

Engage People with Lived Experience of Mental Health Conditions and Addictive Behaviours Workbook

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**Canadian Mental
Health Association**
British Columbia
Mental health for all

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Preface

This workbook is a “how to” guide and has two sections. Section One contains tools that you can use to enhance the engagement of people with lived experience of mental health conditions and addictive behaviours within your organization. These tools include Engagement Defined, the Three Domains, Appreciative Inquiry, Framework for Support, Spectrum of Participation, and Patient Journey Mapping. Section Two includes resources that you can use to work within each of the domains including Self-Help Strategies, Recovery Education, Peer Support, Leadership Skills Training and Patients as Partners | Patient Voices Network.

Section One includes the Four E's: 1) Explanation (what is it?), 2) Exploration (think about it), 3) Engagement (do it), and 4) Expansion (improve it). Following the Explanation, the Exploration section is where you can write down what your thoughts are about the tool that was introduced and how you see its potential use within your organization. This is followed by the Engagement section which is where you can write down how you plan to use the tool within your organization. Lastly, the Expansion section is where you can write down the impact of the use of the tool within your organization and what action you can take next.

Section Two begins with an example of an individual's personal journey through the three domains without the use of any resources. This is followed by an example of their journey with the use of resources. The resources are then described including how to obtain further information about each resource.

You can use this workbook in a number of ways. One option is that as leader of your organization, you could go through the workbook responding to the questions to determine where you are at with regards to the engagement of people with mental health conditions and addictive behaviours within your organization. Alternatively, as leader of your organization, you could get together as staff team and participants and respond to the questions together. When finished, you would see where

things are at and work towards engagement. Another option is to choose one of the tools that could benefit your organization and work through the process as a team. These are just a few options of how you can use this workbook. You will find your own way of using this workbook to enhance what you are already doing with regards to the engagement of people with mental health conditions and addictive behaviours within your organization.



Test Your Knowledge

Circle either true or false for the following statements:

- Engaging people with lived experience of mental health conditions and addictive behaviours is:
 - A new phenomenon T F
 - Mandated by the government T F
 - An active part of most mental health programs T F
 - May be therapeutic T F
 - May encourage greater social inclusion T F
- Barriers to engagement include:
 - Challenges about thinking about and working with service users T F
 - Resistance to the idea of engaging individuals T F
 - Too much information for service users T F
 - Financial and time costs T F
 - Concerns over representativeness T F
- Individuals can be engaged in:
 - Prioritizing and conducting research T F
 - Staff selection T F
 - Employment as service providers T F
 - Educating and training T F
 - Planning and delivery of services T F
- Meaningful engagement requires:
 - Extra financial resources T F
 - An appropriate organizational culture T F
 - A genuine partnership with service users T F
 - One or two interested individuals in each organization T F
 - Commitment at every level of the organization T F

Answers

- F T F T T
- T T F T T
- T T T T T
- F T T F T

Section One Tools to enhance the engagement of people with mental health conditions and addictive behaviours

Engagement Defined

Explanation

Meaningful engagement of people with lived experience of mental health conditions and addictive behaviours needs to be part of the overall operation of the organization and not a one-off endeavor. Everyone involved needs to be treated as equal partners because everyone brings something different, but equally valuable (National Schizophrenia Fellowship, 1997). You may have to experience engagement before you can fully appreciate the difference that it makes.

Lord, J. (1989) states, “paternalism, the dominance of the medical model, and the professionalization of mental health services have all contributed to maintaining consumers in their ‘client’ status” (p. 15). These historical and social reasons contribute to the lack of engagement.

After investigating how patients are engaged in service design, delivery and evaluation, the Canadian Foundation for Healthcare Improvement developed a series of briefs on promising practices, entitled, “Ingredients for Successful Patient Engagement.” They can be found at www.cfhi-fcass.ca

In October 2011, the Health Council of Canada (HCoC) held a national symposium on patient engagement highlighting initiatives across Canada that put patients first, such as BC’s Patients as Partners Project. The symposium’s recommendation is to “Start with what is working. Find all those examples, then ask, ‘How can we get more of that? How can we help the best to spread?’ As the best spreads it begins to isolate the worst. People can get engaged with developing the best. People can become very discouraged just trying to fix problems.” (HCoC, 2012, p.12).

Exploration

- What does participant engagement mean in relation to your organization?
- In general, how important do you think it is that participants are engaged in your organization and why?
- How willing are your participants to be engaged in your organization?
- How satisfied are you with the current level of engagement within your organization and why?
- To what extent are participants currently engaged in your organization?

- What do you think are the main barriers to participants being more engaged in your organization?
- What are some strategies for overcoming these barriers?
- If there was one thing that could be done to enhance participant engagement within your organization, what would it be?

Engagement

Looking through the following list of ways in which you could potentially engage participants, put a check mark beside the ones you already do under the ✓ and a check mark beside the ones that you would like to implement under the ★ on the next page. →

Expansion

- How did it go?
- What can you do differently?

✓ ★ Things to Consider

	Create a charter along side participants —stating your promise to them to offer opportunities of how to be involved—and display this across programs
	Conduct regular participant meetings across all levels; program and service level
	Conduct ‘meet-the-manager’ sessions
	Involve participants in audits, both internal and external sources
	Use regular participant satisfaction questionnaires—get participants involved in the design and delivery
	Use questionnaires about up and coming changes and new project ideas
	Use a 360 degree appraisal approach
	Ensure you have a complaints procedure which is active, up to date and transparent
	Involve participants in policy review on a regular basis
	Get participants to run their own meetings—can you offer training on how to do this?
	Recruit participants for the Board of Directors
	Involve participants in the recruitment of new staff
	Encourage participants to access training alongside staff
	Use group peer support—do participants want to set up a self-help group?
	Explore volunteer opportunities available to participants—how can participants become volunteers either within your organization or externally?
	Involve participants in the delivery of training
	Get participants involved in delivering conferences and presentations—could you get a participant to talk at an AGM or present to the Board of Directors?
	Involve participants in leaflet design and branding the organization—remember who it is meant to appeal to
	Get participants to help with fundraising
	Introduce peer research—are you conducting research to help you develop your services? Could you train participants to become peer researchers?
	Involve participants in creative groups—newsletters, interactive websites, forums, video, drama, arts
	Take the message into the community—if you deliver education in the community, would a participant like to be part of that?
	Other:

Three Domains

Explanation

To enhance the engagement of people with lived experience of mental health conditions and addictive behaviours in 2011, the BC Ministry of Health's Integrated Primary and Community Care Patient and Public Engagement Framework identified three domains which corresponds with Lord, J.'s identification of engagement within these same three domains (1989). The three domains identified in BC Ministry of Health's Integrated Primary and Community Care Patient and Public Engagement Framework are shown in Table 1.

Exploration

- **Individual Care:** How do you currently involve people with mental health conditions and addictive behaviours in their own health through self-management and decision-making?
- **Program and Service Design:** How do you currently involve people with mental health conditions and addictive behaviours, families, community organizations and strategic partners in the design, delivery and evaluation of the services you provide?

- **System and Community:** How do you currently involve people with mental health conditions and addictive behaviours, families, community organizations and strategic partners in policy development or strategic planning?

Engagement

- **Individual Care:** How can you enhance the involvement of people with mental health conditions and addictive behaviours in their own health through self-management and decision-making?
- **Program and Service Design:** How can you enhance the involvement of people with mental health conditions and addictive behaviours, families, community organizations and strategic partners in the design, delivery and evaluation of the services you provide?
- **System and Community:** How can you enhance the involvement of people with mental health conditions and addictive behaviours, families, community organizations and strategic partners in policy development or strategic planning?

Expansion

- How did it go?
- What can you do differently?

The Use of Appreciative Inquiry

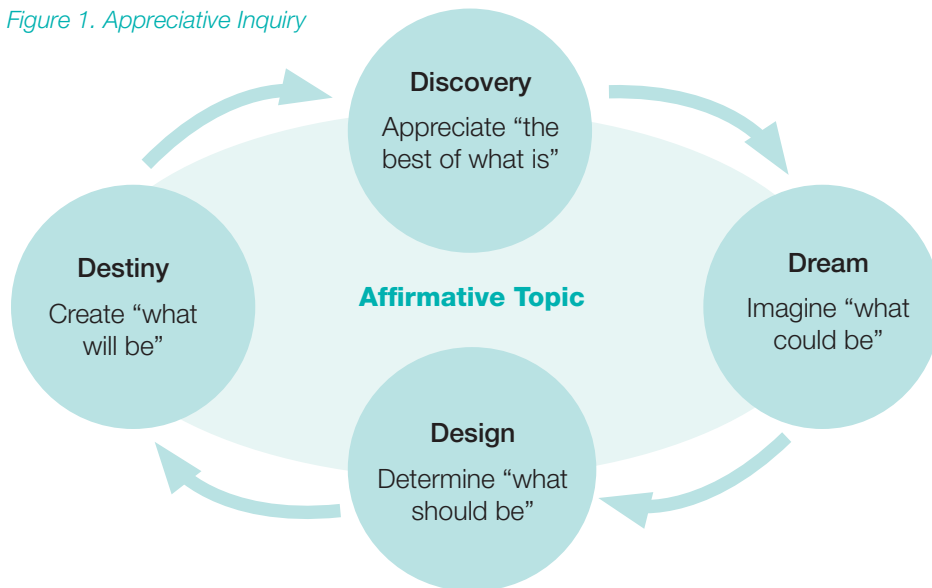
Explanation

Appreciative inquiry can be used to create a team's vision and values and to determine the action needed; to initiate organizational transformation; and to support organizational transition (Whitney, D. & Trosten-Bloom, A., 2003). Appreciative inquiry focuses on strengths and what is working rather than fixing what isn't working, analyzing why it is working well and then doing more of it. It has the capacity to introduce a positive culture into an organization. Busche (1995) states that "the basic process of appreciative inquiry is to begin with a grounded observation of the 'best of what is', then through vision and logic collaboratively articulate 'what might be', ensuring the consent of those in the system to 'what should be' and collectively experimenting with 'what can be'" (p. 15). The four key areas of appreciative inquiry are shown on the next page. →

