Best Practices in Mental Health Reform

Discussion Paper

Prepared for the
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Health Systems Research Unit
Clarke Institute of Psychiatry

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Preface

The Best Practices in Mental Health Reform Project was developed and funded by the **Federal/Provincial/ Territorial Advisory Network on Mental Health (ANMH)**, which comprises government officials in Health Canada and in the provinces and territories. The ANMH provides an intergovernmental forum for national collaboration on the identification, critical analysis and research on mental health issues. This project addresses one of the priority issues for the ANMH, namely, best practices in mental health policy and programs with respect to developing effective services and supports, components of a comprehensive community support system, and strategies to create the necessary conditions and incentives to foster their widespread implementation.

The Health Systems Research Unit of the Clarke Institute of Psychiatry was commissioned to undertake this body of work, which culminated in three deliverables: this discussion paper and two background papers, a critical, evidenced-based review of the current state of knowledge and a situational analysis of mental health reform policies, practices and initiatives in Canada which approximated "Best Practices" documented in the literature review. The Background papers are being published separately. It should be noted that the views expressed in both this publication and the background papers are those of the authors, and do not necessarily represent the views of the ANMH.

This discussion paper should be of interest to a variety of stakeholders in the health/mental health field, including policy makers, administrators, care providers, professional associations, consumer and family organizations and researchers.

It is also important to note that although mental health reform has implications for those with less severe problems, and for special populations with unique mental health needs, including, among others, children, older adults, and members of ethno-racial groups, this project focuses on chronic and severe mental disorders.

Valuable insights and suggestions were provided by volunteer, consumer and family groups (Canadian Mental Health Association, Schizophrenia Society of Canada, the National Network for Mental Health and the Depression and Manic-Depression Association of Canada) as well as national professional associations (Canadian Psychiatric Association, Canadian Psychological Association and the Canadian Association of Social Workers). Their timely and constructive input is gratefully acknowledged.

The ANMH appreciated the expertise, professionalism, dedication and spirit of cooperation of the principal investigator, Dr. Paula Goering and her excellent team of co-investigators, without which this complex and challenging project would not have been successfully completed within the required time frames. These researchers are at the cutting edge of health services policy related research in the mental health field. The contribution of Health Canada staff, particularly Carol Silcoff and Carl Lakaski of the Health Promotion & Programs Branch, is also recognized.

Executive Summary

This document completes a three-part project conducted by the Health Systems Research Unit (HSRU), Clarke Institute of Psychiatry for the Federal/Provincial/ Territorial Advisory Network on Mental Health (ANMH) and Health Canada. The project identified best practices in mental health reform and strategies for their implementation, focusing on those with serious mental illness. Since the mid 1980s, provinces have pursued various courses of action to develop mental health care systems that can better support individuals with severe mental illness, maximizing their community tenure, independence and quality of life. There has been remarkable consistency in the goals and value bases that are cornerstones of reform.

The project consisted of three phases:

Phase I of the project was a critical evidence-based review of the current state of knowledge about 'best practices* relevant to mental health reform, with a focus on chronic and severe mental illness (ANMH). The summary of best practices from Phase I provides the basis for a comprehensive checklist of the key elements that should be present within a reformed system of care for persons with severe mental illness (Tables 1A & 1B). They tell us **what should be done**.

Phase II of the project was a situational analysis of mental health reform policies, practices and initiatives in Canada which approximated 'best practices* (ANMH). These are descriptions of **what can be done** through innovative initiatives. Factors that facilitate change were identified and include: clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders and skilled staff, and the Canadian Mental Health Association National Framework for Support.

This document summarizes and synthesizes the findings from phases I & II, then addresses the **implementation of best practices across entire systems of care.** The benefits and timeliness of integrating mental health services are discussed, separation from the rest of health care is described as a necessary developmental stage and those best practices which should be given priority are identified. The following recommendations for action were identified:

Best practices should be used as guidelines for systems planning and as criteria for the assessment of performance.

Each region should develop strong mechanisms (e.g. assertive community treatment teams and a Mental Health Authority) for service integration with clearly designated responsibility for all aspects of

care and sufficient influence to bring together the four solitudes, i.e. Community Mental Health Programs, Provincial Psychiatric Hospitals, general hospitals and consumer and family initiatives.

The creation and protection of a separate, single funding envelope that combines various funding streams for the delivery of mental health care is an essential component of system reform. Greater use of incentive contracts and grants as levers for change is warranted.

The setting of explicit, operational goals and performance indicators within each province is a prerequisite for systems change and for evaluation. The possibility of achieving a national consensus about selected issues should be explored.

This report also discusses future research needs and valued methods of knowledge transfer, recommending that:

Further research on the effectiveness of services and supports and the impact of system change needs to be mandated and funded.

The exchange of research and experiential knowledge should be facilitated through commissioning research summaries and convening meetings focussed upon the topics identified.

1. Introduction

The past 30 years have seen dramatic changes in the treatment of mental disorders and the organization of mental health care systems. Between 1960 and 1976 the number of beds in Canadian mental hospitals decreased from 47,633 to 15,011 while bed capacity in general hospital psychiatric units rose from 844 to 5,836. This deinstitutionalisation process resulted in a dispersion of clients into the community without the necessary services and supports to allow them to function successfully (Wasylenki, Goering and Macnaughton, 1992). In recent decades, jurisdictions have made an effort to develop a mental health care system that can better support individuals with mental illnesses and maximize their community tenure, independence and quality of life.

Since the mid 1980s provinces have pursued various courses of action to improve their mental health care systems. The primary focus has been on the subgroup of individuals with severe mental illnesses. This group, which represents approximately 2% of the population, has been poorly served by past policy initiatives and, as a result, has consumed a disproportionate share of expensive inpatient and treatment services, with little benefit to themselves and their families. Mental health reform does not intend to ignore the needs of those with less serious mental health problems – approximately 18% of the population. Rather it is felt that with better systems of care in place for those with severe mental illness and a better interface between the primary and mental health specialty sectors (Canadian Psychiatric Association, 1996), all members of the community who need assistance for mental health problems will be better served.

1.1 Cornerstones of Mental Health Reform

In his summary of provincial reform activity across Canada, Nasir (1994) noted a remarkable consistency among the provinces in embracing three common goals for mental health reform. These include:

- correcting the historical imbalance between institutional and community-based care
- offering a comprehensive range of services – treatment, rehabilitative, preventive and promotional
- devolving governance of health/mental health services at the regional/local level to make the system responsive to local needs

Two other critical cornerstones of mental health reform being pursued include:

- recognition that mental health care should not be limited to formal mental health supports
- acknowledgement of consumers and families as critical partners in planning, delivering and evaluating mental health care delivery.

The Canadian Mental Health Association (CMHA) Framework for Support (Trainor et al., 1993), a policy orientation which is reviewed in depth in Phase II of this project, has achieved considerable success in changing thinking about the capacities and roles of consumers; in encouraging provinces to direct resources and develop structures that support consumer participation; and in encouraging involvement of a broader array of human and social services in the lives of citizens with mental illness.

In pursuing program and system reform, the ultimate goal is to improve the lives of those with mental illness. William Anthony (1993) reinforced this perspective when he noted that recovery is what people with mental illness do, while services such as case management and treatment are what helps to facilitate recovery. In this context, best practices must be implemented within a clearly articulated value base that puts the consumer in the centre and focuses on consumer empowerment and recovery. The values established at the outset of reform will influence many aspects of reform implementation such as desired individual, program and system outcomes, human resource strategies, training programs, and views on the capacities of consumers and their roles in the system. Over the last decade many consumers have given voice to the concept of recovery, offering eloquent and insightful chronicles of their recovery experiences (Deegan, 1988; Long, 1994). It is important to realize that in this context recovery is not equivalent to cure. There may be ongoing symptoms and need for treatment and support. It is the level of adjustment and meaning of illness that are modified for those who “recover”.

