Ministry of Health: Mental Health and Addiction Services

A Field Practicum Report
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By
Keri Ann Hutchinson
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Abstract

This report reflects my practicum experience with the Ministry of Health: Mental Health and Addiction Services. My objective for choosing a macro environment in which to complete my practicum was to learn about senior level management and gain a deeper understanding of policy and research. The paper is intended to reflect my learning experiences with the Ministry of Health. In this paper I will explore past and current trends in health care and the application of the Lean management system. I will provide a description of my practicum setting and discuss what is currently being done in mental health and addiction services. In addition, I will provide information on my work of mental health and addiction wait times and research information on eating disorders. Future directions of the Ministry of Health will be discussed that include mental health approaches and therapies, along with the integration of mental health and addiction services within primary health care. I will address ethics, values and human rights that are central to mental health and the social work profession. I will conclude my report discussing strides that health care in Saskatchewan has made against the challenges and barriers that still exist. My reflections and experiences will be incorporated throughout this paper.
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Chapter One: Introduction

This report reflects my practicum experience with the Ministry of Health, Community Care Branch in Mental Health and Addiction Services. My practicum took place between September 3, 2014 and December 04, 2014. This report follows the Direct Practice Framework recommended for Integrative Practicum Reports as outlined in the Master of Social Work Manual, Faculty of Social Work. This report is a synthesis of my observations, research, participation and personal experience in my practicum. The purpose is to highlight critical thinking, and experiential and reflective learning.

1.1 Agency

The Community Care Branch, within the Ministry of Health is located at the T.C Douglas Building on Albert Street. The Community Care Branch is divided into four program support areas that include;

- Mental Health and Addictions
- Research, Evaluation and Central Support
- Continuing Care and Rehabilitation
- Licensing

My practicum was within Mental Health and Addiction Services. I also had a brief experience working with staff from the Population Health Branch. The Population Health Branch is also located in the T.C Douglas Building. They provide guidance to team-based approaches with community agencies in primary health care.

The priorities of the Community Care Branch are to provide administration of the Minister’s Plan for Growth and to manage the many programs and initiatives within the Ministry of Health, in cooperation with the Regional Health Authorities. The Ministry of Health develops
policies, establishes and monitors standards, provides funding to the health regions and ensures
the provision of essential and appropriate services (Community Program Profile, 2012-13).

The areas of health services in Saskatchewan are vast. It was surprising for me to
discover the many different areas that health encompasses. I was initially overwhelmed gaining
insight into all of the health areas since I did not have any experience working in health services.
The terminology used within health was another new aspect of my learning experience. My
professional experience has been in micro environments, working directly with clients. By
choosing a practicum within a macro environment, I experienced a significant learning curve.
My interest was in policy implementation and consultation and therefore, I embraced the
challenge and the work experience.

This placement was situated in a multidisciplinary team environment that was dominated
by people who had various educational backgrounds; from business graduate degrees to nursing
degrees. In the four months of my practicum, I had opportunities to consider various perspectives
on how best to improve health care for people accessing the services. From a macro perspective,
the focus was often on the success of the programs, in terms of quality of care and access, and
how well the operation of programs ran. The focus was less on how the programs impacted the
clients using them. I observed how other professionals view service delivery and how these
views could differ from a social work perspective. I noticed differences in values and
perspectives between health employees that were in direct contact with clients from those who
do not have direct client contact. I understood the perspectives of direct health care employees
because of my own direct service background. I was encouraged to explore service delivery in a
larger context. The Ministry of Health operates under management systems that aims to
streamline programs and services in order to save costs, while direct practice health care
employees are concerned about meeting the client’s needs. It was valuable to learn various perspectives because I now have a practical understanding from both the administrative and practice program areas.

1.2 Practicum Goals

With the assistance of my professional associate, Lorne Sier, we identified five areas of focus that were a part of my learning goals. My learning goals were:

1) To use quality assurance approaches to measure, monitor and evaluate wait times for mental health and addiction services in order to ensure quality standards are being met. To meet this goal, I was responsible for compiling data, or metrics from 2012 onward for outpatient mental health and addiction wait times and develop charts to show the results for each region. I displayed the information in a PowerPoint presentation and presented it to the managers, directors and regional health directors at quarterly meetings.

2) To work in collaboration with the Ministry of Health, other Ministries and health regions on provincial initiatives. I had an opportunity to visit a health district outside of Regina to discuss the progress of the integration of Mental Health and Addiction Services within a primary health care setting. I also took part in face to face meetings, teleconferences and conversations with other health care professionals in the community and with staff from other areas in the Ministry of Health.

3) To review the literature on best practices in mental health and addictions in terms of service delivery, administration and identified how these practices improve client care. A major component of my practicum was researching evidence informed practice in the treatment of eating disorders across jurisdictions and to compare how
Saskatchewan was doing. The information I gathered was presented to managers and regional directors in a PowerPoint presentation during the last month of my practicum.

**4) To be involved in the spread strategy for early detection and treatment of mental health and substance use/misuse issues in primary health care.** I had opportunities to work with staff from the Population Health Branch to develop a pamphlet on safe practices of crack cocaine use, safe disposal methods of equipment such as needles and screens and the effects of using illicit substances on a person’s health.

**5) To assist in research and preparation of briefing notes for senior government officials.** Briefing notes are requested by the Minister of Health and the staff at the Community Care Branch to provide factual information on concerns brought forward by the public. Briefing notes are expected to be completed within a limited time frame which can place significant pressure on staff. Often staff must put aside their other work responsibilities in order to complete the briefing note to meet the deadline. I worked on briefing notes on two occasions. One of the briefing notes was in regard to an incident in a youth facility and the other briefing note discussed mental health expenditures and resources.
Chapter Two: Overview of Health Care

This chapter will provide a brief overview of the provincial government followed by a historical look at how the Canadian health system evolved. The development of the regionalization system in health care will be examined and how regionalization has impacted health system governance.

2.1 Ministry of Health

My practicum placement was with the provincial government. The provincial government is divided into three areas that have their own responsibilities and obligations. The Ministry of Health is in the executive arm of government. Below is a chart depicting the provincial government structure and the division of powers.

Table 1

Provincial Government

![Provincial Government Diagram]
The Ministry of Health works under the executive arm and serves the elected government officials. One of their roles is to provide objective advice to the cabinet or government who makes decisions regarding policy, financial/budgets, programs, and other related matters on behalf of the government. As public servants, the staff of the Ministry of Health are representatives of the minister and the provincial government.

Within the provincial government, under the executive arm, the Minister of Health answers to the Premier who has his own chief of staff and deputy minister. The Premier appoints the Deputy Minister and cabinet members, but does not appoint staff of the Ministry. The Minister of Health is appointed by the government and is the sole authoritative voice for the Ministry that they are responsible for. The Ministry of Health is responsible to the Minister of Health and oversees programs and services within the health region, along with enforcing standards in privately delivered programs, such as personal care homes, administering public health insurance and benefits and looks at prevention and control of disease measures (Ministry of Health, 2014). On occasion, public grievances are directed to the Ministers and they will instruct the Ministry staff on how to address the grievances and how to implement the government’s agenda. The Minister will seek out information from the Ministry of Health staff that will collect and compile the information in the form of briefing notes to be approved and forwarded to the Minister. As already mentioned, I had the opportunity to assist in gathering and putting information together on a briefing note for the Minister of Health regarding mental health and addiction resources and financial expenditures.
The goal of the Ministry of Health and health partner’s is to work together to achieve the mission, vision and goals of government. The mission of the Ministry of Health is for “the Saskatchewan health care system to work together with you to achieve your best possible care, experience and health” (Ministry of Health Plan for 2013-14, p. 2). The Ministry of Health’s aim is to develop and promote innovative and sustainable solutions to support Saskatchewan’s growth and ensure quality of life for their residents (2013-14). The Plan for Growth is a document that is produced yearly by the Ministry of Health that sets out strategic plans on how to achieve certain targets for the next fiscal year. Within the Growth Plan, “ministries will review all programs to ensure the programs and services delivered by government are being delivered as efficiently and effectively as possible and are aligned with government priorities” (Ministry of Health, 2013, p. 3).

With a brief understanding on the divisions of the provincial government and the responsibilities of the Ministry of Health, I will now provide a synthesis of how health care services have developed through history. Reforms in health care have been ongoing based on changes within government, health and societal demands. It will become evident that many positive improvements have occurred over the years yet challenges and obstacles remain for health care.

2.2 Past and Current Trends in Health Care

Canada’s health care system was primarily privately funded and delivered prior to 1939 (Health Canada, 2011). The economic depression and the major drought of the 1930s caused rethinking of early governance models in Saskatchewan (Philippon & Braithwaite, 2008). Following the economic hardships of the 1930s, a new government was formed under the leadership of T.C. Douglas in 1944. To support public health care costs, the government
established a cost-sharing program under federal legislation for all provinces to allow for more flexibility in investments on health priorities and needs (Health Canada, 2011). Other provinces followed suit with the assistance of the federal government but in 1945, relationships between the provincial and federal governments were strained. Despite the strained relationships between governments, the first publically funded health insurance and Hospital Services Plan was established by T.C. Douglas in 1947 (Philippon & Braithwaite, 2008). The governments resumed discussions on health matters and in 1958, the federal government agreed to share health care costs with the provincial governments (Philippon & Braithwaite, 2008). In 1961, all provinces had hospital plans. The federal government was able to sustain health care costs by providing equalization payments to less flourishing provinces and territories, as well as supply cash and tax transfers (Snowdon, Schnarr, Hussein & Alessi, 2012). This was to allow for more fairness among provinces to try and maintain equal standards of health care for everyone regardless of where they live.

