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MEASURING PROGRESS:

Resources for Developing a Mental Health and Addiction
Performance Measurement Framework for Canada

July 2018

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- Krystine Abel, MEd., Aboriginal Engagement and Outreach, Provincial System Support Program, CAMH
- Julie Bull, MAHSR, Aboriginal Engagement and Outreach, Provincial System Support Program, CAMH
- Amanda Butler, PhD Student, Faculty of Health Sciences, Simon Fraser University
- Steven Clelland, MA, Director, Provincial Addictions and Mental Health, Knowledge Performance and Planning, Alberta Health Services
- John Dick, Patient Advisory Coordinator, Ontario Shores Centre for Mental Health Services
- Cheryl Forchuk, MScN, PhD, Professor, Lawson Health Research Institute, Western University
- Joanna Henderson, PhD C Psych, Director, Margaret and Wallace McCain Centre, CAMH
- Wayne Jones, Data Analyst, Centre for Applied Research in Mental Health, Simon Fraser University
- Steve Kisely, MD FRCPC, PhD, School of Medicine, University of Queensland
- Alain Lesage, MD FRCPC M Phil., Professor, Department of Psychiatry, Université de Montréal
- Steve Lurie, MSW MM, Executive Director, Canadian Mental Health Association, Toronto
- Ian Manion, PhD C Psych, Director Youth Mental Health Research, Institute of Mental Health Research, School of Psychology, University of Ottawa
- Kwame McKenzie, MD FRCPC, Professor, Division of Equity Gender and Population, Department of Psychiatry, University of Toronto
- Gail McVey, PhD C Psych, University Health Network, Associate Professor, Dalla Lana School of Public Health, University of Toronto
- Brian Rush, PhD, Professor, Departments of Psychiatry and Public Health Sciences, University of Toronto
- Gillian Mulvale, MA PhD, Assistant Professor, Health Policy and Management, McMaster University
- David Streiner, MS PhD C Psych, Professor, Department of Psychiatry and Clinical Epidemiology and Biostatistics, McMaster University; Department of Psychiatry, University of Toronto
- Helen-Maria Vasiliadis, MSc. PhD, Department of Community Health Sciences, Faculty of Medicine and Health Sciences, Sherbrooke University
- Charlotte Waddell, MSc. MD CCFP FRCPC, Director, Children's Health Policy Centre, Simon Fraser University
- Samantha Yamada, PhD C Psych, Child Development Institute, York University

Table of Contents

ACKNOWLEDGEMENTS	3
INTRODUCTION	8
CANADA'S MENTAL HEALTH AND ADDICTIONS CONTEXT	10
HOW THIS DOCUMENT WAS DEVELOPED	11
MAKING THE CASE FOR A FRAMEWORK	12
KEY STEPS IN FRAMEWORK DEVELOPMENT	15
1. <i>Recognize and acknowledge key issues</i>	16
2. <i>Cultivate shared language and a common understanding of key concepts</i>	18
3. <i>Define the overall scope of performance measurement</i>	21
4. <i>Define the framework's key dimensions and domains</i>	26
5. <i>Select indicators</i>	29
KEY INSIGHTS ABOUT SYSTEMIC ENGAGEMENT AND CONSULTATION PROCESSES	31
GETTING FROM FRAMEWORK TO SYSTEM	34
THINKING BIG, STARTING SMALL, ACTING NOW	36
REFERENCES	38
APPENDIX A: DETAILED METHODS AND MATERIALS	44
APPENDIX B: DEFINITIONS – ADDITIONAL DETAIL	49
APPENDIX C: MENTAL HEALTH AND ADDICTIONS PERFORMANCE MEASUREMENT FRAMEWORKS	52
APPENDIX D: PROVINCIAL AND TERRITORIAL INDICATOR SELECTION PROCESSES AND CRITERIA	56
APPENDIX E: LIST OF ADDITIONAL RESOURCES	59

Executive Summary

Over the last few decades, more and more countries have come to recognize the immense impact of mental health problems and illnesses — including addiction — on individuals, families and communities. This has driven changes to policy and practice in Canada and other jurisdictions. It has also triggered calls for better data to determine if such steps are having a positive impact and to inform further system change.

This report identifies strategic areas of focus for developing a pan-Canadian information and performance measurement framework specific to mental health and addiction (MHA). Such a framework could be parlayed into a performance measurement *system* that would make it possible to measure and report on MHA outcomes across the country — stimulating data-informed service change, enabling greater collaboration and making a difference in the lives of Canadians from coast to coast to coast.

The Mental Health Commission of Canada (MHCC) initiated the project that led to this report with four main goals:

1. systematically compile resources to support the development of a pan-Canadian, system-level performance measurement framework for MHA
2. map common policy priorities across provinces and territories
3. learn from existing performance measurement frameworks and related development processes
4. formulate recommendations for an engagement and consultation process to drive framework development

Making the case for a framework

A pan-Canadian MHA framework would help focus performance measurement on aspects of Canada’s complex system that are key to effecting change. It would articulate a “system” vision that, ideally, aligns with common policy directions and shared stakeholder values — increasing the likelihood of impact. It would also help ensure balance across sets of indicators, protect against unintended effects,²⁷⁻²⁹ clarify relationships among indicators and reveal gaps (i.e., where indicator development is needed).⁵ It would be designed to complement, rather than duplicate, existing and planned provincial/territorial performance measurement initiatives.

The full benefits of a *framework* could be realized through a pan-Canadian performance measurement *system* with the capacity to compile and report on common system-level measures and with a forum for sharing improvement practices and solutions across jurisdictions. There are reasons to be optimistic this vision can be realized, including the fact that other federations around the world have established national, system-level MHA performance measurement initiatives. There is also a strong Canadian example in the pan-Canadian performance measurement framework of the Canadian Partnership Against Cancer (CPAC), which includes mechanisms for reporting and collaborative improvement.

This report provides insight into the five key steps involved in developing a performance measurement framework as follows:

1. Recognize and acknowledge key issues

To develop a consensus-based system-level framework across 13 jurisdictions and in collaboration with key national-level stakeholder organizations would be a complex undertaking complicated by differing values. It will be important to identify and address key issues and concerns inherent to performance measurement early in the process. These include determining the ultimate purpose of performance measurement, whose performance will be measured, whether comparisons will take local conditions into account and if there is sufficient capacity to generate quality measures and support action on findings.

2. Cultivate shared language and understanding of key concepts

A critical starting point is to establish shared understanding of key terms and concepts.³⁶ This is especially important in Canada due to the complexity of the Canadian context. While a pan-Canadian performance measurement framework would not require partners to have the same service models or approaches, shared understanding would facilitate consensus on the framework's main features. Establishing shared principles and values is also important. The research team assembled an initial set of concepts as a starting point, but stakeholders must be able to suggest additional concepts, frameworks and world views — especially those whose views have not been well represented to date in work related to performance measurement.

3. Define the overall scope of performance measurement

Scope refers to the breadth of services/interventions, levels of service and service recipient populations covered by the framework. The framework should be reasonably aligned with the parameters of the MHA service system model, but there may be good reasons for its scope to be developed in stages,^{e.g.,60} or even to have separate but related performance measurement frameworks for service components or special service populations. The important thing is that decisions about scope (and the costs and benefits of those decisions) be explicit.

The provincial/territorial policy documents reviewed for this report had broad predominantly models that included the social determinants of health as well as a full continuum of interventions. Twelve of the 13 policy documents included substance-related problems/addiction, which subject-matter experts (SMEs) agreed would be important in a pan-Canadian PM framework. Special consideration of populations including children and youth and Indigenous peoples were viewed as important as well, as was honouring Indigenous stakeholders' values, principles and data standards.

4. Define the framework's key dimensions and domains

The literature is unequivocal that performance measurement frameworks and indicators should relate back to strategy aims.⁵ Provincial and territorial policy priorities — especially those held in common — offer key information for framework development. The top five policy priorities in common across provinces and territories identified through the research described in this report were access, promotion/prevention, children and youth, person-centred care, and Indigenous peoples.

Notably, some SMEs felt reviewing past frameworks could result in a backward-looking pan-Canadian framework. It will be important to look ahead to build progressive frameworks with forward-looking indicators. SMEs also noted it will be important and desirable for stakeholders, in particular Indigenous and other equity-seeking groups, to lead the aspects of the work that relate to their communities.

5. Select indicators

Four general approaches to choosing performance measurement indicators emerged from the literature: simple selection by a project team, selection by an expert panel, systematic ranking approaches (e.g., Delphi methods) by experts or broader stakeholders and approaches like care mapping/concept mapping. There is wide variability in indicator selection processes across Canada, from gradual, informal operational processes to expert panel/research team processes, to formal processes that included local stakeholders engaged via consultation meetings, and further to research-based, multi-stakeholder, multi-stage Delphi rating processes.

SMEs did not consider existing indicators to be sufficiently visionary, arguing that they will only result in “more of the same.” Aspirational indicators that could move the system more quickly in the desired direction are needed, as well as indicators based on the voices of people with lived experience and those that capture information for Indigenous and other equity-seeking groups.

Systematic engagement and consultation processes

The task of developing a pan-Canadian MHA performance measurement framework is value-laden, which creates a divergence of opinions. A systematic and intentional approach is necessary to develop a framework and set of indicators that stakeholders can endorse despite their plurality of views. The process of deliberative dialogue used to create the *Mental Health Strategy for Canada* is an important general model.¹⁴ The research team also found five

specific initiatives that involved and reported on systematic processes for MHA service or performance measurement frameworks, which can inform pan-Canadian framework development.

SMEs stressed that engagement must be “meaningful,” which includes a co-designed/participatory process with reflection on and acknowledgement of social-historical context and biases, as well as recognition of who gets to decide and who benefits. This requires time and resources.

Getting from framework to system

Performance measurement has been criticized for stalling at the conceptualization stage.³⁵ The capacity to regularly generate and report on existing indicators, and resources to develop strategic, aspirational indicators are required to realize the ultimate objective — in this case, to improve Canada’s MHA system. While the plurality of data systems across Canada’s makes coherent performance measurement as challenging within this country as it is between countries in other parts of the world, there are exemplary models for a pan-Canadian system. These include CPAC’s Cancer System Performance initiative, which has been reporting by province/territory since 2009, with indicator values available to all stakeholders online. While the cancer field has some distinct advantages that MHA lacks, it is reasonable to aspire to a system with similar features.

Thinking big, starting small, acting now

The resources SMEs compiled for the current project can inform and support a plan for developing a pan-Canadian MHA performance measurement framework. They are grounded in provincial and territorial policy priorities, features of existing frameworks and lessons learned from systematic developmental processes used for framework development in Canada.

While there is substantial diversity among existing performance measurement frameworks, there is also a richness and depth of approaches that, with thoughtful selection, could inform an effective process and a quality outcome for MHA.

In the research team’s view, work should begin immediately on developing a pan-Canadian, policy-driven performance measurement framework with key stakeholders. Once a framework is in place, existing strategic indicators that fit that framework can be selected and critical gaps for immediate indicator development work identified. With the necessary capacity for indicator development and reporting, the production of a first collaborative pan-Canadian report on MHA system performance is an attainable goal. Ideally, this would include capacity for a mechanism that enables logically connected and collaborative activities aimed at system improvement.

Introduction

Over the last few decades, more and more countries have come to recognize the immense impact of mental health problems and illnesses on people, families and communities.¹ This has driven changes to policy and practice in Canada and other jurisdictions — and triggered calls for better data to determine if such efforts are having a positive impact and to inform further system change.

This report identifies strategic areas of focus for developing a pan-Canadian information and performance measurement framework specific to mental health and addiction (MHA).² Such a framework could be parlayed into a performance measurement *system* that would make it possible to measure and report on MHA outcomes across the country. This would stimulate data-informed service change, enable greater collaboration and make a difference in the lives of Canadians from coast to coast to coast.

Moving toward better data

Calls for better data to inform and support system change at all levels go back at least two decades. Organizations such as the Canadian Institute for Health Information (CIHI), the Public Health Agency of Canada (PHAC), the Canadian Centre on Substance Use and Addiction (CCSA), Statistics Canada and provincial and territorial authorities have all undertaken MHA data-related initiatives (which have been documented in detail elsewhere).¹ While this activity has been encouraging, the initiatives themselves have been relatively disconnected.

Changing Directions, Changing Lives: The Mental Health Strategy for Canada (the Strategy) — the first-ever comprehensive pan-Canadian mental health policy document, released in 2012 — spoke to the importance of improving information and measurement for Canada’s mental health care system.² Its recommendations included identifying an initial set of measures to track progress, and developing a framework for reporting on outcomes over the longer term.

The Mental Health Commission of Canada (MHCC) has advanced this agenda incrementally. In 2014, the Commission released *Overview on Mental Health Data in Canada: Background, Needs, and Gaps*.¹ In 2015, it reported on a first set of national-level indicators in *Informing the Future: Mental Health Indicators for Canada*.³ More recently, the MHCC had a supportive role in a proof-of-concept project funded by the Graham Boeckh Foundation. As part of that project, a team of researchers generated six indicators for MHA based on administrative data for five provinces. These indicators were reported out, by province, in the July 2017 *Toward Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces*.⁴

In June 2017, the MHCC started work on the Strategy’s second recommendation. The team began with a review of key barriers earlier work had identified, including:

- lack of a shared conceptual framework to organize such a complex task (which is what prompted the Strategy recommendation in the first place)
- lack of shared understanding about such a relatively abstract and technical topic
- confusion among players about roles and responsibilities for different actions at different levels of the system

¹ Throughout this document, references to mental health and illness are inclusive of substance-related issues, ranging from problem use through misuse, abuse and dependence/addiction. Similarly, mental health and illness services include the full continuum of substance and addiction-related services, even when the latter are not explicitly named. The common acronym “MHA” (for “mental health and addiction”) is used for brevity, but in every instance, this refers to the full spectrum — from wellness to illness — across these traditionally separate areas.