Fortunately many provinces have spent considerable time developing a vision and value base to guide the reform process. One consumer consultant reminds us that any reform approach which does not include these aspects as key elements will not lead us to the future.

1.2 Context for Implementing Reform

In pursuing mental health reform, provinces have used various legislative and policy tools, and have revised methods of resource allocation and system organization. Activities have been pursued within the broader context of substantial reconfiguration of all health care delivery, especially as regards hospital downsizing, regionalisation and integrated care delivery. In the midst of these many changes, reform proponents have strived to protect mental health dollars within shrinking health care budgets and to make certain that community supports are put in place prior to hospital closures and downsizing. They also have focussed on developing governance and funding structures that can better respond to regional/local needs, and can integrate services/supports across community and institution, across mental health and primary care, and across mental health and social services sectors. (See Literature Review, ANMH, for discussion of governance and funding strategies related to implementing reform.)

The mental health system in Canada has a number of unique characteristics that have facilitated implementation of reform or are encouraging with regard to future progress (Goering et al., 1996).

- At a time when accountability is paramount, we have a growing body of evidence on the effectiveness of models of service delivery to inform decision-making and influence funders (see Literature Review, ANMH).
- There are numerous examples of horizontal and vertical linkages that have been developed across both agency and sector boundaries (see Situational Analysis, ANMH).
- In comparison to primary care and long-term care, mental health services for the severely ill are a smaller, more manageable piece of a much larger configuration of providers and organizations.
- We are operating within a single payer health care system, a major advantage in comparison with the complex administrative and funding environments in the United States.
- Finally, and perhaps most importantly, many of the leaders and players within mental health share a common core of beliefs about the value of collaboration and the need to overcome vested interests in order to work effectively as a group.

2. Project Methodology

This report completes a three-part project conducted by the Health Systems Research Unit (HSRU), Clarke Institute of Psychiatry for the Federal/Provincial/Territorial Advisory Network on Mental Health (ANMH) on behalf of Health Canada.

Phase I resulted in a critical evidence-based review of the current state of knowledge about 'best practices* relevant to mental health reform, with a focus on chronic and severe mental illness.

The review examined knowledge about efforts to:

- improve the organization, efficiency and effectiveness of mental health systems, and
- find better and more appropriate models of care for persons with severe mental illness, with an emphasis on community-based services.

In assembling evidence on program models, our intention was only to review studies and reports that met accepted standards of methodological rigour, using criteria as specified in Burns (1989), Forchuk and Roberts (1992), Hall et al. (1994) and Wortman (1994). Both qualitative and quantitative studies were reviewed, as both types of research can offer valuable information if the method is appropriate to the research question. Because the quality of available evidence varied across program domains and was weaker for some (e.g., crisis response) than others (e.g., case management), our inclusion criteria necessarily became more flexible. Summaries of research findings reported in the Literature Review (ANMH) are careful to acknowledge the strength of the studies on which they are based.

A less scientific methodology was utilized for assembling knowledge on systems level strategies. For each area of system intervention – policy, governance and funding, monitoring and evaluation, and human resources – strategies successfully used in other jurisdictions were summarized, with emphasis on critical issues and lessons learned. Key articles and documents (published and unpublished) which analysed experiences of other jurisdictions were reviewed.

Phase II of the project was a situational analysis of mental health reform policies, practices and initiatives in Canada which approximated 'best practices*. Each provincial/territorial ANMH representative nominated initiatives from their region which conformed to the 'best practices* strategies identified in Phase I. National initiatives were nominated by the entire ANMH group. Since resources did not permit a follow-up of all nominated strategies, selections were based on:

- representativeness in terms of regions of the country and key programs/strategies of mental health reform;
- conformity with the elements of best practice outlined in the literature review.

For each selected initiative documents were reviewed, interviews were conducted with key informants, and some sites were visited for more intensive coverage. Not all provinces submitted nominations nor did submissions represent every best practice program/strategy. As a result, not every region was represented in the situational analysis and examples of some important strategies, e.g. system-wide evaluation, were not included.

The purpose of this report is to synthesize the findings of two previous phases and to summarize what has been learned, identify what facilitates innovation and change in achieving mental health reform, and recommend future priorities for action and change. We begin with a summary of Phase I findings, including presentation of a checklist that could be used to assess a jurisdiction*s progress in mental health reform.

3. Phase I Findings - Best Practices

The Phase I Review summarized proven and promising approaches for providing individual supports, inpatient/outpatient care, crisis response, housing, employment and self-help. The Review also identified practices related to policy, governance and funding, evaluation and human resource management which promote change and progress in mental health systems reform. As noted, research evidence was stronger for some types of services and supports than others, and the level of rigour was acknowledged when best practices were identified.

In the area of *individual support and case management*, a strong body of research evidence demonstrates that Assertive Community Treatment (ACT) programs are superior for improving clinical status and reducing hospitalization. A smaller body of studies show that rehabilitation and personal strengths case management models are appropriate for serving individuals with less intensive needs and can help them to improve functioning, residential stability and independence.

While research evidence is weaker in the area of *crisis response*, studies support the use of crisis response programs to divert people from inpatient hospitalization using minimally intrusive options. Components of the crisis response continuum include telephone crisis and warm lines, mobile crisis units, crisis residential services and psychiatric emergency services in hospitals. Crisis programs need to incorporate evaluation protocols to generate more knowledge about the nature and impact of these programs.

In the area of *housing and community support*, studies tend to be quasi-experimental and cross-sectional. Research in this area indicates that a range of different housing alternatives needs to be provided, but that there should be a shift in resources and emphasis to supported housing. The supported housing approach encompasses use of generic housing widely dispersed in the community, provision of flexible individualized supports which vary in intensity, consumer choice, open-ended tenure and provision of case management regardless of whether a client moves or is hospitalized. While supported housing is appropriate for many individuals, an array of staffed community residential housing must also be available for those with special needs. Studies have found that assertive community treatment is effective for very difficult-to-house populations such as the homeless.

Research on approaches for delivering *inpatient and outpatient services* is extensive and fairly rigorous. Best practices derived from this research include moving long stay patients from psychiatric hospitals into the community, with carefully planned transitions to alternative care models. Programs which provide alternatives to inpatient admission and care include home treatment and day hospital. Keeping length of stay as short as possible is appropriate most of the time. New service delivery models are needed that can link family physicians with mental health professionals.

While there is variability in the quality of studies to evaluate *self-help and other consumer initiatives*, findings support the need to fund and nurture the development of alternative supports. The general public and mental health professionals need to be educated about the value of self-help, and steps should be taken to attract and train strong leaders. Evaluation of consumer initiatives using methods that are both scientifically sound and acceptable in such settings are needed. Consumer participation in program governance and delivery was not reviewed in this section but is discussed in sections on system policy, human resource management and evaluation.

Research on *family self-help* is limited in quality and quantity but provides direction for identifying best practices. Family groups should receive funding and should participate in planning and evaluation of care delivery. More evaluation of family self-help using acceptable methods is encouraged.

Rigorous studies of *vocational and educational services* provide evidence for shifting from traditional vocational services to supported employment. This approach includes provision of continuous, time-unlimited individual support and attention to client preferences. Supported education and social recreational programs are promising models in need of further evaluation.

To identify best practices in system level reform, reports on system strategies used in other jurisdictions were reviewed.

Studies demonstrated the importance of having a free-standing *mental health reform policy* that is supported by an explicit vision and quantifies the magnitude and pace of change for reform. Stakeholder participation in policy development and a planned approach for implementation, for example through legislation, are also essential to successful reform. Policy should support the development of services and supports that go beyond formal mental health care. Key policy issues to be addressed include reallocation of fiscal and human resources, coordination of care, integration of services and supports, consumer and family participation, and monitoring quality and outcome.