By 1961, all hospital services were publically funded while physician services remained privately funded. The government attempted to create a plan to include physicians in the public funded areas, however the physician’s opposed this arrangement and they remained contractual and independent service providers (Philippon & Braithwaite, 2008). Today, funding to physicians is provided publically and on a fee for service basis.

The health insurance system in Canada has been evolving for decades. Health insurance systems are managed by thirteen health insurance plans that are designed to ensure that all people have ‘reasonable’ access to health services without an obligation for Canadian residents to pay for health services (Health Canada, 2011). In 1984, under federal legislation, the Canadian Health Act (CHA) was passed. The Canadian Health Act (1984) established criteria
on five main principles; portability, accessibility, universality, comprehensiveness and public administration (Health Canada, 2011). Most of Canada’s health care services are delivered through the provinces and territories that follow these principles within the Canada Health Act (1984). It is interesting to note that thirty-one years later, the provincial government is still striving to achieve many of the same principles.

In the 1990s, the provinces and territories worked to control costs and improve service delivery by having decision making occur at the regional level (Health Canada, 2011). Saskatchewan was one of the first provinces to implement a regionalized system to enhance better community involvement in decision-making, establish a more effective continuum of care, transfer of resources to areas that required more funding and to determine the needs in rural areas (Marchildon & O’Fee, 2007). A primary objective for regionalization was to achieve more efficiency in health resources and reduce escalating costs (Philippion & Braithwaite, 2008).

The Regional Health Authorities are responsible for delegating authority to local and public health officers. They are held accountable under The Regional Health Services Act (2002). The Regional Health Authorities are governed by boards of twelve people who are appointed by the Minister of Health and primarily consist of public citizens. “Regionalization is both an end in itself and a vehicle for improving continuity of care between hospital and physician services with other, occasionally lower-cost and more appropriate, health care services” (Marchildon & O’Fee, 2007, p.53).

In 1993, Saskatchewan had 32 health authorities that functioned within eleven district health boards. The board members’ role is to increase public participation within health care. In 2002, the 32 health authorities were reduced to 12 regions. The Ministry of Health is in regular communication with the Regional Health Authorities to enhance the delivery of services. Along
with quarterly meetings, Regional health directors and the Ministry of Health maintain regular contact through conference calls, emails and other meeting forums, many of which I was apart of.

The Ministry of Health provides support to the 12 Regional Health Authorities (RHA) and the Athabasca Health Authority. The Athabasca Health Authority is part of a tripartite agreement between the federal, provincial and municipal government and therefore is separate from the other RHAs. The RHAs are depicted in the following chart:

Source: Health Region Map. www.saskatchewan.ca
The RHAs provide the majority of health services, either directly or indirectly to Saskatchewan residents. Saskatchewan health has a mandate to achieve a responsive, efficient and integrated health system in the Department of Health Act (1996). The Act sets out the powers and duties of the Minister and sets out regulations, provisions, services and fees of the Minister and provincial government.

Regional Health Authorities receive funding from the Ministry of Health which is used to carry out health plans to achieve quality and care in services. The RHAs are directly responsible for the delivery of all health services under their mandate, while the Ministry of Health is responsible for the entire province and for long term planning in order to realize health goals and targets. The Ministry of Health is also responsible for practicing ‘good governance’. The system of governance is shared between the Regional Health Authorities and the provincial government. The shared responsibility for health care can and has resulted in some tensions between the two governing bodies in determining the direction and operation of the health system (Elson, 2005).

The governance of healthcare systems in Canada has become increasingly challenging. The provincial and territorial governments are struggling because of rising healthcare costs that result from a number of factors including: an aging population, rise in chronic diseases, and implementation of new technologies (Phillipon & Braithwaite, 2008). In the years following 2002, a number of formal agreements and reforms took shape in areas of health. In 2003, an Accord on Health Care renewal was agreed upon by the provincial Ministers of Health. Health Canada (2011) reported that structural changes were needed within the health care system in order to support access, quality and sustainability. In 2004, another reform was implemented that built upon the Accord. This was a 10-Year Plan to Strengthen Health Care that obligated federal, provincial and territorial governments to work together in reforms to improve areas in
health resources, wait times, primary health and other health related services (Philippon & Braithwaite, 2008). Healthcare governance systems across provincial jurisdictions began modifying and adapting their systems to better manage the health care system as a result of societal pressures and health related concerns (Philippon & Braithwaite, 2008). Many jurisdictions made changes to their governance models, and continue to adapt and evolve.

There is a growing recognition of the role that systems-level governance plays in managing these challenges. All provincial governments are facing serious fiscal pressures, requiring them to look for ways to deliver high quality services in the most efficient and cost effective manner possible. Provincial, regional and local models of care all have an impact in ensuring quality of care, equity, and access and in managing costs to increase integration. Effective governance of health care strives to remove barriers, set directions, and better allocate resources that enable change.
Chapter Three: Overview of Practicum Placement

As discussed earlier, my practicum placement was with Mental Health and Addiction Services at the Ministry of Health. This chapter provides information on the administration of the Mental Health program and the program areas it encompasses. I will conclude this chapter with the two primary projects I completed during my practicum placement.

3.1 Mental Health and Addiction Services

The strategic plans that the Ministry of Health set for 2013-14 years identified four strategies: Better Health, Better Care, Better Value and Better Teams (Community Program Profile, 2013-14). Along with these strategies, three key areas were identified by health leaders in their 2013-14 plans. The three areas are to improve access in Primary Health Care, improve surgical care that is sooner and safer and to focus on patient and staff safety. In addition, the Ministry of Health added an additional three areas, one of which I was a part of; Strengthening Mental Health and Addiction Services.

The Mental Health Program is administered by the Regional Health Authorities (RHA). The RHAs provide mental health care either directly through their employed staff or indirectly through community-based service delivery. Mental health services are delivered on a continuum of care that includes both direct and indirect services. The goal of the mental health service program is to support the needs of people by providing quality services and care to people accessing health services.

The Mental Health Program consists of Child and Youth Services, Adult Community Services, Psychiatric Rehabilitation Services, Mental Health Inpatient Services and Mental Health Promotion. Each service area is an integral part of the mental health program. The
Provincial Rehabilitation and Forensic Services located at the Saskatchewan Hospital in North Battleford are included in the Mental Health Program area.

The mental health programs that are managed by the Regional Health Authorities operate according to the standards and guidelines that are set out in the *Mental Health Services Act (2008)*. The mandate for the mental health program is derived from Section Three of *The Mental Health Services Act (2008)*. This section empowers the Minister of Health to “do anything pursuant to this Act that he considers advisable for preventing the circumstances that lead to mental disorder and distress and for promoting and restoring the mental health and well-being of the people of Saskatchewan”(*Mental Health Services Act, 2008, Sec 3*). The Minister delegates much of the responsibility to the Provincial Director of Mental Health Services, who is situated at the Community Care Branch.

As mentioned earlier, the Community Care Branch at the Ministry of Health serves managerial functions to the Minister. They are responsible for implementing the government’s agenda and plan. As public servants of the government, employees are essentially guardians of the government process and are responsible for carrying out their plan.

A priority in the government’s plan is to strengthen mental health and addiction services. A key area is to reduce wait times for outpatient mental health services and addiction services. The Ministry of Health has identified this as an important area to continue to focus on. In accordance with Lean principles, the Ministry of Health implemented a standardization process that included establishing categories of mental health risk and setting time frames of when to see clients depending on their level of risk. The categories or levels of risk are defined as ‘very severe’ mental health care needs which require the patient to be seen within 24 hours. ‘Severe’ mental health needs require a patient to be seen within 5 days. A ‘moderate’ category of mental
health requires a patient to be seen within 20 days and a ‘mild’ category of mental health means the patient should be seen within 30 days. The time frames associated with each level of risk are referred to as benchmarks and begin at the point of referral until a patient is seen by a clinician.

In order to monitor wait times and risk categories, the Ministry of Health requested monthly statistics (metrics) from each health region for outpatient mental health and addiction clients beginning in April 2012. Outpatient psychiatry began submitting statistics in April 2014. The Ministry of Health also requires corrective action plans (explanations and plans to correct their response times) from health regions where their response times fell below the time frames allotted for each category. In April 2014, a standardized benchmark of 70% was set for patients in outpatient mental health and addictions to meet with a clinician in all triage categories. A benchmark has not been set for outpatient psychiatry clients. It is the government’s vision to strengthen mental health and addiction services whereby the benchmarks will increase to 85% in the next reporting year. The time required to see a patient for outpatient psychiatry will be determined in the next fiscal year based on discussions between the Ministry of Health and psychiatrists.

3.2 Measuring Wait Times Project

Within the first month of my placement setting, I was responsible for using quality assurance approaches to measure, monitor and evaluate wait times for mental health and addiction services to ensure standards were being met. To achieve this, I compiled statistics (metrics) from 2012 onward for outpatient mental health and addiction wait times. The results were placed on a chart showing how each region was doing in relation to meeting the triage benchmarks. This information was displayed in a PowerPoint presentation to the regional directors at a quarterly meeting. I also incorporated provincial run charts to show results
cumulatively. Provincial run charts showed the cumulative results of each region in one month. One of the purposes of this presentation was to invite discussion on reasons for a significant number of patients in the mild and moderate categories being treated by psychiatric services. People who are experiencing mild or moderate risks in mental health and addictions can often be treated by less intensive treatment models. Patients with lower mental health risks who are waiting for psychiatric service will increase the overall wait times in accessing care for the entire population.