² Where this report mentions an MHA performance measurement framework, it is in reference to a collaborative, system-level pan-Canadian framework designed to complement, rather than duplicate, existing and planned provincial/territorial performance measurement initiatives.

- lack of connection between existing indicators and policy directions

As with policy and services, views diverge over the best course to take for performance measurement. Nevertheless, there are observable areas where MHA stakeholders' values and current performance measurement practices converge. The MHCC sought to identify this common ground as the first step in designing a development process for a pan-Canadian performance measurement framework.

Informing the framework development process

The central aims of the current project were to:

- systematically compile resources that can support development of a pan-Canadian, system-level performance measurement framework for MHA
- map common policy priorities across provinces and territories
- learn from existing performance measurement frameworks and related development processes
- formulate recommendations for an engagement and consultation process for framework development

Advancing the project entailed a review of the current Canadian MHA performance measurement landscape, including comparative analyses of recent provincial and territorial documents relevant to framework development. Selected content from international initiatives and relevant research literature were also used to put findings in a broader context. Relevant performance indicators from all materials were extracted to allow for cataloguing according to framework concept at a later date.

A central premise of this work, consistent with the performance measurement research literature, was that measures should be *strategic* — that is, they should follow *policy priorities*.^{5,6}

About this document

This report presents key findings synthesized from all sources. (Full details for all resources are available separately.) It gives background on Canada's MHA context, briefly describes the methods used to compile and synthesize relevant information, proposes the initial rationale for a pan-Canadian performance measurement framework, and identifies concepts and issues related to developing such a framework.

The report's final section offers thoughts on moving beyond framework development to full performance measurement system, with conclusions based on all information through the project. At the end of each section is a summary of subject-matter expert (SME) perspectives on the ideas just presented, with divergences noted where they occur.

It is important to reiterate that the material herein is meant to *inform* a comprehensive stakeholder consultation process to develop a pan-Canadian framework, rather than *determine* any aspect of the framework.

Canada's mental health and addictions context

Mental health service policy, planning and delivery pose some of the greatest challenges in health and human services. This is because mental health problems and illnesses are themselves complex phenomena, with substantial differences in presentation across the lifespan and cultural contexts.

Issues related to MHA span the full range of acuity, from single episodes to repeated episodes to chronic conditions, and the full range of severity, from minor situational distress to severe, life-threatening illness. Illness can have a substantial impact on functioning and quality of life — and recovery depends on more than just treatment.

Disparities in need and care received

The determinants of MHA are many and diverse. They include social and structural determinants, with health services influencing outcomes only in part. Most concerns related to MHA first appear in childhood and adolescence. Effective prevention and early intervention are extremely important due to the lifelong impact of such conditions. Broader mental health promotion is also a must, as the quality of life and productivity of a society is fundamentally associated with its population's level of mental wellness.

Unlike most other illnesses, with MHA only a proportion of those in need of services are identified as such or seek care.⁷⁻⁹ It has been estimated, for example, that less than one-third of children and youth who need specialized services receive them.⁹ The proportions of people with substance-related issues who seek care and receive *appropriate* care are similarly very low.^{10,11} Indigenous people in particular experience substantial inequities in mental health and wellness, and in access to care that honours Indigenous conceptions of mental health and illness and that is culturally safe.^{8,12,13}

Service delivery in Canada is complex

Provincial and territorial governments are primarily responsible for health and social service delivery in Canada. However, Canada's federal government has an important role in providing services for employees of the RCMP, members of the country's military, federal workers, Indigenous peoples on reserves and people in federal prisons. The Government of Canada also sets critical national direction for policy — for example, ratifying the United Nations *Convention on the Rights of Persons with Disabilities*.¹⁴

Funding comes from all levels of government — directly and indirectly — and from charitable and private providers. Service settings for MHA are also very broad, ranging from land-based approaches³ through to tertiary-level hospital care. The context for this care in Canada is characterized by considerable geographic diversity and increasing demographic diversity: there are profound differences across provinces and territories in population numbers and demographic composition, rural and urban proportions, as well as health issues and healthcare challenges.¹⁵ This complexity creates considerable challenges when it comes to delivering interventions and measuring system performance.⁸

“Broader mental health promotion is a must, as the quality of life and productivity of a society is fundamentally associated with its population's level of mental wellness.”

³ A “land-based approach” is one that reflects an Indigenous understanding of the world — in this context, the connectedness of land and water with human health and wellbeing. This concept underpins First Nations, Métis and Inuit conceptions of mental health and wellness.

Improvement is on the agenda

Despite the challenges associated with the complexity of service delivery in Canada, there are some promising developments in the field. There has been remarkable growth in the number of new and enhanced effective treatments, service innovations and collaborative models that could substantially improve outcomes.

Mental health and addiction has also become a policy priority at the federal level. Public support for MHA as a federal policy priority is above 80 percent.¹⁷ This has led to additional funding as well as a commitment by all levels of government to improve access to MHA services, outlined in the *Common Statement of Principles on Shared Health Priorities* of August 2017.¹⁶ This commitment includes reporting on the outcomes of new investments. CIHI is currently leading a consultation process to select three to five indicators of improved access to care.

How this document was developed

The research team used a range of methods to compile and synthesize national, provincial/territorial and international information relevant to MHA policy and performance measurement.

Gathering the initial materials

The project primarily targeted current MHA policy documents, as well as provincial and territorial performance measurement frameworks related to MHA. Systematic search processes with standard terms elicited 139 initial documents, validated by SMEs and policymakers from MHCC's Provincial and Territorial Advisory Group.

Searches of 11 organizations' websites garnered national materials. International web searches where researchers knew relevant work has been done yielded 21 additional documents from six countries. Adapted rapid review methods were used to update the very recent performance measurement research literature (N = 56 articles, 75 percent dating from 2010 to present).¹⁸

Selecting policy documents and frameworks for mapping

The research team determined through consensus which policy documents and frameworks should be included in the mapping process: 19 provincial/territorial policy documents and 10 provincial/territorial frameworks (including two still in development) emerged. Given the relatively small number of frameworks found, the definition of "framework" the research team used was very liberal.

The team used content analyses to identify priority themes in current provincial and territorial MHA policy documents. Coding was validated for the two policy documents that were most challenging to code, and agreement was found to be very good. However, variability in length, format and terms usage means these findings should be treated as overall patterns rather than precise or definitive results.

Performance measurement framework details were tabled more directly. Where present, indicators (both in use and aspirational) or indicator-related concepts were extracted and listed. Duplicates were removed and an initial classification was applied. The indicators represent a resource for reference for future performance measurement development. Findings were written into a draft report.

Soliciting feedback

Twenty SMEs provided feedback on the draft report. These experts were selected to represent the top nine provincial/territorial policy priority areas. They were also chosen for their expertise in MHA services and performance measurement, and included people with lived experience and/or their family members. SMEs suggested 68 additional indicators or priority areas for indicator development, along with 26 additional documents.

The research team synthesized the information across all sources and presented the findings in this report as they relate to what the literature describes as major conceptual components of MHA performance measurement framework development. The full details of methods and lists of materials can be found in Appendix A. More detailed resources are available separately.

Making the case for a framework

Better data on Canadians' MHA status and needs, the services they receive and outcomes they experience could guide significant improvements to Canada's MHA services and systems. That potential makes it worthwhile to pursue the development of a collaborative, system-level pan-Canadian MHA performance measurement framework despite challenges such as service complexity, fragmented service delivery, data silos and other issues.

Recognizing the challenges

Service delivery in Canada remains quite fragmented across settings. As well, it is rare — even within a single province, territory or health region — for data collection systems to be integrated, which prohibits the description of service users' full care journeys. Processes for accessing and reporting from existing data systems can be technically complex and expensive, as can those generating primary data in service settings. That said, population-level survey work (such as through the Canadian Community Health Survey [CCHS]) has helped provide “the big picture.”

It has been pointed out repeatedly that there is no one organization responsible for MHA information and performance measurement in Canada.¹ There is also considerable confusion and conflation of closely related but distinct performance measurement concepts and approaches even among those directly involved in the work. Practically speaking, the ultimate aim of performance measurement is to track progress toward service and system improvement to inform future action — and a growing body of research and practice literature has documented the positive impacts of performance measurement systems on services when properly conceptualized, designed and evaluated.^{8,19}

“The ultimate aim of performance measurement is to track progress toward service and system improvement to inform future action.”

The complexity of Canada's MHA context is one reason why developing a consensus performance measurement framework will be challenging — but it is also an important reason why such a framework is needed. Relying on a haphazard approach can be wasteful at best and harmful at worst.¹⁹

Performance measurement best practices

One longstanding performance measurement approach, driven by the desire for immediate reporting, is to catalogue lists of potentially relevant indicators and select those that can be generated from existing data sources (a feasibility criterion). While it is often acknowledged that aspirational indicators should be developed, the process frequently stalls there.

This “availability” approach has resulted in sets of measures that are backward-looking (in that they reflect what has already happened) and narrowly focused.^{20,21} Most reporting in MHA has reflected the more formal and acute components of the healthcare delivery system. It has also focused on services for adults (rather than community-based services for all ages, including family practices),^{8,21} where most of the care is provided and most of the policy direction is focused.

Using lists of existing indicators as a starting point is also increasingly impractical. There are now thousands of health and MHA indicators,^{5,6,19,22-26} a circumstance characterized as “indicator chaos.”²⁶ It has become nearly impossible to choose indicators for performance measurement without using a coherent conceptual measurement framework to substantially narrow the field.^{5,6}

The promise of pan-Canadian framework

A pan-Canadian MHA performance measurement framework would make it possible to define the scope for measuring aspects within Canada’s complex system that are important for effecting change. It would articulate a “system” vision that, ideally, aligns with common policy directions and shared stakeholder values, increasing the likelihood of impact. It would also help ensure balance across sets of indicators, protect against unintended effects,²⁷⁻²⁹ clarify relationships among indicators and reveal gaps (i.e., where indicator development is needed).⁵

Such a framework could also help identify complementary roles and responsibilities among partners for developing and generating indicators. This would be beneficial in an environment where several pan-Canadian organizations have some responsibility for MHA data and information, but no one organization has the sole leading role.¹

The capacity among provinces and territories for MHA performance measurement varies widely. Some jurisdictions are developing full systems for this purpose; others have not yet started. Overall, technical capacity (both subject matter and measurement expertise) is quite scarce in Canada, which adds to the importance of sharing expertise to help advance learning and reduce duplication.

Agreement on common indicators would allow for benchmarking — and further elevate MHA as an important national policy focus. A performance measurement framework could also point to areas for provincial/territorial data system and measures development such as patient experience and patient-reported outcomes.³⁰

The benefits could very well offset the costs if such a framework reflected the common policy directions of provincial and territorial governments, complemented existing jurisdictional performance measurement approaches, fostered sharing of technical capacity and best/promising performance measurement practices, and enabled service system improvement.

“The benefits could very well offset the costs if such a framework reflected the common policy directions of provincial and territorial governments, complemented existing jurisdictional performance measurement approaches, fostered sharing of technical capacity and best/promising performance measurement practices, and enabled service system improvement.”

Realizing the vision

Some may wonder if the vision is attainable: to develop a pan-Canadian performance measurement system with the capacity to compile and report on common system-level measures, and with a forum for sharing improvement practices and solutions across jurisdictions. Today, most MHA services are delivered under the authority of the 13 provincial and territorial governments, meaning most activities related to performance measurement belong under the same authorities.

Some countries, however — including federations like Canada — have established national, system-level MHA performance measurement initiatives.^{e.g.,31,32} In Canada, the Canadian Partnership Against Cancer (CPAC) has successfully engaged multiple stakeholders in developing a pan-Canadian performance measurement framework and system for reporting and collaborative improvement that can serve as a model.³³

There are other reasons to be optimistic:

- *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* — which was influenced by and has influenced provincial and territorial mental health policies and practices¹⁴ — generated an admirable level of consensus among MHA stakeholders.
- It is possible for provinces and territories to report out several of the indicators identified in the MHCC’s *Informing the Future: Mental Health Indicators for Canada*.

- The selection of access indicators as part of *A Common Statement of Principles on Shared Health Priorities*, led by CIHI, has stimulated momentum and set the stage for more comprehensive work.
- Provincial and territorial governments have expressed explicit commitments to monitor and report on progress and outcomes in virtually all current MHA policy documents.

One example of a provincial commitment is the Government of Saskatchewan’s *Working Together for Change* action plan, which includes the goal: “Measure and publicly report on quality, progress and outcomes as part of being accountable for ongoing change. People with lived experience and their families want to see improvements to the system. They need to see results, to ensure the system is working for them.”³⁴

“People with lived experience and their families want to see improvements to the system. They need to see results, to ensure the system is working for them.”

— From Saskatchewan’s *Working Together for Change*³⁴

The starting point for a Canadian framework

The ultimate benefit of a pan-Canadian MHA performance measurement framework — and, ideally, system — would be for all stakeholders to have a shared understanding of key concepts related to performance measurement frameworks in MHA services.