A number of best practices were identified in *governance and funding*. Of critical importance is the creation of a separate, single funding envelope that combines various funding streams for delivery of mental health care. Funding allocations should be linked to the unique characteristics and needs of area residents, and program allocations should be tied to desired program and system changes. The benefit of establishing mental health authorities at regional or local levels with responsibility for planning, organizing and monitoring services and supports, and for dispensing funds, has been demonstrated. A variety of fiscal and clinical tools can be used to achieve more integrated care delivery. A consumer-centred information system is essential to support decentralized planning, funding and management of the system.

A well functioning mental health system requires comprehensive *monitoring and evaluation*. Assessment must occur at the consumer, program, system and population level, with the ongoing involvement of the full range of stakeholders, including consumers and families. Program activities and outcomes should be monitored on a routine basis, and results cycled back to stakeholder groups

for continuous improvement. Adequate resources are needed to fund evaluation activities and an information system that has common and local data elements must be developed.

Staff redeployment and training are key concerns in the *human resource area*. A best practice labour strategy for staff redeployment should clearly articulate the time frame, pace and magnitude of redeployment, allocate adequate funds to cover related costs, and explicitly address issues related to collective agreements. A training strategy also should include reskilling initiatives. Strategies to enhance consumer involvement as providers are needed.

4. Applying Best Practices

The best practices identified in the literature review define what one would expect to find in a reformed mental health system in terms of the types of services and supports and the infrastructure in which they are located. Best practices can be used as guidelines for systems planning and as general criteria for the assessment of performance but they are not detailed blueprints which can be immediately mapped onto a region or province, specifying the quantities and interrelationships of the various components. The best practices provide a more general program of action that requires further specification to fit the particular circumstances in which the system of care is being implemented.

4.1 Implementing Model Programs

A number of reasons account for the lack of an exact correspondence between elements of best practice derived primarily from research and applied examples as described in the situational analysis. As Leona Bachrach has often reminded us, there are many differences between the world of model programs (1980) and synthesized community support systems (1982) developed and tested for demonstration purposes, and the realities of service delivery in normal conditions. This means that there is always a process of adaptation rather than simple adoption when a program with demonstrated efficacy is transplanted to another circumstance. The planning principle is one of cultural relevance (Bachrach, 1984), i.e. tailoring to local conditions. A supported housing approach in British Columbia may look different in many respects from a supported housing approach in Vermont. The same is true with system-wide strategies. We can learn that regional authorities are a promising approach based on studies and experience in other jurisdictions, but it is not appropriate for an administrative and funding arrangement to be exactly replicated in a different political and environmental context. The Mental Health Commission in New Brunswick was designed for a province with a population of about 738,000 and a mental health budget of $50.6 million[1] in 1995/96 (Black, 1997). The concepts have wide relevance, but the particulars will have to be rethought in Ontario with a population of about 10,750,000 and a mental health budget of $1,555.7 million in 1993/94 (Ontario Ministry of Health, 1996). It is important to distill from the best practice descriptions the essential components that define the approach, as we have tried to do in Phase I. This inevitably means that the best practices are at a level of generality that falls short of being immediately operational.

1 Estimate does not include billings by psychiatrists working in psychiatric hospitals or psychiatric units of general hospitals.

There are also important differences between descriptions of ideal community support systems and those that are actually functioning. Systems of care in natural conditions are far more complex and dynamic than are the representations that are used to describe them. For heuristic purposes, it is common to subdivide into categories the types of services and supports that are essential components within a system, so that we talk about promising approaches to treatment, vocational rehabilitation and housing etc., as if they are separate entities. But, as anyone knows who has tried to develop an inventory of programs, these categories are not mutually exclusive or clear-cut. Programs, like patients and psychiatric diagnoses, often do not fit neatly into the classifications that have been devised. Bachrach*s (1984) principles of functional equivalence and potential trade-offs remind us to focus on function, not form, when developing programs. This admonition is relevant to the widespread tendency to equate community care with a particular type of sponsoring organization. There is no reason to assume that hospitals cannot provide excellent community services. In fact both the literature and the situational analysis clearly demonstrate this point. "The central issue in reforming services, therefore, is not so much geographic – hospital versus community – as it is functional. It centres around the ability to provide the right kinds of services to the right people" (Trainor et al., 1993, p 10).

4.2 Forming Best Practice Checklists

Although there is a gap between a description of best practices and a detailed blueprint of how to build a system of care, this does not mean that there is latitude to pick and choose only those aspects which are easiest or most convenient. Just as engineers are given the specifications for a bridge (location, weight bearing, weather resistance) that will condition and shape its design and construction, best practices should guide the planning, implementation and evaluation of mental health reform. They can be used as a checklist to assess whether a system is attending to critical issues and processes. A valuable resource in this regard is the discussion guide on Mental Health Reform prepared by the Canadian Mental Health Association (1995a) under the direction of the National Mental Health Services Work Group.

The discussion guide is intended to help advance the reform agenda for the seriously mentally ill population in a period of economic challenges. A series of questions are posed to identify both what has been accomplished within a region or province, and the areas of greatest need. Sections of the guide focus on the overall context and on three critical outcomes of mental health reform i.e., a balanced and effective service system, a range of consumer and family initiatives, and promotion of community integration. These questions came from many years of consultation with various stakeholders, including three national policy forums. The coverage and emphasis are somewhat different than what would be in a discussion guide derived purely from a best practice orientation, but still there is remarkable overlap in the issues and approaches to be monitored.

Borrowing on the concept of the discussion guide, we have incorporated the findings from Phase I into a checklist of best practice programs and strategies that provinces can use to examine their progress in mental health reform (see Tables 1A and 1B).

Recommendation 1

Best practices should be used as guidelines for systems planning and as criteria for the assessment of performance.

Table 1A : Checklist of key elements of a reformed system of care: Core programs

Best Practice Area	Checklist Criteria
Case Management/ACT	An array of clinical case management programs are in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models. There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders.
Crisis Response/ Emergency Services	A continuum of crisis programs are in place to help people resolve crises using minimally intrusive options.
Housing	There is a variety of housing alternatives available, ranging from supervised community residences to supported housing, with emphasis on supported housing. Housing needs of the homeless mentally ill are addressed.
Inpatient/outpatient care	Inpatient stays are kept as short as possible without harming patient outcomes. An array of treatment alternatives to inpatient hospitalization are available, including day hospitalization and home treatment. Long stay patients in provincial psychiatric hospitals are moved into alternative care models in the community. Service delivery models link family physicians with mental health specialists.
Consumer initiatives	Consumer initiatives are in place that have diverse purposes such as mutual aid, skills training and economic development. Consumer initiatives are supported through funding, consumer leadership training, education of professionals and the public about consumer initiatives, and evaluation using appropriate methods.
Family self-help	Funding is provided to family groups who also participate in planning and evaluation of care delivery.
Vocational/ educational supports	There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation.

Table 1B: Checklist of key elements of a reformed system of care: System strategies

Best Practice Area	Checklist Criteria
Policy	There is a free standing mental health reform policy based on an explicit vision that is shared among various stakeholders, including consumers and families. There is a planned strategy for implementing policy. Policy preserves the mental health envelope, prevents losses due to downsizing institutions, and increases the proportion of funds spent on community care. Policy defines concrete, measurable targets for reform.
Monitoring and Evaluation	Regular monitoring of all services and supports is the basis for program and system accountability, and for continuous quality improvement. Preset goals, performance measures and time lines are established. An information system has common elements for system evaluation (provincial) and local elements for program evaluation (agency level). There is a sufficient, protected evaluation budget.
Governance and funding	At the regional/ local level one organizational entity or mental health authority is responsible for mental health care, and is a clear point of accountability for system performance. The authority uses clinical, administrative and fiscal mechanisms to promote cost containment, transfer resources from institutional to community care, implement best practices and increase accountability. Diverse funding sources are consolidated into a single funding envelope that can be used flexibly. Funding allocations to a region or local area are linked with unique characteristics and needs of residents. A consumer-centred information system supports decision-making in planning, funding and managing the system. Administration of mental health care is connected with the broader health system and with generic services.
Human resources	A detailed labour strategy is in place to facilitate redeployment of staff. Strategies enhance consumer involvement as providers and educators.

