the mental health and well-being of adolescents and young people, designed to bridge the gap between data derived from research and data that comes from practice, with the ultimate goal that they and their families receive effective interventions in health, social services and education.[155]

The MSSS also considers the Australian model "Headspace" to be an interesting source of inspiration. This model creates facilities for 12-25 year olds, where they can find services, support and guidance about physical health, mental health, alcohol and drug consumption, addiction, studies and jobs.[156] The experiences of the public and community sectors in Quebec also have shown the advantage of integrating services for young people into their living environment.

MEASURE 15

In order to develop an organization and offer of services adapted to the reality of young people, including those who are hard to reach or living at a distance from services, the MSSS will support research and deployment of innovative practices in this regard. To this end, the MSSS makes the following commitments:

[155] GRAHAM-BOECKH FONDATION and CANADIAN INSTITUTES OF HEALTH RESEARCH, *Transformational Research in Adolescent Mental Health*, 2013, p. 2, accessible online: http://tramcan.ca/sites/tramcan.ca/files/uploads/articles/2013/tram_phase_i_rfp_with_summary_-_jan_31-13_1_0.pdf.
[156] NATIONAL YOUTH MENTAL HEALTH FOUNDATION, *About headspace* (online), Australia, 2014, http://www.headspace.org.au/about-headspace/what-we-do/what-we-do (accessed November 26, 2014).

1. To support, through 2021, the creation of a thematic network in mental health for children and adolescents, resulting from a partnership between the Fonds de recherche du Québec – Santé, the Graham Boeckh Foundation and the MSSS. This network will work on the development of transformational research, notably by focusing on new technologies.

2. To support the implementation, in cooperation with community resources, of integrated care delivery initiatives in the community for young people from 12-25 years of age.

5.3 PROVIDE ADEQUATE SERVICES TO YOUTH WITH A MENTAL DISORDER RECEIVING SERVICES UNDER THE YPA

The integrated centres offering protection and rehabilitation services to youth with adjustment difficulties and their families, work to ensure the security of children under their responsibility, in particular by supporting parents in improving their skills and in exercising their parental role. The youth clientele in need of protection and rehabilitation is composed of children and adolescents who are victims of neglect, abuse or abandonment.

These young people are particularly vulnerable and many have behavioural difficulties. A significant proportion of young people sheltered in integrated centres providing rehabilitation services for young people with adjustment problems are diagnosed as having a mental disorder or give the impression of having one.[157] After the release of MHAP 2005-2010, multidisciplinary consulting teams with mental health expertise (second-line) were established in the youth centres of the time. Their mandate is to support clinical staff in contact with the youth (first-line interveners) by responding to their requests for consultation on mental disorders or suicidal tendencies. Although all centres providing integrated protection and rehabilitation services for young people are equipped with second-line teams, they are sometimes incomplete.

Moreover, work is still underway to implement the recommendations of the working committee, including on updating the intervention protocol in problematic suicidal situations in youth centres and the acquisition by staff of skills related to best rehabilitation practices for this clientele.

Among the main challenges facing the youth centres of the time in responding to the needs of youth and their parents regarding mental health, the Association des centres jeunesse du Québec made mention of difficulties in accessing monitoring and medical care in a timely manner, which was an obstacle to the systematic screening of the young people under their responsibility.

[157] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Proposition d'orientations relatives aux services de réadaptation pour les jeunes présentant, outre les problèmes de comportement ou un besoin de protection, des troubles mentaux et qui sont hébergés dans les ressources des centres jeunesse du Québec – Rapport du comité de travail sur la santé mentale des jeunes suivis par les centres jeunesse*, Gouvernement du Québec, 2007, p. 14, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000987/.

MEASURE 16

To promote the optimal development, proper monitoring and rehabilitation of young people receiving protection and rehabilitation services from integrated centres, as well as their screening for mental disorders and suicide risk detection, each facility offering rehabilitation services for troubled youth:

1. will ensure, upon admission to or registration for rehabilitation services, that an assessment of the health of the child by a nurse will be conducted and, if necessary, they will be quickly referred to a doctor;

2. will ensure the systematic implementation of the mental health and risk of suicide intervention protocol, as required;

3. will fully staff the second-line teams specialized in mental health and suicide prevention.

5.4 INTERVENE EARLY AND IN AN ADAPTED WAY WITH YOUTH EXPERIENCING A FIRST PSYCHOTIC EPISODE

Psychosis precipitates a loss of contact with reality and causes disturbances in perception, hallucinations, delirium, adherence to irrational beliefs or disorganized thinking. The people most at risk of experiencing psychosis are young men 15-30 years of age and young women 18 to 35 years of age. It is estimated that 4% to 5% of young people experience a psychotic episode during their lives.[158]

Schizophrenia is the most common diagnosis associated with the presence of long-term psychotic disorders. Although it only affects approximately 0.6% of the Canadian population during a year,[159] it is the most expensive mental illness per person for society, both in terms of direct costs and indirect costs. The magnitude of the economic burden of schizophrenia and other psychotic disorders is easily understood by the fact that these diseases are associated with increased rates of suicide, substance abuse, victimization, joblessness and crime.

The first years of a psychotic episode are decisive in terms of cognitive damage, social problems and trouble with the law. An untreated psychosis leads to increased risks of overconsumption of alcohol or drugs, family distress, depression and suicide. Indeed, 10% of people with

[158] INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE DOUGLAS, *Psychoses: causes, symptômes et traitements* (online), updated July 26, 2013, http://www.douglas.qc.ca/info/psychose (accessed October 10, 2013).
[159] P. SMETANIN *et al., The Life and Economic Impact of Major Mental Illnesses in Canada: 2011 to 2041*, Toronto, RiskAnalytica, for the Mental Health Commission of Canada, 2011, p. 102, accessible online: https://www.mentalhealthcommission.ca/English/system/files/private/document/MHCC _ Report_ Base_Case_ FINAL_ ENG_0.pdf.

psychosis end their lives and two-thirds of these deaths occur during the five years following the onset of the first episode.[160]

Unfortunately, psychotic disorders can be ignored for months and even years. The delay in obtaining treatment is often due to a lack of knowledge of signs and symptoms, to the individual's resistance to consult or to the absence of therapeutic services.[161] Early detection and intervention with young people is an issue that relates to family members, but also family physicians, school staff and other interveners working in the schools or with young people in their living environments. In this regard, various tools have been developed, including the refer-O-scope, developed as a result of collaboration between experts, professionals and organizations representing people with mental illness and members of their entourage, institutions and interveners.[162]

Studies have shown that the establishment of first-episode psychosis programs would result in a reduction of hospitalizations to such an extent that the net cost to the network would be unchanged or even reduced,[163] without even considering the financial benefits associated with the maintenance of academic or professional activities, or a return to these activities. Like the members of a SIM team, first-episode psychosis program interveners work where people live, in order to maintain contact with the people affected and to prevent their alienation from services and the community. From the perspective of rehabilitation, a strong emphasis is placed on psychosocial interventions, including family interventions. Interventions in the context of a first-episode psychosis program are individualized and adjusted according to the stage of the psychosis.[164]

Given the impact of psychosis on the lives of sufferers and members of their entourage as well as on society, it seems that more emphasis should be placed on early detection[165] and referral of young people with first-episode psychosis to the appropriate resources, as is done in other health care systems.

MEASURE 17

In order to intervene early and effectively with young people experiencing first-episode psychosis, to maximize their chances of recovery, to support them throughout the process and ensure support for the members of their entourage:

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[160] ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE, Early Psychosis Intervention Standards, Toronto, Government of Ontario, March 2011, p. 6, accessible online: http://www.health.gov.on.ca/english/providers/pub/mental/epi_program_standards.pdf.

[161] *Ibid*.

[162] SOCIÉTÉ QUÉBÉCOISE DE LA SCHIZOPHRÉNIE, *Refer-o-scope – L'outil pour observer et agir avant la psychose*, (online), https://www.refer-o-scope.com/accueil (accessed November 26, 2014).

[163] M.P. MCCRONE *et al.,* "Cost-effectiveness of an early intervention service for people with psychosis," *British Journal of Psychiatry*, vol. 196, no. 5, 2010, pp. 377-382.

[164] P.D. MCGORRY, E. KILLACKEY and A. YUNG, "Early intervention in psychosis: concepts, evidence and future directions," *World Psychiatry*, vol. 7, no. 3, 2008, pp. 148-156.

[165] Research also demonstrates the relevance of early detection for other conditions. The MSSS will work for the early detection of other mental disorders in the years to come.

1. the MSSS will support the development and dissemination of best practices backed by evidence-based standards, serving as a framework for the composition of teams and the provision of specific services for these young people;

2. each institution responsible for providing mental health care and services will make available specific services for children, adolescents and young adults experiencing a first psychotic episode, employing evidence-based practices.

6 /

PROMOTING CLINICAL AND MANAGEMENT PRACTICES THAT IMPROVE THE CARE EXPERIENCE

MHAP 2005-2010 enabled the establishment of specific first-line mental health services while clarifying the hierarchy of services, with the aim of improving access to them and promoting the efficient use of resources. The CSSSs have established first-line youth and adult mental health teams, including the single-window access to mental health service, in addition to establishing support services in the community.

In MHAP 2015-2020, the MSSS aims to achieve an efficient and effective organization of services that responds in a timely way to the needs for mental health services. To this end, it is imperative to ensure that in collaboration with partners in the public, private and community sectors, a variety of care and services are accessible and provided with a commitment to continuous improvement of quality.

In addition, pursuant to the recommendations of the CSBE[166] on equitable access to psychotherapy services for people with mental disorders that require them, the MSSS currently follows the work done by the Institut national d'excellence en santé et en services sociaux (INESSS) on different models for improving access to these services and the funding arrangements to be implemented for this purpose. In light of the results of the ongoing work, the MSSS will be able to determine the most appropriate strategies to adopt in Quebec.