Drawing from the relevant performance measurement literature, we offer the following as an *initial* and *minimal* description of what a pan-Canadian MHA framework and system could look like:

- The framework would define the scope of measurement and priority areas for measurement, and:
 - organize a set of existing and aspirational indicators and explain their relationships to each other and with intended system outcomes, and ensure balance across multiple priority areas
 - spell out which indicators are most desirable and suitable for pan-Canadian measurement, and which are more suitable for local collection and reporting (aiming for complementarity wherever possible)
 - define partners’ roles and responsibilities for oversight and generation of specific indicators or types of indicators
- The system would add collaborative capacity for compiling and reporting on the indicators:
 - Data would come from multiple sources including aggregated provincial/territorial data submitted according to common definitions and/or data from national surveys (which could be reported out by provinces and territories, and, potentially, by region).
 - The audiences for these reports would be people with lived experience and their families, service providers, service system planners, policymakers and decisionmakers, and the general public.
 - The system would ideally include the capacity for collaborative federal/provincial/territorial discussions about areas for improvement, reviewing relevant evidence and sharing promising practices aimed at improvement.

“The framework/system would not include or collect indicators that relate to local or setting-specific quality improvement processes (e.g., rare inpatient safety incidents).”

The framework/system would *not* include or collect indicators that relate to local or setting-specific quality improvement processes (e.g., rare inpatient safety incidents). As well, it would *not* be a single, physical information system that extends from the local system on up, across jurisdictions, and collects or stores primary data from individual service users.

EXPERT PERSPECTIVES

Resources for Developing a Mental Health and Addiction Performance Measurement Framework for Canada was informed by more than 20 SMEs, who brought sometimes divergent views to the material. Their perspectives are shared in boxes like this one — titled *Expert Perspectives* — at the end of each core section of the document.

On making the case for a pan-Canadian information and performance measurement framework for MHA, SME perspectives were as follows:

- There was general concurrence on the value of a pan-Canadian framework. Only one SME argued work should focus on indicator development without a guiding framework.
- SMEs agreed the ultimate aim of performance measurement systems is to realize improvements that yield better outcomes.
- A few SMEs felt a performance measurement framework should be based on population needs in addition to policy priorities, since these may not be entirely aligned.
- Children and youth, Indigenous peoples and substance-related/addiction services were identified as critical areas for consideration in framework development.
- Several SMEs underscored the need to consider equity and equity-seeking groups.
- SMEs expressed a general fatigue associated with the many initiatives over the years that have not produced the desired aim or been able to parlay commitment to measurement into an adequate measurement strategy.
- The complexity of Canada's MHA system is not necessarily the principal barrier to a pan-Canadian system. It may have more to do with performance measurement not being a high priority for investment.

Key steps in framework development

Performance measurement literature offers guidance on six key steps to follow in developing a performance measurement framework.⁵ Those steps are as follows:

1. Recognize and acknowledge key issues.
2. Cultivate shared language and a common understanding of key concepts.
3. Define the overall scope of performance measurement.
4. Define the framework's key dimensions and domains.
5. Select indicators.
6. Systematically engage and consult with stakeholders. (Findings related to this step are covered in the next core section of this report.)

The literature is clear that having a plan and having capacity to act on performance measurement findings are both essential to changing processes and outcomes positively. Technical capacity to generate and report on indicators, capacity to interpret the findings (subject-matter expertise), and capacity to support policy and practice in improving performance are all vital. With all of these capacities in place, a developed MHA performance measurement framework could become a fully realized MHA performance measurement *system*. The final section of this document summarizes findings and advice related to this transition from framework to system.

1. Recognize and acknowledge key issues

Developing a consensus-based system-level framework across 13 jurisdictions and in collaboration with key national-level stakeholder organizations would be a complex undertaking complicated by differing values. Key issues and concerns inherent to performance measurement would need to be identified and addressed early in the process. Some of the issues and questions that may come up are presented here with the research team's initial thoughts.

What is the ultimate purpose of performance measurement?

It is widely agreed that performance measurement is important for informing improvement in a whole range of human endeavours, including health and social services. Evidence that performance measurement can have the desired effect (if done well) is accumulating. Modern performance measurement has evolved from early approaches based on a “report card” approach to more progressive approaches that engage stakeholders in interpreting the findings and sharing, formulating and implementing solutions. Effective performance measurement involves regular reflection on purpose and process, including through formal evaluation, and the flexibility to respond to emerging issues.

“Effective performance measurement involves regular reflection on purpose and process, including through formal evaluation, and the flexibility to respond to emerging issues.”

It is important to note that performance measurement can have unintended effects if poorly implemented, including diversion of public resources from other important investments and even diversion of attention from important policy or practice issues.²⁷⁻²⁹ Performance measurement is also neither the only tool for improving services nor are quantitative measures the only source of information for informing policy or practice. Other forms of knowledge and other types of data are essential for interpreting indicator values in context and for finding solutions.

Whose performance will be measured?

MHA has gone from being seen as a health-system responsibility to a societal one in recent years: it is all of our responsibility. A pan-Canadian framework for information and performance measurement should illuminate the effectiveness of the MHCC and its national partners in shifting policy, of governments in reforming delivery systems, and of advocacy groups, the community and individuals in changing attitudes and supporting those in need.

The framework should help us determine how we are doing as a society and a country in this essential realm of human health. This has implications for the overall orientation to framework development as well as its scope.

Will comparisons be fair and take local conditions into account?

All indicators will be influenced by factors that go far beyond the health service or intervention of focus, such as urban and rural contexts, social and physical environments, population demographics (including culture and language differences) and socioeconomic differences. Indicators should be interpreted as pointers for where further analysis and discussion are needed — as jumping-off points for conversation and more in-depth examination of underlying issues.

While statistical tools such as risk adjustment attempt to parse out jurisdictional differences across indicators, they are imperfect and sometimes misleading.⁸ Instead of attempting to artificially “correct” for these differences, it is often more helpful to try to understand those that are most significant and invest energy in finding ways of solving the indicated healthcare issues that consider those differences in context.

Will there be sufficient capacity to generate quality measures and support action based on findings?

This is an essential question. It has been pointed out repeatedly that there is no organization with the *singular* responsibility, mandate or resources for mental health information and performance measurement in Canada at either the national or provincial level. Ontario's *The Road to Demonstrating Our Success: A Proposal to Develop a Comprehensive Data and Performance Measurement Strategy for the Mental Health and Addictions System in Ontario*

underscores the importance of sustainable capacity for this purpose.⁵³ No other province or territory has likewise publicly proposed raising capacity to collect and report on MHA indicators, or funded any initiatives to that end.

Core approaches for performance measurement systems in health care

The following suggested approaches generally relevant to a system-level performance measurement framework were compiled from 17 foundational articles on performance measurement in health care:³⁵

- ensure leadership and commitment of senior decisionmakers
- take a systems approach, including consideration of organizational and contextual issues
- maintain a positive, constructive, solution-focused orientation — not a blaming approach
- use performance indicators as flags to identify areas for improvement, not as absolute measures of performance
- commit to performance measurement as a long-term/routine endeavour
- resource performance measurement appropriately; ensure that the appropriate technical and managerial expertise and adequate funds are available
- foster continuous, open communication with emphasis on interpretation of findings, avoiding simplistic explanations
- encourage ownership of performance measurement through collaborative, participatory approaches
- consider all stakeholders' perspectives
- plan for performance *management*, not just measurement, i.e., ensure that mechanisms are in place to use results

EXPERT PERSPECTIVES

There are unquestionably many other issues to identify and discuss in a pan-Canadian performance measurement framework development process. The SMEs who informed the project contributed the following for further discussion:

- How and by whom will framework development be led?
- How will lead organizations work collaboratively with provinces and territories and other national organizations?
- Who will fund framework development? Who will fund a full system?
- Who will benefit most and least from a system?
- How will the system justify diversion of resources from direct service delivery?
- How will buy-in be achieved among those who collect data, including provincial, territorial and more local stakeholders?
- Who will own the information collection and reporting process?
- How will community oversight and peer review be incorporated?
- How will quality of work be assured?
- How will stakeholders overcome fatigue brought on by the failure of so many past projects to meet expectations?

2. Cultivate shared language and a common understanding of key concepts

A critical starting point in performance measurement framework development is establishing a shared understanding of key concepts.³⁶ This step is especially important here due to the complexity of the Canadian context and the task itself.

Table 1 contains a non-exhaustive list of terms that should be understood in a common, agreed-upon way as part of a framework. This list is based on the research team’s review and SME input. The included terms fall into three categories: 1) terms related to conditions of concern, 2) terms related to the systems or services aimed at their amelioration and 3) terms related to performance management. Full consensus on every term would not be necessary for framework development.

A pan-Canadian framework would not require partners to have service models or approaches in common — only a shared understanding of terms used to come to consensus on its main features.

Table 1: Terms related to MHA performance measurement for which shared understanding could benefit framework development

Related to status or condition	Related to MHA system/service models	Related to performance measurement
<ul style="list-style-type: none"> • Mental health • Mental illness • Substance-related problems • Addiction • Wellness • Flourishing • Languishing • Recovery • Resilience 	<ul style="list-style-type: none"> • Mental health system • Substance-related/addiction service system • Integrated systems • Continuums of care • Core services • Wrap-around care • Pyramid of care model • Stepped care models • Cascading model • Hub model • Network model • Evergreen framework for children and youth • Tiered model (promotion/prevention) • Population/public health model 	<ul style="list-style-type: none"> • Information • Performance measure • Indicator • Performance measurement framework • Performance measurement system • Quality

Definitions, either explicit or implied, were extracted from reviewed materials and are briefly discussed here. A more detailed discussion of definitions, including schematics for definitions and service models, has been compiled as a separate resource.

Definitions of health statuses and conditions of interest

The World Health Organization’s (WHO’s) definitions of mental health and mental illness (disorders)^{37,38} are frequently cited but not universally favoured. PHAC has also provided definitions for positive mental health and mental illness.³⁹ Canada’s First Nations peoples have offered valuable perspectives on mental wellness through the First Nations Mental Wellness Continuum Framework,⁴⁰ and other Indigenous groups also have unique conceptualizations of health.⁴¹⁻⁴⁴

Corey Keyes’ two continua model of mental health and illness, which posits that mental health and mental illness are separate, independent phenomena that can have different trajectories for a given individual over his or her lifetime,

is also widely regarded as a helpful concept.^{45,46} It has been further elaborated in the Canadian context to include recovery and well-being,⁴⁷ which have been operationalized in MHCC's *Guidelines for Recovery-Oriented Practice*.⁴⁸

Formal medical systems for classifying mental illness (i.e., *the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* [DSM-5]) and the WHO definitions have included substance-related problems and addiction for many years.⁴⁹ These conditions are now also commonly included in recommendations for progressive practice, current provincial and territorial MHA policies and other mental health policy approaches.

Definitions of MHA system and service models

The WHO defines mental health systems as “all the activities whose primary purpose is to promote, restore or maintain mental health.”⁵⁰ The WHO has also developed approaches for defining systems based on structural elements (separately for mental health service systems and substance use and addiction treatment systems).^{51,52}

The 2006 Canadian Standing Senate Committee report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* did not define the mental health system specifically, instead underscoring that there really is no “system.”⁵³ The report promoted a population-health approach that took into account the social determinants of mental health, and a broad continuum of care model that included housing, work and related supports.

Since that report, a range of common models (listed in the middle column of Table 1) have been described and used with a clear trend toward broader, population-health models.⁵⁴ For example, the Evergreen Framework for child and youth mental health, which the MHCC tabled in 2010,⁵⁵ emphasizes promotion, prevention and social determinants of health as important parts of the system. Tiered approaches, which are needs-based population health approaches,⁵⁶ have gained favour more recently. These newer models take a conceptual approach in addition to a structural one, which can be helpful when considering an MHA performance measurement framework.

When cross-mapping provincial and territorial policy documents for the current project, the research team found wide variability in the terms and concepts used to discuss mental health systems. Only Prince Edward Island provided a specific definition of the mental health system for the purposes of its 2016–26 MHA strategy, *Moving Forward Together*. That document describes a mental health system as comprising “all involved and connected to the delivery of mental health programs and services. It includes multiple government departments, agencies and community organizations.”⁵⁷

Regarding service models, there was little consistency in the terms used across provinces and territories, with a few each referring to the various terms listed in Table 1. Despite this variation in specific terms, there are clear trends toward service models that specify appropriate levels of services according to need and broader models that extend beyond the boundaries of formal health services systems.

Definitions of terms related to performance measurement

There is a fairly mindboggling variance in usage of terms related to performance measurement across the research and practice literatures. Hundreds of definitions can be found.⁵ A few examples are offered to spark dialogue. The intent is not to find perfect definitions but rather to facilitate shared understanding of concepts central to an MHA performance measurement framework.