Table 1. Domains

Individual Care	Program and Service Design	System and Community
"The patient is activated, involved in their own health through self-management and an engaged role in health care decision-making. The health care system is patient-centred, responsive, respectful and collaborative" (2011, p. 3).	"Patients, families, community organizations and strategic partners are engaged in design, delivery and evaluation of health care programs and services" (2011, p. 3).	"Patients, families, communities, and strategic partners are engaged in policy development or strategic planning. There may be representation from patients, families, communities, and strategic partners in governance" (2011, p. 3).

Figure 1. Appreciative Inquiry



Two processes of conducting an appreciative inquiry process will now be described.

First, to identify what Canadian Mental Health Association (CMHA) Branches were currently doing with regards to participant engagement, CMHA BC conducted an appreciative inquiry in 2012. Branch executive directors were asked two questions:

1. Discovery—Please provide some examples as to how participants are engaged?
2. Dream—If you could engage participants in any way you wanted, how would you like to see participants engaged?

Participants were also asked two questions:

1. Discovery—Please provide some examples of how you are or were involved within CMHA?
2. Dream—In what ways would you like to be more involved in CMHA?

The results of this inquiry informed the tools and resources that are presented in this workbook.

Second, a process for conducting an appreciative inquiry team building activity using the World Café approach looks at the “best of what is,” “what

could be,” “what should be” and “what will be.” There are two parts to this process:

1. Team Activity
2. World Café Activity

Set-up: Have three tables set up with some distance between each table. Have flipchart pages on each table, each with a different heading. The first table will have a flipchart page saying **Discovery: appreciate the best of what is.** The second table will have **Dream: imagine what could be.** The third table will have **Design: determine what should be.**

Introduction: It is important to involve all members of the team and point out that the purpose of the activity is to focus on strengths, what is already working well and what can be done to do more of what is working well.

Team Activity: Have a pre-drawn picture of a tree on the wall. In the top part of the tree ask the group to identify strengths of the team. In the trunk ask the group to come up and write down one strength that they bring to the team. Summarize by pointing out the value of a team and how they fit into the overall organization.

World Café Activity: Part 1: Introduce the World Café activity by stating that each table will brainstorm responses to what is written on the paper. After 15 minutes team members will go to a different table and after another 15 minutes team members will go to a different table. All team members will have gone to each table once. Tell them to try to not stay with their same group, but to switch around with other members of the team. After 15 minutes ask the group to go to a different table. When finished debrief how that activity was for members.

Part 2: Post flipchart pages on the wall. Have a fourth flipchart page labeled **Destiny: create what will.** To begin, you identify the themes and patterns from the first three flipchart pages that were completed during the World Café activity. These themes and patterns will help inform the final phase of this activity. On the flipchart page labeled **Destiny: create what will,** you can look at what you want to start, stop and continue within the program or organization based on the themes and patterns that were identified.

Exploration

- What is the value of using appreciative inquiry as a team building tool within your organization?
- What are some other ideas of using appreciative inquiry within your organization?

Engagement

- What are you going to do to introduce appreciative inquiry into your organization?

Expansion

- How did it go?
- What can you do differently?

Framework for Support

Explanation

The framework for support is a tool developed by CMHA National and represents a “commitment to both partnership and a person-centred approach to mental health policy” (Trainor et al., 2004, p. 1). The authors state that “a good policy will start with people, not systems” (p. 1). The goal of the framework is “to ensure that people with serious mental health problems live fulfilling lives in the community” (CMHA, 2005, p. 2). The utilization of the Framework for Support can aid in a shift in the organizational culture and from leadership requires “dynamic and sustained change if it is to become a reality” (CMHA, 2005, p. 23). The framework focuses on three resource bases. See Table 2 below.

The Framework For Support is shown on the next page. →

Exploration

Community Resource Base: Trainor et al. (2004) state that “the CRB [Community Resource Base] is a reminder that all policy development and program delivery should start by listening to consumers” (p. 10) which corresponds with the program and service design domain.

- How is your organization listening to people with mental health conditions and addictive behaviours with regards to policy development and program delivery?
- What services do you provide that address the fundamental elements of housing, education, income and work?

Knowledge Resource Base: The challenge of the Knowledge Resource Base is to include people with mental health conditions and addictive behaviours more fully in society which corresponds with the system and community domain.

- How does your organization assist with the integration of people with mental health conditions and addictive behaviours into their community?
- What services do you provide that offer assistance for people with mental health conditions and addictive behaviours to understand mental illness and addictions?

Personal Resource Base: The Personal Resource Base emphasizes that it is essential that people with mental health conditions and addictive behaviours identify the resources they need which corresponds with the individual care domain.

- How does your organization assist people with mental health conditions and addictive behaviours find the resources they need in their communities?

- What does your organization provide that assists people with mental health conditions and addictive behaviours to deal with their condition and live a full life?

Engagement

Hess, Clapper, Hoekstra, and Gibison, Jr. (2001) state that “significantly involving people who use mental health services in system planning and evaluation is essential to the development of an effective and responsive system of services” (p. 257).

- What can your organization do to involve people with mental health conditions and addictive behaviours at every stage of program development including planning, implementation and evaluation?
- Anthony (2000) identifies client involvement as a characteristic of a recovery-oriented system. Since recovery is at the heart of The Framework for Support (Trainor et al., 2004), what can you do to ensure that the services you provide are recovery-oriented?

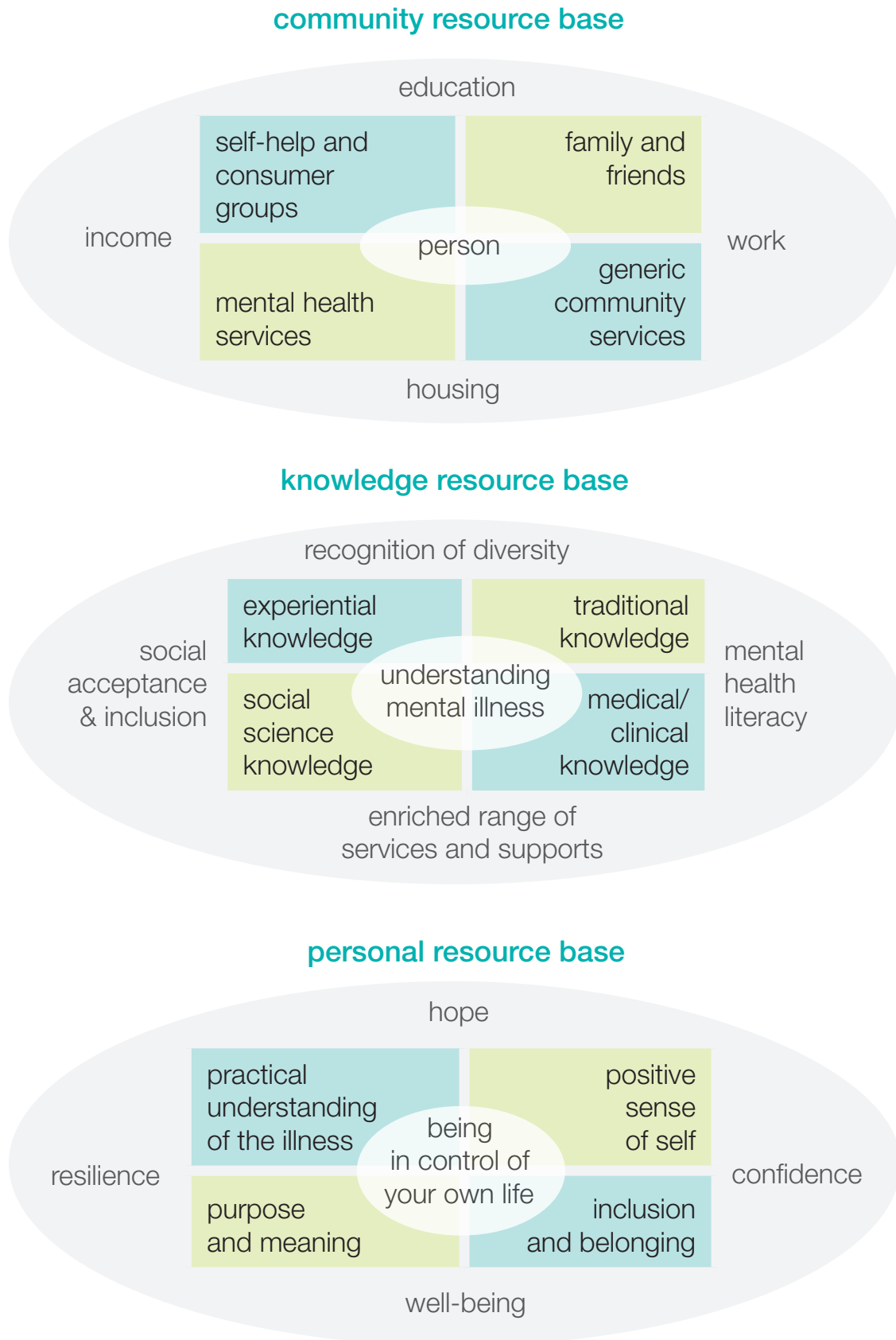
Expansion

- How did it go?
- What can you do differently?