This chapter describes various measures that support the actors concerned with mental health services, but also those in other sectors, so that people with needs related to mental health can receive appropriate services adapted to their specific situation.

6.1 SUPPORTING INTERPROFESSIONAL PARTNERSHIP AND COOPERATION

The MSSS intends to promote collaborative work and the transmission of knowledge and skills among interveners and partners.

[166] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Rapport d'appréciation de la performance du système de santé et de services sociaux 2012 – Pour plus d'équité et de résultats en santé mentale au Québec*, Québec, Gouvernement du Québec, 2012, 192 p., accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Rapport_Appreciation_SanteMentale_2012.pdf.

To that end, the health and social services network can count on the support of the *instituts universitaires en santé mentale* (IUSMs) in the improvement of services, the acquisition of new knowledge and the implementation of new models of care. Additionally, the IUSMs help demystify mental illness among the population through their interventions in the public sphere.

The following measures relate to continuity of mental health care and services, and support to interveners involved in the area of mental health, including family physicians.

6.1.1 STRENGTHEN THE CONTINUITY OF MENTAL HEALTH SERVICES

6.1.1.1 Practices that promote the continuity of services

Continuity of care and services involves a continuum in which the available resources and providers are considered as many components of a single network of integrated care and services, in which each of these components interacts to compose a coherent trajectory from the point of view of the experience of the service user.[167]

At least three types of continuity apply to health care and health services: informational continuity, relational continuity and continuity in terms of approach.[168] A continuum of services in the mental health sector also helps maintain the social and personal relationships of the service user in the community, while leading to an improved quality of life.[169]

Under the role of coordination and concertation vested in the integrated centres under the AHSSS, the MSSS expects that they will ensure the concertation between the various sectoral and intersectoral partners from the public and community network. If necessary, effective and continuous communication and coordination mechanisms as well as the conditions for the development of mutual trust must be developed.

MEASURE 18

To facilitate a comprehensive vision of the continuum of services while ensuring that the challenges in the area of mental health are squarely faced by its senior management, each institution responsible for providing mental health care and services will appoint and support senior management that is responsible for and accountable to clinical and organizational results across the continuum of care and services for people with needs in mental health.

MEASURE 19

To promote continuity of services, to ensure that interventions are effective and to improve accessibility of services:

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[167] See Appendix II.

[168] CANADIAN FOUNDATION FOR HEALTH CARE IMPROVEMENT, *Defusing the Confusion: Concepts and Measures of Continuity of Healthcare*, Canadian Health Services Research Foundation, 2002, p. i, accessible online: http://www.fcass-cfhi.ca/Migrated/PDF/ResearchReports/CommissionedResearch/cr_contcare_e.pdf

[169] G. FREEMAN *et al., Promoting Continuity of Care for People with Severe Mental Illness whose Needs Span Primary, Secondary and Social Care: A Multi-method Investigation of Relevant Mechanisms and Contexts*, London, National Coordinating Centre for Service Delivery and Organisation, 2002, p. 91.

- each integrated centre will establish and facilitate territorial concertation mechanisms between the various partners of the public and community network, in the health sector and in other sectors.

MEASURE 20

To promote the development of a culture of collaboration among institutions, to complete the definition of the hierarchy of services and thus improve the accessibility and quality of care, the MSSS will create a *réseau universitaire intégré en santé* (RUIS) (integrated university health network) table in mental health, which will have as one of its responsibilities to:

- propose an organization of second- and third-line mental health services.

6.1.1.2 Integrated management of the continuum of mental health care and services

MHAP 2005-2010 enabled the establishment of specific first-line mental health services, in a hierarchical continuum of services. The response to needs and the clinical outcomes associated with it are not the sole responsibility of specific mental health services: the general services, and other specific or intersectoral services, collaborate to provide people suffering from mental illness with a complete range of services based on their needs. The organization of services must develop in full accordance with this shared responsibility. The performance of the continuum of care and services must be assessed in terms of the contribution, clinical results and expectations of all the actors involved.

To be optimal, the organization of services requires that the requests and needs of the service user be analyzed. The general social services, through the interventions of the reception, analysis, orientation and referral service in integrated centres, are mandated for that purpose.

The reception, analysis, orientation and referral service is the main entry point to the integrated centre with respect to the requests for service of a social or psychological nature.[170] This service usually follows a request by the person concerned or by a member of his or her entourage, or a reference from another service of the integrated centre, another institution or a community resource, including a family physician. The interveners of this service have the required expertise, appropriate tools and an overview of services offered in the institution and by nearby community resources, to refer the person to appropriate services while respecting the hierarchy of services.[171] When the situation demands, interveners from the reception, analysis, orientation and referral service can refer the person to mental health services. MHAP 2005-2010 introduced the single-window access to mental health[172] function in the first-line

[170] The reception, analysis, orientation and referral service is offered with or without appointment during the day and evenings on weekdays and during certain hours on weekends. It is accessible 70 hours a week for in-person meetings and 70 hours a week by phone.
[171] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Services sociaux généraux, Offre de services, Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience*, Gouvernement du Québec, 2013, p. 20, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000345/.
[172] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Guichet d'accès en santé mentale pour la clientèle adulte des CSSS*, Gouvernement du Québec, 2008, p. 8, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000890/.

mental health teams. This structuring and fundamental function is designed to ensure the accessibility and continuity of mental health services by observing the hierarchy of all of these services, including specialized services.

MEASURE 21

To ensure integrated management of access to mental health care and services, each integrated centre:

1. will employ, even within the single-window access to mental health service, procedures for referral and access to specialized services, including making appointments for a consultation with a psychiatrist;

2. will make managers of specific and specialized mental health services jointly responsible for documenting the achievement of results in terms of access to services across the continuum of mental health care and services.

Quebec recognizes the autonomy and responsibility of non-agreement First Nations communities to develop their own health services and social services under the conditions and with the goals of their choosing. Network institutions have a responsibility to offer to the Aboriginal clientele the same services that they offer to all Quebecers, whether they are first-line services or second- and third-line specialist services. Moreover, Quebec recognizes a liability for the continuity and complementarity of services offered by the health and social services network with those of non-agreement First Nations communities. It does so in particular by ensuring the existence of appropriate referral mechanisms, when members of these communities receive services in the institutions of the Quebec network, and by facilitating the transfer of skills and knowledge to meet the needs of these communities.

MEASURE 22

To enable non-agreement First Nations communities to improve the accessibility and continuity of mental health and addiction services while clarifying service trajectories, and also to provide better coordination between the services offered by the health and social services network and those offered in their communities, the MSSS:

- agrees to continue, in collaboration with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), the implementation of collaboration agreements in mental health and addiction between institutions and non-agreement communities. Specifically, these agreements aim to:

    a. collaborate in the establishment of better mechanisms for referral and service bridging the Quebec network and community services;

    b. make training offered by the Quebec network more accessible to community interveners (knowledge transfer and skills development).

6.1.2 SUPPORTING FAMILY PHYSICIANS AND PEDIATRICIANS

Family physicians are the health professionals who are most often consulted for mental health needs.[173] Despite the frequency of consultations by this sector, monitoring of persons with mental disorders by family physicians is not optimal: a number of obstacles, including the maintenance of solo practices, lack of knowledge about available resources, (mission of the CLSC within the integrated centres, mission and expertise of community organizations and alternative resources, etc.) and the lack of support for family physicians, are still present.[174] Many family physicians feel competent to follow people with a moderate degree of mental disorder but poorly equipped to intervene with people who have a severe mental disorder.[175] This finding reaffirms the importance of the responding specialist in psychiatry function, while reiterating the importance of initial training and continuing education provided to physicians on best practices concerning mental health and suicide prevention.

In addition, although many children and young people are followed by a family physician, some are followed by a pediatrician. Medical evaluation and care for mental health are part of the standard practice of pediatricians, whether it consists of an intervention with a child with multiple risk factors or the care given to a youth suffering from a mental disorder. In order to promote an adequate response to the needs of children and youth, pediatricians must also receive support for their mental health practices.

Given the expertise of first-line mental health teams and the need to establish and maintain, in each territory, the foundations of mutual trust between physicians and integrated centres, the MSSS believes that sustained and structured concertation between partners at the local level is a powerful lever for the accessibility of services, the creation of alliances, and the fluidity and continuity of services. In this regard, we note that the Code of Ethics of Physicians mentions the obligation to collaborate with other health professionals and other persons authorized to provide health care to a patient.[176]

MEASURE 23

To support family physicians and pediatricians in their practice with people who have a mental disorder, each integrated centre will:

1. provide clinical support to physicians and pediatricians, in particular concerning:

    a. the interventions to prioritize with respect to mental disorders and their manifestations,

[173] A. LESAGE *et al., Prévalence de la maladie mentale et utilisation des services connexes au Canada – Une analyse des données de l'Enquête sur la santé dans les collectivités canadiennes,* Rapport rédigé pour l'Initiative canadienne de collaboration en santé mentale, Mississauga (Ontario), 2006, p. i, accessible online: http://www.iusmm.ca/documents/pdf/hopital/publications/prevalence_maladie_mentale.pdf.

[174] M.J. FLEURY *et al.,* "La prise en charge des troubles de santé mentale par les omnipraticiens du Québec," *Le médecin de famille canadien,* vol. 58, 2012, p. 728, accessible online: http://www.cfp.ca/content/58/12/e725.full.pdf.

[175] *Loc. cit.*

[176] Code of ethics of physicians, chapter M-9, division X, section 112.1, [Québec], Éditeur officiel du Québec, 2002.

b. the services offered, the referral mechanisms, access and possible adaptations of the continuum of care and service to their practice.

2. establish referral and access mechanisms adapted to the needs of family medicine practices and will ensure they are publicized;

3. define systematic and standardized procedures of follow-up and collaboration with family physicians and other physicians.