5. Phase II Findings Best Practice Examples

The Phase II situational analysis compiled 13 Canadian examples of best practices in mental health reform selected from provincial and territorial nominations. The selection was conducted in collaboration with the Advisory Network on Mental Health which is composed of senior mental health provincial and territorial government officials from across Canada and Health Canada representatives. Four programs/strategies selected for site visits were reviewed in Section I of the report while Section II contained descriptions of nine other initiatives. The report concluded with a discussion of lessons learned, characteristics which facilitate innovation and general considerations for implementation of best practices.

The **site visits** afforded an opportunity for an in-depth examination of each of four initiatives that included observation and meetings with different stakeholders.

- Ø The Mental Health Commission of New Brunswick is an example of a successful system reform effort based on an aggressive re-engineering of governance and fiscal mechanisms. Among key ingredients for success were the creation and management of an integrated funding envelope, regionalisation, and adoption of a mental health policy committed to reallocating resources from institutions to the community.

- Ø The Seven Oaks Project in Victoria, British Columbia provides a regional alternative to long term hospitalization in a psychiatric hospital in a highly staffed community-based residential setting. This pilot initiative was implemented as part of a 10-year project to downsize the Riverview Psychiatric Hospital and to develop alternatives in the care of a difficult-to-manage group of long stay patients.

- Ø The Consumer/Survivor Development Initiative is a project of the Ontario Ministry of Health that directs resources to, and fosters the development of new consumer groups across the province. The result has been the formation of 36 consumer-run projects involved in a range of activities from self-help and advocacy to operating businesses and providing sensitization training to mental health professionals.

- Ø In Halifax, Nova Scotia, the Connections Clubhouse is a comprehensive psychosocial rehabilitation program which although strictly speaking is not a 'best practice* model as identified in the Literature Review, incorporates in one program a number of the core services outlined in the Phase I Review. As a multi-service agency and through linkages and partnerships with every facet of the community, this program is striving to provide fully integrated and seamless support to its members. The program is committed to a participatory philosophy.

Nine **less intensive reviews** describe programs that range from offering core services and supports to implementing strategies for system-wide change. The following seven programs offer examples of core services:

- The Assertive Community Rehabilitation Program in Brockville demonstrates a successful implementation of case management following a Program in Assertive Community Treatment (PACT) model, with the added dimension that the program is sponsored by a hospital and is staffed by re-deployed and trained hospital staff.

- The Phoenix Residential Society in Regina, Saskatchewan offers a residential and treatment program for persons with mental illness and substance abuse problems. Staff have training in both psychiatric rehabilitation and addictions treatment, and program services combine assertive community treatment, housing and vocational services.

- A crisis response program in Winnipeg in which a social service agency with a provincial infrastructure plays a key role in service delivery and program dissemination.

- The British Columbia Housing/Mental Health Program demonstrates how a mutually beneficial partnership between two government ministries has been able to increase housing stock and provide persons with serious mental illness with more opportunities for independent living.

- AMI-Québec is a family self-help initiative that has expanded from a nucleus of four families to an organization that offers support to families through education, support groups, telephone support, various networks including one for siblings, and advocacy.

- The Community Approach to Skills Development Training program is operated by CMHA in Lethbridge, Alberta. This employment preparation program allows students to learn skills in a normalized setting at the training work site.

- Five communities in the Northwest Territories have implemented a pilot project to hire their own mental health workers. This approach to providing care in an under-served area has reduced the need for residents to leave the community to obtain services, and has allowed the community to become involved in defining and implementing a program to meet its mental health needs.

Two programs offer examples of system-wide projects:

- The Manitoba Training Initiative represents an explicit commitment by government to training and skill development to facilitate mental health reform. Training has been incorporated into university and college programs for various health professions, and courses are offered to community mental health workers as mandatory and optional continuing education programs.

- The goal of the CMHA National Office New Framework for Support project is to encourage a new way of thinking about the capacities and potential of consumers, and how their role as full citizens

can be enhanced. Implementation activities have focused on promoting the Framework in order to change mental health policy and practice in governments and communities across Canada.

5.1 Lessons From the Situational Analysis: What Facilitates Change?

While the situational analysis examined a diverse selection of Canadian initiatives, there was remarkable consistency in the tools and strategies used to facilitate change and innovation. A summary of these follows:

- Clearly articulated philosophy and principles typically underlie the specific innovations that have been implemented. Psychosocial Rehabilitation offers a value and attitudinal base for many of the programs that have been described. The Framework for Support has broadened thinking about the components of community support and the capacities of consumers. This survey of the field supports the importance of drawing on conceptual bases such as these to articulate a common language and set of values as a basis for major change.

- A wide range of stakeholders were meaningfully involved in the planning and operation of innovative programs. An openness to input from multiple perspectives increases opportunities for collaboration and problem solving and fosters creation of an explicit vision of the future which is shared by various stakeholders.

- Political will is a special dimension of system change. In order for radical, widespread changes in funding and policy to occur and be maintained, it is critical that elected governments endorse and support the reforms. Influence can be exerted by advocacy groups, professional groups issuing position papers, academics, senior ministerial staff and elected officials who are acting on personal experiences and convictions.

- Infrastructure support is another essential element with powerful consequences. Many of the innovations described could not have happened without the active assistance of the larger organization within which the program resides.

- It is possible to successfully reallocate funds and personnel from institutional to community care. Many innovative programs are funded with dollars that have become available through the downsizing of inpatient care within provincial hospitals. With enlightened program managers and appropriate opportunities for training, hospital clinical and support staff can become excellent community workers.

- When support extends beyond health services to involve agencies from other sectors, it becomes possible to better address the broad range of needs among those with severe mental illness. It also expands the resource base that is available for community support and allows persons with severe mental illness to participate in a broader range of community activities.

- With concerted action, stigmatizing attitudes can be changed and resistance to change overcome. Positive experiences with the integration of persons with severe mental illness in the community are a powerful means of reducing stigma and promoting reform.

- The enthusiasm and dedication of skilled program directors, staff and volunteers is essential for making the programs work. Program directors are not only good managers, their demonstrated willingness to take risks and ability to inspire and lead others make innovation possible. Both professionally trained staff and trained non-professionals have valuable roles. The contribution of expertise that comes from the experience of being a consumer or a family member is another critical ingredient.

- The Canadian Mental Health Association – National Office is an important force in promoting a common set of principles through the diverse provincial and territorial mental health reform efforts, especially in encouraging formation of partnerships between mental health and other health and social service agencies (in recognition of the range of supports and resources that all citizens need), and in emphasizing consumer involvement in planning, management and evaluation of services and supports.

6. Implementing Best Practices Across Systems of Care

The summary of best practices from the literature review provides a comprehensive list of the key elements that should be present within a reformed system of care for persons with severe mental illness. They tell us **what should be done**. The descriptions in the situational analysis give us Canadian examples of some of the best practices. They demonstrate **what can be done** through innovative initiatives and factors that facilitate change. Yet, for the most part, they describe only selected aspects of systems reform. The question that needs further consideration is how to promote the implementation of best practices **across entire systems of care.** We need to achieve radical change on multiple fronts across an entire region, province or territory, without introducing further disorganization and confusion. The most successful example of broad-based mental health system reform in Canada has been in New Brunswick (Chapter 1, Situational Analysis, ANMH). There, planning and implementation were based upon a simultaneous re-configuration of philosophy, power relationships, resources and clinical programming. Achieving a true system of care will necessitate giving priority to those programs and strategies on the checklist of best practices that directly address the lack of continuity that currently exists. It should not be forgotten that generic community services and family/friends also are important sectors of support, and need to be acknowledged, fostered and formally involved in the care of individuals with serious mental illness.