Table 2. Resource Bases

Community	Knowledge	Personal
“Assumes the perspective of the person in the centre” and “acknowledges the fundamental elements to which every citizen should have access: housing, education, income and work” (2005, p. 7).	“Its goal is to promote a constructive dialogue that will lead to a more balanced and comprehensive understanding of mental illness” (2005, p. 12).	“Creates a new model for how consumers [clients] can see themselves and how they can be seen by others. It is based on a balance between the reality and challenge of illness and the resources needed to deal with it and live a full life” (2005, 16).

Figure 2. Framework for Support



The Spectrum of Participation

Explanation

The Community Engagement Framework is a model of quality where the clients/residents are “the primary drivers of clinical and policy decision-making” (VCH, p. 3). The framework adopts The Spectrum of Participation, shown below.

One strategy is not inherently better than the other. How you plan to engage people with mental health conditions and addictive behaviours will define the strategy that would work the best. For more information about the Spectrum of Participation check out www.bit.ly/spectrum-of-participation

Exploration

Check the strategy/strategies your organization currently uses to include people with mental health conditions and addictive behaviours:

- Inform (educate)
- Consult (gather information)
- Involve (dialogue)
- Collaborate (engage)
- Empower (partner)

Engagement

Looking at the examples of each strategy shown below, identify

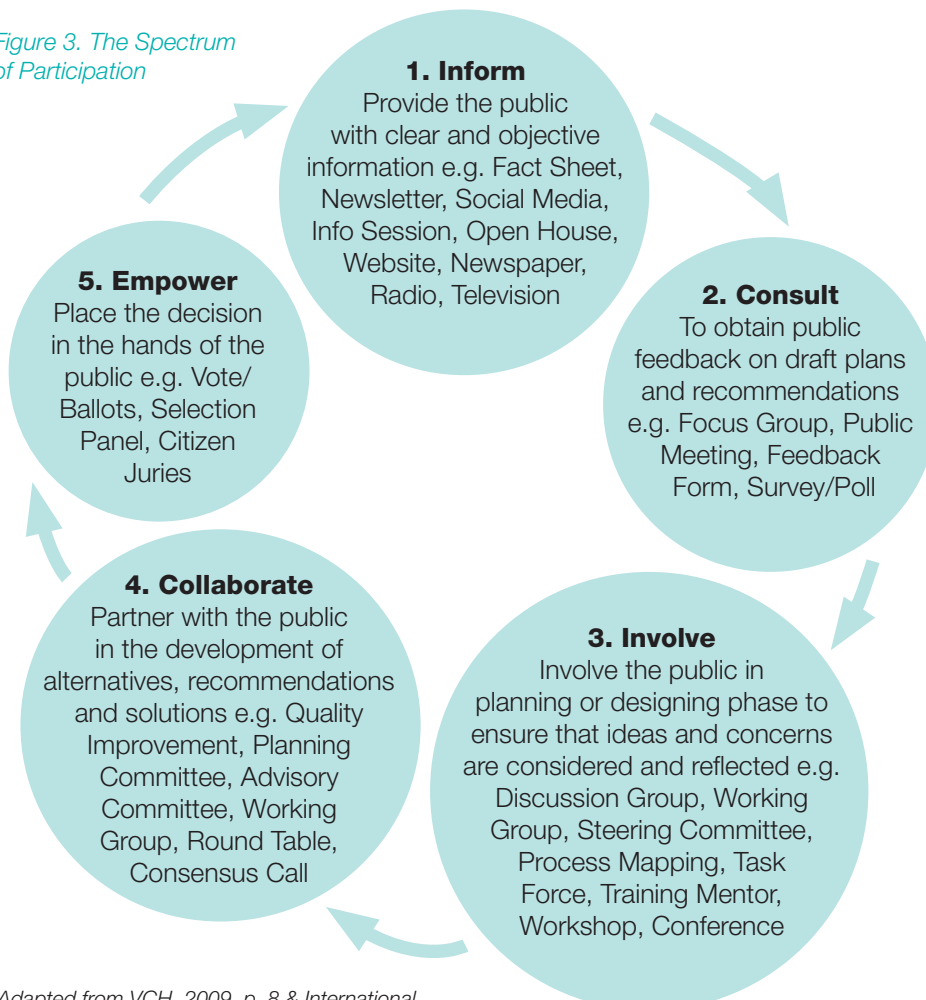
- **Inform (educate):** When you want to provide information and are prepared to keep individuals informed, what technique(s) could you use?

- **Consult (gather information):** When you want to get feedback and are prepared to listen and report back on how input influenced the decision, what technique(s) could you use?
- **Involve (dialogue):** When you want to understand and consider concerns and are prepared to include input and report back, what technique(s) could you use?
- **Collaborate (engage):** When you want to partner in all aspects of the decision and are prepared to seek ongoing advice, incorporate advice to the maximum extent possible and report back, what technique(s) could you use?
- **Empower (partner):** When you want to let individuals make the decision and are prepared to implement what they decide, what technique(s) could you use?

Expansion

- How did it go?
- What can you do differently?

Figure 3. The Spectrum of Participation



Adapted from VCH, 2009, p. 8 & International Association for Public Participation

Patient Journey Mapping

Explanation

To understand how patients proceed through the care delivery system can be achieved through process mapping. Patient Journey Mapping focuses on how care is received not how it is delivered, and how things are and what happens, rather than what should happen (Patients as Partners | Patient Voices Network).

The value of doing a Patient Journey Map is that it gives everyone a broader perspective, has the potential to improve team building because everyone is involved, is cost-effective with the only cost being the time commitment of those involved, and by having the patient as the focal point can have a ripple effect throughout the organization (Patients as Partners | Patient Voices Network).

The process of mapping the patient's journey can give patients and their families the opportunity to tell their stories, to make sense of their experiences, and to reflect on what has happened to them in the presence of family and supportive professionals (Dartington, 2007).

Three examples of how to conduct a Patient Journey Mapping process will now be described.

First, Kamloops Child and Youth Mental Health conducted a Patient Journey Mapping process in 2012. The process brought together patient experts and/or patient's parents, health authority staff, community partners and physicians. Traditional Patient Journey Mapping processes are conducted around one large group, where everyone listens to one patient at a time. Due to the sensitive nature of the child and youth population, the room was arranged into four tables with each table focusing on one patient's experience to accommodate privacy and ensure a safe space to share. The morning was spent creating the map using sticky notes and an artist captured the map visually. The afternoon was spent analyzing the map looking at successes, challenges

and opportunities. The group voted on the list of opportunities by choosing their top priorities resulting in the identification of five key opportunities (CYMH, 2012). To view the report please go to www.bit.ly/kamloops-patient-journey-mapping.

Second, CMHA BC conducted a Patient Journey Mapping process in 2012 using a one-to-one approach. Three individuals volunteered to share their experience. The Engagement Facilitator worked with the individuals one-to-one in putting together a map to ensure a safe and supportive environment to share. They are actual depictions of the individual's experience navigating the system. Looking at these maps one can identify what was working, barriers, gaps, and opportunities for growth. Please see Appendix A to view the Patient Journey Maps that were created.

One last suggestion for the use of Patient Journey Mapping is to conduct a workshop describing the process and then together, participants design their journey map. Putting together a Patient Journey Map in this way would allow for a safe and supportive environment for participants to design their maps.

Exploration

- How do you know if people with mental health conditions and addictive behaviours are getting the most efficient care at the most appropriate time in the right place within your organization?

Engagement

- How can you use the Patient Journey Mapping process within your organization to identify the experience of the people you are serving to ensure that you are providing the most efficient care?

Expansion

- How did it go?
- What can you do differently?

Summary

The Framework for Support is the model CMHA fully adopts and The Spectrum of Participation could be the framework implemented to bring the model alive. The Domains, Spectrum of Participation and The Framework for Support complement each other as outlined in the table below.

Table 3. Domains, Spectrum of Participation and The Framework for Support

Domains	The Spectrum of Participation	The Framework for Support
Individual Care	Empower—encouraging action projects through funding sources (VCH, 2009, p. 9)	Personal Resource Base—understanding clients as actors who can direct their own recovery process (CMHA, 2005, p. 4)
Program and Service Delivery	Involve—community participating on VCH internal committees Collaborate—providing resources and assistance for community partners undertaking community-driven initiatives	Community Resource Base—rethinking the nature of services and supports
Community and System	Inform—communicating and educating the community Consult—seeking input from the community	Knowledge Resource Base—bringing into focus the diverse kinds of information relevant

Section Two Resources to enhance the domains

Introduction

To assist in the integration of The Framework for Support and the Spectrum of Participation in the domains the resources shown in Table 4 are available. The use of these resources can help one gain a sense of control over one's life, build a life beyond mental health conditions and addictive behaviours, and pursue one's hopes, wishes and dreams.