6.1.3 SUPPORTING THE INSTITUTION'S INTERNAL AND EXTERNAL PARTNERS

6.1.3.1 The deployment of the function of responding mental health professional

Like all citizens, people with mental illness can have multiple health needs that require them to use different services in the health and social services network. Because mental disorders affect a significant proportion of the population, interveners in every area of the network are confronted with it in their practice and may need support. Several factors can cause institutions or interveners to be reluctant to follow people with a mental disorder, especially when it is a serious mental disorder. Although this reticence may be reinforced by prejudices about mental illness and people with the disease, it is usually based on a lack of experience, a feeling of incompetence on the part of the interveners or fear that they will not receive support in their practice. This has negative repercussions on the person requesting the services, but also on integration, the performance of services and the overall capacity of the health and social services system to adequately serve the population.

The responding mental health professional has expertise in this area and works in an institution that provides mental health care and services. The responding mental health professional's function is to support internal and external partners of the institution in particular or complex clinical situations involving mental health. To meet the needs expressed by the partner, this support can take various forms: study of clinical situations, theoretical courses, regular participation in clinical meetings, etc. The responding mental health professional's activities are governed by service agreements and do not undermine collaboration and clinical support between teams and interveners outside these agreements.

In the particular goal of promoting clinical concertation, MHAP 2015-2020 proposes to deploy the responding mental health professional function. This function shall include:

- an integrated and adequate response to the needs of service users, including those with concurrent disorders;
- leveraging the expertise of professionals in mental health and the bilateral transfer of skills beneficial to both parties;
- supporting the development of interveners' skills;
- the development of a culture, of approaches and a common language among interveners in different sectors;
- the reduction of waiting lists and referrals to specialized services;
- the uncluttering of emergency departments.

Under the populational responsibility of integrated centres and their partners, they must pay particular attention to responding to the specific needs of the population of the territory served.

The complexity of the needs of certain population groups can render the support of a responding mental health professional particularly relevant. This is especially true of services (public or community) provided to children and families who have several risk factors at once, troubled youth, seniors and people who manifest concurrent disorders associated with an addiction or a disability. Thus, the challenges faced in the practice, the frequency of certain realities as well as the demographic context can lead integrated centres to consider certain areas of intervention as priorities for the establishment of agreements between a responding mental health professional and a partner from the public or community network.

MEASURE 24

To increase support for the practice of interveners from different programs, institutions and partners and to ensure service users of an integrated and adequate response to their needs:

1. The MSSS will prepare and disseminate a reference document governing the responding mental health professional function for 2015-2020;
2. Each integrated centre providing mental health care and services:
    a. will develop a portrait of the needs of its internal and external partners,
    b. will develop service agreements governing the activities of the responding mental health professional in various programs, care settings or with partners of the institution responsible for providing mental health care and services,
    c. will deploy the responding mental health professional function based on assessed needs.
3. Each integrated centre providing responding mental health professional services for all of its partners and that has a segment of the population it serves living in a non-agreement First Nations community will support and assist the professional teams working in these communities.

6.1.3.2 The deployment of the function of responding specialist in psychiatry

The responding specialist in psychiatry function has been introduced to foster collaborative care and to support first-line interveners in the monitoring of people with a mental disorder.

The responding specialist in psychiatry is a psychiatrist who practices in an institution that provides mental health care and services. The function of the responding specialist in psychiatry is to support mental health teams, family medicine groups and teams from integrated centres offering protection and rehabilitation services to troubled youth and their families in particular,

or complex clinical psychiatric situations. In response to the needs expressed by the partner, this support can take various forms: studies of clinical situations for educational purposes, theoretical courses, regular participation in clinical meetings, etc.

As an outcome of MHAP 2015-2020, the MSSS wishes to see all regions of Quebec benefit from this function.

MEASURE 25

To increase support for the practice of first-line interveners in the integrated centres or in family medicine and thus ensure the service users adequate monitoring and an appropriate response to their needs:

1. Each integrated centre providing mental health care and services:
    a. will develop a portrait of the needs of its internal and external partners,
    b. will develop service agreements governing the activities of the responding specialist in psychiatry with first-line mental health teams of the integrated centres, family medicine groups and teams from the integrated centres providing care and rehabilitation services to youth with adjustment difficulties and their families,
    c. will deploy the responding specialist in psychiatry function based on assessed needs.
2. The MSSS will discuss with the Fédération des médecins spécialistes du Québec the possibility of expanding the responding specialist in psychiatry agreement to enable it to support, upon request, professional teams serving non-agreement First Nations communities.

6.1.4 SUPPORTING THE INSTITUTIONS: THE NATIONAL CENTRE OF EXCELLENCE IN MENTAL HEALTH

Institutions can be supported in various ways, including the networking of institutions, clinicians and researchers for the development, dissemination and maintenance of good practices.

To this end, in 2008 the MSSS established the National Centre of Excellence in Mental Health (NCEMH), which initially specialized in intensive community treatment to enhance the expertise of teams and compliance with the evidence-based model. Other types of intervention have gradually been deployed, including support of varying intensity teams and first-line mental health services for adults.

The NCEMH's support and assessment of clinical practices has greatly contributed to the adoption of best practices and efficiency in the provision of mental health services in

Quebec.[177] In order to ensure support for institutions that is consistent with the ministerial guidelines for the organization and delivery of mental health services, the NCEMH will be looking at the entire continuum of mental health services, in addition to remaining the point of reference in regard to the promotion of quality standards as well as clinical and organizational management. To this end, it benefits from the mission (care, teaching, research, evaluation, implementation of new technologies and new modes of practice) and collaboration of the IUSMs (including that of the Centre d'études sur la réadaptation, le rétablissement et l'insertion sociale de l'Institut universitaire en santé mentale de Montréal), the INSPQ and INESSS.

MEASURE 26

To support the institutions in the deployment and maintenance of a quality offer of services founded on best practices, in particular those based on evidence, and promote the maintenance of a continuum of integrated services, the MSSS:

- will extend the mandate of the NCEMH to cover the entire continuum of mental health care and services, for children, youths, and for adults.

6.2 SUPPORT AND PROMOTE BEST PRACTICES IN CLINICAL SUPERVISION

Clinical supervision[178] is a strategy for maintaining skills that must be actualized in every professional workplace, especially when major organizational changes occur. It is a periodic review with the professionals on the team, individually or in a group, of clinical situations in order to achieve the following objectives:[179]

- Avoiding individual management of complex clinical problems;
- Assisting in decision making;
- Optimizing treatment through periodic assessments for the benefit of service users;
- Promoting continuing professional development through the mutual sharing of knowledge and skills;
- Improving access to care and services;
- Preventing burnout.

Clinical supervision enables the development and maintenance of good clinical practices among interveners, promotes an increase in professional confidence as well as services whose duration and intensity are adapted to the needs of the service users. It thus contributes to improving the effectiveness and efficiency of interventions as well as the optimal use of available resources.

[177] A. DELORME and M. Gilbert, "Que serait une œuvre sans son cadre?" *Santé mentale au Québec*, vol. 39, no. 1, Spring 2014, pp. 47-60.

[178] Clinical supervision, as it is described in this MHAP and in the Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte des équipes de santé mentale de première ligne en CSSS, differs from professional support, which is the responsibility of professional orders. The clinical supervision that is being discussed here is directly related to the mission and service offering.

[179] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS*, Québec, Gouvernement du Québec, April 2011, p. 27, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000672/.

Clinical supervision has a positive impact on improving the performance and accessibility of services.[180]

To this end, this MHAP reintroduces the clinical supervision function. With this measure, the MSSS seeks the continuous improvement of the quality of mental health services, including greater stability of personnel.

MEASURE 27

To help maintain a culture of continuous improvement of service quality and improve the care experience of mental health service users, while promoting the retention of interveners and the deployment and maintenance of good clinical and organizational practices, each institution responsible for providing mental health care and services will ensure the provision of clinical supervision measures for mental health interveners.

6.3 STRENGTHEN THE MEASURES INCLUDED IN MHAP 2005-2010

MHAP 2005-2010 enabled significant gains, though its implementation is not complete. A number of actions proposed in the plan need to be consolidated.[181,182] In MHAP 2015-2020, the MSSS reiterates the importance of completing the work leading to the achievement of the targets included in MHAP 2005-2010. This section includes some of the measures that are set out in this plan to ensure that the earlier targets are addressed.

6.3.1 FINANCIAL SUPPORT FOR COMMUNITY ORGANIZATIONS

The MSSS reiterates the importance of adequate support for community organizations whose expertise is critical to the establishment and maintenance of a quality offer of services, diversified and adapted to the needs and preferences of the population. Thus, as mentioned in MHAP 2005-2010, funding for community organizations should reach the level of at least 10% of the budget for mental health spending in all regions of Quebec.