Since **performance measurement framework** is the most central concept to this work, three definitions found in sourced materials are included below:

- “... a basic conceptual structure which would ordinarily have several domains/dimensions; a valuable tool for conceptualizing and categorizing indicators, to ensure balance across a set of indicators, and for planning the measurement process.”⁵

- “The process of designing a performance measurement system starts with the development of a conceptual model. This is done to identify, organize, and ensure a shared understanding of all of the elements that comprise care quality. The idea is that, by starting with theory, we ensure that the final set of indicators all tap an element of performance (i.e., an aspect of services that is linked to desired outcomes), that all areas of performance are covered, and that some areas of performance are not unduly prioritized to the neglect of others. Deriving and working from a conceptual model also helps to clarify expectations among stakeholders (including the service providers who are being asked to report on their performance, as well as the people who use these services), and facilitates the identification of system supports that need to be in place. It avoids the specification of indicators solely because of feasibility or availability (although these are, of course, still important considerations during indicator selection).”³⁶
- “Indicators are often presented as part of a larger framework. Beyond providing a means of organization, frameworks have the advantage of ensuring that all relevant aspects of a given issue are covered. At the broadest level of a health indicator framework, domains typically represent the main dimensions or categories of health and the factors or health-related behaviours that influence health. For example, health can encompass physical and emotional aspects, and can be strongly affected by a person’s social connections and economic circumstances. Each of these can be represented by a domain and taken together they should provide a relatively complete depiction of the health of the population.”⁵⁹

Authors in the field also emphasize that a performance measurement framework should reflect the real world, be coherent and easy to use, and have a clear connection between measures and intended outcomes (i.e., be a logic-model based).⁵

Performance measures are characterized as being chosen or designed to show change in response to a policy, service system or program intervention.^{5,35} Since it is not practical or feasible to measure most complex performance phenomena directly, the measures are usually called **indicators**. This is because, especially at the system level, they can usually only point to areas for improvement but cannot be considered to be comprehensively or definitively measuring performance.^{5,35} Values usually require more scrutiny to understand underlying reasons in context. For example, values for a service wait time indicator may grow due to more people seeking care, provider shortages, or existing clients with higher needs requiring longer duration of service. A combination of such factors is usually behind the values for any given indicator.

MHA information is a broader term that could encompass many types of data for purposes beyond performance measurement.¹ For example, rates of common disorders, counts of hospital beds and numbers of mental health professionals are often tracked and reported by many jurisdictions, but these types of descriptive data are often not considered sufficient for performance measurement unless they reflect an explicit strategic objective. Descriptive information is often provided as part of a monitoring system (e.g., the tracking of adverse drug reactions in a pharmaceutical post-marketing surveillance system). Such uses are important, and they might be included as part of a broad information and performance measurement framework, but it is helpful to be clear about these sorts of distinctions.

As noted previously, a **performance measurement system** includes not only the framework, but also the infrastructure and processes for producing and reporting on indicators (including development and validation) and, ideally, processes for the collaborative development of strategies for improving services/interventions in the desired direction.

EXPERT PERSPECTIVES

- SMEs generally agreed that shared language and understanding are critical; however, several suggested it is important to come to shared principles and values even *before* shared language.
- SMEs recommended stakeholders should be able to put forth additional concepts, especially those whose views of mental health and illness have not been well represented to date.
- Some suggested that the distinction between mental health and illness is fundamental to discussions about a performance measurement framework.
- SMEs also strongly supported the inclusion of substance-related conditions/addiction in the definition and in the proposed framework. However, Keyes' two continua model was noted by some to be an imperfect fit for substance-related conditions/addiction — though the concept of “recovery” resonates in both fields.
- Several stressed the importance of an equity lens in the work and that the concept of equity should be defined as a first step, and more sophisticated approaches to its measurement should be pursued.^{e.g.,59}
- With respect to systems, SMEs pointed out that provinces and territories currently have collections of services (mostly related to *illness*) that are not yet fully networked, though integration and collaboration are increasingly being sought.
- Regarding terms related to performance management, SMEs suggested additional distinctions be made between terms like “performance measures” and “quality measures.”
- SMEs recommended further discussions on the nuances among the ideas of measuring systems, measuring system *performance* and measuring system *transformation*.
- Broader population/public-health thinking was noted as the appropriate breadth for a pan-Canadian framework.

3. Define the overall scope of performance measurement

Defining the scope of mental health performance measurement is an important early step in framework development. Put simply, this process involves making decisions about what is “in” and what is “out.” Scope refers to the breadth of services/interventions to be covered (horizontal scope), levels of service to be covered (vertical scope), as well as which service recipient populations are covered.

The performance measurement framework should have reasonable alignment with the parameters of the MHA service system model for balance, but there may be good reasons for the framework's scope to be developed in stages,^{e.g.,60} or even to have separate but related performance measurement frameworks for service components or special service populations. The important thing is that decisions about scope (and the costs and benefits of those decisions) be explicit. Another issue related to scope is the time frame of both measurement and expected impact (temporal scope).

Vertical, horizontal and temporal scopes

With respect to vertical scope, five service levels have been defined: individual, program, service, system and population. Some models include only three: individual, service and system. Many related but distinct approaches to performance measurement can be taken at each of these levels. For example, specific measures of performance can be used to evaluate individual services, or specific rates of adverse safety events can be tracked for a specialized hospital unit.

These types of measures are important for local quality improvement but do not usually make very good system-level indicators. Measures generated at more local service levels can sometimes be rolled up for higher-level reporting, but this is not usually the case. Ideally, measurement at higher levels complements measurement at lower levels.

“The important thing is that decisions about scope and the costs and benefits of those decisions be explicit.”

Getting clarity and agreement on which indicators are of interest for comparison across jurisdictions and which are better left to within-jurisdiction work is an essential exercise in framework development. One downside of system-/population-level measurement is that it can be more difficult to contribute indicator results to changes made at other levels.

Schematics that address these key elements can be very helpful organizing tools. The Matrix Model,⁶¹ shown in Figure 1, is a commonly cited simple service model that is easily adaptable to performance measurement and illustrates the concept of levels. It also includes the classic “structure, process, outcome” typology proposed by Avedis Donabedian, who is considered the father of healthcare quality.

As highlighted in Figure 1, a pan-Canadian performance measurement framework would by necessity address the system and/or population levels.

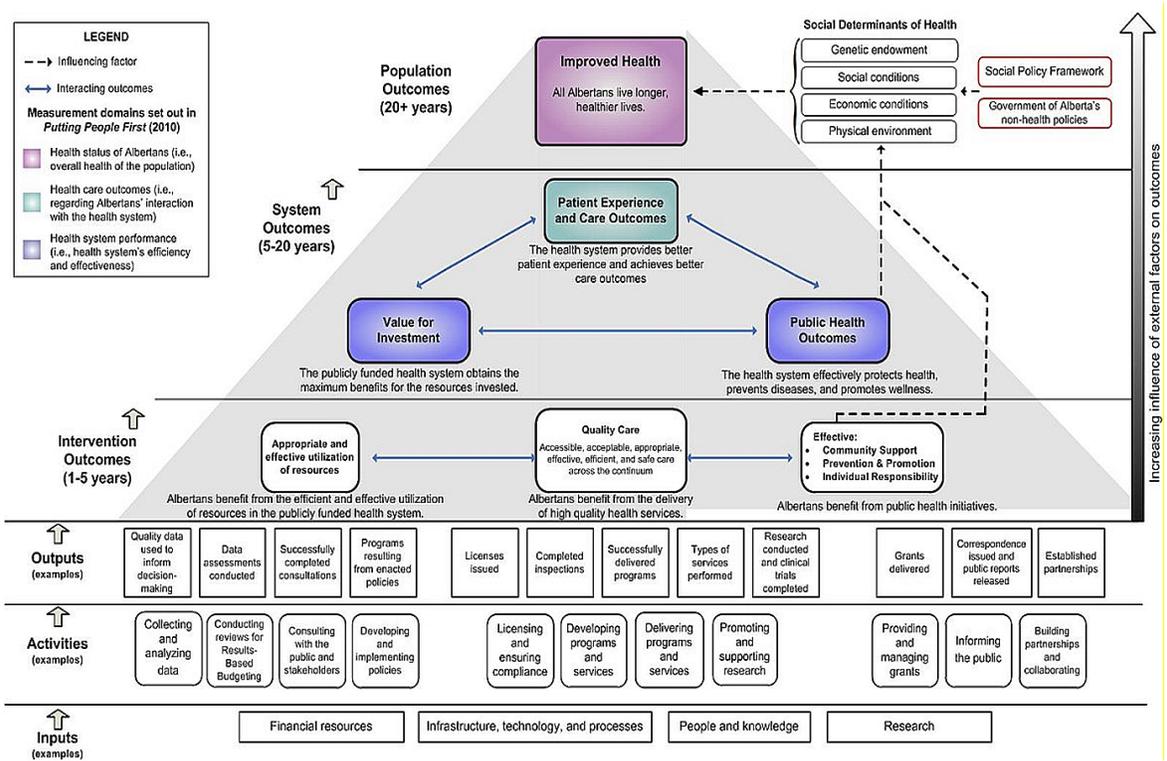
Figure 1: The matrix model as an illustration of performance measurement levels

Level	Structure	Process	Outcomes
System/population	# of specific types of evidence-based services per unit population	Reduction in the gap between need in the total population and proportion receiving services	% of persons in the general population reporting good outcomes after treatment
Program/service	% of ideal program elements included in a given program	% of clients seen within a given time period (program-level access)	Change in average quality of life score for all clients served over a given treatment period
Individual	# of clients served (usually broken down by demographic variables)	Time for each client from presentation to first assessment (person-level access)	Quality of life scores for a given client over time in treatment

A comprehensive schematic depicting the whole system and its complexity may assist with discussions of scope. To that end, more complex and general health services models may be worth analyzing. Figure 2 shows an Albertan example of such a schematic (the Northwest Territories has also adopted this model).⁶²

The horizontal scope refers to the breadth of programs and services at each level. In Figure 2, the population level has a broad horizontal scope, as indicated by the inclusion of the social determinants of health. The system level is not as broad because it does not depict the role of other ministries (as would be the case in a whole-of-government approach). This model also includes temporal scope, i.e., timelines for expected outcomes.

Figure 2: The Alberta Health System Outcomes and Measurement Framework



Insights on framework scope

The research team reviewed the provincial and territorial policy documents for content relevant to performance measurement framework scope. Specific terms varied, but most descriptions indicated the scope of interest fell at the broader end of the following continuum:

- health ministries/departments only
- health ministries/departments plus contracted agency services
- health ministries plus selected other ministries (cross-ministry approaches)
- whole of government (“mental health in all” policies; “healthy public policy”)
- Population health models (which include consideration of social determinants of health and address the health issue along its entire spectrum and for the whole population based on need)

There was a clear predominance of broader models that included the social determinants of health as well as the full continuum of interventions from promotion and prevention to specialized and end-of-life care. For example, the Yukon’s *Forward Together* 2016–26 mental wellness strategy, published 2016, describes the territory’s full-service continuum as including promotion, prevention, community development and education, early intervention, assessment and treatment planning, trauma-informed treatment, long-term intensive/residential treatment, after care and recovery, and end-of-life and palliative care.⁶³ Collaborative care models in MHA (e.g., shared care, integrated youth services, justice diversion, housing programs) and the development of comprehensive school-based mental health services were just a few service trends reflected in the policy documents that introduce challenges for service delivery and performance measurement.

With respect to service scope and special populations, there were more substantive findings and comments from SMEs about:

- substance-related problems and addiction services
- children and youth
- Indigenous populations

These will be discussed in a bit more depth here, though the considerations presented apply to other topics in this report as well.

Substance-related problems and addiction services

In October 2008, the CCSA tabled *A Systems Approach to Substance Use in Canada*, a major report that recommended an integrated and holistic continuum of services and supports using a tiered model.⁶⁴ The report included a strong call for performance measurement. The United States Surgeon General's 2016 *Facing Addiction in America* report also underscored the importance of this area of health as well as the importance of a more modern, evidence-informed and comprehensive response.⁶⁵

Services for substance-related problems and addiction are now clearly considered part of provincial and territorial mental health service policies, with 12 of 13 policy documents the research team reviewed either declaring this position directly or making it clear through their discussion of service directions. Nine policy documents explicitly included substance-use problems or addiction in their titles. Provinces and territories are also currently responding to Canada's opioid crisis and preparing for cannabis legalization, so this policy and service area are highly salient.

Substance-use problems and addiction are without question essential for inclusion in a pan-Canadian MHA performance measurement framework, which will require close collaboration with the CCSA and other critical stakeholders.

Children and youth

The Senate report characterizes child and youth mental health services as the "orphan of the orphan."⁵³ Work to monitor child and youth health more broadly and MHA more specifically is ongoing in Canada (e.g., early work in British Columbia, more recent work in the Yukon) and has been made a service priority in some jurisdictions (e.g., Ontario).

The appearance of most MHA-related conditions in early life, the clear associations with early adverse life events and broader social determinants, and the ultimate costs and burden in adult life of failing to respond early are all well documented. Many of these early-life risk conditions are preventable, and experts and the public have been calling for increased emphasis on promotion, prevention and early intervention for both immediate and downstream benefits.

Service systems for children and youth have historically been very different from those for adults and are becoming more so with the emergence of evidence-based parenting, early life, school-based and youth-specific approaches. Performance measurement systems for child and youth MHA-related issues will need to be broad and tap very different types and sources of data. There are also other performance measurement models that can contribute to the performance measurement discussion for children and youth (e.g., the school mental health system model).⁶⁶

A developmental lens and life-course thinking will be essential for performance measurement framework development.