Another important area that I had the opportunity to contribute to was in the development of the Mental Health and Addictions Action Plan (MHAAP). A specific task group of five individuals worked with Commissioner Dr. Stockdale to lead the Mental Health and Addictions Action Plan. The task group and commissioner worked in cooperation with the Mental Health and Addiction Services staff. The group requested the assistance of Mental Health and Addiction Services staff to provide insight and observations to the preliminary draft of the Action Plan. There were sixteen system goals in the Action Plan that had two to three plans of action for each goal. The Director of Mental Health and Addiction services, addiction consultants and mental health consultants, and I went through each goal and focused our attention on five key points. The key areas we looked at were:

1) Do-ability- is the goal achievable or doable and questioned if the work was already being done;

2) What Ministry would be responsible for heading the program goal.

3) The approximate length of time the goal would take to materialize;

4) The financial cost associated with it and if it was in the low, middle or high financial bracket:
5) The level of importance or priority for the service.

As a team, we arrived at some general comments that we forwarded back to the task group. Through our discussions, we determined that there were too many recommendations and some of the recommendations overlapped. Our team also concluded that many of the recommendations in the MHAAP did not state which Ministry would take the lead in operationalizing the goal. Finally, our group felt that the MHAAP focused primarily on mental health and placed little focus on addiction risks and services despite these programs having a lower anticipated cost. It was determined that Addiction Services were not given adequate priority. The final version of the Mental Health and Addictions Action Plan was released in December 2014 (Mental Health and Addiction Action Plan, 2014).

This was an interesting exercise for me to be apart of. It provided me with insight into how much time, work and financial investment is involved in implementing a service or program. Not to mention, the level of coordinated Ministerial collaboration it requires establishing such a policy agenda.

3.3 Research on Eating Disorders Project

The Community Care Branch also provides research, evaluation and central support for the many program areas. A significant area of focus during my practicum was to review the literature on best practices in eating disorders in terms of service delivery, administration and how these practices improve client care. When my research was completed, I prepared a PowerPoint presentation to show the Regional Directors and other Ministry of Health staff at their quarterly meeting. I will illustrate my research findings on my primary project on eating disorders.
Over the last couple of years, the Ministry of Health has received a number of requests for out of province treatments for eating disorders. In response, I was requested to conduct an inter-jurisdictional scan to determine practices to which we can compare the delivery of mental health services for eating disorders in Saskatchewan. My project included defining eating disorders, identifying best informed practice treatments and to complete an inter-jurisdictional scan. I also developed a survey and sent it to the regional directors in Saskatchewan’s health regions in order to obtain information on how Saskatchewan was managing in the treatment of eating disorders. From the results of the inter-jurisdictional scan of other provinces and the survey, it was evident that Saskatchewan fairs poorly in comparison.

**Definition of Eating Disorders**

The Mayo Foundation for Medical Education and Research (2015) defines “eating disorders as serious conditions related to persistent eating behaviors that negatively impact your health, your emotions and your ability to function in important areas of life” (2015, p 1). There are a number of factors that are present in adults and youth with eating disorders that impair all areas of functioning. These factors include genetics, biological, psychological, behavioral and social factors. Eating disorders have been placed into four classifications. The Diagnostic and Statistical Manual for Mental Health, 5th Edition (DSM-5) states that anorexia nervosa (AN) is characterized by a restriction of food that can lead to extreme thinness and a fear of gaining weight (American Psychiatric Association [APA], 2013). A person suffering from anorexia nervosa often lacks recognition or does not realize the seriousness of low weight due to their distorted view of body image (APA, 2013). Bulimia nervosa (BN) is characterized by recurrent and frequent episodes of eating unusually large amounts of food that is following by forced vomiting, use of laxatives, excessive exercise or a combination (APA, 2013). The DSM-5
describes a third classification as binge-eating disorder (BED) when a person loses control over their eating but does not purge or exercise excessively. Eating disorders not otherwise specified (EDNOS) are a fourth classification according to the DSM-5. This type is described as a person who has struggled with eating disordered thoughts, feelings or behaviors but does not have all the symptoms of one eating disorder classification (American Psychiatric Association, 2013).

**Prevalence**

In 2006, the National Eating Disorder Information Centre (NEDIC) reported, based on survey findings collected from Hudson, Hiripi, Pope & Kessler (2007) that the lifetime prevalence of anorexia nervosa is approximately 1% of women in Canada and 0.3% of adult men (Hudson et al., 2007). Young women in Canada who suffer with bulimia nervosa are approximately 1.5% of the general population and 0.5% of men have bulimia nervosa. People who suffer with binge eating are 3.5% of women and 2% of men in Canada (National Eating Disorder Information Centre, 2006). All classifications of eating disorders have high rates of co-morbidity, particularly with depression, substance use and anxiety disorders (American Psychological Association, 2000). In 2002, the National Eating Disorder Information Centre cited a study completed by Sullivan (2002) indicating that 10% of people with anorexia nervosa will die within 10 years of the onset of the illness (National Eating Disorder Information Centre, 2002). Steinhausen (2009) reported that people with anorexia nervosa have a mortality rate 18 times higher than people without an eating disorder (as cited in American Psychiatric Association, 2011). Many people who suffer from an eating disorder do not seek treatment and therefore are unreported within the health system (Strother, Lenberg, Stanford & Turbenville, 2012). Men are even less likely to seek treatment for an eating disorder than women.
In Canada, in 2012-13, there were 1585 hospitalizations for eating disorders among females: more than half were for women 10-19 yrs old (Canadian Institute for Health Information, 2013). There were 103 male hospitalizations of all ages in Canada (Canadian Institute for Health Information, 2013). Table 1 below, taken from Canadian Institute for Health Information (2013) shows that in 2012-13, Saskatchewan’s average length of stay was 41 days for primary diagnosis of an eating disorder. In Canada, the average length of hospital stay was 33.3 days for females and 31.6 for males. Saskatchewan and Canadian results are comparable. For Canada as a whole in 2012-13, 6% of the hospitalizations for eating disorders were for males. Among females, children/adolescents made up the majority of hospitalizations (17% aged 10-14 and 39% aged 15 to 19) for a primary diagnosis of an eating disorder (Canadian Institute for Health Information, 2014).

Table 1

<table>
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<th>Year of discharge</th>
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<th>Secondary diagnosis</th>
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<td>14.2</td>
</tr>
<tr>
<td>2007-08</td>
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<td>12.8</td>
</tr>
<tr>
<td>2012-13</td>
<td>41.0</td>
<td>15.1</td>
</tr>
</tbody>
</table>

Source: Canadian Institute for Health Information 2013
In Table 2, there were 43 inpatient hospitalizations in Saskatchewan hospitals with a primary diagnosis of an eating disorder and 40 inpatient hospitalizations with a secondary diagnosis of an eating disorder.

**Treatment Approaches**

There are standard treatment approaches for adults and youth with eating disorders. Inpatient treatment, residential, day program and outpatient treatments are utilized depending on the severity of the illness (National Institute for Health Care Excellence, 2004). Outpatient treatment is the most common treatment for people with eating disorders that fit within the low to moderate risk category (National Institute for Health Care Excellence, 2004). From the research I collected, there were three primary evidence-informed therapies recommended to treat eating disorders; cognitive behavioral therapy, interpersonal psychotherapy and family based therapy- Maudsley method (Bailey, Parker, Colautti, Hart, Liu & Hetrick, 2014).

**Table 2**

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<td>40</td>
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</table>

Source: Canadian Institute for Health Information 2013
It is recommended that cognitive behavioral therapy (CBT) should be used for adults and youth suffering from bulimia nervosa. Cognitive behavioral therapy can be effective with persons with anorexia nervosa but only after weight has been restored. A more recent therapy, dialectical behavioral therapy, which is a form of cognitive behavioral therapy, has shown success in the treatment of bulimia nervosa when used in conjunction with CBT. A meta-analysis completed by Vocks, Tushen-Caffier, Pietrowsky, Rustenbach, Kersting and Herpertz (2010) showed that dialectical behavioral therapy protocols were effective for decreasing the number of eating disorder episodes among women. Interpersonal psychotherapy is as effective as CBT in the treatment of adults with bulimia nervosa. Family therapy using the Maudley’s method has shown the most promise, according to the American Psychiatric Association for the treatment of children and adolescence eighteen years or younger with an eating disorder (American Psychiatric Association, 2011).

Outpatient treatment using evidence-informed therapies are suggested as a first step for treatment (American Psychiatric Association, 2011). A cognitive behavioral self-help program on its own or with medication will assist in the treatment of bulimia nervosa. Cognitive behavioral therapy-bulimia nervosa (CBT-BN) is an adapted version of CBT that includes a specific focus on bulimia nervosa symptoms. CBT-BN is recommended to consist of 16-20 sessions over four to five months (National Institute for Health Care Excellence, 2004). Interpersonal psychotherapy can be offered as an alternative treatment for individuals with bulimia nervosa on an outpatient basis, although the treatment is considered more lengthy, covering 8-12 months (National Institute for Health Care Excellence, 2004). The National Institute for Health Care Excellence (2004) guidelines recommends the length of outpatient
treatment should be at least twelve months for anorexic nervosa inpatient. The focus of treatment is on weight restoration.

**Inter-Provincial Scan**

Once I completed the research on best practice methods for the treatment of eating disorders, I turned my focus to how Saskatchewan and other provinces were managing eating disorders using an inter-jurisdictional scan. I narrowed my focus down to three other provinces; Alberta, British Columbia and Manitoba. What I found was that all three provinces had programs specific to the treatment of eating disorders. They each offered a multi-disciplinary team approach of care in order to provide comprehensive assessment and treatment. Services were provided within a hospital setting for adults and for adolescents. The multi-disciplinary team consisted of dietitians, pediatricians, psychiatrists, doctors, psychologists, recreation therapists and occupational therapist as the primary professionals but some had other specialists involved with their treatment team such as social workers.