6.3.2 CRISIS INTERVENTION SERVICES

As is mentioned in the general offer of social services,[183] as a result of the services provided by integrated centres to the general population, the centres have a responsibility to respond to anyone who experiences a social or psychological problem—or who has questions in this

[180] A. DELORME and M. Gilbert, *op. cit.*
[181] COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE, *Rapport d'appréciation de la performance du système de santé et de services sociaux 2012 – Pour plus d'équité et de résultats en santé mentale au Québec,* Québec, Gouvernement du Québec, 2012, p. 139, accessible online: http://www.csbe.gouv.qc.ca/fileadmin/www/2012/SanteMentale/CSBE_Rapport_Appreciation_SanteMentale_2012.pdf.
[182] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Évaluation de l'implantation du Plan d'action en santé mentale 2005-2010 – La force des liens,* Québec, Gouvernement du Québec, 2012, p. 67, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000380/.
[183] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Services sociaux généraux, Offre de services, Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience,* Gouvernement du Québec, 2013, p. 14, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000345/.

regard—who for this reason, present themselves to an integrated centre. People manifesting a problem, usually of an immediate or short-term nature but that can also be acute and reversible, and people affected in a civil security context, constitute the main clientele.[184]

General social services are responsible for providing the following crisis services:[185]

- Very short-term crisis intervention:[186] When it comes to a problem that can be solved by a minimum number of meetings (maximum of three meetings), very short-term crisis intervention can be performed by the reception, analysis, orientation and referral service (e.g., crisis intervention).
- 24/7 psychosocial telephone consultation (Info-Social):[187] This psychosocial telephone consultation service (Info-Social) is accessible day and night by dialing 811. It includes psychosocial intervention activities, psychosocial activities in the context of civil security and activities in support of interveners.
- 24/7 community crisis intervention:[188] Crisis intervention in the community environment offered day and night is a service offered 24 hours a day, 7 days a week, with no appointment needed. It is for anyone in a crisis situation for whom an intervention in the community environment is deemed necessary by the reception, analysis, orientation and referral service, the Info-Social service or by a partner from a community organization that has an agreement for this purpose with the integrated centre. This service is provided at home or in another suitable place, by an intervener from the integrated centre or a community organization according to an agreement entered into for this purpose.

The complete range of crisis intervention services also includes shelter in times of crisis and psychiatric emergency. Crisis shelter is available in the vast majority of the regions of Quebec. This service is mainly offered by community organizations according to an agreement entered into for this purpose.

The range of crisis intervention services needs to be consolidated in several regions of Quebec.[189] In addition to constraints on access, difficulties are encountered in certain regions, particularly where there are transport and distance problems. Problems with recruitment and retention of a skilled labor force affect the entire province.[190]

[184] *Ibid.,* p. 33.
[185] *Ibid.,* p. 14.
[186] *Ibid.*, p. 23.
[187] *Ibid.,* p. 27-28.
[188] *Ibid.,* p. 32-35.
[189] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Évaluation de l'implantation du Plan d'action en santé mentale 2005-2010 – La force des liens,* Québec, Gouvernement du Québec, 2012, p. 29, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000380/.
[190] *Ibid.*

MEASURE 28

To meet the needs of the population, each integrated centre will ensure the availability of crisis intervention services in its territory and ensure that the full range of services are publicized.

6.3.3 SUPPORT FOR PEOPLE AT RISK OF SUICIDE

The latest data confirm that the drop in the suicide rate that began in the early 2000s has persisted, allowing Quebec to have a suicide rate comparable to that of 40 years ago.[191] Among Quebec men, the suicide rate is 3.5 times higher than that of Quebec women. The highest rate is among men aged 35 to 49 years.[192] However, the Québec Population Health Survey reports that in 2008, women were three times more likely than men to report having attempted suicide in the previous 12 months. The gender gap regarding suicidal ideation is not very significant.[193] Suicide mortality remains a major public health problem and efforts in raising awareness and prevention must be maintained. Mental illness is an important factor in suicide risk.[194]

Suicide prevention has improved in Quebec, notably through the implementation of measures to facilitate partnerships between people working in different institutions and service environments, and because of the dissemination of best practices.[195] Thus, the *Guide de bonnes pratiques à l'intention des intervenants des CSSS*[196] and the *Guide de soutien au rehaussement des services à l'intention des gestionnaires des CSSS*[197] were published by the MSSS in 2010, particularly to support the achievement of the objectives enshrined the *Programme national de santé publique 2003-2012*[198] and MHAP 2005-2010.[199] These guides outline the directives governing the close monitoring of suicidal people and people who have attempted suicide. This measure[200] is designed to ensure that people who are or were in serious danger of attempting

[191] INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC, *La mortalité par suicide au Québec: 1981-2012 – Mise à jour 2015*, Québec, Gouvernement du Québec, 2015, p. 6, accessible online: http://www.inspq.qc.ca/pdf/publications/1939_Mortalite_Suicide_2015.pdf.
[192] *Ibid.*, p. i.
[193] MINISTERE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Idées suicidaires et tentatives de suicide au Québec,* Québec, Gouvernement du Québec, 2012, p. 6, accessible online: http://publications.msss.gouv.qc.ca/msss/ document-000486/.
[194] STATISTICS CANADA, Health at a Glance - Suicide rates: An overview (online), Canada, http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm (accessed August 18, 2014).
[195] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Évaluation de l'implantation du Plan d'action en santé mentale 2005-2010 – La force des liens*, Québec, Gouvernement du Québec, 2012, pp. 61-62, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000380/.
[196] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Prévention du suicide – Guide de bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux,* Québec, Gouvernement du Québec, 2010, 83 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000751/.
[197] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Prévention du suicide – Guide de soutien au rehaussement des services à l'intention des gestionnaires des centres de santé et de services sociaux,* Québec, Gouvernement du Québec, 2010, 64 pp., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000752/.
[198] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Programme national de santé publique 2003-2012,* Gouvernement du Québec, 2003, p. 40, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000917/.
[199] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Plan d'action en santé mentale 2005-2010 – La force des liens,* Québec, Gouvernement du Québec, 2005, p. 61, accessible online: http://publications.msss.gouv.qc.ca/msss/ document-000786/.
[200] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Prévention du suicide – Guide de soutien au rehaussement des services à l'intention des gestionnaires des centres de santé et de services sociaux*, Québec, Gouvernement du Québec, 2010, pp. 29-33, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000752/.

suicide and who leave the organization that was managing their suicidal crisis (e.g., hospital, crisis centre) may have access to immediate and intensive monitoring.[201]

It is important to prioritize certain practices with people who are at risk of suicide and who belong to vulnerable populations, including Aboriginal populations. A member of such a population is two to three times more at risk of committing suicide than is a non-Aboriginal person.[202] Thus, a project to adapt the guides to best practices in suicide prevention and the training of interveners that serve non-agreement First Nations communities is underway. This project is under the responsibility of the FNQLHSSC and is being implemented in close collaboration with the CSSS – Institut Universitaire de Gériatrie de Sherbrooke—now the Centre Intégré Universitaire de Santé et de Services Sociaux (CIUSSS) de l'Estrie – Centre Hospitalier Universitaire de Sherbrooke.

MEASURE 29

To ensure close monitoring of individuals who are or have been in serious danger of attempting suicide, every integrated centre will:

1. provide close monitoring and ensure it is accessible;
2. ensure its crisis management partners are aware of these close monitoring measures;
3. establish a referral process for access to these measures with its partners.

MEASURE 30

To specifically address one segment of the population where the risk of attempting suicide is among the highest, the MSSS will continue its collaboration with the FNQLHSSC to adapt the guides to best practices in suicide prevention and the training of interveners that work with non-agreement First Nations communities.

The MSSS will also collaborate with key actors in the implementation of similar approaches to Aboriginal communities under agreement.

6.3.4 FIRST-LINE MENTAL HEALTH TEAMS

One of the main objectives of MHAP 2005-2010 was the concrete implementation of specific first-line mental health services through the establishment of mental health teams for youth and adults in the CSSSs. As described in the *Orientations relatives à l'organisation des soins et*

[201] *Loc. cit*.
[202] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Prévention du suicide – Guide de bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux,* Québec, Gouvernement du Québec, 2010, p. 59, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000751/.

des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS,[203] the principal roles of these interdisciplinary teams were:

- assessing, using recognized clinical tools, requests that are forwarded to them;
- providing evidence-based care and services relying on practice guidelines in a first-line care context, taking into account the members of the service user's entourage;
- providing support to internal and external partners, including community resources.

The objective is to ensure that 70% of the needs of the population are responded to in first-line care, which includes ensuring access to care and services in a timely manner and, in certain territories, the transfer of resources from second-line services to the first line. Efforts must be maintained to improve and optimize practices and to establish and maintain a culture that promotes the first-line and hierarchical access in this sector.

Access to first-line mental health services in a timely manner is crucial in terms of meeting the needs of service users and the members of their entourage, and in terms of the performance of the entire Quebec health network. Indeed, first-line services contribute to significantly improving the network's response to the needs of service users and their access to these services by ensuring a culture of collaboration and the hierarchical service structure, including linkages with all programs and first-line actors (general social services, family physicians, family medicine groups, community pharmacies, community organizations, etc.) that can provide responses to the needs before having recourse to specific or specialized services.

MEASURE 31

To ensure the accessibility of the specific first-line mental health services, the MSSS:

- will continue, with the collaboration of the NCEMH, deploying and optimizing specific first-line mental health services.

6.3.5 SUPPORT AND MONITORING IN THE COMMUNITY OF PEOPLE MANIFESTING A SERIOUS MENTAL DISORDER

Support and monitoring in the community are the types of services that are oriented towards rehabilitation. Their main function is to promote the acquisition of an optimal level of independent functioning in society. They thus play a key role in the process of recovery and integration of people with a serious mental disorder, while promoting the judicious use of services. Their intensity and duration vary according to the needs and the situation of the people to whom they are addressed.

[203] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS, Québec, Gouvernement du Québec, April 2011, p. 27, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000672/.

The MSSS published, in 2002, a document entitled *Lignes directrices pour l'implantation de mesures de soutien dans la communauté en santé mentale,*[204] in which three different models to meet specific needs are described, namely:

- Non-intensive core support
- Support of varying intensity
- Intensive community treatment

These three service models form a continuum. According to their needs and their situation, people can pass, depending on the periods, from one level of service intensity to another. To support the process of the recovery of service users, which is not necessarily linear, and to promote the effective use of available resources, these transitions from one level of service intensity to another must be promoted.

Even though the three models of support and monitoring in the community (non-intensive core support, support of varying intensity and intensive community treatment) contribute in a complementary way to an effective offer of services, the MSSS prioritizes the deployment of support of varying intensity and intensive community treatment services, which are aimed at people manifesting a serious mental disorder, whose situation is unstable and who would be most likely to be hospitalized for long periods or frequently resort to emergency services without the presence of adequate services in the community.