The resources in Table 5 correspond with *Healthy Minds, Healthy People, A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia 2012 Annual Report's* identified population strategies of mental health promotion, targeted prevention and risk/harm reduction, and therapeutic intervention as shown below.

A Picture of Before and After the Use of Resources

The table on the next page depicts an individual's experience in the three domains before and after the use of resources demonstrating the impact of their use. →

Table 4. Domains and Resources

Domains	Resources
Individual Care	<ol style="list-style-type: none"> 1. Self-Help Strategies: <ol style="list-style-type: none"> a. Bounce Back: Reclaim your Health b. Living Life to the Full c. Strongest Families 2. Recovery Education: <ol style="list-style-type: none"> a. Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) b. Your Recovery Journey c. Wellness Recovery Action Plan (WRAP) 3. Peer Support
Program and Service Delivery	Consumers In Action Leadership Skills Training Program
Community and System	Patients as Partners Patient Voices Network

Table 5: Strategies and Resources

Strategies	Resources
Mental Health Promotion	<ol style="list-style-type: none"> 1. Living Life to the Full 2. Consumers In Action Leadership Skills Training Program 3. Peer Support
Targeted Prevention and Risk/Harm Reduction	<ol style="list-style-type: none"> 1. Living Life to the Full 2. Bounce Back: Reclaim your Health 3. Strongest Families 4. Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) 5. Wellness Recovery Action Plan (WRAP) 6. Your Recovery Journey 7. Peer Support
Therapeutic Intervention	<ol style="list-style-type: none"> 1. Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) 2. Your Recovery Journey 3. Wellness Recovery Action Plan (WRAP) 4. Peer Support

Source: *Healthy Minds, Healthy People, 2012*

Table 6. Before and After the Use of Resources

Before the Use of Resources	After the Use of Resources
Individual Care	
<p>“When I went to see the mental health team after my first break from reality I was terrified and didn’t know what was happening to me. I was told I had a biochemical imbalance and I’d need to take medication, that I wouldn’t be able to work and to keep my stress low. I felt helpless and hopeless. Every time I expressed how miserable I was feeling I was told to take my medication and make sure I keep my stress low.”</p>	<p>“When I went to see the mental health team after my first break from reality I was terrified and didn’t know what was happening to me. Every time I expressed how miserable I was feeling I was told that recovery was possible and was given a variety of resources including a number of peer support services. I met other people who were going through similar experiences. I no longer felt alone. I took responsibility for my recovery, made new friends and became less dependent on mental health services.”</p>
Program and Service Design	
<p>“The first time I was asked to be on a mental health advisory committee I was totally unprepared. I felt invisible and didn’t know the jargon. I was too scared to ask any questions because I was the only person with a mental illness there. I didn’t return.”</p>	<p>“The first time I was asked to be on a mental health advisory committee I was totally prepared. I just finished the Consumers In Action Leadership Skills Training Program, which included a module on how to be a member of a committee. This gave me knowledge to feel comfortable within my role on the committee. I also felt comfortable because there were a number of people with a mental illness on the committee. I was assigned a buddy who would debrief with me after each meeting and explain the processes and what we were working towards.”</p>
System and Community	
<p>“When I was a client, everything I did was within the mental health system. I lived in mental health housing, attended a mental health clubhouse, went to groups at the mental health team, and went on recreational outings with my peers. When I expressed that I wanted to get further involved in my community or within the mental health system I was told there weren’t anything like that and it was within my best interests to keep going to group.”</p>	<p>“When I was a client, everything I did was within the mental health system. I lived in mental health housing, attended a mental health clubhouse, went to groups at the mental health team, and went on recreational outings with my peers. When I expressed that I wanted to get further involved in my community or within the mental health system I was told about the local mental health advisory committee and trainings that would help prepare me to be a member. We came up with a plan and I got a peer support worker to help me work towards my goals. My peer support worker also told me about the Patients as Partners Patient Voices Network if I wanted to be more involved. After being on the committee for a year I wanted to get more involved and became a member of the Patients as Partners Patient Voices Network.”</p>

Resources

Bounce Back: Reclaim Your Health™

Bounce Back is specially designed for people with milder mental health troubles that get in the way of life. Bounce Back is a free, skill-building program for adults experiencing low mood or stress, with or without anxiety. The program offers two forms of help:

1. an instructional Living Life to the Full DVD with practical tips on recognizing and dealing with signs of stress, low mood and worry
2. a workbook-based program with motivational telephone coaching to teach skills for overcoming difficulties such as inactivity, unhelpful thinking, worry and avoidance.

If you are interested in Bounce Back, please talk to your family doctor because a doctor's referral is required.

Source: www.cmha.bc.ca/how-we-can-help/adults/bounceback

Living Life to the Full

Living Life to the Full was developed by Dr. Chris Williams, a UK psychiatrist. Living Life to the Full is an evidence-based, interactive course based on cognitive-behavioural principles to help participants to deal with their feelings when fed up, worried, or hopeless, and learn skills that help tackle life's problems. For more information on the findings check out www.bit.ly/LLTTF-EABCT-poster

The topics include:

- Why do I feel so bad?
- I can't be bothered doing anything
- Why does everything always go wrong?
- I'm not good enough
- How to fix almost everything
- The things you do that mess you up
- Are you strong enough to keep your temper?
- 10 things you can do to feel happier straight away

Source: www.lltff.ca

Strongest Families

Strongest Families is an effective, accessible educational service for families of children with mild to moderate behaviour problems (ages 3 to 12) offered through the Canadian Mental Health Association, BC Division. Strongest Families was developed by Dr. Patrick McGrath at the IWK Centre, Nova Scotia.

Strongest Families is delivered to parents and/or caregivers via telephone in the comfort and privacy of their own homes at times that are best for the family, and at no cost. Trained coaches give weekly guidance and telephone support to families as they work their way through the program. Coaches and parents work together to solve problems as parents apply new skills in their daily lives.

The Strongest Families Parenting the Active Child program includes:

1. An established, evidence-based program presented in handbook format with video clips to demonstrate specific skills
2. Step-by-step instruction with practice exercises
3. Highly trained and supervised coaches providing regular telephone contact

If you are interested in Strongest Families, please talk to your family doctor because a doctor's referral is required.

Source: www.cmha.bc.ca/how-we-can-help/children-families/strongestfamilies

Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES)

The purpose of the BRIDGES Education Program is to help participants gain knowledge and skills that will empower their journey to recovery. BRIDGES has the potential to enable people with a mental illness to participate more actively in their treatment; to reduce hospitalization; to forge stronger social ties; and to develop more satisfying and productive lives.

BRIDGES consists of three components:

1. BRIDGES Course:
 - The Foundation of BRIDGES
 - Mood Disorders: Depression, Bipolar Disorder
 - Thought Disorders: Schizophrenia
 - Anxiety Disorders and Mini Module Chosen by Class (Personality Disorders, Eating Disorders, Attention Deficit Disorder, Concurrent Disorder, Dissociative Identity Disorder)
 - Helpful Support
 - Medications and the Brain
 - Problem Management Method
 - Communication
 - Module Chosen by Class: (Healthy Spirituality, Self-injury)
 - Advocacy and Graduation
2. BRIDGES Support Group: Open to anyone who has a diagnosis of mental illness whether or not they have graduated from the BRIDGES course.
3. BRIDGES Footsteps Workshops:
 - Recovery and Support
 - Mood Disorders and Thought Disorders
 - Anxiety Disorders and Personality Disorders
 - Mental Health Treatment and Medications
 - Mental Health Services and Advocacy

Source: www.bcscs.org/programs/2007/05/bridges-education-and-support-program

Your Recovery Journey

Your Recovery Journey is based on the premise that there is hope, that people with mental illness can get well and stay well for long periods of time. The goal of the program is to increase participants' ability to meet their personal recovery goals by enhancing their self-determination and quality of life. Workshop topics include:

- What is Recovery?
- Quality of Life
- Self-Management
- Medication as a Tool for Recovery
- Moving Forward: Personal Action Planning

Source: www.your-recovery-journey.ca/english.htm

Wellness Recovery Action Plan (WRAP)

WRAP is an evidence-based practice. For more information on the findings check out www.mentalhealthrecovery.com/wrap/program-descriptions.php

WRAP is a self-designed plan toward a lifestyle that enhances one's personal wellness and being at their best.

WRAP is designed to decrease and prevent intrusive or troubling feelings and behaviors; increase personal empowerment; improve quality of life; and assist people in achieving their own life goals and dreams. The components of WRAP include:

- Wellness Toolbox
- Daily Maintenance Plan
- Triggers and Action Plan
- Warning Signs and Action Plan
- When Things are Breaking Down and Action Plan
- Crisis Plan
- Post-Crisis Plan

Source: www.mentalhealthrecovery.com

Peer Support

The Peer Support Resource Manual (MOH, 2001) defines peer support as “a process in which consumers/survivors offer support to their peers. Peer supporters experience their own mental health issues and therefore are in a unique position to offer support to others in order to improve the quality of their lives” (p. 11). In their research on psychiatric rehabilitation, Farkas and Anthony state, “promoting the hiring of individuals with serious mental illness as peer providers as well as in the role of helping professionals and administrators reflects a culture of full partnership” (2010, p. 123).