**How Does Saskatchewan Health Compare?**

To understand how Saskatchewan compared with other provinces, I prepared an on-line survey that asked questions related to treatment methods, age and gender of persons treated, professional staff utilized in the treatment of eating disorders and I inquired about follow up and referral processes. I forwarded the survey monkey to thirteen regional directors or their managers with a deadline to respond. I also included Bridgepoint in the survey and incorporated the information they provided with the results from the other Saskatchewan health regions. Bridgepoint is Saskatchewan’s only provincial resource that specifically works with people with disordered eating. Three major themes emerged from the survey monkey. Nearly all regions stated that they needed more education and specialized training on eating disorders. In addition,
they require an increase in staff and thirdly, many of the regions mentioned that their services are largely limited to outpatient treatments. Unlike Manitoba, Alberta and British Columbia, Saskatchewan does not offer specific outpatient day programming for eating disorders.

From the literature review on evidence informed practice for eating disorders, it is recommended that treatment should begin with a structured self help program and outpatient therapies that utilize cognitive behavioral therapy, interpersonal therapy and family-based therapy (American Psychiatric Association, 2011). Meta-analytic research suggested that prevention interventions were effective in influencing eating disordered knowledge, attitudes and behaviors and risks by 51% (Cororve, Warren, Cepeda-Benito & Gleaves, 2006). I included a section in my presentation on prevention as it was apparent that prevention is an important area of focus but due to time restraints, it was not included in the presentation I provided to the regional directors.
Chapter Four: Recent Initiatives

In this chapter I will reflect on some recent initiatives that the Ministry of Health has been working on. The Ministry of Health is guided by evidence based research in managing their programs and services. I will define evidence based practice and offer an explanation as to why many clinicians prefer the less rigorous method of evidence informed decision making into their everyday practice.

4.1 Evidence Informed versus Evidence Based Practice

I learned that there is a distinction between evidence-informed practice and evidence based practice pathways while researching information on eating disorders. Although the two terms are very similar in nature, the level of ‘evidence’ that is used for evidence informed practice is not as strong as the evidence that is required for an evidence based practice (National Center for Community-Based Child Abuse Prevention, nd). Evidence informed practices learn from existing literature while becoming more established in practice, while evidence based practice is grounded in proven scientific research.

Sackett, Rosenberg, Gray, Haynes & Richardson (1996), report that evidence based practice has been around since the 1990s and is evolving. Evidence based practice is the approach to prevention or treatment that is supported by documented scientific evidence that has been rigorously evaluated. Evidence based practice means using current research evidence in making decisions about the care of patients. Types of evidence include quantitative and qualitative research, randomized controlled studies, meta-analysis and expert opinion (Canadian Nurses Association, p.1). The Ministry of Health strives to implement proven research evidence into policy in order to provide effective and efficient service to the public.
Any level of evidence should integrate clinical expertise and patient preferences with proven evidence from systematic research (Sackett, et al., 1996, p.71). Clinical expertise means using clinical skills and past experience to recognize each patient's unique health, risks and benefits of potential interventions, to align with their expectations (Canadian Institute of Health Research, 2015). Patient preferences or patient-centered care means respecting the patient’s preferences, concerns and expectations that must be included into their treatment to bring value to their experience (Sackett et al., 1996). Supporters of evidence based practice state that clinicians need to stay current in their practice and using evidenced-based research recommendations in their day to day practice helps them to do this. Evidence based research and treatment methods can enhance a patient’s health care outcome and quality of life when each element is integrated into practice.

Some clinicians will argue that using evidence based research approaches stifles their practice. To further this argument, criticism have been made that evidence based research insults the clinical expertise (Canadian Institute of Health Research, 2015). Some research has suggested that evidence informed practice is a preferred method of practice as it provides more flexibility in implementation that can better meet the needs and wishes of their patients (Nevo & Slonim-Nevo, 2011). According to the Canadian Nurses Association, evidence informed practice came to be as a result from the criticism of evidence based practice and to acknowledge that other forms of evidence are useful in decision making (2010). From my own experience in working with clients, it is necessary to be fluid in communication and models of practice. After all, one style or approach will not work with every client requesting services. “External clinical evidence can inform, but can never replace individual clinical expertise, and it is this expertise
that decides whether the external evidence applies to the individual patient at all…” (Sackett, et al., 1996, p.72). Research evidence is only a piece of the larger picture to improve quality of care.

Evidence based practice and research is not an effective cost-saving tool, as providing evidence-based care directed toward maximizing patients' quality of life often increases the costs of their care (Canadian Institute of Health Research, 2012). Antman et al. (2001) has argued that it can take many years for research to be made into policy and additional years to be implemented in practice that can be more costly (as cited in Canadian Institute of Health Research, 2012). As a result, it would seem to make more financial sense to incorporate evidence informed practice into health care delivery. Utilizing evidence to inform decision making along with clinical expertise will aid in the quality of care patients receive, particularly when the patient’s values and preferences are respected.

The Ministry of Health has implemented programs such as stepped care and internet cognitive behavioral therapies that support the cost saving component of evidence informed practice. These services will be discussed fully in the next section. Driever (2002) reports that stepped care and internet cognitive behavioral therapy do not allow for individualization of services which is suggested as a necessity in quality of care. The challenge is meeting a balance between services that best meets the needs of the patient to the quality standards and compatibility with system policies and resources.

4.2 Stepped Care

Stepped care is a broad and responsive primary care, adult mental health service model that aims to reduce service costs and maximize resources efficiency (Twomey & Byrne, 2012). This is meant to be a first line treatment approach that is more accessible and a less intensive form of treatment. A stepped care model means having a range of services or steps in treatment
that coincide with the person’s needs. The patient can move in and out of the steps to support their need for recovery (National Institute for Health and Care Excellence, 2011). The stepped care model supports prevention, recovery and client responsive approaches. The model also provides a framework for creating a continuum of services for the mental health and addiction populations (Twomey & Byrne, 2012). Stepped Care supports treatment recommendations for improving accessibility for people who experience mood disorders. The treatment is flexible to meet the patient’s needs for service intensity and the treatment process can be monitored to identify ongoing needs of the patients.

Not all people with mental health and addiction illnesses need to go through intensive services; in fact many go to primary health care providers, such as their family doctor as their first step towards treatment. It became evident through consultations with health care providers, that people accessing primary care were not having their mental health risks and addiction concerns assessed.

4.3 Internet Cognitive Behavioral Therapy

Internet cognitive behavioral therapy (ICBT) is a less intensive form of treatment that follows the stepped care model and provides services without face to face contact. Internet cognitive behavioral therapy is an evidenced based approach to stepped care and a model that may be a preferred method of treatment for some clients who have access to a computer. A University of Regina psychology professor is heading a program on ICBT and receives funding from the Ministry of Health. According to my professional associate, the program has been running for approximately a year in piloted regions in Saskatchewan. Many clients who access mental health services present with mild or moderate forms of mood disorders (Canadian Institute for Health Information, 2013). This form of therapy can be used for people who suffer
from mild or moderate mental health, such as anxiety and depression. ICBT is to be used as an adjunct with other services to address health needs. Internet cognitive behavioral therapy is appealing to rural health areas as it is difficult to attract and keep doctors and therapists that could provide face to face services.

Despite health practitioners receiving positive feedback from some clients who are accessing internet cognitive behavioral therapy, patients continue to express preference for face-to-face contact with clinicians. The Ministry of Health and the psychology professor endorsing ICBT insist on the need for front line staff to promote internet cognitive behavioral therapy to their clients. Health care staff is encouraged to become specialists in ICBT in order to share the benefits of this service with their clients. There has been pressure for more advertisements, mail outs, videos and doctor referrals to promote the use of ICBT and the benefits of using this service. ICBT fits into the conceptualization of Lean of increasing efficiency in service and cost savings and therefore, its use is being encouraged.

Typically, with any change in a program area, resistance by some staff often occurs. Health services staff and clinicians have expressed resistance in providing ICBT, stating that it is hard to change a culture of face to face therapies. Patient experiences and requests are not always considered when promoting a new program or service. The patient’s views need to be balanced with the priorities and objectives of the government. In my experience as a front line worker, I understand the preference for face to face contact. In order to balance clinician’s and client’s preferences with cost savings, face to face treatment services can be limited to only the time needed to address health risks to the client then services can be resourced out to community supports. The Ministry of Health states that ICBT would save resources that would be available
to clients with more severe mental health concerns, by freeing up access to psychiatrists and more intensive treatment options.
Chapter Five: Direction of Health Care

In this chapter I will discuss the Ministry of Health’s plan to integrate health services to provide more comprehensive services using an organized team approach. Information will be provided on the most recent project the Ministry of Health is undertaking for integrating health services into primary health care. I will also discuss a project I was asked to complete using harm reduction approaches. I will conclude this chapter discussing the value the government is placing on incorporating patient views and expectations within service delivery and policy.

5.1 Integration and Collaboration

The Ministry of Health has been incorporating evidence based practice recommendations into policies with the intention to reach people who were falling ‘between the cracks’ of the health system. It is recognized and supported by research, that many clients accessing services have concurrent disorders. This means that people with mental health issues, who access health services, also have substance abuse issues. The Ministry of Health has been working to increase integration and collaboration of mental health and addiction services with Primary Health. They are doing this by creating standard intake forms and screening tools.