6.1 Benefits of Integration and Accountability

It has been recognized for some time that what has been lost in the move from institutional to community-based care is overall accountability (Wasylenki and Goering, 1989). Because there is no system of responsibility in place, care has become poorly organized and inadequately coordinated and, as a result, inefficient and ineffective. Leonard Stein and colleagues (1990) described the typical state of affairs as follows:

> "A 'non-system* of mental health care is where a few patients get more than they need, many patients get less than they need and some get nothing at all. Patients may get lost in this non-system and no one feels obligated to look for them. Patients may refuse to follow a program*s rules and be terminated from treatment by staff who believe that they had no other choice. Patients are moved from the community into the hospital and from the hospital back into the community such that the hospital, the community, the patient, and the family all feel mistreated." (Stein et al., 1990)

In order to remedy this situation it is necessary not only to put innovative services and supports in place, but also to ensure that they provide accessible, continuous care. Replacing a fragmented patchwork of isolated programs requires strong mechanisms for service integration to create a unified community support system with clearly designated responsibility for all aspects of care. These mechanisms must have sufficient influence to bring the four solitudes, i.e. Community Mental Health Programs, Provincial Psychiatric Hospitals, general

hospitals and consumer and family initiatives together. They must overcome resistance to change, facilitate the shift of resources from inpatient treatment to community support and create a recovery-oriented system (Anthony, 1993).

An integrated mental health delivery system[2] holds many advantages over a proliferation of unconnected agencies (Lehman, 1989). Integrated systems provide greater continuity, comprehensiveness and flexibility. Service gaps and service duplications are more readily identified and addressed. This reduces unnecessary burdens on consumers and their families, reduces the risks of poor clinical decisions due to lack of adequate communication, reduces negative interactions among providers and increases coordination of interventions. Integration also more easily allows for improved efficiency in service delivery. New services may be substituted for more expensive programs. Improved communication may reduce costly omissions or duplication of services and incentives may be developed to enhance efficiency. Integration also permits better co-ordination of resources to improve the availability of trained personnel.

6.2 Timeliness of Integration and Accountability

There are many compelling reasons for giving priority to creating a more integrated and accountable mental health system now, at a time when the entire health care system is under great pressure and undergoing unprecedented change (Goering et al., 1996).

- Great strides have been made in the past decade with increasing consumer and family involvement in the planning and delivery of mental health services, but these new participants are rightly frustrated by endless planning discussions coupled with slow or non-existent implementation. Their valued collaboration and good will may be lost unless systems change can proceed in a more effective and responsive manner.

- Better integrated mental health systems offer a means to protect and defend our limited mental health budget envelopes. For example, hospital restructuring poses a real threat of drastically depleting the psychiatric resources located in general hospitals that are closed or merged, unless additional means of external control are put in place. While the last few years have seen closures and downsizing of provincial psychiatric hospitals across the country, provincial governments have not reliably fulfilled promises to provide transitional or bridge funding and redirect resulting savings back into community supports.

2 The term \'93integrated delivery system\'94 also has been used to describe a particular approach to organizing a continuum of care that includes capitation (Dickey and Cohen, 1993) and combines physical and mental health funding into one envelope and organizational structure. This is a different usage than employed in this discussion.

- Ø Many jurisdictions are considering proposals for radical changes in how long-term care and primary care are organized and how family physicians are paid. In order to interface with new models of community care, our secondary and tertiary mental health service must first be better coordinated.

6.3 Separate Management of Mental Health

The question of whether management of mental health care should be separated from the rest of health care is the subject of much debate. In New Brunswick, the Mental Health Commission was brought into the Department of Health and Community Services after a very successful five year tenure and regional mental health has become the responsibility of a regional health director rather than a regional mental health board (see Chapter 1, Situational Analysis). Manitoba is in the process of creating regional health authorities that have mental health as one of multiple health mandates. Ontario is moving to a decentralized model of health care management but a government-appointed Health Restructuring Commission has recommended creation of local mental health authorities in a number of jurisdictions. Evidence from New Brunswick, England and many parts of the United States supports the need for a staged process of implementing mental health reform, with the first crucial step being creation of a stronger mental health system (i.e., evidence based, integrated, accountable, efficient, focused on serious mental illness, consumer centred, compassionate). A second phase would establish mental health care delivery within the "integrated delivery systems" that would be likely to develop in the rest of health care. In the interim, mental health would monitor closely all activity related to reform of primary care, long-term care and other health areas, and identify linking strategies to enhance access, quality and continuity of care.

7. Best Practices that Achieve Integration and Accountability

7.1 Core Services and Supports

Among the core services and supports within a reformed system of care, case management and assertive community treatment (see Chapter 1, Literature Review, ANMH) have the most relevance to the creation of an integrated system of care. In these models of care delivery, accountability is clearly established at a local level, and continuity of care and access to comprehensive services are given priority. **Assertive community treatment** is the most comprehensive approach, combining in one team the elements of crisis intervention, treatment and individual support. It also has demonstrated economic effectiveness by reducing use of expensive inpatient hospitalization.

In response to criticisms about being too coercive and neglecting rehabilitation needs, the ACT model has undergone thoughtful analysis (Diamond, 1995) and has evolved, e.g., by adding supplemental vocational interventions (Chandler et al., 1996). Psychosocial rehabilitation and assertive community treatment should not be viewed as incompatible alternatives. Still, assertive community treatment is a relatively intensive intervention that is appropriate only for those who are at high risk and are unable to benefit from less costly services and supports. **Clinical case management** approaches can serve clients with less severe problems. With the move to supported housing, employment and education there is great potential to reduce the proliferation of separate agencies dealing with only one aspect of a consumer*s needs. They can be replaced with multi-faceted individual support programs which have the capacity to assist with living, learning and working needs.

7.2 System Level Strategies

The system strategies that are critical for integration and accountability are governance, funding and evaluation (see Chapters 9 and 10, Literature Review, ANMH).

Mental Health Authorities

Mental health authorities, which create single envelope funding and are responsible for administrative, clinical and fiscal aspects of care delivery for a designated geographic area, perform many of the functions needed in an integrated mental health system. They play a major role in defining the target population and implementing gatekeeping procedures. Accountability for system performance is decentralized to a level where there is greater knowledge about local conditions. Responsibility for ensuring delivery of comprehensive services and maximizing economic efficiency is given to the authority which can use multiple tools (including training, management information systems, etc.) to achieve its goals (Hoge et al., 1994).

The coordination roles of clinical case management approaches (at an individual level) and mental health authorities (at a systems level) can extend beyond the formal mental health sector. A number of best practice programs demonstrated the feasibility and benefit of partnerships with other service sectors such as housing, social services and private employers. The strategies and tools that would be used to create incentives and partnerships are somewhat different but are more likely to be implemented if authorities and case management programs provide a unified presence that can advocate for and create these opportunities.

Fiscal Strategies

A number of fiscal levers and incentives can be used to promote cost containment, transfer resources from institutional to community care, encourage the implementation of best practices, and increase accountability. Prospective payment[3], capitation[4] and performance contracts[5] all have the potential to contribute to more integrated care delivery if they are used appropriately (see Chapter 9, Literature Review). Few of these innovations were nominated as best practices in Canada but they were the focus of a recent policy workshop aimed at increasing knowledge of alternative fiscal strategies. Mental health economists from the UK (Martin Knapp) and the US (Richard Frank) were asked to discuss experiments in their respective countries. Workshop participants from across Canada discussed the applicability of these experiences to our context. (Clarke Institute of Psychiatry, 1997).