Peer support programs are becoming more widespread yet funding is not comparable to other mental health funded programs. According to Mead et al. (2006) if peer support programs were standardized they could be a “powerful voice in the future design of services” (p. 23).

To address standardization, the Peer Support Accreditation and Certification (Canada) [PSACC] was formed. PSACC is a not-for-profit organization created to provide national certification and accreditation services in accordance with nationally endorsed standards of practice for mental health peer supporters. Its corporate mandate includes undertaking research and evaluation pertaining to peer delivered mental health services and programs.

Having high-quality standards of practice coupled with national certification and evidence based research is expected to result in numerous benefits. A few of them are:

1. better assurance to organizations and service systems that peer support is consistently provided with due care and skill;
2. full acceptance of peer support as complementary to the medical model of mental health care;
3. recognition of peer support as a valued intervention forming part of a holistic approach to mental health and well-being;
4. reduced burden on the mental health care system through increased use of peer support in all parts of Canada; and
5. a national credential allowing certified peer supporters to practice anywhere in the country.

Source: www.psac-canada.com

For more information about PSACC please go to www.psac-canada.com

The Mental Health Commission of Canada developed the Guidelines for Practice and Training of Peer Support in collaboration with peer support workers across Canada.

The intent is to encourage the development of more peer support capacity in Canada and strengthen existing peer support initiatives. They were developed for prospective and practicing peer support workers as a roadmap for personal and program development, and for administrators to

provide guidance for the development and enhancement of peer support programs within their organizations. To view the Guidelines for Practice and Training of Peer Support please go to www.mentalhealthcommission.ca/English/node/18291.

To implement and sustain a peer support program a booklet was designed as an easy-to-use reference guide. To obtain this guide please go to www.bit.ly/RAND-guide-to-clinical-staff.

Mental Health Consumers In Action Leadership Skills Training Program

The Mental Health Consumers In Action Leadership Skills Training Program was founded by the National Network for Mental Health and the Self-Help Connection. The program was designed to enhance one's capacity and leadership skills for full community participation. The curriculum consists of the following components:

- Guide to Maintaining Your Mental Health
- Consumer/Survivor Leadership
- Consumer/Survivor Advocacy
- Consumer/Survivor Community Participation
- Policy and Standards Development
- Self-Help Development
- Tips for Preparing and Delivering Presentations
- A Guide for Writing Funding Grants/Proposals
- Seeking Employment

Source: www.nnmh.ca/AboutUs/Projects/tabid/684/language/en-CA/Default.aspx

Patients as Partners | Patient Voices Network

The Patients as Partners | Patient Voices Network is a community of BC patients, families, caregivers, and others who wish to use their experiences for positive change to the health care system. Patients can provide health system decision makers with important information about how to best serve them and involve them as partners in their own care. The Patients as Partners | Patient Voices Network provides the following benefits to members:

1. **Community Building:** Members represent a variety of backgrounds, cultures and age groups, but they all share a commitment to working collaboratively toward positive change. Members have opportunities to connect with each other to share experiences and learnings.
2. **Skill Building:** The Patients as Partners | Patient Voices Network offers ongoing learning opportunities to help patients strengthen skills and learn more about relevant health care topics and resources.
3. **Support:** Once a patient is matched with an opportunity, the Patients as Partners | Patient Voices Network staff will ensure they have the information, briefing materials, or background they need to feel confident and prepared to participate. Coaching specific to each type of placement is also provided.

Source: www.patientvoices.ca

Summary

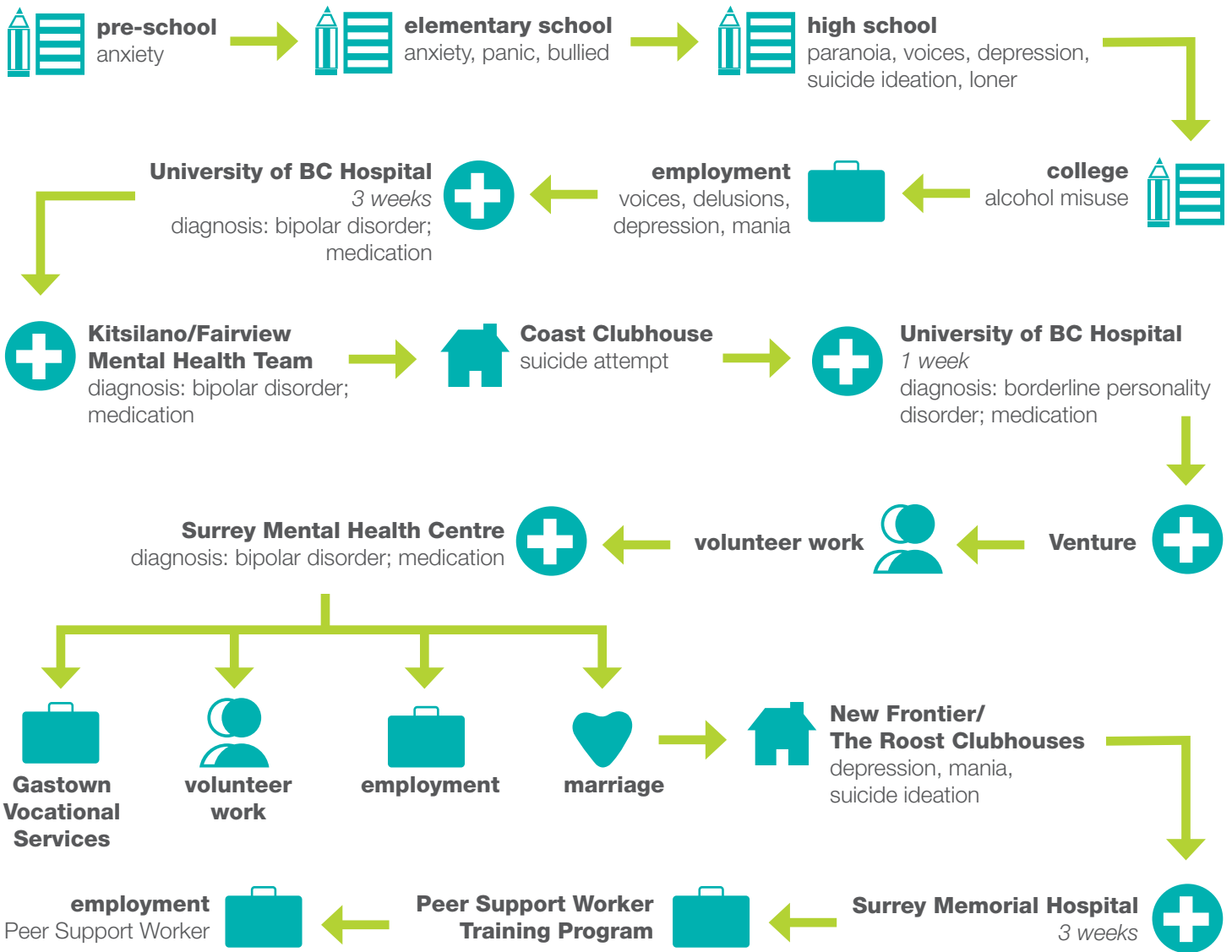
According to the *BC Ministry of Health's Integrated Primary and Community Care Patient and Public Engagement Framework (2011)*, “successful engagement requires rigorous planning, skillful execution and typically involves a series of steps” (p. 11). In addition, Poulton (1999) identifies that the “implementation of user involvement in identifying health needs and shaping health services will require a series of cultural shifts” (p. 1295). Cultures that encourage consumer involvement include “a commitment to genuine partnerships between users and professionals and to the development of shared objectives” (Tait & Lester, 2005, p. 174). Further, understanding the culture will determine what influences leadership. Yukl (2002) states that “cultural assumptions justify the past and are a matter of pride, they influence the selection of leaders and the role expectations for them” (p. 161). Church & Reville (1989) provide a direction for leaders when they recommend that “to achieve real user involvement an organization’s leadership must learn the difficult art of melding disparate ideologies, interests and personalities into a force capable of influencing policy, structure and the flow of resources” (p. 24).

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Appendix A Patient Journey Maps

Karen—39 years old



Karen's story

At a very early age, Karen struggled with anxiety, from pre-school onward. In elementary school, Karen was bullied and the anxiety turned into panic.

Throughout high school, Karen was a loner and began to exhibit signs of paranoia, hearing voices, depression and suicide ideation. Her struggles continued and she began to misuse alcohol when she was in college.

When Karen was employed, she began to slip further away and was tormented by voices, delusions, depression, and mania. She was hospitalized at the University of BC Hospital for three weeks, where she was given the diagnosis of Bipolar Disorder and given medication.