Integration can be described as how practices are organized and managed and collaboration is referred to how health care professionals work together. More precisely, collaboration means building relationships between mental health and primary health providers to offer complimentary services (Kates, Mazowita, Lemire, Jayaberathan, Bland, Selby, Isomura, Craven, Gervais & Audet, 2010). Integration and collaboration should ideally be created along a continuum of services. The Ministry of Health and other health agencies may collaborate to support plans for integration, yet integration may not result. Everyone involved in the planning and integration process needs to be on the same page, at the same time for things to go forward.
“Collaborative models have improved access to mental health care and increased the capacity of primary care to manage mental health and addiction problems” (Kates, et al., 2010, p.1).

The Ministry of Health is working with Regional Health Authorities to integrate primary health care with Mental Health and Addiction Services. The Ministry of Health has allocated a restricted dollar investment to integrate Mental Health and Addiction Services into Primary Health Care. Both services would be provided to the public in the same location, using collaborative care models. The regions that agreed to pilot the integration of services were smaller in size. To monitor the progress of the integration of services, Mental Health consultants travelled occasionally to the pilot regions and maintained regular communication with Primary Health care staff through monthly teleconference meetings that I participated in. In these teleconference meetings, the health care staff shared their experiences with integration and collaboration of services. Health care staff mentioned that over time, communication had improved between the two service areas and members of both teams were supporting a shared care model of mental health service delivery within primary care health services. The pilot health regions have stated that they have received positive feedback from their patients because accessing services is more convenient. Some health regions continue to express reluctance for integration of services, despite positive feedback from the pilot regions. Most health providers want better and more integrated care for their patients however significant changes to practice can be challenging and often a difficult process (Lewis, 2009). People can be resistant to change and have become attached to the way they practice.

5.1a) Ministry of Health’s Pilot Project for Integration

Within health, collaboration is viewed as a method to improve the delivery of service. “While Canada has seen substantial momentum at the systems level toward improved
collaboration between the mental health and addiction sectors, effective strategies for collaboration at the practice level have not yet been systematically developed, evaluated, documented and shared” (Addiction and Mental Health Collaborative Project Steering Committee, 2014, p.1). Treatment of mental health and substance misuse is being integrated with primary health care to assist in early detection of mental health and addiction illness.

Primary health is often the first point of contact for people with mental health and addictions problems. The Ministry of Health worked with a private consultant to develop and refine standardized screening tools and treatment processes to assist in the collaboration and integration of Mental Health and Addictions into Primary Health care. The Ministry of Health, is conducting bi-weekly conference calls to evaluate how results are being achieved at the practice level. The delivery of mental health and addiction services requires a sizeable portion of public resources and therefore, it is necessary for the resources to be accessible and effective to all clients (Snowdon, Schnarr, Hussein & Alessi, 2012). Three locations within Saskatchewan agreed to pilot the project for integration and collaboration of services. The services in mental health focused primarily on anxiety and depression. The focus for substance use was on reducing alcohol misuse, prescription medication misuse and the use of illicit substances (Ministry of Health, 2013).

Standardization processes have some positive attributes in that they provide a solid foundation to address the needs of people with mental health and addiction problems. The use of screening tools also assists health practitioners in determining the level of care that is required. The new screening tool prioritized and placed patients into one of three categories: low risk, moderate risk or high risk. In health care, the categories of low, moderate and high risk are referred to as pathways. These pathways were created to assist patients in moving from high risk
to moderate risk and from moderate risk to low risk. The goal is for the patient to stabilize at low risk in a primary care setting and benefit from its services and health education. Mild and moderate risk patients typically do not require intensive intervention but they create the largest burden on the health system (Ministry of Health, 2014). Primary care interventions are lower in intensity and a more cost-effective way of helping people with mild to moderate risk of anxiety, depression and substance use. When a patient does present with high risk behaviors, referrals to psychiatrists need to be made and there should be collaboration with other health care providers to provide effective treatment intervention.

A healthy living questionnaire was developed to be used at intake to assist clinicians in the referral process. Primary health staff that includes nurses and mental health and addiction counselors have indicated that they are not the only staff using the questionnaire. Health staff mentioned that some doctors have been using the questionnaire at their first point of contact with the patient. The health staff and doctors within their region continue to work through the referral process so as not to duplicate the use of the questionnaire.

The healthy living questionnaire is a tool to separate the people with mild risks of mental health. When a person rates higher for mental health or addiction issues on the healthy living questionnaire, the Gain tool is to be used to determine if a person is at a moderate risk or severe risk for mental health or addiction issues. The Gain tool calculates the level of risk for the patient and the type of service required. When a person scores in the moderate category of risk, brief treatment approaches are to be utilized. If a person scores at the severe or very severe category, intensive interventions are required by a psychiatrist. Some regions indicated that they are using the health living questionnaire as a guide but not utilizing the Gain tool. In conversations with my professional associate, he advised that when the tools are not used as designed, severe
consequences may result for the patient. For example, if a patient is assessed on the healthy living questionnaire with having depression but the Gain/score is not calculated, the client may be referred to a general practitioner when in fact their depression may be at a severe or very severe level of risk where suicide is a possibility. In this type of situation, the health practitioner and/or clinic may be held accountable under the law.

Collaboration and integration is possible and has been showing some success within our health region as shown by the pilot health region. As integration increases and health care providers work together, patients will have better health outcomes. Resistance is slowly diminishing as the Ministry of Health works on educating health regions about the value of utilizing an integrated, collaborative system. Building trust and capacity between systems can be challenging, however it will prove beneficial. Physicians and psychiatrists acknowledge difficulties in accessing services, as do mental health and addiction staff. Each member of a health team has their specific priorities, however it is my belief that all professionals have a commitment to providing quality care and ensuring timely access to services.

Integration of services and programs in mental health and addictions has been more difficult in the larger regions. The directors hope that if mental health is successful in full integration, that addiction services will be more responsive. To offer an example, my professional associate was leading a presentation to a small health region on the clinical pathways or routes of care to meet the needs of patients entering the primary health care site. During his presentation, an addiction staff member expressed concern to me about integrating their services into primary care. She mentioned the different treatment methods and beliefs held by long-term addiction counselors compared to the addiction staff learning under current models of practice. Addiction counselors tended to be more resistant if their practice background was
Based in the abstinence model. Many professionals view abstinence as the only viable approach, and they reject any program that does not demand abstinence (Thompson, nd.). The integration of addiction services with primary health can lead to reduced addiction problems and improved overall healthcare. The benefits, however, will only be realized by the health providers who are willing to explore new opportunities (Vaughn & Williams, 2013). Integration and collaboration can improve patient health outcomes and reduce stigma associated with addiction illnesses therefore, integration and collaboration requires that all health providers need to work together to provide the client with optimal health services and outcomes.

5.1b) Harm Reduction Pamphlet Project

Members of the Addiction Services team at the Community Care Branch are expected to work within their established guidelines for their programs and services. In following evidence based practice recommendations, harm reduction approaches are to be used as the primary model provided to clients. The Population Health Branch at the Ministry of Health, along with the Addiction Services collaborated to provide community agencies with safer practice recommendations for people who use crack cocaine. I was asked to assist the Population Health Care Branch and Addiction Services staff to research practices recommended for the safe use of crack-cocaine and safe disposal methods of equipment. The research would be put on a pamphlet and provided to community health agencies. Initially, the pamphlet was to be directed toward crack-cocaine users. We were later asked to create a second pamphlet for addiction and health care staff to increase their knowledge about safer practice recommendations and harms associated with crack cocaine use. My colleagues advised, that unlike many other provinces, Saskatchewan will not be promoting ‘safe crack kits’ in the pamphlet. The pamphlet is to follow suggestions of safer use and safe disposal methods according to harm reduction approaches.
Reviews of research showed that many provinces in Canada are promoting ‘safe crack kits’ for people using crack cocaine. According to Canada’s source for HIV and hepatitis C information, a safe kit can include a pyrex/glass stem, metal screen, alcohol swab, condoms, matches and lip balm (2011). People who use crack cocaine will often share equipment and this can possibly lead to the transmission of infectious diseases. At this time, the Ministry of Health will not supply a kit but instead will advise on harms associated with the drug use and for others who may come into contact with equipment. I was advised at the onset of this project that it may not be approved for the public even with requests for the pamphlet. Unfortunately, I completed my practicum before knowing the outcome of this project.

5.2 Patient-Centered Care

Health services in Saskatchewan have been focusing on patient-centered care and learning how to achieve this in practice. Patient-centered care involves coordination and integration of care and the continuity of services to meet the needs of the patient (Lewis, 2009). The patient’s emotional needs and physical comfort are important considerations when delivering a system based on the patient’s care. The focus for the Ministry of Health is to provide quality of service to people with mental health and addiction problems using patient-centered care. Administrators and health providers may believe they deliver a patient-centered approach but their patients may disagree. A shift to patient-centered care is about changing a culture of how health care is provided.

People want timely access to services, not hours waiting in emergency rooms or waiting months on end on wait lists to see specialists or for surgeries. The Ministry of Health also fields complaints regarding poor quality of care patients receive in care homes, critical incidents among others. Patients expect comprehensive, coordination of care in health services that is convenient
and respectful. The Ministry is recognizing these needs and working to find ways to improve services. With regards to Mental Health and Addiction services, work is being done to improve wait times by setting time frame targets and piloting an integrated care model. The success for patient-centered care initiative involves structural changes in health care such as looking at where the services are located, changes in the organization for intake processes, appointments and staffing. Despite the work that is being done to include a more patient-centered care model, some initiatives and changes have been slow to implement.