Indigenous peoples

Health and mental health disparities for Indigenous peoples have been well documented worldwide and in Canada. Indigenous organizations in Canada have been calling for better data to document progress toward ending these disparities. The 2015 *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (TRC) includes the following as one of seven health recommendations:⁶⁷

We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

There has been some initial work on Indigenous-related data and indicators, including by Indigenous groups (First Nations, Inuit, Métis), Statistics Canada^{68,69} and researchers.⁴⁴ However, persistent deficiencies in data related to Indigenous peoples in Canada are also well documented.⁷⁰ Progress toward equity in performance measurement will require Indigenous identifiers be included in broader indicators, as well as specific indicators on issues of importance to Indigenous stakeholders.⁷⁰ Innovative community-based data collection methods will also be important to ensure high-quality and appropriate data.^{e.g.,101} Smylie and colleagues summarize critically important data-related issues including “the lack of culturally relevant, consistent and inclusive Indigenous identifiers in source datasets and the need to actively engage Indigenous peoples in meaningful partnerships to govern and manage data that is collected from them.”⁷⁰

The research team’s review of provincial and territorial MHA policy documents revealed Indigenous mental health as one of the top five most frequently included policy priorities (see Table 2 on page 27). There is also some common ground on health priorities expressed by Indigenous organizations. Those in the final TRC report are one example. Another is the list of priorities posted by the National Collaborating Centre for Aboriginal Health (NCCA), which has pillars that address priority issues to which Indigenous values are central, including the social determinants of health; child, youth and family health; diversity (two-spirit health); post-traumatic stress disorder; anxiety and depression; suicide; and land-based healing.⁷¹

In early 2017, the Assembly of First Nations (AFN) published the *First Nations Health Transformation Agenda* to express First Nations priorities in the context of *Health Accord* negotiations.⁷² In a related media statement, AFN Chief Perry Bellegard noted: “We have urgent priorities that need to be addressed, like mental wellness, access to programs and services, and the tragedy of youth suicide.”⁷³ The agenda contains key recommendations related to mental wellness, addiction and First Nations data initiatives, including common indicators on First Nations health outcomes.

Whether MHA indicators for Indigenous peoples would best serve that population as part of a pan-Canadian framework or a separate health framework for Indigenous peoples is up to Indigenous stakeholders and organizations to determine. Some countries, like Australia, have developed separate performance measurement frameworks for advancing the health of Indigenous peoples.⁷⁵ This work is still evolving but may serve as one source of indicators and general lessons for Canada. However, inclusion of Indigenous priority indicators in a pan-Canadian framework could ensure issues of importance to Indigenous peoples have appropriate prominence when it comes to reporting and taking action on the results. The value of conceptual connection of some kind requires thoughtful consideration.

The broader principles of reconciliation provide important guidance for any work in this area going forward. They underscore the need to “listen carefully, challenge old beliefs, and seek new understandings” with an attitude of humility and respect.⁷⁶ Much of what has been discussed in this section is also relevant to broader issues of equity and equity-seeking groups in the context of a pan-Canadian MHA performance measurement framework.

FIRST NATIONS DATA COLLECTION PRINCIPLES

OCAP® — which stands for ownership, control, access and possession — is an important set of standards established and promoted by the First Nations Information Governance Centre (FNIGC). These standards outline how data associated with First Nations peoples should be collected and used.⁷⁴

EXPERT PERSPECTIVES

- SMEs underscored the importance of including substance-related problems and addiction in a pan-Canadian performance measurement framework based on unequivocal service and policy trends.
- SMEs were clear on the importance of special consideration for populations including children/youth and Indigenous peoples.
- For Indigenous peoples, improving services and eliminating health disparities are clearly priorities. It is essential that information from any future MHA performance measurement system be readily available to communities to support planning.
- Honouring Indigenous stakeholders' values, principles and data standards will be an important part of any performance measurement framework development process.
- Several argued for a separate performance measurement framework for children and youth based on the substantive differences between services systems, differences between data sources, and the greater centrality of preventive approaches to children and youth.
- Some SMEs expressed concern that child and youth indicators would not be helpful if lost among those for adults, and that performance measurements efforts that do not highlight this population may perpetuate the "orphan of the orphan" status quo.
- Since many governments have prioritized MHA services for children and youth under 25, some SMEs suggested this population might serve as an appropriate first focus for the development of an MHA performance measurement framework.

4. Define the framework's key dimensions and domains

An important task after making decisions about scope is to set the framework's conceptual parameters — expressed as dimensions and domains. The terms "dimension" and "domain" are frequently used interchangeably in performance measurement research and practice.⁵ For this current project, "dimension" refers to the larger category and "domains" to the groupings under that category.

While systematic processes for selecting indicators are common, this is less true for dimensions and domains. This is true even though the ultimate value of a performance measurement framework depends on agreement about dimensions and domains, as well as articulating the relationships among them.

There are many sources for framework dimensions and domains. They are often simple logical groupings of indicators, particularly when lists of indicators are the starting point for performance measurement or for reporting MHA information more generally (and not necessarily connected to strategic or policy aims). In other cases, they may relate to domains proposed by broader health performance measurement frameworks. For example, Alberta Health Services' *Performance of the Addiction and Mental Health System* report uses the quality domains of the Health Quality Council of Alberta.⁷⁹ Dimensions and domains may also relate back to strategic policy priorities.

"The performance measurement literature is unequivocal that performance measurement frameworks and chosen indicators should relate back to strategy aims."⁵

The performance measurement literature is unequivocal that performance measurement frameworks and chosen indicators should relate back to strategy aims.⁵ For this reason, the research team considered provincial and territorial policy priorities (especially priorities held in common) as key information for framework development. These policies were nearly all based on public consultation processes and so reflect the priorities of citizens in each jurisdiction including people with lived experience and their families. It is important to note, however, that policy priorities *are not a framework in and of themselves*, though they may be useful as "raw material" for discussions about dimensions,

domains and indicators. Instead, these priorities may serve as a check on the degree to which a developed framework connects to policy in a balanced way.

Table 2: Provincial and territorial MHA policy priorities at the macro level

Policy priority (N = 24 priority topics)	# of documents where listed as a macro priority
Access (includes temporal access [time to access, after hours service], availability of the right service and geographic access [distance])	11
Promotion/prevention/early intervention (across the lifespan)	10
Children and youth (including families)	8
Needs-based/person-centred care	8
Indigenous peoples (including cultural safety, culturally appropriate services)	7
Integration/closing care gaps (among directly funded services, e.g., among hospital, primary care and community clinics)	6
Collaboration across boundaries (across separately funded services, e.g., non-governmental organizations and across sectors)	5
Diversity (inclusiveness for all with any type of diversity/equity in all service aspects)	5
Better care effectiveness/quality care/better outcomes	5
Recovery/well-being	4
Knowledge/information/data/measurement	4
High-level leadership/regulations/legislation	4
People with substance-related problems/addiction*	3
Stigma reduction/public education/media	2
Primary care	2
Housing	2
Workforce (innovation/collaboration/training)	2
Innovation via research	2
Persons with disabilities (e.g., developmental disabilities, cognitive impairment, fetal alcohol spectrum disorder, autism brain injury)	1
Seniors	1
Suicide prevention	1
Family involvement/participation	1
Funding reform	1

* Nearly all provincial and territorial documents included substance-related issues/addiction in their overall policy. As such, these issues were treated as overarching in addition to being population-related priorities where mentioned specifically.

Common ground in macro level MHA policy priorities

The research team identified five policy priorities shared by most provinces and territories and an additional four shared by five or more. It is worth noting that the most frequent policy priorities align somewhat with the main strategic directions in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. Those are: promotion/prevention; recovery and rights; access to services; disparities and diversity; First Nations, Inuit and Métis; and leadership and collaboration.²

The team also reviewed 10 provincial/territorial MHA information or performance measurement frameworks for details of scope, domains and dimensions, and developmental processes (see Appendix C for details):

- **Ontario** — three frameworks (two for adults [one of which is in development] and one for children and youth, with data reported out by Health Quality Ontario and the Institute for Clinical Evaluative Sciences [ICES]; the team also looked at another framework being developed by the Ontario Ministry of Health and Long-Term Care’s Mental Health and Addictions Leadership Advisory Committee)⁸⁰⁻⁸²
- **Alberta** — two frameworks (one reporting on mental health services for the past seven years, one in development as part of the new *Valuing Mental Health* provincial policy)^{78,83,85}
- **Quebec** — two reports on MHA-related statistics (one reporting on mental health system attributes, one reporting on findings for Quebecers from the Canadian Community Health Survey [CCHS])^{85,86}
- **British Columbia** — one child and youth mental health framework based on theory and a population-health approach⁸⁷
- **New Brunswick** — one MHA framework developed by the New Brunswick Health Council using a population-health model⁸⁸
- **Newfoundland and Labrador** — a set of hospital and management information system indicators developed by the Newfoundland and Labrador Centre for Health Information (NLCHI)⁸⁹

Framework complexity ranged from simple presentations of indicators in descriptive categories to others with more comprehensive dimensions/domains. Some were quite deeply grounded in research and theory; others were more pragmatic in approach. There were very few concepts in common across the set, with commonly noted concepts in the MHA performance measurement literature such as “outcomes” and “service use” only reflected in three and four of the frameworks, respectively. “Equity” (broadly defined) was a common concept in half of the frameworks, which suggests it is particularly important. Half the frameworks also explicitly included substance-related/addiction issues.

All of the frameworks have unique features that can serve as examples of pan-Canadian work:

- Ontario’s work models innovative use of administrative data sources, a staged approach and identification of important areas for indicator development (aspirational indicators).
- Alberta’s frameworks demonstrate how indicators that emerge from operations can be conceptualized within a broader framework. The province’s recent work on engaging Indigenous groups and values in the indicator selection process can provide important guidance on that front.
- BC’s framework for child and youth mental health is exemplary in connecting concepts to theory and research, incorporating systematic consultation processes and illustrating how a framework can serve to identify important gaps.
- Quebec’s work illustrates how existing datasets can be used creatively for both international and interprovincial comparisons.
- New Brunswick’s work provides a model of how performance measurement concepts can be enriched through dialogue with communities.
- Newfoundland’s work offers an example of health system manager engagement and use of intraprovincial breakdowns.

Commonalities in descriptive information

As a separate exercise, the research team also tabulated descriptive information. This included domains and dimensions from national frameworks (PHAC’s *Positive Mental Health Surveillance Indicator Framework*;⁹⁰ MHCC’s *Informing the Future*)³ as well as more generic frameworks from CIHI⁹¹ and CFHI,⁹² and 11 frameworks from nine countries as well as two international organizations (the International Initiative for Mental Health Leadership [IIMHL] and the Organisation for Economic Co-operation and Development [OECD]). This included both generic and mental

health and/or addiction frameworks. There was also one reporting initiative in the United States led exclusively by an organization representing people with lived experience.⁹³

Here again the research team found very few domains/dimensions or related concepts in common across frameworks. The diversity of domains and dimensions in these broader initiatives, as well as in MHA-specific initiatives outside Canada, is similarly remarkable. As with the provincial and territorial frameworks, approaches that draw from existing data (either administrative or survey sources) naturally group indicators according to content of the available data.

Where broader frameworks are developed in advance of data generation, there are a few dimensions used more frequently. These are service attributes (most commonly grouped under the overarching theme of quality), but there are also dimensions reflecting the types of services (ranging from prevention through to palliative care) and the healthcare needs of the recipient (from healthy through to end of life). Equity is also an important overarching theme in several of these frameworks.

While this variability may initially seem like a barrier to the development of a pan-Canadian MHA performance measurement framework, it can also be seen as a benefit, as it provides a rich set of options for stakeholders to consider.

EXPERT PERSPECTIVES

- Some SMEs felt referring to frameworks developed in the past could result in a backward-looking pan-Canadian framework. It will be important to look ahead to build progressive frameworks with forward-looking indicators.
- Framework comparison could be taken further by evaluating frameworks for desired qualities.
- It may be necessary to go further back and scan more widely to find Indigenous-specific frameworks — and/or to invite Indigenous and other equity-seeking groups to put forth their own frameworks, as well as lead aspects of the work that relate to their communities.
- Shared policy priorities help focus thinking on areas for measurement but should not determine them completely. Other issues should come in, such as need and stakeholder values — for example, the increased need for mental healthcare among seniors due to population demographic shifts despite the relatively lower priority on this group as an overall policy goal.
- An important additional area for measurement “responsiveness,” relating to how health systems anticipate and adapt to changing healthcare needs, was also tabled.⁹⁴
- SMEs suggested another important domain: “the patient-centredness” of services.⁹⁵

5. Select indicators

Four general approaches to indicator selection are noted in the literature:⁹⁶

- simple selection by a project team
- selection by an expert panel
- systematic ranking approaches (e.g., Delphi methods) by experts or broader stakeholders
- approaches like care mapping/concept mapping^{e.g., 97}

Most processes include some criteria to guide indicator selection; these criteria vary widely.⁵ Feasibility (i.e., availability of data) has traditionally been a criterion that often trumps all others, but there are increasing calls to focus on meaningfulness/connection to strategy, alignment with needs and values, and actionability, which often require that new indicators (also referred to as aspirational indicators) be developed. Paying attention to unintended

effects is also recommended.²⁷⁻²⁹ Stakeholder and/or SME involvement according to key domains of interest may also help focus the work, and the meaningful participation of people with lived experience and their families is essential.

Important Indicator characteristics

Indicators are often classified according to other attributes. One prominent method, which originates with Avedis Donabedian, classifies indicators as relating to structure, process or outcomes.⁹⁸ (See Figure 1 on page 21.) Current recommendations call for balance across these types of indicators rather than preference for any one of another.⁹⁹

Another useful characteristic is whether an indicator is “lagging” (i.e., focuses on past occurrences) or “leading” (i.e., focuses on what might happen in the future).¹⁰⁰ A third is interpretability, or that the indicator unambiguously relates to a desired goal.⁵ For its mental health performance measurement framework, New Brunswick grouped indicators by strategic location in the system (similar to levels).⁸⁸ These and other attributes can be used, once a set of indicators has been shortlisted, to assess both utility and balance.