Upon discharge, Karen was referred to the Kitsilano/Fairview Mental Health Team, where the Bipolar Disorder diagnosis was confirmed. She attended the Coast Clubhouse

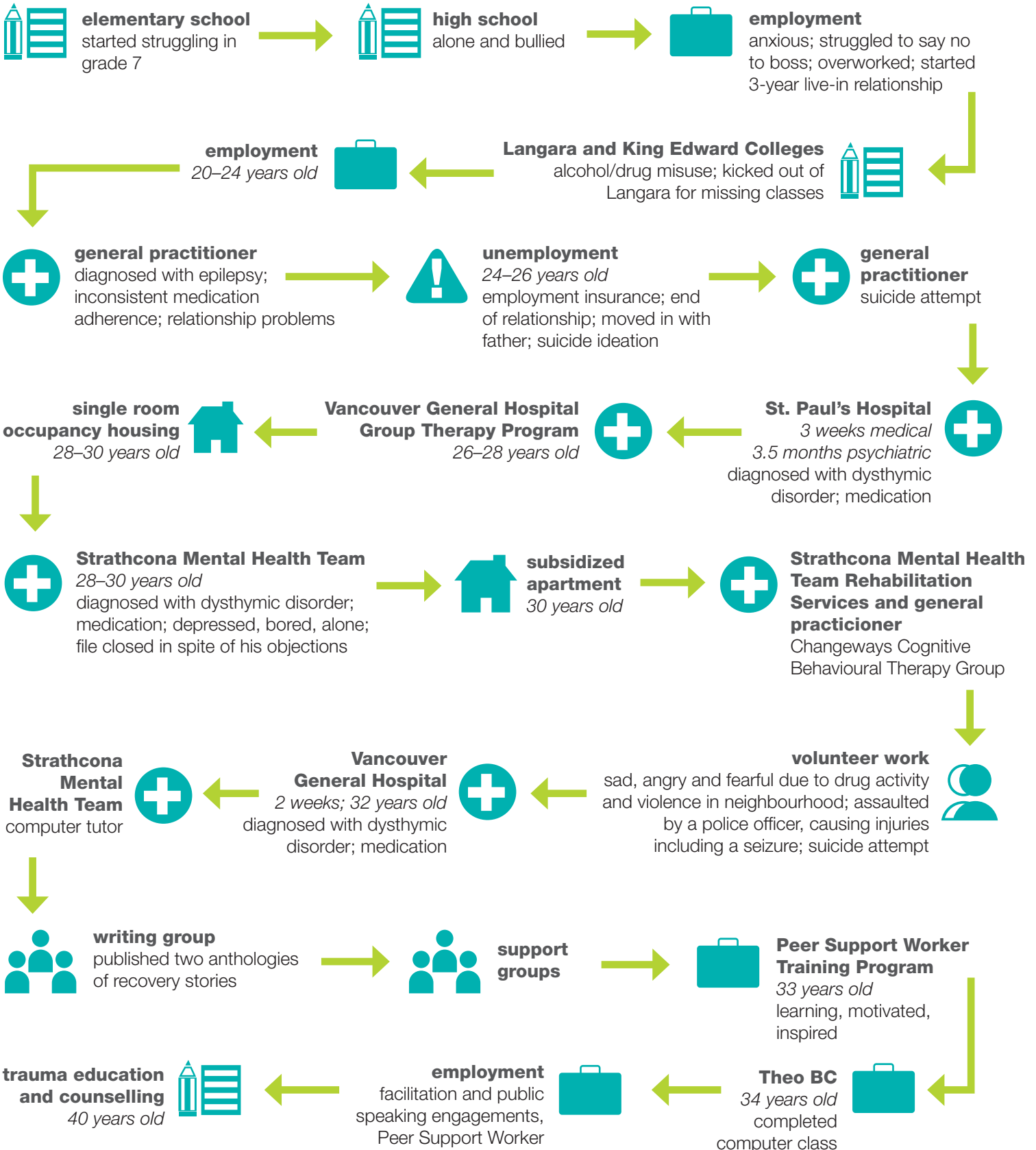
and, after another suicide attempt, was once again hospitalized at the University of BC Hospital for a week, where she received a diagnosis of Borderline Personality Disorder and given medication.

Once discharged and after a short stay at Venture, Karen did some volunteer work. After a move to Surrey, she attended the Surrey Mental Health Centre, where she received a diagnosis of Bipolar Disorder and given medication.

For the next four years, Karen attended Gastown Vocational Services, did volunteer work, got a job and got married. She also began attending the New Frontier and The Roost clubhouses.

Karen then experienced depression, mania and had thoughts of suicide, which resulted in being hospitalized at Surrey Memorial Hospital for three weeks. Upon discharge, she took the Peer Support Worker Training Program and has been working as a peer support worker ever since.

Jude—44 years old



Jude's story

In grades 2–5, Jude's teacher said, "Jude is so smart that we are letting him teach others." In grade 7, he began struggling so he had to receive extra help.

In high school, Jude was alone and bullied due to his small size. His teacher said, "Jude is smart, but seems distracted in class. He could do more, especially athletically, but his mother 'mollycoddles' him."

After graduating from high school, Jude got a job where he was anxious, struggled to say no to his boss, and was overworked. He thought, "I don't see the point of working to make money just to buy and consume. I'm not passionate about what I do." A relationship at work developed into a live-in relationship that lasted three years.

Jude then attended Langara and King Edward Colleges at ages 18–20, where he misused alcohol and marijuana. He was kicked out of Langara College for missing classes. His professor from King Edward College said, "You are brilliant, but I feel you have too big of a heart to get into law."

Jude went on to work for four years. He had trouble saying no to superiors when they asked for more help or hours, and frequently worked over 80 hours a week, 35 days in a row. He eventually gave up and resigned as he said, "there has to be more to life."

His general practitioner diagnosed him with epilepsy, but Jude was not consistent with medication adherence. He had a lot of relationship problems and was unemployed for two years as he lived on Unemployment Insurance. Jude's relationship ended and he moved in with his father. He told his father that he was out looking for work, but instead, he spent his time sleeping at the library.

Jude eventually told his general practitioner in desperation, "I'm thinking of killing myself." His doctor replied, "It's a two year waiting list to see a psychiatrist and, besides, you'll

be fine once you get back to work." After a suicide attempt, Jude was hospitalized at St. Paul's Hospital for three weeks on the medical ward and 3.5 months on the psychiatric unit. He was given a diagnosis of dysthymic disorder and given medication.

June connected well with other patients and felt like he was given a second chance. During this time, he had three job offers. Upon discharge, Jude attended the Vancouver General Hospital Group Therapy Program for two years. He felt good to be around peers that shared their experience. He fell deeply in love with a fellow female group member so he discharged himself because he wanted a deeper relationship with her.

Jude could no longer live with his father and family so he moved into a hotel room. He then started attending the Strathcona Mental Health Team, where his diagnosis of dysthymic disorder was confirmed.

After two years, Jude's file was closed, in spite of his objections, and he was told he could get help and support from his family doctor, and could continue to access Rehabilitation Services. During this time, Jude also got a subsidized apartment. He attended Strathcona Mental Health Team Rehabilitation Services and saw his general practitioner. The team said to him, "You have strengths and can be a full citizen of this society. We will help support you in achieving your goals."

Jude attended Changeways Cognitive Behavioural Therapy group. His doctor did his best to meet his clinical needs and tried to advocate to re-open his clinical file at the Strathcona Mental Health Team. Jude kept busy with volunteer work, which let him use his strengths and abilities and allowed him to contribute to society in a way that was very valuable to him.

The drug activity and violence in his neighbourhood caused Jude to become sad, angry and fearful. He was assaulted by a police officer, which resulted in injuries and a seizure. After another suicide attempt, he was hospitalized at Vancouver General

Hospital for two weeks, where he received a diagnosis of dysthymic disorder and was given medication. At the hospital, he was told, "You are being discharged because you are doing better, but you need to re-connect with the Strathcona Mental Health team."