Although there are similarities between support of varying intensity and intensive community treatment, they differ in the intensity of services offered. Support of varying intensity services are coordinated by an intervener who maintains a special relationship with the person ("case management" model).

For its part, intensive community treatment, which is one of the most studied service models in the scientific literature in psychiatry and whose impact on reducing the use of hospital services is the best documented,[205,206,207,208,209] consists of an organization based on the interventions of an interdisciplinary team that includes a participating physician, and that offers psychiatric treatment, support and rehabilitation services.

The presence of support of varying intensity services greatly influences the efficiency of intensive community treatment teams, which need to have the option of transferring stabilized

[204] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Lignes directrices pour l'implantation de mesures de soutien dans la communauté en santé mentale*, Québec, Gouvernement du Québec, 2002, 28 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-001321/.
[205] T. BURNS *et al.,* "Use of intensive case management to reduce time in hospital in people with severe mental illness: Systematic review and meta-regression," *British Medical Journal,* vol. 335, no. 7615, 2007, pp. 336-340.
[206] G.R. BOND *et al.,* "Assertive community treatment for people with severe mental illness," *Disease Management and Health Outcomes*, vol. 9, no. 3, 2001, pp. 141-159.
[207] G.R. BOND *et al.,* "Assertive community treatment for frequent users of psychiatric hospitals in a large city: A controlled study," *American Journal of Community Psychology,* vol. 18, no. 6, 1990, pp. 865-891.
[208] S.D. PHILLIPS *et al.,* "Moving assertive community treatment into standard practice," *Psychiatric Services*, vol. 52, no. 6, June 2001, pp. 771-779.
[209] E.A. LATIMER, "Economic impacts of assertive community treatment: A review of the literature," *Canadian Journal of Psychiatry*, vol. 44, no. 5, June 1999, pp. 443-454.

service users to a lower intensity service. In the absence of fluid access to support of varying intensity, intensive community treatment teams tend to keep people longer, which leads to difficulties in accessing intensive community treatment. These services play a major role in the continuum of mental health services, while contributing to an increase in the overall performance of the health system for the benefit of people with a serious mental disorder—among the most vulnerable in society—and their entourage.

Respect for the clinical and organizational criteria for the support of varying intensity and intensive community treatment models has a significant impact on the optimal use of resources. Thus, the NCEMH will now ensure the compliance of the services to best practices, both in institutions and in the community. The places attached to measures of community support will be the subject of a process of recognition as to their fidelity to proven support of varying intensity and intensive community treatment service models, which will enable the MSSS to recognize the specific teams and better guarantee the expected impact of these services on the continuum. Some criteria of the recognition process will be prioritized. Regarding support of varying intensity, services will have to address the production of an intervention plan (for all persons served with support of varying intensity), the adequacy of the intensity of services as well as the coordination of services between partners. As for intensive community treatment, the priority for the teams will be to have a psychiatrist assigned to them, a specialist in the work, an addiction specialist and a peer helper.

The requirement for services is estimated at 250 people per 100,000 for support of varying intensity and 70 places per 100,000 inhabitants for intensive community treatment.[210] Nevertheless, the target set out in this MHAP is below the level required, as a consequence of the availability of resources. It remains the case that in the medium and long term, Quebec must achieve the levels of service required based on the assessment of populational needs.

MEASURE 32

To ensure that support of varying intensity and intensive community treatment services apply evidence-based practices:

- the MSSS will continue implementing, in collaboration with the NCEMH, the mechanism for recognition of the quality of support of varying intensity and intensive community treatment services.

MEASURE 33

To improve the offer of support services in the community for people with a serious mental disorder, each integrated centre will:

1. continue the deployment of support of varying intensity services in order to achieve a ratio of at least 145 recognized places per 100,000 inhabitants;

[210] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Plan d'action en santé mentale 2005-2010 – La force des liens*, Québec, Gouvernement du Québec, 2005, p. 85, accessible online: http://publications.msss.gouv.qc.ca/msss/ document-000786/.

2. continue the deployment of intensive community treatment services in order to achieve a ratio of at least 55 recognized places per 100,000 inhabitants;

3. integrate a peer helper into at least 30% of support of varying intensity teams and 80% of intensive community treatment teams.

MEASURE 34

To improve the offer of support services in the community for the benefit of clients who are homeless and who have serious mental disorders, the MSSS reiterates the commitments made in the *Plan d'action interministériel en itinérance 2014-2019*:

- an intensive community treatment team will be established in Montreal for clientele who are homeless and who have serious mental disorders. The interdisciplinary team, which also includes a psychiatrist, will be formed according to the recognized standards of models of intensive community monitoring inspired by the PACT (Program for Assertive Community Treatment) and adapted to the reality of the needs of homeless clients.

MEASURE 35

To enable non-agreement First Nations communities to have access to intensive community treatment and support of varying intensity services, as well as services for young people experiencing a first episode of psychosis, such communities may, if necessary, negotiate agreements with the institutions providing such services, in compliance with the responsibilities of each level of government.

6.4 FORENSIC AND PRISON PSYCHIATRIC SERVICES

In the health and social services network, particularly in mental health, interveners are frequently called upon to apply legal measures regarding a service user. We observe, in this regard, a steady increase in orders for assessment, treatment, care and accommodation issued by the Civil Division and the Criminal and Penal Division of the Court of Quebec and sent to health and social service institutions.[211,212] Large numbers of people with a severe mental disorder are observed to have criminal records, are incarcerated and have problems with the police.[213]

[211] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Rapport d'enquête sur les difficultés d'application de la Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui*, Québec, Gouvernement du Québec, 2011, p. 23, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000695/.
[212] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Rapport du Comité de travail interministériel sur la prestation des services de psychiatrie légale relevant du Code criminel,* Québec, Gouvernement du Québec, 2011, pp. 44-46, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000694/.
[213] SERVICE DE POLICE DE LA VILLE DE MONTRÉAL, *L'intervention policière auprès de personnes mentalement perturbées ou en crise – Plan d'action stratégique en matière de santé mentale 2013-2015,* Montréal, p. 8, accessible online: http://www.spvm.qc.ca/upload/documentations/Plan_stategique_sante_mentale_FINAL.pdf.

As in any other mental health service and in accordance with the principal of the primacy of the individual, an approach that strikes the right balance between protection, security and the preservation of human rights must be adopted and applied. The minimal restriction of the person's rights in the adoption of last resort legal measures, taking into account the assessment of the risk actually incurred that one seeks to counter, must be ensured. Even if a legal remedy is necessary, an effort should be made to select the least coercive actions. Therefore, whenever a legal measure that may impose heavy consequences for the person concerned is envisaged, a search of the Curateur public's Register of Persons under Protection Supervision[214] must be performed, so that the person's legal representative or the Curateur public, as appropriate, can be informed of this decision, in respect of the obligation to ensure that the person receives the services required and that his or her rights are respected.

Concerning the danger or risk incurred, access to a mental health facility cannot automatically be excluded under the pretext of a criminal record or past dangerous behaviour: the current risk must be most taken into account and a good assessment of this risk is, in such a situation, paramount. Also, the degree to which rights can be infringed must be balanced by a real and present danger that justifies the infringement.

The criminal or civil nature of the court order and its contents determine the roles, responsibilities and obligations of interveners in health care and social service Institutions. These elements also determine the roles, responsibilities and obligations expected of the partners and people involved. For this collaborative action to succeed and produce the desired results, everyone involved must have a common vision and understanding of the objective to be achieved, the reason for this common action and how it will be implemented, without losing sight of the mission that they are expected to fulfill.

Certain legal measures, including tutorial, curatorial and mandatory protection supervision, are quite common and pose few management problems. Concerning legal measures that are more exceptional, significant differences between the provisions of the law and how they are implemented in practice were found, both in institutions and in the records of people who use the health and social services network.

These difficulties of application have largely been documented in various reports about the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others[215] and Part XX.1 of the Criminal Code relating to an accused person with a mental disorder.[216,217] Since both measures infringe on personal freedom and integrity, they are

[214] The registers of protective schemes of the Curateur public can be viewed at the following address: http://www.curateur.gouv.qc.ca/cura/en/majeur/inaptitude/role/registres.html.
[215] An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, CQLR, chapter P-38.001, [Québec], Éditeur officiel du Québec, 1997.
[216] Criminal Code, RSC, chapter C-46, [Ottawa], Minister of Justice, 1985.
[217] Part XX.1 of the Criminal Code applies with necessary modifications to the offenses charged to adolescents, in accordance with subsection 11 of section 141 of the Youth Criminal Justice Act (SC 2002 c.1). For its part, the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others applies to everyone, regardless of their status, age or condition or any other characteristic whatsoever.

restrictive in their interpretation and application, particularly in terms of procedures and timetables.

To improve the management of these two exceptional measures, personnel involved in these cases need clear orientations concerning the desired common objective, along the lines of and within the scope of their mission. They must also have access to the knowledge, skills and tools necessary to play their role in this context.

In addition to the principles of the primacy of the individual and respect for human rights, those relating to populational responsibility, the hierarchy of services and their integration, as well as provision of care in collaboration and in proximity to where the service user lives, promoted in this MHAP, should guide the actions to be taken and the measures to be applied in practice.

To ensure that practices in the management of legal measures are in compliance with the law and to promote optimal coordination of actions in the field, concertation between the legal and public safety partners involved in these cases is unavoidable. Although to date, this concertation exists in many areas, it remains insufficient to produce the desired results. Improvements are needed, as evidenced by the recommendations in the reports produced on the subject.[218,219,220,221]

The concertation between the health and social services, public safety and justice networks, as well as the concertation with their affiliated organizations, should be consolidated, expanded and implemented at all levels of decision making.