One of the lessons learned from system change in other countries has been the importance of **defining and protecting the budgets that are allocated for persons with severe mental illness.** For example, in England the establishment of various new forms of commissioning and funding have created a "leakage" of resources that were formerly available for the severely mentally ill population. There has been a gap between "priority rhetoric" and "priority reality". A study comparing the plans of local purchasers with their actual implementation showed that mental health was often a top priority in the plans, but got bumped to lower priorities in the allocation of money (Knapp, 1997). The government is now considering methods of separating and "ring fencing" mental health budgets

3 Prospective payment is a fiscal strategy that puts the client at the centre of the funding policy. The level of payment per client is predetermined based on illness characteristics and needs of the client and is independent of the actual cost of providing services. Prospective payment is aimed at cost containment and uses rewards and risk to encourage efficiency.

4 Capitation is a needs-based form of prospective payment wherein providers receive a preset fee per enrolled client in exchange for delivery of a defined range of services in a specified period of time. Because the fee remains fixed regardless of the client{\f2 \'2a}s level of use of services, the provider assumes risk and responsibility for costs exceeding the capitated amount.

5 Performance (incentive) contracts link funding to program and system performance. Payments are tied to aggregate measures of program performance to promote goals such as improved quality, contained costs, new service developments and increased care for previously neglected populations.

under new authorities that would have responsibility for health/mental health and social services (United Kingdom Green Paper, 1997).

In the US there are a number of situations where the separation of community and institutional care budgets has retarded the shift to community-based care and the implementation of best practice innovations. Dr. Frank summarized these issues with the statement "Fragmented financing results in distorted and fragmented care (Frank, 1997). Giving an authority control over a consolidated funding envelope begins to remedy this problem, in part by discouraging cost shifting and by localizing, within one body, the full consequences of decision making.

The introduction of **competition among provider agencies as a fiscal mechanism to improve quality and efficiency has had generally disappointing results** in the US and UK. Frank (1997) points out that few places seem able to meet the requirements for meaningful quality competition. The following were identified as necessary in order to best meet these requirements:

- information available to consumers so that they can make informed choices.
- a reliable way of determining which service is better than another.
- information that spans the various dimensions of quality.
- a feasible set (at least 3 or 4) of alternative providers who can also deliver the service, in order to have choice.

There also are potential problems when competition is set up using fixed budgets or capitation payments because enormous incentives are created to reduce access for the most severely ill people. Encouraging competition can also interfere with collaboration and information sharing among agencies that need to work together in order to achieve systems of care. The introduction of competition at a higher level, i.e. among those who are running regional systems of care, appears to have had more success when a particular set of conditions have been in place (Frank, 1997).

Incentive grants and contracts can be valuable means of changing systems. In the UK the Mental Health Challenge Fund and Mental Illness Specific Grant have been effective mechanisms to encourage health and social services to improve services (United Kingdom Green Paper, 1997). In Ohio, Local Mental Health Boards were paid bonuses for serving the seriously mentally ill and were made fiscally responsible for public mental health hospital use. These fiscal mechanisms had dramatic positive effects in a short period of time (Frank, 1997; also see Literature Review, Chapter 9, ANMH; Frank and Goldman, 1989).

When considering the adoption of similar approaches in Canada, it needs to be recognized that there are administrative costs associated with the establishment of incentives and contracts. While this is not an inherent disadvantage, the critical question is whether the increased administrative costs are balanced by greater quality and efficiency in the delivery of services and supports. The costs of monitoring contracts can be reduced when obligational rather than adversarial climates are developed. It is also essential that the effects of fiscal incentives be monitored. Several examples were given of unintended negative consequences that prompted revisions in how these fiscal mechanisms were used. Cautions were also raised by both mental health economists about

tying funding to program outcomes. This practice is hampered by the difficulties in defining and measuring mental health outcomes. Furthermore, it can create the same problems with selection bias as does competition.

Recommendation 2

Each region should develop strong mechanisms (e.g. assertive community treatment teams and a Mental Health Authority) for service integration with clearly designated responsibility for all aspects of care and sufficient influence to bring together the four solitudes, i.e. Community Mental Health Programs, provincial psychiatric hospitals, general hospitals and consumer and family initiatives.

Recommendation 3

The creation and protection of a separate, single funding envelope that combines various funding streams for the delivery of mental health care is an essential component of system reform. Greater use of incentive contracts and grants as levers for change is warranted.

Performance Indicators

As central government decentralises responsibilities to regional administrative bodies, there is a need to develop more explicit frameworks for accountability so that some measure of control can be exerted to build and maintain integrated systems of care across regions. This requires the development of performance indicators that spell out the form, quantity and quality of inputs, outputs and outcomes that are expected. Performance indicators are operationally defined, indirect measures of selected aspects of a system that give an indication of how well it conforms with its intended purpose (Glover and Kamis-Gould, 1996). A checklist of best practices is an important first step to developing a consensus about standards and criteria for measuring system performance. But it is not a report card, i.e. it does not spell out how to measure and compare functioning. The setting of explicit goals and indicators is a prerequisite for systems change and for evaluation, and should be tackled within each province or region.

A recent UK report by Huxley and Hughes (1997) provides valuable definitions and guidelines for such activity. They emphasize that the **selection of appropriate indicators and benchmarks is only one step of a process** that must include understanding existing procedures and creating links between benchmarking, continuous improvement and evaluation. As there are many problems associated with the definition of performance indicators for mental health, it is critical that the process of planning and implementation not be imposed from above, but instead be viewed as a dynamic and

iterative process that involves selection, monitoring and refinement of indicators. To build an integrated system of care, provinces should take a lead role in the development of accountability frameworks. The use of round tables which routinely solicit input from regions and major stakeholder groups may be a useful tool to address this task. Although responsibility for monitoring program performance may be delegated to regional bodies, a high degree of uniformity regarding expectations and indicators will be required. As discussed in Chapter 10, Literature Review (ANMH), good system wide evaluation also depends upon the existence of a valid, reliable information database that is client linked, rather than based upon episodes of care.

The desirable features of performance indicators for mental health defined by Glover and Kamis-Gould (1996) are listed in Table 2. Access, delivery and outcome indicators need to be defined for each level of mental health care (i.e. individual, program, region and population), and should reflect the thinking of multiple stakeholders, including consumers and families. Huxley and Hughes (1997) provide examples of the types of benchmarks that might be used for each of 12 cells in a Benchmarks Applied to Behavioural Health and Social Care (BABS) Matrix. Forth and Nasir (1996) compile examples of outcome indicators that have been used at each level of care[6]. The checklist of best practices (Tables 1A, 1B) provides a basis for defining the set of service delivery indicators. For example the ratio of intensive case managers per 100,000 population can be used as one indicator of the implementation of assertive community treatment. Comparisons with progressive jurisdictions can be used to establish benchmark levels.

Table 2: Desirable features of good performance indicators

6 Other valuable materials on performance domains and indicators include the Framework for Planning and Evaluation of Community-Based Health Services in Canada (Wanke, Saunders, Pong and Church, 1995) and Standards for Comprehensive Health Services (Canadian Council on Health Services Accreditation, 1996).

8.

Performance indicators in mental health should:

- Relate to an agreed goal
- Be clear, reliable and valid
- Derive from operational systems
- Express ratios not pure numbers
- Indicate a desired direction
- Compare like with like
- Measure universal features so that comparison is realistic
- State what difference in magnitude is relevant or significant
- Apply to all providers
- Enable comparison with published standards
- Cover the whole mental health service system
- Relate to both health and social care

(Glover and Kamis-Gould,1996)

It would be worthwhile to explore whether agreement could be reached across provinces and territories about some performance indicators and benchmarks. Could we agree that there should be targets for the balance of funding between institutional and community services[7], and also what those ratios should be? Can we achieve common ways of defining and assessing consumer and family involvement in governing services? Would the widespread utilization of a national system of accreditation for community programs be a means of assuring quality?[8] These are worthwhile objectives but should not supersede or interfere with individual provincial/territorial efforts to establish targets and benchmarks within an ongoing accountability framework.