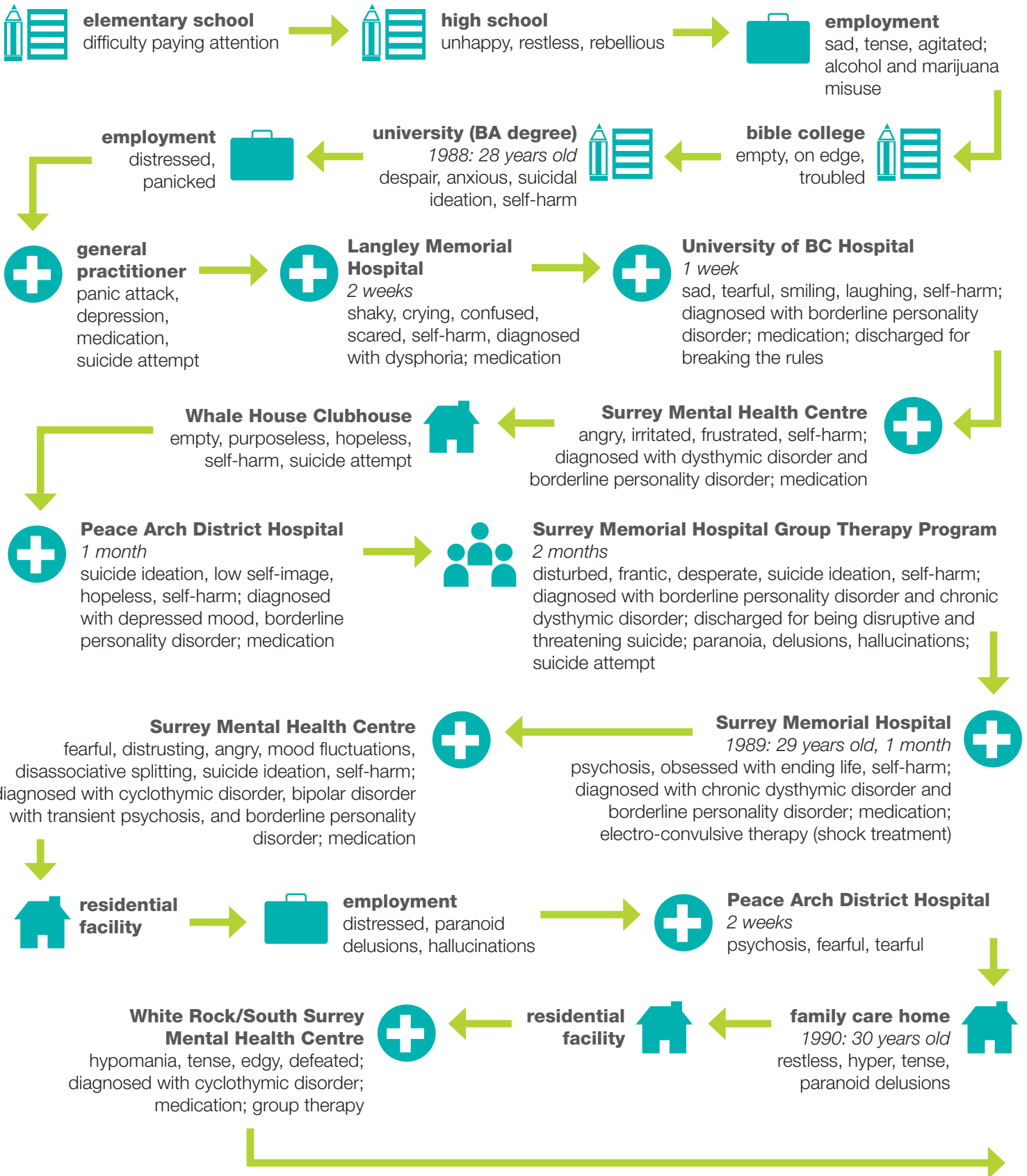
Back at the Strathcona Mental Health Team and with a medication change, Jude was no longer having seizures—he had previously had two a year—and his mood was more stable than it had ever been. He wanted to contribute but didn't want to work a 40 hour a week job so he worked as a computer tutor. He also got involved in a writing group, where they published two anthologies of recovery stories.

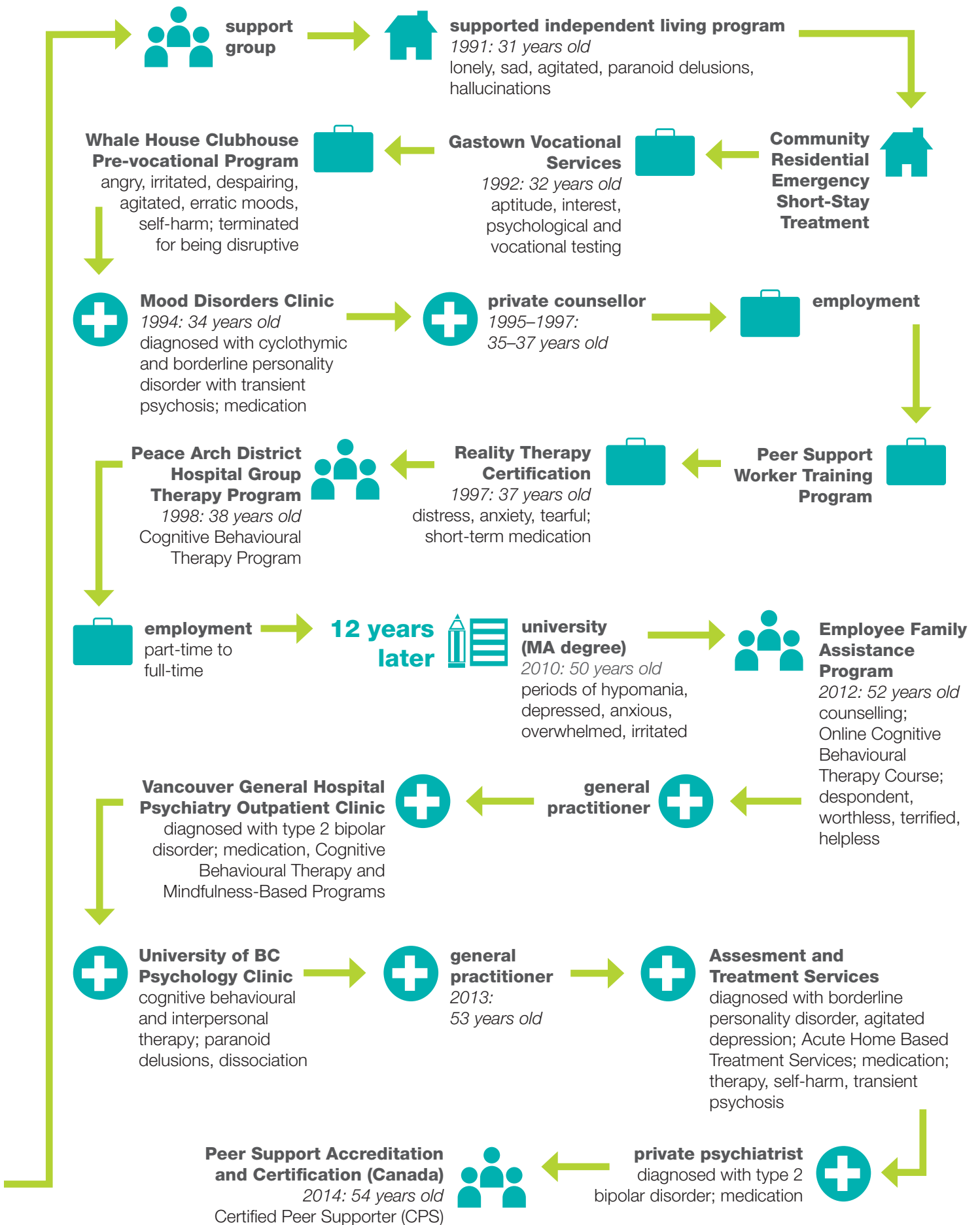
At Theo BC, Jude completed a 12-week computer class in 3 weeks to receive a computer certification. He attended a variety of support groups, where being around and sharing life experiences with peers was an important part of his life. Jude then took the Peer Support Worker Training Program where he was learning, motivated and inspired. He felt like he had found his calling and began working as a Peer Support Worker.

Jude found his passion in peer support work and feels like the world is a better place with him in it. A client said, "Jude, you believed in me before I did, thank you." Jude also does group facilitation and public speaking engagements, finding value in his life experience and feeling lucky to not be saddled with stigma and shame.

After taking trauma education, Jude is now working one-to-one doing trauma recovery work. He is able to gain positives out of previous huge negative experiences. He found ways that work for him and is willing to listen to others' experiences on how things work for them. He says, "There is always hope. I have so much to give, so much to learn and will have problems I can live with until the day I die. Setting boundaries is an important part of my professional and personal life." Jude participated in trauma education and is now doing one-to-one trauma recovery work.

Debbie—54 years old





Debbie's story

In elementary school, Debbie's teachers said, "Debbie doesn't pay attention in class and thinks it is play time."

In high school, Debbie was unhappy, restless and rebellious. Her teachers said, "she is disruptive in class and would rather visit with her friends."

After she graduated from high school, she got a job where she was sad, tense and agitated. Debbie hated feeling this way but didn't know what to do.

She misused alcohol and marijuana to cope. Not knowing what to do with her life, she attended Bible College, where she felt empty, on edge and troubled. The college's counselling department told Debbie she needed more intensive help than they could provide.

At 24 years old, Debbie went to university to obtain a BA in psychology. She felt despair and anxiety, had suicide ideation and began to self-harm. She thought, "what's wrong with me? It hurts so much inside." She went to the university's counselling department.

Thinking she was burnt out from university, Debbie took a trip to Europe. When she returned, she got a job where she was distressed and panicked.

She thought she was having a heart attack so went to her general practitioner, who told her she was having a panic attack and was very depressed. He prescribed medication and, after a suicide attempt, Debbie was hospitalized at Langley Memorial Hospital for two weeks. She was shaky, crying, confused, scared and continued to self-harm.

Debbie was diagnosed with Dysphoria and given medication. The psychiatrist said it would do her no good to try to fight the illness on her own. She was then transferred to the University of BC Hospital for one week. She was

sad, tearful, smiling, laughing and still self-harming. She was diagnosed with Borderline Personality Disorder and given more medication.

Debbie was discharged because she broke the rules and threatened suicide. She was devastated, wanting to end the pain by ending her life. Her university professor intercepted a suicide note and got her in to see someone at the Surrey Mental Health Centre.