As a foundation for the concertation necessary to coordinate actions on the ground, the Justice and Mental Health Forum, bringing together the main partners involved, was established in March 2012. Its primary objective is to develop a provincial concertation strategy in regards to justice and mental health, which will be proposed to the government by the three ministries involved. This strategy includes the creation of regional justice and mental health concertation tables throughout the territory of Quebec, including in First Nations and Inuit communities. In line with the Forum's province-wide character, each integrated centre must designate representatives who will participate in these tables. The names of these “justice and mental-health respondents” will appear on a list maintained by and easily accessible to partners.

[218] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Rapport d'enquête sur les difficultés d'application de la Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui,* Québec, Gouvernement du Québec, 2011, pp. 80-81, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000695/.
[219] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Rapport du Comité de travail interministériel sur la prestation des services de psychiatrie légale relevant du Code criminel,* Québec, Gouvernement du Québec, 2011, p. 83, accessible online: http://publications.msss.gouv.qc.ca/msss/document-000694/.
[220] QUEBEC OMBUDSMAN, *Problems with the application of the Act respecting the protection of persons whose mental state presents a danger to themselves or to others (R.S.Q., c.P-38.001),* Québec, 2011, 39 p.
[221] QUEBEC OMBUDSMAN, *Rapport spécial du Protecteur: Pour des services mieux adaptés aux personnes incarcérées qui éprouvent un problème de santé mentale*. Québec, 2011, 77 p. and annexe.

MEASURE 36

To promote the concertation needed to improve the effectiveness of forensic psychiatric services:

1. The MSSS, the Ministère de la Justice (MJQ) and the Ministère de la Sécurité publique (MSP) will propose to the government the adoption of a provincial justice and mental health concertation strategy, developed by the Justice and Mental Health Forum;

2. Each integrated centre will appoint representatives to regional justice and mental health tables or to a forum where designated actors will meet, becoming the "justice and mental health respondents" of the health and social services institutions.

In addition, a provincial forensic psychiatric institute will be created to collaborate in the development of best practices in forensic psychiatry, in relation to both civil law and criminal law.

MEASURE 37

To enhance the training, implementation, quality and continuity of services in forensic psychiatry:

- the MSSS will create a provincial forensic psychiatric institute to which it will give a mandate to provide leadership to the province.

6.4.1 FORENSIC PSYCHIATRY UNDER THE QUEBEC CIVIL CODE

To standardize practices in this matter and ensure that they conform to the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, ministerial orientations on the application of the Act will be published and their implementation will be supported in the health and social services, justice and public safety networks.

This support will be made possible through a system of accountability designed to make boards of directors responsible for the application of the Act within their institution. They will be required to include in their annual management report factual data on the confinement and psychiatric evaluation of people without their consent, in a format that will enable the MSSS to monitor implementation.

The boards of directors must also ensure the adoption and distribution of a "confinement protocol" to the personnel concerned, in accordance with ministerial guidelines. In addition, joint MSSS-MJQ-MSP training on the Act, including a section on rights, will be developed and included in the provincial health and social services training plan.

MEASURE 38

To ensure that practices in this area are standardized and comply with the Act:

1. the MSSS, after consulting the MJQ, the MSP and other involved partners, will publish ministerial guidelines on the application of the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others;

2. the board of directors of each institution shall include in its annual management report, factual data on the confinement and psychiatric evaluation of a person without his or her consent;

3. The board of directors of each institution will adopt and distribute to the personnel concerned, a "confinement protocol" in compliance with ministerial orientations;

4. the MSSS, MJQ and MSP will develop training in collaboration and offer it jointly in their respective networks.

6.4.2 FORENSIC PSYCHIATRY UNDER THE CRIMINAL CODE

As for orders issued by the Criminal and Penal Division and following the report published in 2011,[222] work designed to develop the hierarchical structure and delivery of services will continue to be pursued within the Justice and Mental Health Forum and in regional concertation tables.

As a first principle, the partners involved in this issue must agree that a hospital's mission is first of all to treat people and not to confine them without being able to care for them or needing to do so, either because they refuse treatment, or because their health does not require acute inpatient care.

Moreover, the shift to outpatient care which, over the past 20 years, has enabled many citizens to obtain medical and surgical care and services without monopolizing hospital beds must now be extended to forensic psychiatry under the Criminal Code.

In this sense, assessments as to a person's mental state to determine fitness to appear before a judge or criminal liability, as well as treatment orders intended to render a person fit to stand trial, ordered under Part XX.1 of the Criminal Code, should be performed most often on an outpatient basis, without needing to keep the accused in a hospital bed. If, for public safety reasons, a court orders the confinement of the accused until a verdict is delivered, he or she should remain under the responsibility of the correctional services, whose mission it is.

[222] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Rapport du Comité de travail interministériel sur la prestation des services de psychiatrie légale relevant du Code criminel,* Québec, Gouvernement du Québec, 2011, 226 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000694/.

Obviously, as permitted by the Criminal Code, this requires that the wording of the orders provide for travel between the detention facility and the health institution designated to perform the assessment or treatment.

This wording must also provide for keeping the accused confined in a hospital as long as the situation requires, in the event that the outpatient examination reveals a health problem requiring hospitalization for acute care, rehabilitation, or because the assessment of the accused requires it.

Furthermore, the duration of orders for assessment or treatment, except in rare exceptions, should not exceed the maximum limits provided in the Criminal Code, or five days in the case of aptitude and 30 days in the case of criminal liability or treatment. Only the filing of a petition with the competent court should permit an agreement to extend these deadlines. Moreover, regardless of the amount of time provided in the order to carry out the assessment or treatment, as soon as this assessment or treatment has been completed, the designated institution should request the immediate appearance of the accused, as provided under the Criminal Code. In this way, the MSSS hopes to stabilize, if not reduce, the average length of stay of detainees, for assessment or treatment, occupying acute care hospital beds.

MEASURE 39

To encourage the provision of outpatient forensic psychiatric services under Part XX.1 of the Criminal Code:

1. The MSSS is committed to reviewing the ministerial order designating facilities in which an accused may be confined in order to ensure that these places are located as close as possible to detention facilities;

2. The MJQ and the MSP are committed to continuing the work of the Justice and Mental Health Forum designed to educate the entire justice system so that orders for an assessment of competence to appear or criminal liability, or for treatment in order to render a defendant fit to stand trial, support the use of outpatient services and reserve hospitalization for defendants whose mental condition requires it.

The same outcomes are to be hoped for in regard to the decisions of the court or the Commission d'examen des troubles mentaux (CETM), once a verdict of incompetence or criminal nonresponsibility is rendered. As stipulated by the Criminal Code, as soon as the mental state of defendants permits, and they no longer represent a danger to themselves or others, they must receive care, including monitoring and supervision in an outpatient setting close to where they live.

In this regard, the designated institutions are invited to make the necessary representations to that effect before the CETM, including obtaining a delegation of power allowing them to loosen or tighten the conditions of detention or release or by submitting a request for a hearing before the CETM to vary the decision to that effect as soon as it is relevant to do so.

6.4.3 PRISON PSYCHIATRIC CARE

A special report issued by the Quebec Ombudsman on this question[223] reveals how inmates with mental illness have a significant impact, both financially and organizationally, on detention facilities, not to mention the distress and suffering of these people who don't receive the required services there to which they are entitled.

Specifically, the report highlights a number of problems concerning the accessibility, quality, continuity and monitoring of care for inmates with a severe mental disorder, referring also to service ruptures and the forced discontinuation, at the time of incarceration, of the prescribed psychotropic medication.

In addition, the mechanisms that control the practice of a nurse or professional defined in the AHSSS to ensure that citizens receive quality care and services do not apply in detention facilities.

In this context, as recommended by the WHO,[224] it appears inevitable that health care and social services in detention facilities be provided by personnel from the health and social services network, regulated by the defined mechanisms in the AHSSS. This would allow record keeping to conform to the law and ensure better continuity of service, both during incarceration and following the release of the person, who would be already known to the local health services network, which would help to reduce the revolving door and recurring incarcerations phenomena.

MEASURE 40

In order to provide all citizens, even when they are incarcerated, with ongoing and quality health care and social services, the MSSS and the MSP will file a joint request to the government to effectuate the transfer to the MSSS of the management and responsibility for health care and social services provided in provincial detention facilities.

[223] QUEBEC OMBUDSMAN, *Rapport spécial du Protecteur: Pour des services mieux adaptés aux personnes incarcérées qui éprouvent un problème de santé mentale*. Québec, 2011, 77 p. and annexe.
[224] WORLD HEALTH ORGANIZATION, *Good Governance for Prison Health in the 21st Century: A Policy Brief on the Organization of Prison Health*, Copenhagen (Denmark), 2013, 32 p., accessible online: http://www.euro.who.int/_data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1.

7 /

IMPLEMENT MHAP 2015-2020 AND ENSURE THE PERFORMANCE AND CONTINUOUS IMPROVEMENT OF MENTAL HEALTH CARE AND SERVICES

The fulfilment of the MHAP is a major project that requires the establishment of a rigorous methodology and work structure in order to support and monitor the implementation of the measures. Moreover, the achievement of objectives must be verified and the impact of MHAP assessed, with a view to continuously improving the quality of health care and social services.

7.1 THE IMPLEMENTATION AND MONITORING OF MHAP 2015-2020

MHAP 2015-2020 will be supported by ministerial and territorial implementation plans describing:

- the ministerial and territorial measures relative to the objectives of MHAP;
- the specific measures in each territory (if necessary);
- the specific measures for people with special needs;
- the established timetables;
- the primary responsibility for the implementation of each measure;
- the roles of partners in the implementation of measures;
- the implementation process (work organization, project management, etc.);
- the targets and expected results in relation to each measure;
- the methodology and tools for ongoing monitoring of the implementation.