Recommendation 4

The setting of explicit, operational goals and performance indicators within each province/territory is a prerequisite for systems change and for evaluation. The possibility of achieving a national consensus about selected issues should be explored.

7 Policy makers should take into account differences regarding what is included in the envelope.

8 Standards for Comprehensive Health Services (Canadian Council on Health Services Accreditation, 1996 draft)

Future Research and Knowledge Transfer

In this discussion document it has been argued that we have sufficient knowledge to direct mental health reform and identify strategies that will build integrated systems. Nonetheless, many questions still need to be addressed. To move ahead with the implementation of broad reaching reforms it is important to consider ways of continually learning about their impact and effectiveness.

8.1 Sources of Knowledge

There are many sources of knowledge that can be drawn upon to increase our knowledge about how to improve the lives of those with severe mental illness. The Framework for Support (Trainor et al., 1993) defines four components of a knowledge resource base for understanding mental illness, i.e. medical/clinical; social science; experiential; and customary/traditional. Experiential knowledge encompasses the direct experience of individuals who live with mental illness. If the scope of the concept is expanded to include drawing on the experiential knowledge of providers, the same sources can be used to understand approaches to providing services and supports.

In the literature review we focused on knowledge that is gained from medical and social science research. The situational analysis provided an opportunity to learn from the experiences that arise during actual applications in less controlled conditions. Future evaluation and research efforts will be enriched if they continue to incorporate the experiential knowledge of those who provide and receive the services and supports that are being studied. One way of accomplishing this aim is to conduct effectiveness studies using a combination of qualitative and quantitative methods (Goering and Streiner, 1996). Involving consumers in the design and conduct of evaluation studies further enriches the relevance and usefulness of the findings (Everett and Boydell, 1994).

8.2 Programs of Research

Services and Supports

There is still much to be learned about best practices concerning services and supports. As is clear from the literature review, our level of knowledge is very uneven from one area to the next. For those interventions where there is the strongest evidence concerning effectiveness (assertive community treatment, community placement of long-stay inpatients, supported employment) there is a pressing need for a more refined level of information about what works with whom. Research is needed which tests modifications of the models/ approaches to determine whether they work with special populations and how they might be applied in various settings or in more cost efficient ways. Methods of conducting this type of research are evolving and the next generation of studies will be expected to meet even higher standards. For services and supports where evidence

of effectiveness is weaker, there is a need for more creative approaches to assess effectiveness when traditional randomized controlled trials are not feasible or appropriate (Orwin and Goldman, 1996). Appendix A is a compilation of directions for future research extracted from the research reviewed in Phase I.

System Level Strategies

System strategies have only recently been subjected to empirical examination and evaluation. In addition to ongoing monitoring of systems reform for the purposes of accountability and improved service delivery (see Chapters 9 and 10, Literature Review, ANMH) there is a need for health services research that has as its purpose producing valid and generalized knowledge for the field. Mowbray (1992) discusses conditions for facilitating implementation of **programs of research** that would play a significant part in restructuring public mental health systems. These include a clear articulation of the objectives of the reform strategy and the means that are expected to produce change. Utilisation of evaluation is also dependent upon having knowledgeable and motivated decision-makers who will incorporate the findings from such research into policy and practice. This means that evaluations should be structured to address the pressing concerns of those in governmental and administrative positions. Access, quality of care, cost and the potential adverse consequences of broad-based system reform (criminalization of the untreated mentally ill, homelessness, etc.) are examples of such concerns.

Challenges in Mental Health Systems Research

There are a number of challenges facing the emerging field of mental health services research (Mechanic, 1996). They include adjudicating between competing priorities, identifying the key elements in successful interventions, and defining outcomes more broadly to reflect consumer and family preferences and quality of life. Attempts to demonstrate that integrated organizational systems result in better client and family outcomes so far had have limited success. It may be that the links between selected aspects of care delivery and particular outcomes will have to be established in more focused studies. For example, if continuity of care is shown to be a process variable which strongly predicts quality of life in controlled trials of various community services, then it makes sense to use continuity of care, which has potential to be collected from an administrative data base, as a proxy for outcome when studying systems reform. It can also be argued that studies of system impact are in their infancy and that understanding the link between structural change and individual consumer outcome requires better methods of system measurement. It may be that the appropriate questions have not yet been asked. A NIMH funded study of the effects of major system changes in Ohio found few direct relationships between service variables and client outcome (Roth et al., 1996). The predictors of outcome that showed the most promise were questions that were introduced by consumer groups: whether consumers think services meet their needs, whether they feel like a genuine part of the process and whether they feel they have enough contact when they need it.

There are a number of pressing research questions concerning systems reform and a paucity of Canadian studies which address them. The following illustrate just some of the possibilities:

- What do consumers define as the most important things they need to live successfully in community settings? What needs can be met through the service system? What needs require other kinds of approaches and what are they?
- What impact does regionalisation of services have upon quality and access?
- Do separate (i.e. restricted to serious mentally ill) capitation funding mechanisms facilitate the transfer of patients from provincial hospitals to local communities?
- What are the predictors of service needs (according to providers and users) that could be incorporated into prospective payment methods for inpatient and outpatient care?
- What is the relationship of population health indicators to the need for, and utilisation of psychiatric services?
- How do fiscal incentives compare with non-fiscal strategies for changing practice patterns and improving the quality of care?
- What is the impact of involving new constituencies (family, consumer) in the planning and governance of service delivery?
- What are the most cost-effective methods for training/re-skilling professional staff for community work?

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Recommendation 5

Further research on the effectiveness of services and supports and the impact of system change needs to be mandated and funded.

8.3 Exchange of Research and Experiential Knowledge.

Research Summaries

Projects such as this can play a crucial role in the **transfer of knowledge from the research literature to the field**, a critical step in the utilisation process. There are serious limitations to the use of publications in scientific journals and presentations at scientific meeting as a means of influencing policy and practice (Backer, Liberman and Kuehnel, 1986). They are read by small audiences and are usually oriented to other researchers rather than to practitioners or policy makers. Summaries which collate and appraise this literature and translate it into implications for policy and programs are more likely to facilitate use. There is also real value to descriptions of applications which demonstrate feasibility. A study of mental health decision-makers* reactions to research reports (Weiss and Bucuvalas; 1980) concluded that they apply both a **truth** test and a **utility** test. Truth is judged by research quality and conformity to prior knowledge. Utility is judged by feasibility and the degree of challenge to current policy. These two criteria and the relevance of the topic determine the assessment of usefulness.

There are a number of similar Health Canada funded projects related to mental health that have particular relevance to system reform. Reports that summarize the state of our knowledge about such common disorders as depression (CMHA, 1995b) and anxiety (Health Canada, 1996a; 1996b) provide a valuable educational resource for the general public and for practitioners who want to keep up-to-date about clinical interventions. Theory and practice concerning the evaluation of schizophrenia programs are described in two reports prepared by Goering for Health Canada (1994;1996c) that include program applications. Descriptions of innovative court diversion programs in place across Canada provide useful examples and contacts for those who are struggling to meet similar needs (Health Canada, 1995a). A recent Health Canada funded report published by CMHA (Ristock and Grieger, 1996), addresses “the challenge of forging a network of health/mental health professionals, social service providers, educators, survivors of family violence, consumer groups, and policy makers” to respond to the particular needs of survivors of violence. Reports that discuss directions for reform of other health sectors such as primary care and long term care provide important information about the changing health care environment and broad context in which mental health reform is situated (Advisory Committee on Health Services, 1996; Health Canada, 1995b).