Debbie was angry, irritated, frustrated and increased her self-harming behaviour. She was diagnosed with Dysthymic Disorder and Borderline Personality Disorder and given medication. She was told, "You will have mental illness forever. You will be on medication forever. You will never be able to work."

Debbie didn't understand why someone didn't tell her what was wrong—she thought they were the experts. She thought, "Is there really no hope?"

She was referred to the Whale House Clubhouse to add structure to her day, but only went a few times because she was afraid to go on her own. She felt empty, purposeless, hopeless and continued to self-harm. She asked, "Is this all there is to life? I have no identity, No hope."

After another suicide attempt, Debbie was hospitalized for a month at Peace Arch District Hospital. She had a lot of suicide ideation, low self-image, felt hopeless and kept self-harming. She was diagnosed with depressed mood and Borderline Personality Disorder and given medication. During this hospital stay, she said, "I am not alone. Others are suffering just like me." She didn't want to leave the safe hospital environment because she didn't feel ready. She couldn't just return to an empty apartment and insisted on having some place to go once she was discharged.

After discharge, Debbie attended the group therapy program at Surrey Memorial Hospital for two months. She became disturbed, frantic, desperate,

had suicide ideation and increased her self-harming behaviour. She was diagnosed with Borderline Personality Disorder and Chronic Dysthymic Disorder and was discharged for being disruptive and threatening suicide.

Debbie was devastated that she was kicked out and began to slip away from reality. She experienced paranoia, delusions, hallucinations, and, after threatening suicide, was hospitalized for one month at Surrey Memorial Hospital at 29 years old.

Debbie was deeply into psychosis, obsessed with ending her life and self-harming. The psychiatrist told her to sign for electro-convulsive therapy (shock treatment) or they would commit her and then she would have no choice.

She received shock treatment and then signed herself out of the hospital, hitchhiked from Surrey to White Rock and broke into her apartment—none of which she remembers.

Debbie continued to attend Surrey Mental Health Centre, where she was fearful, distrusting, angry, had mood fluctuations, dissociative splitting, suicide ideation and self-harming behaviours. She was diagnosed with Cyclothymic Disorder, Bipolar Disorder with transient psychosis and Borderline Personality Disorder, and was given medication.

She was in such distress that she sought respite at a residential facility for a few months. Living there, she felt relief to not have any responsibilities.

Despite her distress, Debbie tried working a number of times, only to have to quit because mental illness would take over. At work she would become distressed and have paranoid delusions and hallucinations. Once again, she started to slip into a psychotic state and was hospitalized at Peace Arch District Hospital for two weeks, where she was fearful and tearful.

At 30 years old, Debbie could no longer live on her own and moved into a family care home. While living there she thought, "I don't understand why

they kick us out of the house all day. I thought this was our home.”

She became restless, hyper, tense and started having paranoid delusions again. She was then transferred to a residential facility for three months, where she was glad to be away from the chaos of living with a family.

Attending the White Rock/South Surrey Mental Health Centre, Debbie became hypomanic, tense, edgy and defeated. She was diagnosed with Cyclothymic Disorder, given medication and attended group therapy.

Debbie searched for resources for childhood sexual abuse. She found a support group and felt a connection with peers, who were all struggling to some degree, just like her.

Debbie felt ready to live on her own through the Supported Independent Living Program at 31 years of age. The program provided subsidized rent and a support worker. She was relieved to have her own apartment and not have to worry about how to pay rent.

Living on her own was challenging and Debbie became lonely, sad, agitated, and had paranoid delusions and hallucinations. She went to Community Residential Emergency Short-Stay Treatment for a week, needing to get away since everything seemed overwhelming.

At 32 years old, Debbie was referred to Gastown Vocational Services for aptitude, interest, psychological and vocational testing. She enrolled in a pre-vocational program at the Whale House clubhouse. She learned new skills that she had not been able to do because of the effects of shock treatment.

Debbie started to become angry, irritated, despairing, agitated, had erratic moods and increased her self-harm behaviour. She was terminated for being disruptive. She asked for a referral to the Mood Disorders Clinic at 34 years old.

Debbie was diagnosed with Cyclothymic Mood Disorder and Borderline Personality Disorder with transient psychosis and given

medication. She could no longer stand what mental illness was doing to her and decided she could no longer live like this.

At 35 years old, Debbie attended a workshop entitled “Understanding How and Why we Behave the Way we Do” based on Choice Theory/Reality Therapy concepts. She saw a counsellor certified in Reality Therapy, who encouraged her that she could do whatever she wanted.

After two years of intensive counselling, Debbie felt in control over her mental illness. She identified self-harm as an ineffective behaviour, replaced it with more effective behaviours and was free from self-harming behaviours. With the support of her general practitioner, she was able to go off all her medications.

Debbie felt ready to work again. After trying so many times and quitting, it felt good to be able to remain at a job.

Debbie got involved in peer support, including the Building Recovery of Individual Dreams and Goals through Education and Support Program. She took the Peer Support Worker Training Program, feeling that she found her niche and could make a difference.

Because of the profound impact that Reality Therapy had on her life, Debbie obtained her Reality Therapy Certification at 37 years old. She didn’t want to return to mainstream employment after graduating. Instead, she submitted proposals to develop programs for her peers.

One program Debbie developed was based on Choice Theory/Reality Therapy concepts. She delivered the program for three years and consistently had a waiting list. She was asked to work as administrative assistant for the local Canadian Mental Health Association, where she finally felt accepted and valued.

Debbie experienced a brief episode of distress, anxiety and was tearful. She took medication for a short period of time.

To prevent a further decline in her mental health, she attended a Cognitive Behavioural Therapy Group

at the Peace Arch District Hospital Group Therapy Program at 38 years old.

Debbie was discharged from the White Rock/South Surrey Mental Health Centre. She initially panicked at the thought of leaving services she had received for about 9 years with no check-ins or follow-ups.

To make it through, Debbie got more involved in a variety of projects such as chairing mental health advisory committees and serving as president of the local Canadian Mental Health Association.

From 38–50 years old, she was employed. She had a long-term contract job and was working in a unionized position. Her work in peer support ranged from being a peer support worker, researcher, developer and coordinator of the Fraser South Peer Support Program, and program coordinator and trainer of the Vancouver and North Vancouver Peer Support Programs.

Debbie was nominated as one of the BC representatives for the Peer Support Project with the Mental Health Commission of Canada, now called Peer Support Accreditation and Certification Canada.

Twelve years later, Debbie wanted to go back to university, but never thought she would ever get accepted into a master’s program. To her surprise, she was accepted and, at 50 years old, got an MA in Leadership.

Debbie experienced periods of hypomania, but nothing that interfered with her school or work. She was proud of getting her master’s degree, something she never thought she could do before. Upon graduation, she began to feel depressed, anxious, overwhelmed and irritated. Not knowing what was happening, where to go, or what to do, she went for counselling through her work Employee and Family Assistance Program. At this point, Debbie felt that too many traumatic things were happening and that everything was closing in on her.

Debbie took an online Cognitive Behavioural Therapy course. She became despondent, felt worthless, terrified and helpless. Things felt like they were getting worse so she went to her general practitioner and was referred to the Vancouver General Hospital Psychiatry Outpatient Clinic, where she saw a psychiatrist.

Debbie was scared of getting as sick as she had been before. The psychiatrist reminded her she was not the same person that she was when she had been sick before.

She was diagnosed with Type 2 Bipolar Disorder, given medication and participated in a few Cognitive Behavioural Therapy Programs.

Debbie slipped further into a deep depression and was overridden with anxiety. She started seeing a psychologist at the University of BC Psychology Clinic.

She felt at the end of her rope, but the hope that was deeply buried kept her alive, away from self-harming behaviours, and prevented a full-fledged psychotic break. Things improved for awhile, but then worsened. She started having paranoid delusions and experienced dissociation.

At 53 years old, Debbie went back to her General Practitioner and

was referred to North Shore Adult Community Mental Health Services, where she began receiving services from Assessment and Treatment Services. She was diagnosed with Borderline Personality Disorder and agitated depression. She used the acute home based treatment service, was given medication and received therapy. She began self-harm and experienced transient psychosis.

At 54 years of age, Debbie saw a private psychiatrist where she was diagnosed with Type 2 Bipolar Disorder and given medication.

Debbie continues to work despite the turmoil she was enduring and has been actively involved in the Peer Support Accreditation and Certification (Canada) (PSACC).

Subsequently, she became one of Canada's first PSACC's Certified Peer Supporters.

Debbie says, "For me, recovery is about challenging myself to live my life at my full potential. It can be a long road back to recovery, but there is always hope to make it through one step at a time."

*"Sometimes the hardest part of the journey is believing you're worthy of the trip."
— Glenn Beck.*

About the Canadian Mental Health Association, BC Division (CMHA)

CMHA BC is part of one of Canada's most established national mental health charities. Our vision is mentally healthy people in a healthy society.

As the nation-wide leader and champion for mental health, CMHA facilitates access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness or addiction. We do this by building capacity, influencing policy, providing services and developing resources.

Each year, CMHA BC together with a network of 17 BC branches provides services and supports to over 82,000 British Columbians, promoting mental health for all and supporting the resilience and recovery of people experiencing mental illness or addiction.

To learn more visit www.cmha.bc.ca

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