Having a patient-centered approach to health care is consistent with Lean principles for improving quality and accessibility, at the same time, it conflicts with how the health system manages patients day to day. The foundation of Lean is to increase efficiency but this could be at the expense of patient care. From my direct experience working with people who access health services, people are rushed through the health system, regardless of need as quickly as possible. There is limited staffing capacity to handle the number of patients which results in long waits lists to access services. Staffing shortages forces health practitioners to sacrifice quality of care to their patients in order to manage Lean priorities to keep costs down.

There is a collective responsibility in making changes to the delivery of health care services. Providing patient-centered care is what one psychiatrist described as ‘lip-service,’ stating that the health system does not provide an atmosphere for psychiatrists to provide a meaningful patient-centered approach. He added that there is value in patient’s experiences although this has not been central in day to day practice. Physicians and particularly, psychiatrists are often difficult to engage in system level discussions so it was interesting to hear their perspectives during a meeting held in November 2014. Both public and fee for service psychiatrists expressed a desire to operate within a shared-care model of collaboration because it
enhances their practice and provides a better service to their patients. Psychiatrists have suggested that an incentive structure would encourage more time with their patients and they could provide consultations through telephone and email, as opposed to patients waiting for face to face meetings. Discussions between psychiatrists and the Ministry of Health in November 2014 supported changing their current pay structures to incorporate financial incentives. If the government is willing to adopt financial incentives for extra services such as email or telephone conversation for psychiatrists and other medical specialists, this would support the vision of patient-centered care. Incentives would also encourage more timely care to patients without having to wait for services.

Psychiatrists working under the public system supported integrated care and suggested that they could not perform their responsibilities to their satisfaction without a multi-disciplinary team approach. Fee-for-service psychiatrists and publically funded psychiatrists agreed that integration of services is beneficial to improve communication among health professionals which will result in better health outcomes for their patients.

The Ministry’s mandate, vision and values are based on better meeting the needs of those who access health services. Policies that are implemented are meant to support patient centered care and to respect the values of people they serve. The government and the regional health authorities, along with board members are responsible for the policies and holding the system accountable (Lewis, 2009). For patient-centered care to be fully realized, accountability should be given priority. The Ministry of Health holds regular conference calls, meetings and has other methods of communication with health directors, managers and primary care staff to assist in the evaluation of how service needs and targets are being met. The Ministry of Health staff, working as administrators in the health system, encourages, promotes and monitors progress while
encouraging accountability and feedback. The Ministry is invested, both financially and systematically in achieving better health, better values and better outcomes for patients.

5.3 What Canadian’s Expect from the Health System

Governments need to address the expectations that Canadians have of their healthcare system. Patients and their families are looking to their governments to ensure that healthcare institutions deliver care that uses the most recent technological innovations, that is safe and of high quality (Snowdon et al., 2012). Patients and their families also need to be involved in decision-making regarding their care. Snowdon et al. (2012) adds that the public wants the healthcare system to be transparent, accountable, and integrated. In recent years, the Ministry of Health has strived to include patients and their families in decision making and to increase transparency in the health system (Ministry of Health and Healthcare System Plan for 2014-15). Nonetheless, changes to the health care system are often developed through the strategic planning process by government and the values they hold important. Incorporating a patient-centered health system takes time and will continue to develop (Snowdon et al., 2012).

There is a divide between what Canadians expect and value in health care, and how the health system’s performance is measured and funded (Snowdon et al., 2012). Snowdon et al., (2012) add that Canadians value autonomy, safety and personalized services in health care. People rely on a strong health system to receive care and regain personal health. People want to access the system when they need it and not be put on long wait lists. Patients have also expressed that they want to collaborate with health care providers.

Information sharing between the public and health care is a demonstration of the government’s assurance of including patients while working towards patient centered care. For example, The Mental Health Action Plan (MHAAP) that was released in December 2014,
consulted with the public on key areas. However, prior to consultations with the public, the task
group assigned to lead the MHAAD had already devised a set of program areas that they
considered important to include in the Action plan. The task group then approached the public to
ask what they value and hold important in mental health and addiction service care. Despite
consulting with the public on key issues already addressed by Ministerial staff, it was my
understanding that the consultations went well with shared concerns on matters of access for
example.

Health systems are more focused on performance management which is measured by
cost, operational outputs such as services delivered and quality measures rather than on patient’s
experiences (Snowdon et al., 2012). The Ministry of Health is working towards aligning patient
values with government policies through collaborative and integrative models of care. This is
only a small step in considering patient’s values in health care. It is worth noting that systems
cannot be sustained on value driven practice alone; they also have to work within a budget
allocation. “Key stakeholders at the system level are most often policy makers, whose
responsibility is to manage the system and allocate funding to enable the system to provide
health services for Canadians within the financial means of a fixed global budget.”(Snowden et
al., 2012, p.12).

The health system is currently managed by a governance model using a top-down
approach. Finding a way to include patient values in health care and the values of the
government is complex. Perhaps to balance the needs and values of the public with system
health values, more decisions that involve the care of patients should be made at the regional
level. Finding an appropriate balance requires determination, time and commitment from
everyone.
Chapter Six: Strategic Planning and Direction

In 2006, Lean methodologies were first introduced in Saskatchewan, although it was not fully implemented across all health care regions until 2009. In order for health care administrators and policy makers to manage Lean in the most effective way, health incorporated a new strategic approach in their decision-making that is known as Hoshin Kanri. The management of the programs and services in health care are measured by quality improvement methods and performance measures.

6a) Strategic Planning:

The role of strategic planning is to inform daily actions and decisions, generally over the course of a year or longer. A strategic plan helps the Ministry of Health and employees stay on track with day-to-day responsibilities that are crucial to the mission and long-term objectives of the organization (Boisvert, 2012). The strategic plan is referred to regularly and the process generally involves information sharing and requests from the Ministry of Health to private and public sectors regarding program implementation and direction. Strategic management can be simply defined as ‘the art of managing an organization in order to achieve the best possible outcomes in the most efficient manner” (Goding, 2005, p.116).

6.1 Hoshin Kanri

In 2012-13, the Ministry of Health implemented Hoshin Kanri as their strategic planning approach. Hoshin Kanri is a methodology that Saskatchewan health regions and agencies use for strategic planning. Hoshin is not policy but rather an area of focus. It sets out the government’s vision for Saskatchewan and identifies goals and actions to meet the needs of the province (Boisvert, 2012).
Hoshin-style strategic planning differs from customary strategic planning in four important ways: a) the degree of focus b) the involvement of all levels of the organization c) the use of planning and process improvement tools d) the thoroughness of the reviews (Boisvert, 2012). Hoshin Kanri or policy deployment is aimed at ensuring that the strategic planning goals involve all levels of staff, from Ministers to middle management to direct care staff in identifying the main priorities for Saskatchewan’s health system in the 2013-14 fiscal years. The idea behind Saskatchewan’s strategic plan is that everyone in all areas of health would be moving in the same direction.

6.1 a) Lean

Lean was first introduced in Saskatchewan in 2006, although it was not fully implemented in all health regions until 2009. Lean is a philosophy and a management system that incorporates Hoshin Kanri strategies (Livingstone, 2010). Lean is meant to determine what the quality of care is in health and how to achieve greater quality of service in management. Lean is a quality improvement strategy that is intended to improve patient access to health care. Improvements occur when Lean processes increase efficiency and effectiveness of an organization by eliminating ‘waste’ (Livingstone, 2010). To accomplish this, Lean utilizes many tools to achieve successful operations. The use of visual displays or boards is an example of a lean tool that is used to promote and improve problem solving and communication between staff. This was demonstrated through ‘wall walks’ every Wednesday morning during my practicum. Different program areas came together to discuss recent developments in their respective areas. The developments in each area were visualized by statistics and graphs. The Ministry of Health and health employees refer to statistics as metrics or key performance indicators. The purpose of
the wall walks is to track goals that are posted on a wall for all members to see. The visual metrics identified areas where problems existed and program areas that were doing well.

The Lean management system strives to make continual improvements in strategic plans and promote initiatives that will lead to cost savings for the health regions and improve quality of care for patients. The success of Lean is dependent upon the full commitment of staff to use Lean processes and applications in their daily practice. The implementation of Lean has been an on-going challenge for health in Saskatchewan. The Lean leaders are to encourage and promote change by coaching their staff on Lean principles. I had an opportunity to complete a one day training event on Kaizen/Lean Basics. The coaches worked in the Kaizen Promotion office and presented as strong advocates of Lean. They were skilled in engaging everyone and their commitment to the Lean processes was evident. Lean leaders take an active role in the execution of Lean processes and they are expected to lead health providers through a full implementation of Lean in health care.

The Lean management system has resulted in a multi-million dollar investment (Kinsman, Rotter, Stevenson, Bath, Goodridge, Harrison, Dobson, Sari, Jeffery, Bourassa & Westhorp, 2014). To begin the Lean journey, the government hired John Black, a high price consultant from the United States to teach and guide government employees. John Black and other consultants have been hired by the Ministry of Health to work on various projects. Meanwhile, as a cost-saving tool under the Lean umbrella, the government has been cutting staff numbers across all government ministries.