As was discussed in the introduction to the Literature Review (ANMH), there were **many significant topics** that could not be adequately dealt with in this review, but are deserving of similar attention.

- Ø The interface between psychiatry and primary care is a growing policy concern that was only touched upon in this project.
- Ø The unique mental health needs of special populations, e.g. children, elderly, ethno racial, homeless, etc., as well as those with less severe and chronic problems, and promising approaches to providing them with service are other examples.
- Ø Interministerial and cross sector initiatives could be documented and appraised.

- Ø The delivery of mental health services in geographically remote communities is a common issue and there is a wealth of Canadian experience that has not been summarized or shared.
- Ø Implications of the health determinants model for mental health promotion and prevention requires further exploration.

Meeting and Forums

In addition to the publication and distribution of reports, there is real value in convening groups of people with common interests for discussion and problem-solving. Such **forums not only disseminate scientific knowledge, they also encourage the sharing of experiential knowledge** that may never be published but can enrich understanding and expand our range of options. It is important that policy makers across Canada have the opportunity to learn about recent research that is relevant to their concerns as in the recent fiscal policy workshop sponsored by the Mental Health Policy Research Group in Toronto. It is also valuable for research methods themselves to be the focus of deliberation, as occurred in a national workshop that followed preparation of a Health Canada report on quality of life measurement among persons with chronic illness (Health Canada, 1996d). Such activities are a valuable complement to other means of exchanging information and learning.

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Recommendation 6

The exchange of research and experiential knowledge should be facilitated through commissioning research summaries and convening meetings focused on the topics identified.

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APPENDIX A

Summary of Research and Evaluation Directions from the Literature Review (ANMH)

Evaluation must be carried out at all levels of the mental health system: system wide, program and individual. Methodologies required for systems evaluation will differ from those used at program and individual levels. The following section briefly outlines the key principles, derived from the Phase I Literature Review, which should be observed in all future research and evaluation of mental health programs and services/supports.

- The importance of conducting evaluations using methodologies appropriate to the program/service studied was emphasized by various investigators.

- Wherever possible, the use of experimental or quasi-experimental designs with control or comparison groups is optimal. However, the use of participatory research (involving "subjects" in the design, conduct and utilization of research plus the scientist*s involvement in action to improve group or program functioning [Chesler, 1991]) and qualitative designs in the study of self-help groups and consumer/family initiatives is recommended by most researchers in these areas.

- In all evaluation endeavours it is necessary to clearly define and describe the nature of the experimental intervention, including all program elements, to make it easier to relate specific elements of the intervention to outcome and to increase the generalizability of the findings.

- Similarly in relation to outcome, researchers must provide a clear description of the outcomes to be studied, and to use standardized, reliable instruments. The review of the research highlighted the difficulty in achieving experimental effects in the measurement of symptoms and functional outcomes which was ascribed to problems of measurement; the increased sophistication of community programs which reduces differences between experimental and control conditions; and the severity of the illness in patients being studied and limited gains which can be expected during relatively short study periods and typically short follow-up. Longer follow-up of at least two years is recommended.

- In order to determine the cost effectiveness of the program/service it is strongly recommended that cost data be included in all research. Cost effectiveness data must take into consideration the perspectives of clients/patients, family, society and health systems.

- Just as consumers and families must be involved in planning and delivering services/supports, so must they be meaningfully involved in the design and delivery of the evaluations of those programs/services.

Recommendations for future evaluations of specific core services/supports

Case Management

Case management programs and assertive community treatment (ACT) have far more research evidence than any of the other core mental health services/supports reviewed in Phase I. In particular the ACT model has demonstrated its effectiveness and acceptability to clients and families in multiple trials. However, there are still some areas which need further study. Research still needs to be conducted to determine which elements of ACT model programs are related to outcome. This is particularly important since new programs cannot always implement the model programs faithfully due to local or other circumstances. Research needs to be conducted to determine optimal length of intensive ACT service provision and methods of transitioning clients into less intensive community care programs. As mentioned above, all research requires longer term follow-up in order to gain maximal results.

Crisis Response

Research in this area is very sparse. Although the various components of a crisis response system are widely accepted and implemented, no systematic evaluations have been carried out.

Housing/Community Support

The literature contains numerous articles examining aspects of the experiences and outcomes of residents in specific settings or models, but the design and methods of the research remains weak, limiting our ability to draw inferences from the results. Although the supported housing model is gaining wide acceptance as the preferred model, there is sparse research evidence regarding effectiveness to support this choice. Carling (1990) proposed a step-by-step approach for evaluating supported housing:

- Ø define the purpose of each evaluation
- Ø operationalize the concepts involved and the program characteristics
- Ø formulate questions that are relevant to the key constructs in supported housing (i.e., choice, types of living arrangements, and services and supports)
- Ø look beyond traditional mental health outcomes (i.e., to quality of life, physical and material well-being, personal relationships, social, community and recreational activities, and personal development/fulfilment)
- Ø systematically examine the characteristics of programs and residents, and the impact of programs on residents and families and
- Ø study the process of implementing/adapting programs.

Inpatient/Outpatient Care

The British experiences with evaluating deinstitutionalisation provide ample support for the benefits of subjecting all similar endeavours to careful research, and of examining a broad range of client and systems-level outcome indicators in such investigations. Evaluations of new community-based psychiatric services often report that they are more cost effective than hospital care but seldom examine whether such options are more or less effective for specific types of individuals. Researchers are urged to include data and analytic methods which can generate predictive data to guide future policy and program development.

In addition, since much of the care of less severe mental disorders is carried out by primary health care providers, this area deserves more attention by researchers, program developers and policy makers. The promising results of evaluative work *(*eg., Ferguson et al., 1992 Kates et al., submitted) highlight the importance of developing and assessing new service delivery models which feature cooperation between mental health practitioners and primary care settings.

Consumer and Family Initiatives

Until recently there has been little systematic evaluation of the effect of self-help groups. Research on self-help approaches for individuals with mental illness and their families lags behind advocacy for and even operation of such programs. Early research is mostly descriptive, for example, presenting and typing various self-help approaches, describing members of self-help groups , or how mental health professionals feel about or interact with mutual support groups for psychiatric patients. A small but growing body of studies are evaluating the experiences and outcomes of individuals who participate in self help and consumer/family initiatives and these efforts should be supported and expanded. As discussed briefly above, participatory research and qualitative methods are appropriate for use in evaluating these types of programs/supports.

Employment

A number of well-designed studies have demonstrated the benefits of supported employment (SE) programs for individuals with serious mental illness (SMI). Researchers in this field have suggested further areas which require more investigation.

The issue of how long to provide employment support and the best types of support have not been adequately studied. Studies have shown that clients who receive long-term and continuous support keep their jobs longer than those receiving intermittent or short term support.

- Ø Attention needs to be paid to the process of accessing SE services. Traditionally professionals have decided when clients are ready for vocational rehabilitation. This goes against current thinking which says that consumers have the right to decide which services they need and research findings which suggest that if clients are given adequate information about programs and services they will be able to make appropriate choices.

- Ø Once access is assured, researchers should investigate the characteristics which lead to retention in the SE program. The support of a multidisciplinary case management team has been shown to increase retention. Bond and colleagues (1997) speculate that this occurs because services are time unlimited, readily available, include assertive outreach and are sensitive to fluctuations in the client*s clinical condition. Closely related to this is the issue of duration of employment. The few studies which have looked beyond a two year follow-up suggest that longer periods of support will lead to higher employment rates. Job stability and satisfaction with the job are related areas which have not been carefully examined.

- Ø Another little studied process is that of job development. Programs which require the client to take responsibility for finding a job do not appear to be satisfactory for most individuals with SMI. Staff roles and responsibilities in helping clients to find jobs and in the interview process need to be clarified. The issues of disclosure, contact between staff and employers and employers* obligations to make accommodations for SMI employees also require thoughtful study.