There is a notable shift toward the patient/client perspective in healthcare performance measurement — including the use of indicators based on patient-reported experience measures as well as indicators based on patient-reported outcome measures.³⁰ Patient-experience measures focus on the processes of care (e.g., wait time for treatment, follow-up after care) while patient-reported outcome measures focus more on how the person fares in their life more broadly as a result of care (e.g., reduction in symptoms, daily functioning, quality of life).

“Feasibility (i.e., availability of data) has traditionally been a criterion that often trumps all others, but there are increasing calls to focus on meaningfulness or connection to strategy, alignment with needs and values, and actionability.”⁵

Indicator selection across Canada

The research team compared the 10 provincial and territorial frameworks included in the current project in terms of indicator selection process, selection criteria, and the degree to which performance measurement appears to be connected to policy (see Appendix D).

Here again the team found wide variability. Selection processes ranged from gradual and informal routine operational processes and expert panel/research team-based processes through to informal processes that included local stakeholders engaged via consultation meetings, and further to research-based, multi-stakeholder, multi-stage Delphi rating processes. Selection criteria ranged from none reported to well-rationalized criteria based on theoretical models. Notably, guiding principles were reported as an element in only a couple of processes. A key finding from one process was stakeholder feedback on the need for a more principles-based and inclusive process. The degree of connection to policy also ranged from “no explicit connection” to “connection to general policy directions” and “more intentional and specific alignment with current policy.”

Once again, this diversity of approaches should not incite pessimism about the ability to achieve a pan-Canadian MHA performance measurement framework. Rather, it provides a richness of experience and approaches to inform progressive next steps.

For this current project, the research team decided to focus on the broader approach and postpone indicator list compilation until after gathering initial SME feedback. Separate from the present document, the team compiled an omnibus list of 250 in-use or aspirational indicators that appear in provincial and territorial documents as well as national-level indicators and indicators nominated by SMEs. These were given initial classification by policy priority and other key characteristics to serve as an additional resource for framework development.

EXPERT PERSPECTIVES

- Several SMEs expressed concern that traditional indicators are not visionary, and so would result more of the same. More aspirational indicators could move the system in the desired direction more quickly.
- Moving providers from “process thinking” to “outcomes thinking” is difficult.
- Indicators based on the voices of people with lived experience, including patient-reported outcomes, are considered by many to be more important and necessitate getting beyond administrative data.
- Also important are evidence-based indicators and logic models connecting indicators to their desired effects in the system.
- Indicators for children and youth need to cross sectors — education, public health, health services, etc.
- More indicators that encourage the use of evidence-based or informed practice are needed. These may be in the form of structural indicators (e.g., the number of a particular type of team or program per unit of population).
- SMEs underscored the concern that existing indicators fail to capture information for Indigenous and other equity-seeking groups (including lack of ethnic identifiers), as well as importance of these groups choosing their own culturally specific indicators, and designing and leading their own processes.
- To be useful, indicators must connect to local planning and decision making.
- The potential unintended effects of indicators (e.g., readmission rates can be reduced by incarcerating more people) must be recognized, as must possible cross-sector effects.
- There should be more emphasis on equity and more sophisticated ways to measure equity.
- Systematic processes should be used to select consensus *criteria* for indicator selection — not just to select the indicators themselves.
- One SME noted that it is difficult to get the necessary breadth of perspective with expert panel approaches.
- Delphi methods are the most common way to select indicators, but inclusion of validation phases and an equity lens are recommended.
- Innovative approaches should be considered, including ethnography with member checking, concept mapping, and respondent-driven sampling (for indicator development and data collection).^{e.g., 101}

Key insights about systemic engagement and consultation processes

The task of developing a pan-Canadian MHA performance measurement framework is a deeply value-laden one, which creates a divergence of opinions. Thus, a systematic and intentional approach is necessary to develop a framework and set of indicators that stakeholders can endorse despite their plurality of views.

The process of deliberative dialogue used to create the *Mental Health Strategy for Canada* is an important general model.¹⁴ The research team also found five specific initiatives that involved and reported on systematic processes for

MHA service or performance measurement frameworks, which can inform pan-Canadian framework development. These initiatives are summarized here. Consult the references for more detail.

The Project for Ontario Women’s Health Evidence-Based Report (POWER) Study: Depression Module. (Lin et al. 2009)¹⁰²

This study used a set of evidence-based indicators to examine depression and depression care in Ontario by gender, income, age and region. A technical expert panel selected the indicators, which were modified by Delphi processes. A continuum of care framework identified important and meaningful care issues, and panel members identified the two most critical issues for each of six stages of service based on specific criteria.

The identified issues were used to focus literature reviews for candidate indicators, which were then rated for importance, relevance and feasibility. The indicator list was finalized through a two-step modified Delphi process (an online questionnaire and face-to-face meeting) with explicit criteria. The initial continuum of care framework approach ensured the entire care pathway was represented. While small in number, the final indicators told a complete story.

Quality measures for primary mental healthcare: a multi-stakeholder, multi-jurisdictional Canadian consensus (Waraich et al. 2010)¹⁰³

This project, pan-Canadian in scope, aimed to identify a set of quality measures for primary care settings. A core steering committee of provincial stakeholders, along with CIHI and Health Canada, oversaw the work. More than 800 stakeholders from all provinces and territories and with a range of roles in the system (including First Nations and stakeholders from rural locations) were involved in three stages, including two rounds of a modified Delphi process.

In the first stage, a survey and group discussions were used to select 20 priority domains from 86. These domains were used as the framework. In the second stage, literature reviews and expert nomination were used to identify quality measures for each of the 20 priority domains. About 2,000 unique measures were listed at this stage. In the third stage, the steering committee iteratively selected 160 indicators based on evidence and feasibility criteria to include in the final consensus survey.

In the final survey, relevance, actionability, importance and evidence were used iteratively as selection criteria. Weightings were applied to ensure a balance of stakeholder perspectives. As part of each round, respondents received the results of the previous round (per Delphi methods). The process resulted in a final set of 30 consensus indicators and a total inventory of 160 indicators, available for use at the practice to system levels.

The authors noted a considerable gap between identifying measures and implementing them.

Creating comprehensive children’s mental health indicators for British Columbia (Waddell et al. 2013)⁸⁷

This project aimed to identify indicators for population monitoring of children’s mental health. It began with consultations with policymakers about potential applications for indicators, followed by the development of a conceptual framework to ensure both that relevant aspects of children’s mental health were covered and also that the availability of data did not drive decisions.

Selection guidelines were established based on policymakers’ advice and used a unique, dual-axis approach to consider meaningfulness and actionability from both policy and research perspectives. Once useful indicators were selected, the researchers identified data sources that permitted repeated measurement for all regions of the province and mapped indicators for those data sources were onto the framework. The team then identified gaps in coverage for key framework components and made recommendations for closing them.

The framework resulting from this project is one of the 10 model frameworks identified as part of the current project.

A Child and Youth Mental Health and Addictions Framework for the Yukon (Mulvale et al. 2015)^{104,105}

This project intended to develop a child and youth service framework based on the national Evergreen Framework but tailored to the Yukon context using a participatory policy research approach. That approach included document review, individual interviews and focus groups, and deliberative discussion in three research phases.

The first phase involved analysis of the Yukon context from four information sources. The second involved learning from those information sources, as well as a large group of key informants, including from other jurisdictions. In the final phase, a draft framework and service options were developed and stakeholder feedback was incorporated. Three rounds of a modified Delphi method were used in this phase to achieve consensus on the framework, with specific effort to ensure appropriate representation of key groups. This project illustrates a participatory approach to framework development that considers the interface between a pan-Canadian and provincial or territorial conceptual framework.

Monitoring positive mental health and its determinants in Canada: the development of the Positive Mental Health Surveillance Indicator Framework (Orpana et al. 2016)⁹⁰

Orpana and colleagues used systematic methods to develop a framework for generating and reporting on positive mental health indicators at the pan-Canadian level by the PHAC. A focused literature search was the first step to identify existing mental health frameworks. That led to the development of a conceptual framework in consultation with MHCC experts. The framework described relationships between key concepts and was populated with selected indicators. Selection criteria (relevance, actionability, accuracy, feasibility, ongoing) were then used, in consideration of alignment with key broader frameworks and related theories.

An initial set of candidate indicators was grouped by theme to ensure coherence, and definitions for each indicator were developed. Through two rounds of a modified Delphi approach with key stakeholder groups (in workshop and web-based voting formats), 77 indicators were reduced to 25 across four domains (individual, family, community and society). These were reviewed for data sources and assessed again for accuracy, feasibility and the degree to which they were ongoing. Expert and stakeholder advice on the framework were gathered through an online consultation that solicited responses to focused questions.

This project illustrates a multi-stage collaborative process grounded in theory that includes multiple stages of feedback incorporation on a range of considerations.

Establishing guiding principles

Many of the provincial and territorial policy documents, and some of the framework documents, included sets of overarching principles to guide the work. These sets of principles could also be used as a starting point to establish guiding principles for framework development, clarify shared values and guide future activities. There are also good research-based resources for measuring the quality of stakeholder engagement processes more generally that may be very useful.^{e.g.,106}

EXPERT PERSPECTIVES

- Meaningful engagement is paramount — including of youth (which has positive outcomes in its own right), Indigenous and other equity-seeking groups, and persons with lived experience (across the range of severity of illness) and their families, and organizations representing the voices of clients and families.
- Meaningful engagement includes a co-designed/participatory process with reflection on and acknowledgement of social-historical context and biases, as well as recognition of who gets to decide and who benefits.
- Unavoidably, meaningful engagement takes time and appropriate resources.
- Partnerships must be authentic, with excellent communication to all participants.
- Careful thought and transparency around who is involved are important, since indicators will reflect the interests of those involved.
- Principles related to culturally safe engagement processes should be used.
- There should be a stronger emphasis on principle-based approaches, evidence-based engagement processes and health equity impact assessment.¹⁰⁷
- One SME suggested that James Lind processes for priority setting¹⁰⁸ may be useful.
- The focus of measurement could be put on innovation and transformation rather than just simple performance.
- Other key stakeholders include professional organizations, philanthropic organizations and people involved in the delivery of care and data generation at the front line.
- Processes used by other countries (e.g., Australia, New Zealand) should be explored for ideas.
- A series of provincial/territorial or regional consensus conferences followed by a national consensus conference is a possible approach.
- Working out clear roles and responsibilities for lead agencies will be important.

Getting from framework to system

Performance measurement has been criticized for stalling at the conceptualization stage.³⁵ Poor conceptualization can undermine the value of the steps that preceded it, but even if it is excellent, infrastructure, the capacity to regularly generate new indicators and report on existing ones, and resources to develop strategic, aspirational indicators are required to realize the ultimate objective — in this case, to improve Canada’s MHA system.

The national summit report *Think Big, Start Small, Act Now: Tackling Indicator Chaos*²⁶ offers advice for overcoming the “indicator chaos” that seems to have developed in health performance measurement. Sponsored by Canadian health quality organizations, the report cautions against getting bogged down by the confusion associated with the volume of available indicators and advises: “Start with the patient. Don’t talk, act. Name leaders. Create a clearing house. Agree on priorities.”

Lessons from Canada and abroad

The plurality of data systems across and within Canada’s provinces and territories makes the challenge of developing a performance measurement framework here akin to achieving consensus across countries — which a decade of international work on the selection and generation of common indicators has shown to come with many obstacles.^{24,25,109} Provinces and territories have enormous challenges when it comes to mental health care delivery. Adding a pan-Canadian level of generation and reporting on performance measurement on top of that may be an

additional burden. However, countries that have similarly structured healthcare delivery systems, including Australia and New Zealand, have made good progress on national MHA performance measurement systems.^{e.g.,31,32}

There are also exemplary mental health information/performance measurement initiatives that can serve as models for a pan-Canadian system. Learnings about successful strategies from other framework development initiatives and systems at the provincial and territorial levels can inform a “best-of-the-best” approach to pan-Canadian framework development. While making the leap from framework to system may be challenging, the recent *Toward Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces* has shown it is possible to generate MHA performance indicators collaboratively through consensus definitions.⁴ The indicators were not only able to be compared across five provinces, but regional breakdowns within provinces were also possible.

“Start with the patient. Don’t talk, act. Name leaders. Create a clearing house. Agree on priorities.”

— From *Think Big, Start Small, Act Now: Tackling*

Fully integrated information systems, such as the one proposed for development in Ontario,⁶⁰ will enable effective MHA performance measurement at the provincial/territorial level. National-level collection and reporting will depend on cross-jurisdictional collaboration on conceptualization, data collection, reporting and action.³⁵

The Cancer System Performance initiative spearheaded by the Canadian Partnership Against Cancer (CPAC) provides an excellent pan-Canadian model for what can be achieved with a systematic, collaborative approach.³³ Not only has CPAC developed a performance measurement framework for cancer control, but it has also established data collection and reporting by province/territory since 2009 — with indicator values available to all stakeholders online. While the cancer field has some distinct advantages that MHA does not, such as clearer case definitions and a case registry enshrined in legislation, the research team believes it is reasonable to aspire to a system with similar features.