Although a number of benefits can be attributed to Lean, such as streamlining services resulting in reduced wait times and improvements in how health is managed, there are areas that have not shown the same benefits. In January, the CTV News Regina had mentioned a number
of concerns regarding poor care to seniors (Canadian Press, 2015). Lean is meant to be a tool to improve patient outcomes, not diminish quality of care. There can be a variety of reasons for poor quality of care apart from Lean; however, higher quality standards are integral to Lean methodologies. Again, for Lean implementation to be successful, it firmly requires everyone to be committed and practice it on every level of the health system. This is a core premise of Lean. Not all health employees are committed to Lean practices and do not see the overall value in the Lean processes. However, the Ministry of Health maintains their commitment to Lean and believes it will eventually succeed in enhancing health care and in saving the province money. The provincial government wants Lean to succeed to justify for the millions of dollars invested in it with the expectation it will save money and meet the government’s priorities.

Advocates for Lean state that larger savings will occur over time. Lean is a process to increase efficiencies and reduce processes or ‘waste’ to result in cost savings. According to an article in the Regina Leader Post, the larger regions are reporting more cost-savings than the smaller regions (Fraser, 2014).

Since completing my practicum, the media reported that John Black, the lead consultant on Lean was given a termination notice for his contract with health (Graney & French, 2014). The Saskatchewan Party government leaders have stated that John Black’s termination notice is not a result of media criticisms of senior’s health care and the operation of care homes. I would disagree. As I learn more about policy and government operations, the government is exposed to pressures from the public, media and opposition parties. Political parties cannot deny public and employee disparity is not a concern. The government however, states that the Ministry of Health and Lean leaders will continue to implement Lean methodologies in their practices.
6.1b) Quality Improvement

The Ministry of Health has recognized that the effectiveness of mental health policy depends on quality improvement approaches. Quality improvement approaches can assist health regions to find innovated ways to utilize under-resourced services and in managing ways to improve how the services are used. By providing ongoing quality monitoring, it is a means of improving the effectiveness and efficiency of policy, plans and programs (World Health Organization, 2005).

A lack of quality processes in mental health will aid in perpetuating myths about mental illness and negative attitudes towards people who have been diagnosed with these disorders. When people with mental illness learn that their care will be effective and appropriate, they may be more willing to seek treatment. “Quality improvement provides the opportunity to improve mental health care in a systematic way” (World Health Organization, 2003, p.12). Saskatchewan health and community services can focus on providing quality care by monitoring their services.

In order for a mental health policy, programs and services to be successful, consultation and negotiation should occur at each planning stage. Policy has the potential to involve people and give them ownership of the issues that affect them. “Policy-makers (or mental health planners) should provide leadership and should champion good quality in order to facilitate this systematic improvement” (World Health Organization, 2003, p.12).

“Quality management consists of incorporating quality control, systems evaluation, and quality management tools in both health care and business processes to measure and optimize system performance in the delivery of care to patients” (Shayesteh, Golnaz, Kliwer & Morrin, 2010, p.156). Quality management also means integrating change management processes as a means to evaluate how processes are doing and for setting improvement goals for the
organization (Shayesteh et al., 2010). Within the Community Care Branch, tools such as data collection, analysis, process mapping, and the integration and use of change management strategies were utilized to meet the mission and values of the health system. The process of change management theory includes both frontline and managerial staff. Including staff from all levels, from front line up to senior government levels is necessary to assist in making changes to improve quality.

Quality management and quality improvement are used as umbrella terms, covering an array of approaches. Lean is a core example of the quality management strategy. Lean focuses on system-wide evaluation of work processes that include steps to add value and improve flow, and eliminate the processes that create waste (Brennan, McKenzie, Whitty, Buchan & Green, 2009). This type of approach aims to hasten the rate of process improvement.

6.1c) Performance Measures

To determine how funding is allocated in health care systems, measures of performance are used. Measure of performance is more commonly referred to as statistics or data. Snowdon et al., (2012) states that performance measures are used to report improvements in the provincial strategy and are followed by quality controls. Quality control approaches ensure compliance with the performance measures. Performance indicators were established and mandated for all provinces and territories in Canada in 2003 (Snowdon, et al., 2012). In Saskatchewan, data is reported by each region as a way to evaluate and measure how specific areas in health are doing. The Canadian Institutes for Health Information (CIHI) provide up-to-date comparative data. The Ministry of Health refers to this data frequently to access the number of people utilizing services and for particular disorders. The data is also used in the preparation of briefing notes for legislation, for the community profile plan and for other public information.
Performance measures and indicators are often made available to the public. “In such a system, performance measures become a very competitive driver for organizations, which all compete for health resources based on their performance outcomes” (Snowdon, et al., 2012, p. 47). Each region varies in ways of collecting and interpreting data and in the reporting. As previously mentioned, the Community Care Branch has been collecting data (metrics) on outpatient mental health and addiction wait times from each region since April 2012 and questions still arise on how the data should be collected and at what point of client contact should data be collected. Each region has their own methods of gathering data (metrics) which contributes to challenges. An integrated information system is being developed by EHealth to ease reporting in Mental Health and Addictions services, and for other sectors of the health system. It is hoped that an integrated information system will ease the burden of data collection and solve discrepancies in how to report data. Performance measures are central to funding and the allocation of resources within each region.
Chapter Seven: Legislation and Policy

The Ministry of Health is responsible for policy implementation for the programs and services they offer. They provide consultation to the health regions within Saskatchewan and when required, Ministry staff review legislation and make recommendations to government for new laws and policies to be implemented. In this chapter, I will explain legislation and policy as it relates to Mental Health Services.

Mental health practice is formulated around the legislation and policies that are established by government. They provide the guidelines for how people who have mental illness are treated and perceived by health professionals and society. Legislation creates legal rights and provides governments the power to make regulations that outline how the law will be administered (Chammartin, Ogaranko & Froese, 2011). Policies on the other hand, are an interpretation of the legislation and provide guidance and direction on how services are to be directed. Often legislation and policies are developed to reflect a specific social issue or government agenda that can be understood differently from one person to another. Both are written with a vagueness that leaves room for interpretation and places people who have a mental illness at risk for having their rights violated.

Policies are developed at the provincial or federal level, regional and facility level that often cover a variety of issues that relate to the delivery of service (Chammartin et al., 2011). Mental health policies are meant to protect the rights of people who have mental health disorders and to ensure that their rights are respected. Some policies that are developed are program specific, such as focusing on criteria for admission and wait times or related to treatment interventions and therefore, do not focus on the protection of a person’s rights (Chammartin et al., 2011).
The level of priority that a government assigns to mental health and addictions is stated in policy and generally covers a period from five to ten years (Brennan, McKenzie, Whitty, Buchan & Green, 2013). Over the last few years, the provincial government has placed a higher focus on mental health services. The government has been investing more money into mental health programs to increase access and delivery of services in Mental Health and Addiction Services (Ministry of Health, 2014). With a renewed focus on mental health services, the Ministry of Health has been working on amending the *Mental Health Act (2008)* and Regulations to reflect the values, priorities and objectives of the government.

Mental health legislation defines and set parameters on mental health treatments and procedures. The Ministry of Health is responsible for Saskatchewan’s *Mental Health Act (2008)* and keeping it relevant to advances in care. The *Mental Health Services Act (2008)* outlines the obligations of the Minister and staff for mental health services in Saskatchewan. The Act defines individual rights of people accessing mental health services along with providing guidelines on the care and treatment of individuals who are involuntarily subject to treatment (2008).

During my practicum, mental health consultants were working on amendments to the *Mental Health Act (2008)* and the Regulations ensuring that it is congruent with the *Canadian Charter of Rights and Freedoms* (Ministry of Health, 2014). The *Canadian Charter of Rights and Freedoms* is law that guides other legislations and offers protection of human rights. The staff at the Ministry of Health involved community members, other Ministries and the public to address key policy issues and the changes that need to be considered to make amendments to the Act. “Consultation and negotiation about possible components for change are important not only in drafting of legislation but also in its implementation once it has been adopted”( World Health Organization, 2003, p. 3).
Mental health legislation does not guarantee the protection of human rights but it does provide a legal framework for addressing mental health issues, such as access to care, higher quality of care, rehabilitation, integration into communities, and the prevention and promotion of mental health in society (World Health Organization, 2003). The *Charter of Rights of Freedoms* is considered the ‘supreme law’ that all of pieces of legislation are measured against however; violations of people’s rights and freedoms still occur (Chammartin et al., 2011). Many people who have a mental health illness are not aware of their rights or they may see the mental health system too big to challenge. Many health practitioners, including mental health staff are also not familiar with each right and freedom guaranteed to individuals. It would be beneficial to have a training program that speaks to legislation and policy regarding mental health along with training related to the protection of individual rights and freedoms to promote higher quality of care.

There are four key elements that link policy to legislation according to the World Health Organization (2003). The four key areas are human rights, community integration, linking to other ministries and agencies and for enhancing the quality of care for people with mental health disorders (WHO, 2003). Human rights should be considered in the development of policies and in the monitoring and evaluation of mental health policy and programs. Legislation can provide opportunities for more community based care and rehabilitation and limit involuntary admissions to hospitals or institutions (WHO, 2003). Linking to other service sectors and Ministries, such as employment and housing, legislation can provide protection from discrimination and enhance equality to services. The fourth key element is for enhancing the quality of care to persons with mental health in legislation. Focusing on the quality of care can mean protection against mistreatment and lead to improvements in treatment facilities and set standards for professionals working in the field of mental health (World Health Organization, 2003, p. 11).
Historically, the notion of mental illness was not discussed openly. People who have mental illness have been discarded and marginalized in society. The awareness and willingness to discuss mental health matters and the change needed to view all people with having the same rights is slowing gaining momentum (Chammartin, et al., 2011). Challenges remain in reducing barriers that exist for people who live with a mental health condition. People with mental health illnesses face stigma, discrimination and oppression in many areas of life. Many people face barriers to housing, employment and face discrimination in the justice system. There are barriers that exist in receiving treatment that may increase the risks that people’s rights will be abused. The inclusion of human rights into mental health policy and legislation can help to reduce these risks. “Legislation is essential in order to guarantee that the dignity of people with mental disorders is preserved and that their fundamental human rights are protected” (World Health Organization, 2005).