To ensure that the objectives are met within established timeframes, the MSSS and the institutions responsible for providing mental health care and services must together engage in a dynamic process of concertation and accompaniment in the plan's implementation, as well as the establishment of a rigorous monitoring mechanism of measures and results. This ministerial and territorial monitoring must be coordinated in order to mobilize all concerned actors. Its function is to ensure the smooth course of the work and, if necessary, to quickly recognize any differences on what is expected, and initiate whatever changes are needed to achieve the objectives of the MHAP.

For each target in the MHAP, the relevant data will be systematically collected and analyzed. Much of the data will be subject to annual review. To this end, the exploitation of existing

ministerial management data banks will be strengthened. Monitoring tools that can incorporate feedback will also be gradually designed and deployed in order to support the various levels of management in implementing the MHAP. Finally, certain targets that correspond to unique or one-time deliverables (e.g., the development of orientations) or processes (e.g., setting up worksites) will be monitored through a mid-term review and a final report.

In addition, an evaluation of the implementation will be conducted towards the end of the period covered by the MHAP. Concerning the plan's measures, the evaluation will document the achievement of expected results and the factors that significantly contributed to it, or on the contrary, worked against it. The evaluation report will be published and accessible to the actors of the network, its partners and the general public, in the interest of continuous improvement and in respect for the transparency required on the part of the MSSS as an administrator of public funds.

7.2 CONTINUOUS IMPROVEMENT OF PERFORMANCE OF MENTAL HEALTH CARE AND SERVICES

7.2.1 EVALUATION OF COMPLIANCE WITH MINISTERIAL STANDARDS

The MSSS will conduct an evaluation of compliance with ministerial standards relating to mental health services. This process will focus on measuring compliance with ministerial standards, particularly with regard to quality, offer of services, required clinical processes, required organizational practices and wait times.[225] These standards should guide the development of the offer of mental health services in each territory.

The approach will be based on support from two levels of management. Given the limitations of the available data in ministerial databases, the process will require sustained interaction between the MSSS and the integrated centres to gather the relevant (quantitative and qualitative) data.

7.2.2 DOCUMENTATION OF BEST PRACTICES IN THE MOST PRODUCTIVE AREAS AND DEVELOPMENT OF A CULTURE OF CONTINUOUS IMPROVEMENT

The clinical and organizational practices that prevail in territories displaying excellent performance – either globally or in terms of specific aspects – will be systematically documented in order to be eventually disseminated to other parts of the network that can benefit from their adoption, once the necessary adaptations have been made. This approach will also aim, with the help of the NCEMH, to identify the most promising innovative practices – including collaborations between institutions and community organizations – which will then be further tested, monitored, adapted and then disseminated and possibly adopted by other teams working in similar clinical settings.

[225] See Appendix I.

The implementation of best practices and the optimization of existing practices require the establishment of a culture of continuous improvement and a systematic approach to change management in the institutions. A continuous improvement approach requires a constant review of the services offered to the population of a given territory, through a consensual process and therefore involving actors representing all the steps inherent to a given care process, either in an integrated centre or between partners of a territory. The review process aims to gradually improve the continuum of care and services as a whole, by looking at one or more targeted projects with a clear and realistic impact on a defined segment of service users' trajectories of care and service. More specifically, the establishment of a genuine culture of continuous improvement consists of:

- constantly seeking, in a methodical and structured manner, to simplify and standardize the steps involved in the care and service process or in the flow of people within the different services;
- removing barriers, reviewing clinical practices and activities that do not contribute to improving the biopsychosocial situation of the service user;
- drawing upon the different actors involved in the target process (including partners, service users and members of their entourage) to clarify the problems, innovate solutions and implement agreed changes ;
- measuring the results of changes made in order to recognize successes and identify difficulties, maintain improvements and make adjustments as needed;
- mobilizing actors and interveners who participate in the process of providing care and services, recognizing the importance of each person’s contribution within the process and deepening its significance.

The MSSS will promote continuous improvement by sharing experiences, approaches and tools enabling institutions and other organizations to evaluate and improve work processes. The development of a continuous improvement approach in the mental health network, which is well underway, will strengthen the ways people work together in order to offer a better experience to the service user.

The MSSS will continue to gradually establish and clarify the standards that will support the adoption of effective clinical processes. The application of these standards will also be rigorously monitored to support the institutions in the adoption of best practices. The NCEMH and the MSSS will continue their close partnership in this support role and in providing accompaniment to teams.

CONCLUSION

MHAP 2015-2020 – *Working Together in New Ways*, like the previous Action Plan, arrives at a pivotal moment in the organization of the health and social services network. The creation of integrated centres, and changes to the way medical services are dispensed and funded, are factors which invite the actors in the mental health sector to "work together in new ways": new in their ability to break down walls between programs that from now on will be in the same organization, new in their close relationship to the heart of the first line – the family physician's office – and new in the optimal use of resources.

While this Action Plan aims on the one hand to develop clinical services accessible earlier in the life course of the service user, available in the community and responsive to people's needs, it is also designed to lead to the development of a larger network that is particularly effective in responding to the impact of mental illness on the life of service users and their entourage, in the health network but also in the judicial system, schools and institutions of higher education, etc.

Given the magnitude of the impact of mental illness on the individuals who suffer from it and the members of their entourage, but also on the services that the government provides to these people, it is essential to have an overall vision and to closely collaborate to support service users in their journey towards recovery and social participation, while promoting optimal and judicious use of public resources and the expertise of the partners.

APPENDIX I

1. SERVICES TO BE OFFERED TO THE POPULATION

The following table shows the range of services required according to the ministerial standards. These are benchmarks that guide, optimize and develop the territorial coverage. Under the principle of populational responsibility, the institutions are mandated to gradually improve and adapt the supply of services in their territory in order to conform to these standards, in cooperation with their partners.

TABLE 1 – MINISTERIAL STANDARDS CONCERNING THE RANGE OF SERVICES THAT ADDRESS PEOPLE WITH A MENTAL DISORDER

Type of services	Services required
Crisis services: • very short-term crisis intervention • 24/7 psychosocial telephone consultation (Info-social) • 24/7 crisis intervention in the community	Services accessible to the population of each territory, in accordance with the general offer of social services[226]
• Crisis accommodation • Psychiatric emergency	Services accessible to the population of each territory
Support to families and members of the entourage	Service accessible to the population of each territory
Respite care for families and the entourage	Service accessible to the population of each territory
Assessment and treatment services in mental health - across the continuum of specific first-line and specialized services*	Serve 3% of the population according to the standards relating to the clinical administrative context of mental health services (see Table 3)
Measures of support in the community for people with a serious mental disorder*:[227]	Minimum ratio of 1,500 places per 100,000 population, including:
• intensive community treatment	70 places per 100,000 population (minimum ratio)
• support of varying intensity	250 places per 100,000 population (minimum ratio)
• non-intensive core support	1180 places per 100,000 population (minimum ratio)

[226] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Services sociaux généraux, Offre de services, Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience*, Gouvernement du Québec, 2013, 70 pp., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000345/.

[227] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, Lignes directrices pour l'implantation de mesures de soutien dans la communauté en santé mentale, Québec, Gouvernement du Québec, 2002, 28 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-001321/.

Hospitalization and long term*	2 child psychiatric beds per 100,000 inhabitants (reserved beds in child psychiatric units or the equivalent capacity of days/presence in pediatric units) 40 psychiatric beds per 100,000 population, including: • 25 short-term beds (hospital) • 15 long-term beds (accommodation). Of these beds, 3 places must be provided for forensic psychiatric clientele. 6.6 beds reserved for forensic care (regional, supra-regional or provincial mission) per 100,000 population, including: • 5.2 guarded beds in a closed area • 1.4 extended stay or maximum security beds
Varied and comprehensive range of residential services and non-institutional accommodation, favoring independent living*	120 places per 100,000 population (distribution plan according to the needs of the population)
Other services:	
• self-help groups	Services accessible to the population of each territory
• structured community day activities	Services accessible to the population of each territory
• integration services at work, from psychosocial rehabilitation to work, social insertion and job retention	Services accessible to the population of each territory
• promotion, respect and defense of rights	1 group per region
• 2nd-line teams in integrated centres providing care and rehabilitation services to youth with adjustment problems and their families	1 team per integrated centre providing care and rehabilitation services to youth with adjustment problems and their families

* The calculation of service requirements, on the scale of a territory, must be based on a population weighted according to the population mental health needs indicator of the MSSS (*Mode d'allocation des ressources, MSSS, DAR*).

2. WAIT TIMES FOR ACCESS

The Orientations on standards relative to access, continuity, quality, effectiveness and efficiency of general social services[228] and the consensus of experts enables the following standards to be set for access to health care and services. These standards are applicable to the majority of users oriented towards specific first-line mental health services, or in an elective manner, to specialized services.

TABLE 2.1 – MINISTERIAL STANDARDS FOR MAXIMUM AMOUNTS OF TIME REQUIRED TO ACCESS MENTAL HEALTH SERVICES

Experience of users oriented towards specific mental health services	Time limit
Maximum time for the request to be processed and directed to the appropriate service by the reception, analysis, orientation and referral service[229]	10 days
Maximum time for the intervention or treatment by the professional assigned to monitoring or consultation in a first-line or specialized mental health service to begin	30 days
Maximum time for feedback to the referent by specific or specialized mental health services[230]	7 days

As more specifically concerns psychiatric consultation (clientele of all ages), the standards to be met in order to ensure access in a clinically appropriate amount of time were established by expert consensus.[231] The following table specifies the standards associated with certain conditions deemed most representative of the performance of the entire system, according to the applicable level of priority. The single-window access to mental health service is the body empowered to direct the service user to appropriate services. The following standards apply whether the person requires special services or specialized services.