CPAC’s system has the following positive/innovative features and more:

- a framework developed through a systematic, collaborative process and grounded in policy (the Canadian Strategy for Cancer Control¹¹⁰)
- a framework with highly relevant dimensions and domains, yet not so complex as to be incoherent to stakeholders or perceived as not relevant to them
- shared understanding of concepts and terms
- clear delineation of the types of indicators relevant at each level of the system, and logic models that connect indicators across levels
- indicators based on available data, as well as identified gaps and aspirational indicators
- use of multiple data sources to regularly populate indicators, including some primary collection
- comparisons by province/territory and collective processes for quality improvement
- availability of indicator findings to all interested parties through web-based reporting
- commitment to more development in the important area of equity
- a philosophy that supports improvement and avoids perfectionism — that initial information, while imperfect, is better than no information, and that measures can be improved over time

EXPERT PERSPECTIVES

- A mechanism or mechanisms for getting beyond simple reporting to interpretation and “actioning” the findings is essential.
- SMEs generally agreed on CPAC’s system as a good model, though it was acknowledged CPAC is well-resourced and has a clear national mandate and role with respect to data.
- Indicators for a few core concepts, based on strategy and need, are urgently required at the national level, with provinces and territories also collecting and reporting on their own priority indicators beyond these.
- Infrastructure and technical capacity are essential for indicator development and validation.
- Any system will need to evaluate and report on the quality of its own processes and the value of its contributions.
- Getting from framework to system will require both strong leadership and collaboration.
- Thinking about and aligning incentives for participation will be key.⁸ Strategies used for PHAC’s Canadian Chronic Disease Surveillance System¹¹¹ should be considered.
- Lack of sufficient funding/resources and buy-in are major barriers.
- It will be important to address disparities in capacity within and across provinces and territories.
- The MHA system is a “complex adaptive system” that will be changing even as it is measured. Consequently: “...solutions will not be easy, outcomes never likely to be perfect, nor will measurement of outcomes be an easy task.” Attributes like flexibility, adaptability and responsiveness will need to be measured, “...not just inputs, operations and outputs, which are the system characteristics suitable for logic modeling.”
- One SME pointed to the potential usefulness of “VUCA” approaches to dealing with challenges associated with “volatility, uncertainty, complexity and ambiguity.”¹¹²
- With respect to taking action on results, a process for using indicator information to inform solutions could start as a case study focused on promising work in one or more jurisdictions.
- A framework and system would need to be flexible and responsive to emerging evidence and methods and include a regular process to revisit indicators.
- Those involved in submitting/generating data should have a part in interpreting that data, and local and provincial/territorial contexts must always factor into indicator value interpretations.

Thinking big, starting small, acting now

SMEs have compiled and reviewed a set of resources that can inform and support a plan for developing a pan-Canadian MHA performance measurement framework. These resources and recommendations are grounded in provincial and territorial policy priorities, features of existing frameworks, and lessons learned from systematic developmental processes used for framework development in Canada.

While there is substantial diversity across performance measurement frameworks in content and processes used, there is also a richness and depth of ideas and approaches that, with thoughtful selection, can inform an effective process and a quality outcome.

In the research team’s view, “Thinking big, starting small and acting now” calls for immediate work on the development of a pan-Canadian, policy-driven performance measurement framework with key stakeholders. Once a

framework is in place, existing strategic indicators that fit that framework can be selected and critical gaps for immediate indicator development work identified. With the necessary capacity for indicator development and reporting, the production of a first collaborative pan-Canadian report on MHA system performance is an attainable goal. Ideally, this would include capacity for a mechanism that enables logically connected and collaborative activities aimed at system improvement.

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Appendix A: Detailed methods and materials

The project primarily targeted recent mental health policy priorities and performance measurement frameworks in Canadian provinces and territories. A broad definition of provincial/territorial “frameworks” was used: any document reporting on mental health and addiction (MHA) performance measurement framework development processes and/or reporting on MHA indicators was included.

Search terms used on provincial and territorial government websites

‘health’; or ‘mental health’ or ‘addictions’ or ‘substance’

X

‘policy’; ‘performance measurement’; ‘indicators’, ‘frameworks’

Inclusion criteria

- any MHA policy documents including total populations or important subgroups (addiction/major diagnostic groups, children and youth, Indigenous peoples)
- any document on the topic of MHA data or performance measurement including frameworks
- any document reporting on broader health indicators/performance measurement that may contain MHA indicators
- published from 2013 forward or still an active policy in 2013 (unless there was no current document, in which case the research team took the most recent)
- separate action plans or updates for active policy documents
- provincial/territorial or system level (i.e., not regional)

There was no MHA policy document for Nunavut, so the research team used the territory’s broader government policy document.

The final list was reviewed by the full RT for consensus decisions about inclusion.

Research questions

For each framework:

- What are the domains/dimensions? Selection criteria for indicators?
- Does the framework reflect a broader performance measurement model?
- What scope of services is covered in health and beyond health?
- What levels of the system are covered (individual, program, service, system, population)?
- What populations are addressed (e.g., balance of those with illness/vulnerable subgroups versus total population)?
- Who is the primary audience (decisionmakers, the public)?
- What methods were used to decide on the indicators?

For each jurisdiction:

- What are the current MHA policy priorities?
- Is there a performance measurement framework attached to the policy priorities?
- Are there performance measures/indicators attached to the MHA policy directions?
 - If so, what stage of development are the measures/indicators — in-use or aspirational?
- What are the data sources for future performance measurement work?

Methods in detail

A total of 139 documents for the period of 2013 to 2017 were identified through systematic provincial and territorial website searches using standard terms (with one test, revision and re-run) and a set of criteria.

Validating the documents

Lists of captured materials were sent to MHA researchers/data contacts in each jurisdiction, and members of MHCC's Provincial Territorial Advisory Group for validation and/or nomination of additional documents. Twenty informants validated the materials (and three supplied additional materials). National materials were added through website searches for nine organizations, and the very recent performance measurement research literature was updated using adapted rapid review methods. International materials were included through nomination by the research team.

Setting parameters and mapping content

The research team then made consensus decisions on inclusion/exclusion of materials and parameters for comparison. One research team member used content analysis in random order to map the content of provincial and territorial policy documents for the parameters.

Coding the policy documents

Two research team members independently coded two provincial/territorial policy documents judged most challenging to code. This was followed by discussion and consensus decisions. Agreement was 96% and 92% for macro-level policy coding for the two pairs of coders, respectively. Even so, there was substantial variability in the length, format and use of terms in the documents, so the findings should be treated as overall patterns rather than precisely determined categories. Framework details were pulled out and tabled more directly. Indicators were extracted, listed and classified.

Validating the findings

Findings were written into a draft report. Research team members reviewed the draft first, and their comments were incorporated. The team then sent the draft to subject-matter experts (SMEs) across Canada (and one from outside Canada, but with prior MHA performance measurement experience in Canada) for review and response.

SMEs were selected for knowledge and experience of both performance measurement and MHA content in the top nine policy priority areas. The research team sent initial invitations to 26 SMEs, and 20 agreed to review the draft. Feedback came in the form of twenty reviews and input collected via interview of one SME. The group included individuals who, in addition to their content knowledge, have lived experience of MHA and/or are family members of people with lived experience. SMEs responded to a standard set of open-ended questions and offered a gratuity in compensation for their time. SMEs also offered additional scientific articles and materials.

Table A.1.: Policy documents included in mapping

Province/territory	Title, description	Year
Nunavut	Sivumut Abluqta: Stepping Forward Together	2014–18
Yukon	A Child and Youth Mental Health and Addictions Framework for the Yukon	2014
	Forward Together: Yukon Mental Wellness Strategy 2016 – 2026	2016
Northwest Territories	Mind and Spirit: Promoting Mental Health and Addictions Recovery in the Northwest Territories: Strategic Framework 2016 – 2021	2016
Saskatchewan	Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan	2014
Prince Edward Island	Moving Forward Together: Mental Health and Addiction Strategy	2016–26
Newfoundland and Labrador	Towards Recovery: A Vision for a Renewed Mental Health & Addiction System in NL	2017
	The Way Forward: Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador	2017
Manitoba	Rising to the Challenge: A strategic plan for the mental health and well-being of Manitobans	2011 (5-year plan)
New Brunswick	New Brunswick Family Plan: Supporting Those with Addictions and Mental Health Challenges	2017
Nova Scotia	Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians	2012 (5-year plan)
British Columbia	A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use – 10 Year Plan	2013
	B.C.’s Mental Health and Substance Use Strategy 2017-2020	2017
Alberta	Valuing Mental Health: Report of the Alberta Mental Health Review Committee 2015	2015
	Valuing Mental Health: Next Steps	2017
Ontario	Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy	2011 (10-year strategy with 2014 update)
	Better Mental Health Means Better Health	2015
	Better Mental Health Means Better Health: Moving Forward	2016
Quebec	Faire ensemble et autrement: Plan d’action en santé mentale 2015 – 2020	2015

Questions for subject-matter experts

1. The case for a pan-Canadian information and performance measurement framework for mental health

In this section, have we adequately captured the challenges and benefits of a pan-Canadian performance measurement framework for mental health? Are there other developments that set the stage for this work? Other key components necessary for development of a pan-Canadian performance measurement framework?

2. Shared understanding of key concepts

Have we covered off the key concepts essential to shared understanding? Any terms that need better definition? Other mental health system models not mentioned?

3. Defining scope/dimensions/indicators

Are you aware of other exemplary processes for building consensus on these key aspects of a framework, or frameworks themselves that we missed? Do you have key learnings from processes you have led or been involved in that should be mentioned?

4. Recognition of key issues, and getting from framework to system

Are there other key issues that we have not listed? Any important barriers/facilitators for moving the work toward a pan-Canadian consensus performance measurement framework for mental health forward?

5. Suggestions for indicators

We have catalogued existing system-/population-level indicators from the frameworks reviewed and plan to map them to the policy priorities for the final report. At this stage, we are also interested in indicators that you consider to be important for your area(s) of expertise, which for the purposes of this exercise is noted to be [POLICY PRIORITY AREA FOR EACH]. If you do not consider this your area of expertise, please feel free to identify indicators for any other area of interest to you. Note that we are interested in identifying **both** existing and aspirational indicators. We are looking for three or four indicators (or areas of measurement) that you consider to be very important for driving mental health system change or indicating improvement in system-/population-level mental health in Canada. Please add relevant details if available.

Indicator general description	Type (currently available or aspirational)	Technical definition (if available)	Data source (actual or possible)

Comments on any other aspect of the report or the project are welcome here.

Description of materials reviewed

The mapping process included 19 policy documents and 10 frameworks (including two in development). Also included were 22 documents from nine national organizations, and 21 from six countries (or reporting on international initiatives). The research team procured, read and made notes about 56 articles from the research literature, with 75% dating from 2010 to the present.

Finally, the team extracted an initial list of 270 indicators currently being used or proposed for use from the 10 provincial/territorial frameworks. These were then reduced to a unique set of 182 indicators and a preliminary grouping according to the nine policy priorities and other characteristics frequently cited in the literature. SMEs suggested an additional 68 indicators or indicator topics, which the team added to the list to bring the total to 250. Information was synthesized across all sources, and the findings are discussed in the final report in relation to the set of five key conceptual components of performance measurement framework development referenced in the literature.

Mapping the policy priorities was challenging given the differences among the policy documents in terms of length, level of detail and terms used. However, most followed a similar format of defining a set of higher level priorities and,

within those, longer lists of specific priorities (often called actions or strategies or strategic directions). The research team defined the main levels as “macro” and “micro” priorities. If a third level of priorities was used, the team collapsed the second and third levels and treated all of those items as “micro” priorities.

The final report lists the 24 macro priorities coded, their definitions and how frequently they appear in provincial/territorial policy documents. All priorities could be grouped as those relating to populations or services, though the research team opted to do this subgrouping only at the micro level, where the number of priorities (43) was greater. The longer lists of micro priorities and the detailed crossmaps are available separately.

Appendix B: Definitions – Additional Detail

Mental health

The most frequently cited definitions of mental health and illness come from the World Health Organization (WHO):

- “**Mental health** is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”
- “**Mental disorders** comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated.”

The Public Health Agency of Canada (PHAC) defines positive mental health as: “... the capacity of each and all of us to feel, think, act in ways that enhance our ability to enjoy life and deal with the challenges we face.” In the First Nations Mental Wellness Continuum Framework, “mental wellness” is defined in the following way:

*Mental wellness is a balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: **purpose** in their daily lives whether it is through education, employment, care-giving activities, or cultural ways of being and doing; **hope** for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of **belonging** and connectedness within their families, to community, and to culture; and finally, a sense of **meaning** and an understanding of how their lives and those of their families and communities are part of creation and a rich history.³⁶*

Diagrams depicting the conceptual models associated with these definitions of mental health and wellness have been compiled as separate resources.

Mental health system

It is no small feat to define the mental health system. According to a WHO definition dating back to early 2005: “A mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health.”

Approaches to defining mental health systems have evolved considerably since that time. Definitions were more descriptive initially, focusing on a set of structural health service components (e.g., the WHO Assessment Instrument for Mental Health Systems [WHO-AIMS] project includes more than 50 elements in three broad areas, along with policies and legislation and discussion about the importance of equity). The WHO also developed a system for substance use treatment systems in a parallel project (WHO-SAIMS). The Canadian Centre on Substance Use and

Addiction (CCSA) has been reporting to this system for Canada. The WHO, in collaboration with the United Nations Office on Drugs and Crime, also defined continuum of substance use treatment.