It is particularly important in Saskatchewan, for all services in health and other professional sectors, to have relevant policy and practice regarding immigrant and Aboriginal people. The Canadian Association of Social Work Guidelines for Ethical Practice places a commitment on social workers to understand cultural diversity and oppression (2005). According to the Guidelines for Ethical Practice (2005), social workers strive to understand culture, acknowledge diversity and seek to understand a client’s racial and cultural identities, values and beliefs (CASW, 2005, p. 4). Saskatchewan is a culturally diverse province with people accessing health, social services, justice, housing and other service sectors. Therefore, it is important to be culturally relevant and sensitive when directing policy and programs.
Chapter Eight: Reviews and Considerations

In this chapter I will look at some ethical considerations that need to be considered in the area of mental health. I will consider how social work guidelines and ethics can impact health services and how professional ethics can impact decision making. I will review the Health Information Protection Act that is meant for the protection of patient’s health information and consider the implications if the Act is not fully understood.

8.1 Ethical Considerations

The concept of health includes not only an individual’s physical health but also their mental well-being. Many factors can impact a person’s mental and physical health, these are often referred to as the social determinants of health. Social, economic, environmental and relationship factors should all be considered when viewing a person’s health. These factors require that health needs should be considered in an environmental context. Social workers perform roles that encompass the social determinants of a person’s health, along with their physical and mental health. The emphasis in social work is on interaction and ‘person-in-the-environment’ theory. The Canadian Association of Social Workers National Scope of Practice Statement reported that“ the primary focus of social work practice is on the relationship networks between individuals, their natural support resources, the formal structures in their communities, and the societal norms and expectations that shape these relationships” (CASW, 2000, p. 2). A holistic approach includes relationships needs in order to be fully incorporated into the mental health field.

Adopting a holistic approach in mental health services requires an awareness of systemic oppression that can impact clients. A key responsibility for social workers is to advocate and promote change and strive for social justice. “Social workers advocate for change in the best
interests of clients and for the overall benefit of society, the environment and the global community” (CASW, 2005, p. 24). Social workers also have a responsibility to advocate for change in policies and legislation to improve social conditions and social justice issues.

A social justice issue that is at the forefront for health care is access. Throughout this paper, timely access to services has been a focus. Health providers and the Ministry of Health have been working towards addressing these concerns for a number of years. Access to services however, can mean more than just being accepted into a program in a predetermined time frame. Access can also be affected by a person’s limited finances, a lack of culturally relevant programs or the stigma a person may feel entering a program (Chammartin et al., 2011). A narrow definition of access can impact a person’s health negatively. A person who has to wait to access services due to finances or due to a language barrier may experience deterioration in their mental and physical health. The Canadian Association of Social Workers (CASW, 2005) addresses access under the principles of social justice.

- Social Workers uphold the right of people to have access to resources to meet basic needs
- Social Workers advocate for fair and equitable access to public services and benefits
- Social Workers advocate for equal treatment and protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged
- Social Workers promote social development and environmental management in the interests of the people (CASW, 2005, Code of Ethics, p.5).

The social justice component of social work practice is clearly emphasized in the Canadian Association of Social Work Code of Ethics (2005). “Social workers have, simultaneously, ethical responsibilities to address both private troubles and public issues” (CASW, 2005, p.3). The
provincial government has recognized the need for improving mental health in Saskatchewan and addressing the availability of services. I would suggest however, that the broader definition of access is not considered when mental health policy and programs are developed in Saskatchewan. Social workers have an ethical responsibility to advocate for better mental health services, better allocation of resources and for more inclusive mental health policy.

Another ethical consideration that is specific to health care falls under the *Health Information Protection Act (HIPA) (2003)*. HIPA (2003) provides legislation regarding rights of individuals and their personal health information. The *Health Information Protection Act* (2003) applies to all forms of health information including paper and electronic health records. It ensures protection for individuals, but also identifies situations in which information can be shared. Where consent is required by this Act, it must be given voluntary and with an assurance that the person is informed. The person also has the right to consent to the disclosure of information (*Health Information Protection Act, 2003, Sec 6 & 7*). The Ministry of Health is currently working towards an electronic information system that all health providers will be able to access, across services. The development of an electronic patient information system was a result of the fragmentation of health information that was limiting collaborative care. Clients accessing services had to repeat their stories to each health care provider they met. In developing a shared electronic system that incorporates the entire client or patient’s needs in one location will improve health care delivery and will be congruent with the lean philosophy of more efficient and quality care. Section 8 of the *Health Information Act (2003)* acknowledges the rights of such a comprehensive health record. Consent however, is required by the patient in order to place personal information in a comprehensive health record (HIPA, 2003). Many people who access health services, particularly mental health services may not be aware of the
consent clause within the Act. I question whether the receipt of this information will be passed along to health professionals in hopes that they will inform their clients.

8.2 Values

I was fortunate within my practicum experience not to have a conflict with values in my day to day practicum experience since I did not have direct contact with clients or patients. I did experience some hesitation however, when I was requested to research information on safe practices on crack cocaine use for a pamphlet. I have seen firsthand the effects of crack and cocaine on individuals that I have worked with in my career and I was initially surprised that the Ministry of Health wanted to produce a pamphlet related to crack/cocaine use. In discussions with Addiction staff members, they clarified their request and stated that the pamphlet should relay information on the effects of crack cocaine on a person’s health, the safe methods on disposal of equipment and safer practices of using equipment. The Community Care Branch along with the Population Health Branch wanted to provide information that can help reduce the risks of harm to people who use crack cocaine. The pamphlet would also be sent to health and addiction workers who provide the help and support to their clients and for the general public who may come in contact with used needles and other drug paraphernalia.

As a social work student and a working professional, I guide my working practice on treating everyone fairly, with respect and without discrimination. I therefore, put my own views on drug use aside, and focused on the knowledge that I could provide to reduce the risks of spreading illness through the use of unsafe equipment. As outlined in the Social Work Code of Ethics, social workers should recognize diversity and the person’s right for self-determination (2005). The Code of Ethics (2005) also points out that social workers can limit a person’s self-determination in order to protect the person from self-harm and/or from harming others (p.5). As
drug use can have very negative health effects, my hesitation came from wanting to protect individuals from harm.

Another interesting consideration that exists with values comes from working in a multidisciplinary team environment. Within the Community Care Branch, the staff holds graduate degrees from various areas. Working with multidisciplinary teams that hold different values and code of ethics, specific to their profession can present challenges for the values and ethics that social workers practice in. This was particularly evident with the weak social work voice at the management level. For myself, I notice competing value drivers between myself as a social worker with values leaning towards the care of clients, against the beliefs held by administrators where their decisions are primarily based on fiscal and resource pressures. As such, the goals or outcomes were different whereby social workers want to improve the health of people and administrators or economists manage costs. The Ministry of Health staff does however consider the Charter of Rights and Freedoms in their decision making. Expectantly, there will be challenges in managing the differences in strategies, systems and skills used by members from the different professional backgrounds although the different skills and perceptions can be useful to build a stronger, safer and better health system.

I was also challenged by the overarching philosophy of the Lean management system and the ‘cult’ atmosphere that it exudes. “With an initial focus on leadership, strategic alignment, training and the creation of a supportive infrastructure (Lean promotion offices), the goal in Saskatchewan is a whole health system transformation that produces "better health, better value, better care, and better teams" (Kinsman et al., 2014, pg. 1). Within the short time I worked within the Lean system, I noticed faster patient releases from clinical or hospital settings, staff shortages in healthcare and the implementation of some services that result in less face to face
interaction. Better health cannot be achieved when a patient is rushed out of a hospital; better value can be achieved at the cost of overall health or quality of care which compromises better care and developing better teams which results only when everyone is supportive of the process and procedures. The Lean system does not always consider patient values or professional ethics because Lean was developed for vehicle and airline manufacturing. Lean is meant to be a bottom-up approach however; health staff and patient views for improvements are often viewed as secondary to Lean’s methods of cost-savings.
Chapter Nine: Conclusion

The staff I had an opportunity to work with in the Community Care Branch are strong advocates for better, quality care and improved access to services. I witnessed their dedication and hard work in the face of internal pressures and resource constraints. Their dedication however, is restricted to the political views of the government presently in office. The provincial government has imposed a management system across health care that supports their own political agenda. Ken Rasmussen, associate director at Johnson-Shoyama Graduate School of Public Policy was quoted in the Leader post stating “that the government’s job is not to get involved in the details of management, and should not become an advocate for a single managerial theory that will be used to advance its various goals…then demand that it work” (Politics drives, 2015).

My practicum experience at the Community Care Branch within the Ministry of Health was a valuable learning experience; from learning the language of health and Lean philosophies, to collaborating with other professionals and Ministries. I appreciated the opportunity to participate in an area of policy development, particularly in the mental health and addictions field. Throughout my professional career, I have worked with people who have mental health and addiction problems that directly or indirectly affect their lives. Having the opportunity to learn about mental health at a system management level in government provided me with more understanding about how programs and services are delivered and managed. The research projects I was involved with enhanced my skills and understanding of the change process. Through observation, participation and research, I believe I have gained a foundation for advancing my career and enhancing my skills to be an effective social worker and leader.
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