TABLE 2.2 – MINISTERIAL STANDARDS THAT APPLY TO MAXIMUM AMOUNTS OF TIME REQUIRED FOR A PSYCHIATRIC CONSULTATION IN CERTAIN SPECIAL CLINICAL SITUATIONS

Clinical situation	**Crisis**	**Unstable mental state**	**Stable mental state (elective)**
First psychotic episode	24 hours	7 days	15 days

[228] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Services sociaux généraux, Offre de services, Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience*, Gouvernement du Québec, 2013, 70 pp., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000345/.
[229] *Ibid*.
[230] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Guide de Gestion – Accès aux consultations spécialisées et aux services diagnostiques – Gestion intégrée de l'accès aux services spécialisés*, Gouvernement du Québec, 2012, 63 p.
[231] CANADIAN PSYCHIATRIC ASSOCIATION, *Wait Time Benchmarks for Patients with Serious Psychiatric Illnesses*, March 2006, 4 pp., accessible online: http://publications.cpa-apc.org/media.php?mid=383

Manic depressive crisis	24 hours	7 days	-
Hypomanic episode	-	14 days	30 days
Severe postpartum depressive disorder	24 hours	7 days	30 days
Major depression	24 hours	14 days	30 days
Other situations requiring psychiatric consultation	24 hours	14 days	30 days

3. STANDARDS CONCERNING THE CLINICAL ADMINISTRATIVE FRAMEWORK OF MENTAL HEALTH SERVICES

The following standards primarily affect organizational and clinical practices that are essential to ensure that mental health services are consistent with their mission. Onsite accompaniment by the NCEMH contributes to compliance with these standards and is mostly focused on supporting teams in the adoption of efficient and effective practices.

TABLE 3 – STANDARDS RELATING TO THE CLINICAL ADMINISTRATIVE FRAMEWORK FOR MENTAL HEALTH SERVICES

HIERARCHY OF MENTAL HEALTH SERVICES	• Response to the majority of first-line needs of the population (at least 70% of requirements) • Optimal management of access and continuous improvement • The level of care and services is determined based on symptoms and needs, not only in terms of a diagnosis • Access to specialized services requires a recommendation from specific mental health services • The absence of a medical recommendation is never a barrier to access to the specific or specialized mental health services (including psychiatric consultation) • Reserve the use of specialized services: **- at the time consultation for:** * assessment and diagnostic accuracy * making recommendations for treatment in first-line services **- for complex problems:** * that are resistant to conventional treatment * whose prevalence is low * that present the highest risk of social rupture (violence, crime, etc.).
SERVICES TO BE DISPENSED BY	• Single-window access to mental health function (first-line)

THE CONTINUUM OF MENTAL HEALTH SERVICES	• Assessment • Intervention or treatment according to a biopsychosocial approach (various options to suit the diverse needs) • Rehabilitation • Support and knowledge transfer between professionals: internal (institutional), medical clinics and other partners • Agreements relating to the function of responding mental health professional • Responding specialist in psychiatry (2nd-line) Note: The Orientations relative to the organization of care and services offered to adults by first-line mental health teams in CSSSs[232] specify all the conditions of the first-line offer of services.
SUPPORT OF MEDICAL CLINICS AND COLLABORATIVE CARE	• Written or oral communications approximately every three months, when clinically appropriate, during follow-up • Information, training and networking among family physicians that is adapted to the reality of their practice
QUALITY OF THE CLINICAL APPROACH	• Intervention plan and periodic review • Approach focused on recovery - Active role of the service user and his or her entourage • Application of the principle of care by steps • Collaborative care • Participation, with the service user's authorization, of members of his or her entourage in the intervention plan • Use of recognized protocols and tools • Clinical supervision:[233] task centered on the quality of services to optimize the operation as well as the effectiveness and efficiency of services

[232] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS*, Québec, Gouvernement du Québec, April 2011, 54 p., accessible online: http://publications.msss.gouv.qc.ca/msss/document-000672/

[233] *Ibid*., p. 20-21.

4. FIDELITY TO THE RECOGNIZED MODELS FOR SUPPORT OF VARYING INTENSITY AND INTENSIVE COMMUNITY TREATMENT

Concerning certain services in the community, there are practice models whose effectiveness is recognized based on certain essential clinical administrative standards. These standards are established by the NCEMH and recognized by the MSSS. They are not exclusive and may be gradually enhanced. The following table describes these standards. Onsite accompaniment by the NCEMH contributes to compliance with these standards and is mostly focused on supporting teams in the adoption of efficient and effective practices.

TABLE 4 – CLINICAL ADMINISTRATIVE STANDARDS RELATED TO CERTAIN MENTAL HEALTH PRACTICE MODELS

SUPPORT OF VARYING INTENSITY	
Intervention plan	100% achievement of intervention plans of people followed for more than eight weeks
Support intensity	Average of from 14 to 16 meetings in the presence the service user for each support of varying intensity intervener per week
Ratio of cases per intervener	Optimal ratio of 1/18 A significant deviation from this ratio, at the scale of a team, can compromise the fidelity to the support of varying intensity model
Creation and maintenance of partnerships	Each participant systematically carries out interventions with significant partners in the monitoring and support of the user: • physician • members of the entourage • other community partners (education and employment networks, workplace, etc.)

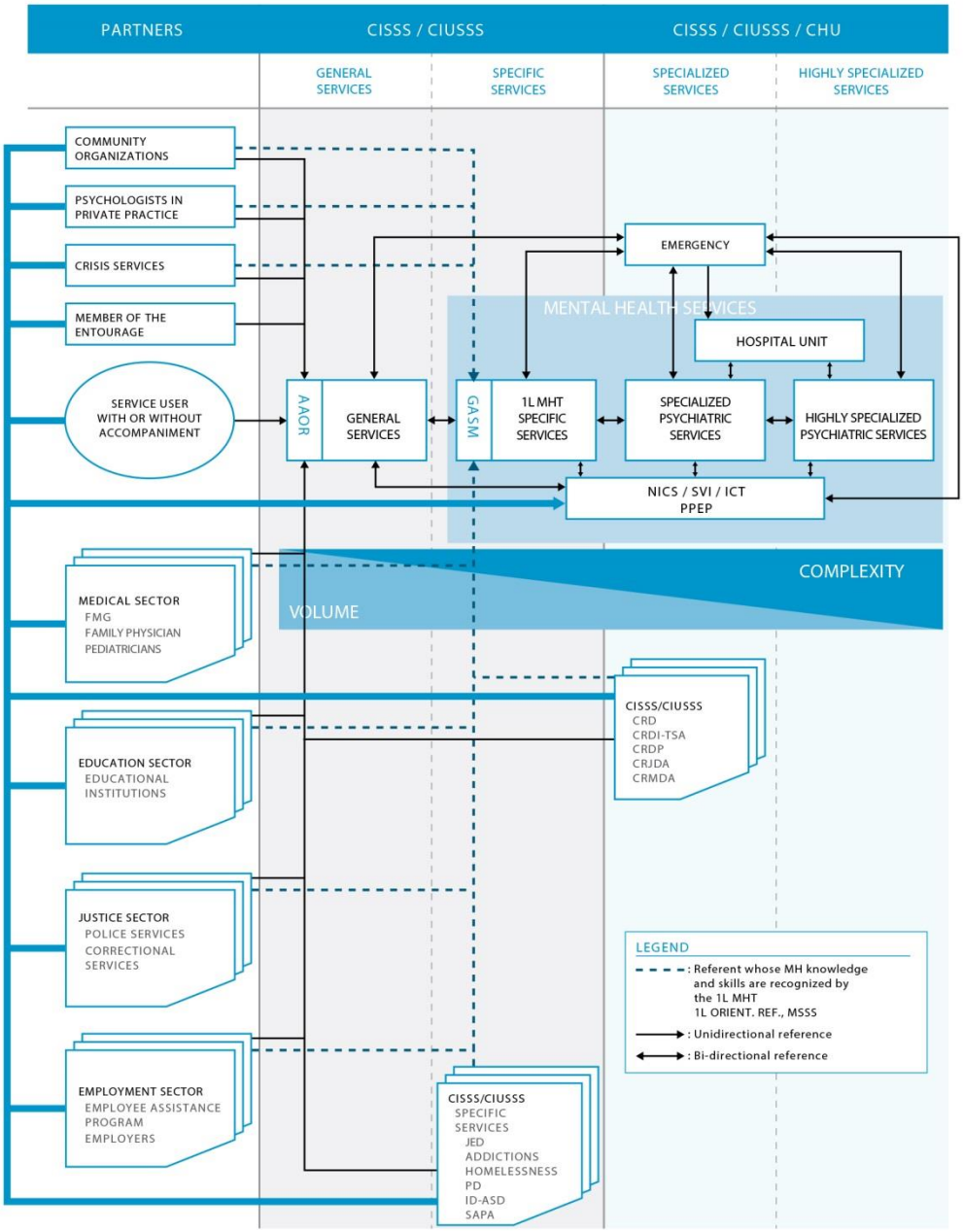
INTENSIVE COMMUNITY TREATMENT	
Recognition criteria	• Minimum score of 3.2 obtained using the tool for measuring fidelity to the intensive community treatment model (T-MACT)[234]
Clinical model	Presence of the following priority elements in the team: • an interdisciplinary team • a designated psychiatrist (responsible for the medical component of

[234] M. MONROE-DEVITA, L.L. MOSER and G.B. TEAGUE, The tool for measurement of assertive community treatment (TMACT), in M. P. McGovern (ed.) *et al, Implementing Evidence-based Practices in Behavioral Health.* Center City, (Minnesota), 2013, 192 pp.

	the entire team's clientele) • a member of the team specializes in addiction and employment • a peer helper

APPENDIX II

USER EXPERIENCE OF THE MENTAL HEALTH CONTINUUM*



*For definitions of abbreviations, refer to the list at the beginning of the document.

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