Incorporating social determinants of health and whole-population perspectives

The 2006 Canadian Standing Senate Committee report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* did not define the mental health system specifically. Instead, it underscored that there really is no “system.” The report promoted a population-health approach that included attention to the social determinants of mental health. It urged reorientation of the system to be person- and recovery-oriented. In terms of structure, it promoted the continuum of care model – with three groupings of services: first line, intensive and specialized, along with cross-level services and supports including housing, work and related supports.

By 2007, the WHO proposed an optimal mix of services, emphasizing primary care, a balance of community-based and hospital care, informal services and self-care. It also developed the pyramid model that illustrated that the numbers of people with no to low need were much greater relative to the number with high needs, which reflected more of a whole-population perspective. In terms of child and youth mental health, the Evergreen Framework, which the Mental Health Commission of Canada (MHCC) tabled in 2010, emphasized promotion/prevention and the social determinants of health as important parts of the system.

Tiered approaches and stepped-care models

More recently, a tiered approach (usually five tiers, but some variants have six) has gained favour, which represents a true needs-based population-health approach that also includes the pyramid model concept. These newer models take a conceptual approach in addition to a structural one, which can be helpful in conceptualization task for information and performance measurement as well.

Stepped-care models from the 1990s focused on the formal healthcare system and initially on adults/longer-term/more serious conditions. These early models were more conceptual, and some included housing/employment components, reflecting some movement toward consideration of the social determinants of health.^{e.g.,39} Australian researcher Dr. Gavin Andrews did in-depth work at the WHO Collaborating Centre on the components of a needs-based, stepped-care model for services (the Tolkien II model). That model focused on care for common disorders, including issues related to alcohol use.

Findings from the current project

In cross-mapping provincial and territorial policy documents, the research team found wide variability in terms and concepts used in the discussion of mental health systems. Only Prince Edward Island (in *Moving Forward Together*, the province’s mental health and addiction strategy for 2016–26) provided a specific definition of the mental health system as “all involved and connected to the delivery of MH programs and services. It includes multiple government departments, agencies and community organizations.”

There was little consistency across provinces and territories with regards to service models, with a few each referring to “integrated care,” “continuum of care,” “community care framework,” “collaborative/shared care,” “cascading model of care,” “hub model,” “network model,” “wrap around care,” “stepped care” and “tiered model” — usually without definitions. Several provincial/territorial policy documents included diagrams to aid conceptualization of their systems. This may be useful, in part or in whole, in settling on a service description for a performance measurement framework. All of these schematics are available as separate resources.

Defining “core services”

Ontario has recently led work to define core services (for adults and children/youth separately), but this work is noted to be still evolving. For adults, the eight core services are listed as (with definitions provided): promotion/prevention/early intervention; information, access and referral; counselling and therapy; peer and family support; specialized consultations and assessments; crisis support services; intensive treatment and services; and housing and social supports.

For children and youth, a continuum of services and supports based on four levels of need with four to eight categories for each level are defined and a schematic is provided. The Canadian Institute for Health Information has also recently produced lists of community-based services in major categories such as assessment, treatment, education and support services.

Mental health and addiction information

Mental health and addiction information is a more encompassing term and includes many types of broad, descriptive data related to mental health and illness. For example, rates of common disorders, counts of hospital beds and numbers of mental health professionals are often tracked and reported by many countries. However, these types of descriptive data are often not considered sufficient to serve as performance indicators.

Appendix C: Mental health and addictions performance measurement frameworks

Table C.1.: Provincial and territorial performance measurement frameworks included in the current project (and their dimensions/domains)

Framework name	Scope (populations covered)	Dimension 1/ Domains	Dimension 2/ Domains	Dimension 3 or higher/ Domains
<i>British Columbia</i> Waddell, Shepherd, Chen and Boyle Creating Comprehensive Children’s Mental Health Indicators for British Columbia 2013	<ul style="list-style-type: none"> Population health framework BC children and youth 	Stage of childhood <ul style="list-style-type: none"> Early Middle Adolescence 	Determinants <ul style="list-style-type: none"> Protective factors Risk factors Status Strengths (flourishing, resilience) Difficulties (symptoms, impairment, disorders) 	Type of intervention <ul style="list-style-type: none"> Universal Targeted Clinical Contexts/domains: <ul style="list-style-type: none"> Child Social Family Emotional Neigh. Cognitive School Physical Community Nation Culture
<i>Alberta</i> Alberta Health Services Performance of the Addictions and Mental Health System 2014–15	Alberta recipients of mental health services – all ages	Quality <ul style="list-style-type: none"> Acceptability Accessibility Safety Appropriateness Effectiveness Efficiency 		
<i>Alberta</i> Alberta Health Services Performance Monitoring and Evaluation Framework (PerMEF) 2016–17 <i>IN DEVELOPMENT</i>	Albertans of all ages; service recipients and total population	Outcome timing <ul style="list-style-type: none"> Intermediate Longer Term Ultimate 		

Framework name	Scope (populations covered)	Dimension 1/ Domains	Dimension 2/ Domains	Dimension 3 or higher/ Domains
<p><i>Ontario</i> Ontario Ministry of Health and Long-Term Care Mental Health and Addictions Leadership Advisory Committee</p> <p>The Road to Demonstrating our Success: A Proposal to Develop a Comprehensive Data and Performance Measurement Strategy for the Mental Health and Addictions System in Ontario 2016</p>	<p>Ontario adult mental health and addiction service recipients, initially directly funded Ministry and Local Health Integration Network services</p>	<p>Quality</p> <ul style="list-style-type: none"> • Client-centred • Safe • Effective • Timely • Efficient • Equity 		
<p><i>Ontario</i> Institute for Clinical Evaluative Sciences (ICES)/Health Quality Ontario</p> <p>Taking Stock: A Report on the Quality of Mental Health and Addictions Services in Ontario 2015</p>	<p>All Ontarians, all ages</p>	<ul style="list-style-type: none"> • Prevalence • Access • Service use 		
<p><i>Ontario</i> ICES</p> <p>The Mental Health of Children and Youth in Ontario: Baseline Scorecard 2015 and 2017 reports</p>	<p>Ontario children and youth receiving services from three ministries, notes mostly treatment — not health promotion</p>	<p>Context</p> <ul style="list-style-type: none"> • Prevalence • System use • Outcomes <p>2017: Care</p>	<p>Performance</p> <ul style="list-style-type: none"> • Access • Quality • Early Identification <p>System response</p>	<p>Equity</p> <p>Equity</p>

Framework name	Scope (populations covered)	Dimension 1/ Domains	Dimension 2/ Domains	Dimension 3 or higher/ Domains
Quebec Institut national de santé publique du Québec (INSPQ) and the Commissioner of Well-being Rapport sur les Indicateurs de Performance in santé mentale 2012	Quebecers all ages	<ul style="list-style-type: none"> • Mental health status • Adaptation • Production 	<ul style="list-style-type: none"> • Level of analysis • International • Interprovincial • Interregional 	
Quebec INSPQ and Institut de la statistique du Québec (ISQ) Portrait statistique de la santé mentale des Québécois 2015	Quebecers ages 15 and up	<ul style="list-style-type: none"> • Mental health/well-being • Distress and stress • Mental disorders • Consumption of substances/dependence • Problematic situations and contexts • Physical health • Determinants of health • Disability and activity limitations • Medications and service use • Sociodemographics 		
New Brunswick New Brunswick Health Council Reporting and Action on Mental Health Data 2017	Population health model; all New Brunswickers	Domains <ul style="list-style-type: none"> • Cost • Satisfaction • Quality 	Quality <ul style="list-style-type: none"> • Safety • Accessibility • Appropriateness • Equity • Efficiency • Effectiveness 	Other parameters in an accountability framework: <ul style="list-style-type: none"> • Context • Outcomes and demand

Framework name	Scope (populations covered)	Dimension 1/ Domains	Dimension 2/ Domains	Dimension 3 or higher/ Domains
<i>Newfoundland and Labrador</i> Newfoundland and Labrador Centre for Health Information (NLCHI) Mental Health and Addictions Programs Performance Indicators 2017	Mental health service recipients all ages	<ul style="list-style-type: none"> • Quality • Safety • Access • Utilization • Efficiency • Spending • Health Outcomes 		

Appendix D: Provincial and territorial indicator selection processes and criteria

Table D.1.: Indicator selection processes and criteria by province/territory

Framework name	Indicator selection processes used	Selection criteria	General observations
<p><i>British Columbia</i> Waddell, Shepherd, Chen and Boyle Creating Comprehensive Children’s Mental Health Indicators for British Columbia 2013</p>	<p>Extensive process involving stakeholders including policymakers and youth, literature reviews, SME workshop for validation and three-stage Delphi process, technical documentation</p>	<p>Guiding principles plus two-dimensional model for selection criteria. Meaningful/policy perspective: <i>Indicator is conceptually coherent to policymakers and relevant to public policy goals</i> Meaningful/research perspective: <i>Indicator reflects research evidence on reliable and valid measures of determinants and status</i> Actionable/policy perspective: <i>Indicator reflects a variable that can be modified through public policy interventions</i> Actionable/research perspective: <i>Indicator is derived from accessible public data that permit ongoing measurement and reporting</i></p>	<ul style="list-style-type: none"> • Did not develop new indicators or collect data for reporting but identified indicators after development of a conceptual framework and then identified gaps in existing measures and made recommendations for development • Connected to an ongoing broader public health reporting process for child and youth wellness
<p><i>Alberta</i> Alberta Health Services Performance of the Addictions and Mental Health System 2014–15</p>	<p>Evolved over seven years; involved key stakeholders</p>	<p>Regular operational work; availability important given this is a routine reporting system</p>	<p>This initiative has been reporting out for seven years.</p>

Framework name	Indicator selection processes used	Selection criteria	General observations
<p><i>Alberta</i> Alberta Health Performance Monitoring and Evaluation Framework (PerMEF) 2016–17 <i>IN DEVELOPMENT</i></p>	<ul style="list-style-type: none"> Literature reviews for initial indicators list; five large consultation sessions plus a sixth with Indigenous stakeholders Systematic feedback collected on each indicator 	<p>Questions put to participants regarding importance, validity, relevance, feasibility, and likelihood of unintended consequences; not reporting out as yet</p>	<p>Currently doing more intense work on a more inclusive and system-wide next stage process using the principles: aligned, targeted, inclusive, collective, data-driven and iterative</p>
<p><i>Ontario</i> Ontario Ministry of Health and Long-Term Care Mental Health and Addictions Leadership Advisory Committee The Road to Demonstrating our Success: A Proposal to Develop a Comprehensive Data and Performance Measurement Strategy for the Mental Health and Addictions System in Ontario 2016</p>	<p>Extensive multi-stage consultation process with multiple stakeholders including a modified Delphi approach</p>	<ul style="list-style-type: none"> Proposed indicators ranked on importance, relevance, actionability, interpretability Considerations also included alignment across levels of the system, cross-sectoral and Health Quality Ontario performance domains Also, a set of guiding principles: across the continuum, grounded in quality, equity, developed in partnership, validation, ultimately inform care standards 	<p>The only initiative proposing a fully integrated electronic data collection system across settings that will include all levels and clear roles and responsibilities in a staged approach; currently includes funding estimates: \$24 million start-up for first three years and \$8 million per year after that in operating costs</p>
<p><i>Ontario</i> Institute for Clinical Evaluative Sciences (ICES)/Health Quality Ontario Taking Stock-A report on the quality of MHA services in Ontario 2015</p>	<p>Developed by a joint multi-disciplinary team from ICES and Health Quality Ontario</p>	<p>Not reported but availability of data important given focus was on reporting out</p>	<p>Process connected back to original mental health policy document (2011)</p>
<p><i>Ontario</i> ICES The MH of Children and Youth in Ontario: Baseline Scorecard 2015 and 2017 reports</p>	<p>Developed by a research team at ICES with advice from a scientific advisory committee</p>	<p>Availability of data; data-related limitations and gaps identified</p>	<p>Process connected back to original mental health policy document (2011)</p>

Framework name	Indicator selection processes used	Selection criteria	General observations
<p><i>Quebec</i> Institut national de santé publique du Québec (INSPQ) and the Commissioner of Well-being Rapport sur les Indicateurs de Performance in santé mentale 2012</p>	Committee of seven researchers	Selected from multiple sources for availability, validity, stability and relevance	No comment on connection to specific policy
<p><i>Quebec</i> INSPQ and ISQ Portrait statistique de la santé mentale des Québécois 2015</p>	Committee of 12 researchers	Available data for Quebec from the 2002 and 2012 editions of the Canadian Community Health Survey	No comment on connection to specific policy.
<p><i>New Brunswick</i> New Brunswick Health Council Reporting and Action on Mental Health Data 2017</p>	HC Working Group plus English and French language groups, Centre de formation Médicale du NB; CIHI and the general public	In progress; populating an Accountability Framework with several sources of indicators – some reporting out including maps for geographic distribution	Focus on identifying health issues for improvement with local stakeholders rolling up
<p><i>Newfoundland and Labrador</i> Newfoundland and Labrador Centre for Health Information (NLCHI) Mental Health and Addictions Programs Performance Indicators 2017</p>	Service/program leaders provided input on relevance of domains.	Focus on reporting out so primary criterion was availability but also used national indicators from CIHI.	Notes alignment with Dept. of Health and Community Services Strategic Plan.

Appendix E: List of additional resources

The following additional resources were compiled for use in future work:

- definitions and model schematics
- provincial/territorial MHA policy priority crossmaps (macro level)
- provincial/territorial MHA policy priority crossmaps (micro level)
- indicator list with preliminary classifications



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada



Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

info@mentalhealthcommission.ca
www.mentalhealthcommission.ca

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